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Communication for Development

Case Study Compendium

15 State Case Studies
2013 - 2017



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Communication for Development

Case Study Compendium 2013 - 2017

Acknowledgement

This compendium of social and behaviour change communication case studies from 15 States has been developed for Communication for Development (C4D) cross-sectoral program of UNICEF India. We begin by acknowledging the C4D India Chief Siddharth Shrestha for his vision and direction in finalising the compendium. Our sincere thanks to the true leaders in State C4D Specialists - Mr. Abhishek Singh, Mr. Bhai Shelly, Ms. Harsha Mehta Pankaj, Ms. Lopamudra Tripathy, Ms. Manjaree Pant, Ms. Mona Sinha, Mr. Nasir Ateeq, Mr. Nilesh Nikade, Mr. Sadique Ahmad, Mr. Sanjay Singh, Ms. Seema Kumar, Ms. Sonali Mukherjee, Ms. Soniya Menon, Ms. Sukhpal Kaur Marwa, and Ms. Veena Kumari - whose critical insights and persistent support enabled us to develop these case studies. We would also like to extend our sincere thanks to the reference network team of UNICEF, comprising - Ms. Arupa Shukla, Ms. Geeta Sharma, Ms. Rachana Sharma, Ms. Rania Elessawi, Mr. Sanjay Singh, Ms. Seema Kumar, Ms. Soniya Menon and Ms. Veena Kumari - whose valuable and objective critique through three writing workshops helped us raise the quality of these case studies. Our thanks also to Ms. Alka Malhotra and Ms. Shalini Prasad for strategic advice and input on relevant case studies.

On behalf of UNICEF, we would like to thank all the State government officials for supporting and helping to take C4D's vision to fruition. We would certainly be remiss to not mention and sincerely thank the partner organisations and field teams of all States who helped us in understanding and capturing the soul of these case studies.

Lastly and most importantly, heartfelt thanks and gratitude to our stakeholders - mothers, fathers, caregivers, adolescents, and children, who trusted us with their stories and helped us bring them to life.

Gratitude to all for this rewarding, insightful journey in the world of social and behaviour change communication.

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Summary Note: Social and Behaviour Change Communication (SBCC) Case Studies Compendium

This compendium of 15 SBCC cases presents results and learning from the Communication for Development (C4D) cross-sectoral interventions from 15 states of India – all implemented during the country programme 2013- 2017. Additionally, a national level C4D Results Report 'Resonating Change' has also been compiled. The case studies at the state level were selected based on the following criteria:

1. Level of maturity - High/Medium/Low
2. Level of Research - Well Researched/Moderately Researched/Not Well Researched
3. Geographical Spread of Implementation - High/Medium/Low

A CMS team then interacted with respective UNICEF state teams to understand the on-ground situation, stakeholders, SBCC initiatives implemented, and subsequent results. The team ensured a visit and interaction with community stakeholders, government officials and other partner agencies – accounting for 2-3 days for each field visit. All of this was completed between May 2017 and December 2017.

The SMART framework adopted to document the cases, considered each intervention through the following lenses:

- Situation – Problem situation that the initiative intended to address
- Method – Activities initiated to address the situation
- Action – Implementation of aforementioned activities
- Results – Outcomes of each initiative
- Transformative Change – Larger level impacts and changes

This was a joint effort of C4D UNICEF and CMS. The C4D team invested significantly in reviewing, inputting, and writing the content and shaping the design of each document. Each case was reviewed by the respective state C4D Specialist and then reviewed by the UNICEF Reference Group, which was specifically constituted for the purpose. Pink Lemonade was the design partner for this assignment.

The states and the initiatives documented are:

1. Gujarat - *Udaan*: An Intervention for Prevention of Child Marriage
2. Odisha - *Sishu O Matru Suraksha*: A Social and Behaviour Change Intervention for Child and Maternal Health
3. Assam - Home Based Newborn Care Voucher System
4. Uttar Pradesh - *Suramya*: Communication to Eliminate Open Defecation
5. West Bengal - District SBCC cells: System Strengthening Through Social and Behaviour Change Communication in Development Programmes
6. Telengana - Nudging the Norms through Faith Based Organization for Promotion and Protection of Child Rights
7. Bihar - *PYARHI*: Breaking the Taboo and Culture of Silence
8. Tamil Nadu - Behaviour Change Communication through mobile technology Promoting IYCF practices among caregivers
9. Madhya Pradesh - *Mamta Abhiyaan: Sneha, Suraksha, Samman*
10. Karnataka - Supportive Supervision to improve demand for RMNCH+A services
11. Jharkhand - *MAHIMA*: Breaking the Taboo Around Menstruation
12. Chhattisgarh - *Ek Kilkari*: System Strengthening for Routine Immunisation
13. Andhra Pradesh - Improving the Lives of Adolescents in Visakhapatnam district
14. Rajasthan - Empowering Communities and Adolescents for Collective Ownership of 'Child Marriage Free Gram Panchayats' in Rajasthan
15. Maharashtra - Intervention for Improving Routine Immunization in Underserved Municipal Corporations of Bhiwandi and Malegaon

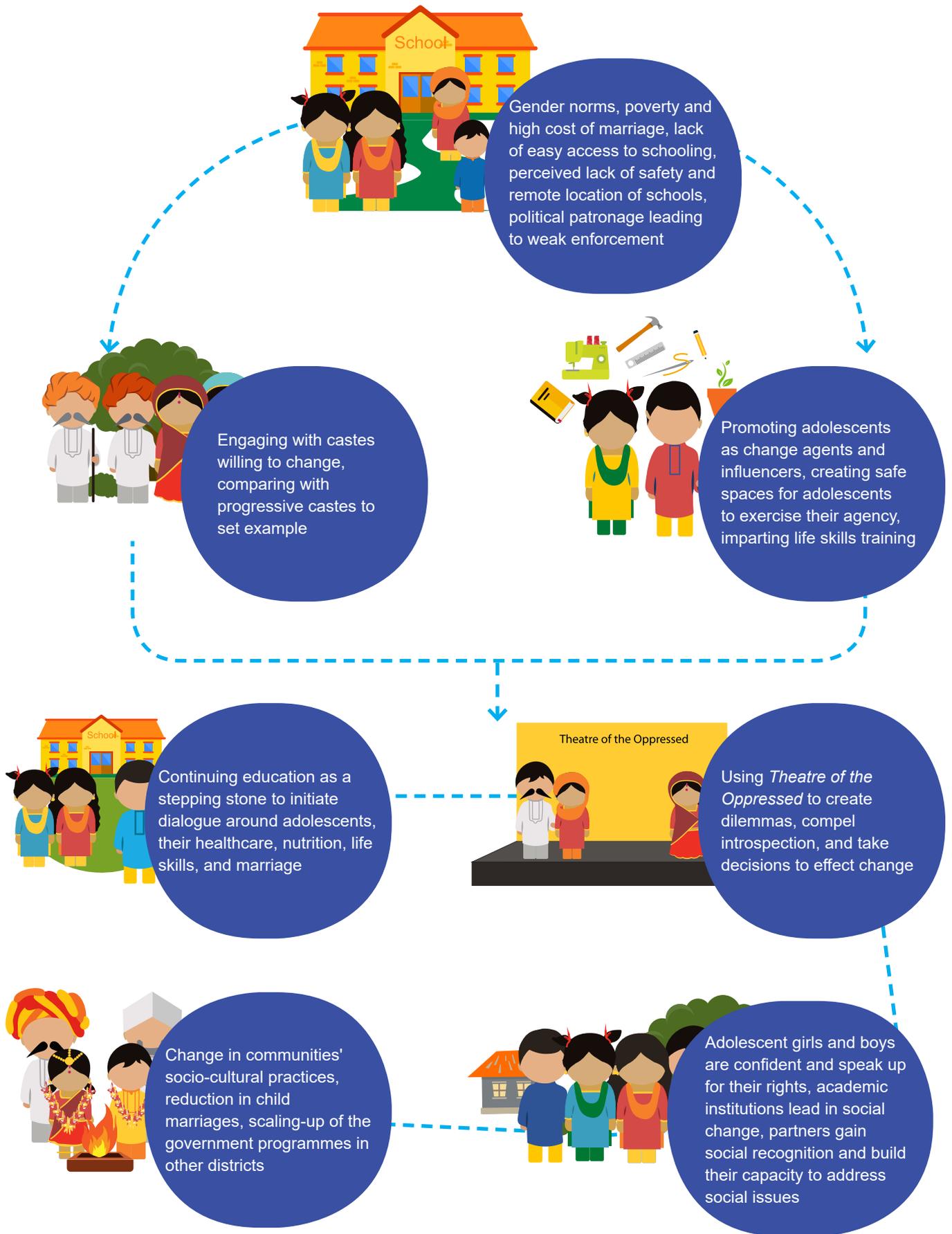
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Udaan

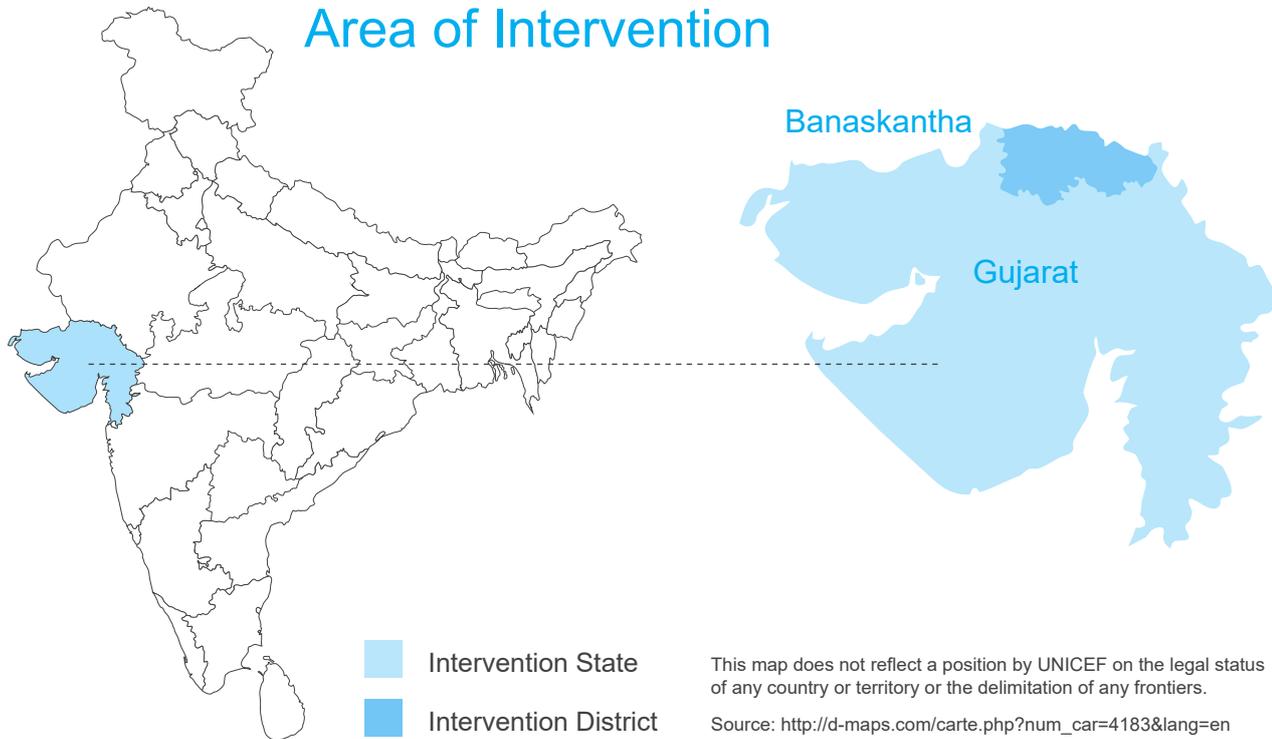
An Intervention for
Prevention of Child
Marriage in **Gujarat**

Udaan is designed to find a community-led solution to the high prevalence of child marriage in Gujarat. The purpose is to initiate a community dialogue that helps reflect and initiate change that affects the prevailing social norms around child marriage. UNICEF^[1], in partnership with the Gujarat State Child Protection Society under the Social Justice and Empowerment Department, Department of Education, Government of Gujarat, and Anarde Foundation (NGO partner), carried out a pilot in 120 administrative blocks of Banaskantha district, Gujarat. The intervention was initiated with a village mapping exercise to identify barriers. Education of adolescents was chosen as the introductory intervention to pave the way for more intensive dialogue around the prevention of child marriage. The intervention resulted in communities engaging in positive dialogue, skill, and confidence building in adolescents. It also led to successful partnerships with Gujarat University, leveraging of government resources for *SABLA*^[2], and the strengthening of government and implementing partner systems in the areas of adolescents' education, life skill building, and child protection.

Theory of Change



Area of Intervention



Situation

Worldwide, more than 700 million women alive today were married before the age of 18. India alone accounts for one-third of this global total^[3], although only accounting for 18 percent^[4] of the world population. India has had a law preventing child marriage since 1929, but implementation has proved to be a challenge. In turn, child marriage has adverse implications on health and several other aspects of life; with high infant, child, and maternal mortality rates being partly attributed to child marriage.

Instance of child marriage in Gujarat:

In Banaskantha, 56 percent of married women (aged 20-24) were married before the age of 18. This, in contrast to the Indian average of 43 percent and the Gujarat average of 35 percent^[5], makes Banaskantha the district with the highest child marriage prevalence in the state^[6].

Drivers for prevalence of child marriage^[7]

Lack of easy access to schooling (mainly due to distance), especially at the secondary level, leads communities to encourage families to marry girls early – so the onus of protecting her and her chastity, which is equated to family honour, is transferred to the bridegroom's household. The safety and chastity of girls is a major concern for parents.

Gender norms mean girls and women have an inferior position in society. Fear of losing family honour in case of a premarital sexual relationship, and child marriage as the means to save the family from any possible dishonour is grounded in prevalent gender norms around virginity. Even the seemingly poverty-driven act of marrying off girls in lieu of debt has its roots in gender norms that privilege men in every aspect and deny any voice to girls.

Poverty, high wedding costs, and other economic considerations sometimes drive families to marry their children early. Practices such as sibling and cross marriages, or *Atta Satta* – the simultaneous marriage of one set of brother and sister to another set of brother and sister from the same village, tribe, or clan – are a result of this.

Political patronage weakens enforcement agencies. Communities with formal groups like caste *panchayats*^[8] form a key voting block, and often have political connections. Enforcement agencies and Frontline Workers (FLWs) find it difficult to go against their accepted rules and norms.

Due to the above reasons, child marriage is widely practised. Socially approved sanctions for child marriage are key contributors to the trend.



Discussions at the Anarde outreach programme.

Method

Acknowledging child marriage and the many challenges it poses, UNICEF, in partnership with Gujarat State Child Protection Society (SCPS)^[9], Department of Education, and Government of Gujarat initiated the *Udaan* Programme with a pilot in Banaskantha district. Within UNICEF, three internal departments – Education, Child Protection, and Communication for Development – converged for this intervention. The objective of the *Udaan* intervention is to bring together caste *panchayat* leaders, who influence the decisions of adolescent girls and their family members, and initiate a dialogue on the consequences of underage marriage. This is done to promote a new social practice that, in due course, could have the potential to change the prevailing social norms around child marriage.

To take this intervention to the field, UNICEF selected Anarde Foundation, a local NGO, as the implementing

partner. Anarde has had a long presence in Banaskantha with experience in water conservation, child rights, sanitation, and hygiene behaviour related interventions. Other initiatives towards the formation of women's Self Help Groups (SHGs) in the district also helped them engage closely with communities.

Udaan started with a caste-mapping exercise across 120 villages in Danta and Kankrej blocks of Banaskantha district. This activity involved village-level mapping of various castes and communities inhabiting the village, status of adolescents, and other key issues for the community. Village-level mapping helped to decipher the community's perceptions on education of girls, and age of marriage. It also aided the understanding of social and gender norms, and how these dictate their behaviour, caste structures, and the role of caste *panchayat* leaders.

Mapping of 19 castes was done over a period of two years and categorised into three groups:

Castes that are rigid and resistant to change^[10]

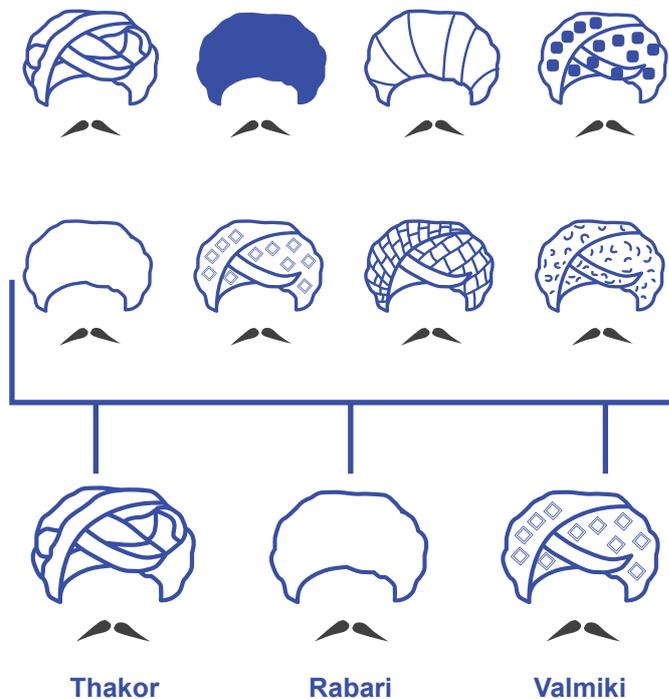
Middle-order castes with a strong presence in the community, but willing to change

Progressive castes, where change has already started

Given that this was the pilot phase and UNICEF had little experience in engaging with the community on the sensitive subject of child marriage, a conscious decision was taken to work with the middle-order caste *panchayats*. The reasons being that these castes have:

- Significant, widespread presence in terms of geography and membership
- Organised cast structures
- Strong norms, but not staunch or rigid beliefs
- High prevalence of child marriage

Out of the eight middle-order castes identified, the *Thakor, Rabari, and Valmiki* communities were picked to kickstart the intervention. These progressive castes were the three most populous communities in the intervention



area, with the village mapping exercise highlighting a high prevalence of child marriage. They were considered to be positive influencers for the middle-order castes, as elaborated later in the document.

Parallel to the village-mapping exercise, the intervention also initiated the formation of organised groups of adolescent girls and boys in 120 villages, with the aim to provide adolescents with a platform to participate and express their opinions on issues concerning them.



Hasumati Sarvarkar is a cluster resource person with Anarde Foundation.

Action

Three key components here were:

1. Intensive engagement with the priority castes:

Focus group discussions, one with each of the three caste *panchayats*, were conducted. These discussions aimed to enable the communities to identify the issues being faced by their adolescents and youth, posing hurdles in their development. To help them in this reflection, UNICEF also brought in members from *Prajapati* (more progressive) communities to illustrate how reforming and revising social norms has helped their communities progress. The key challenges identified were education, substance abuse, unemployment, and regressive social practices like child marriage. The initial interactions focused on establishing inter-linkages with various government schemes, to help facilitate education and employment. This included the *Saraswati Sadhna Yojana*^[11] that provides bicycles to girl students, and the *SABLA*^[12] scheme that supports nutrition, healthcare, and life-skills education for adolescent girls.

2. Empowering adolescents to act as influencers:

Using the existing adolescent groups as a platform, UNICEF supported the *SABLA* Life Skills programme of the government. UNICEF aimed to strengthen the *SABLA* components with specific reference to life skills. Through this, the government and UNICEF sought to:

- Empower adolescent girls and boys
- Create an enabling environment at the community level by sensitising parents and community functionaries
- Strengthen government service delivery and child protection mechanisms at various levels
- Create safe spaces to ask questions and express concerns



Tejalben Dushuruthbh got a cycle under the *Saraswati Sadhna Yojana*, prompting her parents to continue her education.



Aashaben is a volunteer with Anarde, under the *Udaan* project.

This programme component follows UNICEF's framework of rights, means, and activities for adolescent empowerment. The child helpline number, 1098, was popularised to help register anonymous complaints related to the abuse of their rights. A suggestion box was introduced where adolescent girls and boys could drop their complaints and queries, which would later be shared with the Village Child Protection Committee (VCPC)^[13] for resolution.

3. Communication around child marriage:

After having initiated work on education and life skills, the next step was to bring together the caste *panchayats*, senior leaders, women, and adolescents together and trigger communication around child marriage. A tool was needed that would strategically unfold self-realisation and open conversations around the sensitive topic of child marriage. *Theatre of the Oppressed*^[14] (TOO) was introduced as the communication tool, and UNICEF conducted a five-day capacity building workshop to train team members of [Anarde Foundation](#), [Gujarat State Child Protection Society](#), and [District Child Protection Unit \(DCPU\)](#).

The issue-based performances were typically 15 minutes long. Actors from within the adolescent group would build up a scene – such as the imminent marriage of an adolescent girl – and then stop at a critical point in the story. They would then invite audience participation and questions, followed by a discussion on the right thing to do and how to do it. The scale-up programme plans to include mothers and fathers of adolescents as key influencers, along with caste or *panchayat*^[15] leaders in the child marriage prevention initiative, and make them change bearers of the process.

Partnership for Change

UNICEF partnered with Gujarat University to involve young college students in awareness campaigns around education and child marriage. This was carried out in March 2017, in collaboration with the Child Protection and Education department in Banaskantha district in 300 villages – with the involvement of 450 students from nine colleges in the district. It is a key example of how resources can be mobilised and partnerships can be built with universities to generate momentum for the initiative.



Alkhaji Hajurji Thakor is the caste leader of the *Thakor* community.

Results

The capacity- building investment in adolescents has resulted in them becoming more confident and speaking up for their rights^[16]. Caste leaders from *Thakor Sama*^[17] acknowledged this change and felt that their children could share their newly learnt knowledge with other children. As a community, they felt that they have now become more cohesive and have started to reflect on the factors that deter their communities' progress. They now work together to identify the ways and means to overcome them.

The intervention also showcased a successful partnership with universities, to leverage resources for social causes.

Rameshbhai, the founder of Anarde Foundation, reported that:

- There is an improved confidence in Anarde's staff and delivery of their role because of this intervention
- The intervention has improved the social capital in the district for Anarde and opened the social space for them to work and contribute to their society

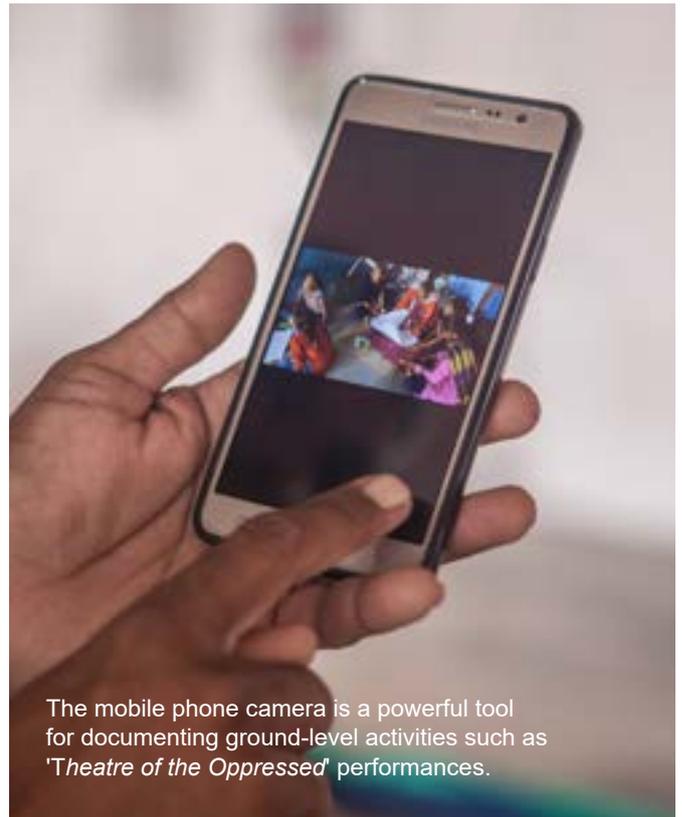
Dr Swarup Rawat, District Child Protection Officer, Banaskantha, stated that the department received 95 complaints of child marriage immediately after a 10-day awareness campaign conducted in March 2017. According to him, the communities now recognise the child protection unit and look up to it for help and support on issues related to child rights, child abuse, exploitation, and violence against children. Additionally, the state government also recognises the key contribution of UNICEF's Life Skills component and has decided to replicate this in other districts where *Kishori Shakti Yojana*^[18] (KSY) is being implemented. Further, as part of *SABLA*, \$248,000 (INR 1,61,27,787) in government funds were leveraged in the programme implementation plan to enhance social and behaviour change and the life skills component in the nine *SABLA* districts.

This intervention has also seen a sectoral convergence for UNICEF, where it has been able to bring together the Education and Social Justice departments to work towards one cause.

Transformative Change

UNICEF's intervention has caused the communities to reflect and initiate the process of revising opinions on mass marriage, more specifically on child marriage. The *Thakor* community has revised its community rule-book to include a bylaw that prohibits child marriage amongst their caste members. This signals a significant movement forward that would help achieve the long-term objective of prevention of child marriage.

The results from this intervention have been acknowledged by the state and district-level child protection departments. In Banaskantha district, the Child Protection Department has already initiated the process to form a [Village Child Protection Committee \(VCPC\) in all its 1,255 villages](#)^[19]. This transformation maps back to C4D's output indicator which aims to strengthen the state government to implement, monitor, and evaluate the programmes with social and behaviour change at its core. Taking the learning from the *Udaan* pilot in Danta and Kankrej, UNICEF, along with the support of DSJE, is now scaling the project to other blocks and eventually other districts.



The mobile phone camera is a powerful tool for documenting ground-level activities such as *'Theatre of the Oppressed'* performances.



Caselet

The first time Chetna Viraji Thakor's parents considered getting her married was in 2014. She was just 13 years old then. Studying further meant travelling around 6km to the nearest school in Tundia. Chetna's parents did not think it would be safe for her to travel to the school alone and on foot.

Kanubhai Prajapathi, the cluster resource person for Anarde Foundation in Danta block of Banaskantha, counselled Chetna's parents. He helped get a cycle for Chetna under the government's *Saraswati Sadhana Yojana*, resulting in the prospect of her marriage being averted for the next two years.

The second time Chetna's parents considered her marriage, she was 15 years old. She had, by then, joined her village adolescent girls' group. Thanks to the training by UNICEF and Anarde Foundation, she was more aware of the problems associated with early marriage. She called upon the group for help, and all 14 girls from the group came over to her house to talk her parents out of the idea of marriage. Chetna is now 17, and working towards a career in computers; happily unmarried.

In Summary

In 2013, UNICEF launched its *Udaan* pilot initiative for prevention of child marriage in partnership with Gujarat State Child Protection Society, Department of Education, Government of Gujarat, and Anarde Foundation. Here is a roadmap of the initiative rolled out in 120 villages across the Banaskantha district.

Action



A network of cluster resource persons and village volunteers is developed to conduct on-ground interventions.



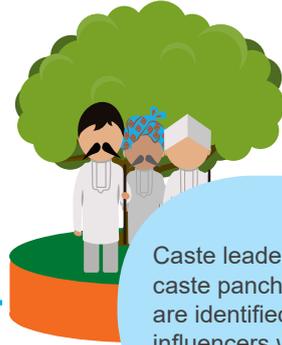
After mapping 19 castes in Banaskantha, three – *Thakor*, *Valmiki*, and *Rabari* – are selected for the intervention.



Communication with communities and adolescents on a common platform to help them reflect on challenges faced by them is initiated.



Groups for adolescent girls and boys are formed for life skill training. Gender sensitisation workshops are conducted for the groups as well.



Caste leaders of caste panchayats are identified as key influencers within the community.



Theatre of the Oppressed is organised across villages of these three communities.



Adolescent girls and boys are more confident and are able to speak up in public forums.



There is increased awareness about child protection within societies in the targeted districts.

Results



Communities now reflect on practices such as child marriage, and their harmful effects on children and their community.



Successful demonstration of partnerships with universities have leveraged resources for social causes.

Transformative Change

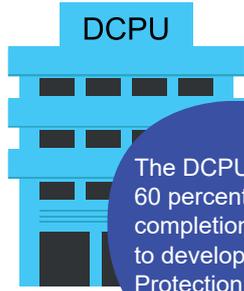


Communities are in the process of revising norms on mass marriage and more specifically, child marriage.



Government departments have been strengthened to implement and monitor such crucial and sensitive interventions.

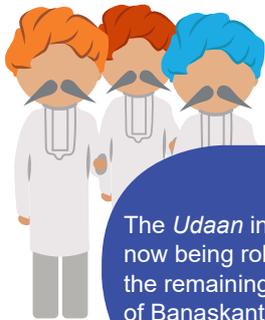
Current Scenario



The DCPU has achieved 60 percent (1,255) completion of the task to develop Village Child Protection Committees.



Mothers of adolescents have been made key influencers in decisions regarding early marriage.



The *Udaan* initiative is now being rolled out in the remaining blocks of Banaskantha.



Upscaling includes plans to involve fathers of adolescents into the conversation as well.

References

- [1] Within UNICEF C4D, 3 thematic teams are working together for this intervention; education, child protection, and communication for development
- [2] *SABLA* is Rajiv Gandhi Scheme for Empowerment of Adolescent Girls. It is an integrated package of services and includes nutrition provision, IFA tablet provision, health check-up and referral services, nutrition and health education, counseling and guidance on family welfare, life skill education, and vocational training for girls aged 16 and above.
- [3] United Nations Children's Fund, *Ending Child Marriage: Progress and Prospects*, UNICEF, New York, 2014
- [4] <http://www.worldometers.info/world-population/india-population/>
- [5] District Level Household Survey-3 (2007-2008)
- [6] According to the National Family Health Survey-4 (2015-2016)
- [7] United Nations Children's Fund, *Reducing Child Marriage in India: A model to scale up results*, UNICEF, New Delhi, 2015
- [8] Caste *panchayats* are caste-specific juries of elders of a particular caste for a village or a higher level in India.
- [9] SCPS is formed under the Social Justice and Empowerment Department (SJED)
- [10] UNICEF has decided that it will work with all the rigid caste members as well in the future after having built its experience from the pilot in Banaskantha
- [11] SSY can be availed by any Indian girl belonging to scheduled caste, scheduled tribe, or other backward caste communities.
- [12] *SABLA* is Rajiv Gandhi Scheme for Empowerment of Adolescent Girls. It is an integrated package of services and includes nutrition provision, IFA tablet provision, health check-up, and referral services, nutrition and health education, counseling and guidance on family welfare, life skill education, and vocational training for girls aged 16 and above.
- [13] VCPC is formed as part of the Integrated Child Protection Scheme of Department of Women and Child Development and Social Welfare. The objective is to have committees that can address child rights and protection related issues at the village level itself.
- [14] '*Theatre of the Oppressed*' (TOO) is a communication tool, developed by Brazilian theatre director Augusto Boal, to encourage discussion about different forms of oppression within society.
- [15] *Panchayat* is a smallest geographic administrative unit in India. It acts as a local self-government organization.
- [16] This is anecdotal and based on inputs from UNICEF's education and C4D team.
- [17] As shared in an interactive discussion with the caste *panchayat* leaders.
- [18] The broad objectives of KSY is to improve the nutritional, health, and development status of adolescent girls.
- [19] As told by Dr Swarup Rawat, DCPO, Banaskantha during an interaction as part of the study for documenting this case study

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Sishu O Matru Suraksha

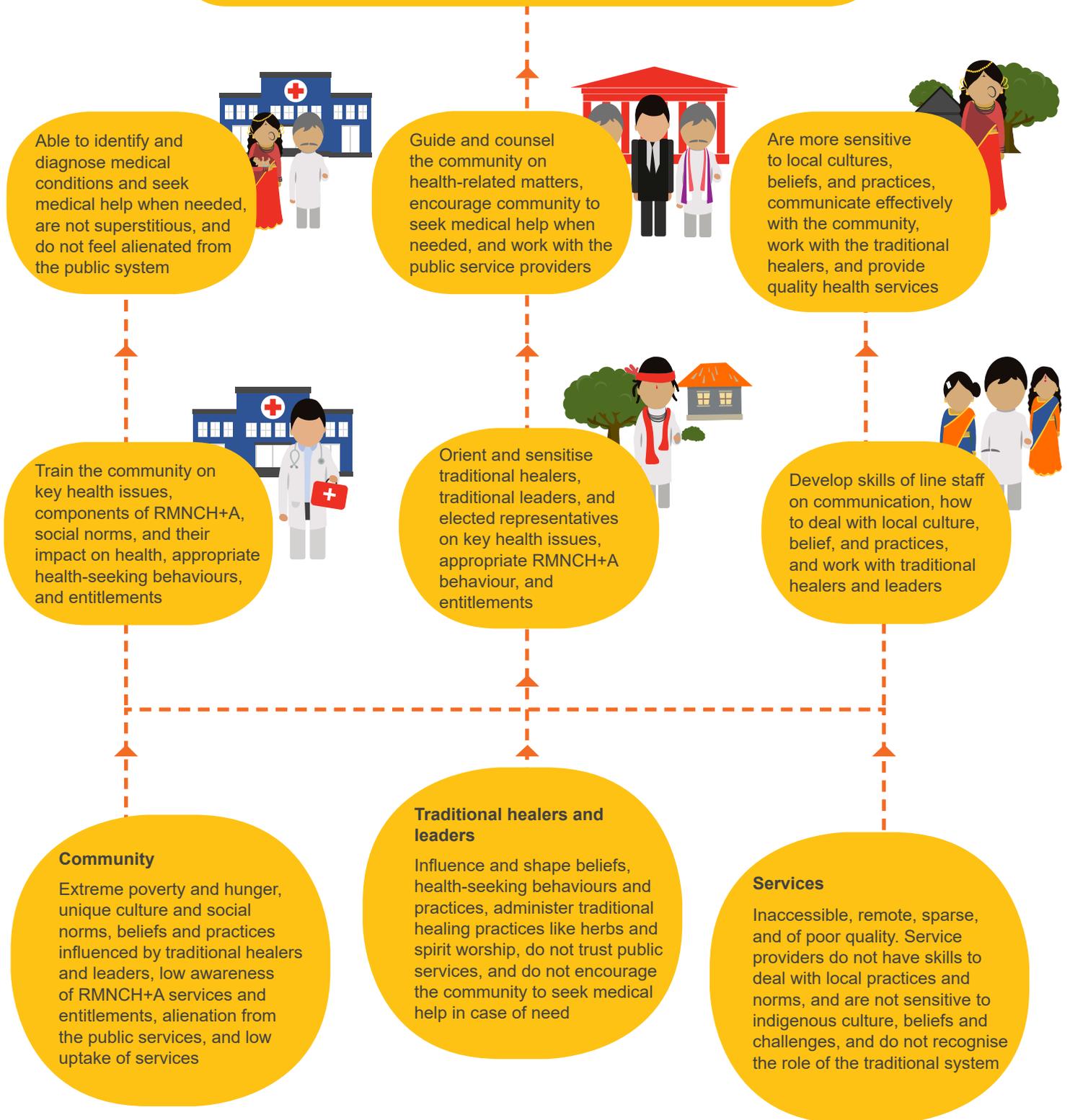
A Social and Behaviour Change
Intervention for Child and Maternal
Health in **Odisha**

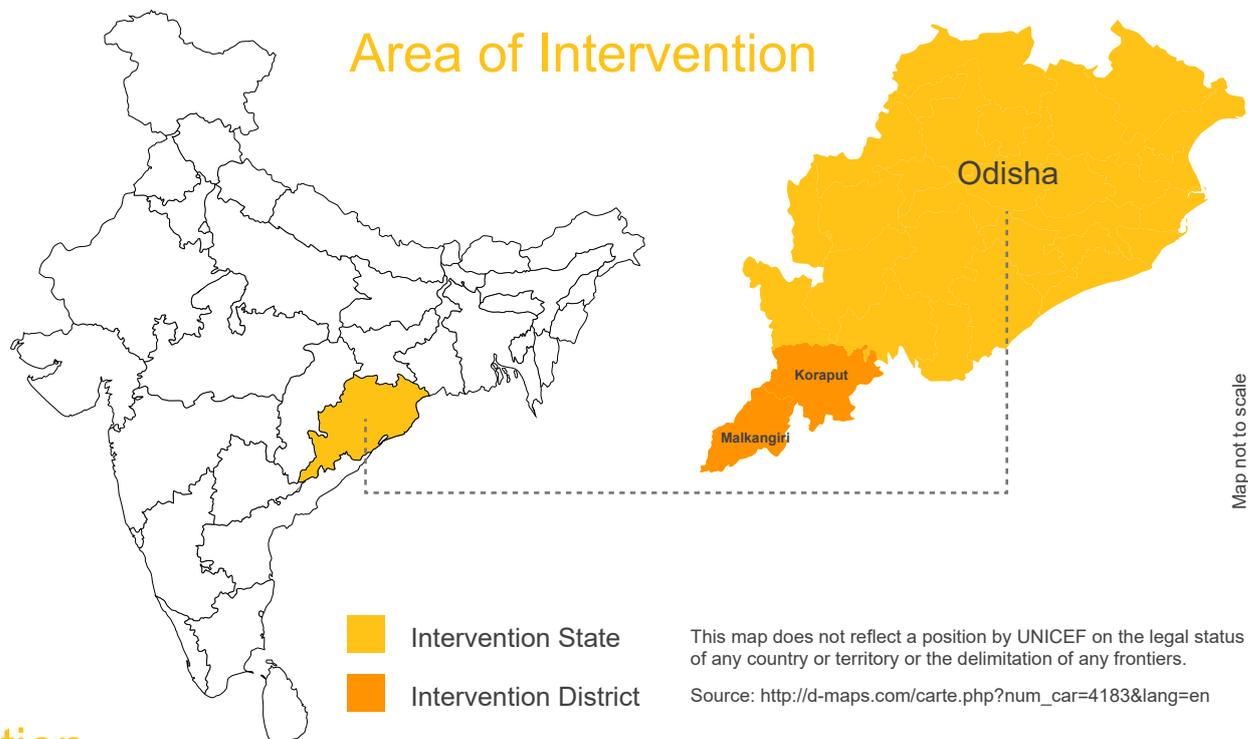
Globally, about 800 women die every day of preventable causes related to pregnancy and childbirth – 20 percent of whom are from India^[1]. Though the Maternal Mortality Rate (MMR)^[2] reduced from 212 in 2007 to 178 in 2012, there remains scope to save more children and mothers.

Underlying reasons for a relatively high MMR and Infant Mortality Rate (IMR) include social norms relating to health and nutrition, and low demand and access for the same. The intervention led by the Government of Odisha is supported by UNICEF, and aims at strengthening community-based institutions through Social and Behaviour Change Communication (SBCC), leading to better access and utilisation of Reproductive, Maternal, Newborn, Child, and Adolescent health (RMNCH+A) services in the region. Local Non-Governmental Organisations – My Heart and *Parivartan* – implemented the programme in extremely vulnerable sub-centres of Koraput and Malkangiri districts. An enabling environment was created to promote change by leveraging already existing community institutions and events, and improved interpersonal communication tools such as Facts for Life (FFL) videos, storytelling, Mother and Child Protection cards – for adult learning, leading to enhanced knowledge and behaviour change communication skills of key actors. As a result, there has been an increase in the knowledge and communication skills of community influencers, inclusion of women and children from hard-to-reach areas, and an increased involvement of community members for demand and utilisation of health services. Interlinkages between government departments have been established, and capacities of partners involved in this programme have been developed.

Theory of Change

Improved access to preventive and curative RMNCH+A services for women and children





Situation

Odisha is an Indian state located on the south-eastern coast. It ranks low in the Human Development Index (HDI) – 17th in 2011^[3]. The IMR^[4] and the MMR^[5] in Koraput and Malkangiri districts are significantly behind the national average, institutional delivery, and full immunisation coverage.

Table 1: Reproductive and Child Health indicators

Indicator (2013) ⁹	India	Odisha	Koraput	Malkangiri
IMR*	42	53	48	48
MMR**	178	235	245	245
Institutional delivery (%)	78.5	80.8	53.4	52.6
Full immunisation coverage (%)	53.5	68.8	51.6	29.6

Source: Annual Health Survey, 2012-13

*per 1,000 live births

**per 1,00,000 live births



The western region of the state in which these districts are located, is geographically difficult to reach due to underdeveloped infrastructure and Left-Wing Extremist (LWE) groups. These factors make it difficult to deliver public services like healthcare.

The state government has taken steps to improve health infrastructure and delivery, and accessibility of healthcare services in the state. It has classified the government health sub-centres^[6] into four categories (**V-1, V-2, V-3, V-4**)^[7] based on degree of inaccessibility, presence of LWEs, and characteristics of the service area. Other issues specific to the two districts were:

- Low awareness on the need and availability of RMNCH+A health services among the community. Members of local self-governing and

community-based institutions like *Panchayati Raj* Institutions (PRI)^[8] and *Gaon Kalyan Samiti* (GKS)^[9] lacked adequate understanding about RMNCH+A.

- Cultures, beliefs, and norms guiding health-seeking behaviours of the population. Institutional health workers were not sensitive to the traditional practices related to healthcare. They did not recognise the role of traditional healers (known as *desharis*) within the community, who are the first point of contact for community members.
- Frontline Workers (FLWs) such as Accredited Social Health Activists (ASHA)^[10] and *anganwadi workers*^[11] come from the same communities they serve, with similar beliefs and norms influencing their interactions with the community.

Deshari counseling a mother about her child.





Deshari carrying out routine check up for a child.

Method

To address the above challenges, UNICEF Communication for Development (C4D) and their Nutrition and Health Department complemented the efforts of Government of Odisha and implemented an intervention on Social and Behaviour Change Communication (SBCC). It focused on strengthening service delivery of Maternal and Child Healthcare through demand generation. My Heart and *Parivartan* were the partner organisations (already working with the government) who implemented the programme in Koraput (48 V-4 sub-centres) and Malkangiri (40 V-4 sub-centres) districts respectively in 2014-15. This intervention incorporated learnings from the implementation of a European Civil Protection and Humanitarian Aid Operations (ECHO)^[12] funded humanitarian action project, which aimed at increasing institutional deliveries, coverage of full immunisation, and improving management of childhood illnesses.

Learnings from the ECHO project were:

- Frontline Workers (FLWs)^[13] require training on behaviour communication skills for service delivery and awareness generation for RMNCH+A services.
- It is important to build capacities of traditional healers and members of self-governing institutions about preventive and curative maternal and child healthcare services and entitlements.
- Need to use adult learning methods to train the identified stakeholders.

- There was low demand from the community due to low awareness about need for health services.

The specific objective of the programme was to improve access to quality health services for women and children by promoting health-seeking behaviour. In particular, it aimed to:

- Create awareness within the community on RMNCH+A related health services, social norms and their impact on maternal and child health, and their health entitlements.
- Orientation and training of traditional healers and leaders about RMNCH+A related health services, behaviours, and entitlements.
- Develop interpersonal skills of FLWs to improve their service delivery skills.

The community was mobilised through different participatory methods to build rapport and gain support. The programme made use of innovative tools to enhance knowledge and behaviour communication skills of primary stakeholders. These included FFL videos^[14] projected using Pico Projectors^[15] or shared as Mobisodes^[16], and Mother and Child Protection Cards^[17] for interpersonal communication. The community was engaged through focus group discussions on healthcare practices for pregnant and lactating mothers and children.



Bimla Bhumia with her son Nabin from the district of Malkangiri.

Action

UNICEF identified and sensitised **community influencers**^[18] and tapped them to build upon existing human capital, rather than create a new community of workers. Further, *panchayats*, *Gaon Kalyan Samiti*, Self Help Groups, Village Health Nutrition Day (VHNDs), and Fixed Immunisation Day (FIDs) were utilised as platforms to facilitate maternal and child health related activities and develop other programmes for the village in general.

- More than 4000 traditional healers in Koraput and Malkangiri districts were trained to mobilise and promote healthy behaviour among community members. They were also sensitised to the importance of institutional deliveries, routine immunisation, and proper nutrition among mothers and children, and encouraged to promote the availing of formal medical care during times of ill health.
- FFL videos were used to build behaviour change communication skills in around 6,500 FLWs across the two districts and train them on methods to work along with *desharis* and the local culture. In turn, FLWs also used FFL videos during their home visits to increase knowledge of common childhood illnesses, underlying behavioural issues, and life-saving practices.



- More than 3,000 quarterly GKS meetings were facilitated as a part of the programme. The *panchayat* encouraged families to attend VHNDs and FID, and monitored the actions of the community during these events. Further, community health workers used the FFL videos to disseminate health and nutrition related knowledge.
- GKS and PRI members were sensitised towards their roles and responsibilities related to maternal and child health. They were provided training focused on building their skills to update village health registers and health information boards, schedule and draft village health plans and annual health reports, and better utilise funds. They were also asked to encourage community members to seek formal healthcare.



24-year-old Dalimba Pujari and her 9-month-old son have been supported by UNICEF's MCH programme.

Results

A joint effort by UNICEF C4D and Government of Odisha, the programme has been successful in reaching disadvantaged women, children, key caregivers, and community influencers. Formal and informal health service providers have contributed to the creation of an enabling environment to influence SBCC in health practices^[19].

- **Increased knowledge and communication skills of health service providers:** The intervention has helped improve knowledge and communication skills of FLWs and traditional healers. They are now able to communicate with their patients effectively and counsel them on child and maternal health. FLWs are able to deliver their services with support from community influencers. In hard-to-reach areas, traditional healers have started following up with pregnant and lactating mothers and their families, and ensure that they receive appropriate healthcare facilities.

Tulabadi Mahanandia, ASHA worker

“Earlier, whenever I used to counsel during trainings, no one paid attention to what I said. Now, they are engaged and there is improved interaction between us because of entertaining videos educating them about maternal and child health. There is better understanding among villagers about it now. We discuss topics like sanitation, diseases like Malaria, facilities like emergency 108 number, etc. Earlier, we used to work alone, but now others like 'desharis' and ward members also support us. 'Desharis' sent us villagers who need help with improving their health. We make plans, conduct regular meetings for GKS and maintain cleanliness in the village. We also give money to people during emergencies and refer pregnant women to hospitals”.

- **Building agency of women:** With participation in community activities like GKS and SHG meetings, awareness among women about health practices and services has increased. Women are able to discuss their health issues with formal health service providers, improving health-seeking behaviours and increasing the utilisation of formal health services among them.
- **Increased knowledge of traditional healers:** The programme has increased knowledge and awareness about reproductive, maternal, and child health issues, and healthcare practices among traditional healers. They are also informed of the rights and entitlements of the mother and child, so that they encourage the community to avail these entitlements.
- **Capacity development of partners:** Partner organisations have been able to increase their understanding of the technical aspects of maternal and child health. Their communication skills have become more effective, and they now understand the criticality of SBCC and how to use it to increase programme effectiveness.
- **Interlinkages between government departments:** The programme has leveraged funds, infrastructure, and human resources of various state departments and central government schemes. This includes Department of Health and Family Welfare, Department of Women & Child Development, Department of *Panchayati Raj* Institutions, and Rural Development Department^[20].



Radhika Pujari has been with the MCH project for the last three years.

Transformative Change

- **Increased community involvement leading to generation of demand for health services:** Institutions like GKS and PRI have started providing an interactive platform to the villagers to step forward and ask questions, clarify doubts, and present the village's problems. Closer engagement between GKS, PRIs, and the community has also helped to develop an informal monitoring and feedback mechanism. These regular reviews and monitoring have helped establish a system of social accountability at the PRI level. There is now an increase in the number of GKS meetings held, from 89 percent to 94 percent in Koraput and from 65 percent to 80 percent in Malkangiri district. Fund utilisation by GKS has increased from 55 percent to 80 percent in Koraput and 51 percent to 80 percent in Malkangiri district, during the programme cycle 2014-16^[21].
- **Referrals to formal institutions and creation of an enabling environment for participants:** Traditional healers motivate villagers to seek help from FLWs who, if needed, refer them to Primary Health Centres (PHCs) for treatment. This has created an enabling environment, thereby increasing the effectiveness of health workers, leading to fewer casualties in the district. Pregnancies registered have gone up drastically, with an increase from 35 percent to 84 percent in Koraput and 50.5 percent to 73.4 percent in Malkangiri^[22].
- **Building continuity and consistency into the system^[23]:** Ensuring sustainability through transfer of knowledge and practices to the government, the project has been successful in mainstreaming the communication strategy into ongoing government programmes such as National Rural Health Mission (NRHM)^[24], Integrated Child Development Services (ICDS)^[25], *Sarva Shiksha Abhiyaan* (SSA)^[26], *Swachh Bharat Abhiyan*, and actively involving other implementers at the district level. Communication tools and strategies developed by UNICEF C4D such as FFL videos have been adopted by the government in these health schemes.



In Summary

UNICEF C4D, in partnership with the Government of Odisha and local NGOs, facilitated an intervention in Koraput and Malkangiri districts of Odisha. This was done in order to improve the utilisation of RMNCH+A services in the region. Since then, there has been an increase in knowledge and communication skills of community influencers, and greater involvement of community members for demand and utilisation of health services.

Action



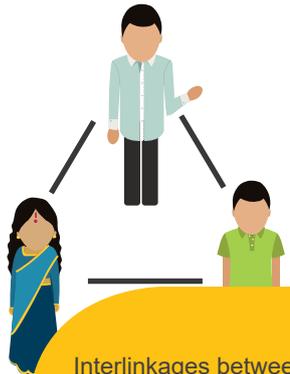
Results



Healthcare providers increased their knowledge and communication skills, enabling them to effectively counsel and communicate with their patients.



Women are now more participative in GKS and SHG meetings, making them more aware of positive health behaviours.

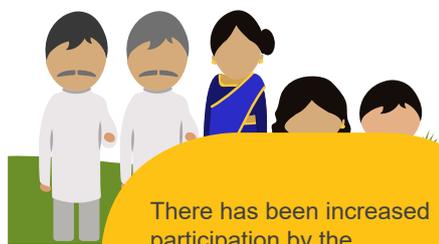


Interlinkages between government departments saw existing schemes, funds, and human resources leveraged for behaviour change.



NGO partners have been able to comprehend technical aspects of child and maternal health and communicate effectively through engaging mediums.

Transformative Change



There has been increased participation by the community with regard to the demand and generation of health services.



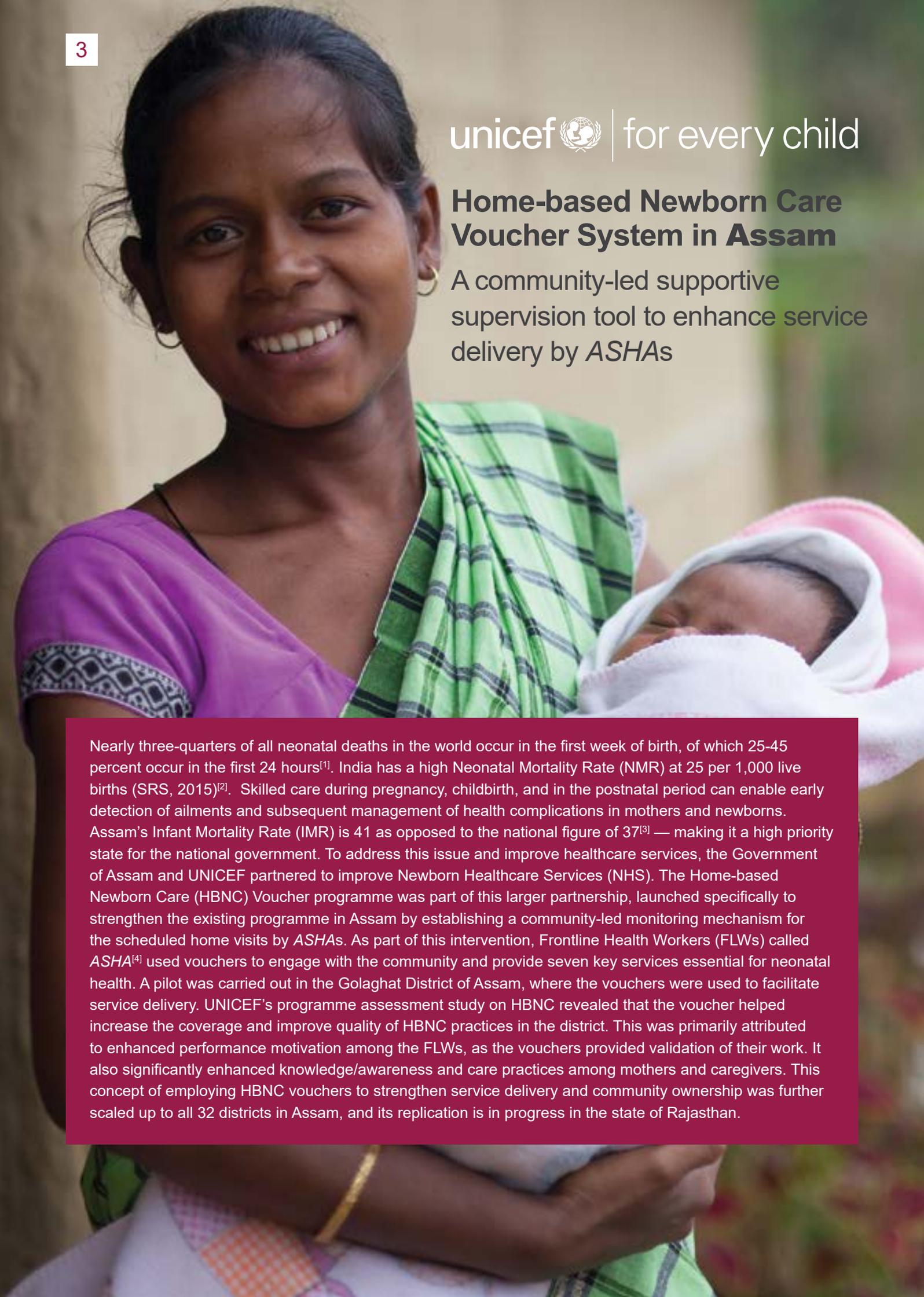
Informal caregivers have begun referring formal institutions, creating an enabling environment for participants.



The intervention has successfully mainstreamed the communication strategy into ongoing government schemes, ensuring the sustainability of the project.

References

- [1] <http://unicef.in/Whatwedo/1/Maternal-Health>
- [2] the number of maternal deaths per 100,000 live births
- [3] http://www.in.undp.org/content/dam/india/docs/orissa_factsheet.pdf
- [4] Infant mortality refers to deaths of young children, typically those less than one year of age. It is measured by the infant mortality rate (IMR), which is the number of deaths of children under one year of age per 1,000 live births.
- [5] Maternal Mortality Rate (MMR) is defined as the number of maternal deaths per 1,00,000 live births due to causes related to pregnancy or within 42 days of termination of pregnancy, regardless of the site or duration of pregnancy.
- [6] In India, Primary Health Centres (PHCs) are the basic first-line units providing primary health care. Each PHC has five or six sub-centres staffed by health workers for outreach services such as immunisation, basic curative care services, and maternal and child health services and preventive services.
- [7] V-1-Less vulnerable, V-2-Moderately vulnerable, V-3-Highly vulnerable and V-4-Extremely vulnerable.
- [8] The *Panchayati Raj* is a South Asian political system found mainly in India, Pakistan, Bangladesh, Sri Lanka, Trinidad and Tobago, and Nepal. It is the oldest system of local government in the Indian subcontinent and forms the third tier of governance.
- [9] *Gaon Kalyan Samiti* (GKS) is structured to help the village promote health activities, improve environmental and sanitation standards, seek support for emergency healthcare services, conduct social audits, and set up regular meetings.
- [10] Accredited social health activists (ASHAs) are community health workers instituted by the government of India's Ministry of Health and Family Welfare (MoHFW) as part of the National Rural Health Mission (NRHM).
- [11] *Anganwadi* workers work for rural mother and child care centres in India in *anganwadi* centres. They were started by the Indian government in 1975 as part of the Integrated Child Development Services programme to combat child hunger and malnutrition.
- [12] Headquartered in Brussels, through ECHO, The European Commission aims to save and preserve life, prevent and alleviate human suffering and safeguard the integrity and dignity of populations affected by natural disasters and manmade crises.
- [13] The first point of contact among formal health service providers in rural India such as ASHA and ANM.
- [14] Series of Facts For Life videos.
- [15] Portable, hand held projector which helped to conveniently project videos in remote areas.
- [16] Mobisode is a short episode of Fact For Life videos made specifically for viewing on the screen of a mobile phone.
- [17] Mother and Child Protection cards are
- [18] This includes traditional healers, traditional leaders and members of the self governing bodies.
- [19] Based on key informant interviews with stakeholders and programme documents.
- [20] The Ministry of Rural Development, a branch of the Government of India, is entrusted with the task of accelerating the socio-economic development of rural India. Its focus is on health, education, drinking water, housing and roads.
- [21] DPMU Endline Survey Report
- [22] DPMU Endline Survey Report
- [23] Based on key informant interview with Odisha UNICEF C4D state representative and programme document.
- [24] NRHM is an initiative undertaken by the government of India to address the health needs of underserved rural areas.
- [25] Integrated Child Development Services (ICDS) is a programme which provides food, preschool education, and primary healthcare to children under 6 years of age and their mothers.
- [26] *Sarva Shiksha Abhiyan* (Education for All Movement), or SSA, is an Indian Government programme aimed at the universalisation of elementary education "in a time bound manner", as mandated by the 86th Amendment to the Constitution of India making free and compulsory education to children between the ages of 6 to 14, a fundamental right.



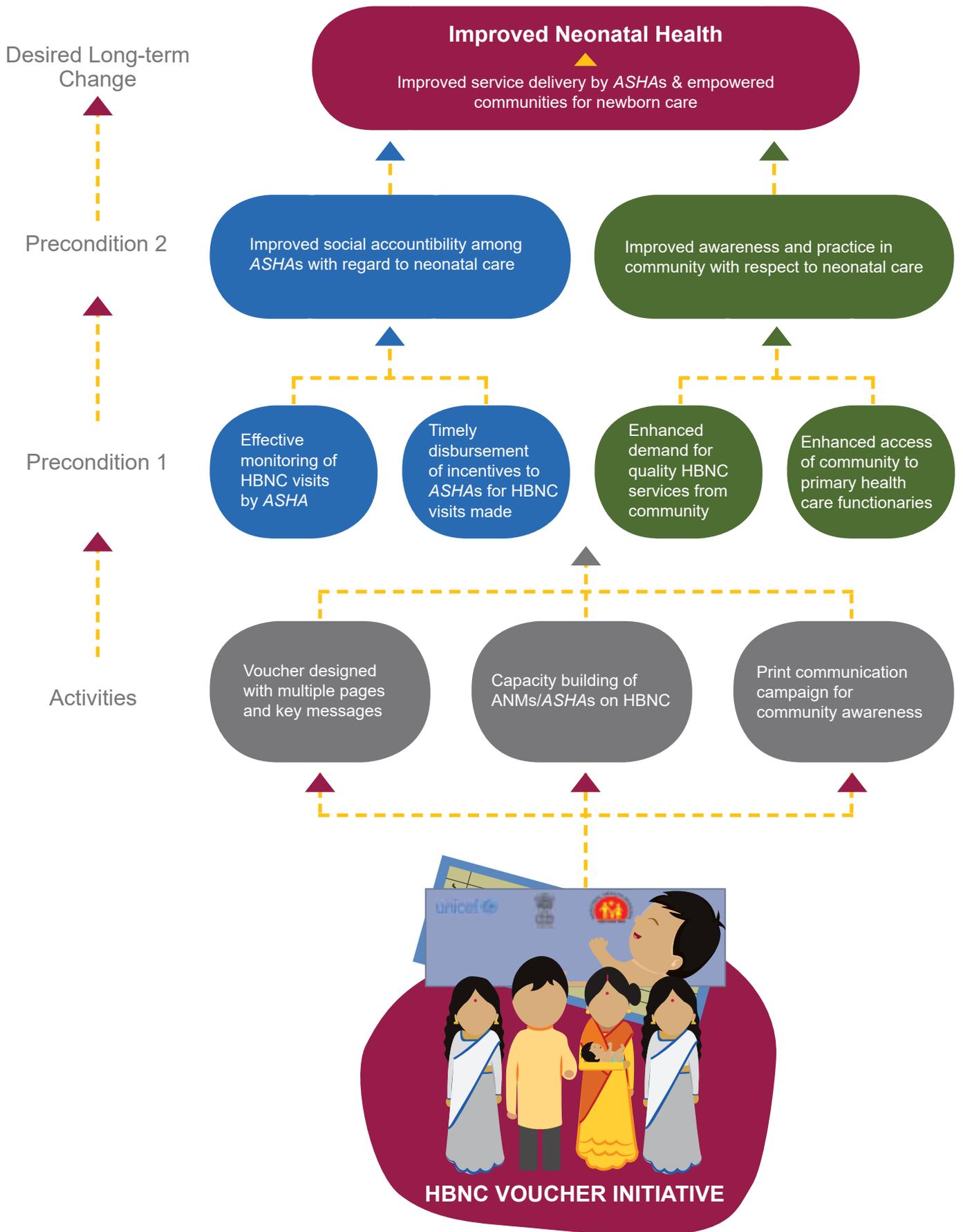
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Home-based Newborn Care Voucher System in Assam

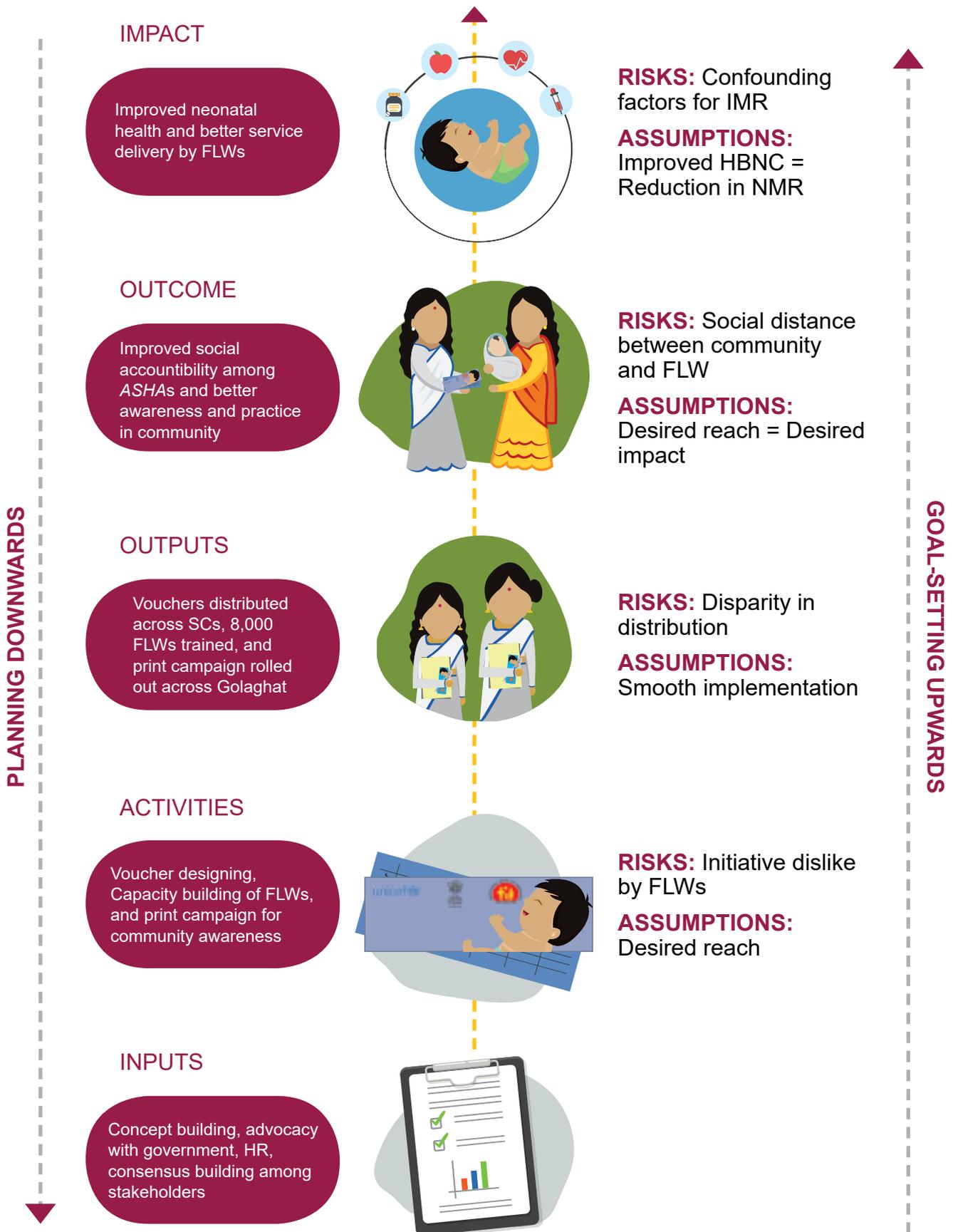
A community-led supportive supervision tool to enhance service delivery by *ASHAs*

Nearly three-quarters of all neonatal deaths in the world occur in the first week of birth, of which 25-45 percent occur in the first 24 hours^[1]. India has a high Neonatal Mortality Rate (NMR) at 25 per 1,000 live births (SRS, 2015)^[2]. Skilled care during pregnancy, childbirth, and in the postnatal period can enable early detection of ailments and subsequent management of health complications in mothers and newborns. Assam's Infant Mortality Rate (IMR) is 41 as opposed to the national figure of 37^[3] — making it a high priority state for the national government. To address this issue and improve healthcare services, the Government of Assam and UNICEF partnered to improve Newborn Healthcare Services (NHS). The Home-based Newborn Care (HBNC) Voucher programme was part of this larger partnership, launched specifically to strengthen the existing programme in Assam by establishing a community-led monitoring mechanism for the scheduled home visits by *ASHAs*. As part of this intervention, Frontline Health Workers (FLWs) called *ASHA*^[4] used vouchers to engage with the community and provide seven key services essential for neonatal health. A pilot was carried out in the Golaghat District of Assam, where the vouchers were used to facilitate service delivery. UNICEF's programme assessment study on HBNC revealed that the voucher helped increase the coverage and improve quality of HBNC practices in the district. This was primarily attributed to enhanced performance motivation among the FLWs, as the vouchers provided validation of their work. It also significantly enhanced knowledge/awareness and care practices among mothers and caregivers. This concept of employing HBNC vouchers to strengthen service delivery and community ownership was further scaled up to all 32 districts in Assam, and its replication is in progress in the state of Rajasthan.

Theory of Change



Logical Framework





Situation

In India, and around the world, the Infant Mortality Rates have decreased over the last two decades. Between **1990 and 2015**, IMR in India had reduced from **87 to 37**. However, in the same period, the share of neonatal deaths were high and had, in fact, increased from **46 percent to 58%**^[5] for deaths under the 5-year category. Three major causes of neonatal death are infections, asphyxia, and preterm birth – accounting for nearly **80 percent** of all neonatal deaths^[1]. Apart from disparity in available healthcare facilities, poor health-seeking behaviours and unscientific practices followed by the community due to prevalent maleficent social norms and customs create further challenges. Their demand for health services is limited or absent, making the situation more complex for interventions targeting healthcare improvement.

Assam has a high IMR at **48 per 1000 live births**^[6]. According to the National Family Health Survey (NFHS), Assam's health indicators have improved between NFHS-3 and NFHS-4. However, there is substantial scope to prevent infant deaths through a targeted focus on neonatal health. One of the gaps identified by various expert reviews and anecdotal evidence was the inadequacy in quality supportive supervision of *ASHAs*. They are trained on maternal and infant care, but their capacity to effectively communicate, engage, and involve the communities warranted continued strengthening. Further, an output-driven supervision system often undermined the quality

of work presented on field. On the demand side, correct and consistent infant healthcare practices in the community were noted to be inadequate (NFHS-4). Based on opinions from health system experts, challenges in the existing neonatal care service delivery model in Assam were as below:

1. Irregular HBNC home visits and inconsistent newborn care advice by *ASHA* pointed towards the paucity of quality monitoring and supportive supervision mechanism.
2. Missed opportunities of Interpersonal Communication (IPC) on newborn care create a void in the sphere of health communication and promotion activities.
3. Limited demand from community for essential HBNC for their infants.

The HBNC voucher initiative provides a window of opportunity for quality counseling during HBNC home visits. It is a Communication for Development (C4D) approach strategically aimed at harnessing behaviour change; both at the service delivery as well as community levels.

Method

In 2013-2014, the Government of Assam (GoA) in partnership with UNICEF launched the HBNC voucher as a pilot initiative through the National Health Mission⁷¹ (NHM). Within UNICEF, health units and C4D converged their efforts for this intervention which was rolled out in 88 health centres in the Golaghat district. The Community Medicine department from Assam Medical College Hospital (AMCH), Dibrugarh was brought on board for its technical expertise and assistance in designing the HBNC voucher.

It involved the following steps:

Step 1

Planning and evaluation: Continuous interactions were carried out between NHM and UNICEF C4D to plan this pilot initiative. The groups also discussed the evaluation design which would be conducted simultaneously to assess the potential of the initiative.

Step 2

Design, pre-test, and printing of HBNC vouchers and sensitisation of health workers: As part of pre-testing, UNICEF C4D presented the voucher to the community and service providers before the actual rollout of the intervention. Based on findings from the pre-testing (based on community feedback):

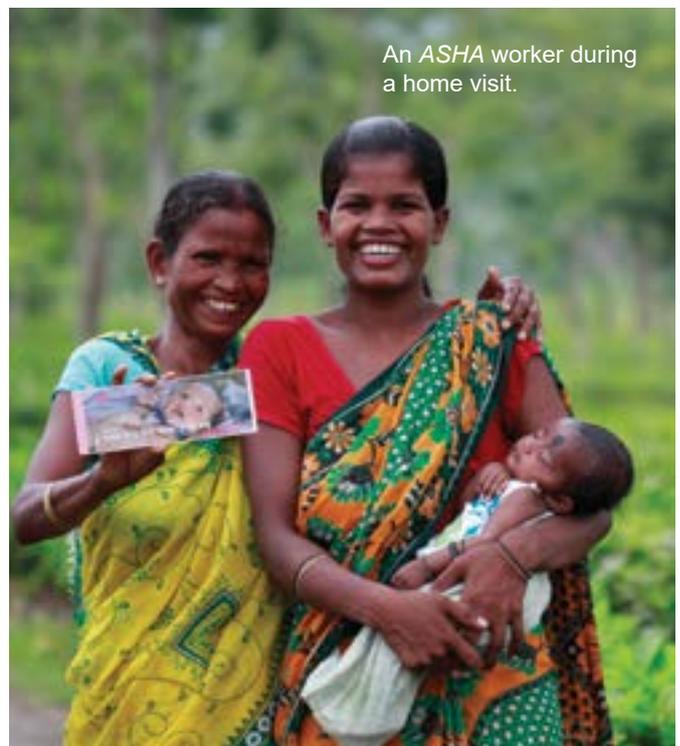
- The back cover and photographs depicting the ASHA activities were finalised
- The number of counterfoils per leaflet were increased from two to three; one for the mother, one for the ASHA worker, and one for submission to the peripheral health centre

Step 3

Communication material development and display in health institutions as well as at Village Health and Nutrition Day (VHND): As an endeavour to promote social equity within the scope of this initiative, the communications team prioritised the need to have different versions of the voucher and posters to suit the needs and expectations of different marginalised communities in the state. It was envisaged that maintaining an equity focus would amplify the adoption and acceptance of the voucher among different distinct communities residing in Assam.

Step 4

Rollout of the pilot: UNICEF undertook the Voucher and Communication approach, apart from capacity-building and supportive supervision of FLWs who implemented the initiative.





Dipali Phukan, a primary healthcare worker, hands the HBNC voucher to a patient.

Action

The pilot was initiated in 2014 and implemented for six months in Golaghat, Assam – one of the six High Priority Districts (HPD)^[8] identified in the state. UNICEF conducted Capacity Building (CB) of FLWs on home-based counseling for HBNC where they were trained on the use of vouchers and how to, in turn, train mothers about the same.

As part of the HBNC voucher programme, an FLW is mandated to visit a newborn six to seven times in the first 42 days post-delivery (six times in case of institutional delivery and seven times for home delivery) and provide the following services: weigh the child, measure the temperature, counsel the mother on breastfeeding, kangaroo-mother care, immunisation, and handwashing. If needed, she issues referral slips for the child, mother, or both for their treatment in the block hospital.

The voucher contains seven^[9] leaflets, each of which is triple perforated and corresponds to *ASHA* visits during the first 42 days. Information on the different activities to be performed by *ASHA*, different government schemes^[10], facilities available, entitlements under RMNCH+A (Reproductive, Maternal, Neonatal, Child, and Adolescent Health) scheme, and essential newborn care are detailed in the communication material. Mothers delivering at hospitals are oriented about newborn care services provided by *ASHAs* through HBNC vouchers.

The process of the visit and use of HBNC was designed as follows:

- On each visit, the *ASHA* is expected to perform the activities listed on the voucher.
- At the end, if satisfied with the services, the mother hands over one signed counterfoil to the *ASHA* and retains a copy.
- Upon completion of all visits, the *ASHA* submits all leaflets at the block health centre and is paid ₹250 per child as an incentive for her work.
- The *ASHA* is mandated to make home visits as part of HBNC on the following days:
 - 1st, 3rd, 7th, 14th, 21st, 28th, and 42nd day of childbirth for children born at home
 - 3rd, 7th, 14th, 21st, 28th, and 42nd day of childbirth for children born in an institutional facility

Communication material included posters with details about the voucher and healthcare practices for infants, which were developed and displayed in the health sub-centres. The HBNC voucher has additional Information, Education, and Communication (IEC) material which includes photographs that highlight entitlements and scheduled visits.

This is an empowering instrument to both the *ASHA* as well as the mother — *ASHA* can validate the home visits conducted and the mother can identify what to expect during home visits and keep track of stipulated visits. The intent of the voucher is to improve the accountability of *ASHAs* towards service delivery and enable them to communicate more effectively with mothers and caregivers. This promotes better community knowledge and awareness in newborn care, stimulating increase in demand. It also helps create a sense of shared responsibility between the *ASHA* and mother/caregiver of the newborn.

Results

UNICEF, in partnership with Assam Medical College and Hospital, Dibrugarh, conducted a programme assessment study to understand the effectiveness of the voucher initiative. Prior to the rollout of intervention, a baseline study was carried out in 88 selected health sub-centres of the district. Within each health sub-centre, a cluster of seven infants less than two months of age were selected. The mother and ASHA of each of these infants were interviewed at the time of the baseline study, and the findings of this baseline survey were compared and analysed with the results drawn from the post-intervention evaluation study.

Key changes observed as a result of this intervention among mothers/caregivers, ASHAs, and the government system — when compared to the baseline — were as follows:

Change in mothers and caregivers

- Statistically significant^[12] improvement in knowledge among mothers and caregivers regarding various government schemes and the available services for newborn care.
- Significant improvement in knowledge regarding availability and importance of Iron Folic Acid (IFA) tablets, deworming, postnatal checkups, birth registrations, vaccinations, and weighing of the child.
- Improvement in knowledge of the ASHAs' visit schedule for home-based newborn care improved after the implementation of the HBNC voucher system.

Table 1: Knowledge-change results from programme assessment study

Description of Indicator	Baseline	Endline
Knowledge about services to be received from ASHA	66.7%	99.2%
Availability and importance of IFA tablets	78.7%	98.6%
Importance of postnatal checkup	46.6%	93.1%
Information on vaccination	66%	97.1%
Exclusive breastfeeding	89.3%	97.4%
Weighing of the child	73.5%	94.9%



Mothers were encouraged to use institutional facility for childbirth.

Change in ASHAs

Approximately 8,000 FLWs were trained on home-based counselling about newborn care. As per the study, the knowledge level of ASHAs showed statistically significant improvement following the implementation of the voucher system.

Description of Indicator	Baseline	Endline
Birth preparedness	18.4%	84.1%
Infant feeding practices	20.1%	91.8%
Infant feeding practices	40.2%	96.7%
Care of young infants	10.9%	85.7%

Table 2: Knowledge change results in ASHAs from programme assessment study



Mothers and caregivers are now more aware of government schemes and their entitlements.

The strong focus on communication skills has helped strengthen the IPC skills of FLWs. This has, in turn, helped them:

- Communicate effectively with mothers about newborn care with the help of communication materials to ensure continuum of care.
- Build trust in mothers and community members about their capacities through effective and quality service delivery.

Change in government health system

- Schedule of actual HBNC home visits conducted by ASHA was streamlined to a considerable extent.
- There's an increase in institutional deliveries and decrease in home deliveries, which could be attributed to the improved level of knowledge and awareness among mothers and families regarding various government schemes listed on the voucher.

Transformative Change

The initiative has been able to establish an osmotic relationship between supply and demand — it empowered FLWs with communication aids to report and substantiate their work, as well as interact and engage better with the communities and rigorously follow up on visits. Mothers and caregivers have also been empowered through the initiative with improved knowledge on neonatal

health, associated complications, care-giving practices, entitlements from the public schemes and access to healthcare.

The Government of Assam has acknowledged the positive outcomes of this pilot intervention and scaled it to all 32 districts of the state, with subsequent inclusion of the initiative into the State Programme Implementation Plan (PIP) 2015-2016. The HBNC voucher has been included as a standard monitoring format for the supervision of FLWs to ensure provision of quality home-based care services for newborns.

The HBNC voucher innovation from Assam found a place among the 60 innovations and good practices included in the 'Good Practices across the Globe' document released at the Call to Action summit in 2015.

Following the success and acceptance of the initiative in Assam, the Government of Rajasthan^[13] has also recognised the utility of vouchers in monitoring service delivery and improving accountability of FLWs, and has decided to replicate the HBNC voucher system.



“The Home-based Newborn Care voucher is a simple yet powerful communication tool which empowers both the community and the Frontline Workers (FLW). It helps engage and involve the community more in newborn healthcare. It helps FLWs execute their role better, and know of the earnings they are entitled to. The HBNC programme was appreciated by the government, and it has now been scaled across all districts in Assam. UNICEF C4D has yet again brought an innovative solution that helps us improve the health scenario in our district.”

Mrs. Laya Madduri
Deputy Commissioner, Dibrugarh district, Assam

In Summary

The Government of Assam, in partnership with UNICEF, initiated Home-based Newborn Care (HBNC) to address the issue of high NMR and IMR rates in Assam. It aimed to strengthen the existing programme by establishing a community-led monitoring mechanism for the scheduled home visits by ASHAs. Here's a blueprint of how the intervention was rolled out in 2014 for six months in the district of Golaghat.

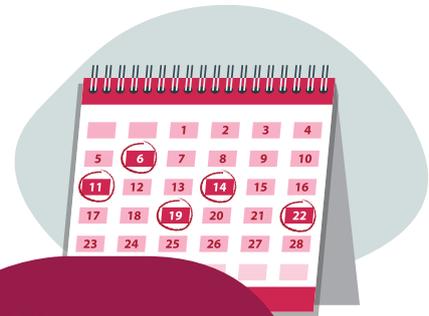
Action



Capacity Building on home-based counseling was conducted for FLWs, where UNICEF trained them on the use of HBNC vouchers and delivering the same to mothers.



Through the voucher, FLWs counseled mothers on various care practices like breastfeeding, kangaroo-mother care, immunisation, etc.



An FLW was mandated to visit a newborn six to seven times in the first 42 days post-delivery — six times in case of an institutional delivery, and seven if home-based.



At the end of every visit, the mother handed over a signed counterfoil to the ASHA which was then submitted at the block health centre. As an incentive, the ASHA was paid ₹250 per child for her efforts.



Communication and awareness on the intervention was done through posters detailing the voucher and healthcare practices, placed in health sub-centres.

Results



Change in mothers and caregivers: There's a significant improvement in the knowledge among mothers and caregivers on the available government schemes and services for newborn care. They are now also better informed about the *ASHA* visit schedule.



Change in ASHAs: About 8,000 FLWs were trained, as a result of which their knowledge level showed statistical improvement. They communicated effectively and built trust about their capacities through effective and quality service delivery.



Change in government health system: Through the intervention, the *ASHAs'* HBNC home visit schedule was better streamlined. Institutional deliveries also saw an increase — a change that can be attributed to improved knowledge.

Transformative Change



Through the voucher and communication aids, FLWs are now better empowered to interact and engage with the communities, as well as report and substantiate their work apart from following up on their visits.



The positive outcomes of the intervention have led to it being scaled to all the 32 districts of Assam, and included in the state PIP. The voucher innovation has also found a place among the 60 innovations included in the Good Practices Across the Globe document.



Mothers and caregivers have also been empowered — with improved knowledge on neonatal health and relevant practices. They're also aware of the public schemes and access to healthcare that are at their disposal.

Caselet

Lakshmi Medha, aged 22, is mother to two boys. The younger one, Ayush, is a healthy 3-month-old infant. When he was just 7 days old, Shanta Kurmi — the ASHA of the village — visited Lakshmi to check on the infant. She identified signs of jaundice, mobilised an ambulance, and quickly referred her to the

hospital. Ayush underwent blood transfusion at the government hospital and, following proper treatment, had a speedy recovery. Lakshmi believes that her ASHA visited Ayush on the 7th day after his birth because of the voucher's reminder, as a result of which her child's life was saved.

References

- [1] <http://www.who.int/mediacentre/factsheets/fs333/en/>
- [2] <http://apps.who.int/gho/data/node.sdg.3-2-viz-3?lang=en>
- [3] Per 1,000 live births; Sample Registration System (SRS) Survey, 2015
- [4] Accredited Social Health Activist (ASHA) is the health activist(s) in the community who create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services.
- [5] https://www.unicef.org/publications/files/APR_2015_9_Sep_15.pdf
- [6] National Family Health Survey-4 (NFHS-4)
- [7] NHM is the flagship programme of the Ministry of Health and Family Welfare's (MoHFW), Government of India.
- [8] To ensure equitable healthcare and to bring about sharper improvements in health outcomes, the bottom 25 percent of the districts in every state according to the ranking of districts based on composite health index have been identified as High Priority Districts (HPDs). This health index is developed by Ministry of Health and Family Welfare.
- [9] For babies born in an institutional facility, only six leaflets are relevant and used.
- [10] Schemes included were *Janani Suraksha Yojana* (JSY), through which ASHA escorts a pregnant woman to facility, provision for getting cash incentives, financial assistance scheme for mother (*Mamoni*) and girl child (*Majoni*), knowledge about JSSK (*Janani Swasthya Suraksha Karyakram*) and *ADORONI* scheme for providing free services for transportation from home to facility and back to home, including free medicines etc.
- [11] Mahanta TG, et al. Effectiveness of introducing home-based newborn care (HBNC) voucher system in Golaghat District of Assam, *Clin Epidemiol Glob Health*. (2015), <http://dx.doi.org/10.1016/j.cegh.2015.08.002>
- [12] The P value, or calculated probability, is the probability of finding the observed, or more extreme, results when the null hypothesis (H₀) of a study question is true. A p-value of less than 0.05 indicates a strong evidence for null hypothesis indicating a statistical significance.
- [13] <http://www.dnaindia.com/jaipur/report-rajasthan-to-adopt-assam-model-to-curb-neonatalmortality-rate-2492375>



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Suramya

Communication to Eliminate Open Defecation in **Uttar Pradesh**

Government of India initiated *Swachh Bharat Mission*^[1] (SBM) (Clean India Mission) in 2014 with the key objective of eliminating open defecation in the country by 2 October, 2019. Information, Education, and Communication (IEC) was identified as a key component of the programme, to bridge the gap between the construction of toilets and their sustained use. Around **5 percent** of the state funds under SBM have been allocated for this purpose. However, the utilisation of IEC funds was slow. Key district officials of the SBM team lacked the capacity to plan, implement, and monitor communication activities which were initiated in an ad hoc manner. Moreover, officials focused more on IEC rather than Social and Behaviour Change Communication (SBCC) to motivate healthy sanitation behaviour, which was not sustainable in the long run. There was also the lack of an SBCC-dedicated and capacitated human resource working on sanitation at ground level. As part of the UNICEF Communication for Development (C4D) initiative in the state of Uttar Pradesh and its technical support to SBM, the development of SBCC plans and calendars was proposed in 25 districts to efficiently allocate resources and utilise the IEC component. The district SBM team was intensely engaged in the process of formulating an SBCC plan and annual implementation calendar during a three-day workshop, along with key line departments and local stakeholders – religious institutions, non-government organisations, and corporate groups. Different communication strategies such as advocacy, Interpersonal Communication (IPC), entertainment education, mass media, and social mobilisation were incorporated in the SBCC plan which encouraged active participation from the community. As a result, SBCC plans and calendars have been formulated in 25 districts and there is an improvement in utilisation of IEC funds. A positive shift can be seen towards the use of SBCC approach to influence the sanitation behaviour of communities to achieve an Open Defecation Free (ODF) status in Uttar Pradesh.

Theory of Change



1. Improvement in utilisation of IEC component under SBM
2. Shift from IEC to SBCC approach; more importance given to communication activities
3. Convergence of line departments to achieve results for SBM
4. Availability of human resource trained in SBCC at ground level
5. Synchronised demand and supply for construction of toilets and its sustained use



District SBCC plan and calendar made with intense engagement from SBM team, line departments, and other stakeholders

Priority given to construction of toilets, and not SBCC to influence behaviour

Lack in convergence of efforts by line departments to achieve results for SBM

Lack of strategic implementation of communication activities

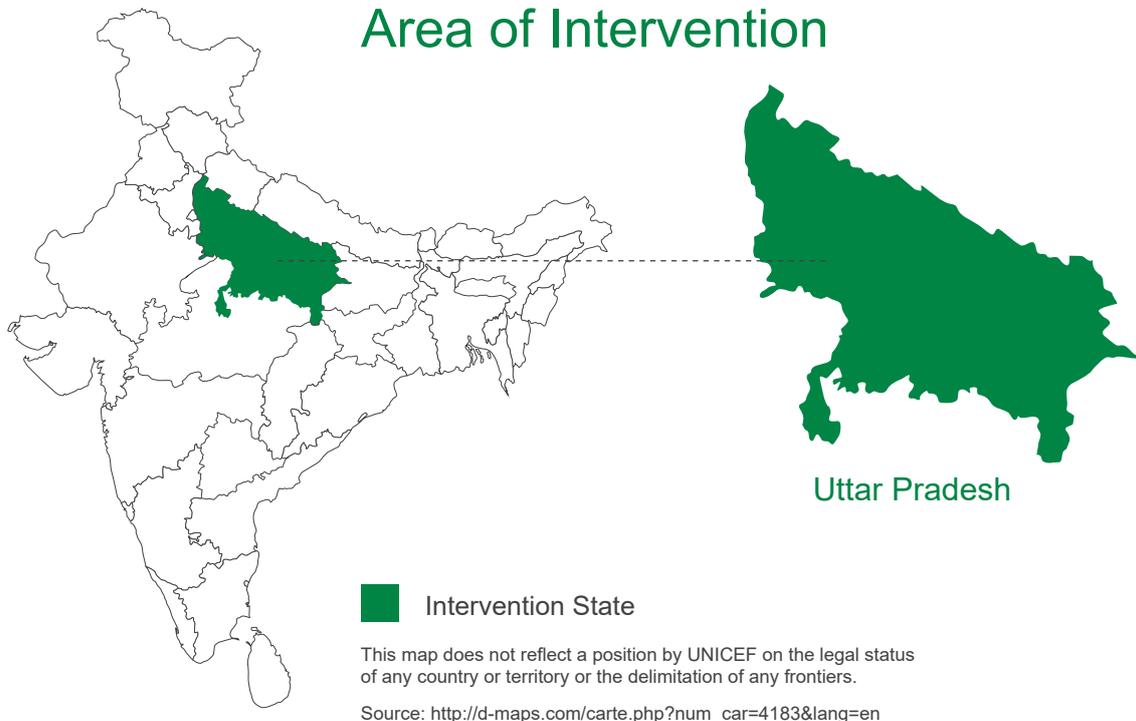
IEC approach rather than SBCC approach

Lack of capacity in key district officials to plan, implement, and monitor SBCC activities

Lack of SBCC skills in existing human resources at ground level

Slow and inefficient progress in utilisation of IEC component under Swachh Bharat Mission (Rural)

Area of Intervention



Map not to scale

Situation

Government of India launched *Swachh Bharat* Mission (SBM) in 2014 to focus on sanitation, and accelerate efforts to achieve universal sanitation coverage in the country. SBM in rural areas intends to improve cleanliness and make *gram panchayats*^[2] Open Defecation Free (ODF). The programme emphasises on community-wide behaviour change to trigger demand for sanitary facilities to achieve its objectives. Guidelines for SBM (rural) have specified the formulation of state and district IEC plans focusing on a long-term strategy for communicating key messages on sanitation to the community. In all Indian states, 5 percent of the total SBM allocation is for IEC, communication activities, and capacity building in rural areas.

The Government of Uttar Pradesh (GoUP) has set a target to achieve an Open Defecation Free status by 2 October, 2018. Out of the 75 districts in the state, 30 aim to achieve it by the end of 2017. To achieve ODF status, over 21 million USD is allocated for IEC activities under SBM in Uttar Pradesh.

Challenges in achieving the behaviour change goals of SBM:

1. Government functionaries lacked the understanding of the need to engage in a holistic Social and Behaviour Change Communication (SBCC) strategy. Additionally, they had limited capacities to plan and implement interventions to influence sanitation behaviour. Hence, utilisation of state funds as per SBM (rural) guidelines made slow progress.
2. Communication strategies and activities were based on IEC approach, rather than a more comprehensive SBCC approach. IEC is more of a short-term awareness building exercise targeted at individuals and communities, which is not effective in the long run. Knowledge is not a necessary and sufficient condition for behaviour change. For sustained use of toilets in households, healthy sanitation behaviours must be sought at individual, community, and institution levels through multi-pronged mobilisation and communication strategies. SBCC involves analysing personal, societal, cultural, and environmental factors for sustainable change.
3. IEC component under SBM lacked strategic planning, implementation, and appropriate budgetary allocations.
4. For human resources available at the ground level under SBM, there is no systematic process of capacity building on community mobilisation and interpersonal communication.

1. SBM was mostly hardware driven, with more focus given to implementing core programmatic aspects. Communication activities were not given priority.
2. There was lack of convergence of key departments for the implementation of IEC activities to achieve results of SBM.

These systemic-level challenges could be overcome through intensive engagement in the formulation of

comprehensive district SBCC plans. SBCC encourages healthy behaviour change, and increases commitment and investment from individuals, communities, and institutions to eliminate open defecation. Additionally, SBCC helps to improve knowledge and increase demand from the community for the construction and use of toilets by creating an enabling environment. It motivates individuals and communities to accept the use of toilets as the new social norm.



Toilets built by the *Pradhan* in a local school in Mirzapur District.

Method

The *Swachh Bharat* Mission (rural) has strongly promoted the Community-led Total Sanitation (CLTS)^[3] approach in Uttar Pradesh, which focuses on triggering behaviour change for adoption of good sanitary practices by communities. UNICEF provided technical support to SBM in Uttar Pradesh for capacity development of officials and communities on CLTS and SBCC. This helped key functionaries of SBM, primarily the Mission Director of Uttar Pradesh, to understand the importance of SBCC in achieving ODF status. Support from the state SBM team ensured participation of key stakeholders, especially government line departments at district and block levels.

Objectives of district SBCC plan and calendar

In the next phase, UNICEF supported the Government of Uttar Pradesh in 25 districts to establish SBCC plans at district levels. This aimed to address systemic challenges and create an enabling environment that helped improve the efficiency of SBM roll-out. The specific objectives of the district-level SBCC plans were to:

- Build and enhance knowledge and interest, and spur the demand for construction and use of toilets
- Promote, reinforce, and sustain practices of safe sanitation and hygiene behaviours

- Increase knowledge about sanitation and hygiene-related products and services
- Provide knowledge and clarifications related to SBM

For effective and sustained impact, the SBCC plan needed to have a strategic implementation timeline (i.e., allocating an appropriate time, at the appropriate place, with appropriate resources) in the form of an annual calendar.

UNICEF's support to district SBM team

UNICEF's C4D programme provided technical assistance to the district administration for the systematic planning and integration of SBCC in the programme delivery of SBM in rural areas. As part of its technical support, UNICEF C4D's role was to:

- Facilitate the district SBM team in preparing an SBCC plan and annual calendar for strategic implementation
- Identify resources for SBCC activities in the context of SBM
- Conduct a dissemination workshop at district level to share the SBCC plan with different stakeholders

SBCC approach and strategies

For a sustained behaviour change, SBCC recognises change at individual, community, and institutional level. The SBCC approach follows a socio-ecological model^[4] which helps understand and remove bottlenecks within the system by designing complex multi-level interventions. It acknowledges interdependency of individuals with policies, interventions, and processes to maximise influence at all levels. Thus, the SBCC strategy focuses on addressing barriers towards demand generation. Recognising this, different communication strategies were used for different stakeholders. These included:

- **Social mobilisation** to engage government line departments and local institutions such as Frontline Workers, community-based organisations, and self-help groups.
- **Interpersonal Communication (IPC)** for sustainable behaviour change in the community via increasing knowledge on the issue.
- **Entertainment education** to capture the

community's interest while educating them on key issues using locally popular mediums.

- **Mass media** for mass awareness and mobilisation around key issues.
- **Social marketing** for pooling resources in the most cost-effective manner by integrating marketing strategies and interventions to influence behaviour change regarding open defecation.
- **Advocacy** to engage with opinion leaders such as elected representatives, local popular persons from arts and culture, and religious and community leaders.



A register maintained by the head of *gram panchayat* to record communication activities and achieve ODF status in Mirzapur district.

Mapping of partners and pooling of resources

To ensure that human resources available at the ground level under SBM have effective SBCC skills, they were first mapped at district and block levels. Existing number of human resource across each village, block, and district from government departments such as *Panchayati Raj*, Health, Education, Rural Development, Uttar Pradesh State Rural Livelihood Mission, were identified. Non-government organisations, religious institutions, youth clubs, corporate organisations, and self-help groups who work in the field of sanitation were also mapped. In addition to human resources, potential platforms, events, and places of mass gathering were identified where ODF messages could be communicated. This was the first step to encourage convergence of departments to achieve the results of SBM.

Capacity development of the identified human resource at the ground level was done through CLTS training in SBM.

Action

1. Formulation of District SBCC Plans

1.1. The pre-planning stage: This stage provided an opportunity for the district SBCC team to look at the situation of open defecation in a holistic manner. It prepared the team with the information required to make district SBCC plans.

- **District Analysis:** A month before the formulation of the SBCC plan, UNICEF shared a template with the district SBM team to record the information required for formulation of the district SBCC plan such as:
 - Existing institutional arrangements for sanitation and hygiene
 - Number of human resources related to sanitation and hygiene within the district
 - Roles and responsibilities of identified human resources

The District *Panchayati Raj* Officer (DPRO) or District Programme Coordinator (DPC) from the district SBM team led the collection of information needed for district analysis.

- **Situation Analysis:** An assessment was carried out to understand existing open defecation practices in communities, factors associated with it, and community requirements to achieve ODF. For this, the SBM team carried out field visits as well as interactions with individual, family, community, and institutional-level stakeholders. The information from the situation analysis was presented on a given template by the district SBM team and shared with UNICEF C4D.
- **Strength, Weakness, Opportunity, and Threat (SWOT) analysis:** This was carried out jointly by the UNICEF C4D and SBM team at the district level. Based on the district and situation analysis, the key strengths to be utilised and the weaknesses that need to be minimised were identified.

Subsequently, a three-day workshop was conducted by the district SBM team and UNICEF C4D to develop an SBCC plan and annual implementation calendar.



Pradhan of one of the villages in Mirzapur district talking about how it achieved ODF status.

1.2. Planning stage

Day 1: Consultation and planning with stakeholders

- A key objective of the intervention was to plan social mobilisation activities rooted in the idea of convergence of different stakeholders to achieve the results of SBM. Few models of convergence existed at district, block, or village level before the SBCC plan.



- A consultation process was held at the district level in the DPRO office with representatives of District Rural Development Agency, Department of Education, Health, Women and Child Development, Uttar Pradesh State Rural Livelihood Mission, Civil Society Organisations/Non-Governmental Organisations, Faith-Based Organisations, and corporate organisations that implement development initiatives. The District Magistrate officially invited the above stakeholders to participate in the consultation workshop which ensured their participation and provided a platform for them to understand different activities being carried out by various stakeholders. Senior officials from these organisations were requested to attend, who then took responsibility for the implementation of activities suggested during the meeting.
- The workshop started with an orientation by UNICEF C4D team on the importance of SBCC in sustaining toilet usage, and the importance of key stakeholders to join hands and integrate the ODF agenda into their programmes and field activities.
- A list of existing IEC activities by different departments and organisations in the district was made. A brainstorming session was then conducted with participants, to come up with innovative and locally relevant ideas to:
 1. Improve knowledge on benefits of toilet use
 2. Motivate communities to eliminate open defecation, and adopt and sustain toilet usage



3. Monitor the impact of the measures adopted in the communities

Capacity and resources were mapped for the stakeholders present during this session.

- Based on consultations with various stakeholders, the C4D team with DPRO, DPCs, *Swachhata Preraks*, and Block *Preraks* finalised the district SBCC plan for one year. Only those activities were included in the plan, which the departments found easy to implement within their routine programme.
- Next, the Standardised Operational Procedure (SOP) for each activity was prepared. SBM functionaries planned behaviour change activities for their *gram panchayat* and blocks.

Day 2: Finalisation of district SBCC plan and calendar

- UNICEF C4D team, with district SBM team, finalised the district SBCC plan with stakeholders which included resource mapping, an annual implementation calendar, and a monitoring framework. The monitoring framework accounted for Monthly Review Meetings held by DPRO with key stakeholders, district-level Monthly Reports, and setting up of SBCC cell in War Rooms.
- Resource allocation including funds, identification of staff, vehicle, equipment, and IEC material was done for each activity.
- The SOP outlined different steps involved in the implementation of each activity with its timeline. The means of verification for the activities being designed was decided with a monitoring and evaluation tool for each.

Day 3: Dissemination

- The District Magistrate approved the SBCC plan and monitoring framework in the presence of other government and non-government stakeholders such as DPRO, DPCs, *Swachhata Prerak*, District Education Officer, Chief Medical Officer, Civil Surgeon, Departments of Education, Health, and Women and Child Development, Uttar Pradesh State Rural Livelihood Mission, Civil Society Organisations/Non-Governmental Organisations, Faith-Based Organisations, corporate organisations implementing development initiatives, and *Mahila Samakhya*.



Pradhan explaining the importance of using toilets to villagers and encouraging its sustained use.

2. Strategic implementation of SBCC activities

Activities planned and implemented under different heads of the SBCC plan were:

2.1. IEC implementation, monitoring, and management

- District and block-level War Rooms were established by SBM in rural areas. The War Room was conceptualised as a 24x7 communication mechanism to enable interaction between the district, block, and village-level stakeholders to eliminate open defecation. It provides for concurrent monitoring of field-level activities from the ODF process.
- Physical verification was carried out for *gram panchayats* which declared themselves ODF by an independent District Level Appraisal Committee.
- Monthly Review Meetings were conducted to review physical and financial progress like the construction of toilets, updating information systems, and progress of SBCC activities.

2.2. Interpersonal communication and capacity development

- CLTS approach was adopted to train identified human resources and communities to understand the situation of open defecation in their village, and form and implement village-level plans for sustained toilet usage by all. A five-day CLTS training module, developed by SBM with UNICEF – before SBCC plans were made – incorporated detailed SBCC training and encouraged participation from communities. This was aimed at generating demand for sanitary facilities and changing sanitation behaviours rather than just constructing toilets.
- Training was conducted by technical and SBCC experts for the participants of CLTS training, such as the head of the *gram panchayat*, Frontline Workers (FLWs), teachers, and religious leaders on social mobilisation, interpersonal skills, and the CLTS approach.
- Masons were trained at the district level on the construction of leach pit toilets. Discussions and demonstrations were held with communities on the benefits of leach pit toilets and its maintenance in the long run.

2.3. Social Mobilisation

- Exposure visits were carried out for the heads of *gram panchayats* and other change agents in the village to share best practices from other districts and influence positive sanitation behaviours.
- *Gram panchayats* which achieved ODF status celebrated and felicitated the change agents to motivate sustained toilet usage by all villagers. Change agents took a torch to the villages which had declared themselves ODF.
- Men, women, and children formed separate surveillance committees (locally known as the *Nigrani Samiti*). The surveillance committees worked as a monitoring mechanism within the village, as they identified people defecating in the open and stopped them from doing so, peacefully, without threats or punishments. Merchandise such as a whistle, jacket, and a cap was provided to the committee members for use during surveillance.
- Street plays and magic shows were carried out by local artists, and a video van was used to spread messages about sanitation and hygiene to the villagers.
- To create mass awareness, International Hand Wash Day and World Toilet Day were observed. Special Screenings of the Akshay Kumar-starrer

romantic-comedy movie '*Toilet- Ek Prem Katha* (a love story)' was organised. Akshay Kumar was made the SBM (rural) brand ambassador for Uttar Pradesh.

- In Mirzapur and Bhadohi districts, a 'Brother Number 1' competition was announced, where male members of the village were encouraged to build a toilet for their sisters during the Indian festival of *Rakhshabandhan*. The quality of toilets built for this competition was verified, and the participants were honoured and rewarded to encourage positive sanitation behaviours. The 'Brother Number 1' competition helped male members of the society understand the need for private space for women.

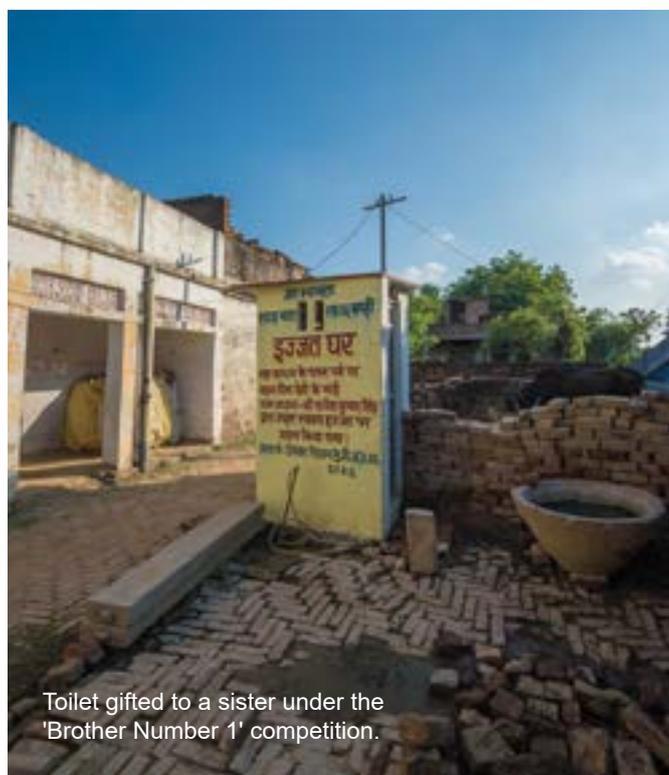
2.4. Convergence with different stakeholders

Education department: Parents of school children were encouraged to discuss construction of toilets, its use, and benefits. Students talked about their success in motivating villagers for the construction of toilet, use of the toilet, or any behaviour change related to sanitation. Events on the theme of sanitation were held on Independence Day, Republic Day, and Gandhi Jayanti.

Health Department: The Health Department used Frontline Workers to motivate women to construct and use toilets. Hoardings and banners were installed in front of healthcare centres. SBM messages and slogans were printed on all OPD (Out Patient Department) prescription slips. During home visits, FLWs counselled the adult members of the family about the construction of toilets, its use, and benefits. In community meetings, public health experts discussed health risks of open defecation, describing contamination of food and water.

Department of Women and Child Development: The department held discussions on construction of toilets, its use and benefits, and personal hygiene using flip charts, calendars, or pamphlets.

GARIMA girls: As part of *GARIMA*, a menstrual hygiene strengthening programme implemented by UNICEF, adolescent girls were mobilised to discuss menstrual health and hygiene, and advocate the importance of using toilets in their villages through engagement with peers, FLWs, and the community. The girls also discussed the need for toilets with their parents before harnessing resources of the *gram panchayat* to demand for toilets.



Toilet gifted to a sister under the 'Brother Number 1' competition.

2.5. Mass Media

- Posters were put up in all government offices, schools, health centres, and prominent places. Pamphlets and flyers were distributed by FLWs through different methods like home visits and village health events.
- To create an enabling environment, success stories and events related to ODF or SBM were shared with communities to raise awareness and improve knowledge.
- Walkathons and marathons were organised where all heads of *panchayats* and local youth participated to spread knowledge on sanitation and use of toilets.
- A video van, street and folk theatre, and audio-video materials were used in local languages in media-dark, hard-to-reach areas.



Children who were part of *Nigrani Samiti*.

Results

1. UNICEF C4D advocated with the district administration to ensure equal focus on SBCC along with construction of toilets through SBM, and developed SBCC plans and annual implementation calendars for 25 districts. The first SBCC plan was developed for Mirzapur district, and eventually followed by 24 other districts. These plans and activity calendars were reviewed and approved by the District Sanitation Committee (DSC) in 20 districts, where implementation has started. A review of the SBCC plan is set up with the DSC for other districts.
2. UNICEF C4D provided technical assistance to develop the structured district SBCC plan to ensure systematic engagement of stakeholders, and their capacity building. It resulted in acceleration of IEC fund utilisation and strategic implementation of communication activities. There is an increase in expenditure from **7.2** percent in September 2017 to **11.28** percent in November 2017, out of the total allocated amount of over 21 million USD for implementation of the SBCC activities.

Transformative Change

The following transformative changes were observed since formulation and implementation of the SBCC plans:

At the system level:

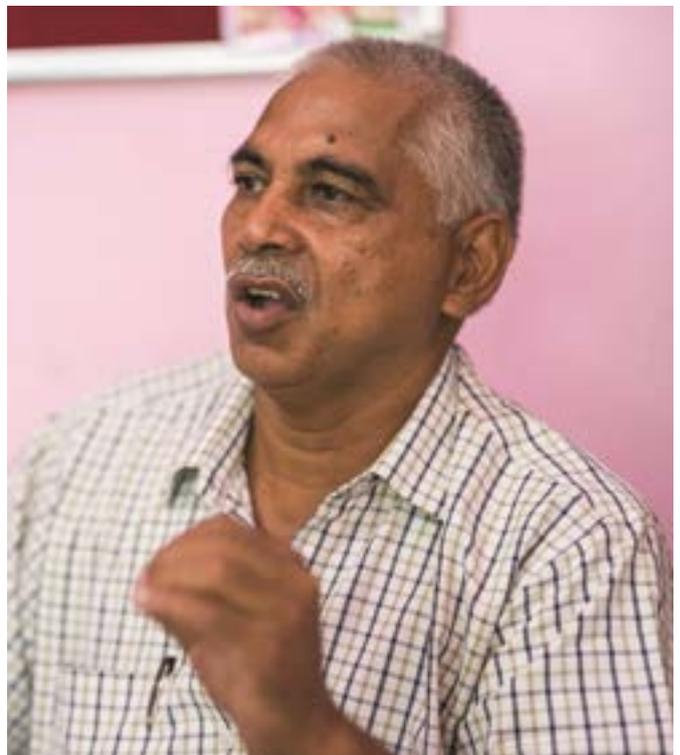
1. With motivation from UNICEF C4D, senior state and district SBM officials were intensely engaged in the formulation of the SBCC plans. A positive change was seen in government officials as they moved from a simple IEC approach for improved knowledge to a more comprehensive and layered SBCC approach. They understand the importance of SBCC in motivating positive sanitation behaviours in communities.
2. Key departments and stakeholders converged to formulate the SBCC plans and annual implementation calendar. They allocated resources for SBCC activities, interpersonal communication, community mobilisation, and advocacy.
3. Existing human resources available at the ground level for sanitation services are skilled in community mobilisation, interpersonal communication, and SBCC.

“We realised the need for Social and Behaviour Change Communication to influence the use of toilets, and UNICEF facilitated the formation of plans to do it. To meet the deadline to achieve the ODF status in blocks of Mirzapur, we planned the activities along with UNICEF at the district level in June 2017. Some representatives were present from each block, both from the government and non-government organisations, who were motivated to be involved in the formulation of SBCC plans. UNICEF was the partner sanctioned by the state government. We made concrete plans and fixed targets to achieve ODF status in the given time. After the workshop, various activities including the Community-led Total Sanitation (CLTS) training began, and it was scaled up across the entire district. We built capacities of the head of panchayat who could convey our messages to the villagers. Earlier, without the participation of the villagers, we could construct toilets; but nobody would use

them. There were a few innovations along the way, supported by UNICEF, like the ‘Brother Number 1’ competition where male members of the community were encouraged to gift toilets to their sisters. The SBCC plan helped in converging efforts of different departments. A district SBCC calendar was also formed with activities scheduled block-wise and day-wise, which guided us on how to roll out the training. It helped us systematically cover the entire district. We did not coerce people into using toilets; instead, we communicated the risks associated with open defecation. We have realised the importance of Social and Behavioural Change Communication in convincing people to change their sanitation behaviour.

There is now a demand from people to build toilets. They are ready to pitch in their own money for the same as they have realised its importance. Not only the rich, but the poor are also ready to construct toilets. With the help of an SBCC plan and calendar, Mirzapur has been nationally recognised for its efforts in eliminating open defecation.”

Arvind Kumar Singh
District Panchayat Raj Officer, Mirzapur
(Excerpt from the interview)





Adolescent girls mobilised by UNICEF to talk about menstrual health and hygiene, and to advocate the use of toilets.

At the community level:

1. SBM has reached out to certain remote areas with the help of SBCC plans.
2. People are building toilets with support from the government and with their own contribution, irrespective of their economic background. In addition, sustained usage of toilets has also been observed in villages, especially by women.

Various government departments and non-government organisations are working in tandem to integrate the issue of open defecation into their programmes. This reflects the success of SBCC plans in reaching out to the community at scale and across various sectors.

In Summary

UNICEF C4D, in providing technical support to *Swachh Bharat Mission (SBM)*, developed and implemented an SBCC-centred intervention in Uttar Pradesh to motivate healthy sanitation behaviour. Here is a blueprint of how the intervention was rolled out in 25 districts.

Action



The district SBCC team analysed the situation of open defecation through district, situation, and SWOT analysis. A plan was formulated after consultation with stakeholders, and relevant resources were allocated for dissemination.



CLTS was used to train resources and communities to understand the situation of open defecation and implement plans for sustained toilet use. The five-day CLTS training was used to impart SBCC training and encourage community participation.



District and block-level War Rooms were established as a 24X7 communication mechanism for interaction among stakeholders to eliminate open defecation. Monthly review meetings were conducted to monitor progress.



Street plays and magic shows were performed by local artists to create awareness on sanitation and hygiene. Exposure visits for change agents were carried out, along with movie screenings and contests for villagers.



UNICEF converged with various stakeholders such as Education Department, Health Department, Department of Women and Child Development, as well as adolescent girls to discuss and promote the use of toilets.



Street and folk theatre, posters, pamphlets, walkathons, marathons, and a video van were used to spread awareness and knowledge on the importance of hygiene, sanitation, and use of toilets.

Results

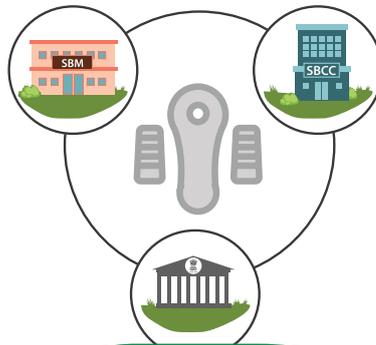


SBM ODF's SBCC plans and activities have been approved by the District Sanitation Committee (DSC), and implemented in 20 districts. Equal importance is given by SBM to SBCC, with the focus being the construction and use of toilets. A review of the plan has been set up with the DSC for other districts.



IEC fund utilisation and strategic implementation has accelerated since systematic engagement and capacity building of stakeholders on SBCC was done. There is an increase in expenditure from 7.2 percent in September 2017 to 11.28 percent in November 2017, of the total allocated amount of over 21 million USD.

Transformative Change



Government officials have moved from a simple IEC approach for improved knowledge to a more comprehensive and layered SBCC approach. Human resources at ground level for sanitation services are skilled in community mobilisation, Interpersonal Communication, and other SBCC activities.



Irrespective of their economic background, the community displays enhanced demand for SBM toilets, and there are frequent cases of people building toilets from their own resources with support from the government. Sustained use of toilets is now a common feature, especially among women.

References

- [1] *Swachh Bharat Mission (SBM)* (Clean India Mission), contains two sub-missions: *Swachh Bharat Abhiyan* ("Gramin" or rural), which operates under the Ministry of Drinking Water and Sanitation; and *Swachh Bharat Abhiyan (Urban)*, which operates under the Ministry of Housing and Urban Affairs. Run by the Government of India, the mission aims to achieve an Open-Defecation Free (ODF) India by 2 October 2019, the 150th anniversary of the birth of Mahatma Gandhi, by constructing 12 million toilets in rural India at a projected cost of ₹1.96 lakh crore (US\$30 billion).
- [2] A *gram panchayat* (village council) is the grassroots-level institution of *Panchayati Raj* (formalised local self-governance system in India at the village or small-town level) and has a sarpanch as its elected head.
- [3] Community-Led Total Sanitation (CLTS) is a community-wide behaviour change approach that mobilises communities to undertake their own appraisal and analysis of sanitation issues and take their own actions to become open defecation free (ODF).
- [4] https://www.unicef.org/cbsc/files/Module_1_SEM-C4D.docx
- [5] Uttar Pradesh Rural Livelihood Mission is a poverty alleviation project implemented by Government of Uttar Pradesh. This scheme is focused on promoting self-employment and organisation of rural poor. The basic idea behind this programme is to organise the poor into SHG (Self Help Groups) groups and make them capable for self-employment.
- [6] Coordinates work of the local governance system at the district level.
- [7] District Planning Committee (DPC) is the committee created as per the Constitution of India at the district level for planning at the district and below. The Committee in each district should consolidate the plans prepared by the Panchayats and the Municipalities in the district and prepare a draft development plan for the district.
- [8] DRDA has traditionally been the principal organ at the district level to oversee the implementation of anti-poverty programmes of the Ministry of Rural Development in India.
- [9] Uttar Pradesh State Rural Livelihood Mission (UPSRLM) is a society formed under the aegis of Department of Rural Development to promote and improve livelihoods of the disadvantaged sections of the rural population of the state. UPSRLM is registered under the Societies Registration Act of 1860.
- [10] *Swachhata Preraks* and Block *Preraks* are the catalysts of the programme at the district level, facilitating *Gram Panchayats* to achieve the 100 percent Open Defecation Free status. To achieve the ODF status, *Swachhata Preraks* will spearhead the activities of SBM by planning, coordinating, monitoring, and executing the annual implementation plan for sanitation in their respective districts.
- [11] District Education Officer is responsible for monitoring Educational, Administrative and Legal activities for schools in District under the Department of Education, Government of India.
- [12] Chief Medical Officer (CMO) in India is the senior government official designated head of medical services at the national level. The post is held by a physician who serves to advise and lead a team of medical experts on matters of public health importance.
- [13] A civil surgeon is a senior designated post in the government medical and health service.
- [14] The *Mahila Samakhya* Programme (Education for Women's Equality) that started in 1989 is a concrete programme for the education and empowerment of women in rural areas, particularly those from socially and economically marginalised groups.
- [15] Developed by UNICEF Water, Sanitation, and Hygiene programme, where C4D pitched in with the SBCC session.
- [16] A type of toilet that collects human faeces in a hole in the ground. They use either no water or one to three liters per flush with pour-flush pit latrines. When properly built and maintained they can decrease the spread of disease by reducing the amount of human feces in the environment from open defecation.
- [17] Akshay Kumar is an Indian actor, producer, martial artist, stuntman and television personality. In a career spanning more than twenty five years, Kumar has appeared in over a hundred Hindi films and has won several awards.
- [18] *Rakhi* or *Rakshabandhan* is a Hindu festival as part of which sisters tie a decorative thread on the wrist of their brother as a symbol of love and brothers promise to protect them all their life. The festival involves exchange of gifts, usually by the brother to the sister.
- [19] Responsible for implementing SBM in India, they look after the overall policy, planning, funding and coordination of programmes of drinking water and sanitation.
- [20] These changes have been observed within a small timeframe.

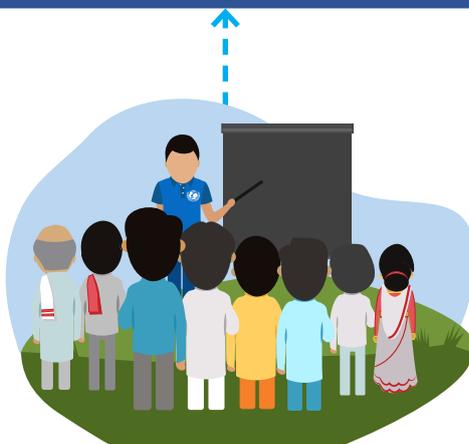
District SBCC Cells System Strengthening for Improved Capacity in Social and Behaviour Change Communication in **West Bengal**

The Government of West Bengal implements various flagship programmes to protect and promote the rights of children. These include Integrated Child Protection Scheme^[1], *Sarva Shiksha Abhiyan*^[2], Integrated Child Development Scheme^[3], National Health Mission^[4], Mission *Nirmal Bangla*^[5] for development of children, adolescents, and women. These programmes approached communication from a knowledge and education lens, and included an Information, Education, and Communication (IEC) component rather than the broader perspective of Social and Behaviour Change Communication (SBCC), which includes dialogical processes to bring in individual, societal, cultural, and environmental changes for desired norms and choices. Different government departments implementing the programmes did not have a strategic and structured approach to behaviour change communication, and had limited human resources and the lack of skill to deal with SBCC. The district administration of Purulia, Murshidabad, South 24-Parganas, and Malda established district SBCC cells with support from UNICEF's Communication for Development (C4D) programme in West Bengal. It aimed to integrate planning and implementation of SBCC to achieve the goals of flagship programmes. In order to develop a critical mass of grassroots personnel capacitated on concepts and processes of SBCC, human resources were identified within the system at district, block, and *gram panchayat* level, and training was cascaded for capacity building. Various communication approaches such as Interpersonal Communication (IPC), mid-media, folk media, and mass media were used to positively influence behaviour at the individual and community level. Influencers such as religious leaders and *gram panchayat* members were mobilised and involved in the process. As a result, key functionaries adopted the SBCC approach, and a pool of skilled human resources with improved communication, planning, implementation, and monitoring skills is now built within the system. The programmes communicate with people living in remote areas in a more effective and systematic manner, creating more demand for services and better adoption of desired behaviours.

Theory of Change



1. Shift to SBCC approach
2. Building of a pool of human resource skilled in SBCC
3. Strategic planning, implementation, and monitoring of SBCC component
4. More stakeholders demand for services and adopt the desired behaviours



1. Structuring of three-tiered district SBCC cells
2. Mapping and identification of human resources at district, block, and *gram panchayat* level

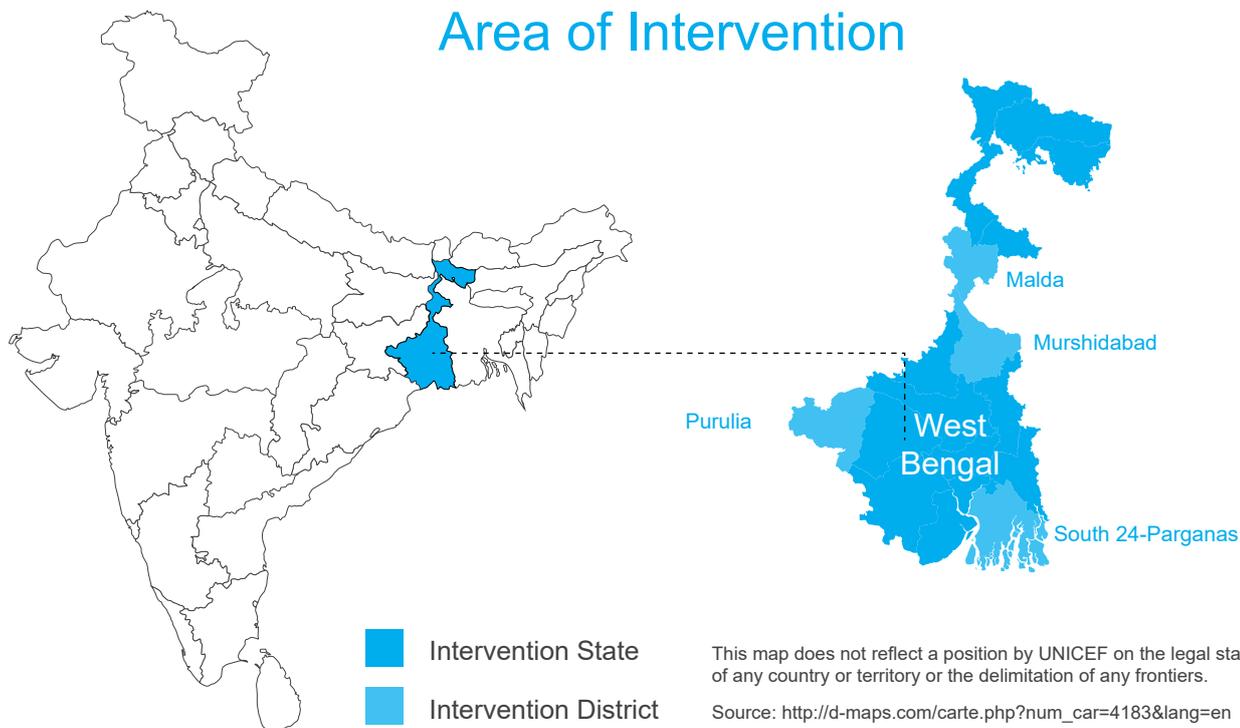
IEC approach rather than SBCC approach

Lack of structure and planning for SBCC component under development programmes

Lack of human resource trained in SBCC within the government

Priority given to implementation, SBCC not considered important

Area of Intervention



Situation

In West Bengal, an eastern state of India, various programmes are implemented by the government to address poor development indicators such as low institutional delivery, high school dropout rates, high incidence of anaemia in children, and low immunisation coverage. The flagship development programmes include Integrated Child Protection Scheme, *Sarva Shiksha Abhiyan*, Mission *Nirmal Bangla* (MNB), Integrated Child Development Scheme, and National Health Mission among others. These programmes strongly contribute to the survival, development, protection, and empowerment of children, adolescents, and women, especially those belonging to poor and remote communities.

Information, Education, and Communication (IEC) is a component of these programmes, with existing budgetary allocations and guidelines for its utilisation and planning. Key challenges identified in utilising the IEC component to achieve the results of flagship programmes were^[6] that:

1. IEC only focuses on conveying messages and improving the knowledge of participants to accelerate results of the programmes. There was a need for key functionaries to shift to a more comprehensive SBCC approach, as it includes change at individual, societal, cultural, and

environmental level, and uses a host of strategies and communication approaches.

2. Communication interventions were not evidence-based and lacked proper planning and structure. Hence, communication activities were carried out in an ad hoc manner.
3. The core implementation of development programmes was given more importance. SBCC was considered a soft skill and not given priority by officials.
4. Officials at district, block, and *gram panchayat* level had limited skills to plan, implement, and monitor communication activities. Available human resources who had SBCC skills to carry out social and behaviour change communication at the ground level were also very limited.

UNICEF West Bengal's C4D programme is helping the district administration of Purulia, Murshidabad, South 24-Parganas, and Malda to improve communication of flagship programmes by establishing and strengthening the district SBCC cell. Mapping of human resources is one of the key activities undertaken by the district SBCC cell to improve child survival, growth development, and protection.

The SBCC cell Account Assistant cum Data Entry Operator operating from the SBCC cell room in Malda district.



Method

The district administration established an SBCC cell for evidence-based change communication to achieve the results of flagship programmes and schemes. It coordinates with various line departments and their flagship programmes for the systematic planning and review of SBCC activities. UNICEF West Bengal's C4D programme provides technical knowledge to the government for system strengthening and capacity development. UNICEF intends to utilise the learnings from this programme to demonstrate the impact of the SBCC cell. These learnings would be used to replicate and scale up the programmes in other districts.

The objectives of the SBCC cell are to:

1. Identify the scope and plan of social mobilisation activities to increase demand for services under various flagship programmes, especially those related to children, women, and adolescents.
2. Provide technical support to the programmes to plan and implement SBCC activities.
3. Coordinate with different government departments at district, block, and community levels.
4. Develop field-tested messages to influence critical behaviour and social norms.

5. Build Interpersonal Communication (IPC) skills of the Frontline Workers (FLWs).
6. Strategically engage with youth, adolescents, village volunteers, self-help groups, non-government organisations, and religious leaders.
7. Periodically review the progress and challenges of the SBCC activities of different programmes.

For this purpose, human resources were identified within the government at the district, block, and the *gram panchayat*⁽⁷⁾ level and trained for systematic community mobilisation.



District Nodal Officer of Malda district's SBCC cell.

Table 1: Human Resources identified at each level within the government

District level	Key Resource Persons (KRPS)
Representatives of line departments such as Health and Family Welfare, Women and Child Development, Education, and Rural Development.	
Block level	Master Trainers (MTs)
Representatives of line departments such as Health and Family Welfare, Women and Child Development, Education, and Rural Development.	
<i>Gram panchayat</i> level	Critical Mass of SBCC Volunteers
Frontline workers such as Accredited Social Health Activist (ASHA) ^[8] , Auxiliary Nurse Midwife ^[9] , <i>anganwadi</i> workers ^[10] , self-help groups, adolescent peer educators, and other resource persons from government programmes working at grassroots level.	



Key Resource person from Child Protection Unit, Malda district.

At the *gram panchayat* level, human resources were identified to directly engage with the community at regular intervals, with many of them even belonging to the community. Training is cascaded at various levels rather than at one go. Key Resource Persons (KRPs) at the district level were trained on SBCC and, on qualification, they became trainers for Master Trainers (MTs) at the block level^[11]. This is repeated to train a critical mass of SBCC volunteers at the *gram panchayat* level.

They are trained with the help of TARANG SBCC training package, which was essentially developed by UNICEF's C4D programme for health system strengthening. UNICEF West Bengal's C4D programme adapted and expanded the module to cover capacity development and system strengthening of other flagship programmes, in addition to programmes

on health. Further, to plan the SBCC component in the programmes, the SBCC cell used multi-pronged communication approaches, which included:

- **Interpersonal communication:** Facts For Life (FFL) videos^[12], IEC materials, flip charts, posters, and focus-group discussions on different platforms
- **Community mobilisation:** Mid-media, folk media, local performances, drama, and popular traditional media like puppet and magic shows
- **Information and Communications Technology:** Mobile-based messages and WhatsApp
- **Outdoor media:** Hoardings and wall paintings
- **Mass media:** Audio-video spots on television, radio, and print media

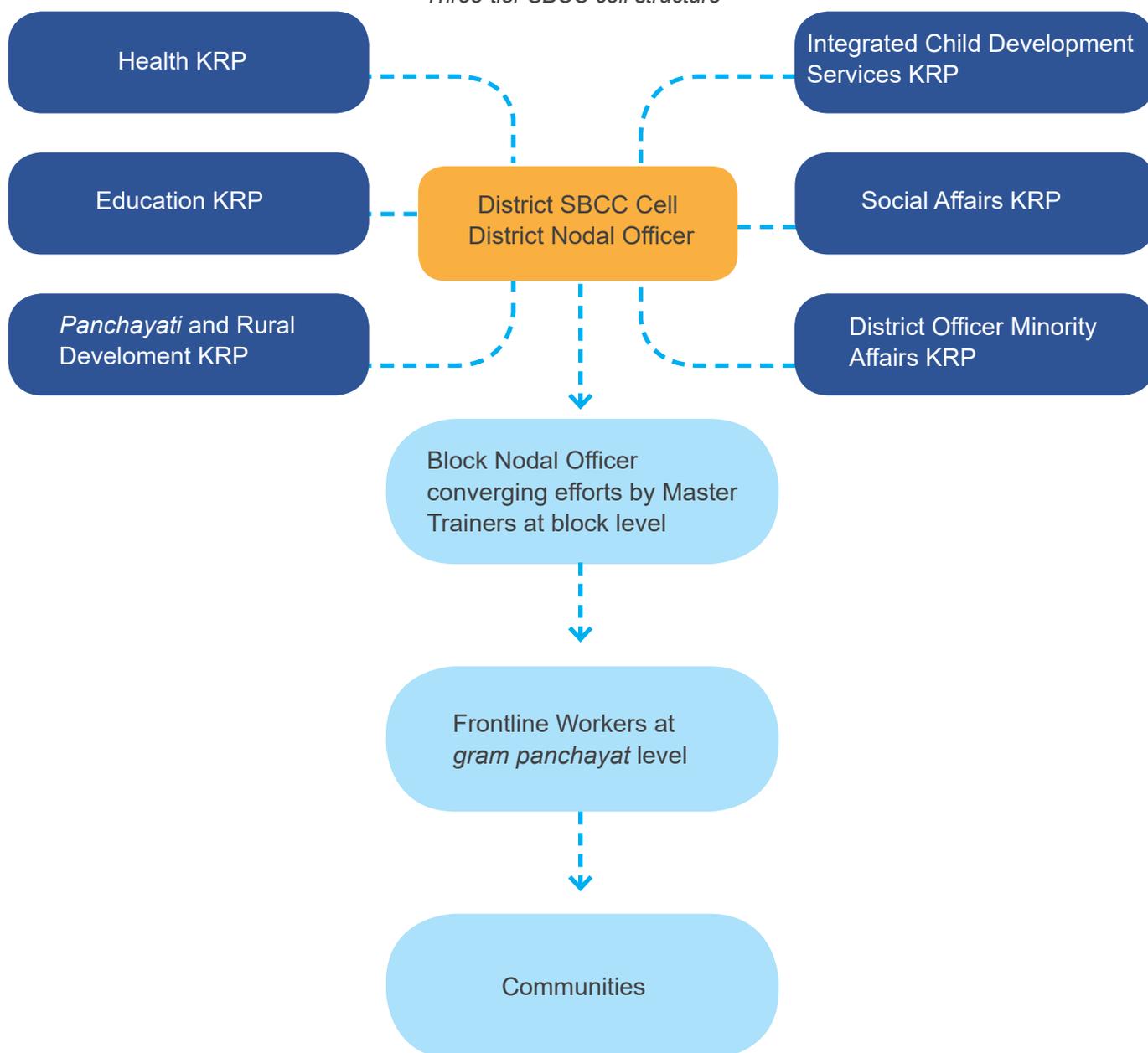
UNICEF West Bengal's C4D programme supported the Malda district administration in developing a mascot for SBCC activities, and popularised *Fazlee Babu* as an innovative strategy for effective communication. *Fazlee* is a famous local variety of mango, which people identify with easily. Malda uses *Fazlee Babu* as the district communication mascot to promote different flagship programmes. The *Fazlee Babu* communication package consisted of audio, animations, hoardings, kiosks, banners, posters, flyers, brochures, stickers, batches, and head/wristbands. Repository of the available SBCC material under different programmes was also revised and used.



Action

Structuring SBCC cell

Three-tier SBCC cell structure





Frontline worker from
Bhutni, trained in SBCC

- The district administration assigned a senior official of the rank of Deputy District Magistrate as the District SBCC Nodal Officer under the aegis of the District Magistrate^[13] and Additional District Magistrate (General)^[14]. The District Nodal Officer leads the district SBCC cell and converges efforts of line departments such as Health and Family Welfare, Women and Child Development, Education, *Panchayat and Rural Development (P&RD)*.
- The District Nodal Officer coordinates with all line departments to systematically map out SBCC provisions of each department, and then chalks out a convergent plan for SBCC activities so that an effective and convergent plan can be made.
- UNICEF oriented the district SBCC cells on:
 - (i) SBCC component of flagship programmes;
 - (ii) the importance of SBCC for development;
 - (iii) behaviour change process; (iv) planning and monitoring of SBCC activities; and, (v) the roles and responsibilities of district and block-level nodal officers. UNICEF supports the district SBCC cell in coordinating with the line departments.
- A Key Resource Person (KRP) was nominated from select line departments implementing the flagship programmes at the district level based on his/her technical knowledge, communication skills, and interest to participate in the SBCC activities. They are responsible for coordinating with the SBCC cell regarding their department's SBCC activities, utilisation of SBCC funds as per annual implementation plan, and monitoring of the SBCC activities. They shared their SBCC plan with the district SBCC cell for effective coordination.
- At the block level, a senior official was identified as Block Nodal Officer (BNO) who led all the activities at the block level. The BNO supports the District Nodal Officer in the functioning of the block SBCC cell and converges inputs from the line departments at the block level.
- Master Trainers (MTs) nominated from line departments implemented the block's SBCC activities and coordinated SBCC's fund utilisation with BNO. MTs developed an SBCC plan for the blocks, and the same was shared with the district SBCC cell for effective coordination.
- At the *gram panchayat*-level, a Critical Mass or social capital of human resource was identified from within the government system through a Human Resource Mapping format designed by UNICEF West Bengal's C4D programme. They are responsible for communicating with women, children, and adolescents to share information about numerous services available for health, protection, education, development, and protection.

Capacity Development through Cascade approach

- SBCC experts from the district administration and UNICEF train KRPs in a three-day workshop to develop their communication skills, interpersonal communication, understanding of SBCC, planning, implementation, monitoring, and documentation for SBCC activities.
- The KRPs train the MTs, which helps them understand planning, monitoring, and evaluation of SBCC activities in different flagship programmes. They are trained to develop SBCC plans for implementation at the block level.
- The MTs train the Critical Mass at *gram panchayat*-level to provide a clear view of the importance of SBCC and to develop village action plans for delivering the key messages to communities.
- Community influencers work in tandem with the government to positively influence behaviour change. Self-help groups, *gram panchayat* members, folk artists, teachers, youth groups, members of various committees, and local Non-Government Organisations are sensitised separately. They are motivated to foster communication and social mobilisation activities such as organising community meetings, SBCC activities, and monitoring at the village level.



Master Trainer training the Front Line Workers

Results

UNICEF has successfully facilitated the formation of district SBCC cells in the four districts. It was established in Purulia in 2006, South 24-Parganas in July 2014, Murshidabad in July 2014, and Malda in September 2015.

Grassroots-level human resources were identified through systematic mapping and trained on SBCC. This was done through the cascading method so that, as key agents, they could bring in social and behaviour change in their respective areas.

Details of human resources mapped in four districts are given in the table below:

Human Resource	Malda	Purulia	South 24-Parganas	Murshidabad
Key Resource Persons	25	27	24	22
Master Trainers	452	361	06	347
Critical Mass of SBCC volunteers	45,982	8,255	50	8,000

Frontline Worker from Bhutni trained on SBCC.



to influence behaviour change at community level. We have invited community influencers such as doctors and religious leaders to interact with the community. A key strategy of the SBCC cell in South 24-Parganas is to communicate with community members regularly on pressing issues to improve institutional delivery, encourage breastfeeding, and improve knowledge on dengue.”

**Mahua Das, District Nodal Officer,
South 24-Parganas**

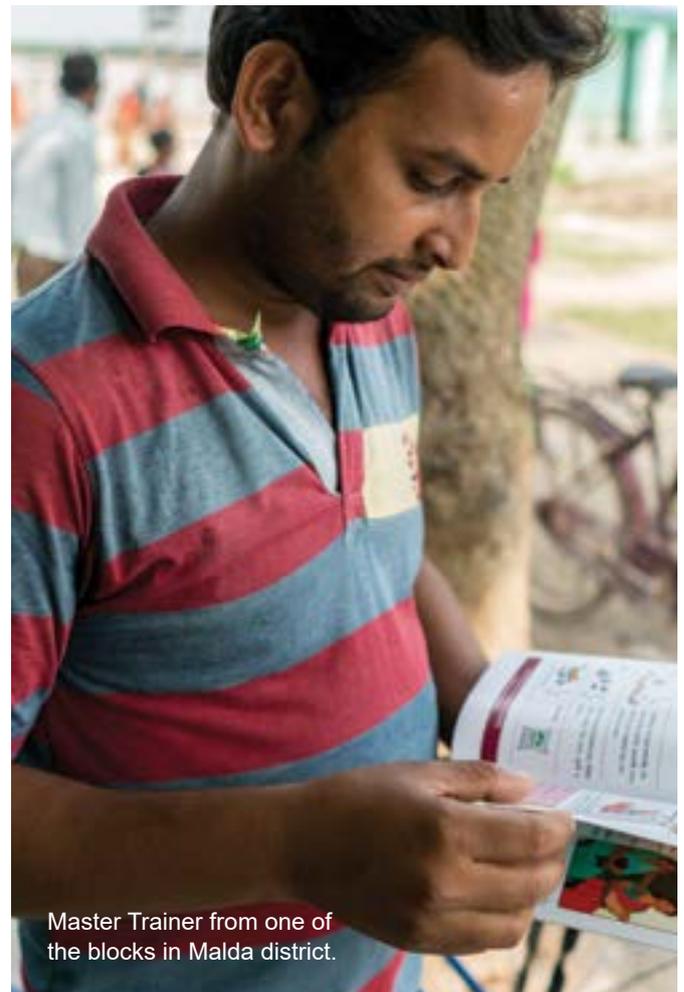
Transformative Change^[16]

The following transformative change can be observed at the system and community level:

At the systems level

1. Key functionaries have moved from IEC to a more holistic SBCC approach which encompasses evidence-based communication strategies at individual and community level. Various government departments now understand and appreciate community-led behaviour change, and have prioritised the SBCC component in flagship programmes for effective implementation to achieve their results.

“The district SBCC cell in South 24-Parganas has helped plan and implement communication activities of different programmes more efficiently, and achieve better results. Earlier we had an IEC approach to communication activities, where we used to convey messages through posters and pamphlets. Now, we have shifted to a comprehensive SBCC approach which is much more than just distribution of posters and putting up hoardings. It is more interactive and involves the community in all activities



Master Trainer from one of the blocks in Malda district.

2. Communication activities under flagship programmes of different departments are better planned and structured. Officials recognise their role in influencing behaviour change, and integrating their efforts to convey key messages in a comprehensive way. The SBCC cells are effective in encouraging integrated planning of SBCC activities in the district.

"Due to gaps in the implementation of the Sarva Siksha Abhiyan, we haven't been able to reach 100 percent enrolment of students in schools. There are other factors at play such as child marriage, trafficking, and labour due to which children don't go to school. The district administration focuses not only on improving education but also controlling these factors. We need to mobilise the community, for which we need to trigger people through SBCC. We achieved mobilisation systematically and developed SBCC plans at district, block, and village level. We organised SBCC activities which included folk artists and religious leaders. The Department of Health, Women and Child Development, and Education are working together to reach 100 percent enrolment. Earlier,



we didn't know what other departments were doing, but now we are working together and delivering better."

**Anjan Mishra,
Key Resource Person
District Planning Co-ordinator, Sarva Siksha Abhiyan, Malda**

3. A large pool of human resources within the government is available who are trained in SBCC, systematic planning, and implementation of communication activities to achieve results of flagship programmes.

"All line departments under the district administration have development programmes with a separate IEC component. However, we now have a more comprehensive Social and Behaviour Change Communication strategy to convey messages and influence behaviour change at individual and community level. We built a team of trained Key Resource Persons, Master Trainers, and Frontline Workers who plan and implement the SBCC activities at district, block, and gram panchayat level. FLWs were deployed at the grassroots-level to reach out to people to influence critical behaviours and norms. We have learned that community-led change is sustainable and community motivation is the key component. We have provided the community with services, and now the community has taken



ownership to improve their own situation. There is also an increase in demand for these services. We are continuously trying to strengthen the SBCC cell so it will run without support from UNICEF, and only then can we call it successful."

**Sulak Kumar Pramanik
District Nodal Officer, SBCC cell, Malda**

4. Implementation of SBCC activities has contributed to the increase in institutional delivery, decrease in school dropouts, child marriage, and elimination of open defecation.



"There are various government programmes like the Swachh Bharat Mission and Sarva Siksha Abhiyan, as part of which we sought to eliminate open defecation and decrease school drop out rates. However, the situation was such that toilets were constructed but not used. In the education sector, teachers weren't delivering to their true potential despite adequate infrastructure in schools, and students failed because of poor education.

District-level workshops were held to assess the situation and come up with SBCC strategies to be incorporated in the flagship programmes. Through the SBCC cell, we conducted programmes to influence change in communities. We organised folk songs and encouraged community influencers such as Imams and Purohits to talk to the community about the benefits of ODF and continuing school education.

A lot of work has been done by all government departments, as evident by the ODF status achieved by many villages in the district, and the decrease in the school drop out rate."

**Debotosh Mondal,
Additional District Magistrate,
Land Reforms Malda**

“The Anandi programme is run by the government to address low institutional delivery in the district, which was 58% in 2014-15. In August 2016, district-wide sensitisation was held to spread messages about the importance of institutional delivery. The situation improved slowly and, currently, institutional delivery has reached 90% in the district. This improvement was because of the use of various communication strategies. We invested our resources to develop need-based communication materials. We put up hoardings at three strategic places in every block, and wall messages on houses. A local mascot, Fazlee Babu (the local mango), was used to popularise the messages. The messages were well researched and sensitive to the local cultural context. We sensitised different stakeholders such as panchayat members and self-help



groups on immunisation. On a scale of 1 to 10, I can say that our communication skill has improved from 2 to 7.”

Dr. Mrinal Kanti Das Deputy II Chief Medical Officer, Malda

“The Child Protection Unit has trained SBCC volunteers such as Frontline Workers and school teachers in 10 blocks of the district on SBCC, and its importance in achieving results of child protection programmes. We focused on improving immunisation, and decreasing child marriage and child labour in the district. We provided community members with information on behaviours for child growth, development, protection, and empowerment. We organised talk shows by community influencers, showed videos, and initiated participatory activities. Due to all the efforts, we have seen a decrease in the prevalence of child marriage in the district. Earlier, girls were not able to complete their education and married before the age of 16. Now, due to improved knowledge of the effect of child marriage on the health of adolescents, especially girls, parents marry them only after they cross 18 years of age.”

Sonali Das, Key Resource Person, SBCC cell District Child Protection Unit, Purulia

At the community level

1. Through the effective communication material and cascade approach of training, the government has been able to reach out to remote areas in large numbers through the critical mass of SBCC volunteers.

“The concept of SBCC cell came to Malda in 2015. SBCC cells at district and block levels have identified Key Resource Persons and Master Trainers, and trained them on the SBCC component and how to use it to implement the flagship programmes. It has helped different departments converge their efforts and implement their programmes more efficiently. Through the cascade method, we have been able to reach out to people at the grassroots level who require help from the government. Communication strategies such as community radio, magic shows, quizzes, and folk songs attract the attention of people and help reach media-dark communities where the government was unable to reach out earlier. These communication activities made it easier to explain key messages to many stakeholders.”

Hemadri Sarkar Department of Self Help Group and Self Employment, Malda district



SHG member being trained by Master Trainer.

2. Community influencers such as SHG members, religious leaders, folk artists, and *gram panchayat* members are mobilised and trained

to carry out SBCC activities to positively influence the behaviour of communities.

"I have been associated with the district administration's development work for the last 6 years, and with the SBCC cell since the last 2 years. Earlier, the administration used to ask me and my team to perform Gombhira, the local folk art, on an ad hoc basis whenever required. After the formation of the SBCC cell, our activities are more systematic and planned. Plans are formed by the government and our activities are incorporated in those plans. We were first given training on the topics we needed to communicate. We were given detailed information on the effects of open defecation and benefits of breastfeeding. We wrote songs and dramas on these topics. Officials reviewed our script and songs before we performed it for better delivery. Frontline Workers mobilise the community and invite them to our performance. The dramas are interactive and educational for the viewers. People do not pay attention if an outsider merely lectures them. We belong to the same community and speak to them in the local language, so people like to listen to us. They learn and enjoy at the same time. After we finish our performance, we ask questions, interact with the villagers, and gauge how much of the content they have actually absorbed. We give out prizes if they answer correctly – which motivates them to pay attention."

Ashok Chakraborty, Folk Artist, Malda

With support from UNICEF West Bengal's C4D programme, SBCC cells were established. They facilitate sustained improvements in the provision, utilisation, quality, and efficiency of services through

the government, and encourage the adoption of healthy behaviours and practices at individual and community levels.

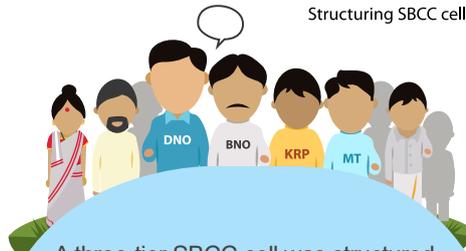


SHG members interacting with each other after a session on SBCC.

In Summary

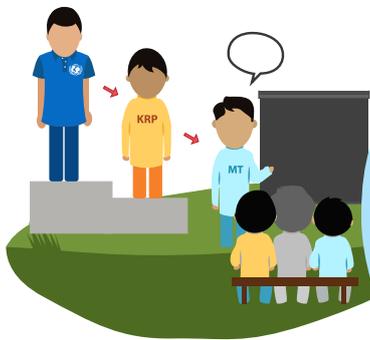
UNICEF initiated an intervention to strengthen the implementation of flagship programmes through an SBCC approach, as opposed to the commonly followed Information, Education, and Communication (IEC) route. It supported administrations in establishing SBCC cells, and mapping and identifying grassroots-level human resources to capacitate them on the components and processes of SBCC. Here's a blueprint of how the intervention was rolled out in four districts of West Bengal, namely Purulia, Murshidabad, South 24-Parganas, and Malda.

Action



A three-tier SBCC cell was structured, consisting of a district and block SBCC Nodal Officer each, who coordinates with line departments. A Key Resource Person (KRP) was nominated at the district level, and Master Trainers (MTs) at block level from the line departments. At the *gram panchayat*-level, a Critical Mass or a social capital of human resource was identified for the same purpose.

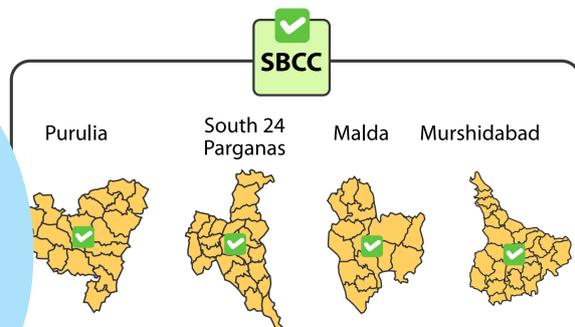
Capacity Development



SBCC experts from the district administration and UNICEF trained KRPs on SBCC and various related areas. The KRPs trained MTs, who in turn trained the Critical Mass. Community influencers, self-help groups, folk artists, teachers, and various other stakeholders were then sensitised separately and motivated to foster SBCC activities.

Results

SBCC cells have successfully been facilitated in the four districts — Purulia in 2006, South 24-Parganas in July 2014, Murshidabad in July 2014, and Malda in September 2015.



Through the cascade method, many human resources were identified and trained to become a social capital for change.





At the system level:

Key functionaries have moved on from IEC to a more holistic SBCC approach. Activities under flagship programmes are better planned and structured, and a large pool of SBCC-skilled human resources is available. There has been an increase in institutional delivery, a decrease in school dropout, child marriage, and open defecation.



At the community level:

The cascade approach of training has helped the government reach out to remote areas in large numbers. Community influencers like self-help groups, religious leaders, folk artists, and *gram panchayat* members also positively influence community behaviour through the training.

Transformative Change

References

- [1] <http://www.wcd.nic.in/schemes/integrated-child-protection-scheme-icps>
- [2] http://www.wbsed.gov.in/wbsed/home_public_pbssm.php?stake_code=19-14
- [3] <http://icds-wcd.nic.in/icds/icds.aspx>
- [4] <http://nhm.gov.in/>
- [5] <http://www.missionnirmalbangla.in/>
- [6] Based on Key Informant Interview with West Bengal UNICEF Communication for Development (C4D) team.
- [7] *Gram Panchayat* (village council) is the grassroots-level of *Panchayati Raj* formalised local self-governance system in India at the village or small-town level, and has a sarpanch as its elected head.
- [8] Accredited social health activists (ASHAs) is community health workers instituted by the government of India's Ministry of Health and Family Welfare (MoHFW) as part of the National Rural Health Mission (NRHM).
- [9] Auxiliary nurse midwife, commonly known as ANM, is a village-level female health worker in India who is known as the first contact person between the community and the health services. ANMs are regarded as the grassroots workers in the health organisation pyramid.
- [10] *Anganwadi* workers work at the rural mother and child care center in India. They were started by the Indian government in 1975 as part of the Integrated Child Development Services programme to combat child hunger and malnutrition.
- [11] http://jespnet.com/journals/Vol_3_No_2_June_2016/12.pdf
- [12] Facts for Life videos, published by UNICEF, contains essential information that families and communities need to know to raise healthy children.
- [13] A District Collector, often abbreviated to Collector, is an Indian Administrative Service (IAS) officer in charge of revenue collection and administration of a district in India.
- [14] Assists a District Magistrate in carrying out day-to-day work in various fields.
- [15] Based on programme documents.
- [16] Based on Key Informant Interview with the District and Block SBCC cell and line departments.
- District SBCC cell, Malda district: <http://www.sbccmalda.org/>

unicef  | for every child

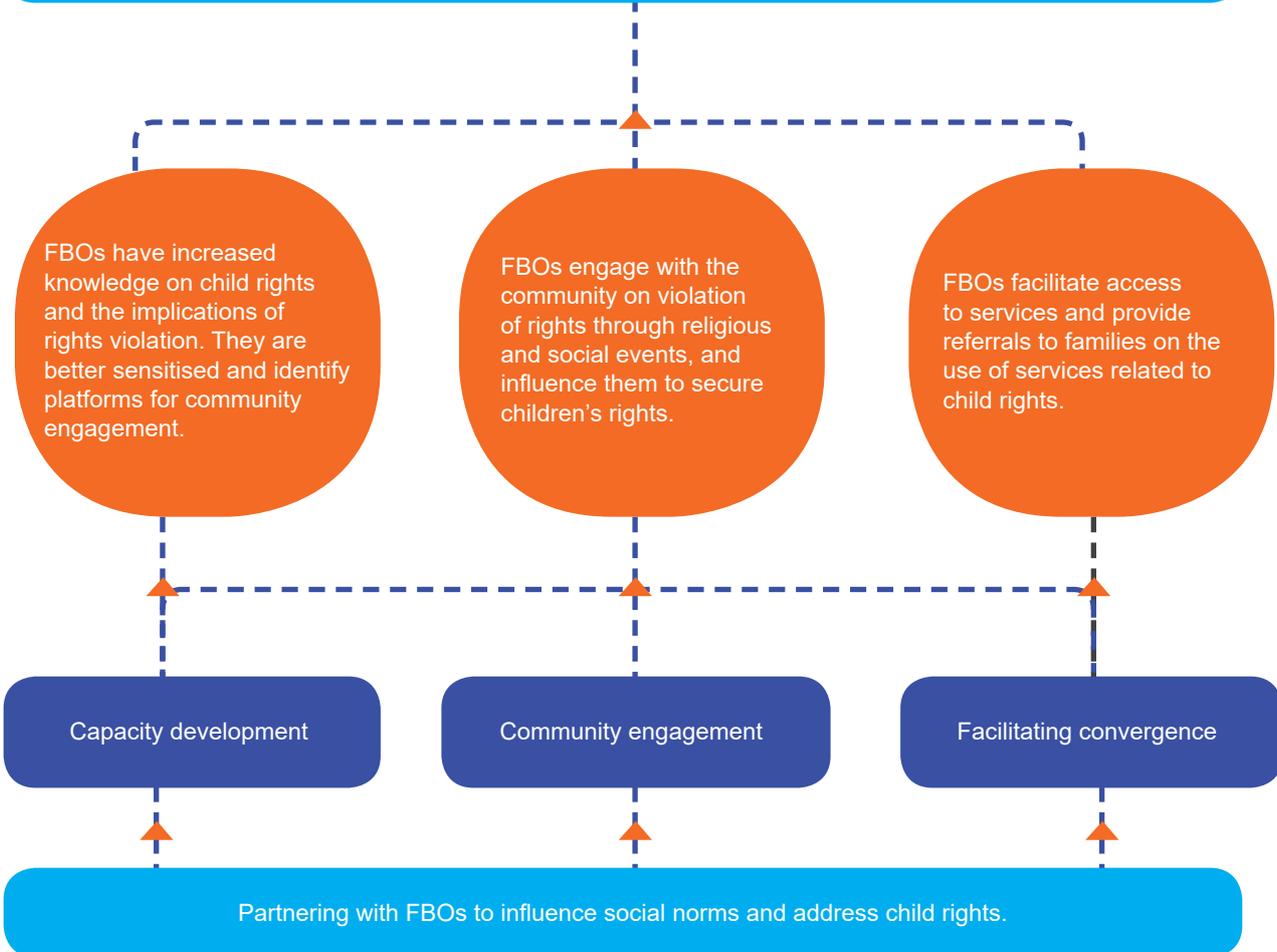
Nudging Norms through Faith Based Organisations for the Promotion and Protection of Child Rights in **Telangana**

Child marriage, child labour, child trafficking, and violence against children are common place in the Khammam and Mahabubnagar districts of Telangana. To tackle these issues, UNICEF collaborated with the Centre for World Solidarity⁽¹⁾ and Faith Based Organisations (FBOs) to implement an initiative to secure child rights in the two districts, in January 2017. UNICEF developed a sustainable and systematic model of collaboration with FBOs — they were identified, mobilised, and given capacity building on Social and Behaviour Change Communication (SBCC), child protection, child rights, and their violation. FBOs influence and shape beliefs, norms, and behaviour as they frequently interact with the community and are highly respected. Based on a successful previous collaboration on polio vaccination facilitated by the FBOs, UNICEF partnered with them in the Mahabubnagar and Khammam district of Telangana to address high child marriage rates and other child protection issues in these areas. Facts for Life (FFL) videos and SBCC materials were used for the capacity development of these FBOs. They actively participated in social and religious events to engage with the community and influence them to effect change in social norms. Moreover, FBOs have begun developing their own child protection policies. Communities are now better aware, and committed to protecting their children from child labour, child marriage, child trafficking, violence, and abuse.

Theory of Change



Communities are now sensitised, mobilised, and committed to the protection of child rights. FBOs in the intervention villages actively participate in social and religious events to engage with community and influence them on children's rights. They are also developing their own Child Protection Policy to protect children's rights



Prevalence of child marriage, child labour, child trafficking, and violence against children in the community.

Situation

Practices like child labour and child marriage deprive children of their childhood, health, and education, putting them at risk of a poor health and immunity, violence, and sexual abuse – all in violation of their basic rights^[2]. According to the Census of India 2011, 4.3 million children aged between 5-14 years were working^[3], and 27 percent women aged between 20-24 years were married as children^[4].

In the Mahabubnagar and Khammam districts of the Indian state of Telangana, the percentage of women who get married and bear children before they turn 18 is relatively higher than the state and national averages^[5]. Child marriage aside, child labour, child trafficking, and violence against children are also prevalent in the two districts. UNICEF’s report on the condition of child workers states that 6.6 percent children in Mahabubnagar and 4.4 percent in Khammam district were involved in child labour in 2011 – the former being higher than the state (4.9%) as well as national (3.9%) average^[6]. As far as human trafficking goes, Telangana ranks 4th in the country^[7].

Social norms around child marriage^[8]:

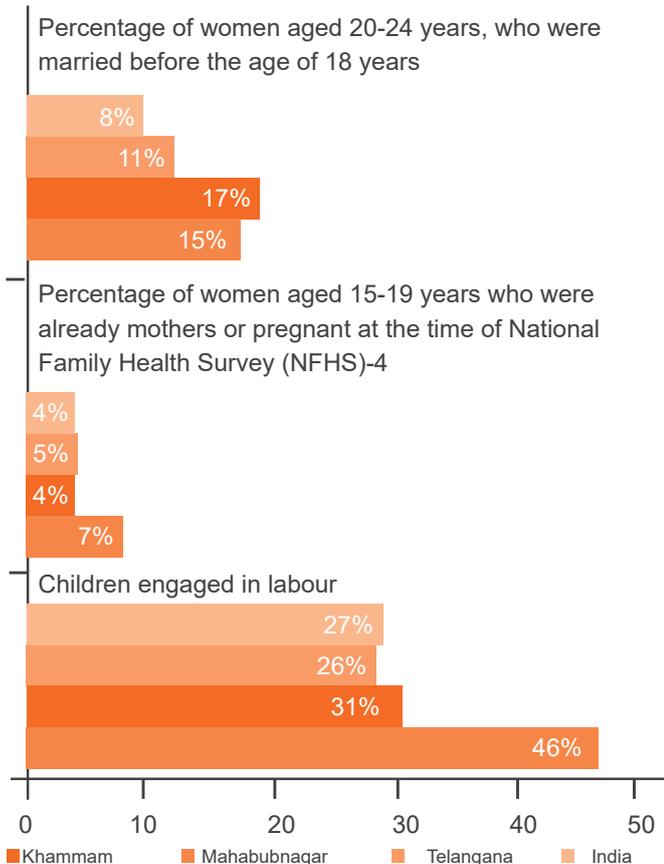


Figure - 1: Prevalence of child marriage, early pregnancy, and child labour



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.

Source: http://d-maps.com/carte.php?num_car=4183&lang=en

Widespread social approval of child marriage is among the most critical factors that drive high prevalence of child marriage in the community. Other norms and beliefs that cause this are:

- Economic considerations:** Unmarried girls are considered an economic burden to the family. A girl is considered *Paraya Dhan*, or someone who belongs to her future husband's family. Hence, parents are unwilling to invest in their daughters' education and nutrition. To reduce the high cost of wedding ceremonies, children are married during other community celebrations. For instance, when a communal feast is held in honour of the death of an elderly person, the opportunity is seized to carry out marriage celebrations — serving the dual purpose of saving money and ending the mourning with an auspicious and happy event.
- Gender norms:** Girls and women are perceived to have an inferior position in society. Major decisions like marriages are taken by the father or by head of the family, who is usually a man.
- Safety and security:** Communities view child marriage as a means to save the family honour, which they fear losing in case of a premarital sexual relationship. This is grounded in the prevalent gender norm of the virginity of girls. Consequently, marriages are arranged either immediately after or before a girl attains puberty.

- **Custom of dowry:** The understanding of many families is that the girl's natal home must bear the expenses of bringing her up and arranging for her dowry. Girls are married off early – as the dowry amount increases with the age and education level of the girl.

Faith Based Organisations

Seventy FBOs that were visited by the most number of vulnerable children were identified in Mahabubnagar (64 Muslim, 4 Hindu, and 2 Christian), and twenty in Khammam (6 Muslim, 7 Hindu, and 8 Christian). UNICEF conducted a baseline study on the identified FBOs to understand their background and the status of children who came in contact with them.

The study concluded that:

- FBOs shelter orphans, children with a single parent, and other children from poor economic backgrounds.
- FBOs functioned in isolation and most of them were not registered with the government. They were either self-funded or supported by philanthropists, and did not avail government schemes and entitlements for children.
- Smaller FBOs, while well-intentioned, lacked a comprehensive understanding about child rights and child protection issues.



Adolescent boys at a *Madarsa* (Islamic FBO Mahabubnagar district).

Method

FBOs were identified as change agents, and their capacities were built to comprehend child rights issues and entitlements, and engage with the community to influence and change social norms around them. UNICEF partnered with Centre for World Solidarity (CWS) and FBOs to initiate the 'Securing Child Rights' programme in Telangana in January 2017.

Partnering with Faith Based Organisations

Faith Based Organisations, apart from having deep and trusted relationships with their communities, often have strong linkages with the most disadvantaged and vulnerable members, especially children. Due to their

moral influence, FBOs and religious leaders highly impact the social and cultural life of communities^[9]. Moreover, religion and spirituality have a profound effect on the norms and behaviours in a society, thus influencing children's development. FBOs have the potential to positively reinforce protection and promote resilience among children. Behaviours influenced by cultural values affect children's development and can be challenged and redressed by FBO leaders.

The idea of partnering with FBOs for securing the rights of children came about after a special Polio Immunisation Campaign was successfully conducted by

the government and UNICEF in Hyderabad. FBOs were instrumental in increasing the intake of Inactivated Polio Vaccine (IPV)^[10]. This campaign was backed by a strong communication and social mobilisation component to increase awareness and mobilise the community for vaccination with active support from media, community-based organisations, and medical professionals. The objective of the partnership was to:

1. Mobilise FBOs and leaders to influence social norms and practices that impact child rights.
2. Have FBOs and their leaders participate in local religious and social events and talk about children's issues such as child marriage, school drop-out, and violence.

Capacity Development of FBOs

The capacity of FBOs was developed on various key issues, to work on child rights and change social norms that violate child rights. UNICEF developed an SBCC kit to train FBOs. It contained posters, stickers, and flip books addressing child labour, child marriage, child trafficking, and violence against children. Facts for Life^[11] videos on Social and Behaviour Change Communication related to health of mothers and children were also used.

Key topics included:



A young girl at a shelter run by an FBO in Mahabubnagar.

- Child rights
- Life, survival, and development of children
- Child participation
- Best interests of the child
- Non-discrimination
- Child protection rights
- FBOs and child rights
- Programmes with child rights perspective
- Use of Interpersonal Communication (IPC)



A caretaker at a shelter home run by an FBO in Mahabubnagar.

Action

Identification of FBOs

UNICEF and CWS carried out the mapping of FBOs operating in the two districts. Twenty FBOs^[12] were identified in each district to implement the intervention. This identification was based on the following criteria:

1. They were from districts where the implementation partner was functional.
2. They were willing to work for children's development as change agents.

A baseline survey was carried out to ascertain the FBOs' understanding on child rights. Many of them engaged in social services for children but did not essentially understand their rights.

Consultation workshops

UNICEF and CWS held workshops in January 2017 at the district level to mobilise and blend FBOs with the programme. The workshops sought to understand the nature of FBOs, their work, and their understanding of child rights issues in the community. Through the workshops, FBOs understood the importance of various factors that drive the current behaviour of the communities. They also volunteered to receive training on child rights to influence the children and communities around them.

Capacity development of Faith Based Organisations

UNICEF trained active members of select FBOs, and Master Trainers, who trained at least three other members of the FBO on child rights. Capacity development helped improve knowledge among FBOs regarding government schemes and entitlements for children. Capacity development helped improve knowledge among FBOs on the importance of securing child rights and their role in influencing communities for social change.

Convergence meeting with district-level officials

UNICEF facilitated meetings between the FBOs and officials from Child Welfare Committee (CWC)^[13], Integrated Child Development Services (ICDS)^[14], and Childline^[15]. The objective was to increase the FBOs' awareness on government schemes and entitlements for children. District officials and Childline representatives shared their experiences in dealing with issues of child marriage, child labour, child trafficking, violence against children, and child sexual abuse. Convergence meetings helped FBOs work in collaboration with government systems for greater impact.

Participation of FBOs in community events

UNICEF, with FBOs, identified religious events and festivals in the two districts. FBOs participated in these social and religious events to engage with communities on issues of child rights, influence norms and practices, and link the communities with the government schemes.

They also identified public spaces such as *anganwadi* centres^[16] and local government buildings to discuss specific child protection issues with the community. These discussions were based on their observations of child rights in religious events, and covered laws and remedial measures on child protection.



Girls at a *Madarsa* in Mahabubnagar. This is the room they sleep in.



Boys studying at an FBO-run shelter in Mahabubangar after school hours.

Results

UNICEF's partnership with FBOs has led to the following results:

Behaviour change in FBOs

FBOs are better sensitised to deal with children and ensure that child rights are not violated. They have realised the importance of a child protection policy for their organisations and are willing to access entitlements for children through various government schemes.

FBOs as change agents

FBOs participate in the community gatherings and influence families to secure the rights of children. FBOs also conduct IPC sessions with families where child rights were reported to be violated.

FBOs influencing communities

FBOs have motivated communities to:

- Send their children to school instead of work
- Take the commitment to not marry them off before the legal age
- Collectively ensure that children are protected from child rights issues

Caselet 1

Community meetings, Seethamma Thanda, Bandameedi Palli

FBO leaders regularly participated in community meetings at Seethamma Thanda, Bandameedi Palli. FBOs explained child rights to the community with the help of FFL videos during IPC sessions. Community meetings concluded with an oath-taking by the members, stating that they will ensure no child marriage takes place, no child goes to work, and no child is abused. This triggered a sense of responsibility among the community members. A series of follow-up sessions were conducted by FBO coordinators with the community on various issues pertaining to child rights, thereby resulting in change in behaviour. As FBO leaders belonged to the same community, they could effectively influence behaviour change. As a result, 1) three family members re-enrolled boys in the government school, 2) six families made a commitment in community meetings that they will get their girls married only after 18 years of age, and 3) eight families ensured that their daughters who had dropped out of school acquire vocational training.

Community meetings, Madarsa Madeer Mahammadeeya

The FBO held community gatherings in small groups (50-60 participants), as well as large ones (more than 500 participants). Religious leaders from the FBO who were trained on child issues, child rights, and social norms, addressed the community members during these gatherings — to positively use their moral and spiritual influence in all communities to reduce the vulnerability of children.

In Rajapur village of Balanagar Mandal, two such community gatherings were conducted by Madarsa Madeer Mahammadeeya to mobilise the community and address social norms around the identified issues. The FBO leader from the Madarsa addressed community members on issues related to children, their rights, consequences of child marriage and child labour, and importance of education. Parents, Frontline Workers (FLWs), self-help group members, and other village-level stakeholders participated in these gatherings. IPC sessions using FFL videos steered discussions around issues related to children. These gatherings addressed by FBO leaders have motivated the community to proactively respond to the violation of child rights.

During one of the interactive sessions, community members came forward to discuss the case of 16-year-old Rafeeq who resides in the same community. He lost his mother at the age of seven, and his father remarried. He was never interested to go to school, nor was he aware of the importance of education. His parents are daily wage labourers who struggle to make ends meet. Rafeeq started working at the age of nine, doing the petty business of selling old papers/ clothes, iron pieces, and plastic trash. Community members made plans to ensure that the child is in a safe environment where his rights are secured. Community members (an anganwadi teacher, village elders, and an FBO leader) visited Rafeeq's home and encouraged his parents to send him to school. A series of IPC sessions were taken up by the community, along with the FBO leader, to influence the behaviour of the family. As a result of the collaborative effort by the community and FBO, Rafeeq's parents agreed to send the child to a Madarsa.

Transformative Change

FBOs who were earlier not aware of children's rights have come forward to develop child rights policies for their own organisations. UNICEF facilitated meetings with FBOs in July 2017 regarding child protection policies. They discussed:

- The need for a child protection policy among FBOs
- Existing protection protocols, if any
- Advantages of having a child protection policy
- Specific preferences, if any, in terms of protection protocols
- FBOs are aware of their role in influencing communities to secure child rights



K Sharvanna, Sandeepani Avasam.

Child protection policies ensure that everyone associated with the FBOs: 1) is committed to influence the social norms that violate child rights, and 2) protects children from c) getting married before the legal age, b) labour, and c) violence and abuse.

Through this intervention, UNICEF has strengthened its partnership with FBOs, who are among the primary caretakers of vulnerable children, and influence the community to bring about change in social norms. The learnings from Mahabubnagar and Khammam can be used as a key strategy to work across Telangana, and other parts of India where similar situations exist.



In Summary

UNICEF, in collaboration with the Centre for World Solidarity, and Faith Based Organisations (FBOs), implemented an initiative to secure child rights in two district of Telangana. It aimed to address high child marriage rates and other child protection issues like violence and sexual abuse, through the capacity building of FBOs. Here is a blueprint of how the intervention was rolled out in the Khammam and Mahabubnagar districts of Telangana.

Action



UNICEF and CWS identified twenty FBOs in each district to implement the intervention. A baseline study was carried out to ascertain their understanding of child rights.



Workshops were held at the district level to sensitise FBOs on the various factors driving community behaviour. They underwent capacity training to improve knowledge on child rights issues.



Apart from *anganwadi* centres and local government buildings, religious events and festivals were identified where FBOs could engage with communities about child rights, influence norms and practices, and sensitise about government schemes.



UNICEF facilitated meetings between FBOs and officials from Child Welfare Committee (CWC), Integrated Child Development Services (ICDS), and Childline to increase the FBOs' awareness on government schemes and entitlements for children.



FBOs are better capacitated and have realised the importance of a child protection policy. They access entitlements for children through various government schemes.



FBOs participate in the community gatherings and influence families to secure rights of children. They also conduct IPC sessions with families where child rights were reported to be violated.

Results



FBOs have engaged with communities to influence social norms.

Transformative Change



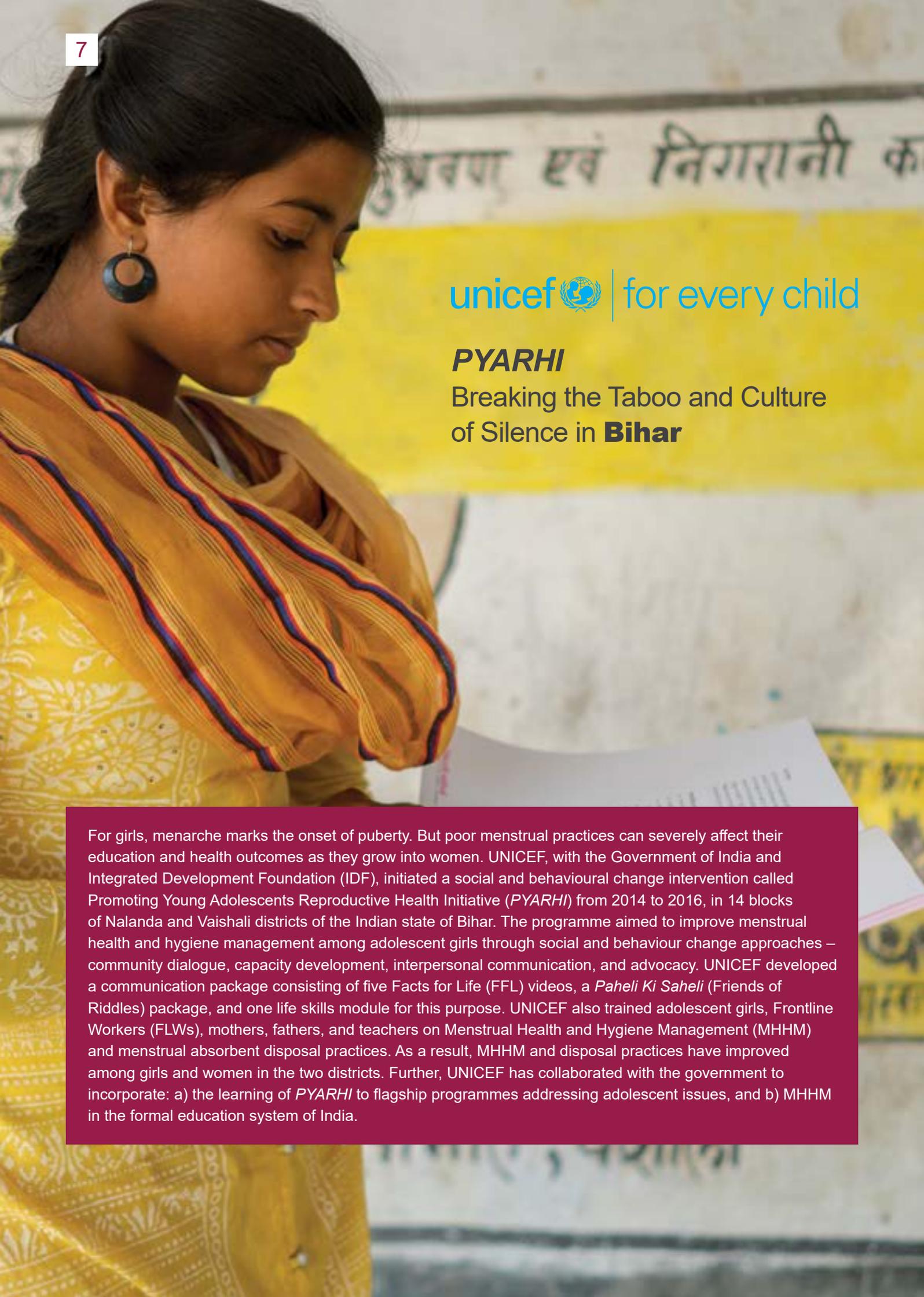
Earlier, FBOs were not completely aware of children's rights. They have now come forward to develop child rights policies for their own organisations. These policies ensure that those associated with the FBOs protect children from early marriage, labour, violence, and abuse, and are committed to influencing social norms that violate these rights.



UNICEF has strengthened its partnership with FBOs, who are among the primary caretakers of vulnerable children and influence the community to effect change in social norms. The learnings from Mahabubnagar and Khammam can be used as a key strategy to work across Telangana, and other parts of India where similar situations exist.

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- [7] <http://ncrb.nic.in/StatPublications/CII/CII2015/chapters/Chapter%206A-15.11.16.pdf>
- [8] United Nations Children's Fund, Reducing Child Marriage in India: A model to scale up results, UNICEF C4D, New Delhi, 2015
- [9] https://www.unicef.org/media/media_4537.html
- [10] Around 3,00,000 eligible children were administered fractional doses of IPV injections over a period of seven days, from 20-26 June 2016.
- [11] Facts for Life videos, published by UNICEF, contains essential information that families and communities need to know to raise healthy children.
- [12] This is a pilot project by UNICEF, based on budget a total of 40 FBOs were finalised.
- [13] Child Welfare Committees (CWCs) have been designated by law as the final district-level authorities for the care, protection, treatment, development, and rehabilitation of children in need of care and protection.
- [14] Integrated Child Development Services (ICDS) is an Indian government welfare programme which provides food, preschool education, and primary healthcare to children under 6 years of age and their mothers.
- [15] Childline India Foundation is a non-government organisation (NGO) in India that operates a telephone helpline called Childline, for children in distress. It was India's first 24-hour, toll-free, phone outreach service for children.
- [16] *Anganwadi* centres were started by the Indian government in 1975 as part of the Integrated Child Development Services program to combat child hunger and malnutrition.



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PYARHI

Breaking the Taboo and Culture of Silence in **Bihar**

For girls, menarche marks the onset of puberty. But poor menstrual practices can severely affect their education and health outcomes as they grow into women. UNICEF, with the Government of India and Integrated Development Foundation (IDF), initiated a social and behavioural change intervention called Promoting Young Adolescents Reproductive Health Initiative (*PYARHI*) from 2014 to 2016, in 14 blocks of Nalanda and Vaishali districts of the Indian state of Bihar. The programme aimed to improve menstrual health and hygiene management among adolescent girls through social and behaviour change approaches – community dialogue, capacity development, interpersonal communication, and advocacy. UNICEF developed a communication package consisting of five Facts for Life (FFL) videos, a *Paheli Ki Saheli* (Friends of Riddles) package, and one life skills module for this purpose. UNICEF also trained adolescent girls, Frontline Workers (FLWs), mothers, fathers, and teachers on Menstrual Health and Hygiene Management (MHHM) and menstrual absorbent disposal practices. As a result, MHHM and disposal practices have improved among girls and women in the two districts. Further, UNICEF has collaborated with the government to incorporate: a) the learning of *PYARHI* to flagship programmes addressing adolescent issues, and b) MHHM in the formal education system of India.

Theory of Change

Improved menstrual health



Communication package – five Facts for Life videos, *Paheli ki Saheli*, life skills module

Capacity development

Interpersonal communication

Community dialogue

Advocacy

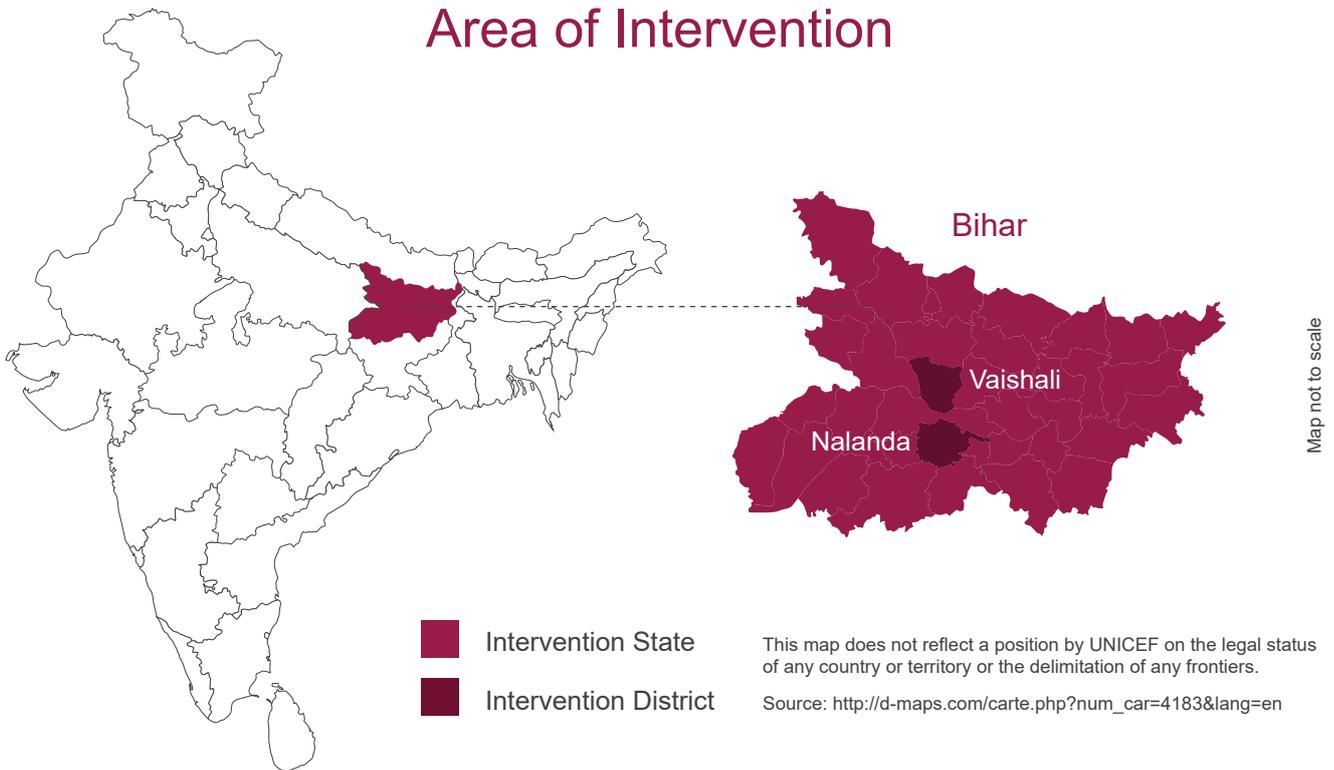


Adolescent girls, Frontline Health Workers, Mothers, Fathers, Community Members



1. Lack of knowledge and clear understanding around menstrual health and hygiene management
2. Silence, embarrassment, and misconceptions around menstruation
3. Social restrictions for menstruating girls
4. Lack of communication between girls, mothers, and FLWs around menstruation

Area of Intervention



Situation

Adolescence, the stage of a child's growth between 10 to 19 years, is considered an age of opportunity for physical, emotional, and mental development. This is a crucial time of being that forms a sense of identity for boys and girls. This juncture involves decisions on how their lives will be shaped; making them their own agents of change^[1]. It is a transitional period which requires protection, care, and access to educational and health services. For girls, correct knowledge about menstruation and its proper management is critical to reproductive and sexual health. But over **113 million** adolescent girls in India need a safe environment that offers guidance during the onset of menarche.

UNICEF conducted a formative research in 2013 to determine the existing knowledge, attitudes, practices, and norms related to Menstrual Health and Hygiene Management (MHHM)^[2] among post-menarche girls and women in Vaishali and Nalanda districts of Bihar^[3]. The findings indicated that MHHM and disposal practices were poor among adolescent girls in the following ways:

- 85 percent girls preferred to use cloth as menstrual absorbent. 96 percent used old clothes and 28 percent didn't wash the menstrual cloth when used for the first time during the cycle.

- Only 45 percent menstrual cloth users and 50 percent of the sanitary napkin users changed their menstrual absorbents twice a day.
- Girls did not use detergent to wash their menstrual cloth and did not dry it in the sun.
- The preferred form of disposal was burying it in the ground (66 percent cloth users, 54 percent sanitary napkin users). 23 percent cloth users and 24 percent sanitary napkin users disposed the absorbent by throwing it in a pond.

The reasons for poor MHHM were manifold and can be understood from different lenses:

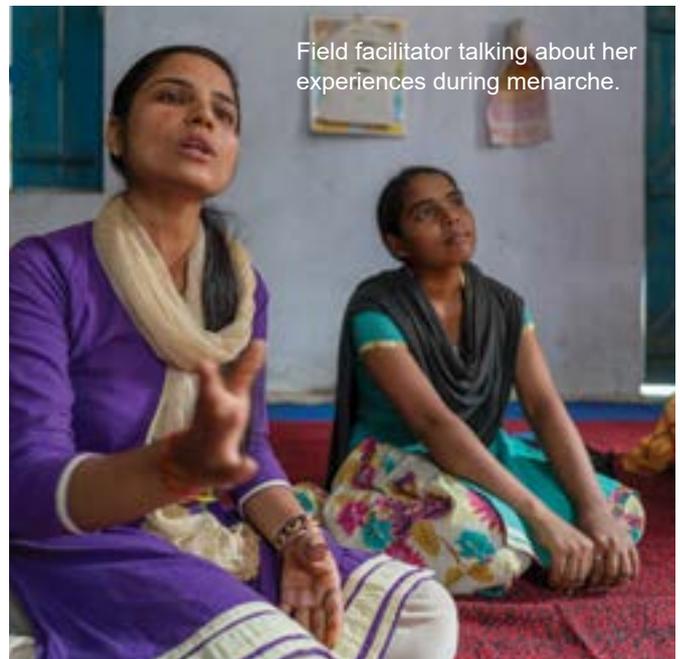
Community: Menstruation is indicative of a girl's ability to get married and bear children. However, in the communities, menstruation was perceived to be an impure process, and menstruating women were considered unclean. This belief was attributed to the dark, thick, and unpleasant smelling blood released during menstruation. This period imposed various restrictions on girls, such as limited mobility and interaction with men. Moreover, menstrual blood was linked to the fertility of a woman; hence, menstrual absorbents were disposed with care by burying them in the soil rather than burning.

Family: Families with adolescent girls believed that it was their responsibility to protect the purity of their daughters and enhance chances for a good marriage. Both fathers and mothers had limited understanding of the physiology of menstruation and its hygiene. They did not allow their menstruating daughters to: a) touch certain food items like pickles, onions, potatoes, b) enter the kitchen or any place of religious significance, c) have a bath, d) move freely, and e) interact freely with men. Fathers had little or no discussion with their daughters about menstrual hygiene. Mothers themselves followed poor MHHM practices and were unable to teach their daughters. They did not communicate well with their daughters about MHHM, pre- or post-menarche, and looked at it as a topic to be ashamed of.

Frontline Workers (FLWs) and teachers: FLWs (including Accredited Social Health Activists (ASHA)^[4], *anganwadi* workers^[5], Auxiliary Nurse Midwives^[6], SABLA^[7] staff) and teachers lacked communication skills and had minimal information regarding menstruation. The majority believed that menstruation was a process through which the body released bad blood and heat. Therefore, they did not oppose the cultural myths and taboos surrounding menstruation. They were unable to communicate with or support the adolescent girls around them on issues of menstruation.

Adolescent girls: More than **80** percent of girls were completely unprepared for menarche. Mothers and friends gave them incomplete and sometimes even incorrect information about menstruation. Hence, girls were scared when they first started menstruating; they accepted the restrictions and taboos imposed on them without questioning the logic behind it. Almost all adolescent girls expressed low confidence in burning menstrual absorbents for disposal. They felt embarrassed and humiliated over the restrictions. Around **73** percent adolescent girls were unaware of the importance of washing menstrual cloth with soap and drying it in the sun to disinfect.

These circumstances highlighted the need to improve knowledge around MHHM and disposal of menstrual absorbents, and in turn improve the reproductive health of girls and women. Providing appropriate knowledge and skills on MHHM to girls would act as a trigger for them to talk freely and create a gateway to engage about other women empowerment issues.



Field facilitator talking about her experiences during menarche.

Method

Given the culture of silence and misinformation around menstrual hygiene, UNICEF, with Johnson & Johnson, the Government of India, and Integrated Development Foundation (IDF), implemented Promoting Young Adolescents Reproductive Health Initiative (*PYARHI*) from 2014 to 2016. The programme aimed at incorporating a Social and Behaviour Change Communication (SBCC) strategy to improve MHHM among adolescent girls in rural areas. *PYARHI* was implemented in 1,607 villages in 14 blocks of Nalanda and Vaishali districts of Bihar^[8]. The objectives of the programme were to empower:

1. Adolescent girls to:

- Talk freely and not be embarrassed about menarche
- Understand menstruation and the benefits of menstrual hygiene
- Have the confidence to discuss and negotiate for menstrual hygiene products
- Improve hygienic management of their menstruation
- Dispose the menstrual absorbent in an environment-friendly manner

2. FLWs and teachers to conduct interpersonal communication and community mobilisation

sessions that promote understanding of menstrual hygiene and its management.

To achieve the above objectives, the following strategies were adopted:

- Capacity development of FLWs, teachers, and adolescent girls
- Community dialogues to engage adolescent girls' groups, mothers, fathers, and the community
- Interpersonal communication with adolescent girls through field functionaries (identified by IDF at the block and village level for capacity development of primary stakeholders) and FLWs
- Advocacy with the government to sustain the results of the programme

To build the capacity of adolescent girls and women and to improve interpersonal communication, the following communication materials were used by UNICEF:

- *Paheli ki Saheli* (Friends of Riddles) communication package consisting of five short films, a storybook, personal diary, apron (displaying the female reproductive organs to explain menstrual cycle), and posters. It provided information on: a) how to prepare for menstruation, b) Menstrual Health and Hygiene Practices, and c) the effects of menstruation on girls.
- Five Facts for Life (FFL) videos, which provided information on key issues that affect mothers and children, focused on addressing myths, gender issues, and a father's role in MHHM.
- *Kishoriyon se Baatchheet* (talking with adolescent girls) for FLWs to improve their interpersonal communication skills with adolescent girls.
- A life skills module was used to improve decision making, problem solving, and interpersonal relationships for adolescent girls.



Shama Parveen talking about how she convinced her parents to build a toilet at home.

Action

Capacity development of field functionaries

IDF identified 90 field functionaries at the block and village level. A block-level field functionary was chosen for each block, and a village-level field functionary was chosen for every 15-20 *anganwadi* centres. They were responsible for capacity development of stakeholders under the programme.

- UNICEF oriented field functionaries about *PYARHI*, its scope, importance, and use of communication material given to them. They were trained on MHHM during a 4-day residential workshop. UNICEF also organised a four-day residential training on life skills^[9] for 28 field functionaries from both districts. It helped them develop critical and creative thinking, effective communication skills, negotiation skills, empathy, coping mechanisms, and its applications in everyday life.
- Field functionaries identified all 3,267 *anganwadi* centres and formed two adolescent girls' groups at each centre with the help of FLWs. Each group had 25 girls so that field functionaries could communicate with them effectively. *Anganwadi* centres were the focal point of activities, where all meetings were organised.

Capacity development of adolescent girls

UNICEF planned to reach out to at least 80 percent of the adolescent girl's population in 14 blocks of Vaishali and Nalanda.

- Field functionaries trained adolescent girls at *anganwadi* centres through fortnightly or monthly meetings. They discussed the process of menstruation, preparedness for menstruation, importance of hygiene, safe disposal of menstrual absorbents, importance of nutritious food, myths and misconceptions, and support required by adolescent girls through videos. *Paheli Ki Saheli* storybook was read out and explained by the field functionaries, which helped them facilitate the sessions. Adolescent girls displayed a keenness to read the story books as they were interesting, simple, and interactive.
- Field functionaries facilitated sessions with adolescent girls with the help of FFL videos. The videos were entertaining and easy to comprehend. Tabs helped the functionaries in spreading the messages effectively, as they were easy to handle and carry. They used an apron with the female reproductive organ drawn on it, from the *Paheli ki Saheli* package, to explain the physiology of menstruation.



A field functionary training adolescent girls at an *Anganwadi* centre at one of the meetings.

- Two adolescent girls' groups of around 25 girls each were formed at every anganwadi centre to facilitate effective communication. Meeting in small groups has given girls an opportunity to get familiar with each other and built a good rapport with the

members and field functionaries. With 1,836 anganwadi centres across the blocks of Vaishali and Nalanda, 3,673 adolescent girls' groups were formed over the two years.

Platform for adolescents to express challenges faced by them.



- Field functionaries reached out to middle and high schools to orient adolescent girls in large numbers. Initially, discussions revolved around the importance of nutritious food, Iron Folic Acid tablets, biological changes, and female reproductive organs to ease the girls into dialogue. Next, the field functionaries discussed the process of menstruation, importance of hygiene and proper use of napkins, and safe disposal of the same. Trained school teachers also supported field functionaries in organising the meeting. During the project period, a total of 33,844 adolescent girls were reached out to in 301 schools.

Selection and training for Peer Educators

Peer Educators, between the ages of 15 to 17, were selected based on their education, willingness to participate and communicate with other girls about MHHM, and the ability to articulate clearly. They were responsible for mobilising girls and interacting with their peers on MHHM.

- Two Peer Educators were selected in each adolescent girls' group. Apart from MHHM, field functionaries trained peer educators on five life skills: a) self-awareness, b) creative thinking, c) effective communication, d) empathy, and e) coping mechanisms.
- In addition to life skills, there were discussions on biological, emotional and psychological changes in adolescents, gender issues, and the difference between sex and gender. The field functionaries used different training methods including role play and games.

- With two peer educators in each adolescent girls' group, 7,344 peer educators were trained in total.

Capacity development of FLWs and teachers

A three-day residential training programme was organised by UNICEF and the government in both districts to orient female teachers, one each from 32 schools^[12].

- The trainings were conducted through participatory activities using SBCC materials and mock sessions to enhance their knowledge and skills on MHHM. Trained school teachers were responsible for conducting sessions with adolescent girls in their respective schools.
- Field functionaries trained FLWs^[13] from identified *anganwadi* centres on the skills for conducting effective and interactive meetings and providing counselling on MHHM. Field functionaries were supported by FLWs in conducting sessions in *anganwadi* centres.

Engagement with mothers and fathers

- More than 36,000 mothers were sensitised on menstruation and related issues during monthly meetings, so that they could share it with their daughters. Functionaries encouraged mothers to share first-hand experiences on how they dealt with their first menstrual cycle, and what support they felt they needed at that time. This exercise sensitised them and made them empathise with the needs and expectations of their daughters.



School girls advocating menstrual hygiene.

- Field functionaries reached out to fathers of adolescent girls to sensitise them about menstruation. FFL^[14] and *Paheli ki Sahel*^[15] videos helped the field functionaries in facilitating the

session with fathers and explaining the importance of nutritious food, safety, and dignity of their daughters during menstruation.



Adolescent girls watching and listening to FFL videos.

Community Dialogue

IDF organised video screenings for community engagement, which helped to build an enabling environment for adolescent girls with no major challenges.

- *Paheli Ki Saheli* and FFL videos talked about the emotional support and safe environment required for girls at the time of menstruation.
- Fathers, mothers, adolescent girls and boys, local leaders, self-help group members, and FLWs participated in the meetings.

Engagement with Government Officials

UNICEF regularly shared the progress of *PYARHI* with the Education, Health, and Women and Child Development^[16] Departments.

- UNICEF organised a state-level dissemination workshop to share the experiences and learnings of *PYARHI*.
- Representatives from the government line departments, non-governmental organisations, adolescent girls, Peer Educators, FLWs, and field functionaries shared their experiences from *PYARHI* and jointly reviewed the outcome of the programme.



A field facilitator showing *Paheli Ki Saheli* videos to adolescent girls.

Results

Results of *PYARHI* are documented at the level of adolescent girls, mothers, FLWs, and field functionaries. All stakeholders have improved knowledge on the physiology of menstruation, MHHM, and disposal practices leading to better practices^[17].

Adolescent Girls

1,98,911 adolescent girls were trained on MHHM issues through *PYARHI*. Knowledge, attitudes, and practices related to menstruation have since improved among adolescent girls^[18].

a) Knowledge

Out of the 1,98,11 girls reached:

- Around **80%** can describe biological changes which take place at the time of puberty
- **78%** are aware about the process of menstruation and the importance of maintaining hygiene

- **65%** understand the importance of safe and environment-friendly disposal of menstrual absorbents

b) Attitude and perception:

- More than 70% of 1,98,911 the girls that were reached freely talk about menarche. Adolescent girls confidently discuss MHHM with their friends, sisters, and mothers.
- Around 47% adolescent girls now share their issues with their mothers, and 62% of them even discuss issues with their friends.
- They are not embarrassed to follow hygienic practices during menstruation, like drying the menstrual cloth in the sun or buying sanitary napkins from shops.
- Many girls experimented with restrictions such as eating pickles, touching vegetables, burning

menstrual absorbents, and entering the kitchen. They found no correlations between menstruation and these activities. Hence, they do not believe in these restrictions anymore.



“Earlier we used to dig deep pits and dispose our sanitary napkins in it, or throw it somewhere far away from home. Now we collect and burn it at the end of our menstrual cycle. Some women in my neighbourhood still tell me that we shouldn’t burn our menstrual absorbent because we will become infertile. But my cousin just conceived a baby despite burning her absorbents. So, I know this is all just a myth.”

Hani Kumari, 18
Bhuj Patti, Vaishali District



“I joined the adolescent girls group in our village and got to know about the importance of maintaining hygiene during menstruation. However, we did not have a toilet at home and had to go out in the open. I felt very embarrassed, especially during menstruation. I told my parents about this, but they refused because of financial issues. I did not lose hope and tried to explain to them again and again about my embarrassment and about the need to maintain hygiene.

During the festival of Eid, I told my father not to buy gifts but to gift me a toilet. I convinced my siblings and my mother not to buy new clothes on Eid. My father was finally convinced and built a toilet.”

Shama Parveen, 17
Narayanpur Buzurg, Vaishali District

c) Practices:

- Girls now change the menstrual absorbent at least twice a day.
- They wash the menstrual absorbent with soap or detergent, and dry it out in the sun.
- **47%** girls dig a pit to bury the menstrual cloth, and **13%** burn it to dispose it.

Adolescent girls negotiate with their family members and ensure the construction of toilets at home to manage their menstruation. Around **46%** girls now have toilet facilities at their home while a bathroom is available for **36%**.

Frontline Workers

- FLWs talk freely about MHHM with girls as they understand it is critical for an adolescent girl’s health. They address queries raised by adolescent girls such as the cause, duration and management, dealing with pain and discomfort, and cleanliness during menstruation.
- They talk about nutrition, advise girls to consume green vegetables, cook in copper utensils, and consume iron tablets to avoid anaemia.



“ASHA workers were able to view menstruation in a positive light through PYARHI. They have improved knowledge about menstruation and know how to communicate effectively with adolescent girls. Menstrual hygiene knowledge among ASHA

workers has improved. Their confidence has also improved, which helps them perform their job better.”

Nibha Rani Sinha
District Community Mobiliser, Vaishali District



“Initially, I was one of the adolescent girls trained under the programme. But later I joined as a field functionary in Vaishali district under PYARHI. During our training, UNICEF held discussions with us about menstrual health. They dispelled all

our misconceptions regarding menstruation, and gave examples for us to understand better.

Menstruating girls in our village are asked not to touch pickles because we were considered unclean during that time, so the pickle will spoil. We need to question whether it's correct. Those who manufacture the pickle cannot do so without touching it and it is made mostly by women. The manager does not come and ask all working women whether they are menstruating or not before they are allowed in the factory.”

Chanda, 20
Field Functionary, Bairai,
Vaishali District

Field functionaries

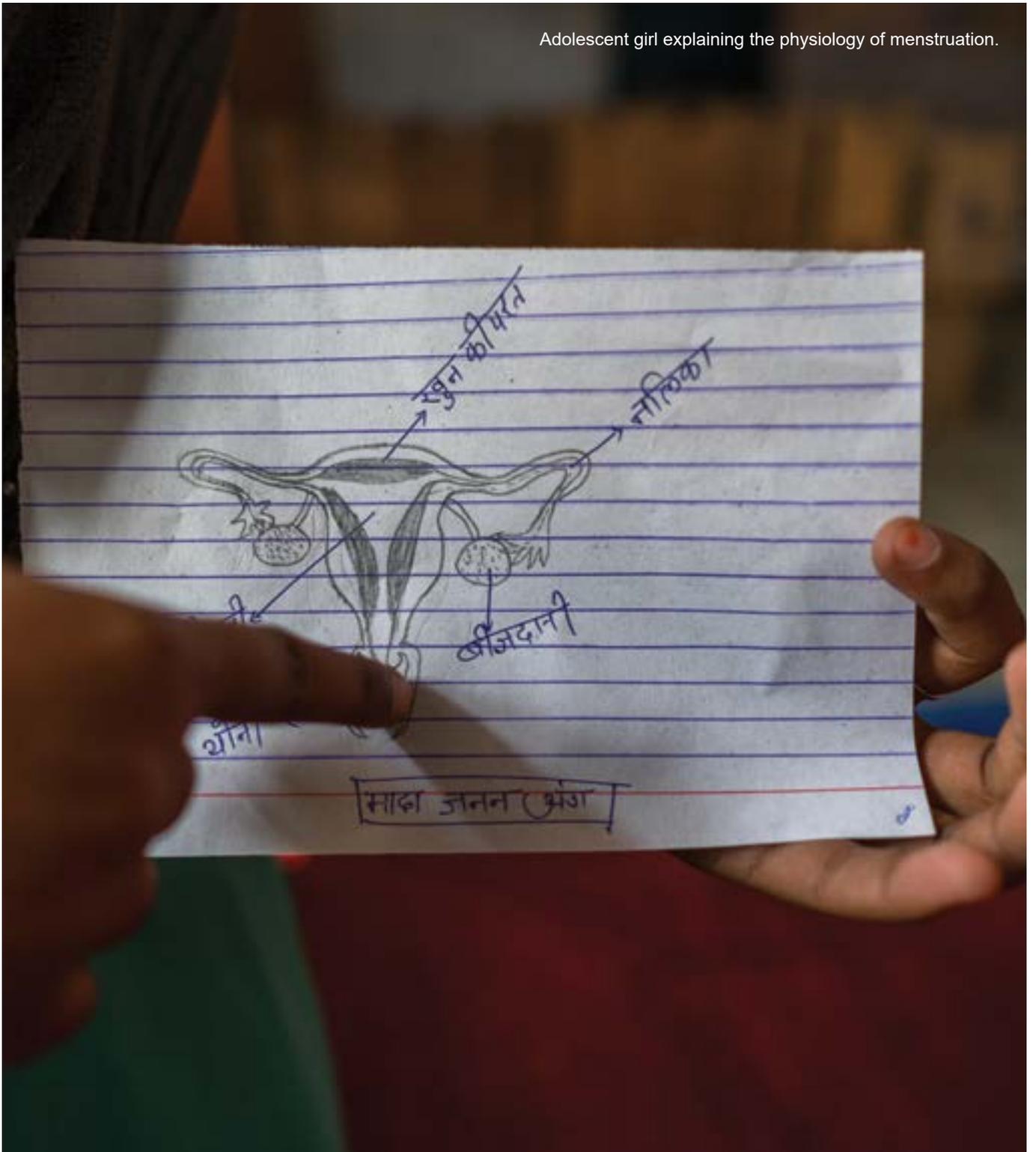
- Field functionaries were shy to work for menstruation-related issues in their village, but now they are proud to be doing so.
- They are not ashamed to talk about menstruation with other girls. They communicate openly about MHHM with them.
- They have experimented and dispelled all misconception surrounding menstruation.
- Field functionaries follow improved menstrual hygiene and menstrual absorbent disposal practices.

Mothers

Mothers communicate with their daughters about menstruation to help them prepare for the onset of menarche and follow hygienic practices during menstruation.

Personnel from IDF engaging with an adolescent girls' group.





Transformative Change

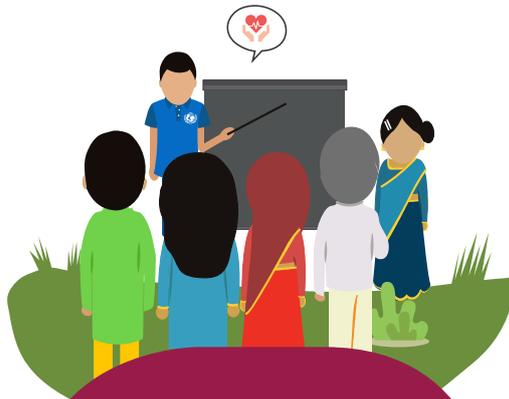
As a result of the evidence emerging from *PYARHI*, the Education Department of Bihar has integrated MHHM as part of their curriculum in lower secondary schools and *Kasturba Gandhi Balika Vidyalayas* (KGBV). KGBVs are residential schools for girls from

socially vulnerable and marginalised communities. Teachers and school wardens trained on *Paheli Ki Saheli* communication package have been allocated across 38 districts of Bihar to implement the programme.

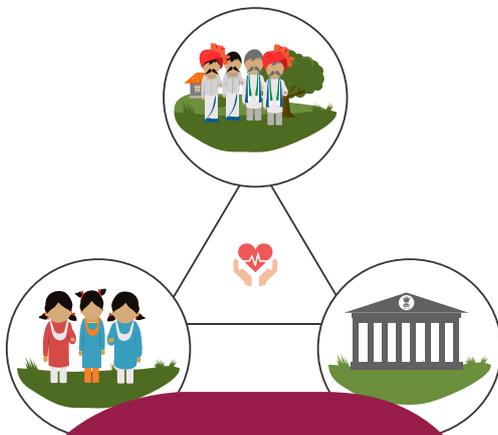
In Summary

UNICEF, with the Government of India and Integrated Development Foundation (IDF), initiated a social and behavioural change intervention called Promoting Young Adolescents Reproductive Health Initiative (PYARHI). It aimed to improve Menstrual Health and Hygiene Management (MHHM) among adolescent girls. Here's a blueprint of how the intervention was rolled out in 14 blocks of Nalanda and Vaishali districts of the Indian state of Bihar.

Action



Field functionaries were oriented on the scope and importance of PYARHI and given training on MHHM. They developed critical and creative thinking, effective communication skills, negotiation skills, empathy, coping, and its application to everyday life.



Peer educators were selected, and various stakeholders were sensitised on MHHM. Community dialogue was facilitated, and government officials were constantly given the progress of the invention.



Adolescent girls were trained by field functionaries about safe MHHM practices through the Paheli Ki Saheli storybook and FFL videos. They discussed matters such as process of menstruation, importance of hygiene, proper use of napkin, and its safe disposal.

Results



Adolescent girls are now aware of the realities of menstruation, and discuss menarche freely. They follow the right MHHM practices without being ashamed, and are recognising the myths and misconceptions built around them.



Frontline Health Workers and field functionaries are now more confident to work on menstruation-related matters in villages and discuss MHHM practices with adolescent girls.



Mothers communicate with their daughters about menstruation and prepare them for the onset of menarche and the hygienic practices associated with it.

Transformative Change



MHHM has been made a part of the curriculum in Lower Secondary schools and Kasturba Gandhi Balika Vidyalayas (KGBV) by the Education Department of Bihar. Trained on the Paheli Ki Saheli communication package, teachers and school wardens have been allocated across 38 districts of Bihar to further implement the programme.

References

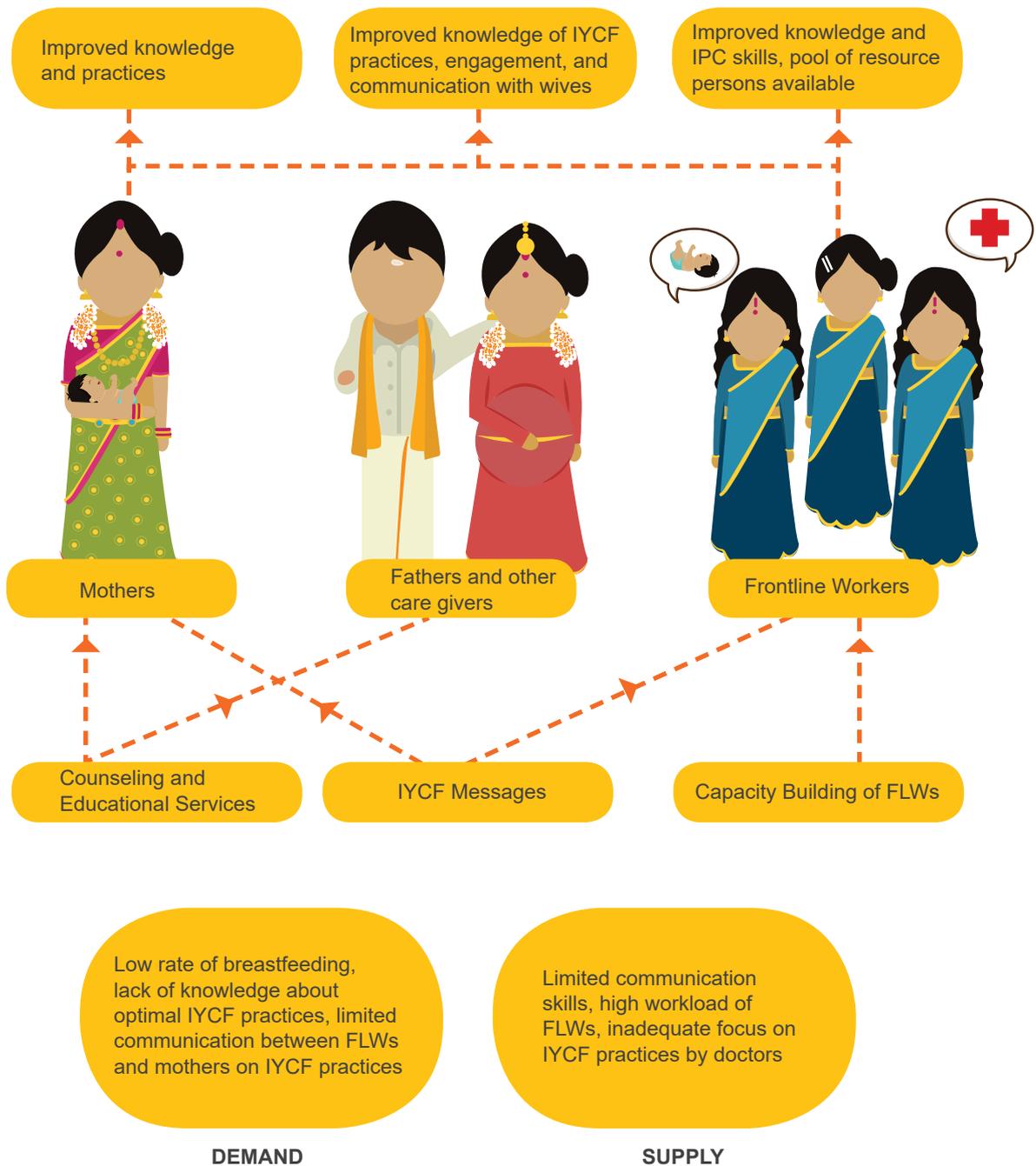
- [1] <https://www.unicef.org/adolescence/>
- [2] The (i) articulation, awareness, information and confidence to manage menstruation with safety and dignity using safe hygienic materials together with (ii) adequate water and agents and spaces for washing and bathing with soap and (iii) disposal of used menstrual absorbents with privacy and dignity.
- [3] <http://www.mdws.gov.in/sites/default/files/Menstrual%20Hygiene%20Management%20-%20Guidelines.pdf>
- [4] Accredited social health activists (ASHAs) is community health workers instituted by the government of India's Ministry of Health and Family Welfare (MoHFW) as part of the National Rural Health Mission (NRHM). They are local women trained to act as health educators and promoters in their communities.
- [5] *Anganwadi* workers are responsible for *anganwadi* centres which is a type of rural mother and child care centre in India. They were started by the Indian government in 1975 as part of the Integrated Child Development Services program to combat child hunger and malnutrition.
- [6] Auxiliary nurse midwife, commonly known as ANM, is a village-level female health worker in India who is known as the first contact person between the community and the health services.
- [7] The Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) *SABLA* is a centrally sponsored program of Government of India initiated on April 1, 2011 under Ministry of Women and Child Development.
- [8] Given the time and resources available.
- [9] *Kishorio se prabhavi Baat Cheet Ke Kaushal*, develop skills to counsel their peers
- [10] 80 percent of 4,02,821 girls in 75 percent villages of Nalanda and Vaishali districts were planned to reach out as per time and resources available for the programme implementation.
- [11] *Meri Saheli Meri Maa, Mahwari Pe Khul Ke Charcha, Amma Ji Kahti hain, Pratiyogita and Bapu*.
- [12] Rolled out as a pilot component in the programme.
- [13] To As per available time and resources for programme implementation.
- [14] '*Bapu (Father)*' from FFL videos.
- [15] 'Father becomes Friend' video from *Paheli ki Saheli*.
- [16] Integrated Child Development Services (ICDS) is an programme which provides food, preschool education, and primary healthcare to children under 6 years of age and their mothers.
- [17] From Key Informant Interviews of primary stakeholders and programme documents.
- [18] Pre-post assessment results of *PYARHI* Particulars.
- [19] 'Father becomes Friend' video from *Paheli ki Saheli*.

Behaviour Change Communication through mobile technology

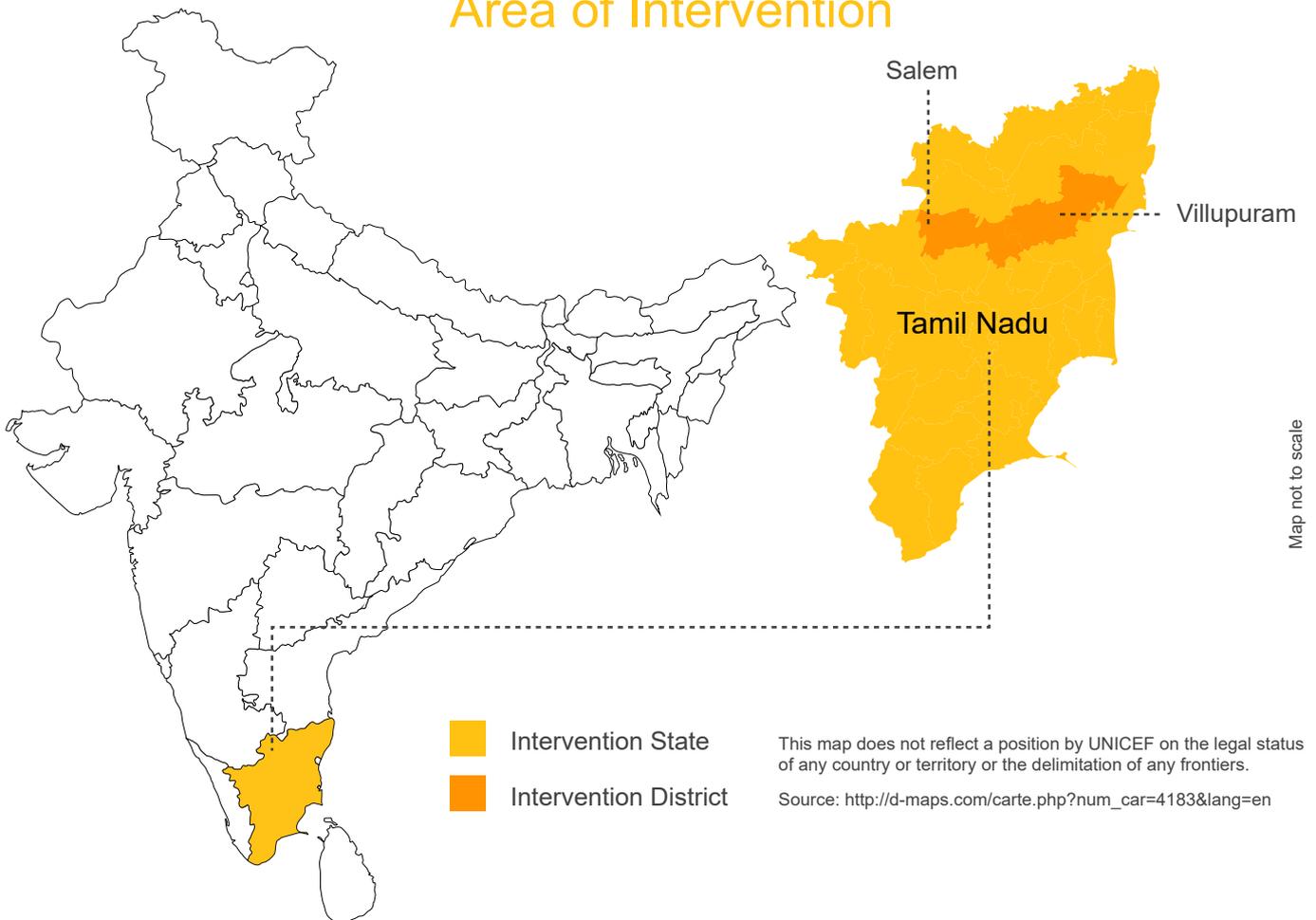
Promoting IYCF practices among
caregivers in **Tamil Nadu**

Tamil Nadu (TN), India's southernmost state, ranks 5th in the Inequality-adjusted Human Development Index (IHDI)^[1] in the country. The IHDI indicators show that the state's performance in economic, educational, and health areas puts it ahead on the Human Development Index. According to National Family Health Survey - 4, the percentage of children under the age of six months who are exclusively breastfed in TN is 48.3%, as compared to the national average of 54.9%. This is despite TN having the highest institutional delivery rate in India, at 99%^[2]. The large gap between institutional deliveries and breastfeeding practices led to the conception of this initiative. To improve the Infant and Young Child Feeding (IYCF) practices, UNICEF — in partnership with Integrated Child Development Services (ICDS), Government of Tamil Nadu — initiated a pilot to improve adoption of IYCF practices using mobile phones for message communication. This was carried out in two blocks in the districts of Salem and Villupuram, which were selected in consultation with the ICDS department. The intervention included the following undertakings: phone messages to mothers, counseling of mothers, capacity building of Frontline Workers (FLWs), and orientation of fathers. These messages were customised for mothers receiving antenatal and postnatal care, with each message focusing on one of the following — health, nutrition, and hygiene practices. As a result of this intervention, the Interpersonal Communication (IPC) skills and knowledge levels of FLWs have improved. There is also an increase in engagement between FLWs, mothers, and their family members. The ICDS department now has a pool of resources trained in Social and Behaviour Change Communication (SBCC), which can be used in the implementation of other interventions.

Theory of Change



Area of Intervention



Situation

The Ministry of Health and Family Welfare (MoHFW) defines Infant and Young Child Feeding (IYCF) practices as “a set of recommendations to achieve appropriate feeding of newborns and children under two years of age so that they achieve optimal nutrition outcomes in populations”. A study showed that the risk of an infant dying was 97% less among those children who were breastfed as compared to those who were not^[3].

In Tamil Nadu, challenges faced from the demand point of view are:

- Low breastfeeding rate: Percentage of children under the age of six months who are exclusively breastfed in TN is 48.3% as compared to the national average of 54.9%^[4]
- Lack of knowledge among women about the importance of optimal IYCF
- Limited communication between FLWs and mothers on IYCF practices like early initiation of breastfeeding and exclusive breastfeeding

On the other hand, challenges from the supply point of view are:

- High workload on FLWs
- Limited IPC skills among FLWs
- Generic and non-contextualised messages given by FLWs to the stakeholders
- Inadequate focus on imparting IYCF practices to mothers by doctors

To help improve the adoption of IYCF practices, UNICEF^[5] partnered with ICDS, Government of Tamil Nadu, and implemented a pilot that leverages mobile phone messages. This was an experimental initiative intended to examine and evaluate the feasibility, time, cost, and possible loopholes of mobile phone-based messaging services for the desired SBCC — with focus on adoption of IYCF practices among caregivers and care providers. A total of 24 messages in the vernacular language, Tamil, were sent every Friday to each of the five categories of stakeholders during this intervention period.

The objectives of this initiative were:

1. To enhance the adoption of IYCF practices among stakeholders through SMS by using mobile phones as tools for behavioural change
2. To provide immediate counseling services to the stakeholders and educate them on IYCF practices through video films
3. To improve the IPC skills of FLWs during house visits and group meetings
4. To extract recommendations from the learnings for the government to extrapolate as an innovative initiative for the ICDS programme

The initiative was implemented from February to April 2017 in two blocks, namely Magudanchavadi in Salem district and Marakkanam in Villupuram district. These two districts were selected based on the following factors:

- Low intake of Antenatal Care and Postnatal Care services
- High number of beneficiaries among all categories (refer Table 1)
- Maximum number of service providers on board in these blocks at that point of time (36 in Magudanchavadi and 17 in Marakkanam)
- Presence of UNICEF consultants to provide necessary hand-holding, support, and supervision

Groups	No. of Beneficiaries		Total
	Marakkanam (Villupuram)	Magudanchavdi (Salem)	
Antenatal Mothers	911	596	
Pregnant Mothers	901	619	
0-6 month old children	901	619	
6-12 month old children	1,103	574	
1-2 year old children	1,931	1,286	
Total	5,747	3,694	9,441

Table 1

Method

When designing this intervention, UNICEF, in consultation with ICDS, decided to use mobile phones as a communication platform. As of April 2017, data from Telephone Regulatory Authority of India (TRAI) shows that there are a total of **1,174^[6]** million wireless phone subscribers in India, of which **43%** are rural subscribers. TN alone accounts for **8%^[7]** of the total in India. Mobile phones have become an important communication platform that help reach participants residing in remote locations promptly. Because of the widespread use of mobile phones and a high literacy rate (Male – **89%**, Female – **79%^[8]**) in TN, UNICEF decided to use mobile phones for the delivery of IYCF messages.

The pilot undertook the following strategies:

IYCF messages through mobile phones: In the two intervention blocks, phone messages were delivered to:

- Expectant mothers (for antenatal healthcare practices)^[9]
 - Mothers in the postnatal phase
 - Mothers of children aged 0-6 months
 - Mothers of children aged 6-12 months
 - Mothers of children aged 12-24 months
1. **Capacity development of FLWs:** FLWs were trained to build their IPC skills and aid the delivery of focused and contextualised IYCF messages to the participants. Facts for Life (FFL) videos^[10] and flip books were used for these trainings.
 2. **Counseling and educational services:** The counseling and educational services conducted imparted IYCF knowledge to mothers, and to sensitised fathers and mothers-in-law. FFL videos were used by FLWs to further elucidate the IYCF messages to mothers receiving antenatal and postnatal care.



FLWs were trained to build their IPC skills and to aid delivery of contextualized messages.

Action

FLWs from 209 sub-health centres were covered as part of this intervention.

Training of FLWs: FLWs were trained on IPC and the importance of behaviour change communication. They were taught to conduct effective two-way communication by using the GATHER^[11] principle. The training also focused on the usage and impact of mobile phones for information dissemination for behaviour change. Examples from other states, where mobile phones were used as a platform for behaviour change, were shared and discussed with trainees.

Messages to mothers and follow up counseling by FLWs: A total of 9,441 mothers^[12] across both blocks were covered in this pilot. The phone messages were contextualised and specific to the life cycle stage of the recipient. For example, expectant mothers were sent messages on the consumption of nutritious food on a daily basis.

During the intervention, the team came across a few challenges that blocked the effective delivery of text message-based communication. Listed below are the challenges, and the solutions provided for the same.

- Non-receipt of messages: 440^[12] stakeholders did not receive messages as they had activated the Do Not

Disturb (DND)^[13] service. Discussions were held with the technical agency handling the phone message dissemination to override DND and deliver the message.

- Illegible messages: 32%^[12] of the beneficiaries received box images instead of text messages. In such cases, FLWs first tried to readjust phone settings and correct the error. If the problem was still not resolved, they visited these households, showed them the messages, and discussed the content.
- Male ownership of mobile devices: Mobile phones in the house were primarily owned by male members, who carried it to their workplaces. Further, those working in towns returned home only once a week. The probability of them sharing these messages with their wives was uncertain and rendered the messages useless. To address this, it was decided that:
 - FLWs would visit 10 such households every day to educate and counsel the mothers on the message of the week.
 - Fathers would be oriented on the importance of IYCF practices for a mother and child, and the father's role in ensuring they are appropriately cared for.

Each FLW visited 10 households a day to educate and counsel mothers on IYCF practices.



Orientation of fathers: Fathers were informed of the phone messages and the importance for them to read, understand, share, and discuss the messages with their spouses. A total of 113 fathers^[14] participated, and

at the end of the session they were asked for written feedback. The feedback showed that all fathers^[15] found these messages useful in understanding IYCF, and said it helped them take due care of their wives.

Results ^[16]

The results from the pilot initiative can be seen across four stakeholders:

Frontline Health Workers

- The IPC skills of FLWs improved, and they now engage participants in dialogue, listen to and counsel mothers and their families.
- Capacity building activities have helped increase knowledge about IYCF practices.
- FLWs now deliver customised communication messages to mothers. Earlier, FLWs would communicate messages to mothers without focusing on their life stage, whereas now they deliver contextual and relevant messages. The FFL videos have helped them remember the right message for the right audience.
- This intervention has helped enhance the self-confidence of FLWs in conducting health and nutrition counseling for stakeholders.

“When I meet pregnant mothers now, I counsel them on not just regular hospital visits but also on consumption of nutritious meals on a regular basis.”

S Gowri, FLW from Magudanchavdi

Examples recalled and shared by FLWs of Marakkanam block are timings, amount, and duration of breastfeeding. A majority of the mothers were also able to recall the messages they had received.

Mothers

- Knowledge of the mothers on IYCF-related practices have improved. Few themes the mothers are informed about include: importance of iron and folic acid tablets, importance of colostrum, feeding-position, time and method, foremilk and hindmilk, and breastfeeding during sickness.
- The messages also served as a reminder for mothers to follow up on their health checkups.

Interaction with male members to orient them about the programme and importance of phone messages for their wives.



- A few of the mothers also reported that they felt assured, as the government was giving due importance to their healthcare by sending them personalised messages.

Fathers

- They now have knowledge about IYCF practices like colostrum feeding and share it with other caregivers in the family.
- Husbands have become more involved as fathers and have started to tend to their wives' healthcare needs during and post pregnancy. Mothers reported that their husbands accompany them during hospital visits and ensure consumption of nutritious, wholesome meals.

ICDS

- Owing to improvement in the IPC skills and knowledge about IYCF practices in FLWs, a resource pool well-versed in SBCC has been created in the ICDS department. This resource pool can be employed for other ICDS programmes as well.
- Social mobilisation abilities of FLWs have also improved.
- As a result of this intervention, demand for services from participants in the intervention blocks has increased^[17].

A group of FLWs interacting with their supervisor.



FLWs participating in a programme to share their experience and feedback.



Transformative Change

“IPC is a strong component of nutrition counseling for reducing malnutrition in the state. Further, through this initiative, the department has realised that men should also be part of interventions aimed at bringing behaviour and attitude change. The department has shared the initiative and results of the intervention with the state cabinet members, and there are ongoing discussions about scaling up this initiative in a phased manner in other blocks of the state.”

-Ms. J M Yamuna Rani, Deputy Director, ICDS Department, Tamil Nadu

Caselet 1



S. Gowri has been an FLW for the last 10 years in Magudanchavadi block, Salem district. In all her years of

work, she believed that it was her role to provide information and the mother's was to listen to her advice. After undergoing training under UNICEF's intervention, she started to use the GATHER principle in her interactions. As a result, she listens attentively to the mothers, other family members, and only then offers counseling. She feels this intervention has helped her deliver services efficiently, perform her role better, and engage more effectively with the community.

Caselet 2



P. Shanti of Magudanchavadi block, Salem district, was six months pregnant when her husband started receiving the phone messages. Her husband showed her the messages, soon

after which an FLW visited and counseled her and her family members. She feels that as a result of these messages, her husband started buying fruits for her, ensured that she got ample sleep everyday, and tried to help her with day-to-day household chores. This helped her stay healthy and happy during her pregnancy.

FLWs

“Previously, young pregnant women were afraid of delivery and the accompanying pain. After our counseling, they are mentally prepared for it and do not fear the childbirth process. Similarly, mothers would give jaggery water to infants but they are now aware of exclusive breastfeeding and its importance, and have thus stopped this practice.”

-S. Sumati, Marakkanam block, Villupuram district, TN

In Summary

UNICEF, in partnership with Integrated Child Development Services (ICDS), Government of Tamil Nadu, initiated a pilot to improve adoption of IYCF practices using mobile phones for message communication. Here's a blueprint of how the intervention was rolled out in two blocks, in the districts of Salem and Villupuram, which were selected in consultation with the ICDS department.

Action



FLWs from 209 sub-health centers were trained on behaviour change communication. They were taught to disseminate information via mobile phones, apart from other capacity building initiatives.

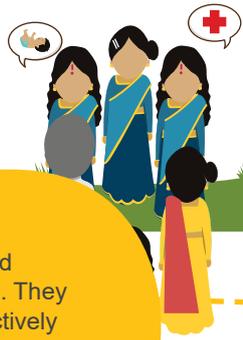


9,441 mothers received contextualised information specific to their pregnancy stage. They were visited by FLWs, who counseled them on the messages they received.



Fathers were oriented on the importance of the messages received on their phones. They were encouraged to be more participative in their child's care.

Results



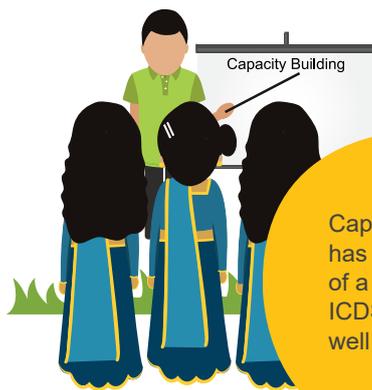
FLWs have enhanced communication skills. They are now able to effectively engage and counsel mothers and fathers on IYCF practices.

Mothers feel assured that the government is invested in their healthcare. There has been an increased uptake of IYCF practices since the intervention.



Fathers have become more involved, and actively tend to the pregnancy needs of their wives.

Transformative Change



Capacity building of FLWs has resulted in the formation of a pool of resources in the ICDS department who are well versed in SBCC.

References

^[1] http://www.undp.org/content/dam/india/docs/inequality_adjusted_human_development_index_for_indias_state1.pdf

The IHDI combines a country's average achievements in health, education and income with how those achievements are distributed among country's population by "discounting" each dimension's average value according to its level of inequality. Thus, the IHDI is distribution-sensitive average level of human development.

^[2] National Family Health Survey-4 (2015-2016)

^[3] Nomita Chandhiok, Lucky Singh, Kh. Jitenkumar Singh, Damodar Sahu, Arvind Pandey, 'Does Breastfeeding Have an Effect on Infant Mortality in India? An Analysis of National Family Health Survey Data', September 2015 (http://file.scirp.org/pdf/OJPM_2015091611264436.pdf)

^[4] Source: NFHS-4

^[5] Within UNICEF, Communication for Development and Health units worked together on this initiative.

^[6] http://www.trai.gov.in/sites/default/files/PR_No_43_Eng_13_06_2017.pdf

^[7] V-1-Less vulnerable, V-2-Moderately vulnerable, V-3-High vulnerable and V-4-Extremely vulnerable.

^[8] Source: National Family Health Survey-4

^[9] Though IYCF focuses on postnatal mothers and infants, based on data and field experience, UNICEF felt it important to include pregnant mothers. Proper maternal health and nutrition, as well as quality of care at delivery and during the newborn period can help to address health problems like low birth weight, birth defects, etc.

^[10] The list of Ammaji video films used is: AN & PN care, exclusive breastfeeding, early initiation and colostrum feeding, growth monitoring, nutrition and care for girl child, diarrhoea-causes & prevention, diarrhoea-home based management and handwashing with soap.

^[11] GATHER stands for the following six activities: Greet, Ask, Tell, Help in the decision-making, Explain, Return. An FLW is expected to do in each of her interaction.

^[12] Source: Programme monitoring data

^[13] https://www.google.com/url?q=https://en.wikipedia.org/wiki/Do_Not_Disturb_Registry&sa=D&ust=1508313389786000&usg=AFQjCNE98ZAMEvYUxsw2kXRNx8FfIRODA

^[14] Source: Internal UNICEF report on the intervention.

^[15] Of the 113 respondents, only 86 who could read and write undertook the feedback.

^[16] These results are based on interaction with ICDS, UNICEF, FLWs and participants (mother and fathers)

^[17] This is anecdotal and based on interaction with government functionaries in ICDS department.

^[18] This includes traditional healers, traditional leaders and members of the self governing bodies.

^[19] Based on key informant interviews with stakeholders and programme documents.

^[20] The Ministry of Rural Development, a branch of the Government of India, is entrusted with the task of accelerating the socio-economic development of rural India. Its focus is on health, education, drinking water, housing and roads.

^[21] DPMU Endline Survey Report

^[22] DPMU Endline Survey Report

^[23] Based on key informat interview with Odisha UNICEF C4D state representative and programme document.

^[24] NRHM is an initiative undertaken by the government of India to address the health needs of underserved rural areas.

^[25] Integrated Child Development Services (ICDS) is an programme which provides food, preschool education, and primary healthcare to children under 6 years of age and their mothers.

^[26] *Sarva Shiksha Abhiyan* (Education for All Movement), or SSA, is an Indian Government programme aimed at the universalisation of elementary education "in a time bound manner", as mandated by the 86th Amendment to the Constitution of India making free and compulsory education to children between the ages of 6 to 14, a fundamental right.

unicef  | for every child

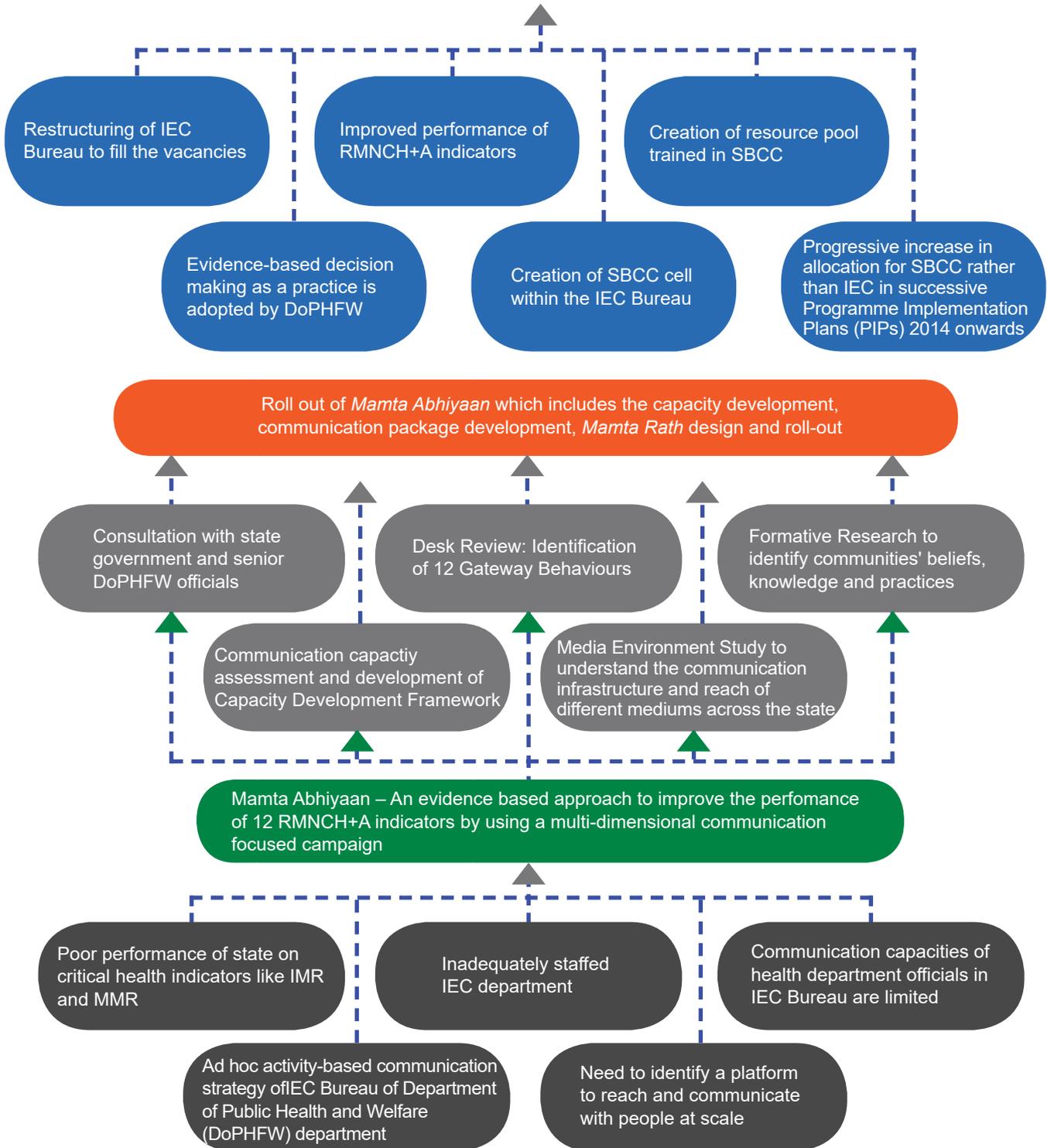
Mamta Abhiyaan

Sneha, Suraksha, Samman

Improving maternal, child, and adolescent health through SBCC in **Madhya Pradesh**

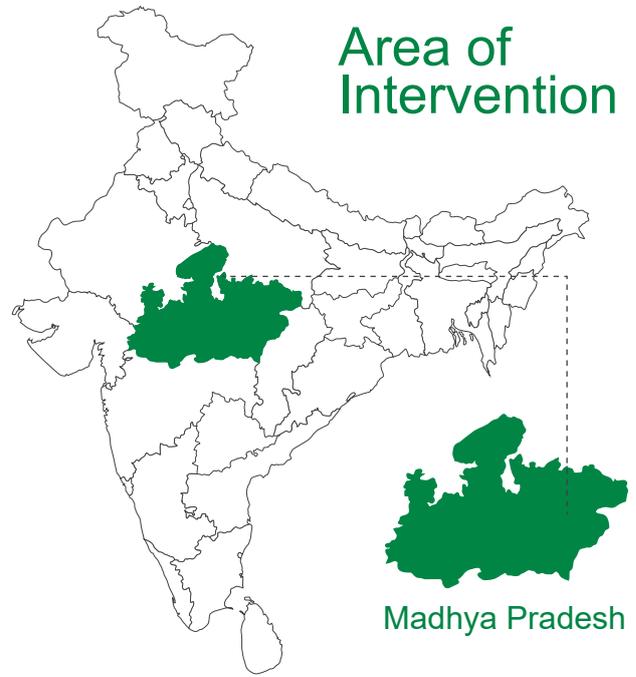
Globally, about 800^[1] mothers die every day of preventable causes related to pregnancy and childbirth — of which India alone accounts for 20%^[1]. The state of Madhya Pradesh (MP) has the highest Maternal Mortality Ratio (MMR) at 2,212 per 1,00,000 live births. The Infant Mortality Rate (IMR) is 51^[2] — 24 percent higher than the national figure. The Department of Public Health and Family Welfare (DoPHFW), in partnership with UNICEF, launched the *Mamta Abhiyaan* in 2013. The objective of *Mamta Abhiyaan* was to strengthen the Information, Education, and Communication (IEC) Bureau of the Government of Madhya Pradesh (GoMP). This was to promote 12 gateway behaviours, and mobilise elected representatives, health officials, community leaders, and family members to prioritise and value maternal and child health. The initiative was designed and developed following extensive consultations with DoPHFW, and GoMP at the state, district, block, and village level. A robust evidence generation exercise was conducted to design the *Mamta Abhiyaan* with a wide range of stakeholders, and was rolled out across all the 51 districts in the state. Capacity building and monitoring frameworks were developed to enhance effective execution of the campaign. One of the media innovations launched as a part of *Mamta Abhiyaan* was the *Mamta Rath* (van), a key vehicle of communication. It was a unique combination of outreach media and mass media products, social mobilisation, group counselling, referral services, and distribution of medicines and supplements. 313 such vehicles toured an equal number of blocks across 51 districts in the state. Approximately 1.3 million USD was leveraged from the government to provide Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) services in 52,000 villages. The success of the *Mamta Abhiyaan* has highlighted the importance of SBCC for the effective delivery of RMNCH+A services. GoMP also recognised the need for a health education cadre, and has filled various positions at the district and block level by re-allocating human resources within the bureau. The IEC bureau was restructured as Social and Behaviour Change (SBC) cell through an official order by GoMP dated 5th June, 2014.

Theory of Change



Situation

The state of Madhya Pradesh (MP), with a score of 0.451^[3], ranks low on the Human Development Index (HDI). It has the highest Maternal Mortality Ratio (MMR) — 221^[4] — which is 32 percent higher than the national figure. The infant mortality rate (IMR) for MP is also high at 51^[5] — 24 percent higher than the national figure. Inadequate infrastructure and a low number of skilled health staff add to the supply-side challenges in the health system in MP. On the other hand, demand for health services is also low; caste disparities, gender norms, education, and economic inequity influence the demand and uptake of health services in rural areas^[6]. The state has an IEC bureau, a nodal unit which is responsible for planning, implementing, and overseeing the IEC activities under the supervision of DoPHFW. It had large number of staff vacancies — 40 percent to 80 percent at block and district level respectively^[7] — and was struggling to provide quality communication support. It followed an activity-based approach and lacked an evidence-based communication strategy to promote NHM outcomes. GoMP recognised the need to adopt a robust and comprehensive communication strategy to deliver quality healthcare services at scale. UNICEF, in collaboration with DoPHFW and GoMP, launched *Mamta Abhiyaan* in 2013 with a focus to develop and implement a comprehensive Social and Behaviour Change Communication (SBCC) strategy. This strategy pushed for collaborated efforts to reach families, communities, and health service providers



Intervention State

This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.

Source: http://d-maps.com/carte.php?num_car=4183&lang=en

to improve demand for health services, with a special focus on the 12 RMNCH+A behaviours. It included large-scale capacity building plans to equip the health staff with SBCC skills to effectively implement the campaign. A multimedia innovation in the form of *Mamta Rath* was rolled out to cover all villages across 51 districts.



The launch of the *Mamta Abhiyaan* with Honourable Chief Minister Shivraj Singh Chouhan and UNICEF ambassador Madhuri Dixit.



Madhuri Dixit addressing the audience at the launch of *Mamta Abhiyaan*.

Method

1. Consultations with Key Stakeholders

As a first step, UNICEF conducted three iterative rounds of consultations with key officials from DoPHFW, MP. These discussions were conducted to:

- Help identify key issues, barriers, and enablers to achieve better health outcomes in MP
- Update and discuss findings from the formative research, communication capacity gap assessment, and media environment assessment carried out by UNICEF
- Gather feedback on the communication strategy being designed

2. Evidence Generation

This was done for the development of a communication strategy that included desk review, formative research, media environment assessment, and communication capacity assessment.

- **Desk review:** National Health Mission (NHM) lists 50+ behaviours that should be practiced across the RMNCH+A life stages. UNICEF, in consultation with the DoPHFW through a desk research, identified 12 gateway behaviours^[8] spread across the five life stages^[9]. Gateway behaviours are ones which, when adopted, lead to positive outcomes on other behaviours. For example, better reproductive health behaviour improves maternal health outcomes, thus preventing maternal deaths and promoting the birth of healthier babies.

12 Gateway Behaviours



Reproductive health:

- Use of contraceptive and birth interval methods



Maternal health:

- Early registration and complete follow-through of Antenatal Care (ANC)
- Use of 100 IFA tablets during pregnancy
- Identification of high-risk pregnancies and immediate provision of healthcare
- Safe medical termination of pregnancy



Child health:

- Encouraging Routine Immunisation (RI)
- Use of ORS for diarrhoea management



Newborn health:

- Increasing institutional deliveries through Janani Express Yojana, and encouraging complete Postnatal Care (PNC) within 48 hours of delivery
- Feeding colostrum, early initiation of breast milk, and exclusive breastfeeding
- Correct newborn care practices including cord, thermal, and kangaroo care



Adolescent health:

- Delaying the age of marriage and childbirth
- Encouraging regular uptake of IFA tablets

- **Formative research:** Following the desk review, a formative research was carried out to understand the communities' knowledge, beliefs, and practices around the gateway behaviours. It also aimed to realise barriers and enablers that influenced the adoption of these behaviours. The barriers to healthcare identified were:

At individual level: Inadequate knowledge about healthcare practices

At family level: Adequate knowledge at the individual level, but lack of family support in health-seeking behaviours

At community level: Adequate knowledge at the individual, family, and community level, but lack of health-seeking behaviours in the community norms

At system level: Adequate knowledge at the individual, family, and community level but lack or unavailability of good quality services

- **Study of media environment in the state:** A research on the media environment in the state was carried out, which studied the availability of communication-related assets^[10], media consumption patterns for newspapers, radio, and mobile, and most effective channels of communication for the intended audience.

This led to the formulation of an overall communication framework, including a media plan for *Mamta Abhiyaan*. The media plan detailed out the multimedia message content, frequency of messages, communication medium, timeline, and the cost of media plan.

- **Communication capacity assessment:** Capacity assessment exercises were conducted with the health communication staff from DoPHFW. The findings from this study brought out deficiencies in communication skills and capacities among the health officials across different levels (district, block, village). A capacity building framework for SBCC was developed based on the findings of this assessment. The framework identified the following key elements for an effective capacity building initiative:
 - Customised **competency-based training**^[11] for the health staff
 - Identification of change agents called '**role models**'^[12] at the block level
 - Restructuring of IEC bureau to develop **ownership towards SBCC programmes** within the cell
 - Building **commitment to performance** within the health department, thereby developing a dynamic and new organisational culture



A mother with her infant for a weekly check-up at the *Aganwadi* clinic.

FLWs were trained on SBCC and IPC skills.



3. Communication Strategy Design

Based on its evidences and research findings, the strategic communication approach of '*Sneha-Suraksha-Samman*' (Care-Protection-Respect) was developed as part of *Mamta Abhiyaan*. This strategy addressed three key audiences:

- **Family and community members** who should provide *Sneha* (Care) to the mothers
- **Community leaders and elected representatives** who should provide *Suraksha* (Protection) to the mothers
- All **health services providers**, from Frontline Workers (FLWs) to doctors and nurses, who should treat mothers with *Samman* (Respect)

Communication including the theme and logo was developed, and existing communication materials were repurposed as part of *Mamta Abhiyaan*. *Mamta Rath* (van), an innovative mobile communication vehicle, was developed as part of this initiative. It was designed to mobilise FLWs, interact with and counsel the community, and provide health service and referrals.

4. Advocacy with the Highest Level of Bureaucracy and Political Leadership

This resulted in active leadership of the Hon. Chief Minister and Hon. Health Minister, along with the Principal Secretary, DoPHFW, and Mission Director, NHM, right from the campaign's inception to its roll out. At the request of the Hon. Chief Minister, the communication strategy was also presented to all elected representatives of the Madhya Pradesh Assembly. With good communication and relevant advocacy, a celebrity was roped in as UNICEF's brand ambassador for the campaign.

In 2014, DoPHFW and UNICEF jointly conducted three meetings with the Health and IEC staff from all 51 districts and blocks to orient them about a) *Mamta Abhiyaan*, b) their roles and responsibilities in rolling it out, c) capacity building and monitoring of framework, d) *Mamta Rath*, e) the development of a communication plan to be integrated in the Programme Implementation Plan (PIP).



An ASHA worker engaging community members.

Action

Restructuring the State Health IEC Bureau:

The GoMP restructured the IEC bureau under the Ministry of Health and Family Welfare (MoHFW) and created four verticals — research and planning, capacity building, mass media and publicity, and evidence generation (monitoring & evaluation). A departmental promotion committee meeting was conducted to fill the health-educator vacancies at the district and block level. 41 out of the total 51 vacant Media Education and Information Officer (MEIO) posts were filled at the district level, and 139 out of 313 block extension educators were filled at the block level.

Capacity building: Based on the capacity assessment framework developed, capacity building of different officials was undertaken by UNICEF. These trainings were done in an iterative manner across the state. Across the 313 blocks, a total of 1,878 health functionaries were trained on different communication aspects based on their role and the communication plan.

Mamta Abhiyaan: It was the core strategy launched with an objective to:

- Promote the 12 gateway behaviours
- Strengthen the SBCC strategy and activities
- Mobilise the elected representatives to prioritise maternal and child health issues in their electoral constituencies

Mamta Rath: A key component of the *Mamta Abhiyaan* was the *Mamta Rath* — a vehicle to promote behaviour change in the community. It was an audio-visual van that disseminated information on RMNCH+A, and followed the strategic approach of the campaign — *Sneha-Suraksha-Samman*. The *Mamta Rath* served as a platform to provide consultation, counseling services, referrals, and health-related entitlements to women, children, and adolescents. It had the following communication tools on it:

Posters: 12 poster of the gateway behaviours were placed on the exterior of the van

Mamta Geet: An anthem saluting the mothers of the state

Television spots: 12 television spots on the gateway behaviours were played on the *Mamta Rath*. These television spots were intertwined with messages from the Hon. Chief Minister Shivraj Singh Chouhan, and UNICEF ambassador, Madhuri Dixit



Mamta Videos: Thirty five 20-minute-long *Mamta* videos on the 12 behaviours were available on the vehicle. The *Rath* facilitator would select one of the life-saving behaviours and play the corresponding video

Mamta corner: This component provided 11 essential drugs for clients in need

The media environment study conducted earlier was used to design the above-mentioned components of the communication package. The study helped understand the reach, penetration, and audience of the different media platforms across the different geographic regions of the state.

The vehicles covered 52,000 villages across 51 districts on a bi-monthly basis. At each village, the vehicle displayed television commercials and educational videos, played the *Mamta* anthem, and conducted a discussion with the group through a facilitator. In these discussions, the messages in various IEC materials were discussed with reference to the local context. It was a platform for counseling, distribution of IFA tablets, ORS sachets, sanitary napkins, and conducting referral to health services. Frontline Health Workers (FLWs) called ASHA were given the responsibility of mobilising mothers, caregivers, and community givers on the day of the visit and delivering information about the *Rath*'s scheduled visit to the village.



A nurse in the *Gram Arogya Kendra* established within *Anganwadi* in each village.

Gram Arogya Kendra (GAK): Under the campaign, GAKs were established within *anganwadi*^[13] centres in each village of MP. These GAKs dispensed 17 essential medicines which were distributed by FHV's to the community members in time of need.

UNICEF facilitated a presentation in the State Assembly to inform and sensitise elected representatives about the *Mamta Abhiyaan*'s strategy. Their role of *Suraksha* (protection) to the children, daughters, and mothers in their constituencies was highlighted. Madhuri Dixit, UNICEF's brand ambassador for maternal and

child health, was brought in to enhance visibility and acceptance of the intervention among the people of the state.

A detailed action plan was developed for effective implementation of the campaign, focusing on roles and responsibilities of each health functionary across levels for every activity. For *Mamta Rath*, capacity development trainings focusing on Planning-Implementation-Evaluation (P-I-E) was conducted for the officials^[15].

Monitoring and Action: A robust monitoring framework was established to review progress on a concurrent basis. The monitoring plan looked at quantifiable indicators which were defined for all levels (state, district, and block) and classified into process, performance, and outcome measures. Regular monitoring and review of the *Mamta Abhiyaan* was undertaken at the block, district, and state level by DoPHFW. Different health programmes at the state level maintained nine^[14] online databases with live dashboards to track the programmes' target, reach, and other elements. Data from these was used to analyse the progress and take evidence-based action for course improvement and correction. Similar reviews were also carried out at the district and block level on a regular basis. In addition to these reviews, monitoring visits were carried out by different health functionaries^[15] of DoPHFW, MP to verify the quality and reach of the programme. This exercise helped the department document progress of the initiative, which acted as evidence and helped add validity to the implementation carried out by the DoPHFW staff and officials.



Anganwadi workers played a key role in effective implementation of *Mamta Abhiyaan*.



Mamta Abhiyan leveraged many innovative tools to highlight better health practices.

Results

- ‘*Mamta Abhiyaan — Sneha, Suraksha, and Samman*’ was selected in the prestigious global conference organised by American Public Health Association (APHA), and a paper on the same was presented in 2016.
- *Mamta Rath*, the innovative media initiative, was identified and recognised by the Government of India (GoI). It was documented as an innovation in the coffee table book launched by the Hon. Health Minister of India, Shri J P Nadda.
- GoI recognised MP as being the best state to implement Mission Indradhanush (MI) as well as the Intensified Mission Indradhanush campaign (IMI), a special purpose vehicle of GoI to ensure full immunisation of all pregnant women and children up to two years of age. Immunisation targets one of the critical health indicators related to infants in the overall RMNCH+A life cycle.
- The government considered Health Education Officers to be a dying cadre and, as a result, there were very high vacancies in this sector.

The success of the *Mamta Abhiyaan* has highlighted the importance of the Health Education cadre, and the GoMP managed to fill the vacant positions of Block Extension Educator (BEE) and MEIOs in all the 313 blocks and 51 districts respectively. This was achieved through Departmental Promotion Committee (DPC) meetings and reorganisation of human resources within the bureau.

Indicators of the progress made in maternal and child health service delivery are:

- Immunisation of **219,859** children who were dropouts from previous immunisation drives
- Registration^[16] of **15,825** newborns
- Immunisation of **86,171** pregnant women
- Distribution of Oral Rehydration Solution (ORS) packets and Zinc tablets among **92,398** children
- Leveraging **1.3 million USD** from the government to provide RMNCH+A services in 52,000 villages

Adolescents were given information about importance of IFA tablets and motivated for regular IFA tablet consumption practice.



Transformative Change

Health System Strengthening

Through structural changes, the initiative has led to strengthening of the state IEC bureau as a Social and Behavioural Change cell in the state. GoMP has, through an official order dated 5th June 2014, constituted an SBC cell under the supervision of DoPHFW. The state has managed to create a structure right from the state to the village level to effectively roll out any communication strategy. The objectives of the SBC cell are:

- To accelerate result achievement of RMNCH+A goals in NHM using SBCC strategies
- To bring positive change in maternal and child health practices using mass media and traditional mediums
- Capacity building of district and block-level staff officials on the use of SBCC strategy for effective delivery of healthcare services that will lead to improvement in RMNCH+A indicators

Communication strategy

The success of the campaign in MP showcases the potential of DoPHFW in terms of strong processes to develop an evidence-based communication strategy for better RMNCH+A outcomes. Apart from development of the strategy, 1.3 million USD was mobilised from GoMP for effective roll out across 52,000 villages.



The *Mamta Rath* – a key component of the *Mamta Abhiyaan* programme.

Enhanced SBCC capacities

DoPHFW now has a pool of master trainers in the SBC cell trained on the use of SBCC, who could act as internal resource persons for training other officials on SBCC. A resource pool of 293 health educators from 51 districts has been created to facilitate SBCC trainings focused on IPC and social mobilisation. 318,461 USD was mobilised from the DoPHFW to roll out a bridge training programme for 46,787 frontline workers in 14 IMI districts. The DoPHFW effectively coordinated a total of 1,337 batches of field training across the 14 districts.

Communication plan for actions integrated in PIPs

There has been progressive increase in allocation of SBCC rather than IEC in successive Programme Implementation Plans (PIPs) since 2014, especially in terms of reduction in mass media allocation and increase in mid-media and IPC interventions.

Caselet 1

Bhupendra Singh Pawar is the Block Community Mobiliser (BCM) of Aron block, Guna district, MP. As part of the *Mamta Abhiyaan* he attended trainings on gateway behaviours, SBCC, and *Mamta Rath*. He says, “The trainings have been very useful for me as a BCM. Through the trainings, I have learnt new and innovative methods to mobilise the community and increase demand for health services. I now know who my actual audience is and how I should communicate with them to get their attention. The campaign motivated me to work for mothers and children in my community.” Bhupendra has selected 30 GAKs out of a total of 133 in his block to do focused work and improve maternal and child health indicators.

In Summary

DoPHFW and GoMP, in partnership with UNICEF, launched the *Mamta Abhiyaan* in 2013. The objective was to strengthen the Information, Education, and Communication (IEC) bureau of GoMP, promote 12 gateway behaviours, and mobilise stakeholders to prioritise and value maternal and child health. Here's a blueprint of how the intervention was rolled out in all 51 districts in Madhya Pradesh.

Action



GoMP restructured the IEC bureau under the MoHFW, and a departmental promotion committee meeting was conducted to fill the health-educator vacancies at the district and block level.



Health functionaries were capacitated on different communication aspects based on their role and the communication plan. For officials, the capacity building focused on Planning-Implementation-Evaluation (P-I-E).



DoPHFW undertook regular monitoring and review of Mamta Abhiyaan to document the progress of the initiative and add validity to its implementation.



GAKs were established within anganwadi centres. They dispensed 17 essential medicines, which FLWs distributed to the community when needed.



Mamta Rath — an audio-visual van — was introduced to promote behaviour change in the community. It disseminated information on RMNCH+A through posters, TV spots, and videos among other methods.

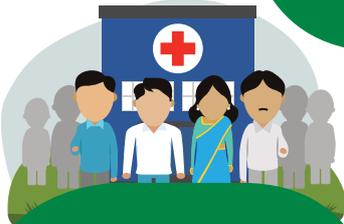
Results



A paper on 'Mamta Abhiyaan — Sneha, Suraksha, and Samman' was presented at the global conference organised by the American Public Health Association (APHA).



Mamta Rath was documented as an innovation in the coffee table book launched by the Hon. Health Minister of India, Shri J P Nadda.



There's now better knowledge of the importance of a Health Education cadre, and GoMP has managed to fill the vacant positions of BEE and MEIOs.

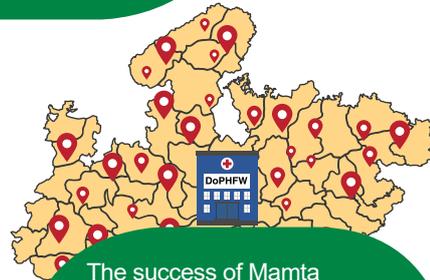


GoI recognised MP as being the best state to implement MI as well as IMI, a special purpose vehicle of GoI to ensure full immunisation of all pregnant women, and children up to two years of age.

Transformative Change



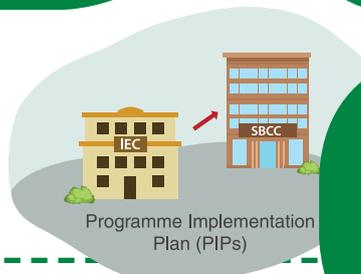
Through structural changes, the initiative has led to strengthening of the state IEC bureau as an SBC cell. There now exists a structure, right from the state to the village level, to effectively roll out any communication strategy.



The success of Mamta Abhiyaan in MP reveals the potential of DoPHFW to develop an evidence-based communication strategy for better RMNCH+A outcomes. The 1.3 million USD mobilised from GoMP enabled effective roll out across 52,000 villages.



There is now an increased allocation of SBCC as opposed to IEC in successive PIPs since 2014, especially in terms of reducing mass media allocation and increasing mid-media and IPC interventions.



Programme Implementation Plan (PIPs)

DoPHFW now has a pool of master trainers in the SBC cell trained on the use of SBCC, capable of training other officials on the same. 293 health educators from 51 districts form a resource pool, and facilitate IPC and social mobilisation-focused SBCC training.

References

- [1] <http://UNICEF.in/Whatwedo/1/Maternal-Health>
- [2] National Family Health Survey-4, measured in 1,000 live births.
- [3] http://www.undp.org/content/dam/india/docs/inequality_adjusted_human_development_index_for_indias_state1.pdf
- [4] SRS 2011-2013, measures in 1,00,000 live births.
- [5] National Family Health Survey-4, measured in 1,000 live births.
- [6] <https://equityhealthj.biomedcentral.com/track/pdf/10.1186/1475-9276-10-59?site=equityhealthj.biomedcentral.com>
- [7] UNICEF report.
- [8] Gateway behaviours are key behaviour in a life stage which, if addressed, would have a positive outcome on the subsequent events in the same and following life stage.
- [9] The five life stages are reproductive, maternal, newborn, child and adolescence.
- [10] Example: television, Radio/Transistor, Telephone/Mobile and Internet.
- [11] The competency trainings would focus on the following three aspects: technical, managerial and communication skills of health staff.
- [12] As per the study, the audience needs to be given examples – they need to know about the benefits of adopting the behaviours as well as the negative consequences of not adopting or discontinuing the behaviours. They need to meet or see role models to understand how the behaviours change has worked.
- [13] *Anganwadi* is a mother and child care center in every village in India. They were started by the Indian government in 1975 as part of the Integrated Child Development Services programme to combat child hunger and malnutrition.
- [14] The 9 databases are Health Management Information System (HMIS), Human Resource Management & Information System (HRMIS), EqMIS, Mother and Child Tracking System (MCTS), *Janani Shishu Suraksha Karyakram* (JSSK), *Nikshay*, Financial Management Information System (FMIS), *ASHA* software, e-Aushdhi
- [15] This includes health staff from DoPHFW, specifically; Block programme managers (BPM), Block community mobiliser (BCM), Block Extension Educator (BEE) District programme managers (DPM), District Media Education and information officer (DMEIO) and Deputy DMEIO.
- [16] Most of these were home-based delivery and children not registered in the Mother and Child Tracking System (MCTS).

Supportive Supervision to Improve Demand for RMNCH+A Services in North Karnataka

Karnataka is a progressive state in India, but it shows disparity in development within the state — northern Karnataka lags significantly in many development indicators compared to the south. According to the Human Development Report for Karnataka^[1], majority of the northern districts have low ranks in health indicators. The report shows that the Infant Mortality Rate (IMR), and Maternal Mortality Rate (MMR) are all higher than the state average, while doctor-patient ratio is lower. Eight^[2] of the northern districts fall under the High Priority Districts^[3] (HPDs) in the state. Changing these indicators for the better require long and concerted efforts from the health department. One of the first steps taken to strengthen the health system was to enhance the skills and knowledge of the Frontline Health Workers (FLW). UNICEF, in partnership with State Institute of Health and Family Welfare (SIHF), Karnataka undertook a Social Behaviour Change Communication (SBCC) intervention in select villages of the eight HPDs. The objective was to improve the knowledge, interpersonal, and communication skills of FLWs called Accredited Social Health Activist (ASHA) and health functionaries (supervisory staff like DHEOs and BHEOs), which would lead to improvement in health services in these districts in the long run. As part of the intervention, SBCC training was imparted to 2,256 health functionaries at district and block level. These health functionaries, in turn, acted as Master Trainers and trained health workers in their work jurisdiction. In the subsequent phase, UNICEF implemented Supportive Supervision (SS) that aimed to help FLWs improve their interpersonal communication skills. Supportive Supervision recognised the crucial role of FLWs as agents of social mobilisation, and intended to help them and their supervisors deliver the last mile service in an informed and engaging manner. As a result of this intervention, performance of FLWs and health functionaries has improved, and they are now able to engage effectively with the community. It has strengthened the health departments' SBCC capacities, and Supportive Supervision has improved their ability to monitor and improve the performance of their workforce.

Theory of Change



Health system strengthening for improved, effective, and relevant communication that can influence improvement in the health and health indicators of stakeholders.

Frontline Workers (FLW)

- Approximately 1,886 FLWs across eight districts received training on SBCC.
- They engaged with the community, and had effective and relevant conversations with mothers.
- Their performance improved.

Supervisors of FLWs

- 103 health education officials were trained on SBCC management.
- FLW supervisors and mentors now monitor and provide appropriate and contextualised feedback to each of the FLWs.
- Their training pedagogy has improved and become more effective.

SIHFW

- An enabling Supportive Supervision environment and a resource base trained in SS was created among the health officials.
- SIHFW has better ability to assess the performance of their health functionaries.

Phase 1: The SBCC, IPC, and facilitation skills of health functionaries was strengthened.

Phase 2: Supportive Supervision was planned and rolled out in all the eight districts.



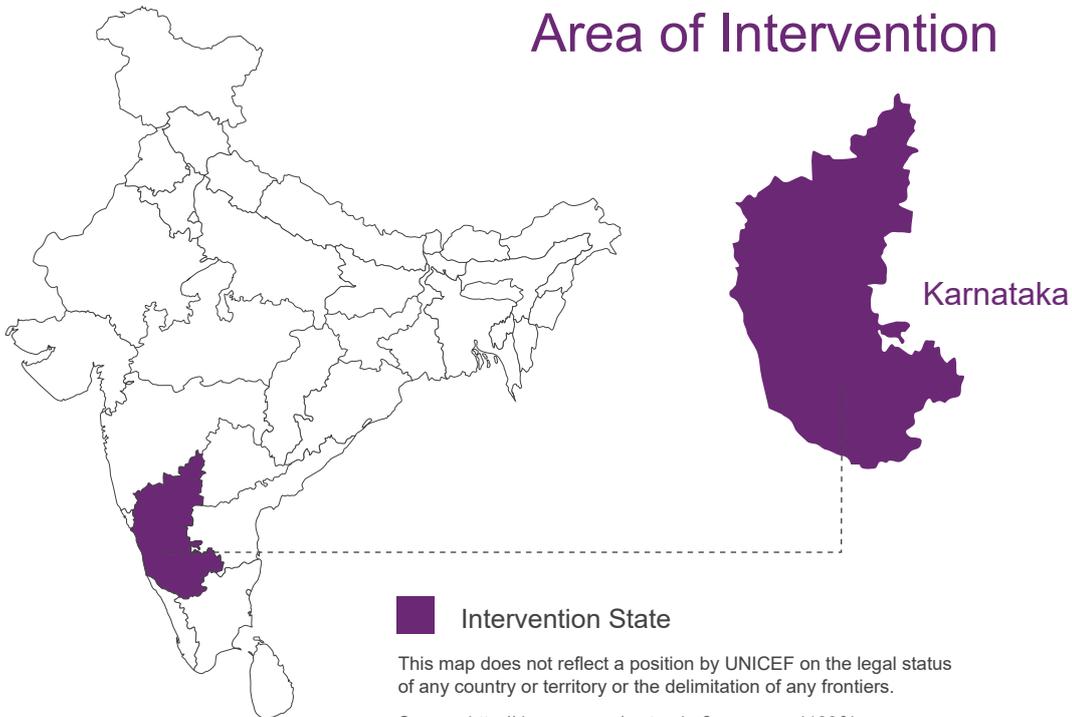
Engagement with SIHFW, and launch of initiative to improve the SBCC, IPC skills of FLWs and their knowledge about the relevant Reproductive, Maternal, Neonatal, Child, and Adolescent (RMNCH+A) Health indicators.

Lack of skilled Frontline Workers (FLW) trained in SBCC and IPC.

No Supportive Supervision system for FLWs.

Poor status of health indicators in the select high priority villages in the eight HPDs in North Karnataka.

Area of Intervention



Intervention State

This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.

Source: http://d-maps.com/carte.php?num_car=4183&lang=en

Map not to scale

Situation

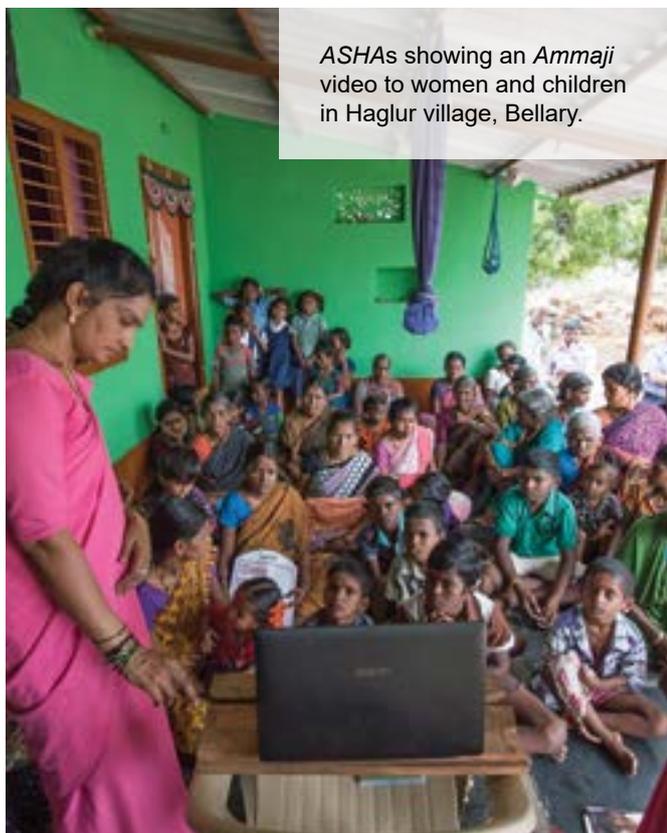
The state of Karnataka is in the southwestern region of India, with wide developmental gaps between the northern and southern regions of the state. Historical neglect of the northern region along with poor leadership are two key factors that have widened this gap within the state. In 2007-2008, the per capita income of South Karnataka was 1.3 times that of North Karnataka^[4]. This also reflects in the health indicators, infrastructure, and health services in the northern region. According to Karnataka's Health Management Information System (HMIS), all the HPDs in the state had an IMR higher than the other districts for three consecutive years, from 2014 to 2017^[5].

To improve the health services in North Karnataka in the long term, the Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A^[6]) programme required strengthening of the system and capacity building of its workforce, enabling them to deliver and execute their roles more effectively. UNICEF, in partnership with SIHFW, Karnataka implemented an SBCC intervention in all the eight HPDs from 2014 to 2016. The objective was to improve the knowledge and Interpersonal Communication (IPC) skills of the health functionaries, which would lead to improved health service delivery in these districts.



Supervisors and mentors conducting a Supportive Supervision visit in Siriguppa block of Bellary district.

ASHAs showing an *Ammaji* video to women and children in Haglur village, Bellary.



Method

The intervention engaged with the following cadres of health functionaries at the district and sub-district level:

- Frontline Workers: *ASHA* and *ASHA* facilitators^[7]
- Mentors: *ASHA* mentors responsible for training and mentoring FLWs
- Supervisors: Block Health Education Officers (BHEOs) and District Health Education Officers (DHEOs) responsible for overseeing and implementing SBCC activities of all the health programmes of the department

The first phase of the intervention focused on strengthening health functionaries' SBCC capabilities, IPC, and facilitation skills. The trainings had the following objectives:

1. Strengthen SBCC skills
2. Improve comprehension about role of facilitator and facilitation skills
3. Provide knowledge about RMNCH+A programmes
4. Strengthen and improve IPC skills with the use of 'Facts for Life' (FFL) videos^[8]

FLWs were trained to engage with the participants and community influencers to promote the demand and utilisation of health services, and the practice of desired behaviours around child, adolescent, and maternal health. They engage with the participants primarily through IPC sessions (one-to-one as well as group IPC) and community meetings using different types of communication aids.

In the second phase of the implementation, Supportive Supervision was planned and rolled out in all the eight districts. Key characteristics of the programme were that:

- Supervision was conducted in a respectful and non-authoritarian way to enable FLWs to continuously improve their performance.
- Supportive Supervision visits were used as an opportunity to improve the knowledge, communication, and interpersonal skills of the FLWs.

The Supportive Supervision model aimed at following up with trained FLWs at the community level to provide on-the-spot guidance and support through the supervisory cadres. The focus was to enhance the quality of transaction between FLWs and the participants.

The four steps in Supportive Supervision were:

1. Identification of supervisors
2. Planning of regular Supportive Supervision visits
3. Conducting the Supportive Supervision visits
4. Regular follow-up

A Supportive Supervision format was developed by UNICEF and SIHFW. The format captures FLWs' performance against the nine communication themes related to antenatal and postnatal care practices followed by pregnant and lactating mothers respectively. These are detailed in Table 1 in the 'Action' section.

Action

The programme was implemented in priority villages^[9] identified in the eight HPDs. Training was provided on two broad aspects, i.e., (i) SBCC, IPC, and facilitation skills, and (ii) Supportive Supervision. Details of the training provided under each aspect is elaborated below:

Type of training	Health officials trained	Number of officials trained
Training on SBCC	FLW	1,512
	Mentors and supervisors	146
Training on SBCC management	Supervisors	103
Training on IPC and facilitation skills	FHV	374

SBCC management training entailed educating the health functionaries on how to plan, implement, and monitor the programmes that have SBCC as their central approach. In each of these trainings, *Ammaji Helluttare* videos^[10] were used to train the participants on SBCC skills. Apart from theoretical sessions, the training also included mock exercises for the participants.

Training on Supportive Supervision

121 mentors and supervisors were trained as Master Trainers (MTs) on Supportive Supervision and use of the format developed for the purpose. These master trainers, in turn, trained the remaining mentors and supervisors in their respective blocks and districts. They were imparted knowledge on nine different communication themes related to Antenatal Care (ANC), Postnatal Care (PNC), and the communication approach to be used when interacting with women on these themes.

The Supportive Supervision trainings aimed to improve FLW supervisors' knowledge and facilitation skills to help them monitor, observe, and give feedback to FLWs on not just the content but their communication skills as well. MTs were then asked to conduct Supportive

Supervision for the next 6 months. Each MT visited and observed interaction between FLWs and mothers for antenatal or postnatal health care every month^[11]. 98 supervisors conducted a total of 1,644 Supportive Supervision visits covering 464 FLWs. During this period, the supervisors:

- Observed while the FLWs interacted with pregnant and lactating mothers and their family
- If required, intervened and demonstrated how interactions should be conducted for the effective delivery of key messages for improving demand generation
- After the completion of the visit, they provided detailed feedback to the FLW on communication and IPC skills and methods for their improvement
- Recorded their observation in the Supportive Supervision format

Table 1: Supportive Supervision Training topics

Antenatal Care	Postnatal Care
Danger signs in ANC	Early breastfeeding
Tetanus immunisation	Kangaroo care of newborn
Early initiation and exclusive breastfeeding	Exclusive breastfeeding
Promotion of birth preparedness	Promotion of hygiene in newborn
Promotion of institutional delivery	Danger signs in newborn and mothers post delivery
Nutrition and IFA	Immunisation
ANC checkup	Follow-up visits
Birthweight	Usage of ORS during diarrhoea
Estimated date of delivery	Spacing method

Results

This intervention aimed at health system strengthening by way of establishing a systematic process for Supportive Supervision for *ASHAs* to strategically and effectively implement SBCC interventions^[12].

The performance of FLWs has improved after this programme. They are able to:

- Identify and take prompt action in critical antenatal and postnatal cases
- Communicate better with the community and motivate them to adopt the suggested health behaviours
- Reflect on their work to improve their communication skills and the content of their messaging
- Document their work and follow a rigorous reporting method

Mentors and supervisors of FLWs:

- Are able to monitor and provide appropriate and contextualised feedback to each of the FLWs
- Have an improved training pedagogy and incorporate the learning from SBCC trainings in all their training sessions
- Recognise the importance of Supportive Supervision and its contribution in helping them perform their role better

The performance of **SIHFW** health officials has improved. Specifically, they:

- Are now able to assess the performance of their peripheral health centre officials and FLWs
- Rigorously monitor and supervise work; handhold and demonstrate effective supervision
- Use Supportive Supervision data for gap analysis and take targeted actions across the HPDs
- Are able to incentivise good performance
- Have been able to create an enabling environment of Supportive Supervision

Supportive Supervision

3,764 Supportive Supervision visits were conducted for 554 FLWs between January and December, 2017. The following was observed from the Supportive Supervision data for the last reporting month.

- Out of the 554 FLWs visited, 521 had a monthly work plan.
- 2,300 couples with a single child were contacted and IPC on spacing between two children was carried out.
- 1,700 registered pregnant women were interacted with during the last reporting month, and IPC on ANC was conducted. Of these, 290 pregnant women with signs of danger were referred to the health facilities.
- 362 community meetings were organised by FLWs in the last reporting month.



A mentor giving feedback to an *ASHA* using the Supportive Supervision format.

Veeramma, an *ASHA* facilitator, wanted to practice the skills she learnt in the training and contribute to the society at large. Prior to the training, she confined her visits to only pregnant or lactating mothers. However, post training, she realised she was able to communicate better with all community members, even on matters which were beyond her defined role. Recalling one such incidence, she talks about how she was actively involved in preventing a child marriage in her community by engaging in a dialogue with the girl's family. She explained the ill-effects of child marriage, as well as the child marriage prohibition act and punishment under the same. With the help of her fellow FLWs, not only was she able to convince them to postpone the marriage, but also to continue education of adolescent girls.

Veeramma
***ASHA* Facilitator, Hosapete block,
Bellary district**

A mother with her infant child. Her ASHA convinced her to have an institutional delivery.



Transformative Change

Engagement with the community has increased and the FLWs now have greater commitment towards their work. The programme has strengthened the health departments' SBCC capacities, and Supportive Supervision has improved their ability to monitor and improve the performance of their workforce^[13].

Caselet 1

Mr. Ishwar Dasappanavar is the district health education officer of Bellary. His main role is to promote health and family welfare programmes in the district with key focus on the SBCC component of these programmes. Mr. Ishwar has also received training on Supportive Supervision as part of the UNICEF intervention which, he mentions, has helped him monitor his staff and their performance. As a result of this intervention, the FLWs' communication skills have improved. He says, "The biggest change for me has been the capacity development of my frontline staff from the trainings. My staff is now able to document and share their work as well as stories of positive cases."

Caselet 2



Mrs. Sujatha is currently a Taluka ASHA mentor in Bellary block. She was trained as a Master Trainer during the SBCC and Supportive Supervision training. She felt it helped her improve not only her own interpersonal skills, but also her training pedagogy. After this intervention, she conducts her trainings in an interactive manner, promoting dialogue between the trainer and trainees. Her improved performance was recognised by her seniors as well, and is now considered a key SBCC trainer in the district.

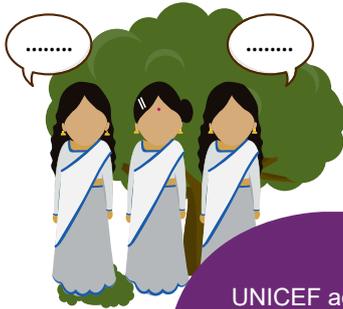
In Summary

UNICEF, in partnership with State Institute of Health and Family Welfare (SIHFW), Karnataka undertook a Social Behaviour Change Communication (SBCC) project in eight HPDs in North Karnataka. The intervention enabled FLWs, health functionaries, and the health department in general to perform better and engage more effectively with the community. Here is a blueprint of how the intervention was rolled out in priority villages in the eight HPDs.

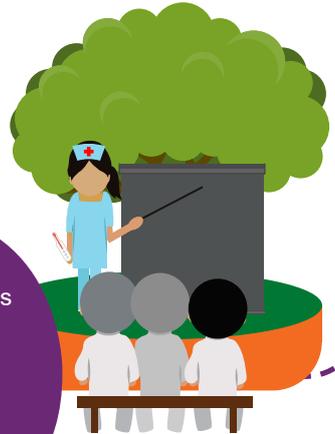
Action



Health functionaries were trained on SBCC, IPC, facilitations skills, and Supportive Supervision at the district and block level.



UNICEF adopted a Supportive Supervision approach, and aimed to help FLWs, health functionaries, and ASHA improve their IPC skills.



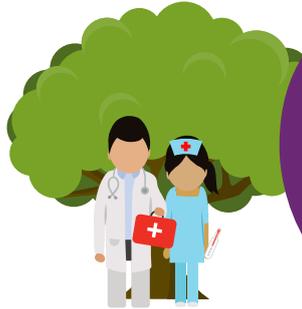
Trained health functionaries acted as Master Trainers, and coached the FLWs in their district. They imparted knowledge on communication issues.

Results



The performance of FLWs and health functionaries has improved, and they are now able to engage more effectively with the community.

Mentors and supervisors of FLWs have started monitoring and providing appropriate feedback, and possess better training know-how.



SIHFW health officials can better assess performances, supervise work, and take targeted actions.

Transformative Change



FLWs have the skill and commitment towards their work and engage more with the community.



The health departments' SBCC capacities have strengthened, and they have an improved ability to monitor and better the performance of their workforce.

References

^[1] http://www.in.undp.org/content/dam/india/docs/human_develop_report_karnataka_2005full_report.pdf

^[2] These districts are Bellary, Kalburgi, Raichur, Koppal, Vijayapura, Yadagir, Bagalakote and Gadag.

^[3] Based on the Maternal and Child Health Indicators, a composite index was developed by Government Of India in order to identify the High Priority Districts (HPD) under the health sector reforms to reach the Millennium Development Goals. Based on these indices, 184 districts across 25 states in the country have been identified as High Priority Districts.

^[4] Shiddalingaswami H, Raghavendra V K, D.M. Nanjundappa Chair, December 2010, Regional disparities in Karnataka: A district level analysis of growth and development, Dharwad.

Reporting Years	2016 – 2017		2015 - 2016		2014 - 2015	
District Type	HPD	Other Districts	HPD	Other Districts	HPD	Other Districts
IMR (Source: reported data HMIS)	13.37	12.85	14.62	12.27	17.03	12.27

^[5] HMIS is a digital initiative of the Department of Health and Family Welfare (DoHFW), Government of India (GoI).

^[6] Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) is a flagship scheme of the National Rural Health Mission (NRHM) , Ministry of Health and Family Welfare, Government of India.

^[7] ASHA Facilitators also work like ASHAs having a fixed population but will supervise 5-6 ASHAs and acts as a communication link between ASHAs and the ASHA mentor, BHEO.

^[8] Facts for Life (FFL) videos provide vital messages and information for mothers, fathers, other family members and caregivers and communities to use in changing behaviours and practices that can save and protect the lives of children and help them grow and develop to their full potential.

^[9] Priority villages in a HPD were selected basis their performance on the health indicators.

^[10] *Kyunki Ammaji Kehti Hain* videos has a total of 42 episodes; these are part of Fact for Life videos that provides essential information about various health practices and government health schemes available for the people. The videos have information on each stage of the RMNCH+A life cycle.

^[11] Each Master Trainer was expected to visit a minimum of 4 such interactions; 2 each with ANC and PNC stage mothers.

^[12] These results are anecdotal and based on the programme data and inputs from the district health education officers, block education officers, SIHFW team, and UNICEF Karnataka team.

^[13] This change is anecdotal and based on the interactions with the district health education officers, block education officers, SIHFW team and UNICEF Karnataka team.

unicef  | for every child

MAHIMA

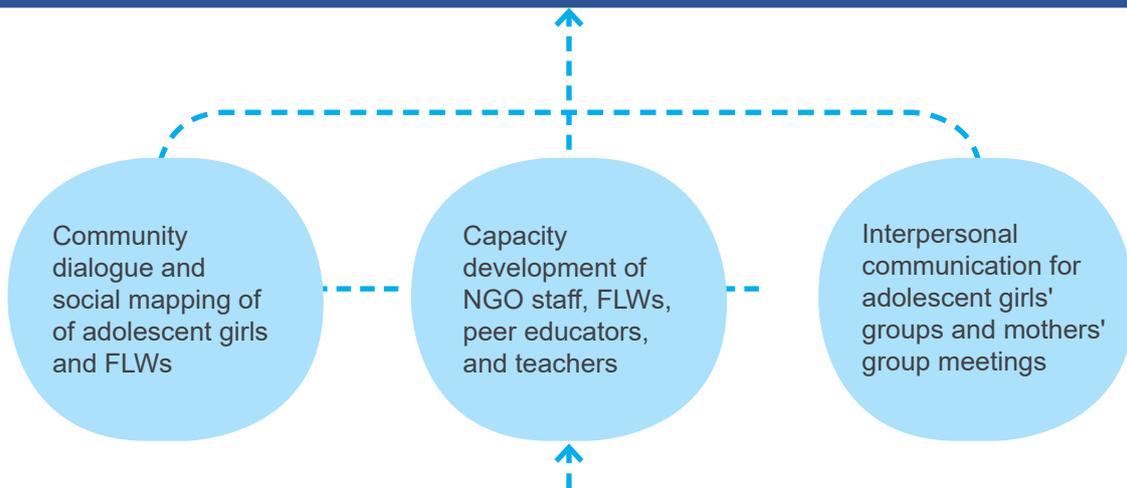
Breaking the Taboo Around Menstruation in **Jharkhand**

Two hundred million women in India lack knowledge of menstrual hygiene and disposal practices^[1], adversely affecting their education and health outcomes. UNICEF thus initiated Menstrual Health and Hygiene Management for Adolescent Girls (*MAHIMA*) in 2013, in partnership with the Government of Jharkhand and local non-government organisations like Development Network (DevNet) and *Lohardaga Gram Swarajya Sansthan* (LGSS). This social and behavioural change intervention focused on seven blocks of East Singhbhum and Gumla districts of Jharkhand. It aimed to improve Menstrual Health and Hygiene Management (MHHM) among adolescent girls via three Social and Behaviour Change Communication (SBCC) approaches, namely, community dialogue, capacity development, and interpersonal communication. UNICEF developed a communication package consisting Facts for Life (FFL) videos, a *Paheli Ki Saheli* (Friends of Riddles) package, and a life skills module. The package was meant for adolescent girls, Frontline Workers (FLWs), mothers, and teachers. Adolescent girls' and mothers' groups were formed to facilitate interpersonal communication and improve knowledge of menstruation among the participants. Thanks to *MAHIMA*, the community addressed myths around menstruation, which eased restrictions on menstruating girls.

Knowledge and practices related to menstrual health and hygiene have improved among adolescent girls, their mothers, teachers, and FLWs in the two districts. Girls now talk about menstruation freely and negotiate for the adoption of sanitary products. In addition, they now burn menstrual absorbents as a means of disposal. *MAHIMA* has helped adolescent girls and the community at large to effectively break the silence around menstruation. Moreover, UNICEF has collaborated with the government to incorporate the learnings of *MAHIMA* into flagship programmes addressing adolescent issues in Jharkhand.

Theory of Change

1. Improved knowledge on physiology of menstruation, MHHM, and disposal practices among community members, adolescent girls, mothers, FLWs, teachers.
2. Better MHHM and disposal among adolescent girls and other women in the community.
3. Adolescent girls associated with *MAHIMA* are empowered to speak openly and negotiate for better health and hygiene.
4. Mothers, FLWs, and teachers openly communicate with adolescent girls about menstruation.



UNICEF in partnership with non-government organisations implemented Menstrual Health and Hygiene Management for Adolescents Girls (*MAHIMA*) Communication tools: 5 Facts for Life videos, *Paheli ki Saheli*, life skills education

Poor MHHM and disposal practices among adolescent girls



Community:

- Put restrictions on menstruating girls
- Poor treatment and neglect of girls who have reached menarche



Adolescent Girls:

- Unprepared for menstruation since they lack knowledge on the topic
- Social restrictions imposed on them
- Low self-esteem, plagued with feelings of embarrassment and shame



Mothers:

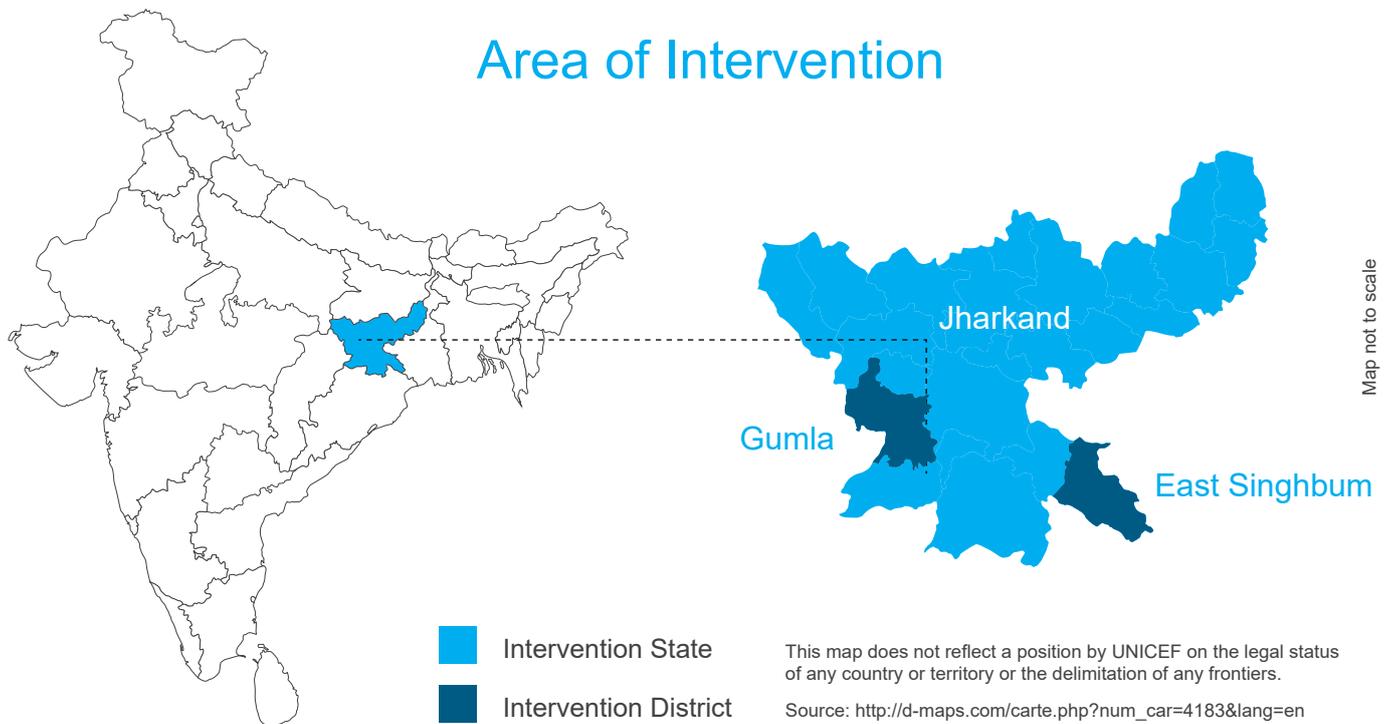
- Had little communication with their daughters on menstruation
- Concurred with the restrictions put by the community
- Had limited knowledge on MHHM



FLWs and teachers:

- Lacked accurate information on MHHM
- Limited communication skills
- Believed in the misconceptions around menstruation

Area of Intervention



Situation

Adolescence is the critical transitional period from childhood to adulthood, when gender norms and identities are shaped. For girls, the onset of menstruation marks the transition into puberty. In India, however, a large number of adolescent girls lack appropriate and adequate knowledge of menstrual health and hygiene. Around 71 percent of adolescent girls are unaware of the concept of menstruation until menarche, and 88 percent of menstruating women use old fabric, rags, sand, ash, wood shavings, newspapers, or hay as menstrual absorbents^[2]. Poor menstrual hygiene in turn leads to negative health and education outcomes^[3]. Health problems such as bacterial infections, burning, and itching are a result of this poor hygiene, and the lack or unaffordability of facilities and sanitary products forces menstruating girls to drop out of school^[4].

UNICEF conducted a baseline study in 2013 to determine existing knowledge levels, attitudes, practices, and norms related to menstrual health and hygiene behaviours. This study was conducted among adolescent girls in Gumla and East Singhbhum districts of the Indian state of Jharkhand. The findings indicated that MHHM and disposal practices were poor among adolescent girls. Majority (98%) of the girls used the same cloth for multiple cycles. Although they washed

this cloth with soap, 80 percent of the girls were unaware of the importance of drying and storing the same in a hygienic manner.

For the community, the onset of menarche indicated that the girl was mature enough for marriage and procreation. Menstruation was also considered unclean and impure, so girls were barred from entering the kitchen and places of religious significance. They were also prohibited from touching food items like pickles, onions, and potatoes; the common misconception concluded that these would get spoilt if touched by a girl on her menstrual cycle.

Adolescent girls were unprepared for menstruation, as their mothers or FLWs hadn't discussed this with them. Around 32 percent of girls knew nothing about menstruation before its onset, leaving them frightened and confused. They lacked knowledge about menstruation, its physiology, hygiene, management, and the health implications of poor menstrual hygiene practices. They accepted the social restrictions imposed during menstruation and were embarrassed to discuss the same with their family and FLWs. The baseline survey found that 54 percent of girls felt humiliated due to the imposed restrictions. Hence, they sought information from their friends and often received incomplete and incorrect knowledge.

Caselet

Anju is a 16-year-old girl from Ghatshila block in East Singhbhum. She began menstruating at the age of 10. The day she reached menarche, she locked herself in a room for hours as she did not know anything about menstruation. Anju sought her mother's advice, but her instant reaction was to keep quiet and not discuss it. She received incomplete and incorrect information in hushed tones, mostly on what to do, what to use, and the restrictions she must follow. Her mother asked her to use a piece of cloth. Anju silently suffered from foul-smelling discharge and severe itching in her genital area. She wasn't allowed to enter the temple or touch certain food items during menstruation. She often contemplated the restrictions imposed on her and what made menstruation so shameful.

Mothers had limited communication with their adolescent daughters on menstruation, as the topic was considered shameful. They told their daughters what to do, what to use, and the restrictions they were under. There was, however, no discussion on the physiology of menstruation and maintenance of hygiene. Even if mothers did discuss it, they lacked accurate knowledge and did not follow proper MHHM themselves. They did not question any restrictions on adolescent girls either.

FLWs and teachers had misconceptions and believed in the social restrictions around menstruation. While they lacked the communication skills required to discuss MHHM with others, their understanding of the same was also minimal. A cloth used as a menstrual absorbent was symbolically considered a woman's womb and it was believed that drying/burning of the menstrual cloth would result in the drying/burning of the womb, making it infertile. Hence, they were against the burning of menstrual absorbents for disposal. Lack of accurate information coupled with myths stopped them from supporting adolescent girls. Additionally, lack of knowledge and communication, along with the misconceptions and social restrictions around menstruation negatively affected the well-being of adolescent girls.

Baseline results revealed opportunities to prepare girls and break the taboo around menstruation. Girls were open to the idea of interacting with a 'peer' — a person

of their age group who could talk to them. Mothers were inclined towards their daughters receiving the right information. About 95 percent mothers were positively inclined towards adolescent girls learning about menstruation before its onset.



Peer educator communicating to adolescent girls about MHHM.

Method

UNICEF, in partnership with the Government of Jharkhand, implemented Menstrual Health and Hygiene Management for Adolescents Girls (*MAHIMA*) in seven blocks of East Singhbhum and Gumla districts of Jharkhand from 2013 to 2015. The intervention was implemented by local non-government organisation (NGO) partners — Development Network (DevNet) and *Lohardaga Gram Swarajya Sansthan* (LGSS).

The programme incorporated learnings from discussions with the different stakeholders involved, such as: a) the government, b) implementation partners — DevNet and LGSS, and c) adolescent girls (through the baseline study findings). A state-level workshop was held with the Departments of Education, Health and Family Welfare, Women and Child Development, and Drinking Water and Sanitation to implement *MAHIMA* in Jharkhand.

Objectives and approach of MAHIMA

MAHIMA was a Social and Behaviour Change Communication (SBCC) intervention whose objective was to improve knowledge and practices around MHHM among adolescent girls. The programme aimed at breaking the culture of silence around menstruation, encouraging girls to discuss the issue freely, and negotiate the adoption of hygienic practices during menstruation.

MAHIMA enhanced knowledge, addressed attitudes, perceptions, and norms of the community around menstruation through three SBCC approaches:

1. **Interpersonal Communication (IPC)** among adolescent girls, between them and their mothers, and between them and FLWs — *Sahiyyas* (Accredited Social Health Activists)^[5] and *Sevikas* (*anganwadi* workers)^[6].
2. **Capacity development** training and skill building of NGO field functionaries, FLWs, teachers, and adolescent girls.

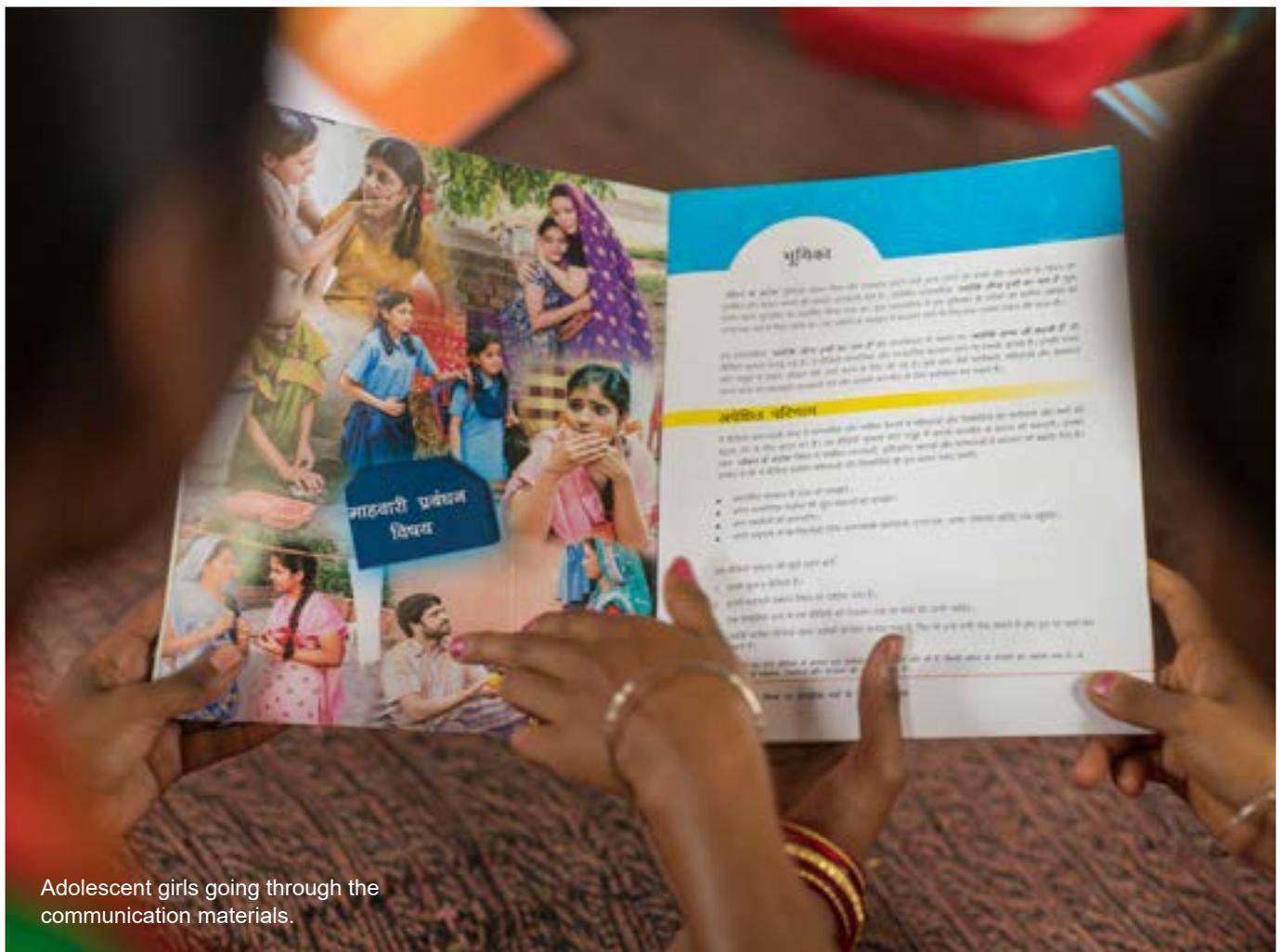
3. **Community dialogue** to build rapport with the community, introduce communication around menstruation, and identify participants.

Communication tools used

The tools used for the programme were built on the learnings of the Girls' Adolescent Reproductive Rights: Information for Management and Action Programme (*GARIMA*)^[7] implemented earlier in Uttar Pradesh^[8]. The communication package by UNICEF used for *MAHIMA* comprised:

Three Facts for Life (FFL) Videos: Addressing myths, gender issues ('Hero Number 1') and the role of fathers (*Bapu*) were extensively used.

A *Paheli ki Saheli* (Friends of Riddles) package: Consisting of films, a storybook, a personal diary, and posters, through which MHHM-related issues were presented to the participants in an audio-visual format.



Adolescent girls going through the communication materials.

An activity-based life skills module: Developed within the context of MHHM to enable open communication between participants and informed decision making.

Themes captured in the communication package were:

Preparation for menstruation: Which dealt with the physiology of menstruation, gave details on what to do during menarche, and how to initiate discussions.

Menstrual health and hygiene practices: Provided knowledge on available menstrual absorbents like

cloth and sanitary napkins, along with the hygienic management of their menstrual cycle, and disposal of these absorbents.

The effect of menstruation on a girl's life: Helped participants understand that menstruation is a normal physical phenomenon, and that restrictions imposed on adolescent girls were unfair. It encouraged adolescent girls to consult FLWs to deal with any mental and physical discomfort during menstruation.



Facilitator conducting a session on menstrual health using the *Paheli Ki Saheli* book.

Peer educator communicating with an adolescent girl.



Action

UNICEF trained 48 NGO field functionaries (of the implementation partners) working at the district and block level, who were responsible for building participants' capacities.

Social mapping of adolescent girls and FLWs

UNICEF reached out to all 1,058 villages through NGO field functionaries across seven blocks in the two districts, and facilitated discussions that created familiarity around MHHM. A mapping exercise identified adolescent girls and FLWs in these villages. In addition, NGO field functionaries held dialogues with the communities, to enhance common knowledge around menstruation in the village.

Capacity development of FLWs, peer educators and teachers

Capacity development of FLWs, peer educators, and teachers was carried out to ensure correct and complete understanding of menstrual health and hygiene. It enhanced their IPC skills which helped them conduct sessions and organise group meetings with girls and their mothers.

- UNICEF educated all 1,723 FLWs available in the seven blocks on why menstruation occurs and the importance of maintaining menstrual hygiene. They were made to understand that, as FLWs, it is their duty to talk to adolescents about their health and nutrition, including menstrual hygiene. To this end, they were encouraged to organise monthly meetings with adolescent girls.
- Around 1,100 peer educators locally known as *perikas*, were identified among the adolescent girls either by the girls themselves or the villagers. Peer educators were trained by NGO field functionaries regarding challenges related to menstruation. They shared their own experiences, which encouraged the girls to be open about the issue. Peer educators were trained twice, through FFL videos and the *Paheli ki Saheli* package, on the three key aspects of MHHM – maintenance, cleanliness, and disposal. It was then their responsibility to spread this message to other girls in their group. They were given training on life skills – to negotiate with family members on the adoption of hygienic products and private spaces to manage menstruation. They were also taught to dispose menstrual absorbents in an

environment-friendly manner. Peer educators were taken for cross-learning exposure visits and training. Additionally, girls from Gumla visited East Singhbhum and vice versa.

Peer educators were girls of the age group 13-17 years, and were selected based on the following criteria :

1. Education up to 8th standard
2. Willingness of the family to let her participate in discussions with other girls on menstrual management
3. Clear articulation

- Teachers were trained by NGO field functionaries on MHHM-related issues. They were motivated to engage their students on menstruation and, in turn, understand challenges the students faced to manage menstruation during school hours. The programme reached out to government schools and hostels in the blocks, covering 1,900 teachers and hostel wardens.

Adolescent girls' Group

Peer educators facilitated monthly meetings in each village with 15-20 adolescent girls, supported by FLWs.

- The meetings were structured and theme-based, and conducted with the aid of the communication package developed by UNICEF and an activity-based life skills module. FFL videos, *Paheli ki Saheli* films, storybooks, diaries, and posters helped keep the participants engaged. It included entertaining videos, interesting riddles, and catchy phrases to grab the audience's attention.
- Menstrual hygiene was explained by also stressing on the importance of taking a bath daily and changing the menstrual cloth thrice a day. Washing the cloth with soap and drying it in the sun, keeping it in a clean place after use, and ultimately either burying it in a deep pit or burning in an incinerator was encouraged. The groups were a space where girls could talk about these issues freely.

Mothers' group meetings

Monthly mothers' group meetings were held separately. They were facilitated by FLWs and focused on enhancing the mothers' knowledge of MHHM.

1. Mothers were encouraged to communicate with their daughters on preparedness for menarche and related issues and its hygienic management. Mothers were also guided to help their daughters explore hygiene products.
2. Through these meetings, mothers gained the confidence to send their girls to trainings that helped them learn about their health and well-being.

District-level dissemination workshop

A dissemination workshop on the *MAHIMA* project was organised by UNICEF to share learnings and seek opportunities to scale up. Adolescent girls from government-aided schools, NGOs working on adolescent-related issues, and representatives from the Departments of Health, Education, Social Welfare, Youth Affairs, and Drinking Water and Sanitation were present at the workshop.



Rina, a peer educator, is pictured with her mother, who no longer imposes restrictions on Rina when she is menstruating.

Results

The programme successfully reached out to the marginalised population in the two districts. Results of MAHIMA were documented at different levels — adolescent girls, mothers, and NGO field functionaries. As a direct impact, knowledge on physiology of menstruation, MHHM, and disposal practices increased among the participants, leading to better practices^[9].

Adolescent girls

Adolescent girls now follow menstrual hygiene and safe disposal practices like:

1. Using a menstrual cloth or sanitary pad during menstruation, which is changed three to four times a day.
2. Washing the menstrual absorbent with soap and drying it out in the sun without being embarrassed. They now keep it alongside their clothes, instead of storing the cloth in a damp and dirty corner.
3. Digging a deep pit to bury it in or burning it as an ultimate step of disposal, as opposed to throwing it in water bodies.
4. Challenging restrictions on the burning of a menstrual cloth, as well as the restrictions on touching and consuming certain food items during menstruation by carrying out these practices.

Caselet



Rina Kumari is a 21-year-old girl from Gumla district in Jharkhand. She lives in Nagpheni village with her family. She began menstruating when she was 14 years old, but did not have any information about it. At first, she didn't inform her mother due to embarrassment; instead, she gathered information from her friend on what she needed to do. Rina had to eventually inform her mother after one year because she suffered from severe stomach aches. Her mobility was then restricted during menstruation. She

did not attend school, enter temples, or play like she used to before. Her family did not let her consume sour food items or have a bath for the entire duration. These practices and restrictions left Rina confused and she often wondered why menstruation was considered an embarrassment. There was no one she could speak to about her queries and dilemmas. She was introduced to MAHIMA in 2014, but she was hesitant to be a part of the programme as she did not understand what it was about. Later, she joined one of the training sessions thinking it would help. After frequent requests from the NGO, she started interacting with the block coordinator, village health workers, and a few mothers from her village. The discussions helped improve her knowledge on menstrual hygiene. She learnt that menstrual absorbents must be changed frequently, washed with soap, dried in the sun, and stored in a clean space along with other clothes. She understood that the ultimate mode of disposal is to burn the menstrual absorbent. Initially, she was hesitant to dry the cloth in the open and dispose it by burning, but when everyone started talking about menstruation openly, she gathered the courage to do it. Since Rina's mother attended the sessions with her, she received her support as well.

Rina believes that the most significant impact MAHIMA had on her life is that her misconceptions have been clarified. She no longer believes that she should not enter temples during menstruation. She has learnt to question the restrictions her family imposed on her. She also tested these restrictions and found that they were untrue. She touched and ate pickles while menstruating, without experiencing any ill effects. She now believes that menstruation is a natural phenomenon among girls who can give birth. Now she has the courage to speak to her mother openly about menstruation. Rina wants to share this information with her future husband and children.



Adolescent girls discussing menstrual hygiene with the help of *Paheli ki Saheli*.

Mothers

- Communicate with their daughters to prepare them for the onset of menarche and teach them hygienic practices to follow during menstruation.
- Support their adolescent daughters in choosing an appropriate menstrual absorbent, keeping it clean, and disposing it safely. They talked to other members in their family to build a private space for their daughters to manage menstruation.
- Reduce restrictions on mobility and their daughters' routine activities. They understand that the blood released during menstruation is not impure, and let girls touch and consume all kinds of foods.

Caselet



Manju Devi Lakhra discusses menstrual hygiene with her daughter, Anupama Tirkey, 20. They reside in Nagpheni in Gumla district of Jharkhand. MAHIMA was implemented in their village in 2014.

Manju previously had little communication with her daughter about menstruation; the topic was considered shameful. Since the menstrual blood looked dark, it was thought to be unclean and hence impure.

Thanks to MAHIMA, Manju discussed menstruation with other mothers and health workers. This helped her realise that she should also speak to her daughter openly. Since then, she has been able to talk to Anupama regarding her experience of menstruation. Manju supports her daughter in buying menstrual pads and disposing them safely. She has reduced restrictions on her mobility and doesn't mind when she touches food items or goes to the temple while menstruating. With Manju's support, Anupama is now a peer educator in their village. It has helped her daughter be confident and encourage others to practice improved menstrual health and hygiene.

NGO field functionalities

- Earlier had the same misconceptions about the physiology and practices around menstruation as the other women from the community.
- Dispelled the misconception that burning a used pad or cloth would cause infertility, and instead followed improved MHHM and disposal practices.
- Discussed menstruation openly. They went against several restrictions and were then convinced that these were baseless. They then encouraged colleagues and girls to do the same.

"Once there was an accident in the family, and I had used a towel to wipe off the blood from the injury. I was menstruating at the time. In the evening, I went to wash both pieces of cloth and smelt both. They smelt exactly the same. This convinced me that menstrual blood is not impure blood — it is just blood."

Neelam Lakra, Cluster Coordinator

Teachers

- Communicate openly with female students about menstruation, understanding the challenges they face while attending school.
- Regularly orient girl students about MHHM.
- Support girls with academics when they are menstruating.



FLWs in East Singbhum.

Transformative Change

There is evident transformation among communities, adolescent girls, and other women associated with the programme. With improvement in their knowledge, communities are now open to discussing menstruation. Importantly, adolescent girls and women are empowered to confidently speak about issues faced during menstruation and negotiate for better health and hygiene^[10].

Adolescent girls

Girls speak freely, and confidently discuss menstruation and MHHM with peers, mothers, FLWs, and teachers.



Ruma Karmakar (in front), 16, from East Singhbhum district learnt about MHHM via the MAHIMA intervention.

Caselet

Ruma Karmakar is a 16-year-old girl from East Singhbhum district of Jharkhand. She lives with her family and studies in 10th standard. Ruma started menstruating when she was 10 years old and at the time, no one had spoken to her about it. She was scared and could not understand what was happening. When she informed her mother that she was hurt and bleeding, her mother told her in a hushed tone that she has now become mature. It was Ruma's sister who advised her to use a menstrual cloth and said that now she was a 'grown-up girl'. Subsequently, in the coming days, her mother did not allow her to visit the temple, enter the kitchen, or touch pickles.

The village Frontline Workers informed Ruma about MAHIMA. She attended the adolescent girls' group meeting, where, for the first time,

she got a chance to ask questions about menstruation. During monthly meetings, she freely interacted with her peers and elders on the subject without any restrictions. She was selected as a peer educator by the girls in her adolescent girls' group. As a peer leader, she was trained in hygiene management as well as life skills to negotiate for hygiene options with her family. She was given the 'Paheli ki Saheli' book and shown Facts for Life videos to help her understand the issue better. She got answers to all her questions and helped her friends who were still struggling with these questions. She faced some resistance initially as her friends looked at the subject with shame, but eventually they joined the adolescent girls' group and began openly discussing menstruation.

Ruma believes what happened to her must not happen with other girls in the village. She has a 9-year-old sister, with whom Ruma talks about menstruation so that she is not caught by surprise. She urges all adolescent girls to ask questions about menstruation openly.

Girls in the two districts are empowered to confidently negotiate with their families for private spaces to maintain hygiene. They have convinced their families to construct the same in order to change menstrual absorbents. Around 900 girls had safe enclosures built in the homes, either with help from family members or by themselves.

Caselet

During the baseline survey, it was found that more than 90 percent girls were reluctant to burn their menstrual absorbents. Girls spent the entire day using the same piece of cloth during menstruation because they were afraid of someone seeing them while they change. After their association with MAHIMA, several girls spoke to their mothers and negotiated with them to arrange for a private space which they could use to clean themselves, especially during menstruation. This was not easy to do, as initially their parents refused, but slowly, after the girls explained their needs, the parents agreed. Around 900 girls have built safe

enclosures in their homes with the help of their parents and now use it to comfortably change their menstrual cloths.

Frontline Workers

- Conduct monthly meetings with adolescents on health and hygiene including menstrual hygiene, as this is critical for improved health.
- Support and encourage girls to communicate freely about menstruation and the challenges it poses. They address queries raised by adolescent girls during these meetings such as the cause of menstruation, its physical manifestations, and the correct use of sanitary pads.
- Suggest ways in which girls can manage their pain and discomfort. They talk about nutrition, advise them to consume green vegetables, cook in copper utensils, and consume iron tablets to stay healthy.

Caselet



Chedni Devi is an anganwadi worker in Podha centre of Gumla district of Jharkhand. Even though she was a Frontline Worker in her village, she did not have the knowledge or confidence to talk about Menstrual

Health and Hygiene to adolescent girls in her village. Chedni Devi believes she gained appropriate knowledge of menstruation only after attending the discussions under the MAHIMA programme. It gave her the confidence to speak and support girls from her village. Chedni Devi understood her role in educating girls and started conducting monthly meetings with girls. These meetings centred around maintaining health and hygiene, often focusing on menstruation and its importance. She gave suggestions to girls and answered their questions on menstruation. Most of the girls would ask her how to manage their pain and discomfort during menstruation. She talked to them about applying hot water packs

and practicing yoga to subdue the pain. She also advised them to consume a nutritious diet, including green vegetables. She uses the Paheli ki Saheli books to get her message across.

NGO field functionaries

NGO field functionaries started believing that, for them to influence other women to practice improved MHHM, they had to undergo a change themselves.

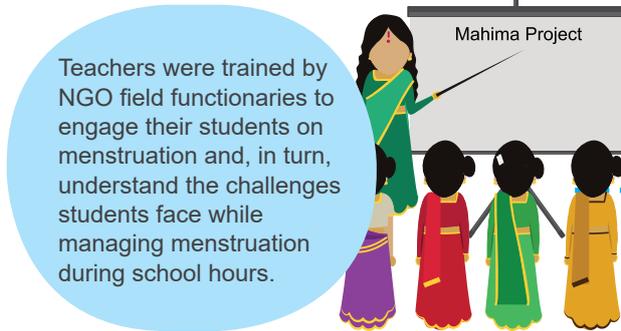
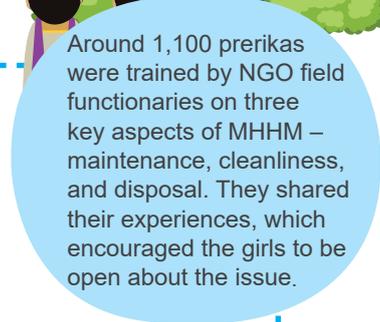
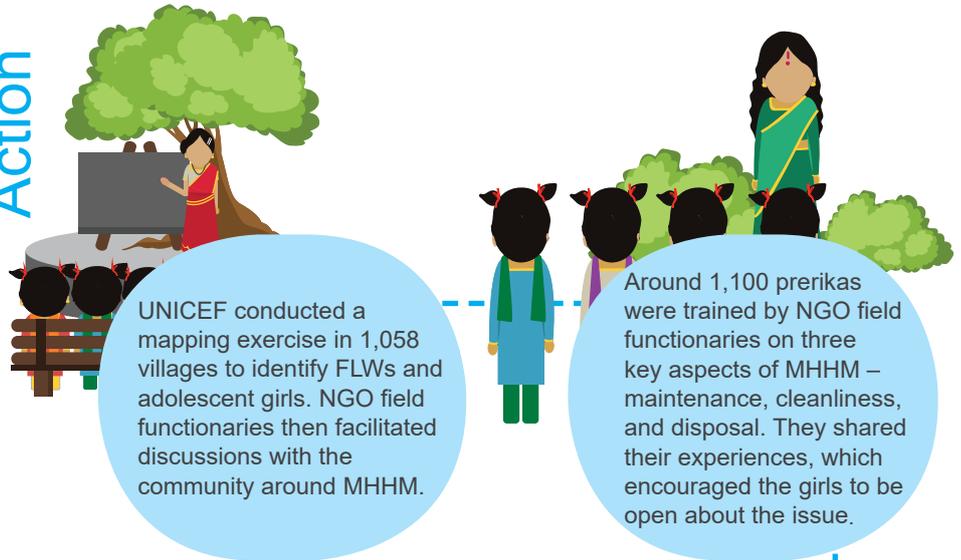
An NGO field functionary interacting with a peer educator.



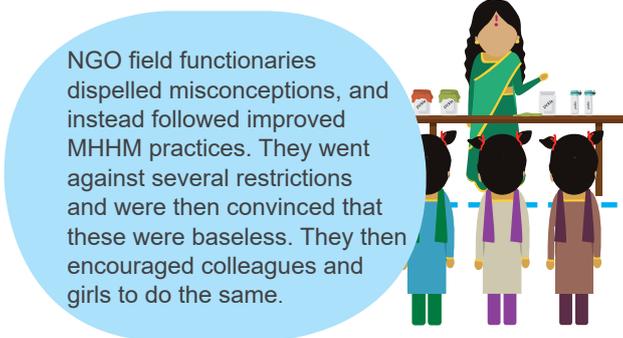
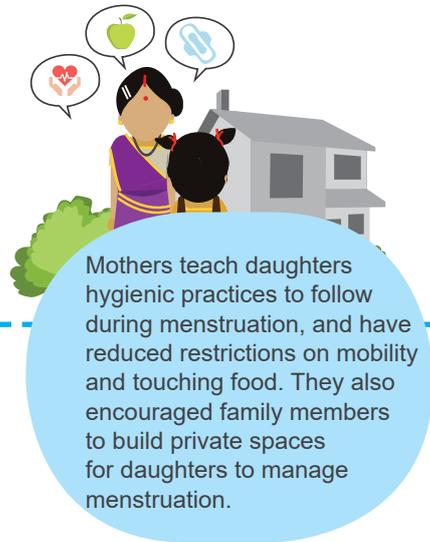
In Summary

UNICEF, in collaboration with the Government of Jharkhand, Development Network (DevNet), and *Lohardaga Gram Swarajya Sansthan* (LGSS), implemented an initiative to improve Menstrual Health and Hygiene Management (MHHM) among adolescent girls in two districts of Jharkhand. Here is a blueprint of how the intervention was rolled out in seven blocks of Jharkhand's East Singhbhum and Gumla districts.

Action



Results





Adolescent girls now confidently discuss menstruation and MHHM with peers, mothers, FLWs, and teachers, and are empowered to confidently negotiate with their families for private spaces to maintain hygiene. Around 900 girls had safe enclosures built in the homes, either with help from family members or by themselves.



NGO field functionaries now see that, in order to influence other women, they must practice improved MHHM themselves.



FLWs conduct monthly meetings with adolescents on menstrual health and hygiene and encourage girls to communicate freely about the issue. FLWs dispel misconceptions and follow improved MHHM. They also suggest ways in which girls can manage their pain and discomfort.

Transformative Change

References

- [1] <https://www.dasra.org/cause/improving-menstrual-health-and-hygiene-and-hygiene>
- [2] <https://www.dasra.org/cause/improving-menstrual-health-and-hygiene>
- [3] <http://www.sswm.info/content/menstrual-hygiene-management>
- [4] <http://www.mdpi.com/1660-4601/9/8/2772/html>
- [5] In Jharkhand, *Sahiya* is the term used in place of *ASHA*. They are the central agents in the community health programmes. The *Sahiya* is nominated by Village Health Committee as outreach worker and selected by the community to support the service providers on health issues with focus on reproductive and child health needs and services.
- [6] *Anganwadi* workers, known as *Sevika* in Jharkhand, are responsible for providing a number of vital services including pre-school education, supplementary nutrition, nutrition counselling, growth monitoring, and so on. *Anganwadis* are part of the Integrated Child Development Scheme (ICDS), a centrally-sponsored scheme whose norms are set by the Government of India.
- [7] UNICEF partnered with IKEA Foundation on *GARIMA* programme. The project aimed at piloting a social and behaviour change communication strategy on menstrual health and hygiene management among rural adolescent girls in the age group 10-19 years in three districts of eastern Uttar Pradesh - Jaunpur, Mirzapur and Sonbhadra from 2013 to 2014.
- [8] Uttar Pradesh is a state in North India.
- [9] Based on programme documents and key informant interview with the State C4D representative.
- [10] Based on key informant interview with the State C4D representative.
- [11] The Ministry of Health & Family Welfare of the Government of India has launched a health programme for adolescents in 2014, for the age group of 10-19 years, which would target their nutrition, reproductive health and substance abuse, among others.



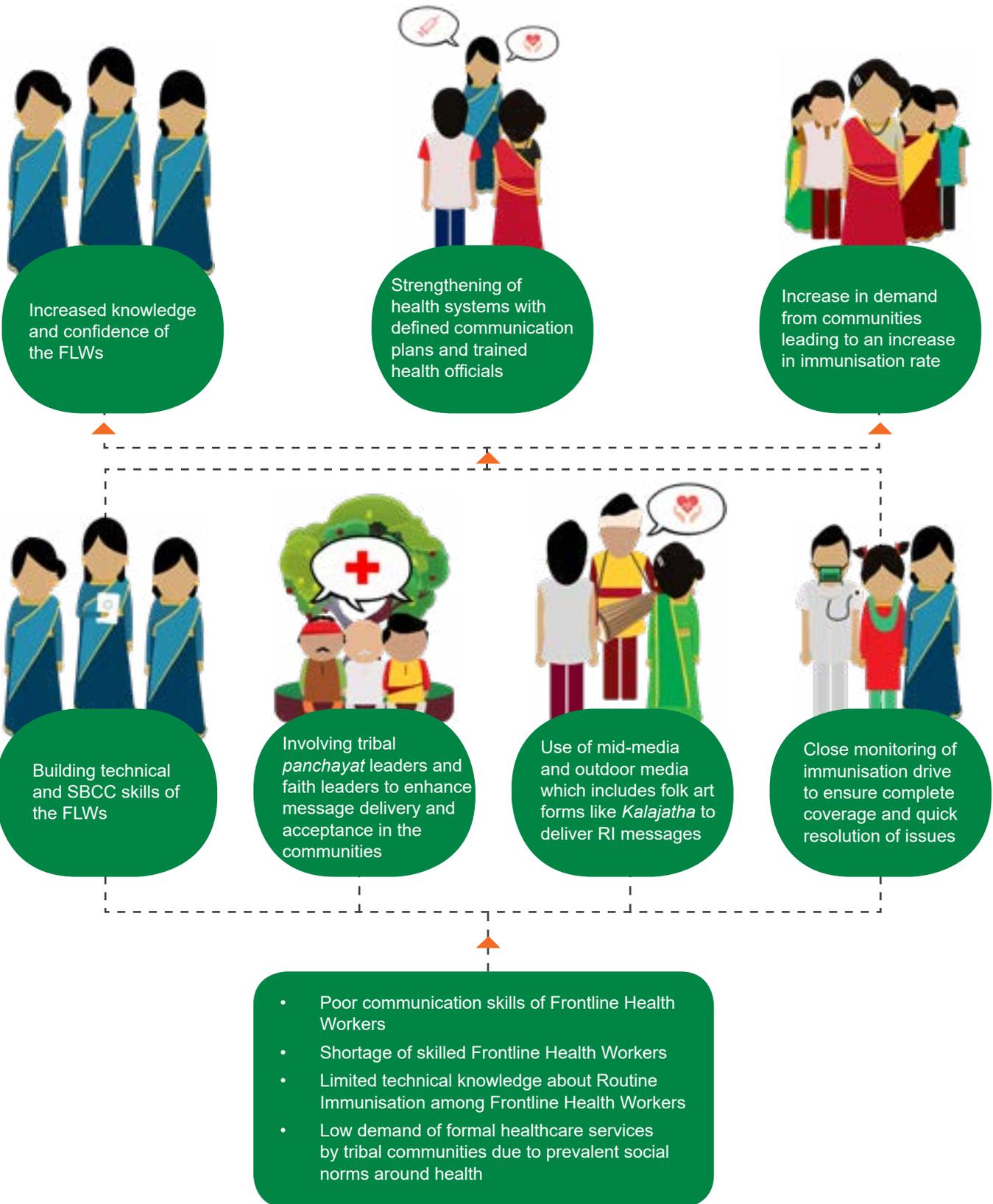
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Ek Kilkari

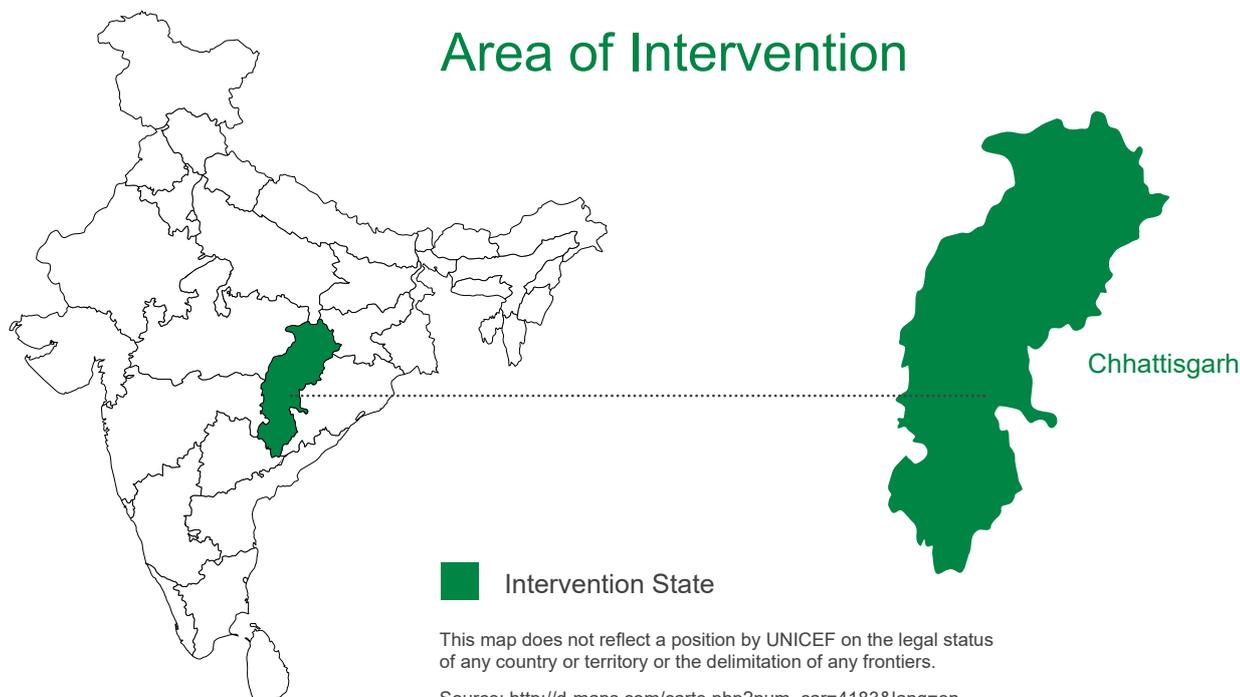
System Strengthening for Routine Immunisation in Chhattisgarh

The state of Chhattisgarh is located in the central part of India, and was carved out of Madhya Pradesh in 2000. Census of India (2011) shows that 30 percent of the state's population is tribal. Only 59.3%^[1] children here in the age group of 12-23 months are fully immunised. The state has a limited number of skilled Frontline Health Workers (FLWs), most of whom have poor communication skills. One of the biggest challenges here is the low demand of healthcare services from stakeholders^[2]. The Department of Health and Family Welfare (DoHFW), Government of Chhattisgarh, partnered with UNICEF Communication for Development (C4D) to develop and implement a communication strategy aimed at improving Routine Immunisation^[3] (RI) in the state. UNICEF also identified the need to target social norms that hinder the promotion of RI-related behaviours. The programme was implemented in five High Priority Districts (HPD^[4]). As part of the programme, capacity building of FLWs and health officials on SBCC, sensitisation of the community and faith leaders, and an RI drive was carried out. This helped increase the demand for healthcare services from the community, improved the immunisation rate, built capacities of FLWs, created a skilled resource pool in the health department, and motivated the FLWs towards better service delivery.

Theory of Change



Area of Intervention



This map does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.

Source: http://d-maps.com/carte.php?num_car=4183&lang=en

Situation

According to the District Level Household Survey (DLHS)-3^[5], only 59.3 percent children in Chhattisgarh aged between 12-23 months were fully immunised. The following issues needed to be addressed to improve the immunisation status and bring about a behaviour change in the community:

- Shortage of skilled Frontline Health Workers (FLW) in the state
- Poor communication skills of FLWs, who were unable to conduct effective demand generation
- Low demand of formal healthcare services from within the community
- Limited technical knowledge, especially about immunisation among FLWs

Tribals are known for living in isolation from the mainstream society, and observe their own traditions and practices related to health. They generally understand disease or illness as being the incapacitation of an individual from performing his/her routine work. Their understanding is hence more in functional terms than clinical, which makes them neglect symptoms such as cough, cold, headache, weakness, etc. and not consider the same as serious illnesses, as they don't hinder them from carrying out daily activities. They have similar notions about other health concerns, such as immunisation. Since lack of immunisation does not hinder the immediate

functionality of their children, they don't see it as a threat to their health.

Some behaviours prevalent in the community hindered the Routine Immunisation (RI) of infants. These include practices like delaying first immunisation, declining immunisation after first vaccination, etc.

Department of Health and Family Welfare (DoHFW), Government of Chhattisgarh, partnered with UNICEF Communication for Development (C4D) to address these gaps by formulating and implementing a Social and Behaviour Change Communication (SBCC) strategy for Routine Immunisation. This programme was implemented between 2014 and 2016. Initially, the initiative was implemented in five^[6] High Priority Districts (HPD), and later in three more districts at the behest of DoHFW. It targeted the following:

- Primary stakeholders – parents and immediate caregivers
- Secondary stakeholders – immediate caregivers (family and friends), FLWs
- Tertiary stakeholders – state, district, and block level institutions, and the community

The focus of this partnership was to strengthen behaviours – a key component of the Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A^[7]) programme.

Map not to scale



An infant getting vaccinated at a primary health centre.

Method

UNICEF C4D formulated the communication strategy in consultation with the state's Health Department, led by the State Immunisation Officer. The various methods adopted were:

- Capacity building of FLWs:** The training administered to FLWs followed an Incremental Learning Training Methodology (ILTM) approach – a progressive learning methodology in which learning goals are broken down into smaller steps. Each step is spread over a longer period of time and the focus is on 'learning by doing.' To implement this approach, five capsule modules were developed using the *TARANG* SBCC module as a base. FLWs were trained incrementally with each capsule focusing on at least one or two communication skills.
- Involving community leaders:** The tribal communities have their own unique traditional systems called tribal *panchayats* which exercise considerable power over the social, moral, religious, and economic affairs of the tribal community members. Most of these communities have preserved their own distinct cultural identities through their unwritten code of conduct and distinct traditional mechanisms to enforce the codes. The customary laws^[8] of the tribes encompassed all spheres of their activity, and jurisdiction of the tribal *panchayat* was all-pervasive – right up until the introduction of statutory *Panchayati Raj (PR)* system in tribal areas. Given the stronghold of these tribal *panchayats*, tribal community leaders were included in the programme system to enhance acceptability of the programme. They were oriented on the importance of RI and how it can save the life of a child. They were sensitised about the role and responsibilities of a community to ensure complete protection of each child through complete immunisation. Their consent helped pave the way towards acceptance of the programme.
- Harnessing community spaces and platforms in villages for RI messages:** Village spaces like *anganwadi* centres, *panchayat bhawan*, and health sub-centres were used to communicate messages and important information about RI.

These messages included information like:

- Two tetanus vaccines for mothers during pregnancy (1st trimester)
- 1st dose of BCG vaccine along with a zero dose of polio vaccine for the child immediately after birth



Platforms like antenatal check-up days were used for routine immunization communication.

- 1st dose of pentavalent^[9] vaccine for the child at 1.5 months
- 2nd and 3rd dose of pentavalent vaccines for the child at 2.5 and 3.5 months along with a polio vaccine each time
- Measles vaccine and 1st dose of Vitamin A for child at 9 months
- **Leveraging special days:** Platforms like Village Health and Nutrition Day (VHND), and Antenatal Checkup (ANC) day were also used for RI communication.
- **Engaging faith leaders:** Faith leaders were engaged in the programme as they have a greater influence over the population. They were educated on the importance of RI, and their proactive efforts were recognised.
- **Mid-media and outdoor media:** Popular folk song and dance forms of the state like *Kalajatha*^[10] were used to deliver RI messages to the community and influence the existing social norms.

Action

UNICEF invited resource persons from Social Mobilisation Network (SMNet), Uttar Pradesh, to help with planning, implementing, monitoring, and evaluation of communication activities during the Mission *Indradhanush* campaign. These resources had extensive prior experience in implementing a similar programme for a polio vaccination campaign in Uttar Pradesh led by UNICEF. A group of four people was sent to each of the five districts. The following actions were undertaken:

Capacity building: FLWs and senior health department staff^[11] had been trained using the *TARANG* SBCC module. *TARANG* training comprises of a module for skill building. The skills included communication, counselling, social mobilisation, community dialogue, and social inclusion. These trainings honed the capacities of the participants in taking forward the key messages on health programming. The details of the Training of Trainers (TOT) held are:

- Five-day TOTs of 22 Master Trainers (MTs) at the state level
- Five-day TOTs of 185 district and block-level trainers in all eight HPDs
- One-day refreshers for all district and block-level trainers on capsule modules

Further, the participants^[12] were oriented on the making of communication action plans, their implementation, monitoring, and evaluation for the purpose of RI.

Workshops for Health Department officials: Eight^[13] workshops were conducted to impart knowledge about the SBCC strategies and approaches, and help officials develop communication action plans for their respective districts. These communication action plans included strategies for social mobilisation, capacity building, mass media, and internal monitoring and review. At the end of these workshops, each of the districts had developed a draft communication action plan.

Street plays: Plays based on local art forms were enacted to spread messages that reach a larger audience in villages. These also served as an opportunity to interact with community leaders and faith healers, and influence them to promote RI in the community.

Monitored immunisation drive: Each district's group worked with the district health official to conduct and monitor the immunisation. Daily meetings to track and update the progress of the implementation were conducted. This RI communication monitoring was done continuously for four months from April to July 2015. All the district reports were collated to help the state department monitor progress and address any arising issues.



The immunization drive was monitored rigorously and concurrently for ensuring effective implementation.



Mothers holding mosquito nets – an incentive given to mothers who attend the antenatal check-up in the Aganwadi clinic.

Result

Following were the results of the intervention:

Stakeholders^[14]

- **Enhanced knowledge:** They have better understanding on the benefits of immunisation for their child and ensure they get it at the right time. The stakeholders are able to recall and recollect the key messages on RI.
- **Change in behaviour:** Mothers now discuss and share information about institutional delivery, immunisation, exclusive breastfeeding, etc. with other family members.
- **Increase in demand:** Enhanced knowledge and changed behaviour led to an increase in demand generation for RI services among the community.

Frontline Health Workers^[15]

- **Enhanced knowledge:** FLWs have acquired IPC skills and are well versed with the GATHER^[16] approach.

- **Behaviour and practice:** There is effective delivery of key messages by the FLWs. They are able to communicate better with all members of the community and convince them to adopt healthy behavioural practices. They are now able to put the GATHER approach into practice and use it for the effective delivery of key messages on RI.

Department of Health and Family Welfare Department

- **Knowledge gain:** There is an improvement in the IPC skills and knowledge about RI in FLWs. They are also better informed about the SBCC strategy and its use in their work.
- **Demand for services:** As a result of this intervention, demand for services from the community in all intervention blocks under the eight^[17] districts has increased^[18].
- **Immunisation rate:** There is an increase in immunisation rate after the programme.

“I have been working as an FLW for the last two decades. I have never been trained in SBCC before. In the training, I learnt about the basics of a conversation. The training focused on having each and every participant speak up and partake in the training. The most important lesson for me was understanding that listening to marginalised groups is critical to help improve the overall society. I use the lessons from the training in my daily work, and can see that my interactions with stakeholders have changed to become engaging and contextual in nature.”

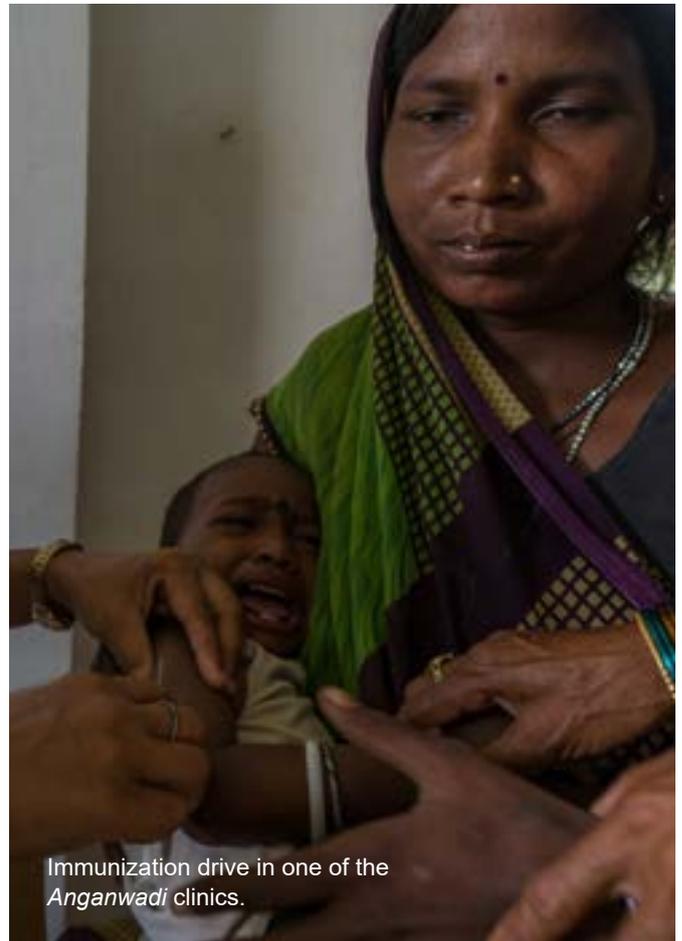
Ms. Urmila Dinar, Mitanin Trainer, Balloda Bazar district, Chhattisgarh

Transformative Change

Self-assured and assertive health workers: FLWs feel more confident about their capacity to deliver services and convince community members to adopt health practices. Male FLWs also reported that they are able to initiate conversations on sensitive topics like safe sex practices with male members in their community. Overall, there has been a positive change in FLWs' outlook towards socially excluded groups and their determination to bring about a positive change in their own areas.

Health system strengthening: Development of a detailed communication action plan for the state Health Department to help improve the RI trend in the state. Further, a resource pool of officials has been created which is trained in SBCC and has improved knowledge, communication, and technical skills.

Jharkhand and MP: These two states also adopted the Incremental Learning Training Methodology (ILTM) introduced in this intervention, and developed 10 capsule modules from the original *TARANG* Module for SBCC skills training.



Immunization drive in one of the Anganwadi clinics.

Caselet



Chitralikha is an FLW and the head of Arjuniya Panchayat. As Sarpanch, she is expected to interact with numerous people and help resolve issues. However, she used to be shy and hesitant, and tried to elude from her work as Sarpanch. After receiving training from UNICEF, she now sees a change in herself, and this has helped her interact and guide the Mitans more suitably. The SBCC training has also made her more confident and outspoken as an individual. This has had a positive impact on her work as Sarpanch. She now listens to all residents in need and attempts to resolve their issues. More importantly, she actively seeks to represent the underrepresented and has become their voice.

Chitralikha, Sarpanch, Arjuniya Panchayat, Balloda Bazar



There has been a visible increase in the demand for health services from the communities in the intervention blocks.

In Summary

UNICEF C4D, in partnership with the Department of Health and Family Welfare (DoHFW), Government of Chhattisgarh, developed and implemented a communication strategy aimed at improving Routine Immunisation (RI) in the state. Here is a blueprint of how the intervention was rolled out in five High Priority Districts (HPDs) in Chhattisgarh.

Action



UNICEF facilitated SBCC training for FLWs through the *TARANG* module on communication skills, counselling, social mobilisation, community dialogue, and social inclusion.



Workshops on SBCC strategies were held for Health Department officials to help them develop communication action plans (social mobilisation, capacity building, mass media, and internal monitoring and review) for their respective districts.



Street plays based on local art forms were performed to cater to larger audiences in the villages. This also helped interact with community leaders and faith leaders to influence them to promote RI.

Result



Stakeholders have better understanding of immunisation and its benefits, and discuss institutional delivery, immunisation, and exclusive breastfeeding with other family members.



FLWs now have enhanced IPC skills and better knowledge on the *GATHER* approach. They communicate better and effectively deliver key messages on RI.



DoHFW has noticed an increase in the demand for their services from communities in the intervention blocks. There is also an increase in immunisation rates.

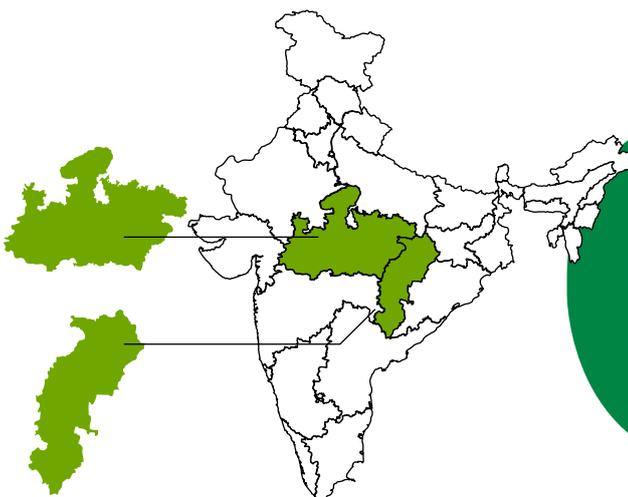
Transformative Change



There has been a positive change in the FLWs' outlook towards socially excluded groups. They are more confident about their capacity to deliver services and counsel community members on health practices.



Detailed communication plans have considerably strengthened the local health departments. There now exists a resource pool of trained SBCC officials with improved knowledge, communication, and technical skills.



The Incremental Learning Training Methodology (ILTM) introduced in this intervention has been adopted by Jharkhand and Madhya Pradesh. Ten capsule modules were developed from the original *TARANG* Module for SBCC skills training.

References

- ^[1] Source: District Level Household Survey-3
- ^[2] Challenges as perceived and shared by UNICEF C4D team.
- ^[3] Universal Immunization Programme(UIP) provides vaccines against nine life-threatening vaccine preventable diseases namely, diphtheria, pertussis or whooping cough, tetanus, polio, tuberculosis, hepatitis B, measles, H Influenza type b and Japanese Encephalitis.
- ^[4] High priority districts are bottom 25 percent districts within a State (taken according to ranking based on Composite Index) plus LWE or Tribal districts falling in bottom 50 percent (As per Ministry of Health and Family Welfare, Government of India).
- ^[5] District Level Household Survey is a household survey at the district level, conducted by the International Institute of Population Sciences (IIPS) under the auspice of Ministry of Health and Family Welfare (MoHFW), Government of India (<http://rchiips.org/>).
- ^[6] 5 HPDs are Bilaspur, Jashpur, Surguja, Dantewada and Bijapur.
- ^[7] Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) is a flagship scheme of the National Rural Health Mission (NRHM), Ministry of Health and Family Welfare, Government of India.
- ^[8] These customary laws of the tribal panchayats are based on their mythologies, beliefs, values, traditions, perceptions of the universe and their transmitted social and cultural heritage through the generations.
- ^[9] Pentavalent vaccine is given to provide protection from five diseases: Diphtheria, Pertussis, Tetanus, Hepatitis B and Hib. DPT
- ^[10] Kalajatha is an Indian art form based on dance and music through which messages are conveyed to people.
- ^[11] Senior Health department staff included IEC Nodal officer and other Officers from the State IEC cell, National Health Mission state level consultants, District Media officers, Tutors from Nursing Colleges and Block Education extension officers.
- ^[12] These included District Training coordinator, District Programme Manager, Block Programme Manager, District media officers.
- ^[13] Initial 5 workshops were conducted in the 5 HPDS but later on as 3 more districts were added to Mission Indradhanush, workshops were conducted in these 3 as well, totaling to 8 workshops.
- ^[14] Few of the stakeholder related results are anecdotal.
- ^[15] Findings from 'SBCC Skills Assessment of Frontline workers' Report, New Concept Information Systems Pvt. Ltd., July 2016.
- ^[16] GATHER stands for the following six activities: Greet, Ask, Tell, Help in the decision-making, Explain, Return. A FLW is expected to do in each of her interaction.
- ^[17] Eight districts are Jashpur, Surguja, Bilaspur, Dantewada, Bijapur, Balloda Bazar, Raipur and Korba.
- ^[18] This is anecdotal and based on interaction with State Immunization Officer of Chhattisgarh.

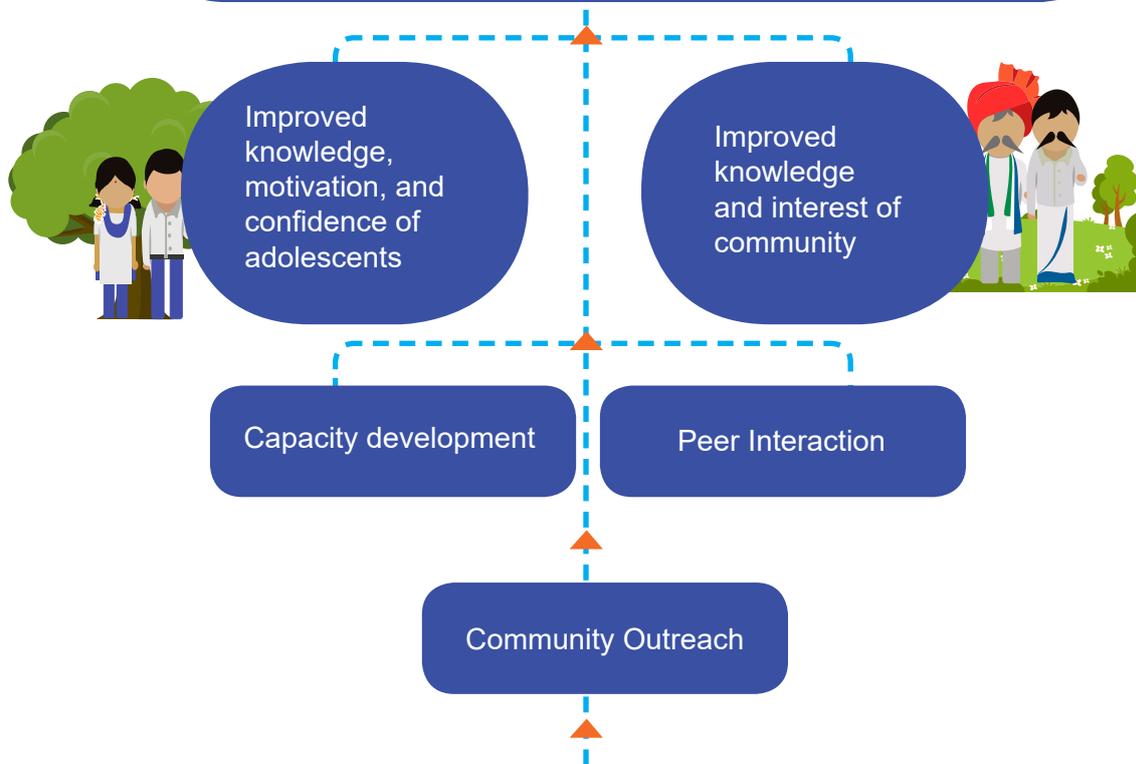
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Improving the Lives of Adolescents in Andhra Pradesh

UNICEF, in partnership with IKEA Foundation and Andhra University, initiated the 'Improving the Lives of Adolescents' programme in the Visakhapatnam district of Andhra Pradesh in 2015. Through Andhra University, UNICEF collaborated with the National Service Scheme (NSS) — a central scheme of the Ministry of Youth Affairs and Sports, Government of India — which aims at personality development of adolescents through volunteerism and community service. The intervention intended to increase the autonomy of adolescent girls and boys over decisions regarding their lives, so as to improve their educational and health status. *Meena* Radio Programme, Interpersonal Communication (IPC) videos, and customised training modules were used to build capacities of adolescents, parents, and the community on adolescent issues. Select NSS volunteers were trained to be Peer Leaders on leadership and community mobilisation skills, so they could interact with other adolescents in their colleges and neighbouring communities through community-based activities, advocacy meetings, and one-on-one interactions. The intervention increased knowledge and confidence among adolescents, and sensitised the communities about adolescent issues. The programme has empowered adolescents to become change agents and take critical decisions which affect their life.

Theory of Change

Adolescents become change agents, speak for their rights and the rights of their peers. Communities protect them against rights violation.

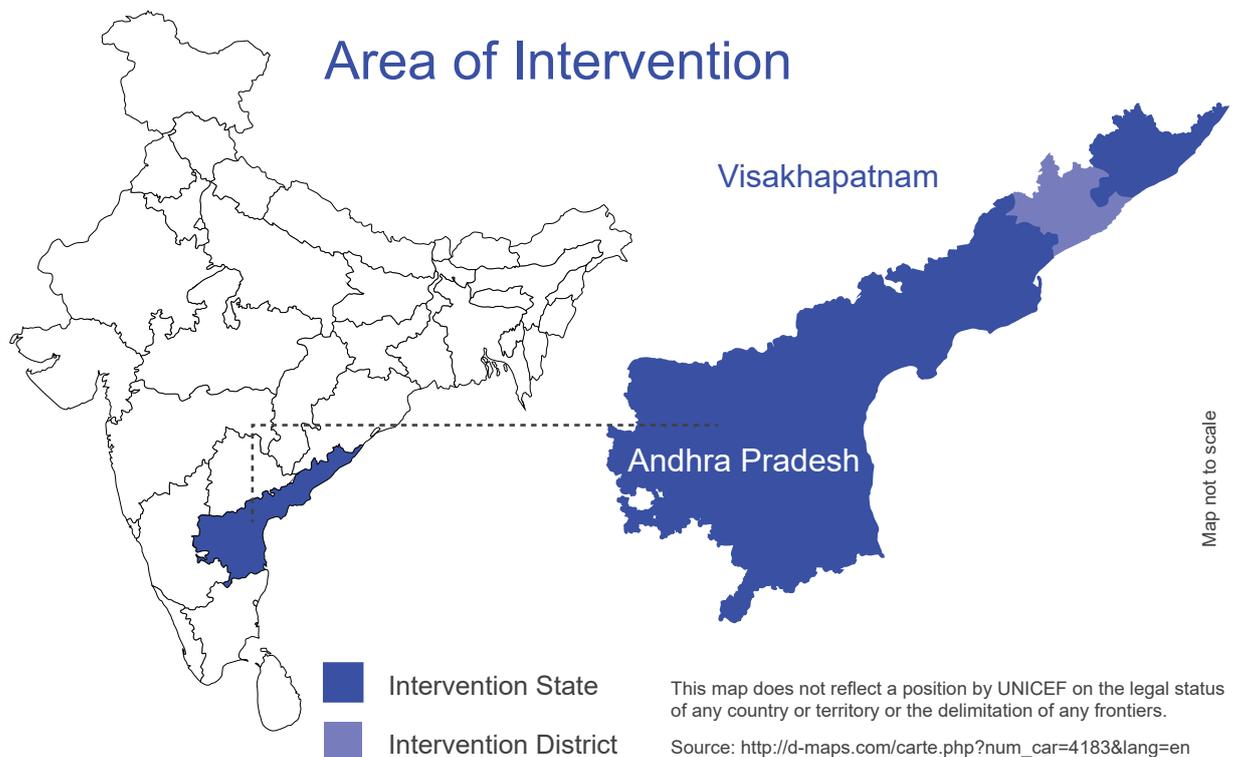


SBCC on adolescent issues, life skills, leadership, community mobilisation carried out. Approaches – street plays, door-to-door interaction, college-level events. Communication material – *Meena* audio content, IPC videos, customised booklets.

Partnership with Andhra University and National Service Scheme.



Prevalence of child marriage, early pregnancy, child labour, anaemia, and school dropout among adolescents. Adolescents have limited knowledge about their health, nutrition, and hygiene. There's a need to reduce the vulnerability of adolescents and increase their autonomy over decisions impacting their lives.



Situation

As per UNICEF's report on adolescents, 47% women aged 20–24 are married by the age of 18^[1] and often drop out of school, get married, and bear children very early in life. This has serious implications on maternal and child health. In India, **47%** of adolescent girls are underweight and **56%** are anaemic^[2]. Child marriage is one of the leading causes for maternal deaths in India^[3].

Across the country, both adolescent girls and boys experience social and economic restrictions. Girls face extensive limitations on their mobility and decision making, which affects their education, work, marriage, and relationships. They are exposed to child marriage, teenage pregnancy, child domestic work, sexual abuse, exploitation, and domestic violence. Boys face issues related to school dropout due to the need for employment to support the family. Located along the south-eastern coast of the India, Visakhapatnam is a port city and industrial centre in the state of Andhra Pradesh. It has a rare mix of urban, semi-urban, rural, and tribal populations. Around 45% of the total population of the city of Visakhapatnam dwells in low income settings^[4]. UNICEF commissioned a baseline study in 2014 to generate evidence in the areas of education, health & nutrition, leisure, participation & life skills, child labour, child marriage, trafficking, violence against children, and the access and use of media by adolescents.

Situation of adolescent girls and boys in Visakhapatnam:

In the district, **52%** boys and **58%** girls are anaemic^[5]. This causes fatigue and affects day-to-day activities as well as academic performance, resulting in them dropping out of school.

- Young children drop out of school to work for their family. In 2012-13, around 3,400 children in the age group of 6-14 years were working as labourers in the district.^[6] In 2012-13, the dropout rate in the district was 36% in children studying in classes 1 to 10, and a particularly high 77% for the Scheduled Tribe^[7].
- In 2013-14, the percentage of boys married under 21 and girls married under 18 was 13.4% and 17.8% respectively, with a higher percentage in rural areas^[8]. Family members get their daughters married as soon as they reach menarche, fearing they might fall in love and marry against their wishes. They also fear the sexual harassment or abuse the girls might face at school.
- Adolescents have limited knowledge about their hygiene, health, and nutrition, and are hesitant to discuss these with others. Often, they don't understand the mental, physical,

and emotional changes they are going through, and have little to no support systems.

- Girls have restrictions around mobility, and are not allowed to travel alone or participate in public events. They have no say in decisions regarding their own lives — such as health, education, and marriage.

To improve the situation in the state, it was critical to reduce the vulnerability of adolescents and increase their autonomy over decisions impacting their lives.



An NSS PO during a peer leaders workshop.

Method

Government of India, in collaboration with UNICEF, IKEA Foundation^[9], and Andhra University, initiated the 'Improving the Lives of Adolescents' programme in Visakhapatnam in 2015. Communication for Development (C4D) and UNICEF's Child Protection programmes converged their efforts for the intervention. The objective of the programme was to increase the autonomy that adolescents have over decisions regarding their lives. For this, UNICEF engaged with three stakeholders:

- **Adolescents:** To help young girls and boys speak for themselves and their community to bring change.
- **Families and community leaders** (such as Self-Help Groups, *Panchayati Raj* members): To create an enabling environment for adolescents.

- **Public services and authorities:** To provide better services related to health, nutrition, education, and protection to adolescents, and to promote their rights among the public department and its officials.

For this case study, only the first two stakeholders have been elaborated upon, since the UNICEF C4D programme was actively involved with adolescents, families, and community leaders.

UNICEF's partnership with Andhra University

UNICEF partnered with Andhra University^[10], which led to a collaboration with National Service Scheme (NSS). Through this partnership, UNICEF reached out to colleges affiliated to Andhra University, and teachers who were a part of NSS and acted as NSS Programme Officers (POs).

The NSS was established by the Ministry of Youth Affairs and Sports^[11] as a voluntary association of young people called NSS volunteers. NSS POs guide NSS volunteers with the primary focus on personality development of students through volunteerism and community service.

The National Service Scheme (NSS) is an Indian government-sponsored public service programme launched in 1969 under the Department of Youth Affairs and Sports of the Government of India. Aimed at developing a student's personality through community service, NSS is a voluntary association of young people at the college, university, and 2nd PU level, working for a campus-community linkage. The scheme is an extension of academic programmes which aim to inculcate social welfare in students, and provide services to society without bias. NSS volunteers try to understand the community in which they work and understand themselves in relation to their community. They identify their needs and problems, and involve them in problem-solving, which helps them develop a sense of social and civic responsibility among themselves. For problem solving, NSS volunteers utilise their knowledge to find practical solutions for individual and community problems, hence gaining skills in mobilising community participation and acquiring leadership qualities. They practise national integration and social harmony, and provide aid

during natural and man-made disasters through food, clothing, and first aid to the victims. They adopt villages for intensive development work such as setting up of medical centres, conducting programmes of mass immunisation, sanitation drives, and blood donation camps^[12].

Capacity development of adolescents

UNICEF built capacities of adolescents to ensure that they have the knowledge, skills, and peer group support for fulfilment of their right to health, education, nutrition, protection, and participation.

NSS volunteers were trained under the programme on the following topics:

1. Emotional and psychological changes that adolescents undergo
2. Social practices like child labour, child marriage, violence against children, sexual abuse, and the implications of these
3. Adolescent health focusing on nutrition, personal hygiene, and sexual health
4. Adolescent rights, entitlements, and laws protecting them
5. Life skills education
6. Peer interaction
7. Leadership skills
8. Community mobilisation skills
9. Intergender relationships

The C4D programme focused on imparting life skills, leadership, and community mobilisation skills to adolescents so they can voice their own issues and further mobilise and share their knowledge with adolescents around them.

Using communication strategies and tools

UNICEF C4D promoted adolescent engagement and participation through Interpersonal Communication (IPC) and advocacy tools. Training material was provided to NSS Programme Officers and NSS volunteers, which comprised of five booklets on the above-mentioned topics in Telugu^[13]. This training

material was developed based on baseline survey findings and the existing repository of training material on Social and Behaviour Change Communication (SBCC) for adolescent issues. UNICEF used the following communication tools during this intervention:

1. **Meena Radio programme^[14]:** Meena Radio Programme is a 15-minute long radio programme aimed at changing perceptions and behaviours that hamper the survival, protection, and development of girls. It uses stories in various media — print, audio, and video — to induce Interpersonal Communication (IPC) and dialogue on gender issues.
2. **IPC tools:** These were used for discussions with girls and boys, parents, and community leaders. Communication tools were based on key child rights issues, and issues related to child health, education, sanitation, and hygiene.
3. **Posters, leaflets, and flip-books:** A set of six booklets on adolescent rights, programmes for adolescents, adolescent health and nutrition, and menstrual health and hygiene was provided to NSS volunteers.





Peer Leader talking to her friends about adolescent issues.

Action

The 'Improving the Lives of Adolescents' programme was implemented in two phases and reached 4,000 NSS volunteers of 21 colleges under Andhra University. Phase one of the programme was implemented in 2015-16 in 18 colleges. Learnings from phase one were incorporated and implemented in phase two during 2016-17 in 10 colleges. The learnings were as follows:

1. Advocacy is necessary for the active involvement of college principals.
2. NSS volunteers need to be identified and capacitated with leadership skills, so as to involve them as an added layer of resource in the programme and enable them to be Peer Leaders for outreach sessions in communities and residential schools.
3. College-level outreach activities must be carefully planned, taking into consideration the academic calendar of the colleges.

Orientation and Capacity Development of NSS Programme Officers

UNICEF trained NSS Programme Officers through Master Trainers responsible for training them on adolescent issues. It was challenging to convince NSS POs to discuss sensitive adolescent issues like sexual health and personal hygiene, as they

were uncomfortable to talk about these. Interpersonal Communication (IPC) and gender sensitivity trainings were carried out to help them overcome their apprehension.

Capacity Development of NSS Volunteers and Peer Leaders

Master Trainers trained NSS volunteers on adolescent issues and its causes and implications. They promoted dialogue between adolescents to address inter-gender disparities by giving real-life examples, and showcasing the *Meena* Radio programme.

Select NSS volunteers were also trained as Peer Leaders who would interact with other adolescents and communities around them. Master Trainers provided life skills education to 1,200 NSS volunteers in junior colleges, leadership, and community mobilisation skills to Peer Leaders through IPC videos and the *Meena* Radio programme. The idea was to enable them to negotiate on decisions regarding their lives, and to have them mobilise other adolescents and communities. The role of Peer Leaders is elaborated below.

Peer Interaction

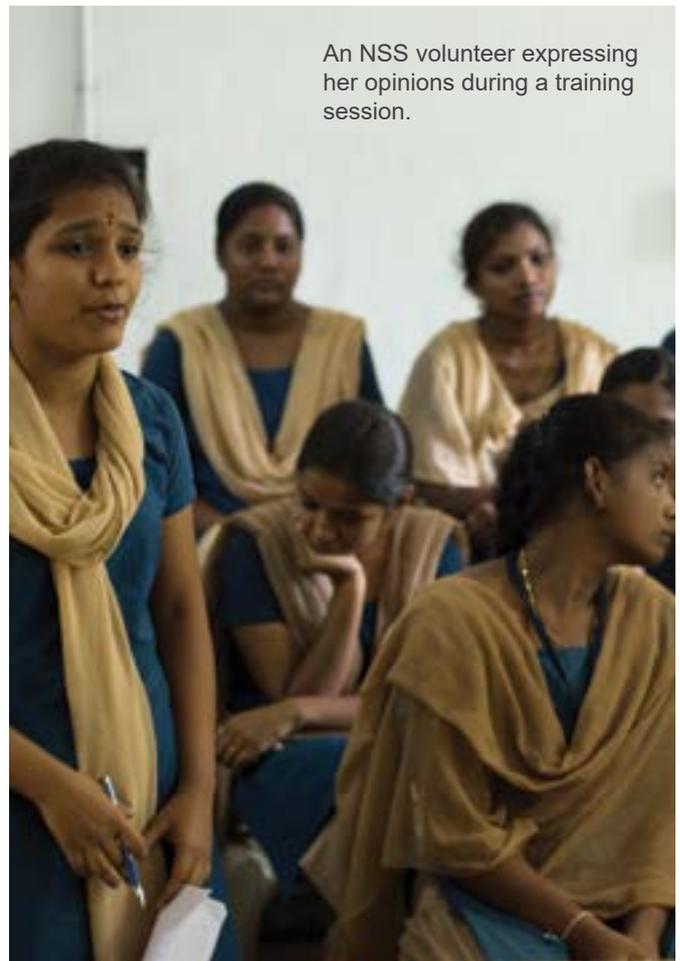
Peer Leaders discussed adolescent issues with adolescents in their college — either individually or in groups.

1. Each college organised events such as essay writing, elocution, theatre, sports, and special camps centred around the theme of adolescent issues. Around 6,000 students were reached in 5 colleges through college-level events.
2. In addition, Peer Leaders and NSS volunteers held interactive sessions with students of 8th and 9th standard in schools on adolescent issues. They performed skits to put across information on the prevention of child marriage, protection from child abuse, maintaining personal hygiene, improving nutrition, and continuing education. Approximately 18,000 students were reached through classroom lectures in urban areas. Moreover, NSS leaders reached out to 2,750 adolescent girls studying in residential schools/hostels.

Community Outreach

Under the NSS scheme, colleges adopt low-income areas and villages for 120 hours of community service by volunteers in an academic year. Around 2,500 adolescents and their families were reached through community outreach by NSS peer leaders of five colleges. Under UNICEF's programme, the Peer Leaders and NSS volunteers carried out the following activities in areas adopted by their colleges:

- **Community-based group activities:** NSS volunteers carried out rallies, performed skits, displayed posters, and sang folk songs about the implications of practices such as child marriage, child labour, and violence against children.
- **Community dialogue:** Peer leaders engaged with the community using IPC videos.
- **Advocacy meetings:** To encourage communities to address these issues, knowledge about laws that protect children was advocated to adolescents' parents and community leaders such as Self-help Groups (SHGs), local government members, and elders.
- **One-on-one interactions:** Peer Leaders had one-on-one interactions with adolescents and their parents to discuss the importance of education, effects of child marriage, and adolescent rights and entitlements.



An NSS volunteer expressing her opinions during a training session.

Results

UNICEF and its partners have achieved the following results in Visakhapatnam district^[15]:

Increased knowledge and confidence of adolescents

Adolescents can now understand the emotional and physiological changes they are going through. There is improved knowledge on the following:

1. Importance of education
2. Effects of child marriage and child labour
3. Legal provisions (rights, entitlements, and laws) protecting them against practices such as child marriage, child labour, violence, and child sexual abuse

They express their feelings about changes in their body and confidently share information about adolescent issues with their friends, family members, and the community. Their confidence has increased, and they can speak freely in public.

"I have been a part of NSS since the last two years. Our college has adopted the Jalarpet slum for community service. Our first experience of community service was eye-opening. We went with a very different mentality but, on our visit, we were shocked to see child brides, 20-year-olds with children, and children dropping out of school. During our initial interaction we found out that most of the boys themselves wanted to get married early. They were not interested in studying and do not consider it important. There are various reasons to this attitude, like poor educational infrastructure, poor sanitation facilities in school, and lack of jobs after school. After seeing all this, we felt lucky for the lives we have. We wanted to work for the community. We performed skits, rallies, wall paintings, and shared our experiences. We also went door to door talking to family members of the affected children. We are proud of what we have done. Through this, we have overcome stage fear. We have learnt how to interact with the community and express our views. We have learnt to come out of our homes and overcome the pressure we have. We have slowly started to motivate others through our actions. We work together to talk to different people.

Snighda Priyanka, 20
Gayatri school



Improved knowledge of community

Communities know about implications of social practices such as child marriage, child labour, violence, sexual abuse, and child trafficking.

They now know about laws that protect children against these, and about appropriate ways to address adolescent issues in their family or community. Families and communities protect adolescents from their rights being abused.

"I was 13 years old when I got married. I got each of my three daughters married when they were 13, 16, and 18. But now, when I look at the students who come to our house and interact with us to explain the consequences of child marriage, I understand that it is a wrong and illegal practice and contributes to domestic violence, and ill health of the girl. I wish there was someone to tell my parents and me that we should wait till 18 to get married; our lives would have been better."

B. Satyawati

Transformative Change

This initiative has built a supportive environment for girls and boys in colleges and the communities they live in. As change agents, adolescents speak for their rights and entitlements. They convince their family members and community to not practice child marriage and child labour. Adolescents are persistent about continuing their education and, when forced by parents to drop out, they refuse and convince them to let them complete their education.



Caselet

“My name is Madhuri and I am a student of St. Ann’s college. I am an NSS volunteer for the past 2 years. I received training from UNICEF on adolescent issues in Visakhapatnam, because of which I understand the consequences of child marriage. My parents wanted me to get married when I was 17. But since I had enough knowledge about the consequences of getting married at an early age, I knew that this was not good for me. So, I spoke to the elders of my family, my father and mother, and explained to them that I was not mature enough to get married. To prove my point, I gave examples of girls in my college who got married and later dropped out of college. Since I wanted to continue with my studies, I told them again and again and, after repeated discussions, I was able to convince them to postpone my marriage. Now, I am pursuing a Bachelors of Arts degree and actively involve in NSS activities as a Peer Leader.

Madhuri, 20 years old
St. Ann’s college

Few boys join the NSS. This stems down to a misconception on what activities the NSS engages in.



UNICEF plans to implement the programme in 40 more colleges in Visakhapatnam and incorporate principals of schools and colleges into the programme.



Students talking about adolescent issues.

In Summary

UNICEF, in partnership with IKEA Foundation and Andhra University, initiated 'Improving the Lives of Adolescents' programme in Visakhapatnam district of Andhra Pradesh. It aimed to increase the autonomy of adolescents over decisions that impact their life. This was done in collaboration with the National Service Scheme (NSS) in 2015. Here is a blueprint of how the intervention was rolled out in the Visakhapatnam district of Andhra Pradesh.

Action



UNICEF trained NSS Programme Officers to improve their confidence to discuss issues like sexual health and personal hygiene.



Select NSS volunteers were trained as Peer Leaders to spread awareness among the adolescents in their community.



Under the NSS scheme, colleges adopted community outreach, targeting low-income areas for 120 hours of community service in a year.



Through various events and one-on-one interactions, Peer Leaders and NSS volunteers discussed adolescent issues with adolescents in their college.

Results



Adolescents are now better aware of child rights and the legal provisions to protect them. They confidently express feelings and share information on adolescent issues.

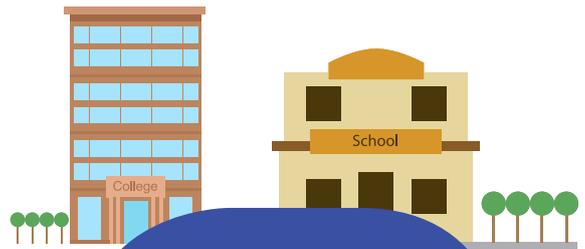


Communities are better aware about the implications of child rights violation. They can effectively address adolescent issues, and are sensitised on laws that protect children's rights.

Transformative Change



Adolescents are now confident change agents, speaking for their rights and entitlements, and convincing their families and communities to not practice child marriage and child labour.



UNICEF plans to implement the programme in 40 more colleges in Visakhapatnam, and incorporate principals of schools and colleges into the programme.

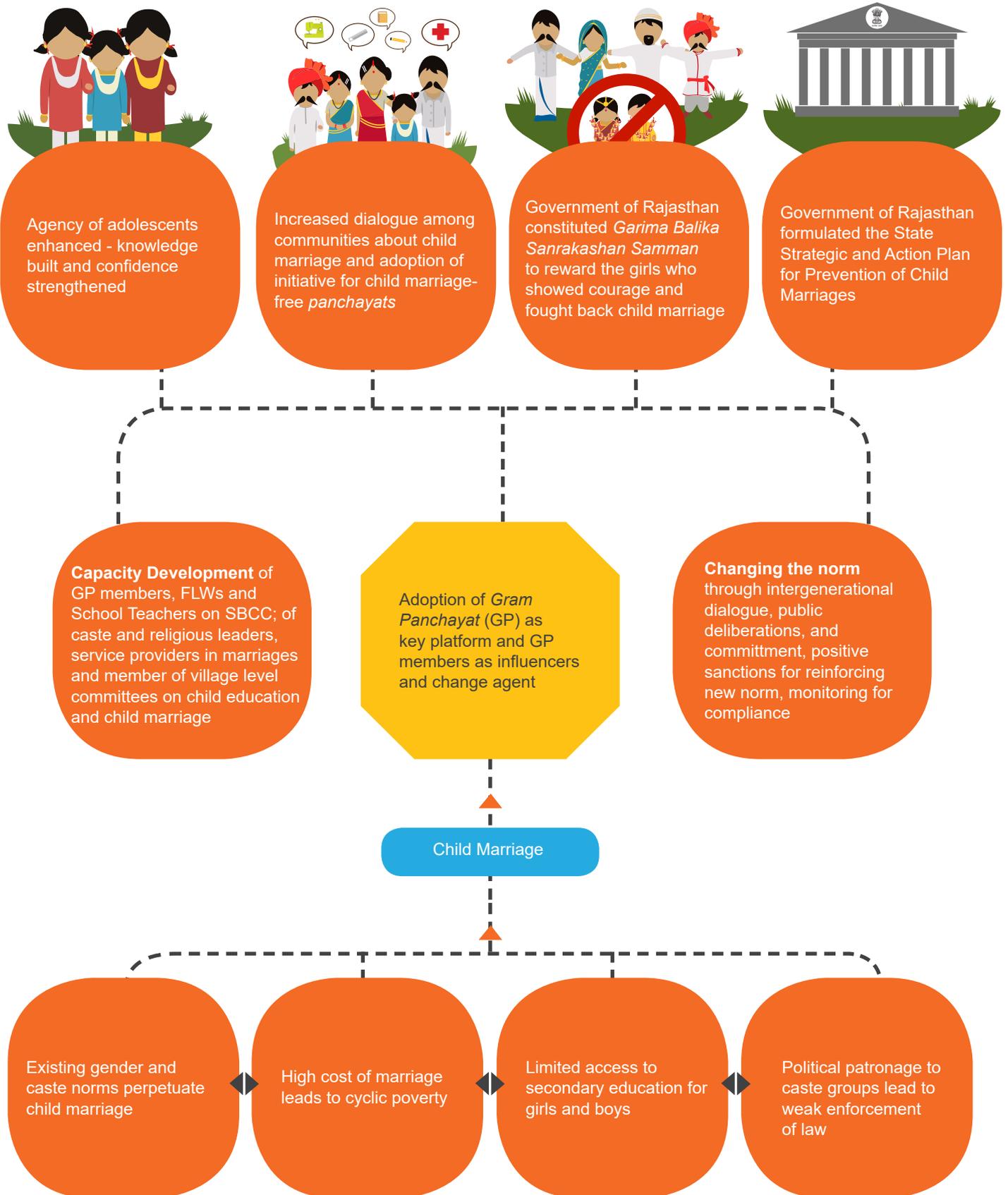
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- ^[2] Ibid., 21.
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- ^[6] Child Statistics. 2012-2013. Andhra Pradesh. Directorate of Economics and Statistics, Government of Andhra Pradesh.
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- ^[8] Household, D.L., 2012. (DLHS-4), 2012-2013 fact sheet Andhra Pradesh. International Institute for Population Sciences Deonar, Mumbai. Ministry of health and family welfare, Government of India, 13.
- ^[9] IKEA foundation, headquartered in Netherlands, founded by Ingvar Kamprad, works to address children's fundamental needs while helping communities fight and cope with climate change.
- ^[10] Andhra University is among the oldest state universities in India. It offers graduate, postgraduate, doctoral, post-doctoral, technical, and professional courses.
- ^[11] The Ministry of Youth Affairs and Sports, a branch of the Government of India, which administers Department of youth affairs and Department of Sports in India.
- ^[12] <http://nss.nic.in/aboutus.asp>
- ^[13] Dravidian language of a people forming the majority population of the South Indian state of Andhra Pradesh.
- ^[14] The *Meena* Radio Programme is an entertainment-education programme that was developed by UNICEF in partnership with the Department of Education, Government of Uttar Pradesh (GoUP) and its *Sarva Shiksha Abhiyan* (SSA) State Project Office.
- ^[15] Based on the inputs shared by NSS volunteers, NSS Programme Officers and community during interactions for this case study's documentation.

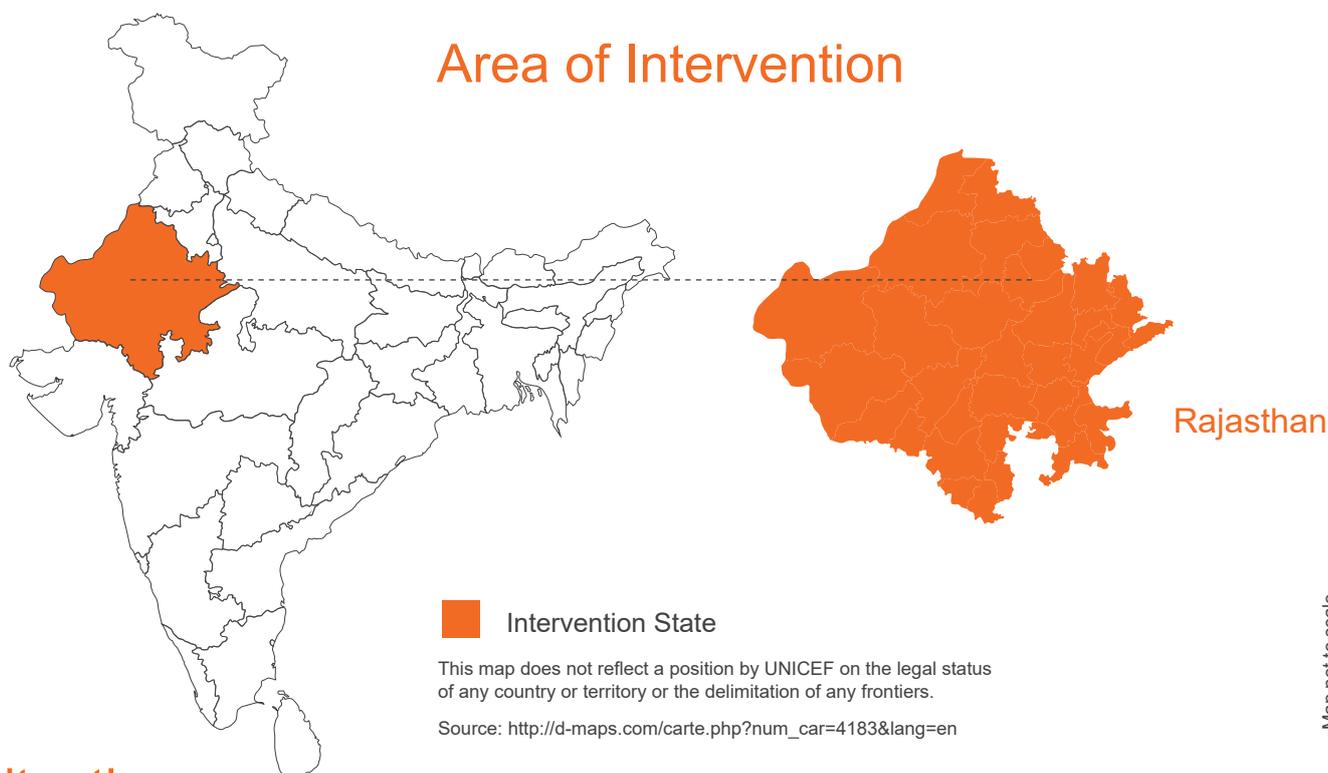
Empowering communities and adolescents for collective ownership of Child Marriage Free *Gram Panchayats* in Rajasthan

Despite the strong laws legislated by the Government of India (GoI) against child marriage^[1], the practice continues across various states in India, including Rajasthan. According to National Family Health Survey (NFHS) ^[2]-4, child marriage is prevalent in Rajasthan with 35.7% boys married below the age of 21 and 35.4% girls married below the age of 18. The practice is sanctioned across most communities in the state and is associated with strong social norms^[3] around caste and gender, poverty, lack of access to schooling, and cultural practices like *Aata Saata Pratha* (bride exchange). Women and Child Development (WCD), Government of Rajasthan (GoR), in partnership with UNICEF, launched an initiative for the prevention of child marriage by empowering communities and adolescents to create Child Marriage Free *Gram Panchayats* (GP)^[4]. The initiative adopted the framework to abandon and shift existing social norms by engaging with the community to formulate new ones around adolescent empowerment, and giving adolescents the opportunity for further learning and development. The framework focused on engaging with key influencers — *Panchayati Raj* Institution (PRI) members, leaders, community members, and adolescents themselves — and imparting to them knowledge about child marriage, influencing change in their outlook, and empowering them to bring about change. The *Sarpanch* and *Sathins*^[5] were seen as catalysts of this social movement for change, and their capacity was adequately enhanced to effectively deliver their critical role. This included their communication and engagement skills for social and behaviour change, counselling skills, and a keen understanding of the importance of education and skill building of adolescents as opposed to the ill-effects of child marriage. During this intervention, a guideline document for Child Marriage Free *Gram Panchayats* (CMFGPs) was developed by WCD in collaboration with UNICEF. As a result of this intervention, adolescents have gained more knowledge about their rights and educational opportunities. They are also more confident, and have the ability to engage and express their thoughts to other members of the community. This is evident in the number of girls who have been awarded with *GARIMA Samman* for coming forward and taking action against child marriage. Hundred and ten PRI members have been recognised by the district administration for their efforts to strengthen this initiative against child marriage. By 2017, 175 GPs have declared themselves child marriage-free, and continue to pursue the dream of empowering their adolescents for a better future with multiple opportunities and alternatives for development.

Theory of Change



Area of Intervention



Situation

Child marriage is a practice that finds its roots in Indian history. Over time, the Indian Government has taken numerous steps to strengthen laws against child marriage and reduce its existence in the country. However, given the social and cultural norms prevalent around child marriage, reducing it has been challenging for more reasons than one. 'Reducing Child Marriage in India', a UNICEF report written by the Centre for Budget and Policy Studies (CBPS), states the following as drivers of child marriage in India:

- **Widely accepted and sanctioned social norms:**

- i Sibling and cross-marriages/*Aata Saata Pratha*: One brother-sister pair is simultaneously married to another brother-sister pair from the same village, tribe, or clan.
- ii Linking marriage to ceremonies: Marriage is solemnised along with a large or important event like *Mrityubhoj*^[6] (UNICEF & ICRW, 2011).
- iii Communal relationships: A practice reported from Andhra Pradesh, where parents marry off their daughters to repay debts. These marriages are solemnised between a bride and groom of different castes as well.
- iv Mass child marriages: On a few auspicious occasions, communities conduct mass marriages of girls and boys. This practice is common during

the *Akshaya Tithiya* and *Mahashivrathri* festivals in the states of Andhra Pradesh, Bihar, and Rajasthan.

- **Poverty, high wedding costs**, and other economic considerations sometimes drive families to marry off their children early. Similarly, big family events/ceremonies^[6] provide opportunities to minimise cost and conduct marriage at the same event with all members present.
- **Lack of easy access to schooling** (mainly distance) combined with low value given to education, especially of girls, leads families to marry girls off early, so that the onus of protecting her and her chastity (which is equated to family honour) is transferred to the groom's household.
- **Political patronage**: Communities with formal groups like caste *panchayats*^[7] form a key voting block and often have political connections. Enforcement agencies and Frontline Workers (FLWs) find it difficult to influence and go against their rules and norms. The other drivers for prevalence of child marriage are:
- **Gender norms** that consider women possessions rather than equals results in their unfair treatment. Fear of losing family honour in case of a premarital

sexual relationship and viewing child marriage as the means to save the family from any possible dishonour is grounded in gender norms around virginity. Even the seemingly poverty-driven act of marrying off girls in lieu of debt has its roots in prevalent gender norms that privilege men in every respect, while denying a voice to girls.

- **Strong sanctions against inter-caste** marriage place more importance on dignity and pride than the choices of a girl or boy. Marriage is perceived as a solution to escape the negative sanctions^[8] of an inter-caste marriage, which leads to many families indulging in child marriage. Negative sanctions such as social ostracism and large fines are imposed to ensure that deviance from social norms are minimal. Data indicates that child marriage is prevalent across both genders.

Recognising the criticality of the predicament, Department of Women and Child Development (WCD), Government of Rajasthan, in partnership with UNICEF^[9], launched an initiative for prevention of child marriage. The initiative initially adopted an individual-case-based approach, followed by a caste-based approach, and finally the *Gram Panchayat* (GP)-based approach. This progression of the intervention is detailed in the 'Method' section.

In the districts of Jodhpur and Bikaner, Government

of Rajasthan and UNICEF partnered with *Urmul* to take this programme to field. *Urmul* has been working across different districts of Rajasthan since 1987 on various social issues like women empowerment, livelihoods, child rights, education, health, etc. Over the years, they have worked towards betterment of girls across villages. This includes their work on prevention of female infanticide, residential education for girls, vocational training, and life skills training. Given the alignment in their goals, the organisations came together for this intervention.

Method

Early in the intervention, it was clear that the nature and proportion of the issue of child marriage was so intense that an individual-change-centric approach was not a long-term solution. This approach was resource intensive, lacked a long-term solution, and at best

produced anecdotal changes led by outliers. A journey to initiate collective change was hence envisaged and planned. Given the high amount of homogeneity within caste groups and strongly demarcated inter-caste lines, it seemed apt to initiate work with caste groups and caste *panchayats*. Reasonable amount of success was achieved through this approach, as the propensity of individuals to adopt change was higher, and encouraged by non-ambiguous empirical^[10] and normative^[11] behavioural evidences. Positive aspects of this experience were drawn and taken to the next level through a GP-driven approach. This approach ensured a larger-scale collective change and adoption of new social norms that could be initiated and sustained through the existing government structure.

In India, *panchayats* form the lowest tier of the local self-governance structure in states, and are responsible for the development of villages under their jurisdiction. Their independent nature gives them complete jurisdiction over all social, economic, and cultural matters within the GP. In consonance with the mandate of the *Gram Panchayat* and an underlying emphasis on sustainability & scalability of change, a field initiative towards CMFGs was mutually conceptualised. A detailed guideline was prepared to declare *panchayats* child marriage-free, and was dynamically reviewed as the implementation progressed.

“A *panchayat* which has the foresight of development and opportunities for all children in its boundary, and ensures the marriage of girls only after the age of 18 years and boys after 21 years — continuously for three years — will be declared as a Child Marriage Free *Gram Panchayat* (CMFGP).”

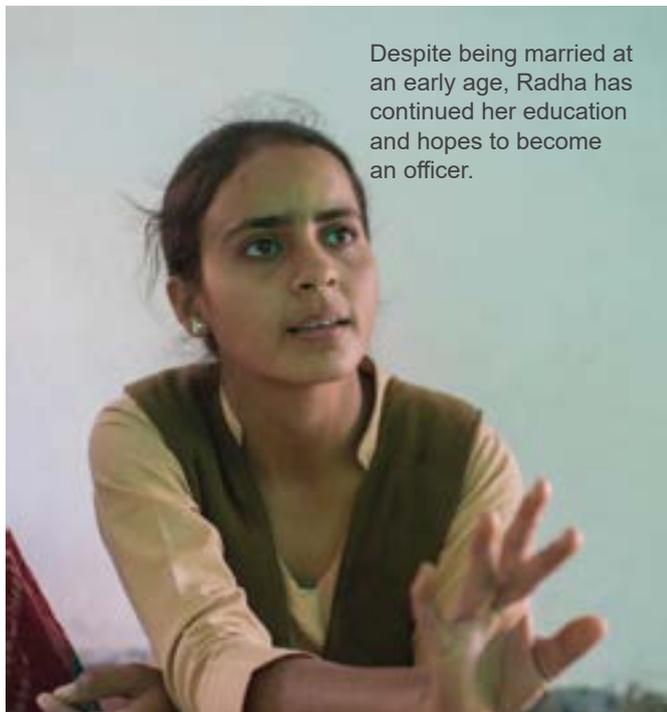
Radha's family sharing their views on the education of girl children.



This plan adopted the social norms framework of creating a new norm. The process includes the following six sequential phases:

- 1. Identification of key stakeholders, reference groups, key change-makers, and influencers:** This phase involved identification of communication networks, channels, vulnerable families and adolescents, key decision makers, and gatekeepers in each given GP.
- 2. Changing the normative beliefs:** Despite the existence of clearly personal normative beliefs that favoured child marriage due to lack of knowledge, it was clear that people's preference to engage in child marriage depended on social expectations. In fact, during one-on-one discussions, it became increasingly clear that there could exist a case of pluralistic ignorance where a large number of community members privately did not endorse the practice yet publicly claimed to do so, hence reinforcing the social norm. It was critical to change these beliefs and ignorance collectively.
- 3. Collective decision-making to change the norm:** Inter-generation dialogues were initiated, focusing on reasons for change and providing opportunities to get exposed to other people's normative beliefs. It also made stakeholders aware of an increasing mass of people shifting towards change, and helped create a tipping point in the community. These exchanges were planned to ensure that the entire reference group participated in the change collectively.
- 4. Introduction of positive sanctions for non-compliance:** Collective ownership was instilled to formulate positive milestones which would in turn help eliminate established externalities and sanctions. This made families aware of other families which were equally keen on changing the status quo, and ensuring girls and boys had equal opportunities to learn and develop rather than get married early. This included identifying and giving recognition to stakeholders who had shown a positive deviance and established their own trend.
- 5. Creation of new normative expectations:** The emergence of new behaviour driven by new normative expectations led to updated empirical expectations of the community members.
- 6. Observance of compliance to new empirical expectations:** This phase included collective observation to ensure that all members of community practice marriage at the correct age. and education of girls is continued.

The details of the steps followed in each of these phases is detailed in the following 'Action' section.



Despite being married at an early age, Radha has continued her education and hopes to become an officer.

Action

Phase 1: Identification of key stakeholders, reference groups, key change-makers, and influencers

As a first step, the districts were categorised into three — high, medium, and low child marriage-prevalence districts based on the secondary data. A total of 14 districts with high prevalence of child marriage in the state were identified. Within these districts, high prevalence blocks and *Gram Panchayats* were identified based on the secondary data available. Further, in each *Gram Panchayat*, communities were mapped. Key influencers and gatekeepers such as faith leaders, caste leaders, and elders were mapped on one hand, and vulnerable families on the other. From these, the details of the children, adolescents (10-19 years), and their marital^[12] and educational status was collated. The information around communication networks, channels, and opportunities was also taken into consideration. This exercise was conducted by the *Sathin* and, at the end of the exercise, each *Sathin* had a social map of the village highlighting the girls and boys at the risk of an early marriage. Girls and boys at risk of getting married early were tracked and their status was monitored regularly. The *Sathins*, in turn, were oriented by many Civil Society Organisations (CSO) along with *Urmul*, who came together to implement the initiative in other districts with support from UNICEF and UNFPA.

Phase 2: Changing the normative beliefs

Capacity Building and Sensitisation: *Panchayat* members, FLWs, and school teachers were trained on Social and Behaviour Change Communication (SBCC). This focused on enhancing their communication skills to engage the community, discuss education and child marriage-related issues, and be the change leaders in their own communities. In addition, caste & religious leaders, service providers in marriages, and members of other village-level committees were sensitised about the importance of education for children (especially a girl child) and ill-effects of child marriage.

Different communication tools like printed material, wall paintings, display boards at prime locations, phone messages, etc. were used to spread information to all members of the community. One such important communication tool was a caravan which was loaded with various communication material like posters and videos, and traversed all schools in villages. Information about government schemes related to education, and processes for availing these schemes were also distributed by resource persons aboard this caravan. Family and school-based engagement with parents, teachers, members of school committees, and other community structures were undertaken to sensitise about child marriage and the importance of education for children by *Sathins*, PRIs, and CSO members.

Phase 3: Collective decision-making to change the norm

It was important to initiate an inter-generation dialogue in public spaces. Innovative communication tools and approaches were employed to stimulate this collective engagement. A case in point was a human-puppet interactive show format, which was familiar yet unique. The scripts for these shows were based on real events that had occurred in the past in relation to adolescent girls and boys of the community. The scripts highlighted the role of fathers and mothers, and how they can take decisions that would help improve the lives of their children. The puppet shows ended with an open discussion among the participants and the facilitator about the importance of education, child marriage, and its ill effects on adolescents' physical and mental health. These shows were able to evoke a strong response from the communities, and many of the participants were able to understand the impact of their decisions on the lives of their children.

Finally, public meetings or *Gram Sabhas* — *Jaajam* — with participation from the entire village were organised, where leaders of the village took public oaths and explained the demerits of child marriage. Self-certification by PRI members, FLWs, and school teachers enhanced the accountability towards their respective responsibilities to prevent child marriage in their *panchayat*. Challenges of families and adolescents towards adherence to this new social agreement was understood and addressed by the community. This involved coordinated actions, collective discussion and decisions, and a series of collective pledges.

Phase 4: Introduction of positive sanctions for compliance to new norm

Ladli samman was initiated in the intervention area to reinforce the new practice. This award aimed to honour families and adolescent girls who took the initiative to delay early marriages, as well as underage brides who continued to stay in their parents' house and pursue their education till they turned 18 years old. Cases of such positive deviance were identified and honoured in a community event with large fanfare. The award winners went back to their villages and communicated the message of 'no child marriage', and shared their experience with other community members. As time passed, these numbers continued to grow and public proclamation inspired more families to adopt the change.

Phase 5: Creation of new normative expectations

The *panchayat* members, in agreement and consent from the community members, defined the new practice of 'no child marriage' in their *panchayats* and submitted a plan to the block office of WCD to become child marriage-free in three years' time.

A team of block and district-level experts conducted an impromptu visit to observe the situation of the village after one year. For a complete year of 'no child marriage' in the *Gram Panchayat*, the declaration was made in a block/district-level function. After validation and internal consultations, the district committee would add the *panchayat* to the list of Child Marriage Free *Gram Panchayats*, and recommend it to the state-level committee in WCD.

Phase 6: Observance of compliance to new empirical expectations

Monitoring stability of the new norm and avoiding slippage was an important activity undertaken by the *Sathins* and GP members. Maintaining three years without child marriage was encouraged through monitoring, and a follow up by block and district officials led to a final certification at the end of three years of no child marriage. This honour was given in a grand function to be a motivation for the villagers to continue practicing the new norm of 'no child marriage'.



School children enthralled by the performance.

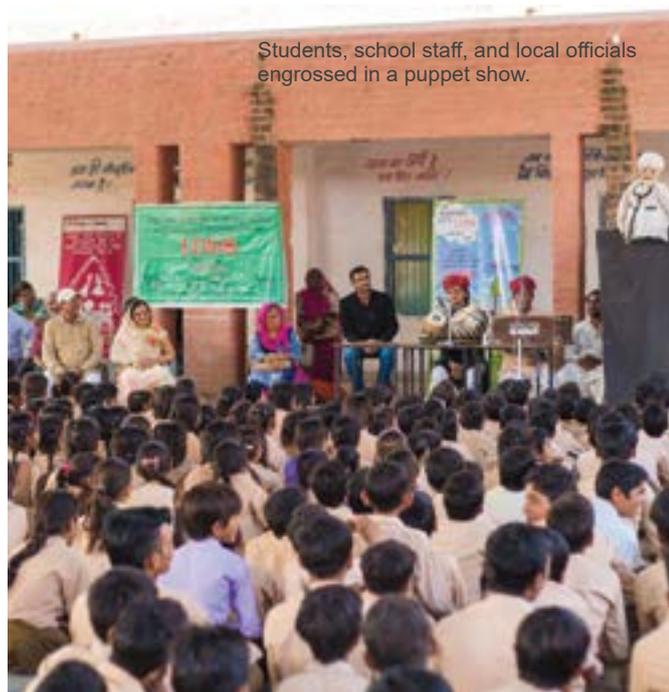
Results

Following are the results from this intervention:

Adolescents

- The members of adolescent groups have gained knowledge about their rights and have enhanced opportunities of education.
- Members of the adolescent girls' group have much more confidence, and can express and share opinions with their families and the community with ease.
- As part of the *GARIMA Samman*, exceptional actions of girls have been identified and recognised^[13]:
 1. 100 girls have been awarded the *GARIMA Samman* across different districts for their commendable work against child marriage.
 2. 2000 girls have become change-makers. They are the ones who have either refused child marriage or have lent their support to someone else fighting child marriage.

Based on the positive response to the *Ladli samman award* in creating change-makers and role models, the Government of Rajasthan adopted and modified it to distribute under the name *GARIMA Balika Sanrakshan Samman*.



Students, school staff, and local officials engrossed in a puppet show.

Community

Communities enjoy a sense of honour and responsibility in providing their daughters security, protection, and access to schooling. They are now empowered to make decisions for girls from their *panchayats* and ensure they get their due rights.

Hundred and ten PRI members have been recognised by the district administration for their work in preventing and strengthening this movement against child marriage.

System

173 *panchayats* have been declared child marriage-free as a result of this intervention. A prize has been constituted to recognise *panchayats* working towards a child marriage-free *panchayat*.

“I am the head of my *panchayat* for the last three years, and it was declared child marriage-free in 2016. According to me, at least 60% girls in the village are enrolled in schools and attend regularly. Girls are more meritorious than boys and perform in the state board exam results. A girl is a change initiator and, if she gets educated, two households get educated. The triggers of change that led to the child marriage-free status of my *panchayat* are education, government laws against child marriage, and the support from UNICEF. I did and continue to encounter opposition from elders in my village about this, but I have learnt how to negotiate and convince them. My biggest supporters are the adolescent girls who have been empowered through the education and training given by UNICEF.”

***Bhagusan Khilaeri, Sarpanch,
Lakhasar Panchayat, Bikaner***

In 2014, the following systemic results were achieved:

- Formulation of guidelines for prevention of child marriage.
- Launch of *Ladli* campaign which opposes against sex determination and sex selection of the unborn child.
- Launch of an award by the government for Child Marriage Free *Gram Panchayats*, and *Zilla Parishad*.



Transformative Change

- In 2015, the Government of Rajasthan constituted *GARIMA Balika Sanrakshan Samman*, an award for girls who have shown courage and fought back child marriage. It is held annually on the 24th of January.
- Formulation of the State Strategic and Action Plan for Prevention of Child Marriages by the Women and Child Development, Government of Rajasthan to create a child marriage-free Rajasthan.

Caselet



Santosh studies in Class 12 in a Senior Secondary School in Lakhasar *panchayat* of Bikaner district. When the UNICEF programme came to her village, it piqued her interest and she joined the adolescent group. With leadership and life skills trainings from UNICEF, she started to feel more confident about herself and was able to fearlessly express her opinion on public platforms. She is now the leader of her adolescent group and facilitates group meetings. As the leader, she checks on any early girl dropouts in her school and follows up to get them back to school. She strongly opposes the practice of *Mrityubhoj* (feast after death) and had protested peacefully in her village with her adolescent group. As part of this programme, she was sent to participate in the International Girl Child Day event in 2016. According to her, this programme has helped her become more confident, given her the opportunity to interact with new people, and participate in different events — thereby increasing her exposure to the outside world.

In Summary

UNICEF, in partnership with Women and Child Development (WCD), Government of Rajasthan (GoR), launched an initiative for prevention of child marriage. The intervention aimed to empower communities and adolescents to create Child Marriage Free *Gram Panchayats* (CMFGP), by abandoning existing social norms and engaging with the community to formulate new ones. Here is a blueprint of how the intervention was rolled out in Rajasthan for stakeholders like GP members, leaders, adolescents, and *Sathins*.

Action



After identifying districts with a high prevalence of child marriage, local communities and government officials were brought into the fold to initiate sustainable change.



Ladli Samman was given to adolescents and their families who took initiative to delay child marriage or put persistent efforts to continue the education of their girl child. This encouraged the villagers to actively participate in the prevention of child marriage.



Capacity building on SBCC was conducted among ***panchayat members***, FLWs, religious heads, and community leaders. Different printed and digital mediums of communication were used.

Results



Adolescent groups now have enhanced knowledge about their rights. Girls are confident enough to express their views and share opinions with family members.



110 PRI members were recognised by the district administration for their work to strengthen the movement against child marriage. The communities take pride in providing girl children security and schooling, and leverage the *panchayat* to ensure girls their rights.



173 *panchayats* have been declared child marriage-free as a result of this intervention.

Transformative Change



The Government of Rajasthan has constituted *Garima Balika Sanrakshan Samman* – an award for girls who have fought child marriage practices.



Women and Child Development, Government of Rajasthan has formulated a State Strategic and Action Plan for Prevention of Child Marriages to create a child marriage-free Rajasthan.

References

- ^[1] Under Child Marriage Restraint Act (CMRA) 1929, also popularly known *Sarda Act* after its sponsor, Harbilas Sarda who hailed from the State of Rajasthan, the marriage age for girls was fixed at 14 years and for boys at 18 years which was later amended to 18 years for girls and 21 years for boys. In 2006, Prohibition of Child Marriage Act (PCMA) was formulated to include stricter legislations.
- ^[2] NFHS is conducted by the International Institute of Population Sciences (IIPS) under the aegis of Ministry of Health and Family Welfare (MoHFW), Government of India to gather essential data on health and family welfare and emerging issues in this area.
- ^[3] Social norms refer to the unwritten rules that govern social behaviour. More details at https://www.UNICEF.org/protection/files/4_09_30_Whole_What_are_Social_Norms.pdf
- ^[4] A *gram panchayat* is the cornerstone of a local self-government organisation in India of the *Panchayati Raj* system at the village or small-town level and has a sarpanch as its elected head. There are a total of 2,40,355 GPs in India, and Rajasthan alone has 9,199 GPs (source: nird.org.in). GP is responsible for conducting the administrative and development functions of the *panchayat*. This involves solving local disputes, undertaking work for safety, sanitation, health, education, agriculture, etc. in their *panchayat*. Number of villages under a *gram panchayat* are dependent on the population density of the region.
- ^[5] A *Sathin* is a paid resource appointed in each village by the local governing body. The essence of *Sathin's* role is to give support to the problems of the women of the village as a friend, mentor and guide.
- ^[6] Examples of such ceremonies include *Mrityubhoj* and auspicious days such as *Akha teej* and *Peepul puniya* in Rajasthan. *Mrityubhoj* is a large feast organised after death of an elderly family member. *Akhateej* is the annual spring festival celebrated by Hindus and Jains. More details at https://en.wikipedia.org/wiki/Akshaya_Tritiya
- ^[7] Caste *panchayats* are caste-specific juries of elders of a particular caste for a village or a higher level in India.
- ^[8] Sanctions are socially defined rules against a member of the community for his/her actions. These could be either negative or positive in nature.
- ^[9] Within UNICEF, two departments, Child Protection and Communication for Development worked in close cooperation for this intervention.
- ^[10] Empirical behaviour consists of a pattern of behaviour such that individuals conform to it as they believe that most people in their relevant network conform to it.
- ^[11] Normative behaviour consists of a pattern of behaviour such that people practice or conform to it as they believe that others in their reference network believe they should do so.
- ^[12] Within marital status; the following details were checked and updated. If married, whether they are staying with their parents or at their husband's house.
- ^[13] Source: Programme Data

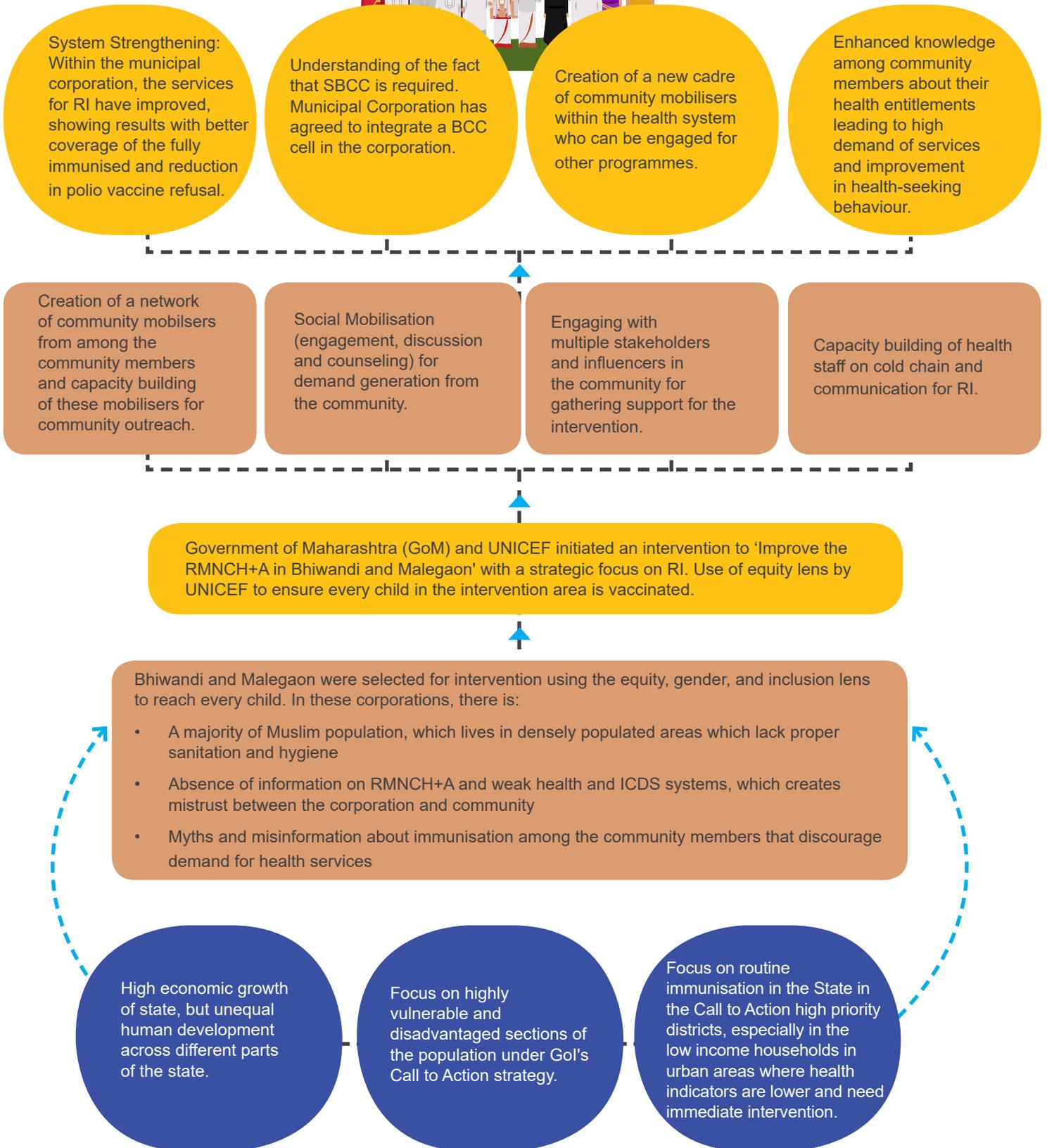
unicef  | for every child

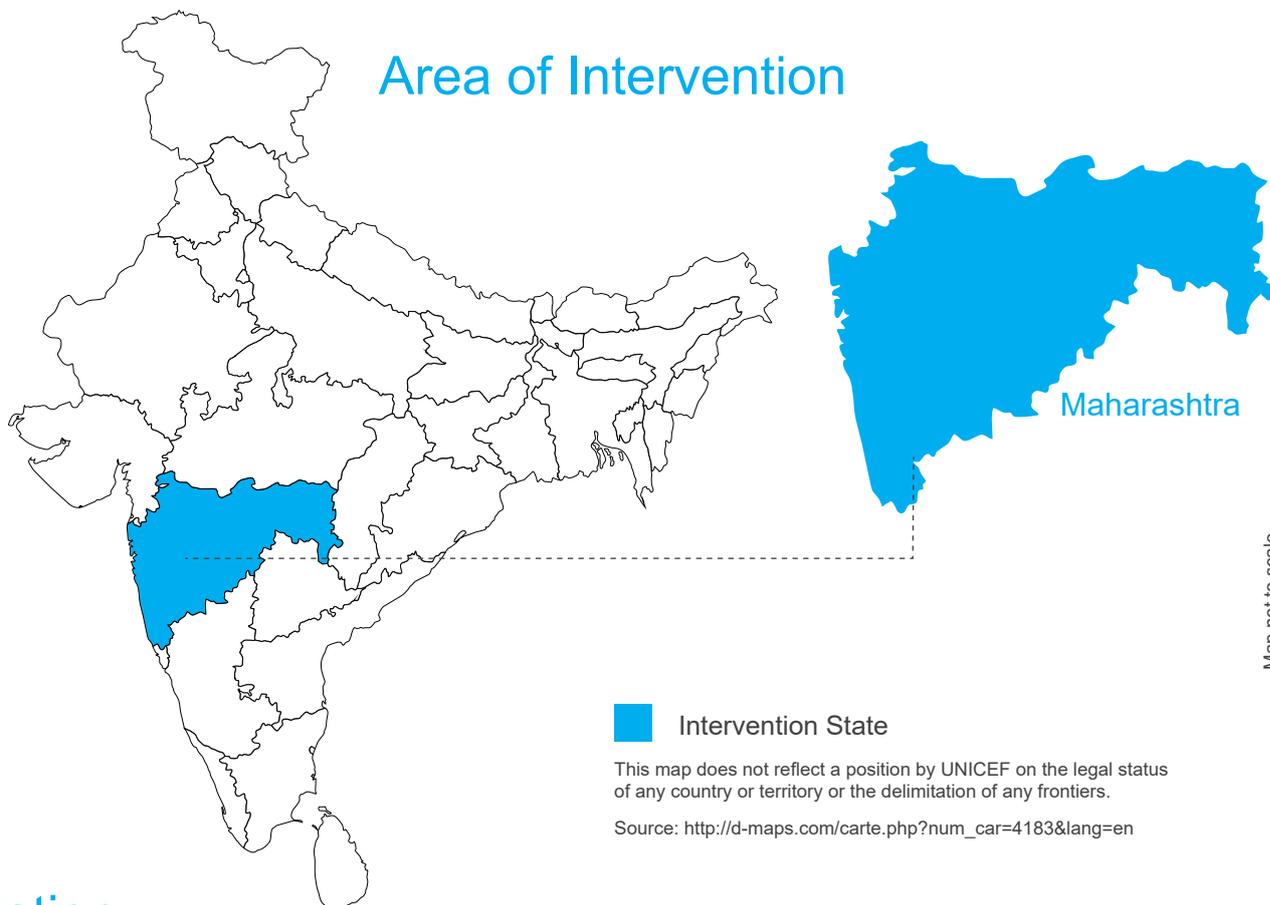
Narrowing the Gap Equity Programming for Improving Routine Immunisation in Underserved Municipal Corporations of Bhiwandi and Malegaon in Maharashtra

Maharashtra — a state in the Western region of India — is the financial, industrial, and economic capital of the country. According to the Economic Survey of Maharashtra (2016-2017), the state's Gross Domestic Product (GDP^[1]) is approximately 15 percent of the country's GDP^[2]. While this indicates high economic growth, it does not necessarily reflect the overall development of the state. According to the National Family Health Survey-4, the rate of immunisation (BCG, measles, and three doses each of polio and DPT) for children aged 12-23 months in the urban areas of Maharashtra is 56 percent — fairly low as compared to the national average of 64 percent^[3]. GoI identified Thane and Nashik districts from Maharashtra as High Priority Districts (HPDs) under 'Call to Action' ^[4]. Within these two districts, Bhiwandi (Thane) and Malegaon (Nashik) were identified as the high focus areas. Given the alignment between the Government of Maharashtra (GoM) and UNICEF, an initiative was decided upon to 'Improve the RMNCH+A in Bhiwandi and Malegaon' in Maharashtra with strategic focus on RI.

UNICEF used the equity lens approach for this intervention to ensure the vaccination of every child in the intervention area. To bring about a change in the RI coverage, the intervention targeted three levels of influencers: Interpersonal (family and friends), Community (mobilisers), and Social Networks (influencers). An integral and critical part of this intervention was the creation of a cadre of community mobilisers who were trained on Interpersonal Communication (IPC) skills and given technical training about RI. These mobilisers conducted one-on-one interactions and organised meetings with mothers, fathers, elders, and religious leaders. They engaged with them to sensitise them about RI and its importance for a child's good health. As a result of this intervention, the demand for health services has increased in both Bhiwandi and Malegaon. Community mobilisers now have improved interpersonal skills and can support the government for other development initiatives. The immunisation rate in Bhiwandi has increased by 6 percent after this intervention, indicating progress towards achieving improved RMNCH+A.

Theory of Change





Situation

The Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) 2013 document of the Ministry of Health & Family Welfare (MoHFW), Government of India (GOI) details a strategic roadmap for accelerating child survival and improving maternal health with a continuum of care approach. It lays special emphasis on the most vulnerable and disadvantaged groups, especially in the 264 districts which have been identified as high focus areas. The priority population for the government includes residents of urban slums and tribal areas, vulnerable people falling in the categories of Scheduled Castes (SC), Scheduled Tribes (ST), minorities, urban poor, women, and migrants, as well as occupation-based groups in the underserved areas. Reproductive, maternal, and child morbidity is more likely to be concentrated in these areas. Reaching the entire identified underserved population would ensure equitable development for all. Further, a specific focus has been put on strengthening the Routine Immunisation (RI) programme.

The 'National Call to Action: Child Survival and Development 2013' launched by Government of Maharashtra (GoM) is a follow up of this, and focuses on accelerating child survival and improving maternal

health. The National Family Health Survey (NFHS)-4 shows that the rate of immunisation in urban areas of Maharashtra is 8 percent less than the national average^[5]. Similarly, the percentage of children in urban areas in Maharashtra who have received polio, BCG (for tuberculosis), and DPT vaccines was lower than the national urban area statistics. The percentage of children who had received measles vaccine in urban Maharashtra is same as the national average.

The Department of Health (DoH), GoM identified 10 districts – including two municipal corporations^[6] of Bhiwandi and Malegaon, falling under Thane and Nashik districts respectively – that have low performance in RMNCH+A, and need concentrated efforts to improve RI of infants and children. World Health Organisation (WHO) data shows that these two municipalities were the last polio reservoirs in the state. Bhiwandi was one of the most challenging epicentres in the country to eliminate the polio virus, with 7 polio cases identified between 2002 and 2008. Similarly, Malegaon has been a very high-risk area for polio wild virus transmission. This makes the two municipalities highly vulnerable to resurgence of the polio virus. The high influx of migratory population further increases this phenomena.

About Bhiwandi and Malegaon

Almost half the power looms in India are in **Bhiwandi and Malegaon** — 7 lakh and 3 lakh respectively ^[7]. These looms attract migrants from the northern states of Uttar Pradesh, Bihar, and West Bengal who have migrated and lived in these cities for the last 25 years. Bhiwandi and Malegaon have a predominantly Muslim population; 65 percent and 79 percent respectively according to Census 2011. Most of them live in high-density population areas and belong to low-income households with limited sanitation and hygiene facilities. RI rates in both were low; 42 percent in Bhiwandi and 39 percent in Malegaon^[8].

Absence of information on RMNCH+A, and weak health and Integrated Child Development Services (ICDS) systems created mistrust between the corporation and community. According to the NFHS-4 data, the immunisation coverage for infants in Bhiwandi and Malegaon is 42 percent and 39 percent respectively, which is way lower than the state and national average. 76 percent pregnant women in Bhiwandi and 85 percent in Malegaon were severely anaemic, and the percentage of home deliveries was 13.9 percent in Bhiwandi and 6.5 percent in Malegaon^[9].

The myths and misinformation about immunisation among the caregivers further discourages mothers from seeking immunisation services. Examples of myths as shared by the mothers are: "Vaccination causes illness in children" and "Vaccination causes physical deformities in children". Many of these are based on the fear of Adverse Event Following Immunisation (AEFI) and misinformation is passed on among and within family members, leading to a larger misunderstanding in the community; in turn hindering immunisation.

UNICEF's core commitment focuses on narrowing this gap, and reaching the most deprived and vulnerable children. It is evident that deprivation of child rights is mostly prevalent in the poorest and marginalised groups. With increasing evidence, a paradigm shift has led to renewed efforts in urban areas, since poverty is a critical determinant of inequalities in child survival, growth, and development. As UNICEF's philosophy aligned with Government of Maharashtra's strategy to improve the RMNCH+A (especially RI), it partnered with UNICEF to launch an intervention to improve RI in the two identified municipalities.

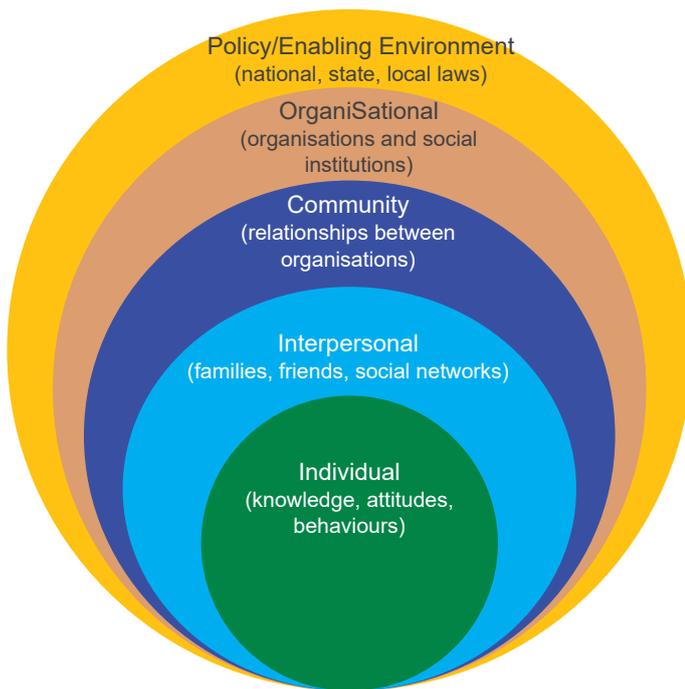
Myths and misinformation about immunisation discourages mothers from seeking immunisation services.



Method

UNICEF Communication for Development (C4D) used an equity focused approach for this intervention. The objective was that every child, irrespective of their community, caste, and economic status should receive immunisation. To identify the most effective means of targeting immunisation, UNICEF used the Socio-Ecological Model (SEM) to identify the different intermediaries who would be able to reach the stakeholders and bring about change.

The Socio-Ecological Model



Of the five^[10] levels in the SEM model, UNICEF identified three around which the intervention worked. These were:

- **Interpersonal:** Comprising of friends, family members, and social networks
- **Community:** Comprising of community mobilisers
- **Organisational:** Comprising of religious and community leaders, SHGs, and educational institutions — whether educational or religious — called *madrassa*

SBCC System Strengthening with Municipal Corporation: SBCC strategy endorsement, capacity building, and supportive supervision for social mobilisation activities was ensured. A cadre of mobilisers created by UNICEF drove this initiative,

reached out to the community, and bridged the last-mile gap in the health system. The following ‘Action’ section details the creation process of these mobilisers.

Interpersonal Communication (IPC) skill building for community outreach: Mobilisers were trained in IPC to reach out to the community, engage with them, and gain their trust. This was necessary, as the community was known to strongly oppose vaccination and formal healthcare. Strong communication from mobilisers was key for this intervention to be effective and reach the intended stakeholders.

Social Mobilisation for demand generation from the community: Technical training on RI and its benefits was provided to mobilisers. Thereafter, mobilisers engaged with the community to:

- Discuss RI and its importance
- Inform about the dates and venue of immunisation
- Counsel them to go for immunisation and AEFI
- Support the immunisation process for social mobilisation

Engaging with multiple stakeholders and influencers: Mobilisers interacted with multiple stakeholders to gather support in bringing about a behaviour change in the community. These included religious and community leaders, midwives, elected representatives, and loom owners and supervisors.





One of the housing lanes in Ansar mohallah.

Action

As part of the intervention, the following activities were undertaken:

Creation of Community Mobilisation Network:

Urban areas have their challenges, and this is most pronounced in the area of community engagement. For instance, the enrolment of *ASHAs* is low and they are accountable to the Municipal Corporation Medical Officer Health, under the RCH programme. This system is weak with minimal technical and capacity building opportunities provided to *ASHAs*. The ICDS and health systems have no convergence, leading to *anganwadi* workers working in isolation in the same community. With this increasing trust deficit between the municipal corporation and community, it was decided that UNICEF would recruit and train a new cadre of community mobilisers from the same areas with the intention of helping them bridge the gap and build trust with their own communities. At the same time, UNICEF aimed to support the process of behaviour change through social mobilisation activities, and increase the demand for services through awareness, discussion, and engagement. For this intervention, community mobilisers were called Community Mobilisation Coordinators (CMC). A total of 50 CMCs supported by two supervisors were deployed in each of the two corporations.

Capacity Building:

CMCs: They were trained by UNICEF on IPC and technical skills related to RI. The focus of IPC skills was to enhance the CMC's capacities to engage with community members and to initiate conversations around their health and health practices. CMCs were taught how to have a two-way conversation using the GATHER^[11] principle.

Health Staff: A total of 81 and 100 health staff in Malegaon and Bhiwandi municipal corporations respectively were trained on cold chain and communication for RI. Training on cold chain was given to impart knowledge about the new vaccines like pentavalent and injectable polio vaccines.

Mobilisation drives in the community: Each CMC was assigned approximately 500-600 households, and asked to conduct field surveys to create a list of eligible children and their immunisation status. The CMCs followed this with counselling visits to each household, conducting meetings for mothers, the community, and religious leaders. The objective of all this was to enhance the demand of RI and increase the RI coverage in their respective areas.

Support from Influencers: The supervisors interacted closely with the influencers and sought their support to convince families, and spread messages about RI events. This was actively pursued in high resistance areas where communities were more resistant than others.

Apart from this, supportive supervision of cold chain was carried out during this intervention to identify bottlenecks and help improve the speed and quality of supply chain processes.

During this programme, between April to December 2016^[12]:

In Bhiwandi:

- The defaulter rate reduced from 60 percent to 55 percent in nine months

- 107 rallies about RI were carried out by children from *Madrasas*
- 26 community meetings, 2,388 mothers' meetings and 7 religious meetings were organised
- A total of 9,764 children and 1,485 pregnant women were reached through the 881 outreach sessions

In Malegaon:

- 130 community meetings and 1,490 mothers meetings were conducted
- A total of 14,552 children were reached through 1,187 vaccination sessions.



A community mobiliser counseling a mother about her infant's vaccination during her daily rounds.

Community influencers were actively involved in this initiative.



Results

System Strengthening: Within the municipal corporation, the services for RI have improved as demand has increased from the community level. There is also an understanding that SBCC is necessary and the commissioners have agreed to develop a BCC cell within the RCH programme unit and requested UNICEF for technical assistance. RI is an entry point and UNICEF will focus on maternal and child health and nutrition (reduction of stunting) including violence against children, and girls' education.

Community^[13]: The interaction with CMC and the doctors has helped them reduce their myths around vaccination and its perceived ill-effects. They are now aware that vaccinations help keep the child & mother healthy and safe from preventable illnesses.

System

1. Cadre of community mobilisers formed: A community network of social mobilisers is formed which

can carry out IPC. They can support the health department in implementing programmes in the future as they have established a trusted relationship with their community.

2. RI coverage has increased from 42% in 2013 to 52% in 2016. (According to the WHO concurrent RI monitoring data)
3. WHO monitoring data captures refusals between Feb 2014 to Jan 2017 – 496 households refused the oral polio vaccine as of January 2017.
4. Continuous System Strengthening of both the Municipal Corporations is under progress, and convergence with other departments is a way forward to improve services and increase demand for child survival in an urban context with underserved communities.

Transformative Change

Members of the community have improved knowledge about their entitlement to health benefits like free vaccinations, and this has led to an increase in the demand for health services from the community.

“As a practitioner of Islam and the leader of this educational institute called Madrasa where Islamic education is provided, it is my duty to help people stay healthy and happy. Prior to this intervention, there was a lot of misconception among the community members about health and its services. We participated in this intervention and provided support in the form of announcements, rallies, and a space for vaccination camp. We gave a logical explanation on the benefits of RI which was also linked to religion. This increased acceptance of vaccination and its benefits in having a healthy child. Now I am starting to see slight change in people’s perspective from my community. They have begun to ask about vaccination dates and about other vaccines which they are entitled to. They have started to move towards formal health care and avail services from government health facilities. With continued effort, consistent demand and uptake of health services can be created.”

**Mufti Mohammed Huzaifa Qasmi, President
Jamiat Ulama-E-Hind, Thane**



A primary health centre worker.

Caselet 1



Sheeba is mother of 1.5-year-old Mohammad Azan. Mohammad is her only son, and she wants to ensure that he stays happy and healthy. When CMC Saira Asad Mirza went for field visits to capture immunisation data about infants and children, she was not allowed to discuss RI with Sheeba. Sheeba’s mother-in-law had misconceptions about vaccines and their effects on the children. She believed that vaccinations led to sickness in children and were unnecessary. CMC made multiple visits to Sheeba’s house and, on each occasion, spoke to her mother-in-law and explained vaccination and its benefits. The CMC also roped in Sheeba’s neighbours to convince her mother-in-law. After multiple such conversations, she was able to convince the mother-in-law and meet Sheeba. Sheeba understood the importance of vaccinations and agreed to get all the vaccines for her son at the right time. She and her husband now go together to get him vaccinated as per the vaccination schedule.

Caselet 2

Reshma Dilshad Ansari is mother to a two-month-old child and a nine-year-old daughter. After her daughter’s birth, she had conceived six times; but all the six children passed away within a few days of being born. All the deliveries were at home by midwives. When this intervention started, her mother-in-law heard of the CMC vaccination drive. The mother-in-law brought the CMC home and asked her to guide them on precautions to be taken during Reshma’s pregnancy. The CMC asked them to initiate prenatal checkups and to have the delivery at a hospital itself. When Reshma’s son, Mohammad Qasim was born, she and her mother-in-law ensured he received his vaccinations. Her son has survived for two months, and she is hopeful that he will grow up to be a healthy boy and have a long life.

In Summary

UNICEF, in partnership with Government of Maharashtra, devised an initiative to promote the uptake and acceptance of Routine Immunisation (RI) in underserved municipal corporations. This intervention aimed to create a cadre of community mobilisers trained on Interpersonal Communication (IPC) skills and RI. Here's a blueprint of how the intervention was rolled out in the municipalities of Bhiwandi (Thane) and Malegaon (Nashik).

Action



A community mobilisation network was created to bridge the gap between the community and the municipal corporation. These community mobilisers were called Community Mobilisation Coordinators (CMCs).



CMCs conducted meetings with mothers, field surveys, and households to enhance the demand for RI.

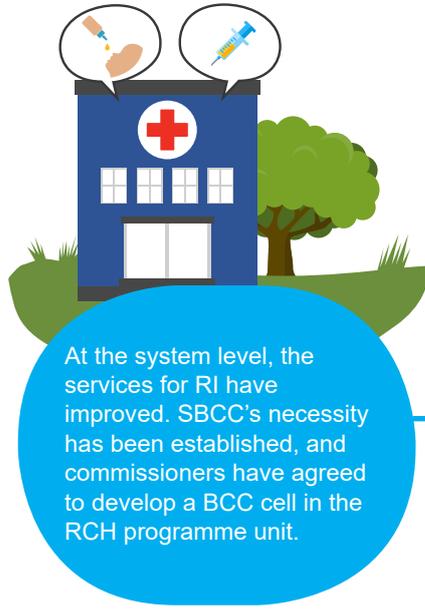


CMCs and the existing health staff were trained on IPC and the technicalities of RI, so as to generate effective awareness and engagement with the community.

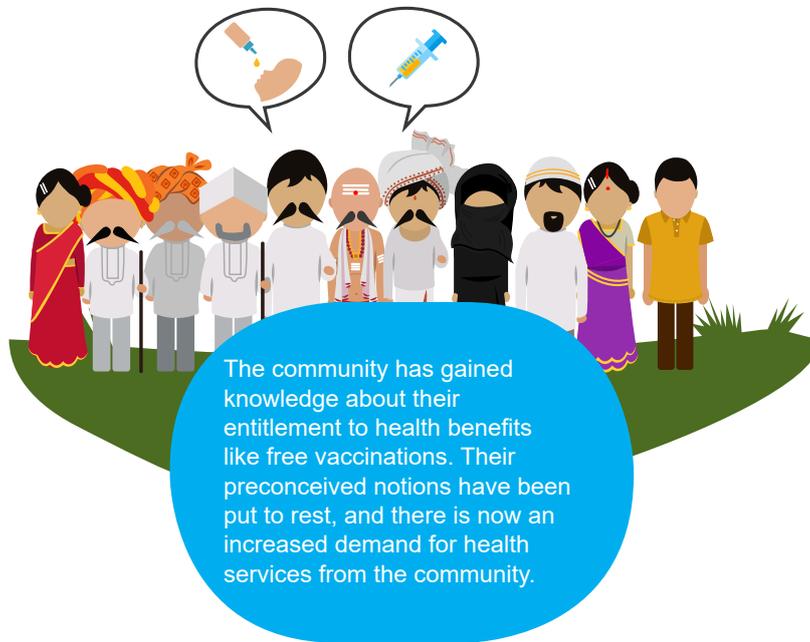


Influencers such as religious and community leaders, midwives, loom owners, and elected representatives were closely interacted with to spread messages about RI events.

Results



Transformative Change



References

- ^[1] Gross domestic product (GDP) is a monetary measure of the market value of all final goods and services produced in a period (quarterly or yearly) of time.
- ^[2] <https://www.maharashtra.gov.in/Site/upload/WhatsNew/Economic%20Survey%20of%20Maharashtra%202016-17.pdf>
- ^[3] Source: National Family Health Survey-4 by Population Council of India.
- ^[4] Mission Indradhanush is a health mission of the GoI. It aims to immunise all children under the age of 2 years, as well as all pregnant women, against seven vaccine preventable diseases.
- ^[5] Source: National Family Health Survey-4 by Population Council of India.
- ^[6] A municipal corporation is a governing body that caters to urban areas with a population of more than one million. They look after the necessary community services like health, education, housing, transport, etc. by collecting property tax and fixed grant from the State government.
- ^[7] Source: UNICEF internal reports (Bhiwandi: Final 1 ppt for visit and Malegaon: Intensifying Routine Immunisation in underserved areas of Municipal Corporations of Bhiwandi and Malegaon in Maharashtra)
- ^[8] Source: Coverage Evaluation Survey 2013, Government of India.
- ^[9] Source: Maharashtra State Family Welfare Bureau for the year 2016-17
- ^[10] The five levels are individual, interpersonal, community, organisational and Enabling environment/Policy
- ^[11] GATHER stands for stands for the following six activities: Greet, Ask, Tell, Help in the decision-making, Explain, Return. One is expected to do all these in his/her interaction.
- ^[12] UNICEF Internal Programme data
- ^[13] This is anecdotal and based on the interactions with the community conducted as part of this documentation.
- ^[14] Source: WHO concurrent RI monitoring data
- ^[15] WHO monitoring data captures refusals between Feb 2014 to Jan 2017.



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