

Health Communication Strategy Jharkhand



Parivartan

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PARIVARTAN

Jharkhand Health Society
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MESSAGE

Communication as we know is a powerful force for public education and behaviour change. To improve the quality of life of our children, women, families and communities, it is important that we look at strategic communication as an indispensable tool. Effective public policy and communication strategies, in the long run, establish new community norms and provide support for stronger and more effective policies and programmes.

Both Government and non-Government sector spends substantial amount of resources each year on designing and implementing behaviour change communication (BCC) campaigns on health issues. Given the role of IEC/BCC in causing social, behavioural and normative changes related to maternal and child health, adolescent health, family planning, and reproductive health, it has been included as an integral part of NRHM and RCH-II activities also.

I'm glad that recognizing the long standing need, ITAP project (Futures) from USAID has taken this initiative to develop the Jharkhand Behaviour Change Communication Strategy for health. This document which has been developed through an in-depth analysis, consultation and inputs from Government, non-Government and diverse stakeholders working in Jharkhand will provide a blueprint for designing and implementing all our IEC /BCC initiatives.

I would encourage the health department officials to continue with their relentless effort to use all possible tools to meet the objectives of our health policy which will help us come closer to our ultimate goal of "health for all".

(Bhanu Pratap Shahi)



Dr. Pradeep Kumar
Secretary



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Health, Family Welfare &
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MESSAGE

Jharkhand is predominantly a rural state with majority of the population residing in the rural and far to reach areas. More than half of the population belongs to the disadvantaged and marginalised groups. Poverty is pervasive; literacy is low and infrastructure and communication facilities are poor. There are wide cultural variations and people living in remote and inaccessible areas speak more than fifteen dialects. Jharkhand is rich in mineral reserves and forest cover. However, the benefits of such vast natural resources have not percolated down to the masses. Given these conditions, providing high quality health services is a challenge in the state. Often, poor communication efforts have acted as a barrier in meeting the challenges.

Several efforts have been initiated towards this in the state to realign the communication approaches being employed in the state and improve the health seeking behaviour. However, absence of a holistic strategy has proved to be a major impediment.

One of such efforts is this Behaviour Change Communication strategy document. This document has been developed with technical support from ITAP, Futures and in collaboration with Department of Health and Family Welfare, Government of Jharkhand. All the key stakeholders who are playing a major role in the health sector have contributed in a participative manner for development of this strategy document. A total of six key issues covering Maternal Health, Child Health, Family Planning, Adolescent Health, Tribal Health and Urban Health have been covered.

I commend the efforts of ITAP team to have led the process of bringing together all stakeholders working in the state for two state level workshops aptly titled “Parivartan”. This strategy document is a reflection of the commitment of the government to improve the health status and overall well being of its people in the state.


(Dr. Pradeep Kumar)



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FOREWORD

With growing evidence and understanding of the integral role of communication on health behaviour change, strategic Behaviour Change Communication (BCC) has become an important component of any successful health programme.

The second phase of the Innovations in Family Planning Services Project (IFPS), launched in October 2004, focuses on improving access to affordable quality family planning and reproductive and child health services. Creating demand for reproductive health services and products, as well as, stimulating health behaviour change is one of five key focus areas of the IFPS project.

The Jharkhand Communication Strategy provides a conceptual framework for the development and implementation of behaviour change programmes which are specifically designed to meet the reproductive and child health needs of the state. The strategy is intended for use by state-level decision makers and planners, district-level managers, and non-governmental organisations (NGOs) responsible for implementing information, education and communication (IEC) activities in the state of Jharkhand. The document also covers the critical components of social mobilisation, training, implementation plan development and monitoring & evaluation.

The state communication strategy was drafted based on discussions and experience sharing from two state-level consultative workshops held with the active participation of the Department of Health, NGOs, other development partners, and key stakeholders working in the health sector Jharkhand.

I am very pleased to see the active leadership being provided by Jharkhand Government representatives and Health Department officials to help make this initiative a success. The contribution of ITAP and JHU in the facilitation and design of the final document has also been instrumental in moving the statewide consultations and strategy development process forward. I hope that this strategy will be a relevant and useful tool for the state in meeting its objectives under NRHM and, more broadly, to the overall improvement of health outcomes in the state.

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EXECUTIVE SUMMARY

Given the role of strategic communication in achieving the NRHM objectives and the need to move from an event-oriented and isolated approach, the task of developing a State BCC Strategy was undertaken by ITAP/USAID under the leadership of Department of Health, Jharkhand, with inputs from NGOs and all stakeholders working in the state under various health programmes. The document has also benefited immensely from the expert guidance of the team from Johns Hopkins University, Baltimore.

To gain insights, a detailed situational analysis was carried out by studying the current health scenario, IEC efforts till date, the gaps, etc. The key objective of this communication effort is to enhance awareness, generate demand and facilitate behaviour change in specific target populations for health services related to Family Planning, Maternal Health, Child Health, HIV/AIDS and ARSH and to improve the indicators related to Infant Mortality Rate, Maternal Mortality Rate and Total Fertility Rate.

With the aim to develop a comprehensive strategy on the above listed health issues, the participants at two state level workshops worked in groups, to develop the BCC matrix to identify the primary and secondary audiences for the communication, underlying social barriers to be addressed and the tools & channels recommended to achieve the desired behaviours. These outputs were further studied and developed into a proposed strategy framework, which has the ability to work as a blueprint guiding the IEC/BCC campaigns and efforts for the state and other partners. The strategic plan also includes the detailed implementation framework and a monitoring and evaluation plan.

Under the specific health issues, strategies have been defined for focused and targeted interventions, e.g., Family Planning covers unmet need for spacing, unmet need for long term methods and knowledge of STI/RTI; Maternal Health covers anaemia, ANC follow up and compliance, haemorrhage, sepsis and obstructed labour; HIV/AIDS covers knowledge and awareness, understanding needs of high-risk groups, reducing stigma and issues on quality service; Child Health covers colostrum feeding, exclusive breastfeeding, care for the newborn, immunisation; ARSH covers early pregnancy, age at marriage, contraceptive use, RH hygiene.

Issues on tribal and urban health were also discussed during the workshops and some valuable suggestions from the participants have been captured.

INTRODUCTION

Strategic communication is a critical and integral component of National Rural Health Mission (NRHM)/ Reproductive and Child Health (RCH)-II activities, for facilitating social and individual behaviour change for positive health outcomes. This comprehensive strategy provides a framework for information, education and communication (IEC), social and behaviour change communication (SBCC), and interpersonal communication (IPC) to facilitate social, behavioural, and normative changes related to maternal, child, and adolescent health, family planning, and reproductive health in Jharkhand.

The Population and Reproductive Health Strategy of Jharkhand strongly advocates such a strategic communication programme to support the NRHM/RCH-II programme's objectives, which include the reduction of the infant mortality rate (IMR), the maternal mortality ratio (MMR), and the total fertility rate (TFR). While the current strategy addresses family planning and reproductive health, child health, maternal and neonatal health, adolescent health and HIV/AIDS, it was agreed upon, through discussions with stakeholders, that

this will be treated as a live and dynamic document that will continue to incorporate other health issues under NRHM, with feedback from key stakeholders in the state of Jharkhand.

The focus of the RCH programme is to reduce the IMR, MMR, and TFR and to improve upon a number of other reproductive health indicators for specific audiences, including the increase in couple protection rate (CPR). Steps are being taken to accelerate and enhance the programme's capacities to address the health needs of people, particularly at the grassroots level, as envisioned in numerous strategies and policies including the National Population Policy (NPP) 2000, State Policy, Millennium Development Goals and NRHM/RCH-II.

Any comprehensive SBCC strategy should accomplish the following:

- **Address underlying causes of identified health problems and issues,** recognizing that in order to motivate health-seeking behaviours, we need to create an enabling environment at the household, community, and policy levels.
- **Link the development, shared understanding and ownership, implementation, monitoring and evaluation of appropriate communication initiatives** and activities through mass media, group and interpersonal channels with service provision.
- **Create demand for services and healthy behaviours and help ensure quality services** by working with providers to improve interpersonal communication and counselling, partner with the private sector to address supply of commodities and services, as well as brand and promote accredited services which utilise clinics as a place for patient empowerment and education.
- **Identify primary, secondary and tertiary audiences who are affected by or involved in health problems and issues,** reaching them through multiple and integrated media channels. Audiences may include health providers, NGOs, community-based organisations (CBO), women and men of reproductive age, children and adolescents, as well as those who have the power

to influence the health status of others, such as mothers-in-law, older men and women, community leaders, and the public and private sectors. Strategic communication includes advocacy for policy

change, behaviour change communication, and social mobilisation of community leaders and decision makers, allies and partners such as the private sector – all of whom become involved in facilitating

the desired health outcomes. Furthermore, it contributes to institutional strengthening and capacity building of providers and functionaries in the health, family welfare and allied systems.

Chapter II

DEVELOPING A COMMUNICATION STRATEGY FOR JHARKHAND

In response to the need for a communication strategy by the RCH-II and NRHM Programme Implementation Plan (PIP), a series of meetings, discussions and workshops with stakeholders, partners, and beneficiaries were conducted by the Jharkhand Health Society and Ministry of Health and Family Welfare (MoHFW), Government of Jharkhand, with support from Innovations in family planning services Technical Assistance Project (ITAP). This consultative process ensured the evolution of a comprehensive yet focused results-oriented communication strategy for RCH-II and NRHM for the state of Jharkhand.

The process included the following steps:

Step 1: The ITAP team organised and facilitated a one-day, pre-workshop meeting on March 13, 2007 with representatives of the Government, AIR, NGOs, International NGOs, and State level agencies involved in developing and implementing SBCC programmes and materials in Jharkhand. The purpose of the meeting was to understand what SBCC activities and programmes are already underway and to analyse lessons learnt by the implementing organisations. The

meeting served as a part of the programme and materials assessment for strategy development.

Step 2: Based on an extensive literature review and findings from the March 13, 2007 meeting, the ITAP team began identifying possible issues and approaches for the communication strategy and met with key Government stakeholders to seek clarification on priorities and key health issues to be addressed in Jharkhand.

Step 3: The programme and situation analysis meeting on March 19, 2007 included a review of State priorities. ITAP had prioritised five

main health issues to be addressed under NRHM: family planning (FP) and reproductive health (RH), child health (CH), maternal health (MH), HIV/AIDS and adolescent health. Participants from the workshop were pre-assigned, based on their expertise, to select health issues under each programme area. Each group conducted a causal analysis to identify underlying causes for each health issue. The groups developed individual strategies and presented them in a plenary session for further discussion and prioritisation.

Each group then developed a strategy matrix which consisted of key health issues under their programme area, underlying causes, target audiences,





Communication Strategy Development Workshop

The communication strategy development workshop initiated by the Health and Family Welfare department and supported by ITAP adhered to a results-oriented framework. The workshop was organised on 19-20 March 2007 and was followed by an implementation design workshop on 29 May 2007, in Ranchi. Both workshops involved the active participation of stakeholders from the Health Department, NGOs and agencies that provide technical and financial assistance in the state.

expected behaviours, and media channels and activities to address the identified underlying causes. Measurable behavioural indicators for each audience were identified at a later point by communication researchers during strategy finalisation.

Step 4: Improving intra-communication is one of the key goals of NRHM. Intra-communication constitutes effective communication about NRHM across different stakeholders. Shared and equal access to knowledge and key documents, and skills to effectively communicate about NRHM across multiple levels within the Government system is defined as intra-communication. NRHM employs various interventions including web-based information, sharing space and Management Information Systems (MIS) implementation across multiple

divisions of the Government, to meet the communication and information needs of all involved stakeholders.

Strategic communication is an essential ingredient for building the skills of health care providers at all levels, to educate them about the communication processes and tools required for effective advocacy of NRHM services. The need for State capacity building in SBCC had been identified during a series of one-on-one meetings with Government stakeholders, prior to the conduct of the programme and situation analysis meeting.

The ITAP team, therefore, invited key stakeholders (Government and NGOs) to a post-workshop one-day meeting to identify capacity building needs and make recommendations for ensuring capacity building during the implementation of the communication strategy.

The objectives of the workshop were:

- To facilitate a situation analysis of the current practices of select health programmes to highlight the gaps and concerns;
- To share experiences of communication efforts to date for the issues and areas identified;
- To develop a comprehensive communication strategy for the specific issues under the NRHM such as Family Planning and Reproductive Health, Maternal Health, Child Health, Adolescent Health and HIV/AIDS for the State of Jharkhand;
- To facilitate development of an implementation and action plan for the communication strategy.

The participatory workshop included representatives of Government departments, the media, NGOs, development partners and communication experts. The first workshop

explored the role and importance of strategic communication based on evidence. It also prioritised the areas to be addressed, identified barriers to the adoption of health behaviours as well as promising interventions.

The second workshop focused on the development of an implementation plan for the communication strategy. The communication strategy presented here evolved from the inputs from the participants and further reviews from Government of Jharkhand, ITAP and other partners.



SITUATION ANALYSIS

The ITAP team conducted a secondary literature review of demographic and epidemiological state level surveys that shed light on current health practices and knowledge on maternal, & child health, family planning, nutrition and other key health issues related to IMR, MMR and TFR. The programme analysis consisted of an assessment of current SBCC activities and materials in the state of Jharkhand that address NRHM programme areas. The ITAP team also conducted an analysis of mass media access and media habits of the target audience.

3.1 ABOUT THE STATE

Jharkhand, formerly a part of Bihar state, was formed on November 15, 2000, with Ranchi as its capital. Jharkhand is the 28th state of the Indian Union. The new state largely comprises the forest tracks of Chhotanagpur plateau and Santhal Parganas, and has distinct cultural traditions.

The total geographical area of Jharkhand is 79,714 sq. km. with a population of 26.9 million (Census of India, 2001) and a sex ratio slightly higher than national average (941 females per 1000 males). There are 24 districts, 211 blocks and 32,621

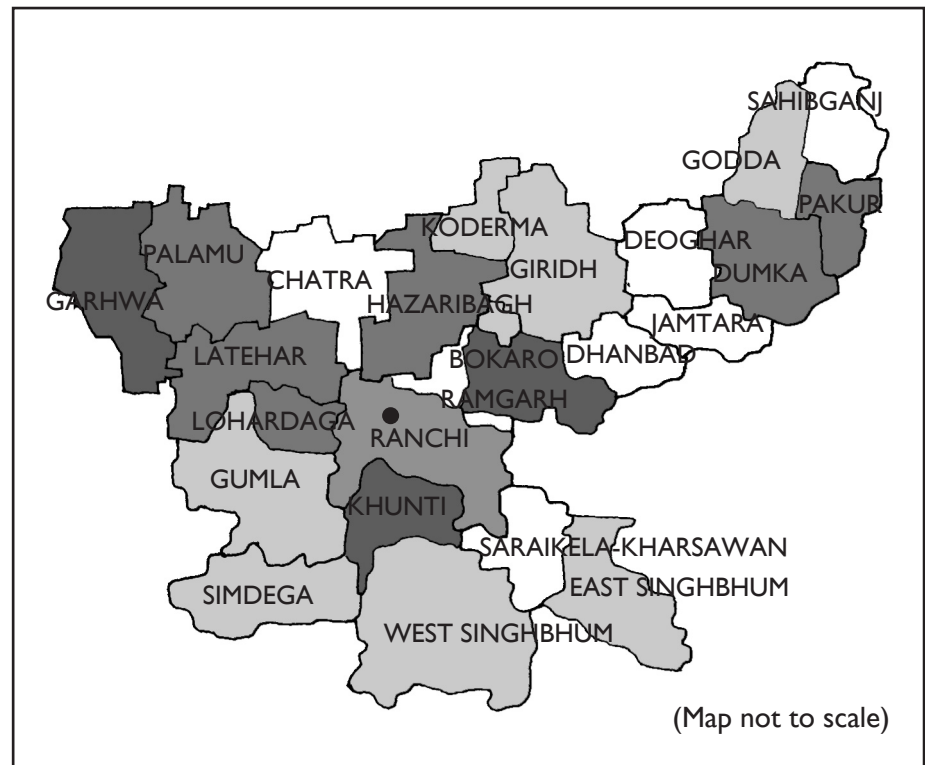
villages. The state has population density of 338 per sq. km. (compared to the national average of 324 per sq. km.) with wide variation among districts. The decadal growth rate of the state is 23.36 percent (compared to 21.54 percent for the country) which is slightly higher than the national level.

The state of Jharkhand is divided into five regions: Santhal

Parganas, Daltanganj, Kolhan, North Chhotanagpur and South Chhotanagpur. The state has 32 tribes, which comprise 27 percent of the total population of the state.

Among the tribal population, the Santhal, Oraon, Munda and Ho are the major tribal groups in Jharkhand. Nine other indigenous tribes constitute only 3 percent of the total tribal population.

Figure 1: Map of Jharkhand



Source: www.jharkhand.gov.in

Table 1: Demographic, Socio-economic and Health Profile of Jharkhand

Characteristics	Jharkhand	India
Total Population (in millions)	26.9	1028.6
Decadal Growth (%)	23.36	21.54
Sex Ratio	941	933
Population Below Poverty Line (%)#	N.A.	26.10
Scheduled Caste Population	11.8	16.2
Scheduled Tribe Population	26.3	8.2
Female Literacy Rate (%)	38.9	53.7
Crude Birth Rate*	26.8	23.8
Crude Death Rate*	7.9	7.6
Total Fertility Rate**	3.5	2.9
Infant Mortality Rate*	50	58
Maternal Mortality Ratio**	371	301

Source: Census of India 2001.

MoHFW, Govt. of Jharkhand 2007. *SRS Bulletin October 2006. **MoHFW Govt. of Jharkhand 2008

Note: N.A.= Not Available

Based on 20 years of experience in strategic health communication, we know that in resource-poor health care environments, it is critical to promote only those services which are of an approved standard of quality and which are widely available, in order to avoid making false promises and possibly triggering a backlash from potential clients.

Tables 2 and 3 demonstrate the health infrastructure, shortfall of medical & paramedical staff and other health institutions in Jharkhand. These two tables reveal significant shortcomings in the state's ability to meet the health needs of the population.

3.2 HEALTH INDICATORS

The TFR of Jharkhand is 3.3 (NFHS-3, 2005-06), an increase from 2.8 during the 1998-99 (NFHS-2). The TFR differs by geographic (urban/rural) and educational characteristics.

The TFR among urban women is 2.3, while among rural women it is 3.7. Educated women who have completed 10th class or more have a below replacement level of fertility (2.04 per woman) compared to 3.9 children for illiterate women.

The MMR is higher than the national average at 371 (SRS 2001-03). The health care infrastructure, while undergoing improvement, falls short of providing adequate health facilities, personnel and services to Jharkhand's population.

Table 2: Health Infrastructure of Jharkhand

Health Infrastructure	Number
Sub-centre	4,462
PHC	193
CHC	7
APHC	368
FRU	37
District Hospital	24
Sub-divisional Hospital	10
Shortfall (Medical & Para-medical Staff)	
Doctor	1,412
Lab Technicians	505
X-Ray Technicians	59
Staff Nurse	434
Health Supervisor	1,196
Male Health Worker	4,809
Female Health Worker	1,949
Pharmacists	703

Source: MoHFW, Govt. of Jharkhand

Table 3: **Health Institutions in Jharkhand**

Health Institution	Number
Medical College	3
RFPTC	1
ANM Training Centres	11
Ayurvedic Dispensaries	122
Unani Dispensaries	30
Homeopathic Dispensary	54
Other Public & Private Sector	5
Diagnostic Centre*	5
Trauma Centre*	5

Source: MoHFW, Govt. of Jharkhand.

Note: *In Plan

Inequitable access to health care must be addressed to ensure that health facilities and services adequately reach rural and tribal areas. In addition, other forms of health services such as Ayurvedic, Homeopathic and Unani dispensaries, and the upcoming Diagnostic Centre & Trauma Centre can be utilised for educating and motivating individuals on healthy behaviour.

3.3 EXPOSURE TO MASS MEDIA

In India, women are less likely than men to be regularly exposed to any media. In Jharkhand, the proportion without any exposure to media is the highest in the country, for both women (60 percent) and men (40 percent).

Table 4 shows that about one-fifth (20 percent) of the population watch television and as few as 19 percent listen to radio at least once a week. The proportion of exposure to television is almost negligible among the scheduled tribal population (5 percent);

Table 4: **Exposure to Mass Media by Selected Background Characteristics, Jharkhand**

Background Characteristics	Read a newspaper or magazine at least once a week	Watch television at least once a week	Listen to the radio at least once a week	Visit the cinema/theatre at least once a month	Not regularly exposed to any media
Residence					
Urban	27.8	66.1	31.9	13.1	27.9
Rural	5.1	10.4	14.9	1.4	80.2
Education					
Illiterate	0.0	10.5	10.2	0.8	83.8
Literate	23.3	38.6	32.9	5.8	42.3
Middle school complete	39.8	50.0	43.2	71.2	22.6
High school complete and above	62.8	72.4	59.6	23.6	15.7
Religion					
Hindu	9.4	20.0	18.5	3.6	70.8
Muslim	5.4	23.7	11.5	2.2	72.6
Other	10.0	12.3	21.8	3.3	74.8
Ethnicity					
Scheduled Caste	5.4	22.4	14.0	1.7	71.1
Scheduled Tribe	2.6	4.6	10.7	1.1	87.8
OBC	7.4	21.2	18.7	2.7	69.1
Others	30.2	45.3	34.1	12.0	43.9
Total	9.0	20.0	17.8	3.4	71.2

Source: National Family Health Survey-2 (1998-99)

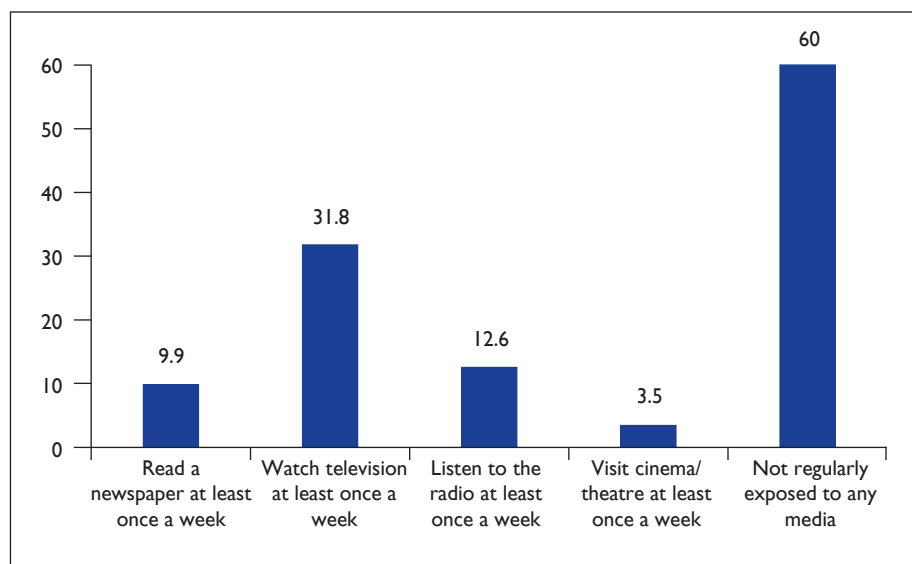
slightly over one-fifth of the scheduled caste population (22.4 percent) is exposed to television at least once a week.

Exposure to radio is slightly higher among the scheduled tribe population vis-a-vis exposure to television. About 14 percent of the women belonging to the scheduled caste category listen to the radio at least once a week.

The exposure level in urban areas is much higher than in rural areas. According to NFHS-3 (2005-06), more than 80 percent of men and women in urban areas are exposed to some form of mass media.

Figure 2 demonstrates that in Jharkhand, 6 out of every 10 women are not regularly exposed to any media. Compared to the other media, exposure to television is high among women.

Figure 2: **Women’s Exposure to Mass Media in Jharkhand**



Source: National Family Health Survey-3 (2005-06)

3.4 REPRODUCTIVE AND CHILD HEALTH SCENARIO

According to NFHS-3 (2005-06), the TFR in Jharkhand is 3.3. Only 31 percent of married women (ages 15-49) use any modern method of contraception. Of these women, 23 percent have opted for female sterilisation, 4 percent use the oral contraceptive pill (OCP), 3 percent reported that their husband is using condoms, 0.6 percent of women use intrauterine devices (IUD), and less than a percent (0.4 percent) reported that their husbands are sterilised. Condom usage is higher in urban areas (7.9 percent) than in rural areas (1.2 percent). Female sterilisation as well as IUD and OCP usage is higher in urban areas.

According to the DLHS RCH 2002-04 survey, the majority of current users of modern contraceptives obtain their method from Government sectors (57 percent), followed by the private sector (26 percent), chemists (15 percent) and others (2 percent).

3.4.1 Maternal Health

Jharkhand has a higher maternal mortality ratio than the national average. The MMR is around 504 per 100,000 live births. The major cause of these deaths is haemorrhage, sepsis, anaemia, and obstructed labour (CARE, 2006). The DLHS RCH 2002-2004 survey found that 76 percent of women reported complications during delivery. Of these women, 55 percent reported obstructed labour, 24 percent prolonged labour, 22 percent premature labour, 7 percent excessive bleeding, and the remaining 5 percent breach or other complications. Around 44 percent of women reported post-delivery complications (DLHS, RCH, 2002-04). Given the high percentage of women reporting complications during delivery and post-delivery, the acceptability of institutional delivery is disproportionately low (only 14 percent of women interviewed in the NFHS-3 survey reported availing institutional delivery). About 54 percent of institutional deliveries

occur in urban areas and 11 percent in rural localities.

According to the NHFS-3, about 36 percent of all mothers interviewed had at least three antenatal care (ANC) visits during their last pregnancy, of whom 67 percent were from urban areas and 29 percent from rural areas. Only 15 percent of mothers interviewed during NFHS-3 reported consuming iron and folic acid (IFA) tablets for 90 days during their last pregnancy, with a higher percentage in urban areas (25.9 percent) than rural areas (11.9 percent).

The Communication Needs Assessment conducted by CARE in 2006 found that women generally report their pregnancy to their mothers-in-law. Women experiencing problems during pregnancy prefer using home remedies before going to the doctor, auxiliary nurse midwife (ANM) or other trained health professional.

In certain communities such as in the Dumka district, people are apprehensive about disclosing their pregnancy because they believe that such a disclosure might lead to a miscarriage. Therefore, reporting a probable pregnancy to an Anganwadi worker (AWW) or ANM is rare in most of the villages, partly because of such misconceptions, but also due to the unavailability of workers at the village level.

The women are aware that the complete gestation period takes nine months followed by delivery. In Lohardaga, the people use indigenous methods of keeping track of the nine months, such as counting the number

of full moons which equate to the months of the pregnancy.

The study found that young women universally accept that resting during pregnancy is important; however, it is not always possible to adhere to this practice due to household and other work. ANMs and AWWs are available only in certain districts. Traditional healers and medicines are an integral part of the culture and they are the main providers in areas without ANMs. Thus, there is a need to take these stakeholders into consideration in planning any communication effort. The women also reported experiencing night blindness during pregnancy and preferred to see a TBA (traditional birth attendant) rather than a doctor during their pregnancy.

3.4.2 Child Health

According to the NFHS-3 data, there were 69 infant deaths per 1,000 live births during the five years prior to the survey. Over half of the children under six months of age were exclusively breastfed (57.8 percent) and 65 percent of the children between 6-9 months of age were breastfed, with complementary feeding. Colostrum feeding in rural areas at 9.5 percent is almost half that of colostrum feeding in urban areas (17 percent). However, exclusive breastfeeding for children under six months is higher in rural areas (61.8 percent) than urban areas (42.5 percent).

More than 20 percent of children suffer from diarrhoea and acute respiratory infections in Jharkhand. Eight out of every 10 children suffer from some form of anaemia, and more than half the children suffer

from moderate to severe anaemia. Only 34.5 percent of the children are fully immunised, with almost 80 percent of the children having received 3 doses of polio vaccine and 73 percent having received BCG vaccines. 40.3 percent of the children received all three doses of DPT and 48 percent received the measles dosages (NFHS-3, 2005-06).

3.4.3 Adolescent Health

Jharkhand has a diverse youth population in terms of ethnic origin, religion, and socio-economic status. There are 32 scheduled tribes and hundreds of other communities each with distinctive customs, cultures, and values. Such diversity requires customised communication initiatives in order to appropriately engage young people on key health issues.

Some of the key concerns related to the youth in Jharkhand are thought to be lack of educational facilities, information and recreational avenues, as well as inadequate health services. In addition, there are issues of gender discrimination, superstition (including belief in witches), unsafe sex, unsafe motherhood, and unsafe abortion. These issues will need to be addressed, if population stabilisation goals - such as spacing and delaying age at marriage and at first birth - and HIV/AIDS prevention efforts are to gain ground. Such goals can only be achieved in a scenario where youth are fully informed and can make responsible choices about sexual and reproductive matters.

3.4.4 HIV/AIDS

The prevalence of HIV/AIDS among ANC mothers in Jharkhand is 0.18 percent (NACO, 2006). According

to NFHS-3, only 52 percent of ever married men and 29 percent of ever married women between the ages of 15-49 had ever heard of AIDS. There is a major awareness gap about AIDS between the urban and rural population. Around three fourths (72 percent) of married women in urban areas and 16 percent of married women in rural areas were aware of AIDS. Similarly, 89 percent of married men in urban areas and 42 percent in rural areas had ever heard of AIDS. The survey found that 46.7 percent of men and 21.8 percent of women knew that consistent condom use can reduce their chances of getting HIV/AIDS (NFHS-3, 2005-06).

While HIV/AIDS has not become a generalised epidemic in the state, two studies (CEDPA, 2003; Mukhopadhyay, 2004) highlight the need to address the reproductive health (RH) needs of the three most at-risk populations due to migration: girls and women engaged in sex work, truckers, and men who have sex with men (MSM). Furthermore, HIV/AIDS programme research has shown that in low prevalence regions, it is more effective to address the needs of most at-risk populations (rather than the general public) in order to mitigate the impact of HIV. The strategy, therefore, focuses on the three at-risk populations mentioned above.

3.4.5 Tribal Health

The state's scheduled tribe populations have unique socio-cultural characteristics and health behaviours. There is limited access to, and availability of, health services for these populations, which is further compounded by their low

acceptance of services. There are about 32 tribal groups with distinct cultures and dialects. Nine of the primitive tribes will become extinct if appropriate measures are not taken. Currently, their population numbers only 1,92,425.

A comprehensive strategy for health communication in Jharkhand will provide the basis for the development of a specific communication action plan for reaching the primitive tribes.

3.4.6 Urban Health

In view of the increasing urbanisation, growth of slums and low income population in the cities, the provision of consistent and credible primary health services of acceptable quality in urban areas has emerged as a priority for both the Central and State Governments. The focus up to this point has been on the development of a three-tiered rural health delivery system.

Health indicators of people living in slums are poor. Demand generation Information, Education and Communication (IEC) activities should be designed specifically to facilitate behaviour change, particularly for the adoption of family planning methods as well as of other maternal, child health and adolescent health behaviours that are directly linked to RCH objectives.

No specific efforts have been made to create a well-organised health service delivery structure in urban areas, especially for poor people living in slums. RCH indicators of urban slums are worse than the urban average. Recognizing the

seriousness of the problem, the Government of Jharkhand has identified urban health as one of the thrust areas in the Population and Health Policy and the RCH programme.

3.5 COMMUNICATION EFFORTS TO DATE

The formulation of state health and population policies have provided a platform from which organisations can initiate communication efforts to address adolescent, child, maternal and sexual health issues in Jharkhand. Most Government and NGO programmes think of communication in narrow terms. Generally, communication efforts have consisted of print materials, though there have been efforts to use mass media and participatory communication techniques. For example, NEEDS, an NGO, utilised participatory photography through their life skills education programme for adolescents, with print materials for improving RH knowledge. Doordarshan produced “Kalyani” to address multiple health issues. All India Radio airs a weekly interactive radio programme called “Swasth Jharkhand Sukhi Jharkhand”, which focuses on family planning and reproductive health issues. NGO programmes on tuberculosis, malaria and HIV have utilised print, mass, folk and outdoor media.

Through discussion of lessons learnt, the ITAP team and stakeholders concluded that IPC is the most effective channel of communication for ensuring behaviour change. The family welfare/RCH programmes have relied heavily on ‘frontline workers’, who engage in face-to-face communication with their clients,

thereby achieving the objectives of their respective communication strategies. Participants also noted that combining mass media with IPC has contributed to broad reach of messages and has influenced social norms.

While there have been some attempts at coordination, it was clear that many communication efforts were ‘stand alone.’ There was a lack of synergy between multiple channels and programmes. Participants also noted the absence of communication evaluation, lack of formative research for intervention design, low capacity in media planning and materials dissemination, lack of provider training within the state on IPC, lack of training in use of materials for service providers, and need for understanding the role of strategic communication.

The following section highlights some of the gaps in current communication programming in Jharkhand. These gaps reflect the need for a comprehensive strategy, which allows stakeholders to create synergy across programmes and use multiple channels of communication to maximise reach and depth.

3.5.1 Programme Analysis: Lessons Learnt and Gap Analysis

The most salient feature of communication programming for the population/RCH programmes is a **focus on inputs, as distinct from results**. The change in the information environment has not been incorporated into a strategy.

The focus on inputs also has given **priority to individual messages**

and specific interventions, rather than to the development of an integrated strategy. Individual messages have been conceived and translated into materials on specific issues, resulting in a wide range of materials with seemingly little connection. The absence of a comprehensive and coordinated strategy underlying these efforts may have resulted in diluted impact, inefficient use of resources, and information overload for audiences.

Even with the emphasis on print materials, there has been relatively little monitoring of their actual utilisation or effectiveness. Posters and pamphlets are printed and dispatched, wall signs painted and booklets created – but whether they are received in time, actually seen by the audience they are meant for or whether other methods and materials would have been more suitable, are questions that are not often raised. Utilisation has been equated with expenditure.

In keeping with the technical – as opposed to client – orientation of the programmes, communication **messages have been prescriptive, rather than motivating.** A key requirement for successful behaviour change communication is that messages should recognise the social and cultural setting of the audience, describe the advocated behaviour with clarity and convey the reason why the audience should adopt the advocated behaviour.

The **production quality of materials has been inconsistent.** The look, feel and sound of communication materials play an

important role in determining effectiveness. Materials of high production quality are more likely to be appealing, attractive, and engaging to target audiences.

The selection and coordinated use of different media – such as television, radio, posters and folk theatre – is a crucial decision in implementing the communication strategy. This review leads to the conclusion that there has been **relatively little media planning** in most cases.

Since communication strategies have emphasised inputs, **outcomes have rarely been measured.** Depending on the issue and the target group, a comprehensive, results-oriented communication strategy could attempt to place an item on the community agenda, raise levels of knowledge, build attitudes and encourage the adoption of specific behaviours. Tracking a communication strategy in this manner enables identification of the barriers to behavioural outcomes and allows for corrections.

3.5.2 Strategic Communication
Stakeholders in the process agreed that not only does much more need to be done in the area of communication, but that a strategic, sustained, and coordinated response is needed. While the older term, IEC, signifies more a collection of activities, strategic communication is systematic and research-based, requiring the extensive use of data, careful planning, participation from multiple stakeholders, creativity, high quality programming, and linkages to other programme elements and levels to stimulate positive and measurable

behaviour change among target audiences (McKee et al., 2004).

In strategic communication, there are three distinct and useful terms which represent three broad, inter-related strategic approaches. These are: **Advocacy, Social Mobilisation and Behaviour Change Communication (BCC).**

Advocacy is a continuous and adaptive process of gathering, organizing, and formulating information into argument to be communicated through various interpersonal and media channels with a view to raising resources or gaining political and social leadership acceptance and commitment for a development programme, thereby preparing a society for its acceptance (McKee et al., 2000).

Advocacy is used to garner political commitment and policy change, to mobilise human and financial resources and to accelerate the implementation of programmes. The process of establishing such a movement is called social mobilisation. This term has been defined and understood in various ways. The definition most aligned with the thinking in this section, however, is as follows:

Social mobilisation is a process of bringing together all feasible and practical inter-sectoral social partners and allies to determine felt-need and raise awareness of and demand for a particular development objective. It involves enlisting the participation of such actors, including institutions, groups, networks and communities, in identifying, raising, and managing

human and material resources, thereby increasing and strengthening self-reliance and sustainability of achievements (McKee et al., 2000).

Building a multi-sectoral response entails the involvement of all levels of Government, NGOs, CBOs, foundations, service clubs, the private sector (including retail and manufacturing), the informal sector, and financial services. It also means collaboration among public sectors that are often vertically organised: health, nutrition, agriculture and fisheries, education, social services, law, sports, media, culture, children and youth, gender, media, communications and transportation, uniformed services etc. This is not to say that each and every member of these categories, levels, and sectors must work together from the start, but that there exist numerous opportunities for partnering and coordination to extend the reach of messages and avoid duplication of costs.

Social mobilisation may also include mobilisation at the community level or community mobilisation. This approach has many definitions, including the following:

Community mobilisation is a capacity-building process through which community individuals, groups, or organisations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others. (Health Communication Partnership, 2003)

Social mobilisation and advocacy are necessary, but not sufficient

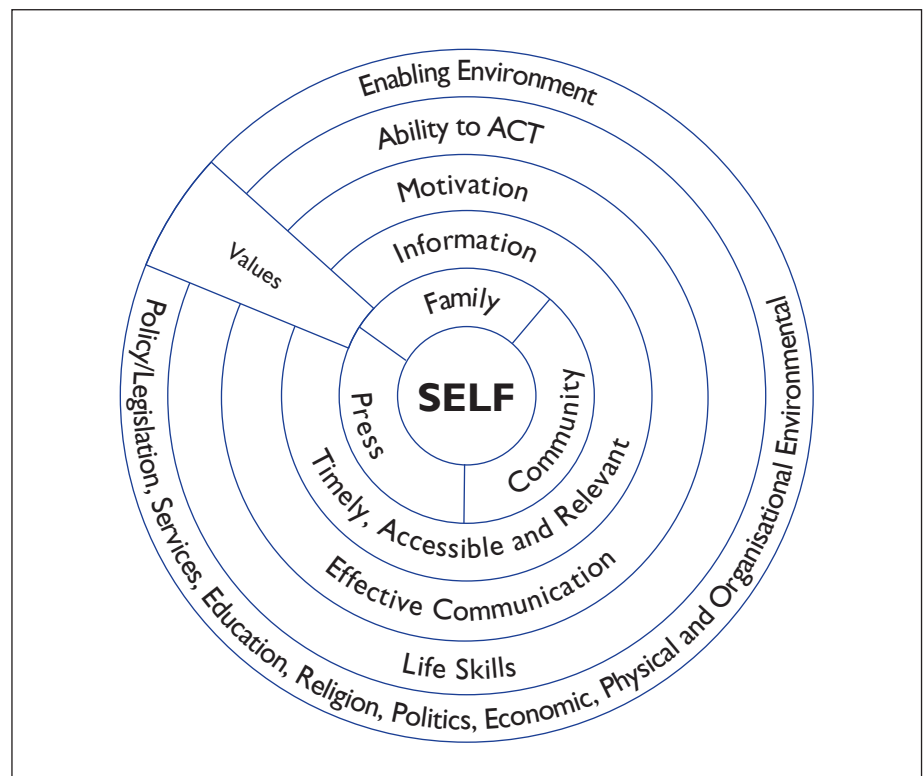
components of strategic communication for social and individual behaviour change. There is a third concept, behaviour change communication (BCC), which has been defined as:

Behaviour change communication is a research-based, consultative process of addressing knowledge, attitudes, and practices through identifying, analysing, and segmenting audiences and participants in programmes and by providing them with relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group and mass-media channels, including participatory methods (Adapted from McKee et al., 2000).

BCC with a focus on adolescents and youth is sometimes called **communication for behaviour development and behaviour change**, in light of its emphasis on promoting the development of new and healthy behaviours, as opposed to changing the established unhealthy adult behaviour.

Evidence from around the world consistently demonstrates the important influence of communities and social organisations on individual behaviour change. Sustained behaviour change requires going beyond the individual to address social factors that influence individual behaviours. While BCC addresses the individual and their families, social mobilisation and advocacy are tools

Figure 3: **Behaviour Development and Behaviour Change in the Social and Environmental Context**



Source: McKee et al. (2000 a)

that influence social and structural changes needed to facilitate individual behaviour change.

At the individual level, strategic communication is needed to address issues of awareness, attitudes, knowledge, beliefs, acceptability; at the structural level, service delivery level communication can be used to achieve results on issues of access, cost recovery, quality of care, and availability; at the social and community level, communication

may influence norms that form the undercurrents of a behaviour, such as gender or cultural norms. Effective communication identifies for the audience the tangible, immediate and personal benefits of adopting the intended behaviour. The following social and behavioural communication model provides a framework for understanding the process for behaviour change.

Figure 3 depicts an inner social environment that must be influenced in order for individual behaviour

change to take place. It also shows that people need timely, accessible and relevant information. But mere information is not enough; people must be motivated through effective communication programmes, which focus on their needs, emotions, motivations, and feelings of self-efficacy. They require the skill to act and the confidence to do so, elements often overlooked in simple IEC strategies. The enabling outer environment allows for sustained social change, as detailed on the outer ring of the model.

COMMUNICATION OBJECTIVES

The communication strategy for Jharkhand RCH/NRHM has the following three strategic objectives:

1. To enhance awareness, generate demand and facilitate behaviour change in specific target populations for health services related to FP, MH, CH, HIV/AIDS and adolescent reproductive and sexual health (ARSH), to improve indicators of IMR, MMR and TFR.
2. To build trust in and improve the image of the health system, by increasing the IPC skills of providers through training and capacity building, and by creating linkages between the private and public sectors to ensure quality of services.
3. To create an enabling and supporting environment through community-based dialogue, advocacy, and social mobilisation.

4.1 AUDIENCE SEGMENTATION AND BEHAVIOUR ANALYSIS

Men and women of reproductive age are the primary target audience for the communication strategy. This group will be further segmented

by urban, rural, tribal and other characteristics.

Primary Target Group

Men and women in reproductive age group

Secondary Target Group

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

It is crucial to understand the relationship of the audience with their peers, relationship of the audience with secondary target groups, the influence of secondary target groups on the audience and the interaction among the secondary target groups regarding the audience.

Audience Segments

The National RCH-II PIP has suggested that the following six priority groups should be targeted:

- **Couples with one or more children** will determine national RCH outcome in the short to medium term.
- **Couples wishing to have no more children** constitute a prime target group for SBCC.
- **Mothers-in-law** perceived as key decision makers and

influencers would be another prime target group.

- **Adolescents** constitute a priority target group because they constitute 23 percent of the population; they are physically vulnerable and relatively more amenable to change.
- **Service providers in the public and the private sector** determine the accessibility, equity, quality and availability of care. They will be targeted to change their behaviour to become more client-centred.
- **Panchayati, religious and other village leaders** are important gatekeepers of information flow and potential facilitators for removing obstacles to behaviour change (such as gender preference or age of marriage for girls).
- **Media** as an audience and a tool for advocacy will increasingly play an important role in providing information and projecting a positive image of providers and services.
- **Private sector advocacy and partnerships** will open up market opportunities and enhance service delivery quality and the accessibility of contraceptives and other RH services.

COMMUNICATION STRATEGIES

Traditional IEC programmes tend to focus on giving information and creating awareness. SBCC is a wide range of activities and interventions targeted towards specific individuals and groups that are intended to facilitate and promote changes in behaviours. SBCC uses a multi-channelled and reinforcing approach to create social conditions that encourage healthy behaviour among target audiences. SBCC is not a collection of different, isolated communication tactics, but rather a framework of linked approaches that function as part of an ongoing, interactive process.

A carefully planned SBCC strategy ensures that the behaviours identified for change are feasible and realistic, given the social and cultural context in which people live. The starting point, therefore, is to identify current actual behaviours and the context in which they take place (task analysis). The ultimate goal is to create/reinforce social conditions that facilitate and encourage healthy behaviours. Two principles are paramount:

- Behaviours must be doable, given the context and living conditions.
- Behaviours must be amenable to change.

The programme will lose credibility if, for example, it encourages the use of contraceptives that are not available in the programme area. On the other hand, SBCC activities may be used to provide the cues for a community to press for changes in service provision (for example, to demand better services), thus beginning the process of producing 'active consumers' of health care services.

A SBCC strategy may also localise the way in which messages are given and the means of delivery. This strategy advocates using 'multi-channelled' activities that include the use of various mass media channels of communication (e.g., television, radio and print) and more localised 'folk' media and IPC to reinforce messages. One to one communication is highly effective in conveying empathy and respect, addressing specific concerns, and reinforcing messages in the context of everyday life.

5.1 GENDER ISSUES

Sexual and reproductive health is strongly affected by gender norms. Norms favouring male children and promoting women's economic dependence on men contribute to high rates of fertility in many settings. Inability to negotiate sex,

condom use, or monogamy on equal terms leaves the majority of women and girls worldwide at high risk for unwanted pregnancy, illness and death from pregnancy-related causes, and sexually transmitted infections. Research has consistently shown that men play key roles in the spread of sexually transmitted disease, and that women bear greater reproductive health hazards.

Planning for effective SBCC requires that programme managers and media practitioners observe the ways people may be marginalised because of their gender (their defined social role in society), their race/ethnicity, class/caste, and age. These and other factors determine how people experience the health care system and their perceptions of it. Who gets health coverage? What is the perception of services? What does the quality of care for that person or group reveal about widespread and entrenched stereotypes? Are communication activities helping to advance gender quality and equity in society or are they simply reinforcing (whether or not inadvertently) traditional attitudes and values? Are women's or men's concerns being separated from the concerns of society in general?

5.2 PROPOSED APPROACH

- Necessarily selective (prioritised) to choose that which is achievable and feasible
- Highly focused to enable better use of scarce resources
- Phased approach to move consumers from passive to active seekers of information/ health services

5.3 OVERALL MESSAGE THRUST

- Benefit of action/method
- Access/availability of services and information
- Efficacy at individual/community level (It can be done/I can do it)

5.4 MEDIA HABITS OF JHARKHAND

In recent times, the state has witnessed growth in information communication technology (ICT). This growth remains largely in the prominent urban centres; a very low percentage of the population have true access to mass media. In hard to reach rural and tribal areas, current programmes have focused on using local media such as folk media to

reach communities. These media have low reach and frequency, as described earlier in the situation analysis.

5.4.1 Media Strategy

Three factors are crucial in determining a media strategy:

1. **Reach:** The number or percentage of members of a defined audience segment that will be exposed to the message at least once. Reach helps to build momentum quickly.
2. **Frequency:** The average number of times that one person is exposed to a message. Frequency helps ensure message penetration.
3. **Likeability:** Is the channel selected for the communication effort appreciated and liked by the target audience, for the purpose of communicating about health issues?

Consideration of these factors is needed during the development of a media plan.

Health communication for Jharkhand will use the following strategies to ensure greatest impact:

Strategy 1: Integration of mass media efforts with below-line and IPC activities to increase the Opportunity to See (OTS) of the health campaign.

Strategy 2: Use of radio for specific health messages, to ensure maximum reach of the campaign in a cost-effective way for the duration of the campaign.

Strategy 3: Extensive use of IPC and mid-media in rural and hard to reach areas. This strategy may be implemented for a short period due to cost constraints.

Strategy 4: Leverage of existing social networks, festivals and cultural practices to disseminate health information more widely.

Strategy 5: Identification of existing supply points such as chemist outlets, PHC and cinema halls, to reach large number of people with reminder health messages.

COMMUNICATION STRATEGIES FOR PROGRAMME-FOCAL AREAS

The communication framework will be applied to the programme specific health issues, including:

1. Family Planning and Reproductive Health
2. Maternal Health
3. HIV/AIDS
4. Child Health
5. Adolescent Health
6. Tribal Health
7. Urban Health

Each section contains data related to the health issue from the NFHS, followed by a description of the underlying causes of the behaviours and barriers to behaviour change, strategic approach, audiences, desired behaviours, activities and media channels. While the barriers to behaviour change in this document are based on the situation analysis discussions conducted during the workshop, formative research is currently in progress to add to programme planner’s understanding of the barriers and underlying causes of behaviours.

6.1 FAMILY PLANNING AND REPRODUCTIVE HEALTH

Contraceptive knowledge is nearly universal, with 99 percent of all married women knowing of at least one modern family planning method. However, only 31 percent of currently married women

(ages 15-49) use any modern method of contraception (NFHS-3), compared to 48 percent of currently married women on the national level. High awareness of contraception, thus, has not translated into demand and use of family planning.

Approximately 20 percent of married women in Jharkhand have an unmet need for family planning. During the causal analysis, participants contextualised low contraceptive use within socio-cultural influences such as family size norms, religious beliefs, demonstrations of manhood, the desire for a male child, and low age at marriage and first pregnancy. Rumours and misconceptions about family planning methods, lack of availability and access to contraceptives are also underlying causes. These identified barriers will form the basis for future formative research to inform the communication campaigns for family planning in Jharkhand.

Communication has a critical role to play in converting high knowledge and unmet need into actual use.

During the causal analysis, three main sub-health issues were identified for family planning and reproductive health:

- A. Unmet need for spacing methods
- B. Unmet need for limiting methods
- C. Lack of knowledge and treatment of STI/RTI

Each of these FP and RH issues is dealt with in the following sub-sections.

Overall Strategic Approach

The strategy will employ a life cycle approach to address specific family planning needs, as they change over time, across young and older couples. A life cycle approach acknowledges that each stage of a person’s life is marked by specific vulnerabilities, needs and life circumstances. In this context, the table below segments the audience based on where they are with reference to family planning at their stage of life, to determine the specific behaviour to be promoted by the communication intervention.

Table 5: Proposed Communication Intervention Per Audience Segment

	User	Non-User
Space births	<ul style="list-style-type: none"> • To stay on method. • To change to a more suitable method. 	Start using method of choice
Limit births	<ul style="list-style-type: none"> • Change to more effective method, either IUCD or sterilisation. 	

6.1.1 Unmet Need for Spacing

About 11 percent of women in Jharkhand have an unmet need for spacing. Even in districts with higher use of methods for limiting, there remains a high unmet need for spacing. Of the 31 percent of currently married women (ages 15-49) who use any modern method in Jharkhand, only 4 percent use the OCP and 3 percent reported their husbands as using condoms. Literature shows that increasing spacing methods not only helps to reduce fertility, but also helps to reduce infant mortality and maternal morbidity.

6.1.1.i Underlying Causes and Barriers

Some of the underlying causes of current behaviour and barriers to behaviour change identified by participants are the lack of method compliance due to low accurate knowledge of spacing methods, including information on side effects and how to manage them, rumours and misconceptions. Health providers tend to not provide complete information to clients about specific spacing methods, their side effects and management of side effects. Socio-cultural norms that support bearing a male child and proving fertility soon after marriage contribute to the reasons for low spacing method use.

6.1.1.ii Strategy

The overall strategic approach will reposition birth spacing and promote the benefits of birth spacing: healthy mother delivering a strong and healthy child. The strategy is to use integrated communication media to stimulate demand for birth

spacing and improve quality of provider communication for spacing methods.

6.1.1.iii Audiences and Desired Behaviour

Primary audience

Couples between the ages of 15-24 (rural and urban) with one child, who will:

- Adopt and maintain a FP method for the purpose of spacing births.
- Increase communication with spouses about FP methods.

Secondary audience

- a. Service providers will counsel clients with accurate information on spacing methods, including side effects and their management, including ANMs, AWWs, Sahiyya and other field functionaries.
- b. Popular opinion leaders (POL) such as religious leaders will promote family planning in their communities.
- c. Mothers-in-law will support their daughters-in-laws and sons in the use of spacing methods.

6.1.1.iv BCC Indicators

Modern methods:

- % of women who discuss FP methods with their friends
- % of couples of reproductive age that discuss FP
- Number and % of leaders in every district that support modern contraception
- % of providers providing counselling on modern FP
- % of pharmacies/health centres with modern FP promotional materials displayed
- % of audience who can report correct knowledge about individual modern FP methods

- % of increase in contraceptive use in target audience
- Number of FP mentions in media
- Number of journalists trained in FP
- Policies intended to consistently increase contraceptive availability
- % of distribution points with contraceptives not in stock

Unmet need for spacing:

- % of women who discuss modern spacing contraceptive methods and the number of children they plan to have, with their friends
- % of couples of reproductive age that discuss how to stop having children
- % of audience reporting approval for using spacing methods
- % of audience seeking information on spacing methods
- % of audience reporting that they can seek and find information on temporary FP methods
- Number and % of leaders in every district that support FP
- % of providers providing counselling on modern FP methods

6.1.2 Unmet Need for Long Term or Limiting Methods

About 10 percent of married women in Jharkhand have an unmet need for limiting. In districts with high use of spacing methods, there remains a high unmet demand for limiting methods. Of the 31 percent of currently married women (ages 15-49), who use any modern method in Jharkhand, 23 percent use sterilisation, 0.6 percent use

IUD, and 0.4 percent reported that their husbands have had a vasectomy.

6.1.2.i Underlying Causes and Barriers

Lack of accurate information, misconceptions and rumours about long term methods, lack of quality of care and services, lack of information at supply points, and inadequate supervision within the health system contribute to low levels of long term FP use, especially vasectomy.

6.1.2.ii Strategies

The concept is that couples move from being spacers to limiters when they do not desire more children or do not want to have more children for a long time. The strategy is to reposition vasectomy and the 10-year IUD, specifically:

- a. To promote spousal communication about family planning and involvement of men in discussions about vasectomy with their spouses, religious leaders, and community elders.
- b. To address the supply side of methods used for a long term by training service providers in IPC and counselling, and by strengthening contraceptive distribution through social marketing in the private and public sectors.

6.1.2.iii Audiences and Desired Behaviour

Primary audience

Couples (rural and urban), age 25 and older, who have reached their desired number of children will:

- Discuss the use of limiting methods with each other and

their families and agree upon a given family size.

- Adopt a long term method when they decide it is right for them.

Secondary audience

- Service providers will counsel clients with accurate information on limiting methods, including side effects and their management.
- POL such as religious leaders will promote long term methods, especially vasectomy, with men and women.
- Mothers-in-law will support their daughters-in-law and sons in their use of long term methods.

6.1.2.iv Activities and Media Channels

This section delineates the interventions and media channels through which the strategy aims to reach identified audiences:

- **Use mass media messages to promote the benefits of ‘birth-spacing’ and increase knowledge about methods.** Non-users will be encouraged to determine whether family planning is appropriate for them, and if so, which method is suitable. Balanced information will be provided rather than an emphasis on a particular method. Mass media will promote each method and all spots will be integrated under a multi-media campaign with an umbrella theme. Mass media will promote methods, inform clients on where to get these methods, and project role model appropriate behaviours such as couples talking with one another about

FP methods, mothers-in-law supporting couples in adopting appropriate methods, and service providers counselling their clients properly on FP methods.

- **Train healthcare providers in the effective counselling of FP methods,** their potential side effects and management of these side effects. Identify family planning users among the service providers and further train them as champions and advocates for family planning within their communities. This approach ensures that those who are advocating for FP are satisfied users of FP methods, making them a more credible source of communication through IPC. Provide print and point-of-purchase materials to service providers and pharmacies, respectively. IPC materials will allow service providers to improve their counselling with clients. Materials for clients such as Q cards will remind users of what to do when, for example, if they forget to take the pill.
- **Link experiential marketing activities,** such as folk performances and video-on-wheels, to radio (community or other) or when possible, radio talk-shows, to enhance impact and increase scale. Establish community meetings or ‘health clubs’ to maximise internalisation of attitudes, beliefs, learned facts, and behaviours, as behaviour change takes time to consolidate. The meetings or clubs would foster dialogue among users to provide reinforcement and to learn to become effective method advocates.

- **Conduct media advocacy** to expose the low availability of contraceptive methods in areas of Jharkhand and the need for clinics to offer contraceptives. Use advocacy and social marketing efforts to enlist the private sector in identifying new market segments for specific contraceptive methods, e.g., Standard Days Method (SDM), Depot medroxyprogesterone acetate (DMPA), Progestin Only Pills (POP), or female condoms, depending upon the needs and preferences of select audience segments. Models for public/private sector partnerships will be pursued.

6.1.2.v BCC Indicators

- % of women who discuss long term methods with their friends
- % of women who discuss family size with their friends
- % of couples of reproductive age that discuss how to stop having children
- Number and % of leaders in every district that support long term methods
- % of increase in couples using long term methods
- % of providers providing counselling on modern FP methods
- % of adopters reporting satisfaction with chosen FP method
- % of adopters reporting satisfaction with FP counselling
- % of audience who can mention x number of FP sources
- % of providers reporting adequate supervision

6.1.3 Knowledge and Treatment of STI/RTI

Among women in the age group of

15-49 years who ever had sexual intercourse, 2 percent reported having STI/symptoms of STI in the past 12 months, 12.3 percent reported bad smelling and abnormal genital discharge, 2.9 percent reported genital sore or ulcer and 13.8 percent STI/genital discharge/sore or ulcer.

Among men, around 3.6 percent reported abnormal genital discharge, 3.9 percent genital sore or ulcer and 6.2 percent reported having either STI/genital discharge/sore or ulcer.

6.1.3.i Underlying Causes and Barriers

Some of the underlying causes for the low levels of knowledge and treatment of STI/RTI include fear of discrimination, low quality of services, lack of follow up on the part of clients and service providers, and lack of awareness/information about treatment. Most couples are not aware that both partners need treatment when one has tested positive for a STI.

6.1.3.ii Strategy

The STI strategy will communicate the key message of celebrating and ensuring good health, and that identifying and seeking treatment for RTI and STI is a crucial part of maintaining good health. The idea is to help people take responsibility for themselves and their loved ones and seek immediate treatment and information for preventing STI.

By involving pharmacists and service providers, the message to the general population is: Caring and committed providers are available to help women and men learn the information they need to prevent STI and to facilitate treatment as soon as needed.

6.1.3.iii Audiences and Desired Behaviour

Primary audience

Women in the age group of 15-49 and couples will:

- Have an increased knowledge of STI and RTI symptoms, an increased knowledge of STI prevention, and an increased knowledge of where to go for treatment.
- Seek treatment as soon as symptoms appear.
- Increase discussion about STI/RTI with spouse and ensure that both partners are treated for STI/RTI.

Secondary audience

- School teachers will integrate STI/RTI education in school curriculums.
- Service providers will be trained in counselling and referral for STI/RTI treatment. Service providers will stress the importance of treating partners.
- Pharmacists will become advocates for treatment of STI/RTI.

6.1.3.iv Activities and Media Channels

- Develop IPC tools for use in community women's clubs to promote discussion on relevant health issues, including STI/RTI symptoms and treatment-seeking behaviour. Similarly, teachers will be trained in integrating STI/RTI treatment within their health curriculums.
- Equip service providers with IPC support materials and training in counselling and referral for STI/RTI treatment. Service providers will receive training on how to follow up

with clients on treatment, how to engage in sensitive counselling to address fear of discrimination, and how to provide accurate information and timely referrals.

- Provide print materials to pharmacists for use as counselling aids to promote treatment-seeking behaviours related to STI/RTI.

6.1.3.v BCC Indicators for STI/RTI

- % of audience reporting correct knowledge of STI other than HIV
- % of audience knowing difference between RTI and STI
- % of audience knowing how to prevent RTI and STI
- % of audience seeking treatment
- % of audience fully complying with treatment
- % of audience reporting confidence that they can convince their partners to seek treatment for STI
- % of providers counselling couples on STI
- % of providers trained to provide counselling services for RTI/STI

6.2 MATERNAL HEALTH

Each year, for every 100,000 live births, 371 women die during child-bearing, delivery, or the post-partum period, due to causes that are preventable through simple interventions.

During the causal analysis, three sub-health issues were identified for maternal health:

- A. Anaemia and low rates of antenatal care (ANC)
- B. Lack of ANC follow up and compliance

C. Haemorrhage, sepsis and obstructed labour as the main causes of maternal mortality

Only 40 percent of pregnant women receive ANC and 50 percent receive two doses of TT injections. One third of pregnant women receive any IFA supplements during pregnancy. Demand for ANC services is very low in Jharkhand, particularly in tribal districts. Interestingly, cost, travel and time were not factors associated with low demand for ANC. Instead, because pregnancy is considered a normal part of one's life and not a sickness or disease, many women do not feel the need to avail ANC services.

Anaemia is prevalent among 72.9 percent of women, ages 15-49, in Jharkhand (NFHS-2). Going for medical services is associated with illness and, therefore, the concept that ANC services facilitate a healthy delivery and health for both the mother and the child would require the creation of a new social norm.

In Jharkhand, 18.4 percent of the total births in the past three years (NFHS-3, 2005-06) took place in an institutional setup. Of the total institutional deliveries, 13.2 percent took place in private hospitals and 3.4 percent in public hospitals. With a large proportion of maternal deaths occurring due to haemorrhage, sepsis and obstructed labour, improving institutional and safe delivery is a priority.

Overall Strategic Approach

The overall strategic communication approach is to promote the concept of "celebrating womanhood" to help women (at the individual

level) understand the importance of taking care of their health during pregnancy, childbirth and the postnatal period. The concept will also influence social norms to create a conducive environment for sustained behaviour change.

Each of the three maternal health issues is dealt with in the following sub-sections.

6.2.1 Anaemia and Low Rates of ANC

6.2.1.i Underlying Causes and Barriers

Only 15 percent of mothers interviewed in NFHS-3 reported consuming IFA tablets for 90 days during the last pregnancy. Women do not register early in their pregnancy due to cultural myths and misconceptions related to revealing pregnancy early on during the first trimester. There is a belief that disclosing pregnancy early may lead to miscarriage, therefore impacting early registration for ANC.

There is a lack of information and clarity on the benefits of ANC. On the supply side, women prefer going to doctors rather than ANM for pregnancies. Where ANM are not available, women seek advice from traditional healers. Most importantly, there is lack of self-esteem among women who do not attach importance to taking care of themselves, therefore not availing ANC and not paying attention to their nutritional needs.

6.2.1.ii Strategy

The overall strategy will be to encourage women to celebrate motherhood, and therefore, place importance on taking care of themselves.

6.2.1.iii Audiences and Desired Behaviours

Primary audience

Pregnant women and women of reproductive age will feel a sense of joy about the pregnancy. For a woman, pregnancy is a time of celebration for herself and her family, and therefore, it is important for her to care for herself and use ANC.

- Contact the Sahiyya as soon as she learns about her pregnancy to register for Janani Suraksha Yojna (JSY)/ANC.
- Obtain at least 3 ANC checkups from the nearest health centre.
- Pay attention to nutritional needs and work to ensure proper nutrition during pregnancy and breastfeeding.

Secondary audience

- Service providers will counsel pregnant women and families on appropriate ANC services and their benefits. They will identify pregnant women and facilitate early registration.
- Mothers-in-law, older sisters-in-law or aunts will encourage pregnant women in their households to seek information from Sahiyya on ANC, nutrition and IFA and support the woman in early registration. They will communicate the benefits of ANC to the pregnant woman and ensure that she receives proper nutrition.
- Husbands will accompany the pregnant woman to seek timely registration and to receive ANC checkups during pregnancy.

6.2.1.iv Activities and Media Channels

- Use mass media in the promotion of 'celebrating motherhood'.

- Establish health clubs for pregnant women (using village health committees or *mahila mandals*) and their relatives (older sisters-in-law or aunts and mothers-in-law) to discuss the benefits of nutrition and ANC for healthy pregnancy. Supplementary print materials will be provided to facilitators (community leaders or health providers), who will be trained to facilitate group discussions.
- Use community radio in health clubs to stimulate discussion on various issues related to pregnancy, including ANC, nutrition and IFA tablets. While entertainment education through community radio and the mass media will highlight celebrating motherhood and what it means in terms of taking care of oneself during pregnancy, the health clubs will stimulate IPC dialogue to internalise messages and help clients practice some of the behaviours by creating a supportive environment.
- Train service providers and traditional healers to co-facilitate women's health club discussions.
- Disseminate IPC materials and educational materials to ANC clinics to educate and motivate pregnant women and their families to ask health providers the right questions and practice the desired behaviours.

6.2.1.v BCC Indicators

- % of the audience who recall messages on the importance of ANC and early registration
- % of audience who feel the right thing to do is to visit a health provider for information and

instructions on ANC during pregnancy

- % of audience who know the importance of 3 ANC visits
- % of audience who are confident that they can register
- % of providers who provide counselling for registration, nutrition and IFA tablets

6.2.2 Lack of ANC Follow up and Compliance

6.2.2.i Underlying Causes and Barriers

Most clients do not perceive a clear benefit in complying with the requirement for multiple ANC visits. Furthermore, seasonal migration is common in Jharkhand and causes the men of the household to move often, restricting women's mobility in seeking multiple ANC checkups when clinics are far from home. On the supply side, lack of supportive supervision for ANM leads to low motivation for the ANM in ensuring follow-up visits.

6.2.2.ii Strategy

Linking health providers with the community through interactive IPC sessions will increase the likelihood of quality IPC and trust between ANM and clients. Entertainment education programmes that support ANM and recognise them for their good work will provide motivation for ANM to do their job well. The strategy will utilise "satisfied users of ANC services" as advocates, who will talk with others about the benefits of seeking all ANC visits.

6.2.2.iii Audiences and Desired Behaviour

Primary audience

Pregnant women, who will:

- a. Complete the full schedule of ANC checkups;

- b. Understand the danger signs during pregnancy;
- c. Know the steps of birth preparedness;
- d. Discuss the benefits of ANC follow-up visits and birth preparedness with spouses and family members.

Secondary audience

- Spouses will help women monitor their ANC visits and requirements (nutrition, IFA tablets etc).
- Mothers-in-law will support ANC visits and counsel the couple on benefits of ANC.
- Health providers and traditional healers will counsel clients on the importance of follow-up visits and explain the steps for birth preparedness.

6.2.2.iv Activities and Media Channels

- Utilise women's health clubs to encourage women to make follow-up ANC visits. IPC materials and training will be given to health providers and traditional healers, who serve as facilitators of the group discussions.
- Identify and train POL to hold group counselling sessions for married men. POL can be respected men and elderly leaders of the community, who can encourage young men to support their pregnant wives in availing ANC. For the men, print materials would be developed to serve as a monitoring tool that explains the ANC schedule and helps men track their wives' ANC visits.
- Organise community events such as a 'best couple' mela to publicly recognise couples

who have registered early and followed up on all ANC visits. The mela will be a social mobilisation activity to provide positive reinforcement for couples who act upon messages promoted via mass media.

- Build the capacity of medical officers, ANM, AWW, Sahiyyas and traditional healers to counsel women about the benefits of ANC and motivate them to make follow-up visits.

6.2.2.v BCC Indicators

- % of audience who can recall accurately the requirements of ANC visits
- Increased number of husbands who talk with their wives about importance of ANC follow up visits
- Increased number of men who talk with other men about the importance of ensuring all ANC visits for their wives
- % of providers who provide counselling for ANC follow-up

6.2.3 Haemorrhage, Sepsis and Obstructed Labour

6.2.3.i Underlying Causes and Barriers

Only 14 percent of deliveries occur in the healthcare setting in Jharkhand. There is no concept of birth preparedness because there is a lack of clear benefits associated with emergency preparedness and institutional delivery. Only 19.6 percent of deliveries were accompanied by a postnatal check up and 17 percent underwent checkup within two days of birth, both these referred to the woman's last live birth in five years.

6.2.3.ii Strategy

The main objective is to improve the

status of institutional delivery and safe delivery.

6.2.3.iii Audiences and Desired Behaviour

Primary audience

Pregnant women will understand the steps for birth preparedness and the clear benefits of these behaviours.

Secondary audience

- Mothers-in-law and husbands will understand the benefits and steps to be taken for birth preparedness. They will support the woman in seeking institutional delivery by talking with health providers (Sahiyya), who can facilitate the arrangements for emergency preparedness.
- Service providers will facilitate JSY schemes for clients and their families for birth preparedness. Service providers will counsel clients and their families in the importance of birth preparedness and institutional delivery.
- Community mobilisers will support health providers and families in seeking institutional delivery and birth preparedness.

6.2.3.iv Activities and Media Channels

- Tap into community women's clubs to encourage discussion about danger signs during pregnancy, delivery and the post-partum period and ways to prepare for emergencies.
- Identify families who have used institutional delivery and are satisfied clients to become advocates for facility-based delivery within their communities, and dispel fears and myths surrounding the practice.

- Build upon socio-cultural practices such as *godh bhara*i through community-level village health committees (VHC) to convey messages about birth preparedness.
- Utilise service providers in the facilitation of group discussions with pregnant women and their mothers-in-law about birth preparedness, emergency preparedness, identifying nearby health facilities, setting aside funds, ensuring blood donation, and arranging for transportation.
- Develop mass media messages to promote institutional delivery schemes and services with information on the benefits of institutional delivery. Television or radio spots will explain that there is a scheme that can help clients ensure safe institutional delivery and promote the specific action of contacting the Sahiyya for help.
- Train service providers in IPC for promotion of institutional delivery and JSY.
- Develop materials for health providers at the institution where delivery is to take place to help clients understand the process, and also to remind doctors and health providers at the hospital to make the clients feel comfortable.

6.2.3.v BCC Indicators

- % of audience who recall messages on birth preparedness
- % of audience who can list x items required to prepare for birth
- % of audience who will seek help of service provider for knowing more about institutional delivery
- % of audience who are confident that they can undertake specific birth preparedness actions
- % of audience who feel it is important to prepare for birth
- % of audience who think it is important to seek institutional delivery

6.3 HIV/AIDS

The prevalence of HIV/AIDS among ANC mothers in Jharkhand is 0.13 percent (NACO, 2005). According to NHFS-3, only 52 percent of ever-married men and 29 percent of ever-married women between the ages of 15-49 had ever heard of AIDS. There is a colossal awareness gap between the urban and rural populations about AIDS. Around three fourths (72 percent) of married women in urban areas and 16 percent of married women in rural areas were aware of AIDS. Similarly, 89 percent of married men in urban areas and 42 percent in rural areas had ever heard of AIDS. The survey found that a total of 46.7 percent of men and 21.8 percent of women knew that consistent condom use could reduce the chances of getting HIV/AIDS (NFHS-3, 2005-06).

During the causal analysis, the four main sub-health issues identified under HIV/AIDS were:

- A. Lack of accurate knowledge and awareness of HIV/AIDS among the general population and service delivery system professionals.
- B. Lack of understanding about the needs of most-at-risk populations commercial sex workers (CSW), truckers and helpers (TH), and MSM for

the development of effective programmes.

- C. Stigma associated with HIV/AIDS both among the general population and service providers.
- D. Lack of infrastructure and services to address the counselling and testing needs of clients, as well as to provide treatment.

Each of these issues is dealt with in the following sub-sections.

6.3.1 Lack of Accurate Knowledge and Awareness of HIV/AIDS

6.3.1.i Underlying Causes and Barriers

According to NFHS-3, only 52 percent of ever-married men and 29 percent of ever married women between the ages of 15-49 had ever heard of AIDS. Low literacy, lack of information access, language barriers, migration, myths and taboos are some underlying causes for low levels of knowledge and awareness about HIV/AIDS.

6.3.1.ii Audiences and Desired Behaviour

Primary audience

- General population (men and women of reproductive age) will openly discuss HIV/AIDS with their spouses and in their communities.
- Couples and community members will seek information from service providers on HIV/AIDS and its prevention.
- Young people (rural, urban and slum) will practice safe behaviours, because they are knowledgeable about HIV/AIDS and have developed the life skills for prevention.

Secondary audience

- Service providers will have accurate knowledge about HIV/AIDS and be able to counsel clients with empathy and provide accurate information on prevention, testing and treatment.
- Teachers will incorporate HIV/AIDS education into their school curriculums to enhance the life skills of young people.
- Community leaders (Panchayat and VHC members) will support HIV/AIDS awareness events in their communities.

6.3.1.iii Activities and Media Channels

- Develop mass media messages and programmes to portray open and frank discussion among couples and community members on HIV/AIDS, and positive attitudes toward counselling and testing. The communication will include messages to dispel myths about HIV/AIDS and its transmission.
- Social mobilisation activities will sensitise community and religious leaders about HIV/AIDS. These activities will train them in using IPC materials and participatory techniques with the community, to provide accurate information about HIV/AIDS and facilitate a healthy dialogue among community members.
- Train teachers as facilitators of life skills training for young people. This activity will include the development or adaptation of a curriculum to dispel HIV/AIDS myths and misconceptions and to promote life skills related to RH and HIV/AIDS.
- Train health providers in IPC skills to improve interactions

with clients, particularly during counselling and testing.

6.3.1.iv BCC Indicators

- % of audience who know HIV prevention methods
- % of audience with no incorrect beliefs about HIV/AIDS
- % of audience who report initiating discussion about HIV within their social networks
- % of audience seeking information from health care provider on HIV/AIDS
- % of audience with accepting attitude towards HIV positive persons
- % of audience having visited a voluntary counselling and testing centre (VCTC) or HIV/AIDS/STI health service centre

6.3.2 Lack of Understanding about the Needs of Most-at-Risk Populations

6.3.2.i Underlying Causes and Barriers

Migration is a common phenomenon in Jharkhand. Gaining an understanding of how the HIV/AIDS epidemic spreads within the population of migrant workers, especially among truckers and their helpers, is the first step to planning effective communication interventions. Similarly, there is a need to conduct formative research to understand the needs of CSW and MSM.

6.3.2.ii Audiences and Desired Behaviour

Primary audience

The most at-risk groups of CSW, TH, and MSM will:

- Know ways to prevent HIV transmission.

- Seek counselling, testing and treatment.
- Use condoms with regular and non-regular partners at every sexual act.
- Reduce the number of partners (MSM as well as TH).

Secondary audience

- a. Peer educators will use IPC materials to educate peers about routes of transmission and prevention.
- b. People living with HIV/AIDS (PLWHA) will be encouraged to reach out to other PLWHA for promoting safe behaviours and to advocate for seeking counselling, testing and treatment. Due to heavy stigma, the intervention may link with the Positive People's Network within the state to identify the best approach for ensuring greater involvement of PLWHA and protecting them from stigma or harm.
- c. Health providers will display compassion and understanding towards most at-risk populations and PLWHA. They will treat their clients without judgement and with empathy.

6.3.2.iii Activities and Media Channels

- Utilise mass media (e.g. radio songs) and IPC materials at various dhabas or clinics on the trucking route to display VCT-seeking behaviours. Mass media can be used to show compassionate and non-judgemental health providers.
- Engage peer educators (from within the most at-risk populations) in activities to raise awareness and disseminate

messages about prevention of transmission.

- Maximise the entertainment-education potential of folk media to engage large crowds and disseminate messages about HIV transmission. Such events can be used as a way to initiate dialogue among community members to dispel myths and misconceptions about HIV/AIDS.
- Partner with the private sector to ensure condom availability at various truck routes, *panwalahs* and pharmacies through social marketing efforts.
- Link with the Positive People's Network to identify ways to involve PLWHA in the programme, safely and effectively.

6.3.2.iv BCC Indicators

- % of most at-risk populations to recall ways to prevent HIV transmission
- % of TH who perceive their regular partners as potentially high risk partner
- % of TH, CSW, and MSM who perceive themselves to be at risk of HIV infection
- Number of sexual partners reported by TH and MSM
- % of TH, CSW and MSM reporting condom use in the last sex act and in all sex acts with commercial, regular, and non regular partners
- % of TH, CSW and MSM seeking STI treatment from qualified health care professionals
- % of TH and MSM who can locate the nearest VCTC, STI clinic and nearest condom outlet
- % of voluntary walk-ins where TH and MSM receive pre-test counselling, testing (if advised)

and post-test counselling at VCT centres

- % of CSW seeking STI treatment from qualified health care professionals and satisfied with service
- % of CSW who feel discriminated against and made a report
- Reports from MSM on tolerant attitude of counsellors
- % of service providers who display compassion for PLWHA
- % of service providers who counsel with empathy and accurate information/referral for HIV testing
- % of PLWHA who feel that the community supports them and accepts them as a part of the family
- % of PLWHA who feel confident to seek counselling from health providers and treatment
- % of PLWHA reporting condom use with all partners and other safe sex behaviours

6.3.3 Reducing Stigma

6.3.3.i Underlying Causes and Barriers

A number of factors contribute to the high levels of stigma toward PLWHA, including traditional beliefs; lack of correct information; non-participation from opinion leaders, political and religious leaders to address HIV/AIDS in the community; poor and ineffective communication by service providers and poor service delivery environment (e.g., lack of confidentiality etc).

6.3.3.ii Audiences and Desired Behaviour

Primary audience:

- a. Community member (ages 15-49) will:

- Accept PLWHA as an integral part of their community and provide care and support to them and their families.
 - Understand their risk for HIV and increase their practice of safe behaviours.
- b. Service providers will be trained to reflect upon and overcome their internal prejudices, myths and misconceptions related to HIV/AIDS. They will be supported to provide compassionate and accurate counselling to PLWHA and those who come for testing to the centre.

Secondary audience

- a. Political, community and religious leaders will integrate HIV/AIDS prevention, treatment, and care messages in various festivals and community events. The leaders will actively counsel families with PLWHA to promote compassion and care. Leaders will serve as a link between the community and the health care providers to ensure appropriate testing, counselling and treatment.
- b. Family members and friends of PLWHA will support them.
- c. The media will accurately and sensitively report on HIV/AIDS and in support of PLWHA.

6.3.3.iii Activities and Media Channels

- Develop IPC to address stigma for multiple audiences/age groups in the general population for use in community meetings and other public forums.
- Train medical and paramedical staff in hospitals and testing

centres as well as grassroots service providers to confront their stereotypes and negative attitudes toward PLWHA.

- Use advocacy to reach community, religious and political leaders to sensitise them about HIV/AIDS and to encourage them to integrate HIV/AIDS education into their regular and ongoing activities.
- Tap into positive networks to reach families of PLWHA to increase compassion and remove misconceptions.
- Link positive people with religious leaders willing to address HIV/AIDS to promote treatment, care and support; enlist religious leaders who are willing to help families address HIV/AIDS with compassion and care.
- Conduct media advocacy workshops to sensitise media professionals to the importance of accurate and responsible reporting about HIV/AIDS. The media too will be encouraged to advocate for friendly policies.

6.3.3.iv BCC Indicators

- % of audience with no incorrect beliefs about AIDS
- % of audience with accepting attitudes towards those living with HIV
- % of audience who report practicing preventive behaviours in the past year
- % of providers who provide counselling on HIV
- % of audience who report trust for providers
- % of providers displaying positive attitudes towards people living with HIV

6.3.4 Lack of Infrastructure For Quality Services

6.3.4.i Underlying Causes and Barriers

Lack of resources and commitment among policy makers prevent the appropriate budgetary allocations needed to ensure adequate service delivery, confidential counselling and testing, and follow-up for HIV/AIDS.

6.3.4.ii Audiences and Desired Behaviour

Primary audience

The State AIDS Control Society (SACS) and policy makers will allocate resources and increase their commitment for ensuring quality counselling, testing, and treatment services for HIV/AIDS.

Secondary audience

Civil societies, faith based organisations, CBO, and NGO will provide appropriate and compassionate counselling and testing services for their target populations.

6.3.4.iii Activities and Media Channels

- Build the capacity of NGO and CBO. NGO and CBO staff and health providers working in the field of HIV/AIDS will undergo sensitisation training to confront their own internal prejudices and attitudes in order to ensure quality counselling and services.
- Work closely with Jharkhand SACS to integrate communication into the existing programme. This will enable HIV/AIDS services to increase quality and link demand generation with quality of care.

6.3.4.iv BCC Indicators

- % of audience who advocate

for increase in health facilities, providing services for people living with HIV

- % of local leaders who publicly acknowledge their support for increasing the VCT facilities and services for PLWHA
- % of NGO and CBO staff who are able to counsel clients appropriately for prevention, testing and treatment related issues
- % of NGO and CBO staff who feel comfortable addressing the needs of PLWHA and most at-risk populations

6.4 CHILD HEALTH

According to NFHS-2, the infant mortality rate is 54.3 per 1000 compared to the national average of 67.6. About 60 percent of all infant deaths occur during the neonatal period. Low birth weight, malnutrition, acute respiratory infections, diarrhoea, measles, whooping cough and tetanus are the main killers.

The sub-health issues are:

- a. High infant mortality and malnutrition due to lack of colostrum feeding, exclusive and complementary breastfeeding practices.
- b. High infant mortality due to improper care of the newborn.
- c. Low rates of immunisation.

6.4.1 Colostrum Feeding

Breastfeeding is universal in the state; however, only 10.9 percent of the infants are fed immediately after birth within the first hour (NFHS-3) and less than one-third are fed on the first day.

6.4.1.i Underlying Causes and Barriers

CARE's Communication Needs Assessment (2006) found various cultural reasons behind low colostrum feeding in rural areas, especially among tribal populations. Thin looking milk is considered unhealthy for the infant and it is thought to cause upset stomach in the baby. In many communities, the newborn infant is given water rather than colostrum.

The study found tribal variations in colostrum feeding practices. Among the Santhals, newborn babies are usually provided with colostrum; however, if there is insufficient milk, then goat milk is given to the infant immediately. Another reason for low colostrum feeding is that communities are not aware of the benefits of colostrum feeding. Birhor tribe, for example, believes that colostrum causes stomach problems for the newborn. In this community, the infant is given breast milk 2-7 days, post-delivery.

6.4.1.ii Strategy

The communication approach promotes the concept of a 'good mother' who provides colostrum to her new born and body warmth immediately after birth. This concept attempts to change social norms surrounding healthy newborn behaviours. The approach will appeal to women's aspirations to be a 'good mother'.

6.4.1.iii Audiences and Desired Behaviour

Primary audience

- Mothers of newborns will breastfeed their babies within one hour of birth, if possible.

- Pregnant women will understand the importance of breastfeeding colostrum within the first hour post-partum.
- Mothers-in-law will understand and advocate for/be supportive of colostrum breastfeeding.
- All are aware of the importance of colostrum feeding.

Secondary audience

- Fathers of newborns and husbands of pregnant women will understand the importance of feeding colostrum within the first hour post-partum.
- Service providers will counsel pregnant women on breastfeeding within the first hour and the benefits of colostrum feeding.
- Community leaders will promote the concept of a good mother and link it with colostrum feeding.
- Sahiyya, TBA, and AWW will provide counselling on colostrum feeding and dispel myths associated with colostrum feeding.

6.4.1.iv Activities and Media Channels

- Work with community women's health clubs (*mahila mandals*) to initiate discussions of relevant issues related to health and social issues, including breastfeeding within the first hour post-partum.
- Train service providers in IPC and use of IPC materials for counselling clients about colostrum feeding and to dispel myths and misconceptions.
- Use cultural rituals such as *godh bhara* as opportunities to talk about the importance

of colostrum feeding with a pregnant woman and her family members (husband and mother-in-law). Training for community leaders will motivate them to provide support at these important events to promote the concept of the redefined "good mother". Elderly men may talk with younger married men to encourage them to support their wives in breastfeeding within one hour after the child's birth.

- For urban audiences, use mass media and billboards to promote the desired behaviour.

6.4.1.v BCC Indicators

- % of audience who recall messages on immediate breastfeeding
- % of audience who approve of immediate breastfeeding
- % of audience who talked about immediate breastfeeding with friends
- % of couples who talked about immediate breastfeeding
- % of community-based providers who report counselling on immediate breastfeeding

6.4.2 Exclusive Breastfeeding to Prevent Malnutrition

6.4.2.i Underlying Causes and Barriers

Malnutrition is the silent killer among women and children in Jharkhand. Based on international standards, 54 percent of children 3 years and younger in the state are underweight. About one fourth of the children suffer from acute under-nourishment, especially in rural areas and among disadvantaged socio-economic groups. Over one third of the children are born with low birth

weight. More than 80 percent of the children (age 6-35 months) are anaemic. Prevalence of anaemia is as high as 92 percent among children belonging to the ST population.

Only half of children under six months are exclusively breastfed. Lack of knowledge about importance of exclusive breastfeeding during the first 6 months of life is a significant cause for malnutrition among infants. In addition, there is lack of knowledge about correct nutritional practices for babies 6 months and older. Finally, certain cultural beliefs work against the practice of correct nutritional practices for infants.

6.4.2.ii Audiences and Desired Behaviour

Primary audience

- Mothers will exclusively breastfeed infants for six months after birth and continue with complementary breastfeeding until two years of age or older.
- Mothers-in-law will talk with their peers about the importance of encouraging daughters-in-law (and their own daughters) to breastfeed exclusively for six months after delivery, and continue with complementary breastfeeding until the child is two years of age or older.

Secondary audience

- Fathers of the newborn are aware of the importance of exclusive breastfeeding for six months after birth and complementary breastfeeding until two years of age.
- Service providers will counsel mothers about exclusive breastfeeding for six months

after birth and about complementary breastfeeding until two years of age.

- Community leaders will promote the redefined concept of a 'good mother' to include exclusive breastfeeding for six months after birth and complementary breastfeeding for two years.
- Other family members such as the sisters-in-law or sisters of the new mother will support the new mother in ensuring exclusive breastfeeding for six months after birth, and complementary breastfeeding until the child is two years of age.

6.4.2.iii Activities and Media Channels

- Use mass media (electronic mass media and hoardings) to promote appropriate feeding of infants and children.
- Working through women's clubs, utilise health providers or identified mothers-in-law or sisters-in-law who can provide accurate information about exclusive and complementary breastfeeding.
- Distribute IPC materials to service providers for use in counselling clients on exclusive and complementary breastfeeding.

6.4.2.iv BCC Indicators

- % of audience who recall messages on exclusive breastfeeding
- % of audience who approve of exclusive breastfeeding
- % of audience who are confident they can promote exclusive breastfeeding
- % of community-based providers

who report counselling on exclusive breastfeeding

- % of audience who recall messages on complementary feeding
- % of audience who approve of waiting for 6 months to begin complementary feeding
- % of audience who know the correct age to begin complementary feeding
- % of audience who are confident they can promote complementary feeding after six months of age
- % of providers who report counselling on appropriate complementary feeding for babies 6 months or older
- % of audience who recall messages on sustained complementary breast feeding for kids between 6 months and 2 years old
- % of audience who approve of complementary breastfeeding
- % of mothers, mothers-in-law and husbands able to recall the type of food in their community that defines a balanced complementary feeding
- % of mothers who sustain complementary breastfeeding until kids are 2 years old
- % of audience who are confident they can promote complementary breastfeeding until kids are 2 years old
- % of providers who report counselling on appropriate complementary breastfeeding until kids are 2 years old

6.4.3 Care for the newborn

Skin-to-skin contact is a crucial intervention that prevents infant/neonatal morbidity and mortality. Delayed breastfeeding and the

cultural practice of exposing the newborn to cold (leading to hypothermia) create an environment in which the neonate is most vulnerable to morbidity and mortality.

6.4.3.i Strategy

The concept is to use the 'gateway behaviour' of breastfeeding as a way to introduce and promote skin-to-skin contact and body warmth for the neonate. Breastfeeding allows for this contact to occur naturally. Skin-to-skin care will be added to the redefined concept of a 'good mother'.

6.4.3.ii Audiences and Desired Behaviour

Primary audience

- a. Mothers and mothers-in-law will wrap the newborn baby for warmth and implement the 5 cleans in handling the newborn.
- b. Pregnant women and mothers will promote proper newborn care practices.

Secondary audience

- a. Husbands will support the wife in practicing newborn care behaviours. Fathers should hug the baby after the birth to provide warmth to the infant.
- b. Service providers will counsel patients in appropriate care of newborns.
- c. Community leaders will promote accurate newborn care behaviours as part of the 'good mother' concept.

6.4.3.iii Activities and Media Channels

- Through community meetings, initiate discussion about appropriate care of newborns.
- Identify individuals who are

practicing newborn care behaviour and engage them in advocacy about the benefits of breastfeeding and body warmth care for newborns with others in the community.

- Promote messages through IPC and support materials that link with mass media programmes (e.g., radio drama) about appropriate care and feeding of the newborn.
- Train service providers in counselling clients on appropriate care and feeding of the newborn.

6.4.3.iv BCC Indicators

- % of audience who know that a newborn should not be bathed immediately after birth but fully wrapped to avoid cold instead
- % of audience who can cite x reasons for not bathing the newborn immediately
- % of audience who can cite x reasons for wrapping the newborn immediately
- % of audience who express approval for wrapping the newborn's body to avoid cold
- % of audience who feel confident they can promote wrapping the newborn's body
- % of audience who feel confident they can promote not bathing the newborn right after birth
- % of audience who can correctly identify the 5 cleans
- % of audience who can name a source to acquire a clean delivery kit
- % of providers who report counselling on wrapping the newborn's body, not bathing the baby immediately after birth and the 5 cleans

6.4.4 Compliance and Rate of Immunisation

6.4.4.i Underlying Causes and Barriers

The severely restricted access to health care in the state is reflected in the low rates of immunisation. The percentage of children fully immunised is at an abysmally low 8 percent compared to the national level of 42 percent.

People in Jharkhand are not aware of the clear benefits of immunisation, let alone the process or schedule for immunizing their children. Other barriers include a lack of trust in providers and the widespread rumours and myths surrounding immunisation.

6.4.4.ii Strategy

The communication programme will work to promote accessibility and availability of immunisation across public and private sectors, and to communicate the clear benefits of the immunisation process.

6.4.4.iii Audiences and Desired Behaviour

Primary audience

- a. Mothers will complete the immunisation routine for children up to 12 years of age, which includes knowing where to obtain immunisations, understanding and following the schedule, and safekeeping of the children's vaccination cards.
- b. Mothers will talk with their peers about the importance of fully immunizing children.

Secondary audience

- a. Husbands are aware of the importance of full immunisation and talk with other husbands

about supporting their wives, keeping the card in a safe place for the next immunisation visit, and accompanying wife and children for immunisation.

- b. Service providers counsel clients about full immunisation, update vaccination cards with date and type of immunisation given and date of next visit, and counsel clients on the management of any side effects of vaccination and the importance of dose compliance.
- c. Community leaders mobilise community members to have immunisation competitions, where the families who have completed child immunisation will be recognised in public as role model families.

6.4.4.iii Activities and Media Channels

- Utilise community and women's clubs to initiate discussion of immunisations.
- Train service providers in IPC and the use of support materials to ensure higher quality counselling of clients.
- Train community leaders in organizing group competitions that recognise model families who have completed their immunisation schedules, thereby creating a support and reward system for the desired behaviour.
- Work with community leaders and health providers to distribute vaccination cards at community meetings and other public forums.
- Work with teachers and community leaders to organise community mobilisation activities that stress the

importance of immunisation at school and community functions.

- Use electronic and print media in urban areas to clearly communicate the benefits of specific immunisations and the importance of full immunisation.

6.4.4.iv BCC Indicators

- % of audience who know x risks of not getting their children immunised (by type of vaccine)
- % of audience who approve of complete immunisation for children
- % of audience who are confident that they can take specific action to ensure complete immunisation
- % of community-based providers who report counselling on complete immunisation
- % of audience who advocate for greater access to routine immunisation
- % of audience who report trust for vaccinations and service providers

6.5 ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH

“Young people, especially, as they embark upon their sexual and reproductive lives, must be able to protect themselves from disease, abuse, and exploitation. They have a right to information and to services...giving young people information does not encourage promiscuity; rather it fosters mutual respect and shared responsibility.” - G. H. Bundtland, ex-Director General, World Health Organisation.

Marriage occurs at a young age for girls in Jharkhand. According to NFHS-3, 61.2 percent of women, ages 20-24, were married by the age of 18 at the time of the survey. Childbearing soon after marriage is a nearly universal practice. A baseline survey of adolescent health conducted by International Center for Research on Women (ICRW) in Bihar and Jharkhand showed that 93 percent of married girls and 91 percent of married boys in the sample had at least one child, with the first child born 18-24 months after marriage. According to NFHS-3, 27.5 percent of women, ages 15-19, were already pregnant or mothers at the time of the survey.

This same survey showed that school enrollment is low for adolescents in Jharkhand, with only 15 percent of girls and 27 percent of boys currently enrolled. Given the context of early marriage and childbearing, opportunities for girls and young women to take advantage of existing reproductive health services, educational options and economic pursuits are severely restricted.

The baseline study also found that access to reproductive health services in both Bihar and Jharkhand is low. About 80 percent of young women gave birth outside of a medical clinic (either at their own home or at a neighbour's home) and less than half of the babies born were delivered by a trained service provider. Use of modern contraception is low, with merely 12 percent of married girls and 15 percent of married boys using any family planning method. Unmet need is high; 20 percent of married girls

and 23 percent of married boys reported a desire to delay the first birth. Finally, more than 20 percent of both girls and boys who had two or more children reported a desire to delay a second birth (ICRW, 2006).

In this context, during the causal analysis, two main health issues were identified: early pregnancy and RTI among adolescent girls. Early pregnancy is due to the low age at marriage and low level contraceptive use among young couples. This section on adolescent sexual and reproductive health focuses on addressing:

- A. Early pregnancy
 - Low age at first marriage
 - Low contraceptive use
- B. RTI among adolescent girls

Overall Strategic Approach for Adolescents

The ICRW baseline survey found that young people exhibited high self-confidence and self-esteem in both Bihar and Jharkhand. 72 percent of boys and 78 percent of girls in Jharkhand believe they have good qualities and skills. Furthermore, 71 percent of boys and 76 percent of girls interviewed are confident in their abilities to do as many things as others. Both boys and girls feel like important members of their households in Jharkhand (80 percent for boys and 79 percent for girls, ICRW, 2006). While these high levels of self-confidence were surprising to the researchers - given the difficulties faced by young people in the state - the findings suggest that young people can be motivated to take charge of their own health, if they are well-supported through quality health interventions. The findings

also suggest that further research about the aspirations of young people in Jharkhand is needed to inform communication efforts in the state.

In this context, the overall strategic approach is to motivate young people to take charge of their lives, so that they continue to support one another in achieving their aspirations and goals. The programme will emphasise responsible and healthy decision-making, with the key benefit of ensuring that young people have the life they want to live. The strategy will train service providers in youth-centred IPC in order to create adolescent friendly health services. Advocacy with policy-makers will focus on creating adolescent- friendly corners across the state in an incremental way.

6.5.1 Early Pregnancy

6.5.1.i Underlying Causes and Barriers

Lack of knowledge about the risks of early pregnancy and the salient socio-cultural norms of having a child soon after marriage contribute to early pregnancy among adolescents in Jharkhand.

6.5.1.ii Audiences and Desired Behaviour

Primary audience

- a. Newly married young couples from urban and rural areas will understand the risks of early pregnancy and know how to prevent early pregnancy.
- b. Young couples will seek premarital counselling/marital counselling to help them plan their families.
- c. Young people will discuss delaying pregnancy with their

family members and adopt a family planning method for the purpose of preventing early pregnancy.

Secondary audience

- a. Mothers-in-law will discuss the benefits of avoiding early pregnancy with their daughters-in-law and sons, and support them in seeking accurate information from a health provider.
- b. Fathers-in-law will discuss the benefits of avoiding early pregnancy and using modern family planning methods with their sons.
- c. Opinion leaders will support young couples in delaying pregnancy.
- d. Service providers will counsel young married couples and provide appropriate family planning counselling, in the context of informed choice.
- e. Peers will support other young couples' decisions to delay first pregnancy.

6.5.1.iii Activities and Media Channels

- Establish peer groups for married adolescents to discuss health and social issues. Identify champion couples who have chosen to marry later or to delay pregnancy to become advocates and educators in their communities.
- Provide premarital counselling for engaged couples and marital counselling for newly married couples using selected facilitators including school teachers, health providers, mothers-in-law and fathers-in-law, *bhabhis* and opinion leaders.

- Develop information print materials and decision-making tool kit for use by service providers to help young married couples make healthy RH decisions.
- Train frontline service providers on RH issues for adolescents (unmarried and married).
- Use mass media to portray young couples marrying later and pursuing alternative paths, such as seeking education and career opportunities.

6.5.1.iv BCC Indicators

- % of audience who recall the risks of early pregnancy
- % of audience who believe that the community disapproves of early pregnancy
- % of audience who feel confident that they can take action to delay early pregnancy
- % of the secondary audience that supports young married adolescents in delaying pregnancy
- % of health care providers who counsel young couples on early pregnancy and ways to avoid it

6.5.2 Age at first marriage

6.5.2.i Underlying Causes and Barriers

Age at first marriage is low among adolescent girls and boys in Jharkhand. Most couples live in joint households, where elders are the key decision makers. While adolescents express desire for delaying marriage, this decision is largely determined by older household members (ICRW, 2006).

6.5.2.ii Audiences and Desired Behaviour

Primary audience

- a. Parents and family members of unmarried adolescents will

support the delay of marriage until after age 18 for girls and after age 21 for boys.

- b. Unmarried adolescents (boys and girls) and parents talk with one another about the benefits of waiting to marry and collectively working with teachers and community leaders to arrive at future plans in education and/or careers.

Secondary audience

- a. School teachers will facilitate life skills education in classrooms to include ARSH issues, including early pregnancy and low age at marriage.
- b. Neighbours/close relatives/religious leaders will support the delay in age at marriage and work with families to help adolescents' progress in education and careers.
- c. Service providers will counsel parents and adolescents about the benefits of delaying marriage and will work with community leaders and teachers to ensure alternative life paths until adolescents are older. Service providers will explain to families and adolescents about risks of early marriage and early pregnancy.
- d. Policy makers will support the law on legal age at marriage.
- e. Media/journalists will advocate for legal age at marriage.

6.5.2.iii Activities and Media Channels

- Mobilise youth groups to discuss alternative paths to life, benefits of marrying later in life, benefits of education and other social issues. These groups can be facilitated by opinion leaders of the community, mothers-in-law, fathers-in-law,

or service providers who are respected by youth.

- Integrate adolescent reproductive health (ARH) life skills education in schools to help adolescents learn about RH, the disadvantages of early marriage, emotional and physical changes associated with puberty, and the risks associated with early pregnancy. Teachers will be trained in facilitating the life skills education kit. Materials developed for this initiative may include print materials such as comic books, entertainment-education (EE) drama series for radio, radio talk shows, and life skills training curriculum and guides.
- Initiate parent-adolescent School Days with games and discussions on ARH issues, including age at marriage.
- Work with mothers and mothers-in-laws to lead discussions about ARH issues, and specifically, age at marriage in self-help groups (SHG) or *mahila mandals*.
- Advocate with policy makers to ensure enforcement of law on legal age at marriage.
- Train journalists on accurate and appropriate reporting on age at marriage, promoting 'role models' and real life stories of young adolescents choosing to delay marriage, to help create a new social norm around this issue.
- Develop press articles, radio and TV products to role model appropriate behaviours and promote champions to create social norm.
- Advocate with Kasturba Gandhi Balika Vidyalaya-Jharkhand Education Project Council

(KGBV-JEPC) for universal integration of the life skills curriculum in schools.

6.5.2.iv BCC Indicators

- Increase law enforcement by policy makers against those who marry their children before the legal age
- Increase reporting on illegal age of marriage and promoting role models for marriage after legal age
- % of young people who believe that there are alternative successful paths to early marriage
- % of young people who feel confident that they can take action to delay early marriage
- % of parents who talk with other parents and families about delaying early marriage
- % of parents/families who plan alternative paths of life other than early marriage with their children, such as education and career
- Increase in delay of marriage until legal age
- % of families who perceive the benefits of delaying early marriage for their adolescents

6.5.3 Low Contraceptive Use among Married Adolescents

6.5.3.i Underlying Causes and Barriers

Families often place social pressure on young couples to have their first child soon after marriage. However, the ICRW survey reported that many young men and women expressed the desire to delay first birth. Young people also reported that elders do not often consider their preferences. Amongst the youth in Bihar and Jharkhand, 59 percent of

males and 38 percent of females reported that elders never take their opinion on childbearing into consideration.

Young men may feel especially excluded from childbearing decisions, because young women were more likely than young men (33 percent and 18 percent, respectively) to report that elders considered their opinion about when and how many children to have. However, both girls and boys mentioned that they were able to openly discuss childbearing with their spouse.

The survey revealed that young people know very little about contraception. Adolescents recognised oral contraceptive pills and condoms more than IUDs and injectables. 78 percent of boys and 46 percent of girls know how to obtain at least one method of contraception. However, the lack of FP methods available to young people acts as a barrier to contraceptive use.

6.5.3.ii Audiences and Desired Behaviour

Primary audience

- a. Newly married couples/couples to be married will openly discuss FP with one another.
- b. Young married people will discuss FP methods with their peers inside and outside of youth groups.

Secondary audience

- a. Mothers-in-law will support their adolescents in seeking information from service providers on FP and using FP.
- b. Fathers-in-law will support their sons and sons-in-law to

seek information from service providers on FP.

- c. Older uncles/aunts/*bhabhis* will talk with their younger counterparts to use FP to delay first birth or second birth as desired by the young couple. They will advocate on behalf of young married couples with the elders in the house to use FP methods and delay first birth.
- d. Young couples, who are current users of FP methods and are satisfied users, will become champions to advocate for FP use among families and other peers, so as to establish a new social norm.
- e. Service providers will provide appropriate counselling to adolescents and their families about FP.
- f. Journalists will provide wider coverage of the contraceptive shortage/lack of availability to advocate for availability of FP methods.
- g. Policy makers will promote FP.

6.5.3.iii Activities and Media Channels

- Mobilise youth groups of married adolescents to allow for discussions about how to plan their future (continued education, FP, RTI preventions, IPC skills between couples etc).
- Create an ARH package for married adolescents, that includes information about FP; train facilitators to lead groups of married adolescents in the use of the ARH package.
- Develop an ARH drama (entertainment education) for newlyweds, either in the form of mass media (TV or radio) and/or using community media.
- Identify champions who are current satisfied users of FP

among married adolescents to motivate peers in youth groups.

- Train service providers in IPC with adolescents on FP issues.
- Train media professionals in advocating for availability of FP methods.
- Conduct media advocacy with the end result of obtaining commitment of policy makers, to ensure adequate supply of FP methods.

6.5.3.iv BCC Indicators

- % of couples who discuss FP with one another
- % of adolescents who talk about FP methods with their peers
- % of families who support the use of contraception among young married adolescents
- % of adolescents who feel confident that they can negotiate contraceptive use with their partner
- % of young married adolescents who can report on correct knowledge about individual FP methods, especially, spacing births
- % increase in use of spacing methods
- Number of journalists trained in advocacy
- Policy makers supporting FP policies

6.5.4 RTI and RH Hygiene among Adolescent Girls

6.5.4.i Underlying Causes and Barriers

During the causal analysis, the participants mentioned that there is a lack of knowledge on personal hygiene, including menses management, among married and unmarried adolescent girls. Topics such as menses, hygiene, or RTI are sensitive and difficult to discuss.

There is a lack of follow-up from the service delivery sector with adolescents about RTI and there is a lack of knowledge among families and adolescent girls about available treatment for RTI.

6.5.4.ii Audiences and Desired Behaviour

Primary audience

- a. Married and unmarried adolescent girls will have increased knowledge about the menstrual cycle, RTI and personal hygiene.
- b. Married and unmarried adolescent boys will have increased knowledge about RTI.
- c. Older siblings and sisters-in-law will increase communication with young adolescent girls on issues of hygiene, menstruation, and RTI prevention/treatment.

Secondary audience

- a. School teachers will integrate RTI education and RH hygiene in their curriculum and into activities such as sports, arts, and dance competitions.
- b. Service providers will counsel families and adolescents about RTI, menses management and personal hygiene. They will refer the girls for appropriate treatment and provide follow-up services.
- c. Pharmacies/private outlets will distribute IPC materials to adolescent girls and their families about hygiene, menses management, and RTI (when appropriate).

6.5.4.iii Activities and Media Channels

- Establish young girls' and married adolescents' clubs to

discuss issues of hygiene, menses management, and RTI (when appropriate).

- Conduct IPC peer education training for older siblings and sisters-in-law to facilitate discussions and help younger adolescent girls in practicing the desired behaviours.
- Build innovative partnerships with the private sector to provide cloth materials/pads at a cost-effective price for girls to manage menses.
- Provide IPC materials to pharmacies and adolescent-friendly clinics.
- Develop life skills education and training courses for teachers to provide education on hygiene, menses management and RTI.
- Integrate RTI, hygiene and menstrual cycle questions in school competitions, such as essay competitions, arts, sports or festivals, especially to teach boys about RTI.
- Train service providers through EE programmes to improve IPC skills for discussing these health issues with adolescents.

6.5.4.iv BCC Indicators

- % of audience recalling correct information about menstrual cycle
- % of audience able to recall steps to maintaining personal hygiene
- % of audience able to define RTI
- % of audience who know where to seek treatment for RTI
- % of peer educators providing correct information to younger siblings about personal hygiene, menstruation, and RTI prevention and treatment

- % of audience able to name x number of symptoms for RTI
- % of audience seeking treatment for RTI
- % of audience who feel that menstruation is no longer a barrier for continued schooling, once they have a solution for menses management
- % of audience that can afford cloth/pads for menses management
- % of private sector selling affordable products for menses management to the BOP population
- % of providers accurately providing counselling and treatment for RTI
- % of boys who can recall various RTI

6.6 TRIBAL HEALTH

In Jharkhand, there are 32 tribes residing mainly in five regions. These tribes are: Santhal, Oraon, Munda, Ho, Lohara, Kharwan, Kharia, Bhunig, Mahli, Mal Paharia, Beli, Gond, Chero, Chik Bariek, Sauria Pharia, Karmali, Kora, Parhaiya, Kisan, Korwa, Binghia, Asir, Gorait, Birhor, Birgia, Baiga, Savar, Bathudi, Khohd, Banjara, Kole, and Kaber. Of these, nine are primitive: Birhor, Korwa, Savar, Asir, Parhaiya, Sauria Pharia, Birgia, Kharia, and Mahli. However, the primitive tribes constitute only three percent of the total tribal population.

The Santhal, Oraon, Munda and Ho are the largest of the tribal groups in Jharkhand, with 19 other tribes having less than 1 percent each of the total tribal population. The remaining nine tribes comprise 1 to 3 percent each of the total tribal population in the state.

6.6.1 Objectives

- To provide an integrated and sustainable system of primary health care, including RCH services and the National Diseases Control Programme as well as curative and referral service delivery in the tribal areas of the state.
- To improve service coverage and its accessibility, acceptability and utilisation.
- To promote and encourage the tribal system of medicine in collaboration with the state-specific Ayurveda Yoga & Naturopathy Unani Siddha Homeopathy (AYUSH) mechanism.

6.6.2 Strategies

- Service delivery model: Mobile health clinic
- Outreach camps
- RCH awareness mela
- Strengthening networking
- Capacity building of tribal medical practitioners

6.6.3 Sahiyya Strategy

Access to health services is a major problem in Jharkhand due to tiny villages scattered in hills, without any transport facilities and road connectivity. In some districts, the problems are more acute. ANM, who are supposed to cater to a population of 3000, often cover more than 8-10 villages. As a result, ANMs' visits to villages are irregular and their contact with each household is infrequent.

To increase the availability of basic health services and information in villages, Sahiyya will be recruited from within the villages to engage in community mobilisation activities and basic health service delivery.

These volunteers will act as a link between the health department, particularly the ANM, and the community. They will collect information from pregnant women, inform villagers about RCH outreach and immunisation camps, encourage women to utilise institutional services for deliveries, act as depot holders (e.g., condoms, oral pills, IFA tablets) and provide transport to pregnant women from BPL families.

Sahiyya will coordinate their activities with panchayat members, community-based organisations, AWW and female health workers. Sahiyya will work with the community to generate demand for health services and to educate people about their health rights. Educated and married women, who are acceptable to villagers, will be selected by community consensus. *Dais*, who are educated and acceptable to the community, will be given preference over Sahiyya.

Training curriculum will be designed for Sahiyya with an emphasis on community mobilisation, counselling skills, and delivery of basic health services.

6.6.4 Panchayat Strategy

The basic structure of institutions in Jharkhand has been inherited from its parent state of Bihar. Medical health, family welfare, social welfare, women empowerment, child development and welfare of scheduled castes and tribes are issues addressed by specific committees. These committees have been constituted but are not fully functional. Many of the members of these committees are not aware of their roles and responsibilities.

Panchayats can play a major role in community mobilisation for health programmes, organisation of RCH camps, establishment of coordination linkages, monitoring of programme performance, collection of information from households, selection of Sahiyya and *dais* for training, resource mobilisation, and above all, in creating awareness about available health services and influencing health care seeking behaviours.

The fact that one third of elected representatives at all levels in the system are women is an added advantage to maternal and child health services. Involvement of elected representatives in the planning and implementation of all health programmes at the grassroots level is central to the success of such health programmes.

6.7 URBAN HEALTH

6.7.1 Objectives

- To improve the health status of the urban poor community by provision of quality primary health care services, with focus on RCH services to achieve population stabilisation.
- To provide an integrated and sustainable system for primary health care service delivery, with emphasis on improved FP and child health services, for urban poor living in slums and other health vulnerable groups.

Coverage:

- Urban cities and townships
- Urban health posts

6.7.2 Activities

Community level activities:

To develop and maintain a link

between the health facility and the community, the programme envisions the engagement of social community workers/link volunteers (females from the community) who can work 3-4 hours a day. Broad eligibility criteria for the volunteers would be: a) they should belong to the slums and b) they should be acceptable to the community. Ideally, these volunteers would be engaged by local NGOs and receive remuneration/honorariums for their efforts. The need for volunteers would be reassessed periodically. Possibilities should be explored to stabilise and integrate volunteers with other slum development schemes/activities during the life of the project, so as to make the system self-sufficient after the completion of the project period.

The capacities of the link workers to facilitate health improvements in the community would require training and support, preferably provided through NGOs. Women's health groups may be formed by the link workers to expand the base of health promotion efforts at the community level and to build sustainable community processes. Capacity building should focus on FP and MCH services, so that link volunteers and women's health groups are able to promote modern contraceptives, immunisation, and other related maternal and child health practices. Activities should be aimed at fulfilling the unmet family welfare needs of the community.

Outreach activities: Activities that reach out to the most vulnerable and the underserved should be planned in order to increase utilisation of critical health

care services. An outreach plan for each urban health centre (UHC), focusing on the most vulnerable slum communities with poor health indicators, should be developed. The composition of the outreach team and the frequency of outreach activities should be outlined, with an emphasis on creating rapport with the community. Mobility support for outreach activities should be planned in the budget.

The outreach service package may also be outlined, but at a minimum, it should be directly linked to the promotion of FP (oral pills, condom use, counselling for adoption of terminal methods), child health services (including immunisation), and household-level support for appropriate newborn care, institution-based delivery and utilisation of ANC. The programme will collaborate with NGOs on outreach services, if required.

Communication strategies for urban audiences should: (a) focus on IEC for behaviour change in RCH; (b) establish linkages; and (c) enhance selected activities of other schemes providing benefit, in order to leverage existing services for the promotion of RCH. The programme will build partnerships with the private sector and NGOs, particularly with partners demonstrating needed skills and proven experience in IEC/SBCC.

The IEC plans/activities will focus on IPC and group communication plans that outline the desired behaviour change for each audience segment. The IEC plans will focus on building community awareness and knowledge, enhancing skills for

practicing healthy behaviours, and strengthening confidence to access health services.

6.8 MAINSTREAMING

Mainstreaming is a process that enables partners to address the cause and effects of FP/RH in an effective and sustained manner through their ongoing and regular

activities. Mainstreaming is an acknowledgement that FP/RH affects all levels of society, and therefore, can be addressed most effectively as a multi-sectoral concern.

Mainstreaming of FP/RH has been recognised as an effective way to address concerns about FP/RH,

both in India and internationally. In most states in the country, mainstreaming activities (or inter-sectoral collaboration) are the responsibility of the Communication Officer. In the State Health Society (SHS), where mainstreaming teams are present, IEC officers provide support in the form of materials, resources and coordination.

CAPACITY BUILDING/TRAINING

Effective health communication is a combination of art and science; the combination of tools and methodologies with the technical and communication skills needed to “step into another’s shoes” and design interventions that trigger behaviour change through awareness generation, attitudinal change, and ultimately, social change. There is a need for training on the systematic and strategic planning for communication. Training can be incorporated in other ongoing training courses and/or specific and intensive communication training on different subjects and topics can be offered independently of other trainings.

7.1 AUDIENCE SEGMENTS FOR COMMUNICATION CAPACITY BUILDING/TRAINING

There are several audience segments at different levels (state, district, block, panchayat and village) for capacity-building (CB) activities. These include:

- State Project Management Unit (SPMU)
- District Project Management Unit (DPMU)
- Health and support functionaries (doctors, media officers, ANM, AWW, TBA, Lady Health Visitor (LHV), PHN, BEE and Sahiyya)

- NGO and CBO
- Policy, law and programme managers
- Media professionals
- Community institutions and functionaries (Panchayati Raj Institution (PRI), SHG, VHC, Rogi Kalyan Samiti (RKS) etc.)

7.2 TOPICS FOR COMMUNICATION TRAINING

Topics to be covered in the communication training include:

- Communication - IEC/SBCC/IPC messages, material, activity, event development & use
- Advocacy, Networking and Mainstreaming
- Community/Social mobilisation
- Dissemination, Monitoring, and Documentation
- Communication Research and monitoring & evaluation (M & E)

7.3 COMMUNICATION TRAINING MECHANISM

Communication capacity building would be undertaken through State-level Training Teams, District-level Training Teams and Block-level Training Teams. These teams would be constituted by state-level resource persons, faculty from the Institute of Public Health (IPH), consultants, communication experts and resource persons.

7.4 MONITORING, RESEARCH AND EVALUATION

Monitoring involves counting what is being done and routinely looking at the quality of services.

Evaluation is the use of social research methods to systematically measure a programme’s effectiveness. Evaluation involves:

- Study design
- Control or comparison group
- Measurements over time
- Special studies

7.4.1 Overview of Monitoring and Evaluation Framework

Monitoring and evaluation takes place at multiple stages of a programme. At each stage, it is important to gather information that documents how the project is being conducted and what has occurred as a result. It is important to identify at the outset how to gather the information needed for each level of evaluation.

Some of these stages overlap and can, in different situations, represent different levels. For example, outcome data on risk behaviours of target groups can be used to evaluate the effectiveness of a programme or set of programmes, without associating any of the changes with a particular programme.

Table 6: **Work Plan for Communication Capacity Building**

Activity/Task	Q1			Q2			Q3			Q4			Responsible
	1	2	3	4	5	6	7	8	9	10	11	12	
1 Communication (IEC/SBCC/IPC)													
2 Advocacy and Networking													
3 Community and Social mobilisation													
4 Documentation/Dissemination													
5 Communication Research and M & E													
7 Sahiyya Training on SBCC and IPC													
8 Media Persons Orientation													
9 Other Stakeholders Orientation													
10 Refresher/Special IEC, SBCC and IPC													

Table 7: **Proposed Budget for Communication Capacity Building**

Activity/Task	Batches	Numbers	Average Quarter cost	Amount in Rupees (Total)
State-level functionaries	4x25	100	1,00,000	4,00,000
District-level functionaries	22x25x2	1100	8,00,000	32,00,000
Media professionals	5x25	125	1,00,000	4,00,000
Sahiyyas	500x25	12500	25,00,000	1,00,00,000
Other stakeholders	5x25	125	1,00,000	5,00,000
NGO/CBO functionaries	22x25	550	4,00,000	16,00,000
			40,00,000	1,60,00,000

Evaluation requires a careful look at every aspect of the programme, including inputs and outputs, process for implementation, and roles and responsibilities of personnel. In addition, evaluation will reveal whether the programme was implemented as planned.

Evaluation is the process of determining whether programmes—or certain aspects of programmes—are appropriate, adequate, effective, and efficient and, if not, how to make them so. Evaluation also shows if programmes have unexpected benefits or create unexpected problems. It is a tool used to assess the way a programme is put into

effect and the outcomes of the programme, its efficiency and impact over time, and to demonstrate accountability.

Programme managers and staff often informally assess their programme’s effectiveness with these questions:

- Are participants benefiting from the programme?
- Are there sufficient numbers of participants?
- Are the strategies for recruiting participants working?
- Are participants satisfied with the services or communication activities?
- Do the staff members have the necessary skills to provide

the services or communication action?

7.4.2 Participatory Monitoring

Participatory monitoring—a process of evidence-based learning for action in collaboration with stakeholders - aims to improve understanding of results, while also strengthening local capacity, institutional development, and sustainability of efforts.

Participatory monitoring endeavours to put the power to define and measure success in the hands of the people that programmes are intended to benefit. The premise is that understanding what works in

programmes should not be the exclusive domain of evaluation experts, donors, and international programme planners. Rather, the people on the ground, those most affected by a programme, should also understand how the programme works.

Monitoring may be quantitative or qualitative.

Quantitative monitoring tends to document numbers associated with a programme, such as:

- **How many** women with one child were reached?
- **How many** SBCC materials (by type) were distributed?
- **How many** counselling sessions were held?
- **How many** peer educators were trained?

It focuses on **which** and **how often** programme elements are carried out. Quantitative monitoring tends to involve record-keeping and numerical counts.

Qualitative monitoring asks questions about how well the elements are being carried out, such as:

- **How** are peoples' attitudes changing toward a FP method or male participation?
- **How** effective is a film in conveying intended SBCC messages to target populations?

Indicators are clues, signs, and markers as to how close we are to our path and how much things are changing. These point to or indicate possible changes in the situation that may lead to improved health status. For example, if you are driving in a car and the petrol/fuel meter shows you are low on fuel, it is not actually the fuel you are looking at, but rather you are looking at an indicator of the amount of petrol you have.

Examples of indicators for HIV programmes are:

- Number of new adopters with one child who accept IUD
- Number of health functionaries trained in counselling and communication skills

7.4.3 Key actions for M&E of Communication Implementation

1. Process indicators developed prior to implementation by the community/implementers.
2. Mechanism established to ensure monitoring of the activities, prior to implementation.
3. Behaviour Change Impact Survey (BCIS) conducted to identify determinants of the prioritised health issues, for the purposes of developing impact indicators.
4. Mechanism for continuous review and feedback, created to provide a means for consistent and regular reporting by the districts.
5. Training on M & E of SBCC organised at state and district levels.

OPERATIONAL MECHANISMS AND MODALITIES

8.1 COORDINATION

8.1.1 Coordination with the Centre

Activities such as media production and release of information are the responsibility of the central national level. The health communication strategy for Jharkhand will build upon the materials and activities produced at the central level.

8.1.2 Coordination with Other Departments

There are several departments and ministries who have infrastructure and resources that could be leveraged or piggy-backed on to

make the reach and impact bigger and faster. In fact, this could prove to be mutually beneficial.

8.1.3 Coordination with Other Development Partners

In Jharkhand, several big and small development partners, international, national and local NGOs have programmes and projects that have common and overlapping issues and audiences. It is important to work together to avoid duplication and message fatigue. A coordinating mechanism will be developed to ensure open sharing of information and transfer of lessons learnt.

8.2 IMPLEMENTATION LEVELS

A distinctive operations plan and corresponding resources should be developed for effective implementation, as well as for monitoring the progress and outcome of the communication activities at different levels - state, district, block, and village. The district level action plan should encompass activities that are coordinated at the central and the state level. Activities and priorities should be clearly marked for different levels of operations.

KEY RECOMMENDATIONS

1. Conduct a BCIS for developing baseline indicators, and formative research across a broad range of health issues for developing communication concepts.
2. Jharkhand is a media dark state. Conduct an assessment of different media outlets available in the state, including mass media, in order to understand the reach of different media options.
3. Finalise the development and implementation of two integrated multi-media campaigns on Birth Spacing and Maternal Health issues.
4. Initiate PPP models for introduction of new contraceptives, e.g. SDM and DMPA in the state.
5. Develop and implement IPC training protocols, manuals and materials for health providers to support IPC and group sessions on prioritised health issues.
6. Identify and ensure visibility at both public and private health facilities about the availability of immunisation services.
7. Initiate PPP models on prioritised adolescent health issues.
8. Develop capacity of health providers to provide information and counselling to adolescents.
9. Introduce telephone help line to disseminate information on HIV/AIDS and other priority health issues.

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LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AIR	All India Radio
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARSH	Adolescent Reproductive and Sexual Health
AWW	Anganwadi Worker
AYUSH	Ayurveda Yoga & Naturopathy Unani Siddha Homeopathy
BCC	Behaviour Change Communication
BCIS	Behaviour Change Impact Survey
CB	Capacity Building
CBO	Community Based Organisation
CBR	Crude Birth Rate
CCP	Centre for Communication Programme
CDR	Crude Death Rate
CEDPA	Centre for Development & Population Activities
CH	Community Health
CPR	Couple Protection Rate
CSW	Commercial Sex Workers
DLHS	District Level Household Survey
DMPA	Depot Medroxyprogesterone Acetate
DPMU	District Project Management Unit
DPT	Diphtheria, Pertussis, Tetanus
EE	Entertainment Education
FP	Family Planning
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Services
ICPD	International Conference on Population and Development
ICRW	International Center for Research on Women

IEC	Information, Education and Communication
IFA	Iron and Folic Acid
IFPS	Innovations in Family Planning Services
IIPS	International Institute for Population Sciences
IMR	Infant Mortality Rate
IPC	Interpersonal Communication
IPH	Institute of Public Health
ITAP	IFPS Technical Assistance Project
IUD	Intrauterine Device
JSACS	Jharkhand State AIDS Control Society
JSY	Janani Suraksha Yojna
JHS	Jharkhand Health Society
KGBV-JPEC	Kasturba Gandhi Balika Vidyalaya-Jharkhand Education Project Council
M&E	Monitoring & Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MH	Maternal Health
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MoHFW	Ministry of Health and Family Welfare
MSM	Men who have Sex with Men
NACO	National AIDS Control Organisation
NFHS	National Family Health Survey
NGO	Non-Governmental Organisation
NPP	National Population Policy
NRHM	National Rural Health Mission
OBC	Other Backward Caste
OCP	Oral Contraceptive Pill
OTS	Opportunity to See
PHC	Primary Health Centre
PIP	Programme Implementation Plan
POL	Popular Opinion Leader
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
RH	Reproductive Health
RKS	Rogi Kalyan Samiti
RMP	Registered Medical Practitioner

RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SC	Scheduled Caste
SDM	Standard Days Method
SHS	State Health Society
SPMU	State Project Management Unit
ST	Scheduled Tribe
STI	Sexually Transmitted Infection
SBCC	Social and Behaviour Change Communication
SRS	Sample Registration System
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TH	Truckers and Helpers
TRI	Tribal Research Institute
USAID	United States Agency for International Development
VHC	Village Health Committee

