सत्यमेव जयते

Department of Women and Child Development
Government of Rajasthan

Social and Behaviour Change Strategy

TO FIGHT UNDERNUTRITION

नए समाज की ओर
Towards a new dawn

सत्यमेव जयते

Department of Women and Child Development
Government of Rajasthan

POSHAN Abhiyaan
PM's Overarching Scheme for Holistic Nourishment
सही पोषण - देश रोशन

Social and Behaviour Change Strategy

TO FIGHT UNDERNUTRITION

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अनिता भदेल
राज्य मंत्री (स्वतन्त्र प्रभार)
महिला एवं बाल विकास विभाग
राजस्थान सरकार

सत्यमेव जयते

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संदेश

कुपोषण की समस्या राज्य एवं हमारे विभाग के लिए एक चिंता का विषय रहा है। इसके निवारण हेतु निरंतर प्रयास भी किये जा रहे हैं, लेकिन इसके लिए मात्र राजकीय प्रयास ही पर्याप्त नहीं होंगे।

कुपोषण के पीछे सामाजिक, सांस्कृतिक एवं आर्थिक कारणों से कहीं अधिक महिलाओं के स्वयं के खान–पान संबंधी व्यवहार तथा परिवार के सदस्यों के व्यवहार ज्यादा बड़े कारण होते हैं। जब तक हम इन खान–पान संबंधी व्यवहारों को समझ कर उनमें इच्छित परिवर्तन लाने के लिए जरूरी संवाद, जागरूकता एवं व्यवहार परिवर्तन की रणनीतियां नहीं अपनाते तब तक हम कुपोषण की समस्या से छुटकारा नहीं पा सकते।

इस सन्दर्भ में, मैं अपने विभाग द्वारा की गयी पहल की सराहना करती हूँ और आशा करती हूँ कि "व्यवहार परिवर्तन सम्प्रेषण की राज्य रणनीति" कुपोषण की समस्या से निपटने में एक महत्वपूर्ण भूमिका निभाएगी। मुझे विश्वास है कि इस रणनीति को प्रभावी रूप से लागू कर हम गर्भवती एवं धात्री महिलाओं तथा बच्चों में व्याप्त कुपोषण की समस्या को दूर कर पाएंगे।

राजस्थान सरकार तथा महिला एवं बाल विकास विभाग, अंतर्विभागीय समन्वय व इस क्षेत्र में काम कर रही विभिन्न एजेंसियों/संस्थाओं के सहयोग से वर्ष 2022 तक प्रदेश को कुपोषण–मुक्त करने हेतु प्रतिबद्ध है। आईये हम सब मिलकर राजस्थान से कुपोषण की समस्या को मिटाने का संकल्प लें।

(अनिता भदेल)

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ACRONYMS

ANC	Antenatal Care
ARI	Acute Respiratory Infection
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BMI	Body Mass Index
DWCD	Department of Women and Child Development
GoI	Government of India
GoR	Government of Rajasthan
ICDS	Integrated Child Development Services
IEC	Information, Education and Communication
IFA	Iron Folic Acid
IPC	Interpersonal Communication
NFHS	National Family Health Survey
NGOs	Non-governmental Organisations
NHM	National Health Mission
NNM	National Nutrition Mission
NRLM	National Rural Livelihood Mission
PMMVY	Pradhan Mantri Matru Vandana Yojna
RMNCH+A	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SBC	Social and Behaviour Change
SHG	Self Help Groups
THR	Take Home Ration

INTRODUCTION

INTRODUCTION

The Government of Rajasthan (GoR) is committed to accelerated reduction in undernutrition in the state. This determination is guided by the National Nutrition Strategy and the National Nutrition Mission (NNM) which identifies nutrition as 'central to the achievement of other National and Global Sustainable Development Goals' and 'the most important entry point for human development, poverty reduction and economic development'.

The GoR is running a wide spectrum of programmes including the Integrated Child Development Services (ICDS), National Health Mission (NHM) – including Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A), Pradhan Mantri Matru Vandan Yojana (PMMVY), Rajasthan Janani-Shishu Suraksha Yojana, Prasooti Sahayata Yojana, Mukhya Mantri Rajshree Yojana, SABLA programme for adolescent girls, the Rajasthan Kishori Swaasth Evam Swachhata Yojana, Swachh Bharat including sanitation and The National Drinking Water Programme, Mid-day Meals Programme, Targeted Public Distribution System, and National Rural Livelihood Mission (NRLM) among others, contributing to improved nutrition outcomes, addressing both the immediate and the underlying determinants of undernutrition through nutrition specific and nutrition sensitive interventions.

The Government has already developed a state level nutrition strategy 'Nourishing Rajasthan – Vision 2022' which prioritises constitution of an apex coordination mechanism to lead a multi-sectoral response for overcoming undernutrition in the state. The state government is also developing and testing various innovative service delivery models that will enable the state with strategic choices for action, informed by best practices, through decentralised planning and local innovation – with accountability for nutrition outcomes. However, no single standalone intervention can lead to substantive, rapid and sustainable reductions in maternal and child undernutrition. Recent findings over the last decade from Bangladesh, Brazil, Thailand, Senegal and Vietnam point to the fact that improvements in nutrition have come from interventions in multiple areas which include both direct nutrition interventions and indirect interventions focusing on underlying determinants, including changing social norms and individual behaviours.

It is well documented that Social and Behaviour Change (SBC) Communication helps build political and society-wide awareness and commitment to nutrition improvement. It enhances individual behaviours and household practices, promotes collective actions in communities, improves the delivery of nutrition counselling services and the demand for these services and enhances the overall enabling environment for good nutrition outcomes.

Going by the richness of evidence on SBC and importance of communication interventions, the Department of Women and Child Development (DWCD), GoR has developed this SBC framework and strategy to improve mother and child nutrition outcomes in the state. The Behaviour Change strategy builds upon a life-cycle approach, synergising health, nutrition, care and maternity protection messaging across the first 1000 days, adolescence and a multi-departmental convergence to tackle the burden of undernutrition in the state.

Objective of the Document

This document will guide integrated and data-driven SBC interventions across the state. It will promote consolidation of SBC interventions undertaken by various development partners in Rajasthan and simultaneously encourage innovation. It also proposes a roadmap for multi-sectoral response to Behaviour Change through convergence of ongoing programmes within the state steered by other departments such as Health, Rural Development, Panchayati Raj, Education and Food and Civil Supplies. The strategy document is meant to be used by policy makers across the GoR and its collaborators, including nutrition, Behaviour Change and Information, Education and Communication (IEC) experts, NHM, NRLM, state communication agencies, development partners, Non-governmental Organisations (NGOs), and media agencies.

How to use the Document

This document provides a broad framework and strategy for implementing comprehensive SBC interventions focused on improving maternal nutrition and infant and young child feeding practices at the state level. Social, epidemiological, demographic and cultural characteristics are distinct for each district and will influence the choice of priority behaviours and their determinants and the mix of communication channels used. Using the overarching framework prescribed under this document, tailored implementation plans and strategies may be designed.

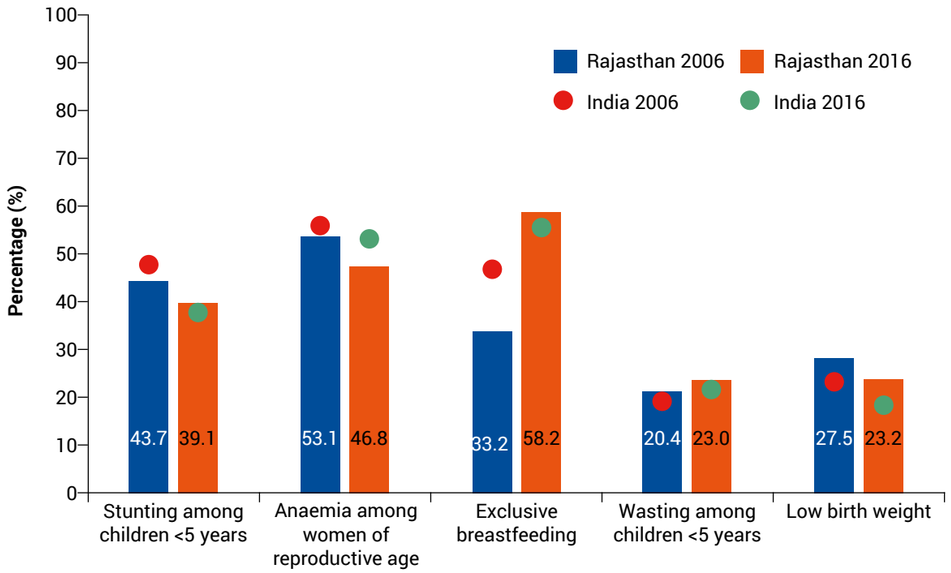
NUTRITION LANDSCAPE IN RAJASTHAN

NUTRITION LANDSCAPE IN RAJASTHAN

Nutrition Outcomes

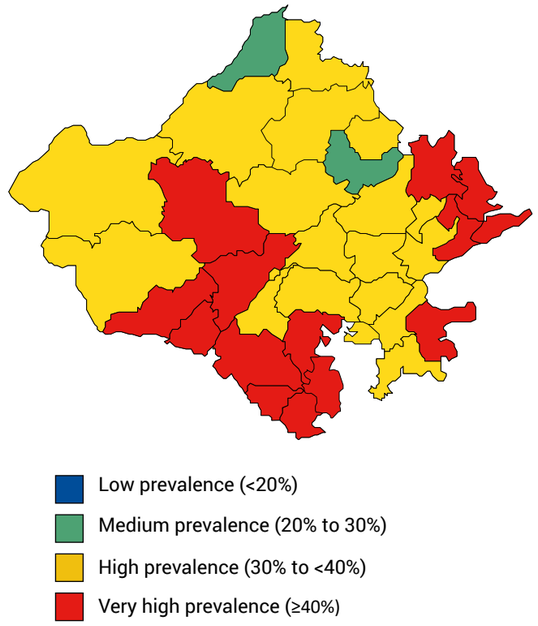
There have been notable improvements in nutrition and health outcomes among children in Rajasthan between 2006 and 2016 (Figure 1). Stunting declined from 43.7 percent in 2006 to 39.1 percent in 2016 and anaemia among women of reproductive age reduced from 53.1 percent to 46.8 percent during the same period. However, nearly half of the women still suffer from anaemia. The state has performed well on exclusive breastfeeding, registering an increase from 33.2 percent to 58.2 percent between 2006-16. In the same time wasting increased from 20.4 percent to 23 percent, and severe wasting grew from 7.3 percent to 8.6 percent. There has been a marginal decline in low birth weight from 27.5 percent to 23.2 percent. While stunting among children less than five years is high in a majority of districts of Rajasthan, it varies widely across districts, ranging from 54.3 percent in Dholpur to 28.4 percent in Sikar. In 12 out of 33 districts, more than 40 percent of children are stunted, which indicates a significant public health concern. Anaemia prevalence also varies greatly in the state, ranging from 76.3 percent (Banswara) to 27.1 percent (Jaipur and Dausa). In two-thirds of districts, more than 40 percent of the women of reproductive age are anemic. The prevalence of wasting is very high in 29 out of 33 districts; it is highest in Pratapgarh (38.2 percent) and lowest in Sikar (11.5 percent). Sikar district has the lowest prevalence of severe wasting (4.1 percent) and Dungarpur the highest (16.1 percent).

Figure 1: Trends in nutrition outcomes in Rajasthan, 2006 to 2016



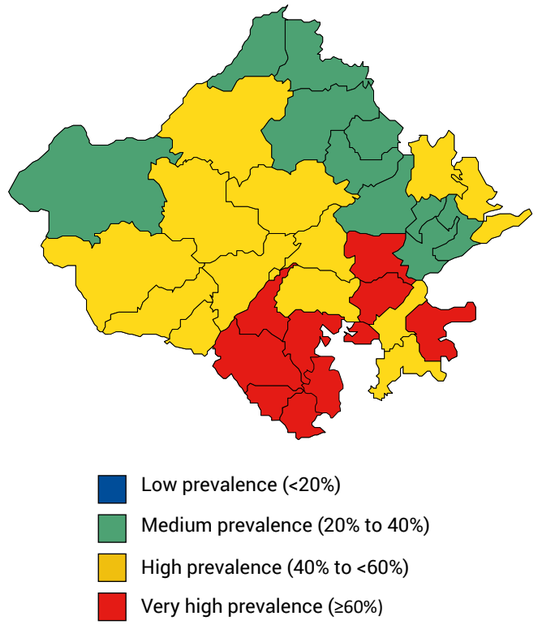
Source: NFHS 3 and NFHS 4; RSoC data used for Low Birth Weight

Map 1: Stunting among children <5 years in Rajasthan in 2016, by district



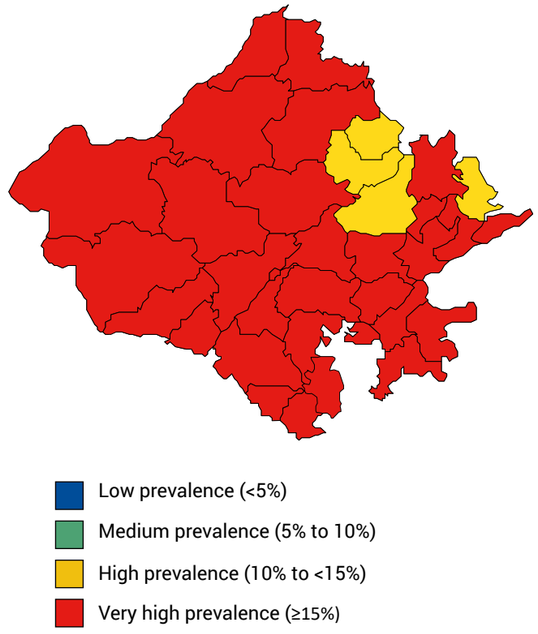
Source: NFHS 4

Map 2: Anaemia (among children <5 years) in Rajasthan in 2016, by district



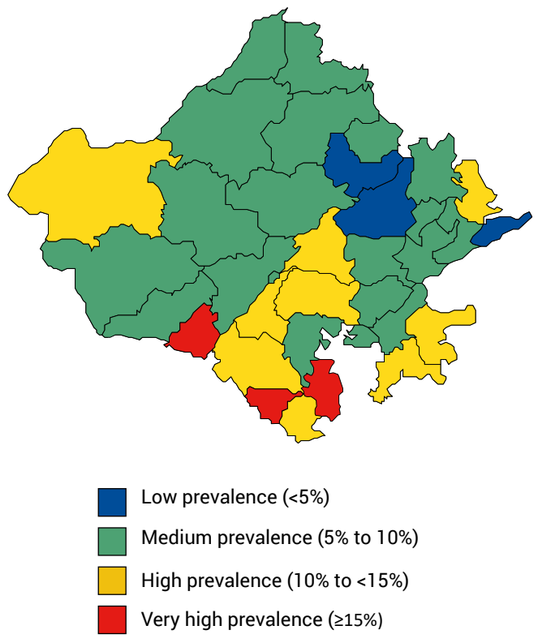
Source: NFHS 4

Map 3: Wasting (among children <5 years) in Rajasthan in 2016, by district



Source: NFHS 4

Map 4: Severe wasting (among children <5 years) in Rajasthan in 2016, by district

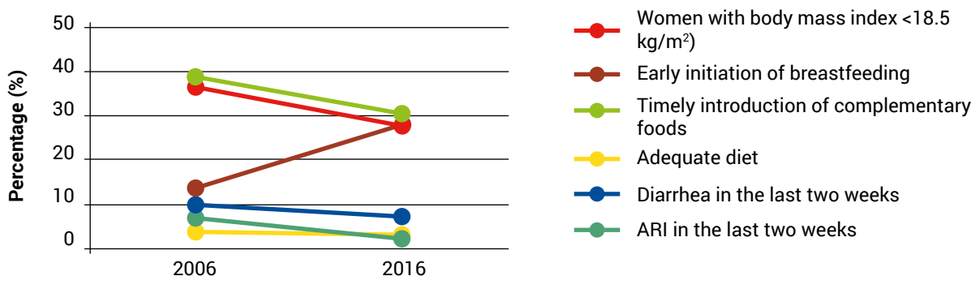


Source: NFHS 4

Rajasthan has also shown improvements on various immediate determinants of nutrition between 2006 and 2016 (Figure 2). The proportion of women with low Body Mass Index (BMI<18.5 kg/m2) declined from 36.7 percent to 27 percent during 2006-2016. Although early initiation of breastfeeding increased from 13.3 percent to 28.4 percent during this period, less than a third of children are breastfed within one hour of birth. Of greatest concern is complementary feeding – timely introduction of complementary foods (between 6 and 8 months of age) declined over the last decade (from 38.7 percent to 30.1 percent) and in 2016, only 3.4 percent of children (between 6 and 24 months of age) received an adequate diet.

The proportion of women who received an Antenatal Care (ANC) visit in the first trimester almost doubled from 34 percent in 2006 to 63 percent in 2016 and the proportion of women who received more than four antenatal visits increased from 23.4 percent to 38.5 percent in the same time period. The proportion of women reporting consumption of Iron Folic Acid (IFA) supplements almost doubled, from 8.7 percent in 2006 to 17.3 percent in 2016, but it is still very low. Interventions related to delivery, such as institutional delivery and births assisted by health professionals, improved dramatically in the last decade with 46 to 55 percentage points increase, reaching above 80 percent in 2016. Nutrition interventions focused on children have also improved in the last 10 years. The coverage of vitamin A supplementation increased from 8.6 percent to 39.6 percent. Even though the proportion of children who were fully immunised doubled (from 26.5 percent to 54.8 percent), more than 40 percent of children did not receive all the requisite vaccinations in 2016.

Figure 2: Changes in immediate determinants of nutrition in Rajasthan, 2006 to 2016



Source: NFHS-3 and NFHS-4;
Note: ARI= Acute respiratory infection.

VISION 2022

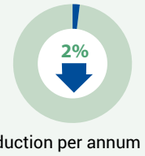
VISION 2022

The NNM has set out a few national targets for accelerated nutritional results, particularly among children from 0 to 6 years, pregnant women and lactating mothers. Through its state nutrition strategy 'Nourishing Rajasthan–Vision 2022', GoR has adopted the targets set out by the NNM as its own, and reinforced its commitment to becoming a leader in the fight against undernutrition.

The state will strive to achieve, by 2022, the following targets:

Reduce stunting in children (0-6 years) from 39.1 percent in 2016 to 35.12 percent (reduction of 2 percent per annum)

reduction per annum



reduction per annum

Reduce underweight prevalence in children (0-6 years) from 36.7 percent in 2016 to 33.03 percent (reduction of 2 percent per annum)

Reduce the prevalence of anaemia among young children (6-59 months) from 60.3 percent to 51.25 percent (reduction of 3 percent per annum)

reduction per annum

reduction per annum

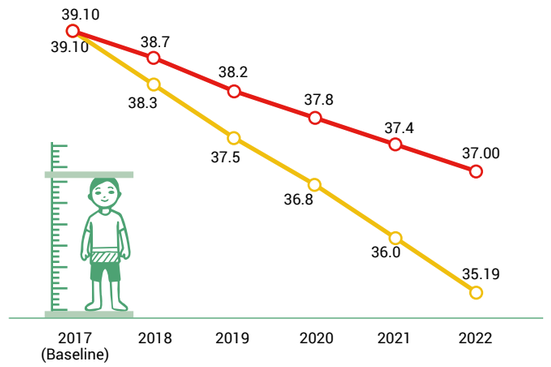
Reduce the prevalence of anaemia among women and adolescent girls in the age group of 15-49 years from 46.8 percent in 2016 to 39.78 percent (reduction of 3 percent per annum)

Reduce low birth weight prevalence from 23.2 percent in 2016 to 20.88 percent (reduction of 2 percent per annum)

reduction per annum

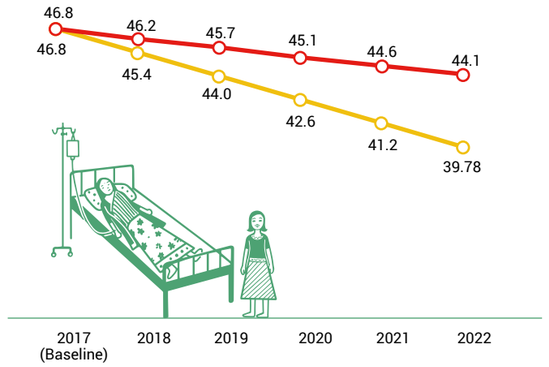
Target Versus Current Reduction

Stunting among children (0-6 years)



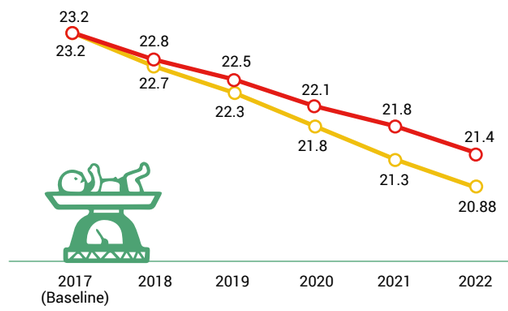
Current AARR-reduction at 1.1% per annum
Target AARR-reduction at 2% per annum

Anaemia among adolescents and women (15-49 years)



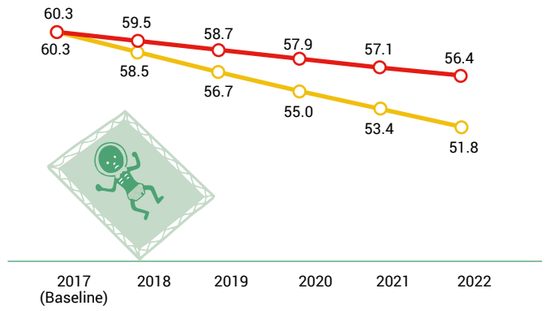
Current AARR-reduction at 1.3% per annum
Target AARR-reduction at 3% per annum

Low birth-weight prevalence



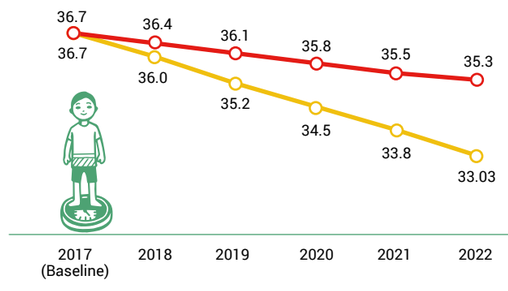
Current AARR-reduction at 1.56% per annum
Target AARR-reduction at 2% per annum

Anaemia among children (6-59 months)



Current AARR-reduction at 1.34% per annum
Target AARR-reduction at 3% per annum

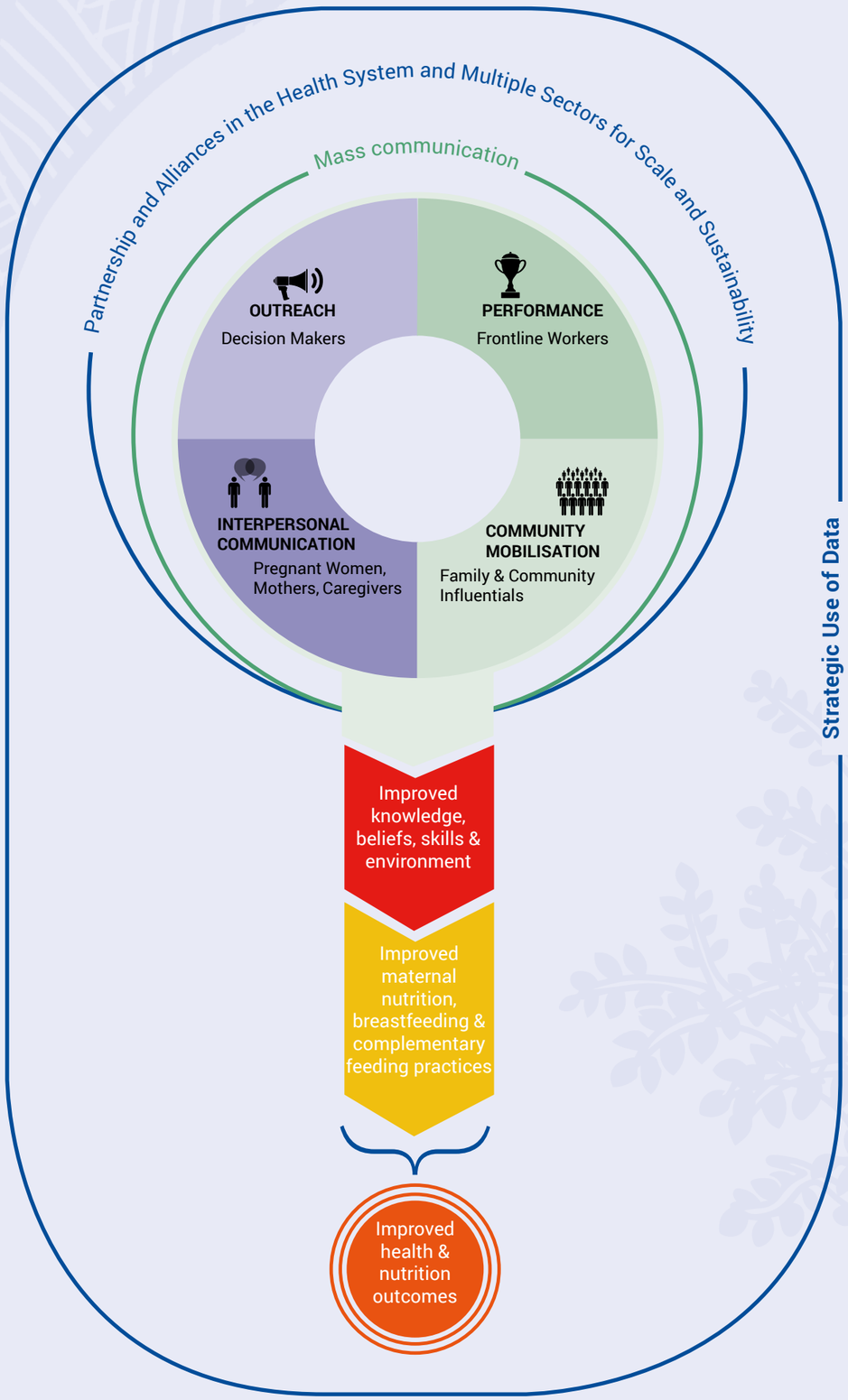
Underweight prevalence in children (0-6 years)



Current AARR-reduction at 0.80% per annum
Target AARR-reduction at 2% per annum

SOCIAL AND BEHAVIOUR CHANGE FRAMEWORK

SBCC Framework



SOCIAL AND BEHAVIOUR CHANGE FRAMEWORK

This SBC framework highlights the need to understand and address several levels of influence so that specific interventions can be tailored to leverage them for fighting undernutrition. It aims to create a pro-nutrition environment to improve maternal dietary practices and infant and young child feeding for accelerated achievement of nutrition results.

This comprehensive framework utilises a variety of programme components and channels and each one has a different role: reaching different audiences, expanding beyond service delivery platforms, and reinforcing/reminding about priority actions. It requires all programme components to work in close coordination to be able to create a change in Social Behaviour. It helps to identify the primary audience to be engaged through different programme components addressing the key determinants of priority behaviours (IPC with mothers, mobilisation of influential family and community members, strategic engagement with decision makers and mass communications for all audiences).

Key components of the Framework include:

Multi-stakeholder convergence

for coordinated action among various supply side stakeholders to address underlying determinants of nutrition, calling for both nutrition specific and nutrition sensitive interventions.

Strategic engagement and outreach

through interpersonal dialogue, group forums/workshops, and print and media channels, aimed at engaging key influential groups, raising awareness of the recommended practices and their benefits, ensuring quality and adequate coverage of proven interventions, and understanding the resources required at community, district and state levels.

Improving system performance

to ensure an enabling environment to facilitate SBC (e.g. skilled and motivated frontline workers, adequate supplies of IFA, continuous supportive supervision and monitoring for corrective action).

Interpersonal communication

to mobilise existing programme platforms such as NHM, ICDS and Self Help Groups (SHGs) to coach and demonstrate age-specific recommended practices, solve common difficulties that mothers face, and deliver consistent and age appropriate messages in a timely and convincing way; implemented through home visits, AWC/PHC visits, Mother and Child Health and Nutrition Days (MCHNDs), and outreach sessions.

Community mobilisation

to engage husbands, mothers-in-law, community influentials such as sarpanch, religious leaders and local doctors to endorse and encourage improved behaviours.

Mass communication

to model the behaviours for mothers and show the actions influential family and community members can take; include the use of TV, traditional channels such as local theater, mobile phones for accessing radio, video clips, text messages etc. for harmonising key messages across all participant groups from decision makers to family members.

Strategic use of data

generated through reporting mechanisms to make course corrections during the implementation and management of this BCC strategy.

This comprehensive framework utilises a variety of programme components and channels and each one has a different role: reaching different audiences, expanding beyond service delivery platforms, and reinforcing/reminding about priority actions.

LIFE-CYCLE APPROACH

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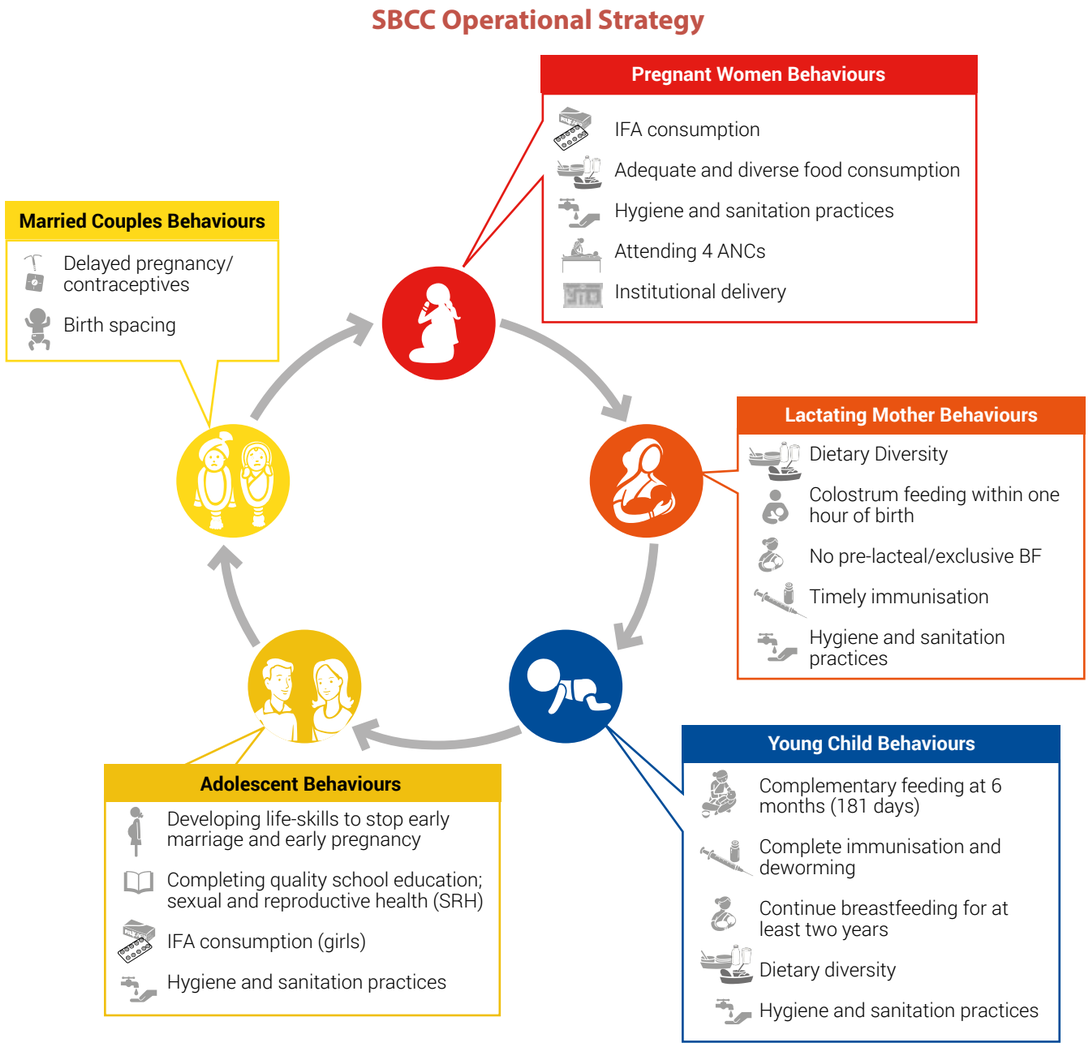
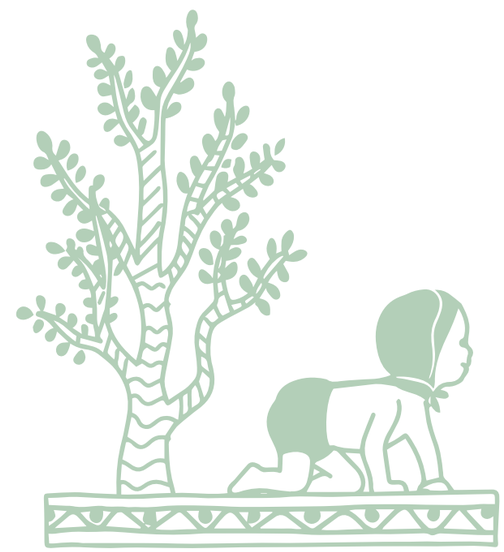
This SBC strategy is underpinned by a life-cycle approach that aims to focus on the current as well as the future generations of yet-to-be-born girls for overcoming the problem of undernutrition. Strategies that go beyond just pregnant and lactating women and improve nutritional behaviours at each step of the life-cycle – infants, adolescents and married but not yet pregnant women – are to be employed.



The strategy aims to reach out to the audience at various stages in the life-cycle to disrupt the intergenerational cycle of undernutrition, which is often perpetuated with a high incidence of babies born with low birth weight, more susceptible to infections, more likely to experience growth failure, reflected in high levels of adolescent and maternal undernutrition and anaemia. It will be critical to improve nutritional behaviours across the life-cycle, to avert irreversible cumulative growth and development deficits that compromise maternal and child health and survival; and undermine the achievement of optimal learning outcomes in elementary education, impairing adult productivity and undermining gender equality.

While working with various target audiences, the strategy will focus on:

1. Highlighting specific priority behaviours and actions for mothers, family members and community members.
2. Generating awareness and motivation among communities, families, individual women, mothers and caregivers.
3. Building demand for services to facilitate the adoption of practices.
4. Mobilising support from policy makers and programme authorities to relieve institutional and community constraints, provide a supportive environment and sustain momentum.
5. Convergence of operational elements to support individual behaviour change with effective service delivery and enabling policy environment.



SOCIAL AND BEHAVIOUR CHANGE STRATEGY

SOCIAL AND BEHAVIOUR CHANGE STRATEGY

The SBC strategy bases itself on a few key principles which have emerged from many years of programme experience and have shown significant effectiveness in improving nutritional behaviours:

- **Listening to mothers** regularly and appealing to their "hearts and minds".
- **Taking a comprehensive approach** and varying ways of delivering support and messages to families, particularly husbands.
- **Planning with an "at-scale" mindset and focusing on a few high impact behaviours.**
- **Coordinating and micro-planning at the district and block levels** to ensure convergence of multiple programmes (e.g. ICDS, NHM, SHG, rural development, agricultural extension, education, PRIs).
- **Basing decisions on data** and field testing innovations to solve problems and conduct rapid household trials.
- **Achieving intensity to reach pregnant women and mothers with different channels** and ensuring frequent, repeated exposure to messages using Interpersonal Communication (IPC) and mass communication channels (print, mobile phone, TV, etc.).
- **Tracking the reach and impact** of community mobilisation and mass media and make adjustments as needed.
- **Allocating adequate resources** and adequate time to shift norms and behaviours.

Priority Behaviours

The priority behaviours that will be focused on, for improving the nutritional outcomes in the state include:

1 Pregnant women	Consume one daily IFA supplement for 180 days Consume adequate amount of food to meet the caloric and protein needs throughout pregnancy Eat at least 5 defined types of foods daily throughout pregnancy Attend 4 ANCs Wash hands with soap before handling food
2 Mothers of infants below 6 months	Initiate breastfeeding immediately after delivery (within one hour) Do not feed pre-lacteal foods or liquids after delivery and feed only colostrum Breastfeed exclusively from birth through 6 months (180 days), do not give water (medicines and vitamins are permitted) Consume adequate amount of food to meet the caloric and protein needs of self and baby Timely Immunisation Wash hands with soap before eating and feeding their children
3 Mothers and caregivers of infants and young children from 6 to 24 months	Introduce feeding of semi-solid/solid complementary foods at 6 months (181 days) Continue breastfeeding for at least 2 years Feed at least 4 defined types of foods daily to children 6 to 24 months Immunisation and deworming Handwashing with soap before preparing and feeding young children
4 Adolescent girls and boys	Consume IFA supplements (girls) Develop life-skills to stop early marriage and early pregnancy Complete quality school education Follow appropriate hygiene and sanitation practices
5 Married couples	Use of contraceptives for delaying pregnancy Birth spacing to ensure adequate care is given to a newborn, as well as to maintain her own health

● Primary Audience ● Priority Behaviours

Audience and Influencer Ecosystem

Behaviour change interventions will encompass the influencer ecosystem including family (husband and mother-in-law) and community members who can influence mothers for practicing desired behaviours. Pregnant women, mothers of young children, adolescents, married couples are the **primary audience**, and those who influence them such as husbands, mothers-in-law, front line workers, influential community members, and doctors are the **secondary audience**.

- **Pregnant women and mothers, as well as adolescent girls** need to understand and believe in the benefits of priority behaviours and acquire skills and confidence to follow recommended practices and dietary recommendations.
- **Family members** need to ensure procurement of IFA supplements; specific nutrient rich food, water and soap for hygiene are available; reallocate family roles and resources and adjust expectations about gender roles. Focus of needs to be shifted towards husband and mothers-in-law to move the "behavioural needle" quickly.
- **Community members** need to be aware of social/gender/work-related norms, and what specific supportive actions they can take to help strengthen womens' connectivity to services/resources/media/markets.
- **Frontline workers** need to ensure coverage/scale/quality, appropriate timing and duration, timely support and problem solving; improvements in supplies and supervision are critical.
- **Policy level decision makers** need to be motivated to prioritise and implement evidence based policies and protocols, establish a robust system of monitoring of proven interventions and increase investments in IYCF and maternal nutrition. Convergence between departments within the state will be key to achieving positive results and impact nutrition indicators.

Data from successful nutrition programmes and other SBC strategies shows that reaching these audiences with targeted messages using multiple channels accelerates the speed of Behaviour Change (Alive & Thrive, 2016). The following table summarises the influencer ecosystem that will be targeted to affect the behaviours for various primary targets.

1 Pregnant women (PW)	Husbands Mother-in-law (MIL) Frontline Workers (FLW) Community Members Doctor	• MCHND • SHGs • Community Events
2 Mothers of infants below 6 months	Husbands MIL FLW Community Members Doctor	• MCHND • SHGs • Community Events • Mothers' Groups
3 Mothers and caregivers of infants and young children from 6-24 months	Husbands MIL FLW Community Members	• MCHND • SHGs • Community Events • Mothers' Groups
4 Adolescent girls and boys	FLW Teachers Peer Educators Community Members	• Ujala Clinics
5 Married couples	Husbands MIL FLW	• Gram Panchayat • SHGs

● Primary audience ◑ Influencer ecosystem ○ Influentials ● Platforms

Messaging and Communication Channels

Messages about what a person should do, even if the health benefits are explained, often are not enough to change practices. Understanding what motivates change or prevents change is key to an effective SBC strategy. Each message or material used for SBC within the state will address one or more of the following conditions:

- The person who is asked to change their behaviour, for example, pregnant women and mothers, must be clear about the specific "small doable action" to be carried out.
- They must believe in the benefits of Behaviour Change, consider those benefits relevant for them, and feel good about making the change (e.g. when a mother perceives that her child cries less and sleeps well when fed appropriately). Often behaviours are linked with outcomes that may have nothing to do with the health and nutrition goals, but the mother sees as immediately beneficial (e.g. the child sleeps better or is less demanding) or it is something she aspires (e.g. a well-educated child).
- Mothers and their families are confident that they can carry out the action without much difficulty. It is feasible, and they have the necessary skills, supplies and materials to act on the knowledge (e.g. improving dietary diversity by identifying a locally available affordable food that is usually in the home or adding an egg several times a week).
- Pregnant women and mothers believe other women in the community are doing the same, and influential family and community members will approve of the action (e.g. this may mean approval of husbands and mothers-in-law or endorsement of doctors for early initiation of breastfeeding).

Messages can be shared in many formats through written or spoken text, photos and illustrations, film, songs and music, drama and theatre, or with charts, graphs and data. The preferences, capacities, and responses of the audience will determine what format is selected. Programmes and platforms such as ICDS, NHM, SHGs and PRIs which regularly communicate with women, mothers and families are a powerful channel of communication for nutrition SBC. Direct interpersonal communication by frontline workers and service providers substantially increases the impact and accelerates Behaviour Change as compared with mass media alone. With careful planning and scheduling, repeated contacts with primary and secondary targets can be achieved. Repetition is positive as different workers reinforce the recommended practices. Mass media can reinforce and deliver the messages in a credible and emotionally appealing way, as well as fill gaps in IPC contacts that may be missed by frontline workers.

Data from successful nutrition programmes and other SBC strategies shows that reaching these audiences with targeted messages using multiple channels accelerates the speed of Behaviour Change.

ELEMENTS OF SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION

NON-CONSUMPTION OF IFA BY PREGNANT WOMEN

MESSAGES

1. Regular consumption of IFA reduces tiredness and ensures baby's development
2. Regular consumption of IFA reduces chances of preterm delivery and excess bleeding during delivery
3. Managing side effects of IFA consumption.

PREFERRED BEHAVIOURS/ACTIONS

PRIMARY AUDIENCE

PREGNANT WOMEN

- Consumes one IFA tablet per day from second trimester (fourth month) of pregnancy
- Asks the frontline worker or her husband to supply her with daily IFA tablets

SECONDARY AUDIENCE

HUSBAND

- Procures IFA tablets, if not available through the ANM, AWWs
- Reminds wife for consumption

MIL

- Can talk to their sons about the need for IFA tablets
- Reminds PLW about taking IFA

FLWs

- Undertake home visits as per schedule, check IFA consumption in recent past (last month) by verifying empty strips, counsel them on the benefits of compliance, address problems, if any (like side effects)
- Monitor regular supply of IFA

MEDIUM/CHANNELS

PRIMARY AUDIENCE

PLW

- IPC delivered at ANC contacts, MCHND and home visits by AWW
- Prompts and reminders by husbands and MIL
- TV/radio spots
- Print materials at AWCs

SECONDARY AUDIENCE

HUSBAND

- By FLWs at first ANC
- Community mobilisation events/ religious gatherings
- Panchayat meetings
- Mobile phones - SMS, Whatsapp, audio/ video messages
- TV/radio spots, newspapers

MIL

- Directly addressed by FLW during home visits
- Community mobilisation events/ religious gatherings
- SHG/women's group meetings
- TV/radio spots

FLWs

- Training on specific messages and counselling techniques
- Appropriate job aids & tools
- Performance monitoring and performance based incentives
- Mobile phone based text messages
- Audio-video clips
- TV/radio spots, newspapers

INADEQUATE CONSUMPTION OF NUTRITIOUS AND DIVERSE FOOD

MESSAGES

1. Good nutrition during pregnancy and lactation protects mothers, and ensures proper growth and development of the child
2. Consume at least 5 defined varieties of food
3. In case increasing food intake in regular meals is not possible, increase frequency of food intake and introduce healthy snacking.

PREFERRED BEHAVIOURS/ACTIONS

PRIMARY AUDIENCE

PREGNANT WOMEN

- Eat three meals a day
- Consume at least 5 defined varieties of food
- Request husband to bring one additional seasonally available defined food group (e.g. yellow/orange fleshed fruit/vegetable, or glass of milk, egg)

SECONDARY AUDIENCE

HUSBAND

- Purchase defined foods
- Reminds wife for consumption

MIL

- Reminds son to buy/ procure food
- Encourage PW to consume at least 5 defined varieties daily

FLWs

- FLW does prompt home visit
- FLW talks to pregnant woman and family and explains the need of eating more (throughout the day) and increasing needs at each trimester
- Explains importance of diverse and healthy food with examples and job aids

MEDIUM/CHANNELS

PRIMARY AUDIENCE

PLW

- IPC by FLWs
- Prompts and reminders by husbands and MIL
- Mass Media
- Print materials at AWCs

SECONDARY AUDIENCE

HUSBAND

- Community mobilisation events/ religious gatherings
- Panchayat meetings
- Mobile phones - SMS, Whatsapp, audio/ video messages
- Mass Media

MIL

- Directly addressed by FLW during home visits
- Community mobilisation events/ religious gatherings, Saas Bahu Sammelan
- SHG/women's group meetings
- TV/radio spots

FLWs

- Training on specific messages and counselling techniques
- Appropriate job aids & tools
- Performance monitoring and performance based incentives
- Mobile phone based text messages
- Audio-video clips
- Mass Media

MESSAGES

1. Early reporting and regular check-ups ensure health and safety of the baby in the womb
2. Preventive check-ups will avoid complications during delivery.

PREFERRED BEHAVIOURS/ACTIONS

PRIMARY AUDIENCE

PLW

- Reports pregnancy as soon as the period is missed or as early as possible within first three months of missing the period
- Attend all 4 ANCs

SECONDARY AUDIENCE

HUSBAND

- Accompanies wife for registration and subsequent ANCs
- Reminds wife for ANCs

MIL

- Encourages son to take his wife for ANCs
- Accompanies the pregnant woman to ANCs if husband is not available

FLWs

- FLWs do home visit to remind pregnant women about ANCs
- FLWs talk to pregnant woman and family and explain the importance of regular check-ups

MEDIUM/CHANNELS

PRIMARY AUDIENCE

PLW

- IPC by FLWs
- Prompts and reminders by husbands and MIL
- Posters/Flipcharts given to them at the time of registration
- Mid-media, nukkad naataks, regional songs
- TV/radio spots

SECONDARY AUDIENCE

HUSBAND

- Community mobilisation events/ religious gatherings
- Panchayat meetings
- Mobile phones - SMS, Whatsapp, audio/ video messages
- TV/radio spots, newspaper

MIL

- Directly addressed by FLW during home visits
- Community mobilisation events/ religious gatherings, Saas Bahu Sammelan
- SHG/womens group meetings
- Mid-media, nukkad naataks, regional songs

FLWs

- Training on specific messages and counselling techniques
- Appropriate job aids & tools
- Performance monitoring and performance based incentives
- Mobile phone based text messages
- Audio-video clips
- Mass Media

MESSAGES

1. Give breastmilk within one hour of delivery to ensure good health of child
2. Mother's first milk saves a child's life by building immunity
3. Do not give water or other liquids/fluids to your baby during the first days after birth.

PREFERRED BEHAVIOURS/ACTIONS

PRIMARY AUDIENCE

PLW

- To ask family members who are present during delivery to ensure that the baby is put to the breast within an hour
- To put the baby to her breast within the first hour

SECONDARY AUDIENCE

HUSBAND

- Can talk with their own mothers to ensure the family has a plan for early initiation of breastfeeding

MIL

- Can advocate for early initiation soon after delivery, whether it is at home or in the institution
- Handing over the baby to the mother immediately after delivery and encourage her to put the baby to the breast
- Refusing to give or allow pre-lacteals and encouraging the mother to give (and not discard) colostrum

FLWs

- Counsel on early initiation of breastfeeding in third trimester of pregnancy during home visit or 'Godbharai' event
- Can encourage pregnant women to have a plan for early initiation and exclusive breastfeeding
- Ensure that the baby is put to the breast in the first hour in home deliveries including recording & reporting
- Promote/counsel during MCHNDs early and exclusive initiation of breastfeeding; record and report early initiation data

MEDIUM/CHANNELS

PRIMARY AUDIENCE

PLW

- IPC delivered at MCHND sessions for immunisation and home visits by AWW
- By the doctor/mid-wife at the point of delivery
- TV/radio spots
- Print materials at AWCs

SECONDARY AUDIENCE

HUSBAND

- Community mobilisation events
- Directly addressed by frontline workers during visits with pregnant women, religious gatherings, mobile phones for delivery of SMS and/ or video or audio clips to be uploaded on mobile phones
- TV spots, newspapers, national media campaign

MIL

- Directly addressed by FLW/Doctors
- Community mobilisation events/ religious gatherings
- SHG/women's group meetings

FLWs

- Training on specific messages and counselling techniques
- Appropriate job aids & tools (possibly including audio or video pieces to play for families)
- Performance monitoring and performance based incentives
- Mobile phone based text messages
- Audio-video clips
- Mass Media

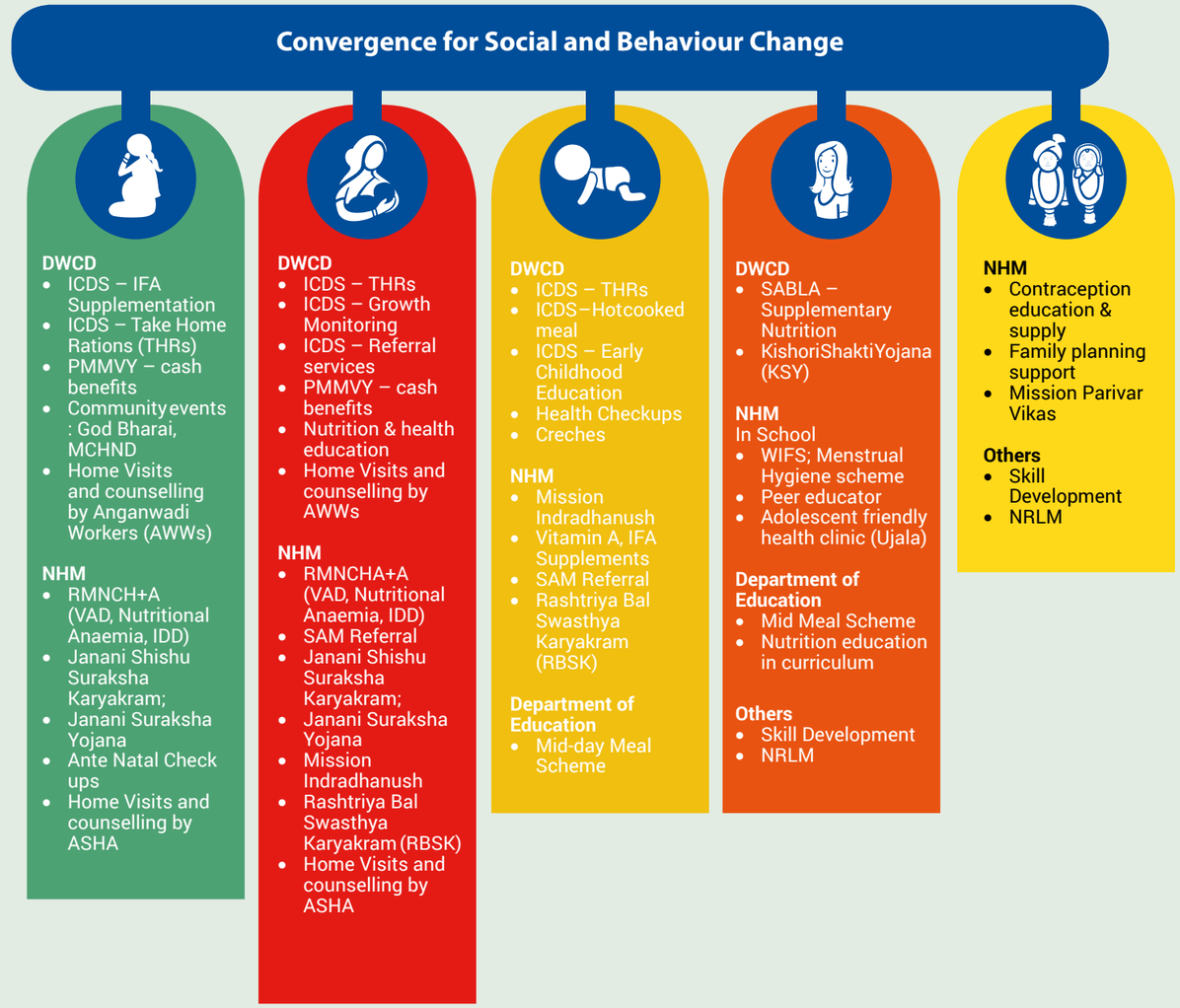
CONVERGENCE

CONVERGENCE

The life-cycle approach that underpins the state SBC strategy also acts as a key catalyst for operational and programmatic convergence between various state departments and their flagship programmes. This SBC strategy will involve various departments within the state such as women and child development, health, food and public distribution, sanitation, drinking water, rural development, livelihoods, education and agriculture, among others to work together in a multi-sectoral nutritional response. Across the life-cycle, various programmes and their concerned departments will play an important role in addressing various determinants of nutrition through Behaviour Change interventions. The state nutrition strategy – 'Nourishing Rajasthan – Vision 2022' has already set out the mechanism for programmatic convergence, through the setting up of a state level convergence committee, and one of the key aims of the committee is to ensure the convergence through joint development of State/District Implementation Plans for ICDS, NHM and Swachh Bharat and others, addressing different determinants of undernutrition together.

The tools to achieve programmatic convergence at the field level, will include:

- MCHND as a platform for convergence of services to the mother and child and a forum for growth promotion and behavioural change counselling.
- Joint community monitoring of nutrition status of children under 3 years at panchayat, village/AWC and health sub centres.
- Joint community communication and village contact drive by mapping and weighing of children, in front of the community, making undernutrition visible.
- Linking the concept of "kuposhan mukt panchayats" to the convergent gram panchayat plans being prepared for rural development. Trained panchayat members (especially women) and women's SHGs mobilised under NRLM will play a key role in this.
- Strengthening of the Village Health Sanitation and Nutrition Committees, recognised as sub committees of panchayats.
- Joint planning, training and capacity development of front line workers on effective counselling and problem solving.



MONITORING CHANGE – TRACKING INDICATORS

MONITORING CHANGE – TRACKING INDICATORS

The NNM has laid out a framework for regular monitoring of nutrition outcomes, including a web enabled Nutrition Information System to monitor the Nutrition Strategy, linking MIS of ICDS, NHM/PCTS and data from Swachh Bharat. It has also proposed integration of child nutrition status monitoring within the Health MIS and the NHM Parent Child Tracking System. The DWCD, on its part, has already initiated work on a similar monitoring mechanism at the state level. To ascertain the impact of the behaviour change and programmatic interventions undertaken by the state for improving nutritional outcomes, the DWCD will monitor the key outcome level indicators periodically. The State and District Level Implementation Plans will also include a number of process indicators such as percentage of FLWs trained on counselling techniques, percentage of Anganwadi Centres (AWCs) supplied with updated IEC materials, number of awareness camps held, etc. that will need to be tracked on a monthly basis.

Category of beneficiary	Indicators to be tracked
Pregnant women	IFA consumption by pregnant mothers % pregnant women gaining 8 kg. or more weight during pregnancy Number of pregnant women who register in first trimester of pregnancy Number of pregnant women attending atleast 4 ANCs Number of women participating in MCHNDs Number of pregnant women counselled through home visits
Lactating women	% infants initiated breastfeeding within one hour of birth Number of lactating mothers counselled on priority behaviours through home visits Participation of lactating mothers at MCHNDs
Infants and children < 5 years	% of infants with low birth weight % children exclusively breastfed for 6 months % children introduced to complementary food on completing 6 months of age Number of children who are stunted Number of children who are wasted Number of children who are undernourished % of severely malnourished children Number of children completing immunisation and deworming cycles % of children who are anemic
Adolescents	Number of adolescent girls consuming IFA supplements (girls) through WIFS % of adolescent girls and women with anaemia

"To keep the body in good health is a duty, otherwise we shall not be able to keep our mind strong and clear"

Buddha

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