TO DEVELOP AND ROLL-OUT SOCIAL BEHAVIOUR CHANGE COMMUNICATION (SBCC) STRATEGY FOR MEGHALAYA HEALTH SYSTEMS STRENGTHENING PROJECTS (MHSSP)

[Inception Report]

Submitted to :

The Project Director

Department of Health & Family Welfare (DoHFW),
Government of Meghalaya,
Meghalaya Health Systems Strengthening Project (MHSSP),
Health Complex, Red Hills,Laitumkhrah,
Shillong-793003, Meghalaya

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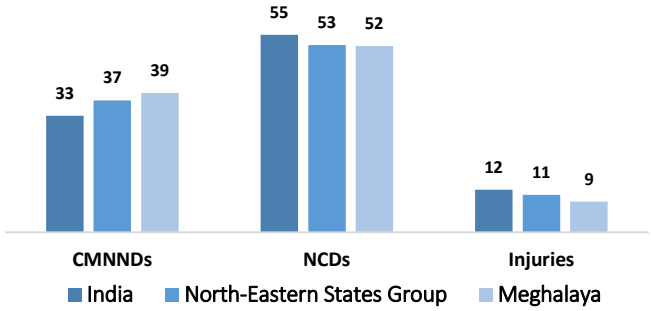
CHAPTER 1

INTRODUCTION

1.1 Background

Meghalaya is part of the North-East region of India and is **predominantly rural**, with a **distinct tribal identity**. The State was formed by carving out two districts from the state of Assam - the United Khasi Hills and Jaintia Hills, and the Garo Hills on 21 January 1972. Compared to the national average, **Meghalaya's performance on key health outcomes is mixed,** with a significant improvement over time, but **with large rural-urban disparities and growing burden on Non-Communicable Diseases (NCDs)**. The total disease burden of Meghalaya vs. the national and regional average is shown in Figure 1.1. It is estimated that in 2016, **NCDs** (such as hypertension, diabetes, cardiac conditions and cancers) **accounted for about 52 percent of all deaths in Meghalaya**, with another 7 percent due to injuries. [1]

Figure 1.1: Proportion of Total Disease Burden (2016)
Meghalaya vs. National & Regional Average



Source: India: Health of the Nation's States Report (2017)

In 2019-20, the Infant Mortality Rate (IMR) of Meghalaya increased from 30 (in 2014-15) to 32 per 1,000 live births, while the prevalence of stunting in children under the age group of 5, increased from 43.8% (NFHS-IV: 2015-16) to 46.5% (NFHS-V:2019-20). An inquiry into the possible reasons reflects **significant gaps and inequalities in health service coverage**. In 2019-20, only 64% children aged 12-23 months were fully immunized and institutional delivery stood at a bare 58%. The rural areas fare poorly across multiple indicators like - the infant mortality rate (33.6 per 1000 live births in rural area as against 23.4 in urban), women who have had at least 4 ANC visits (50% in rural areas and 68% in urban), etc. Further, the prevalence of stunting, low weight and anaemia are higher in rural areas.[2] **At the referral level, only 60% of the 41 District Hospitals & Community Health Centres (CHCs) designated as First Referral Units (FRUs) are functional in the State.**

The **population is more dependent on government health services** compared to other states in India, although household **out-of-pocket spending on health care is still a significant burden** on the poor. The state budget for health in the fiscal year 2019-2020 was 7.4 percent of total public expenditure, which is significantly higher than the national average of 3.9 percent. In Meghalaya in 2017, the average out-of-pocket expenditure (OOPE) incurred by patients for a hospitalization was INR 2,385 for

[1] Indian Council of Medical Research, Public Health Foundation of India and Institute for Health Metrics and Evaluation. 2017.
[2] National Family Health Survey (NFHS-5), 2019-20.

treatment at a public hospital and INR 27,375 at a private hospital.[3] Additionally, there are significant rural-urban differences, with OOPE in rural areas at INR 3,190 and INR 3,353 in urban public health facilities.

1.2 Meghalaya Health Systems Strengthening Project (MHSSP)

Considering the aforementioned challenges, the Government of Meghalaya has partnered with the World Bank to implement the Meghalaya Health Systems Strengthening Project (MHSSP). **The project's objective is to improve both the utilization and quality of health services in Meghalaya**. MHSSP is aimed at enhancing accountability, quality, and utilization of health services in Meghalaya, especially the services provided through public facilities at Primary Health Centres (PHCs), Community Health Centres (CHCs), and at district level hospitals. The project is focused on 4 broad areas of action:

- **Improving accountability and strengthening governance through Internal Performance Agreements (IPAs):** This includes supporting the creation of an enabling environment for reforms, enhancing performance, and improving efficiency at all levels of healthcare services
- **Strengthening systems to sustain the quality of health service** – This includes improving quality of care and augmenting systems related to HRM, waste management, procurement, etc.
- **Increasing coverage and utilization of quality health services** – This entails increasing coverage of the state health insurance program, strengthening primary care, and designing and implementing community interventions
- **Contingent Emergency Response Component**: Setting up an immediate Emergency Response System (ERS)

1.2.1. Strategic Context of the Project

When the Project Appraisal Document (PAD) of the Meghalaya Health Systems Strengthening Project (MHSSP) was reviewed, it was found that there are two broad grounds based on which this assignment has been proposed. These are the **country context** and the **sectoral and institutional context**. As far as the country context is concerned, as described in the PAD document and as has been experienced in the past three years, "India's gross domestic product (GDP) growth had been slowing in the three years before the COVID-19 outbreak, the onset of which is expected to have had a significant impact." Furthermore, while the country has undertaken several commendable measures over the years to ensure the elimination of poverty, the pandemic has caused a reversal in the course of poverty reduction. Between 2011–12 and 2017, India's poverty rate is estimated to have declined from 22.5 percent to values ranging from 8.1 percent to 11.3 percent. However, recent projections of GDP per capita growth, considering the impact of the pandemic, suggest that poverty rates in 2020 have likely reverted to estimated levels in 2016.[4]

[3] Health – NSS 75th Round (July 2017-June 2018). Ministry of Statistics & Programme Implementation. National Statistical Office.

[4] Meghalaya Health Systems Strengthening Project (MHSSP)- Project Appraisal Document, World Bank

On the other hand, when the sectoral and institutional context of the country and the state are examined, several other aspects that support the execution of the MHSSP project in the state are discovered. Some of these factors are listed as follows:

- In India, the health sector has witnessed several reforms, particularly in service delivery and financing. The investments in the health sector have increased over the years through various reforms such as the National Health Mission (NHM), positive revisions in the share of central tax devolution in the 14th Finance Commissions, expansion of the Rashtriya Swasthya Bima Yojana, a health insurance program for the poor, into Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), etc.
- In Meghalaya, the state budget is dependent on central transfers, with significant deficits limiting the fiscal space for investment. The state is mainly dependent on fiscal transfers from the Central Government, as its own resources constitute less than 20 percent of total revenue (Central Statistics Office and state budget documents). This has led to erratic growth in government health expenditures in the state along with lower capital expenditure in the sector.[5]
- Significant gaps and persistence of inequalities in the spread of healthcare services in Meghalaya is another alarming factor that necessitates the implementation of such a holistic health program in the state.
- There are weaknesses in accountability, management, and service delivery systems. In 2017–18, the average number of days taken for the transfer of NHM funds from the state level to implementing agencies was 58 days. While this is on par with other states in India, it is an increase of 20 days from 2015–16.[6] It is further noted that During the three years before 2017–18, district chief medical officers in Meghalaya spent an average of almost two years in their posts, indicating relative stability in management at the district level.

So as to say, the incidence and impact of the COVID-19 outbreak were no different in the state in comparison to the other states in the country. This pandemic has shed light on the gaps in the health system of the state. The lack of adequate and competent staff, unavailability of medicines and drugs, improper healthcare infrastructure, and poor transportation and communication facilities in the state has increased the distance between the service providers and the community. This further aggravates the demand for revisiting the health systems in the state and taking necessary steps to bridge these gaps.

1.2.2. Project Development Objectives

The Project Development Objective (PDO) is to improve management capacity, quality, and utilization of health services in Meghalaya. The PDO Level Indicators for the assignment as listed in the Project Appraisal Document (PAD) have been illustrated in Figure 1.2.

[5] Meghalaya Health Systems Strengthening Project (MHSSP)- Project Appraisal Document, World Bank
[6] GoI 2019.

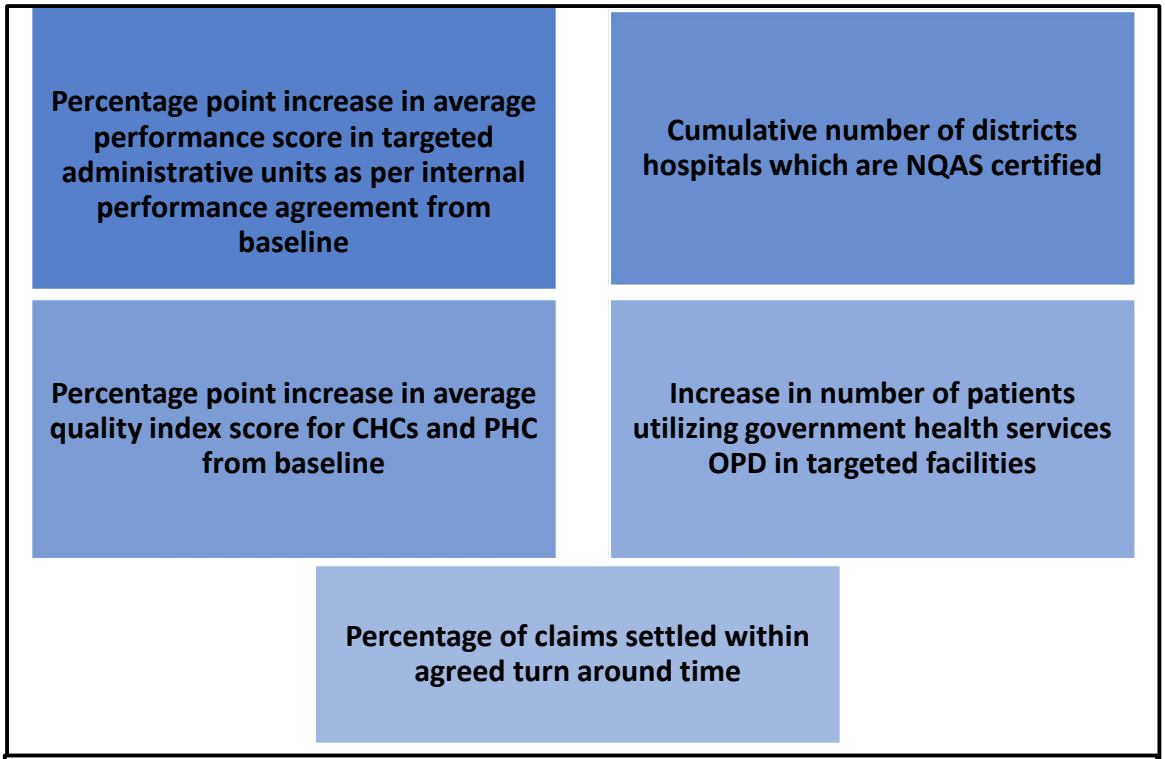


Figure 1.2: PDO Level Indicators for the MHSSP Project
(Source: Project Appraisal Document, MHSSP)

1.3 Rationale of the Assignment

The Government of Meghalaya has identified the **need to implement a carefully designed advocacy, communication, and social mobilization strategy**. The proposed communication strategy is expected to serve the information needs of both the demand and supply-side stakeholders. From the supply-side, the project identified the need for documenting and creating material for awareness generation about the MHSSP interventions, and to create a quality service orientation among the service providers and motive them to adopt a result-oriented Behaviour. Further, to enhance the uptake of Government health services, it aims to generate awareness in the community about the health services offered by the State. The Government of Meghalaya invited proposals with the aim of hiring an independent agency to take up the assignment to **develop and roll-out a Social Behaviour Change Communication (SBCC) strategy** for MHSSP. Our organization (AMS) has been commissioned to undertake this assignment. The sections presented ahead to showcase the technical approach, methodology, and work plan that our organization (AMS) proposes to adopt if offered an opportunity for undertaking the said assignment.

Advocacy: To generate positive orientation among supply side stakeholders

Social Mobilization: To educate and motivate the community to promote positive health behavior

Behavior Change Communication: To create awareness in the community

CHAPTER 2

REVIEW OF LITERATURE

2.1 Basic Profile of Meghalaya

Meghalaya is one of the seven sisters that comprises northeast India. It extends for about 300 kilometers in length and about 100 kilometers in breadth. It is bounded on the north by Goalpara, Kamrup, and Nowgong districts, on the east by Karbi Anglong and North Cachar Hills districts, all of Assam, and on the south and west by Bangladesh. Established in the year 1972, Meghalaya is the home of various tribal communities which mainly belong to three groups- **Garo, Khasi, and Jaintia.** While Garos are believed to be the descendants of the Tibeto-Burmar race who came down from Tibet to the north-eastern states, the Khasis and Pnars or Jaintias are the descendants of Proto Austroloid Monkhmer race. Apart from these, there are many other tribes in Meghalaya. They are Bhois in the north of Meghalaya, Khynriams in the central, and Wars in the southern region. They are all a sub-tribe of Khasis and live a lifestyle similar to that of the Khasis. These communities are settled across the three hills, named after the major tribes of the state- **the Garo Hills, the United Khasi Hills, and the Jaintia Hills,** which is divided into 11 districts at present as shown in Figure 2.1.

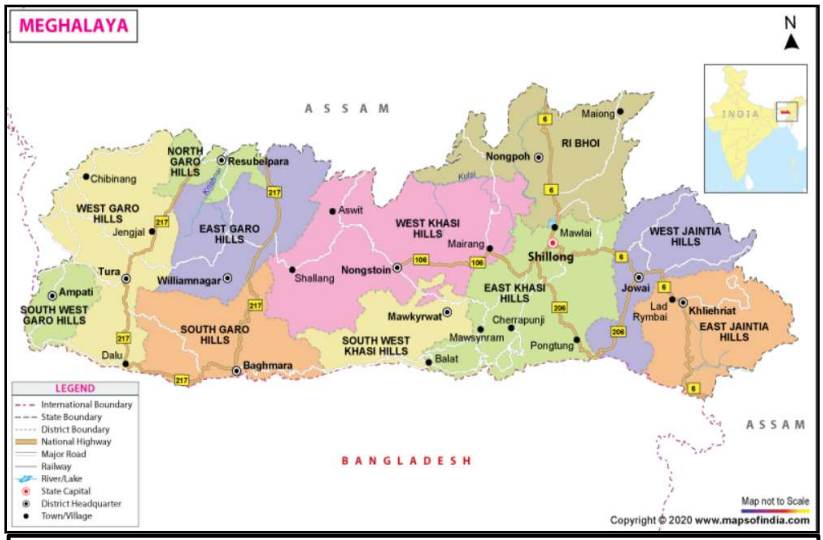


Figure 2.1: District Map of Meghalaya, India (Source: https://www.mapsofindia.com/maps/meghalaya/)

As per the Census of 2011, the population of Meghalaya was noted to be around 29,66,889 with the dominance of the rural population comprising almost 80%. Besides, the decadal growth percentage of the state was found to be around 28% which was higher than the national decadal growth rate of 18%. Furthermore, the major source of livelihood for the state of Meghalaya is agriculture. Altogether, 4 in every 5 people in Meghalaya are primarily dependent on farming as a source of livelihood. Owing to agro-climatic variations, the state has a vast potential for the cultivation of temperate, sub-tropical, and tropical fruits and vegetables.

2.2 Health Systems in the State of Meghalaya

The World Health Organisation, during its constitution, stated that **"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."** This statement has laid the basis to declare someone as healthy or unhealthy for several decades.

Furthermore, the Bhore Committee (1946) has mentioned that inability to afford a secure healthcare service should not act as a hindrance for any individual. It also reported that the health facility should be established at locations that are close to the people so as to ensure that communities receive their maximum benefits.

In India, while the major responsibility for creating infrastructure and building manpower largely rests with the State Government, various disease control programmes and Family Welfare Programmes are financed by the Center, along with some assistance from external agencies. However, they are implemented with the help of the State Health Machinery available.[7]

In Meghalaya, the setting up of health infrastructure has taken place at different levels over the years. While many hospitals have been set up during the period when it was a part of Assam and when it became an independent state, at present the health systems of the state can be understood in terms of the Public Healthcare Infrastructure and the Private Healthcare Infrastructure. The apex body in the state of Meghalaya that is responsible for maintaining health care systems and supervising the Health and Family Welfare Programmes in the region is **the Ministry of Health and Family Welfare (MoHFW), Meghalaya.** The activities of the department include establishment and maintenance of medical institutions with necessary infrastructure, implementation of National Disease Control and Eradication

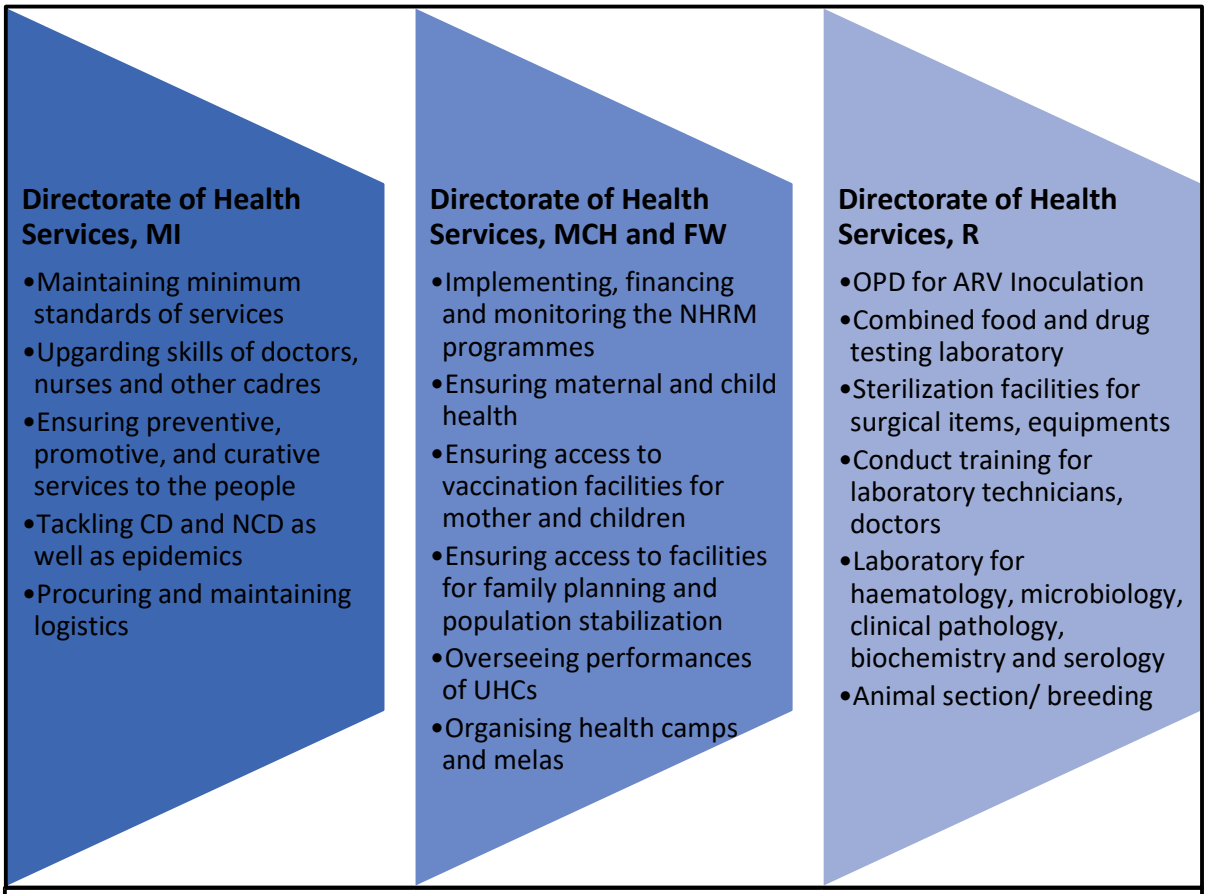


Figure 2.2: Citizen Charter of the Directorates under MoHFW, Meghalaya

Programmes, Control of communicable as well as non-communicable diseases, etc. Acting as an administrative wing, the MoHFW is also entrusted with the task of overseeing and coordinating the

[7] (Meghalaya Human Development Report 2008, 2008)

operations of three main Directorates: **1. Directorate of Health Services, MI (Medical Institutions); 2. Directorate of Health Services, MCH and FW (Maternal and Child Health and Family Welfare); and, 3. Directorate of Health Services, R (Research).** Some of the primary roles and responsibilities of these three Directorates have been presented in Figure 2.2.[8]

Furthermore, the three-tier health delivery system is found to be operational when the public sector health infrastructure is studied. This includes the **Sub-Centers, the Primary Health Centers, and the Community Health Centers.** As per the Department of Family and Health Welfare, Meghalaya, there are **31 Community Health Centers, 110 Primary Health Centers, and 463 Sub-centers along with 13 Dispensaries across the 11 districts of the state.**[9]

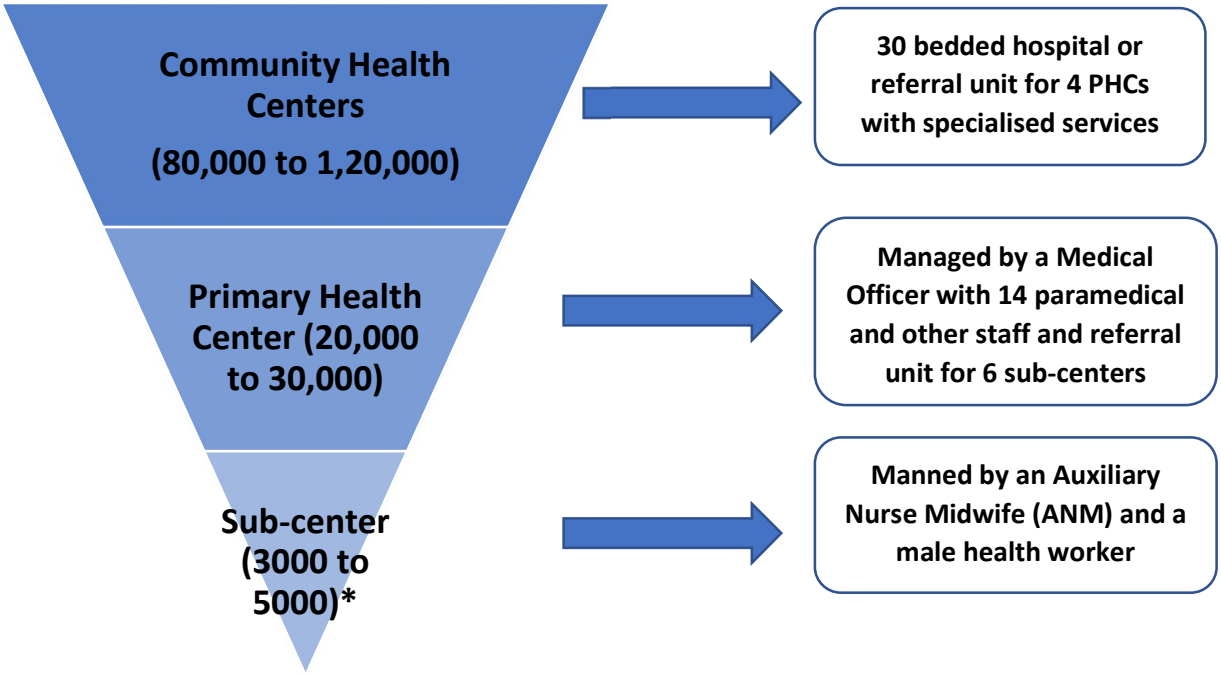


Figure 2.3: Three-tier Health Delivery System in Public Sector, Meghalaya

(*Note: Range in terms of population for hilly/tribal/desert areas to population for plain areas.)

Besides, a district hospital is the major health care delivery system in a certain district or region. It is staffed by medical officers, physicians, surgeons, other specialists, nurses, and paramedical personnel. It has beds for indoor patients as well as for patients requiring intensive care and long-term care. It is equipped with an operation theatre, X-ray, labour room, and laboratory facilities. The state has **district/Civil hospitals** at Tura, Jowai, Nongpoh, Williamnagar, Baghmara, Ampati, Khliehriat, Nongstoin, and Mairang. The state also has a mental health hospital and a T.B. hospital, namely, MIMHANS and R.P. Chest hospital. There are three Maternal and Child Health hospitals i.e., Ganesh Das Govt MCH hospital at Shillong, District MCH hospital at Tura, and MCH Hospital at Panaliar, Jowai. Altogether, there are 15 districts hospitals.[10]

[8] Formulation of the Citizen's Charter of the Health and Family Welfare Department
[9] Department of Health and Family Welfare, Government of Meghalaya (http://meghealth.gov.in/health-centres.html)
[10] Department of Health and Family Welfare, Government of Meghalaya (http://meghealth.gov.in/hospitals.html)

Additionally, around 18 private hospitals, set up in the state, have been noted to have been empanelled with the Meghalaya Health Insurance Scheme (as per mhis.org.in). Certain health institutions have also been established by the Central Government such as The North East Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIHMS), Military and Paramilitary Health Institutions, Regional Directorate of Health Services, Ministry of Health, GoI, Central Government Health Scheme (CGHS) and the Employees' State Insurance (ESI) services. [11]

2.3 Performance of Meghalaya on Various Health Indicators

To understand how has been the performance of the state concerning health, a number of indicators have been taken from the NFHS- 5 data that has been collected during 2019- 2021. The overall performance of the state on several health indicators was compared to the national figures for a number of aspects such as Sex Ratio, Fertility Rate, Maternal Healthcare, Infant Mortality Rate, Family Planning Practices, Institutional Deliveries, Sanitation, Drinking Water Facility, and Coverage of members under Health Insurance/Financing scheme. The comparison has been tabulated in Table 2.1.

Table 2.1: Comparison of Overall Performance of Meghalaya with India on Several Health Indicators

Indicators	Meghalaya	India
Sex ratio of the total population (females per 1,000 males)	**1,039**	1,020
Sex ratio at birth for children born in the last five years (females per 1,000 males)	**989**	929
Total fertility rate (children per woman)	**2.9**	2.0
Adolescent fertility rate for women age 15-19 years	**49.0**	43.0
Neonatal mortality rate (NNMR)	**19.8**	24.9
Infant mortality rate (IMR)	32.3	35.2
Under-five mortality rate (U5MR)	40.0	41.9
Current Use of Any Family Planning Method	**27.4**	66.7
Current Use of Any Modern Family Planning Method	**22.5**	56.5
Mothers who had an antenatal check-up in the first trimester (%)	**53.9**	70.0
Mothers who consumed iron folic acid for 100 days or more when they were pregnant (%)	43.1	44.1
Mothers who consumed iron folic acid for 180 days or more when they were pregnant (%)	**20.6**	26.0
Institutional births (%)	**58.1**	88.6
Home births that were conducted by skilled health personnel (%)	**6.6**	3.2
Average out-of-pocket expenditure per delivery in a public health facility (Rs.)	**3,219**	2,916
Population living in households with an improved drinking-water source (%)	**79.2**	95.9
Population living in households that use an improved sanitation facility (%)	**82.9**	70.2
Households with any usual member covered under a health insurance/financing scheme (%)	**63.5**	41.0
Source: NFHS-5, 2019-2021		

[11] (Meghalaya Human Development Report 2008, 2008)

It can be seen that in nine of the mentioned indicators, the performance of Meghalaya was a cause of concern with respect to the Maternal Health, Adolescent Health as well as the Current Status of Family Planning Practices. It was also found that around 4 in every 5 households in Meghalaya had access to improved drinking water sources against 96% at the national level. However, some of the aspects where the health conditions were reported to have been comparatively better were the presence of skilled health personnel during home births and access of households to an improved sanitation facility. Besides, it was encouraging to note that around 2 in every 3 households have atleast one member covered under health insurance which is significant to ensure access to curative healthcare facilities.

2.4 Areas of Improvement for Enhancing the Reach of Healthcare Services in Meghalaya

There are several factors that influence the performance of Meghalaya with respect to various healthcare indicators. Both the supply side (including the health infrastructure and healthcare providers) and the demand side (referring to the healthcare practices among the community) have brought forward several barriers to the reach of healthcare services, thus, underlining the key areas of improvement. The hindrances concerning the healthcare sector in Meghalaya can be understood in terms of **the 5 As, i.e., Availability, Accessibility, Affordability, Awareness, and Accountability.** The key concerns under each of these areas have been discussed as follows:

- **Availability:** This signifies the **availability of healthcare infrastructure and services to the community.** As discussed in the sections ahead, the state follows a three-tire health delivery system with the setting up of Sub-centers, PHCs, and CHCs along with various other District Hospitals, Private Hospitals, and Central Health institutions. However, the sole construction of these institutions is not sufficient. Along with the physical infrastructure, it is vital to have all the necessary health equipment and machines. Proper amenities such as toilets for women and men, electricity connection, power backup, availability of requisite drugs and medicines, adequate furniture, and fixtures are very much essential to facilitate better delivery of services. Not only is this but the availability of adequate manpower at various levels in abidance by the laid guidelines must also be ensured. While Meghalaya has ensured the construction of hospitals and health centers, **ensuring proper amenities and a sufficient number of doctors, specialists, nurses, and other staff is something the state lacks.**

- **Accessibility:** Another key question pertaining to healthcare is how reachable are the health facilities to the community. The **distance of the health center to the village, mode of transport, time taken to reach the health center, and costs** are the aspects that contribute to accessibility. With difficult hilly terrain and poor road connectivity in the rural areas, accessibility of the community to healthcare becomes a cause of concern, especially for those coming from the remote vulnerable sections.12 As per the Meghalaya Human Development Report of 2008, from a minimum of 16% of the population in West Garo Hills to a maximum of 46% of the population in the South Garo Hills pointed out the inconvenience of the location of the Government Health

[12] (Meghalaya Human Development Report 2008, 2008)

Facilities. The lack of proper roads and modes of transport also acts as an obstacle to reaching the health centers for the community. Studies have shown that most people walk on foot to the health centers, especially in rural areas. Besides, people have to hire vehicles to take patients to the health centers.13 This is directly proportional to the time taken to reach these facilities and the costs the community has to bear to reach the facilities.

- **Affordability:** As noted in the preceding section, the state has performed While it is appreciable to note that Meghalaya has shown improved performance on some of the significant health indicators, the fact that the average cost or out-of-pocket expenditure per delivery in a public health facility was calculated to be Rs. 3,219 against the national value of Rs. 2,916 becomes a cause of concern (Table 2.1). This poses vital questions of affordability as to whether all the communities of the tribal society of Meghalaya could afford the services from the public health sector. Despite the availability of free services at the public health facilities, huge expenditures on transportation, non-availability of medicines, expenses of food are some of the few factors which influence the cost of availing services from the public health facility. The fact that Meghalaya has an agrarian economy makes it all the way vital to ensure the reduction in the out-of-pocket expenditure of the community, particularly in rural areas.

- **Awareness**: One crucial factor which influences the health-seeking behaviour of the community is the level of awareness and knowledge among the community about various health practices and concerns. Unless and until people perceive an ailment as a health concern, it will be hardly possible to expect them availing services offered by the healthcare system. The degree of awareness becomes very crucial for the future of maternal healthcare in the state. There is a predominance of the indigenous population in Meghalaya and the Khasi community constitutes slightly more than half of the population**.** They are one of the largest matrilineal cultures in the world. Despite that, when it comes to health and education, women in Meghalaya lag behind their peers in other northeastern states. [14] Research in the state has shown that women often deprioritize their own health in favour of supporting the needs of others. Although the family structure in Meghalaya is said to be matrilineal, often women are subordinate to spousal decision-making when it comes to reproductive health (Pauline Oosterhoff, 2015). Furthermore, the traditional system of governance is mainly dominated by the men in the village. The village headman ***(rangbah shnong)*** and his village council of executives ***(rangbah dong)*** for judicial and administrative purposes are often chosen by the men in the community. Traditionally, the local councils, known as ***dorbars,*** are accountable to ***syiems***, dynastic rulers of kingdoms formed from grouping village clusters. The women are traditionally discouraged from participating in political matters. Furthermore, in the Khasi community, the traditional women society, ***seng kynthei*** has a confined role in decision-

[13] Nongrum, M. S. (2010). Re-examining the Primary Health Care System in Meghalaya. 1-11.

[14]Pauline Oosterhoff, L. S. (2015). *When the Hen Crows: Obstacles that Prevent Indigenous Women from Influencing Health-care Policies- A Case Study of Shillong, Meghalaya, India.* Shillong: Institute of Development Studies.

making. This limited involvement and acceptance of women's views on various subject matters have affected the health planning undertaken for the state. Besides, societal norms and notions of 'good manners', together with the lack of pertinent words in the Khasi language, contribute to the silence on sexuality within the community (Pauline Oosterhoff, 2015). The non-availability of appropriate words in the local language to discuss sexual and reproductive health further amplifies the seriousness of the issue and spreading awareness among the community through various platforms becomes a necessity.

- **Accountability:** The active involvement of various healthcare providers and the quality of services delivered by them often adds to the accountability of the healthcare facilitators to the community. Along with the other factors, it is equally imperative to ensure that the various secondary stakeholders of healthcare are aware of their roles and responsibilities and are accountable to the community for the successful delivery of services. Most of the community members have reported rude behaviour by the hospital staff with them. On the other hand, they perceive the staff in the private hospitals to be more hospitable. Besides, a notion of free services being offered to the community is often found among the public healthcare staff in Meghalaya. It, therefore, becomes vital to conduct sensitization of the staff and orient them about their roles and responsibilities and the change which it can bring for the community.

In addition to the above-mentioned factors, one other aspect that influences the perceptions of the community towards health, as well as their health-seeking behaviour, is the active role of traditional healers in the rural areas of Meghalaya. The tribal people and ethnic races throughout the world have developed their own cultures, customs, cults, religious rites, taboos, legends and myths, folk tales and songs, etc.[15] The rich culture of flora and availability of dense forests in Meghalaya play a vital role in this culture. Studies have brought forward a range of plant species that are used by the tribals in the state for healing purposes. The list of plants and species dealing with the ethnobotany of 65 taxa from 26 families of angiosperms was provided based on the work on the ethnobotany of some weeds of Khasi and Garo Hills. While ***Pnar and War*** are some of the communities in the West Jaintia Hills that illustrate reliance on the traditional healing practices, studies have recorded a list of 74 plant species to be used for their medicinal purposes in the Khasi and Jaintia hills. Additionally, work on the ethnobotany of Khasi and Chakma tribes of Northeast India has underlined the significance and usage of 37 plant species belonging to 34 genera and 15 families.

Other than the indigeneity behind the usage of plants for medical purposes, the lack of proper transportation and medical facilities in the rural areas has influenced the dependency on traditional healers and local medicines till date. In some cases, prayers to the almighty or chanting of mantras sometimes accompany administering of the herbal medications (SR Hynniewta, 2008). Besides, the expenditure recorded by the households on traditional medications is cheaper than the expenditure incurred on allopathic medicines. Various studies in the region have also shown the dependency on the community on traditional healers for seemingly minor health problems such as fever, cough, cold, diarrhoea, etc. In some locations, it was noted that people access public healthcare only for the

[15] SR Hynniewta, Y. K. (2008). Herbal Remedies among the Khasi Traditional Healers and Village Folks in Meghalaya. *Indian Journal of Traditional Knowledge Vol. 7(4)*, 581-586.

purpose of diagnosis. In fact, people have quoted instances of when they did not get any relief from allopathic medicines and the traditional medications were more impactful than the former.

Altogether, it can be seen that strengthening both the supply and the demand side of the Meghalaya health system is vital to ensure better delivery of services to the community. While some of the efforts need to be made towards improving and innovating the existing health facilities, generating awareness among the community and assisting accessibility to these institutions will be crucial to realise the outcomes in the long-run. Furthermore, the measures taken in this regard will be more effective when knitted with the existing beliefs and practices of the community.

2.5 Information, Education, and Communication (IEC)

The Information, Education & Communication (IEC) strategy aims to create awareness and disseminate information regarding positive health behavior. The objective is to encourage build-up of health-seeking behavior among the masses in order to facilitate promotive and preventive health. The IEC strategy, as used by the Government of India, has catered to the various needs of the rural and urban masses through different tools of communication.[16]

IEC activities encompass a wide range of activities, such as the employment of mass media, along with interpersonal activities so as to disseminate information about various health schemes. In India, IEC has been used for disseminating information on myriad health topics, such as diarrhea, breastfeeding, tobacco control, dengue, H1NI, etc. Usually, IEC activities involve print media coupled with TV and radio plans. Nowadays, social media and outdoor activities are used to strengthen traditional methods.

In print media, articles and advertisements are published in leading newspapers in English and regional languages. The aim of such advertisements is not only to encourage people to adopt positive behavior but to also raise awareness and disseminate information regarding availability and access to quality healthcare provided by the state and central government. Significant health messages are delivered across the country through print media on International Days like World Population Day, World Health Day, No Tobacco Day, etc. Print media has already been used successfully for the launch of massive health schemes such as Mission Indradhanush and Ayushman Bharat.

In television, the Government of India has used the medium to reach their target audience through Doordrashan. This includes telecasting programmes involving specialist doctors, talking about important health issues. Issues such as maternal health, child health, family planning, adolescent health, etc. are discussed. In terms of social media, Youtube and Twitter are two platforms that have been used extensively. This includes short films, video updates, and speeches promoting positive behavior and adoption of a healthier lifestyle.

An example of a successful IEC campaign includes the one by the Food and Nutrition Board, Ministry of Women and Child Development, Government of India. Nutrition and health are the focal points of health and well-being because it is directly related to human development and thus to national

[16] 2015-16. Information, Education and Communication (IEC). Ministry of Health and Family Welfare, Government of India.

growth. India faces high malnutrition rates because of the prevalence of poverty. Female illiteracy, lack of safe drinking water, improper sanitation, and ignorance further exacerbate the issue. A big part of the activities carried out by the board includes Nutrition Education Programmes undertaken in rural and tribal areas to promote a healthier lifestyle. For the purpose of education, mass media communication campaigns are carried out. Educational and training materials are developed on nutrition and are published in national handbooks and guidelines. This material is produced in Hindi, English, and several other regional languages. Mass awareness campaigns are carried out through events such as World Breastfeeding Week (1-7 August), National Nutrition Week (1-7 September), etc. AIR and Doordarhsan are also employed for this purpose. Dissemination of nutrition information to the masses is also undertaken by organizing exhibitions on nutrition in the melas/fairs and advertisements are published with important nutritional messages.

2.6 Meghalaya's IEC Initiatives to Date

In Meghalaya, IEC activities have been employed to raise awareness about various health issues among the people. Similar to the central government, communication channels such as All India Radio (AIR), Doordarshan, and Press Personnel have been used to encourage positive health behavior. [17] Additionally, posters, pamphlets, and stickers have been printed in English and local languages, and outdoor publicity has been done through hoardings, wall paintings, rock paintings, etc.

Some of these successful IEC campaigns are discussed below:

- **Family Health Awareness week:** This was a pilot programme that was implemented in 1999 in Jaintia Hills and South Garo Hills. The issue discussed was about Reproductive Tract Infections and Sexually Transmitted Diseases (STDs), because it was found that there was a lack of knowledge and health services in this area. The event was attended by a large group of people, majorly women, at the various camps and Primary Health Care Centers (PHCs). The pilot programme was launched in East Khasi Hills, East Garo Hills, and Ri Bhoi district.

- **Red Ribbon Club (RRC):** This campaign was launched in collaboration with Nehru Yuvak Kendra (NYK) and National Service Scheme (NSS). It was conducted at 10 colleges and was targeted towards preventive health education for students. Sensitization programmes were carried out for principals, programme officers, NSS, and peer educators in colleges.

- **MACS Radio:** Since HIV/AIDS is a major NCD in today's time and causes significant distress, Meghalaya's AIDS Control Society (MACS) Radio was organized with the objective of spreading awareness about this disorder. This was done through an entertainment-packed programme. MACS includes pre-recorded weekly programmes broadcasted on All India Radio (AIR). In addition to this, a live phone-in session was organized once a month. This content was produced in all three local languages.

- **Monitoring and Evaluation:** Induction training was provided to counselors and lab technicians working in STD clinics. Certain areas and districts were identified based on the fact that they were

[17] 2008. Meghalaya Human Development Report.

recognized as hotspot areas for the spread of HIV infections from various High-Risk Groups. Since there was a presence of high-risk behavior in the general community, comprehensive action was taken to reduce rates of HIV.

- ***National Anti-Malaria Programme (NAMP):*** Epidemiologically, Meghalaya is highly endemic for malaria, except for Shillong and its suburbs. [18] The three districts of Garo Hills are classed as Red-Hot and all areas along the international and inter-state borders are considered high risk for malaria. In order to tackle malaria, the government took several steps at the state and district level. One of these steps was the organization of training and awareness camps. All categories of health staff, including NGOs and community volunteers, were trained in controlling malaria. IEC activities were organized, such as information dissemination through awareness camps, inter-sectoral meetings, print, and other media. Motivation and sensitization meetings were organized for medical officers in East Garo Hills, East Khasi Hills and Jaintia Hills, CRPF units, ASHAs, health care staff, etc.

- **The Revised National Tuberculosis Control Programme (RNTCP) in Meghalaya:** Tuberculosis is a disease that many Indians struggle with, and Meghalaya is no exception. The Government of India has over the years shifted the focus of its health policy towards TB because of its high incidence rate. Meghalaya has been implementing RNTCP since 2001 and some of its program activities, such as preventing Multi-Drug Resistance (MDR) and encouraging community-based volunteers/NGOs to provide TB-related health care services, are in alignment with IEC activities.

- **National Programme for Control of Blindness (NPCB):** The NPCB regularly organizes eye screening and eye camps for the detection of blindness. District Blindness Control Societies (DBCS) were formed in all the districts of the state, except South Garo Hills. This special drive is aimed at the prevention of curable and preventive blindness in Meghalaya. Under the IEC activities of the programme, awareness campaigns are organized in the state.

- **National Rural Health Mission (NRHM):** This is a large-scale project that has been launched by the Government of Meghalaya in order to improve access, availability, and outreach of healthcare services in the state. This project aims at increasing the number and efficiency of ASHAs, VHSCs, Sub-Health Centers (SCs), Primary Health Centers (PHCs), Community Health Centers (CHCs), District Hospitals, etc. The health objectives are to bring down the Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR), universal immunization, leprosy prevention, to engage ASHAs for all villages, etc. With such a broad scope, IEC activities are an integral part of the mission. Keeping in mind the subject of population stabilization, gender balance, and overall well-being of the community, IEC activities have been used as a mechanism for developing appropriate tools for the target population to create awareness and sensitize them about important health issues that they are most affected by.

[18] 2008. Meghalaya Human Development Report.

- **National Leprosy Eradication Programme (NLEP):** One of the core program activities for this health policy is health education, which involves increasing awareness about leprosy and encouraging patients and their families to continue regular treatment.

2.7 Examples of Communication Materials Developed So Far

This section provides a list of the different kinds of materials that have been developed in the state so far. This will help in the formation of IEC materials for the current project.

The Ministry of Panchayati Raj launched the Rashtriya Gram Swaraj Abhiyan (RGSA) programme in 2016-17 to strengthen the capacities of Traditional Local Bodies (TLBs) for better rural governance. Village Employment Councils (VECs) and Area Employment Councils (AECs) were adopted for the implementation of the programme. Capacity Building Programmes and AEC Learning Centers were developed as a part of the programme. A Brochure was designed for the same as a part of IEC. The brochure contained information regarding the RGSA programme, the objectives of the program, and the kinds of benefits that participants can expect from the programme.

As a part of the National Health Mission, a poster was designed to educate people on the risks of tobacco and substance misuse, and how fatal it is. A reference was provided for the nearest adolescent clinic. A poster developed for maternal health pointed out the importance of breastfeeding and how hospitals can support mothers who breastfeed. Another similar poster advised mothers to seek counsel from doctors on the use and risks of feeding bottles, teats, and pacifiers. Similarly, for National Deworming Day, the National Health Mission released a poster highlighting the importance of deworming children and providing information on where deworming tablets are available for their use.

2.8 Achievements, Challenges, and Suggestions

IEC materials can be extremely beneficial in achieving a desired positive result, in this case, better health behaviors. Tools such as IEC and SBCC have proven to be important catalysts for social change and development. There are some specific achievements and benefits of IEC that can be associated with the success of the aforementioned health programmes, and should also be observed after the implementation of MHSPP's SBCC. Given below are some possible reasons for the success of the IEC materials of the health programmes carried out by the Government of Meghalaya:

- **Variety of channels:** When a diverse range of channels is used for communication, the message is more likely to reach the audience, especially when the most commonly used platforms are employed. For example, radios are very popular in Meghalaya and so messages delivered through radios are more likely to reach the audience.

- **Cost-effective:** Program implementation usually requires a lot of resources. IEC is a cost-effective method to ensure that the program succeeds. Social media especially costs nothing other than the internet connection.

- **Logos and Symbols:** The logos and symbols established through IEC, if designed well, can help sustain movements and campaigns. Many of the aforementioned posters and brochures had

symbols of the organization associated with the programme as well as something connected to program activities. These are visually appealing and hold people's attention.

- **Entertainment:** Mass media is known for conveying messages through an enjoyable and entertaining way. When advertisements are engaging, the audience is entertained and is more likely to remember the message.

- **Target Specific:** IEC materials provide a splendid opportunity to directly engage with the target communities and establish good rapport before program activities are laid out. This enhances the effectiveness of the program.

As we can see, IEC materials have a wide range of benefits for the programme that has to be implemented. However, IEC is not without its challenges. The constraints that one may face in developing and executing IEC materials can be classified into two broad categories: design and deployment. These challenges, along with suggestions to overcome these challenges, are discussed below:

2.8.1 Design

Without an *overall planned response,* it would be very difficult to develop social and behavior strategies for change. This step involves conducting a formative assessment to first understand the preventative behaviors, and then identifying knowledge gaps.

IEC materials cannot reach the audience if they are not *designed with illiteracy in mind*. Posters and graphic materials will be difficult to understand if they are full of text and your target audience has a significant proportion of those who are illiterate. It is important to keep illiteracy rates in mind. You can use ticks, boxes, arrows, crosses, etc. to better explain your message.

Your IEC materials should not be different from the general *branding* of the programmer or the organization associated with it. The multiple support materials that you will use for IEC should be under a common umbrella of branding. This could be achieved through a common color scheme or format or logo or characters. Sometimes, it may seem that IEC materials lack legitimacy and the target audience may not take it very seriously. This is why it may be important to include *information from reputable sources.* Usually, quotes or epidemiological data from UN Agencies, trustest government authorities, established NGOs, etc., makes the information look more reliable.

Overall, your IEC materials will probably fail if they do not display *good graphics*, and this can be a challenge to the success of the programme. Make use of attractive colors to get people's attention and use a font style that people are not usually exposed to in daily life. Similarly, for audio-visual material, ensure that it attracts the audience and holds their attention.

2.8.2 Deployment

The next set of challenges comes from those who will be designing and executing the education materials. As discussed above, designing the IEC materials is crucial for their success. Thus, it is important to take note of the core competencies of those who are designing the materials. The advice and opinion of healthcare workers must be taken in order to ensure that the material is accurate and

relevant. Health care workers can also provide a better perspective on what the real challenges are when it comes to certain health issues. For example, a doctor may tell you that the reason why people from a certain district frequent the clinics more than others is because of the high consumption of unhealthy food due to its easy availability. The ground reality of health issues may not sometimes be evident through literature. Hence, consulting healthcare workers is essential. Once the design is done, those who will be implementing the IEC materials will have to receive proper training so that the messages are transmitted to the targeted population accurately and effectively. It has been found that unless the trainer or educator is a healthcare worker, the message may not be well received.

Another challenge that may emerge is that of a poor understanding of the socio-cultural makeup of the state. Meghalaya is a diverse state and every district and area has its own sets of challenges. Unless a thorough understanding of the socio-economic character of each district is developed, IEC materials cannot be designed and executed successfully. For example, the materials will have to be linguistically adapted for each district. It may be found that the proportion of people who understand English in a certain district is higher as compared to others. Keeping this in mind, the materials can be designed in English. Meghalaya is also geographically diverse. How the communication materials will be transported to different areas will have to be planned in advance. It is also important to know the limitations of the transmission of communication materials. For some areas where there is no internet connectivity or electricity, only posters and brochures can be used.

In conclusion, IEC materials should be based on formative research suggesting that there is an information gap that needs to be filled, and it should be pretested/piloted to ensure that the reader or viewer of these materials understands the messages. Pathfinder, a global NGO, published a checklist for evaluating IEC materials that have been attached to this report and can be used for evaluating MHSSP SBCC tools.

CHAPTER 3

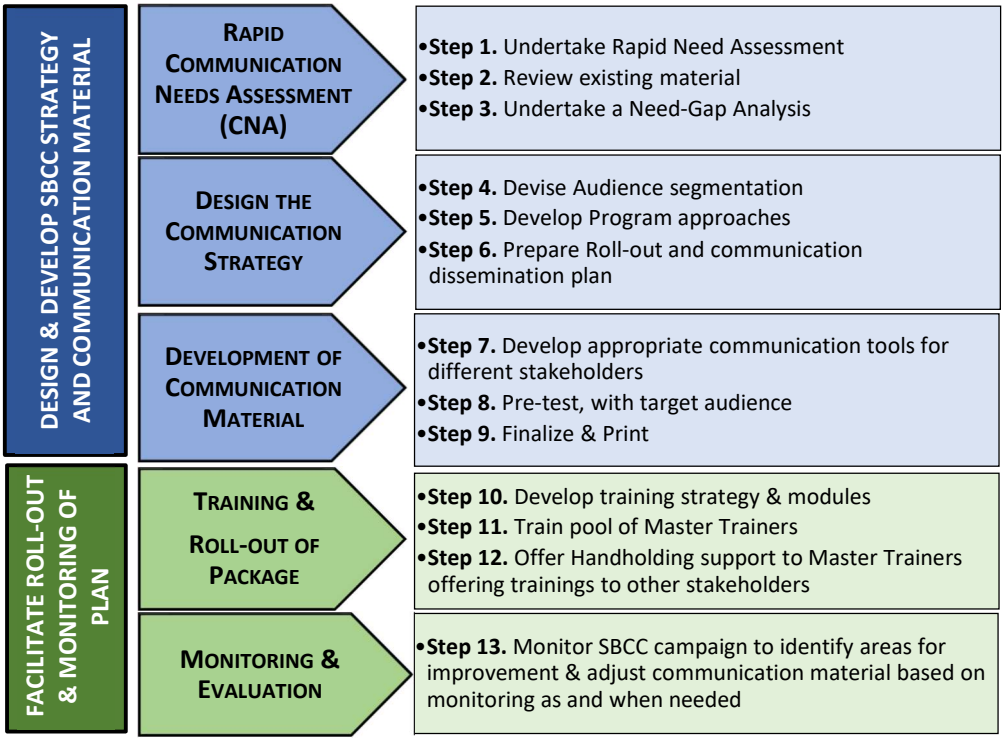
OBJECTIVES, SCOPE OF WORK & CONCEPTUAL FRAMEWORK

3.1 Objectives of the Assignment

The **principal objective** of the assignment is to **provide technical and implementation support to the Meghalaya Health Systems Strengthening Project (MHSSP)** towards enhancing the demand for health services including health insurance, promoting adoption of desired behaviours and practices among both the service providers and the target beneficiaries of the health services in the State. The specific objectives of the proposed consultancy services are as under:

- **Design and develop a comprehensive SBCC strategy** addressing three broad expected outcomes as reflected in the preceding section.
- **Develop/ redesign or adapt the available and appropriate IEC materials** in Khasi, Garo, Jaintia and Bengali to enhance the awareness, understanding, and knowledge of the key stakeholders from both the supply and demand side on the key components of MHSSP.
- **Roll-out the SBCC package and train the relevant staff** to use the same for bringing about desired changes in the behaviours and practices of community around MHSSP interventions.

3.2 Scope of Work



There are 2 phases in the project. In the **first phase**, a **rapid Communication Needs Assessment (CNA)** will be conducted to gather context-specific information on the communication needs of different stakeholders. Information gathered during this exercise will serve as a key input for **designing the SBCC strategy**. It will help identify the target audience and their information needs, ascertain pragmatic approaches to reach out to this audience, and develop a detailed communication plan. Following this, the **SBCC toolkit, including the required communications materials, will be developed, pre-tested, and finalized**.

The **second phase** will entail two key activities: firstly, the agency shall work towards **building capacities of key project staff/ consultants/ master trainers on the utilization of tools developed**. This will be followed by active support to the Department to communicate the SBCC messages to the identified stakeholders. Secondly, the agency shall undertake **concurrent monitoring using a well-designed M&E system to assess the effectiveness** of the SBCC materials and identify areas of improvement. Necessary adjustments will be made to the materials and strategy as and when required.

3.3 Conceptual Framework

The **'P-Process'** model will be used for changing the health behavior of the target population. Originally developed by the Johns Hopkins Centre for Communication Programs (CCP) in 1982, the 'P Process' is a tool for planning strategic, evidence-based, health-centred social and behaviour change communication (SBCC) initiatives. It offers a step-by-step roadmap and an overview of the step-wise description of activities to be undertaken under this assignment–

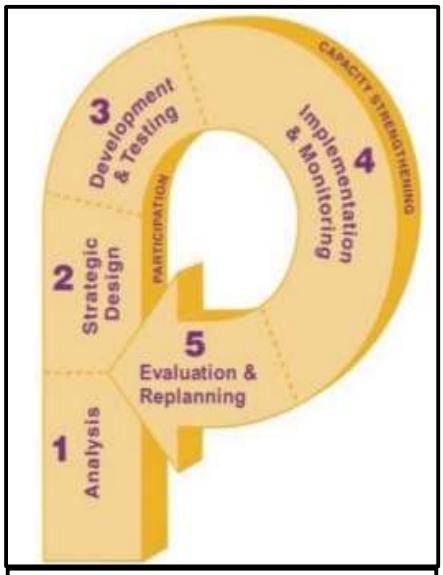


Figure 3.1: The P-Process Model

Step 1: Analysis: 'Formative Research' will be undertaken in the initial stages of the assignment to gain strategic insight into the existing levels of knowledge, attitudes, skills, behaviours, social networks, needs, aspirations, and degree of self-efficacy related to health-seeking behaviour. The focus of inquiry shall revolve around determining severity and causes of problems, identifying factors inhibiting or facilitating desired changes, identifying the target audience, key influencers, and change agents, and assessing the training and communication needs of the stakeholders. The data collected during formative research shall be subjected to the following analysis to carve out strategic insights for the SBCC strategy –

- **Participant analysis –** At the state level, identify partners and allies to help initiate policy change and strengthen communication interventions.
- **Social & behavioral analysis -** Assess knowledge, attitudes, skills, and behaviors of participants at the individual level. Identify social networks, socio-cultural norms, collective efficacy, and community dynamics (including leadership patterns).

- **Communication needs analysis -** Analyse media penetration and use, organizational capacity of partners and allies, and other resource needs. Determine availability of communication materials and skills.

Step 2: Strategic Design: This step shall aim at creating a pragmatic action plan that will take us from where we are to where we aim to be in the future. The strategy will focus on the following –

- **Establishing communication objectives** - Set objectives that are Specific, Measurable, Appropriate, Realistic, and Time-bound (SMART). Select key audience segments and quantify the changes in knowledge, attitudes, skills, behaviours expected.
- **Developing program approaches & positioning** - Select a behaviour change model to base the program on. Explicitly state the assumptions underlying the basic strategy and approach. Explain why and how the program is expected to change health behavior.
- **Determining channels** - Consider a coordinated, multimedia approach for a synergistic impact. Where possible, achieve scale by including mass media tied to community mobilization and interpersonal communication among family, friends, community, social networks, and service providers.
- **Drawing up an implementation plan** - Develop a work schedule with regular benchmarks to monitor progress. Prepare a line-item budget. Complete a management plan, including partners' roles and responsibilities. Make sure all involved know what is expected.
- **Developing a monitoring and evaluation plan** - Identify indicators and data sources to monitor program implementation. Select the study design to measure process outcomes and assess impact.

Step 3: Development & Testing: This stage entails the creation of training and communication tools and products. Guided by the learnings from step 1 and 2, it will involve combining the creative and artistic vision needed to move audiences and inspire desired behaviour change. It will focus on –

- **Development of communication tools:** communication tools, toolkits, including facilitation manuals for interpersonal counselling, job aids for service providers, other social media material for dissemination. This shall be done in active consultation with key project stakeholders to ensure that the end products meet their needs.

  The material development process shall include designing and developing communication messages/ materials for various facets of the project, viz., capacity building initiatives, capturing progress of the project implementation stages through both photographs and video documentation, report documentation, other products for standardization, such as banners, backdrops, and Posters, etc.
- **Testing:** Test the concept with stakeholders and representatives of the audiences to be reached. Follow concept testing with in-depth pretesting of materials, messages, and processes with primary, secondary, and tertiary audiences. Share feedback on results with partners to ensure maximum ownership and use.
- **Revising:** Make changes based on pretest results for messages, stories, or participatory processes that are not understood correctly, not remembered, or are not socially or culturally acceptable.

- **Retesting:** Retest materials to ensure revisions are done well and make final adjustments before replication, printing, or final productions.

Step 4: Implementation & Monitoring: This refers to the roll-out and implementation phase which, under the given assignment, entails building capacities of a pool of State level Master Trainers, and offering them handholding support to implement the strategy among other stakeholders. The steps involved under this phase will include –

- **Production and Dissemination:** Develop and implement a dissemination plan that may include local government, NGOs, the private sector, as appropriate, and the media for maximum coverage.
- **Training trainers and field workers:** Plan for training at state and district levels. Begin with the training of trainers (TOT). Concentrate on building institutional capacity and individual skills to support roll-out of communication strategy.
- **Mobilizing key participants:** Share information, results, and credit with partners, allies, and communities. Keep everyone involved motivated towards the strategic goal.
- **Managing and monitoring program:** Check program output to ensure quality and consistency, while maximizing participation. Track existing service statistics and conduct special studies using surveys, focus groups, observation, and other techniques to measure outputs as well as audience reaction.
- **Adjust program based on monitoring:** Use data from monitoring to make mid-course corrections or adjustments in activities, materials, and procedures and to finetune program components.

Step 5: Evaluation and Replanning: The final stage under the proposed model deals with measuring the key outcomes and impact of the activities in a systematic manner. It involves generating valid and reliable evidence of programme's effectiveness, offering inputs for future advocacy, and scaling-up efforts for sustaining the change at the community level. In the interest of making value addition to the given scope of work, qualitative evidence will be generated in terms of case studies, human interest stories, and mapping change in awareness and practices in the project period. These results may be useful for the State for designing similar interventions in the future.

CHAPTER 4

TECHNICAL APPROACH & STRATEGY FOR THE COMMUNICATION NEEDS ASSESSMENT (CNA)

4.1 Objective of Rapid Communication Needs Assessment (CNA)

A **rapid communication needs assessment (CNA)** is the preliminary activity that will be undertaken in the initial stages of the project. The overarching objective of the proposed CNA is to **develop a thorough understanding of the context, actors, enablers, and barriers that influence the adoption of desirable behaviours**. Further, there is also a need to spread awareness about the intiatives being taken under the MHSSP project to strengthen the healthcare services in the State. The issue will be explored from three perspectives–

- **The Community's Perspective:** Considering the fact that the ultimate objective of this assignment is to promote positive behaviours and practices related to the utilization of public health services, it will be pertinent to focus our gaze on the current levels of readiness of the community for the desired behaviour change.
- **The Provider's Perspective:** As the service providers are expected to serve as key change agents by disseminating required knowledge on nurturing care and motivating behaviour change in the desired direction, it is imperative to gauge their current levels of competency for the same.
- **The Programme Perspective:** The MHSSP officials will be inquired about the progress of various project interventions taken under MHSSP on an ongoing basis. The approach shall be to document the project progress as it achieves different milestones and help create appropriate material to disseminate the information about initiatives, achievements, best practices and success stories.

4.2 Research Framework

The **'Socio-Ecological Model' (SEM)**, originally created by psychologist Urie Bronfenbrenner in the late 1970s, is one of the most widely used frameworks for deriving deep insights into human behavior. This model considers the complex interplay between individual, relationship, community, and societal factors that influence any behavior.

The Socio-Ecological Model examines several levels of influence to provide insight on the causes of problems and find tipping points for change. The rings guide the level of analysis, closely mapping all potential influencers,

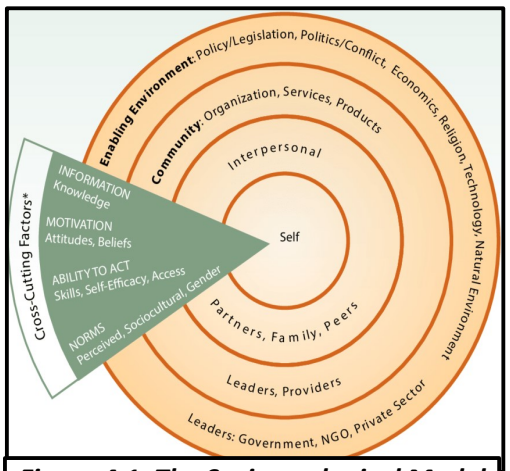


Figure 4.1: The Socio-ecological Model

the underlying beliefs and practices among influencers, direct and indirect ways in which they influence individuals' thought processes, and the degree of influence that they have on people's behaviour. The triangle in the figure presents cross-cutting factors including information, motivation, ability to act, and norms, that are likely to influence all levels of influencers. Inquiry along these factors offers a deeper perspective on the potential communication strategies that will work best in the given scenario.

4.3 Study Design

The communication issues that emerge hereafter the analysis will support the overall communication objectives of the project. This section details the types of analyses that will take place.

4.3.1. Stakeholder Perception Analysis:

The purpose is to identify relevant participant groups, their characteristics, the roles they play in the scheme of things, their existing awareness levels and underlying beliefs and perceptions about the existing health systems, and the resources each group can access to bring about and maintain the desired behaviour change**.** This analysis will help us understand ***'what is the current status of awareness and attitude of the various stakeholder groups?'***. The stakeholders of the project can be classified into three categories:

- **Primary Stakeholders:** These include the community actors and the ultimate beneficiaries of the Health Department
- **Secondary-Stakeholders:** These stakeholders will include those who are directly engaged in service delivery, i.e., key state and district level officials of the health department, hospital staff and service providers, other government functionaries
- **Tertiary Stakeholders:** These stakeholders are those who exert influence on the primary and secondary stakeholders and may thus play an active role in the project. These will include NGOs/ CBOs, Village administration functionaries such as the Dorbar headed by the Rangbah Shnong, Village Health Councils and Village Organizations., private service providers/ associations, local influential groups, and media.
- **Project Officials:** The PMU and the World Bank officials dedicatedly working on implementing the MHSSP interventions shall be important stakeholders to be consulted for progress documentation.

4.3.1.1. Key Issues to be Probed:

The key issues to be probed under stakeholder analysis will include –

- Listing out the stakeholders associated with the state health systems
- The socio-demographic characteristics of the different target audiences (age range, gender, ethnic/cultural background, etc.)
- Language issues—the primary language(s) spoken and the vocabulary they understand
- The motivations that drive the audience's healthcare-related attitudes and behaviors

- The attitudes, beliefs, and knowledge of the audience regarding the health systems
- Their stage of readiness for behavior change
- Roles, skills, and resources with the stakeholders
- Knowledge and awareness levels/ perceptions of gap of the beneficiaries

The following table (Table 4.1) presents a detailed overview of the issues inquiry from each respondent:

Table 4.1: Key Areas of Inquiry for Different Stakeholders under Formative Research

Target Respondents	Issues to be probed
Rural Households covering different types of respondents – • **Parents or caregivers of children under 8 years of age** • **Adolescent Girls** • **Adolescent Boys** • **Adult male members** • **Elderly Caregivers**	• Socio-economic Profile of Households • Demographic Characteristics including HH size, family structure, educational status, etc. • Awareness & practices related to – – Health & Nutrition – Water, Sanitation & Hygiene – Maternal and child health – Infant & Young child Feeding – Education environment • Socio-cultural and gender norms, myths & beliefs influencing ECD • Health seeking behaviour • Key influencers & decision-making dynamics • Key enablers and barriers • Self-efficacy and Psycho-social skills • Social networks & participation • Existing community platforms • Media access & preferences
Key influencers – • **PRI Members** • **Mothers' Committee/ VHC Members** • **Members of Youth Groups/ Peer Educators** • **Political Leaders** • **Representatives of Faith-based Organizations, etc.**	• Health seeking behaviour of community • Socio-cultural and gender norms, myths & beliefs influencing ECD • Key influencers & community level actors • Roles played and potential ways in which they can contribute • Motivational levels and ability to act
• **ANMs** • **ASHAs**	• Awareness, skills & services delivered related to – – Health & Nutrition

Table 4.1: Key Areas of Inquiry for Different Stakeholders under Formative Research	
Target Respondents	**Issues to be probed**
Officials of Stakeholder Departments including – • PMA officials • Officials of NHM-IEC Division • Officials of RBSK Division • Other District level officials including DHEO and DHIEC • Officials of MDBA • Officials of institutions like UNICEF, Jhpiego, JSI, etc. • Officials of the Education Department • Officials of the Social Welfare Department • Sector teams at the Block level including BPMs	– Water, Sanitation & Hygiene – Maternal and child health – Infant & Young child Feeding – Education environment • Health seeking behaviour of community • Socio-cultural and gender norms, myths & beliefs influencing ECD • Key influencers & community level actors • Roles played and potential ways in which they can contribute • Motivational levels and ability to act
Officials of PMU & World Bank Officials	• Key interventions planned under MHSSP • Progress made under the project on various project components and interventions • Major milestones achieved • Best practices institutionalized to realize the goals • Major success stories to be captured for the purpose of dissemination • Content for Vlogs and Blogs to be made for promotion of project interventions

4.3.1.2. Sample Coverage:

The formative research will take place at three levels involving consultation with State-level stakeholders, district level stakeholders and the community level stakeholders. Using the standard statistical formula, the required sample comes to 300, considering the fact that a 95% confidence interval will be used with a 7% margin of error, with a design effect of 1.3 (considering intra-cluster correlation coefficient of 0.05, and cluster size of 10). Taking an inflation of 10%, **330 respondents at the community level will be sampled**. A three-stage sampling approach will be followed–

- **Selection of Study Districts: 1 district from each of the three Hill divisions** (i.e., Garo, Khasi, & Jaintia) will be sampled to ensure adequate representation of the three key tribal communities using **Simple Random Sampling approach.**
- **Selection of Clusters/ Primary Sampling Units: 30-cluster sampling approach will be used** ensuring **due representation of urban and rural areas**. In each district, the urban area surrounding the District Hospital will constitute 1 urban cluster. Thereafter, the concerned

district level Health Officials shall be consulted to stratify the CHCs present in the district into **high, average, and poor performing facilities** depending on some key performance criteria. Thereafter, 1 CHC shall be selected randomly from each performance category. Having all three kinds of CHCs will help uncover both the enablers and barriers to health-seeking behaviour of community and health service delivery by the supply side stakeholders. Thereafter, **from the catchment area of each of the three facilities, 1 urban and 2 rural clusters shall be randomly selected to undertake a community-level survey**. Accordingly, 10 clusters shall be sampled from each of the 3 study districts.

- **Selection of Target Respondents:** The staff deployed at the sampled health facilities and frontline workers serving the catchment area for the same shall be the supply side stakeholders who will serve as the target respondents. At the community level, **the households shall be sampled by adopting a systematic random sampling approach using random start method**. The households to be included will be the ones that have at least one of the following respondent categories – parents or caregivers of children under 8 years of age, adult male members of the household, and adolescent girls or boys.

The proposed sample coverage for the Communication Needs Analysis is depicted in Table 4.2 ahead –

Table 4.2: Proposed Sample Coverage for the Communication Needs Analysis

Physical Coverage		
Districts	One each from Garo, Khasi, Jaintia Hills	3
District Hospital	One per District	3
CHCs	3 per region including one poor, one average and one low performing CHC. To be sampled in consultation with MHSSP officials.	9*
PHCs	6 per Region. 2 PHCs in each of the three CHCs' catchment areas. To be sampled randomly to ensure representation of difficult-to-reach and unserved areas.	18*
Rural Clusters	6 per Region. 2 clusters from the catchment area of PHCs. To be sampled randomly in consultation with PHC officials to ensure representation of difficult-to-reach and unserved areas.	18
Urban Clusters	4 per Region. 1 cluster from each of the three CHCs' catchment area and one cluster around the Govt. District Hospital in each of the selected districts	12
** In case of non-availability of targeted number of CHCs and PHCs in the sampled district, we will consult the State-level officials to select the CHCs or PHCs in the neighbouring district or block to ensure spread across 3 regions. Alternatively, the Sampling strategy shall be suitably altered to meet the needs of the study.*		
Sample for Survey/ Interviews		
Stakeholder Category	**Level**	**Method of Data Collection**	**Proposed Coverage**
Primary Stakeholders	Community Level	• IDIs with Village administration functionaries such as the Dorbar headed by the	• 18 IDIs with Village administration functionaries such as the Dorbar headed by the Rangbah Shnong, Village Health Councils and Village

		Rangbah Shnong, Village Health Councils and Village Organizations. • Semi-structured Interviews with Frontline Healthcare workers • Survey of households. Households with specific sections to be answered by - - Adult male member of the household - Women in reproductive age-group. - Parents or caregivers of children under 8 years - Adolescent girls - Adolescent Boys • FGDs with Mothers Committee Members/ Members of Village Health Committees • FGDs with Youth Group Members/ Peer Educators • FGDs with other key influential members including members of SHGs, members of religious/ tribal groups, etc., political representatives, etc.	Organizations. • 12 IDIs with Ward Officials of sampled urban clusters • 54 Interviews with ANMs (2 Per Facility) • 54 Interviews with ASHAs (2 Per Facility) • 330 Households to be covered (11 per cluster). The respective respondent categories are to be included based on the availability in the sampled households. • 6 FGDs (2 FGDs per Region) • 6 FGDs (2 FGDs per Region) • 6 FGDs (2 FGDs per Region)
Secondary Stakeholders	State-level	Consultative discussions with Project Implementation team of MHSSP Consultative discussions with other health department Officials including PMA, NHM-IEC Division, RBSK team, MBDA, etc.	2-3 meetings depending on the availability of concerned officials 4-5 meetings depending on the availability of concerned officials
	District Level	• IDIs with CMO /CMS • IDIs with Medical Officers • Semi-structured Interviews with Staff Nurse/pharmacists/ other staff deployed at the facility • IDIs with DHEOs/ DHIEC Officials • IDIs with Officials of	• 3 IDIs with CMO/CMS (1 per district hospital) • 27 IDIs with MOICs (1 per facility) • 60 Semi-structured Interviews with staff (2 per facility) • 6 IDIs with DHEOs/ DHIEC officers (2 per sample district)

		Education Department • IDIs with Officials of Social Welfare Department • Sector Team members (MO, BPM-NHM, BPM-NRLM, CDPO)	• 3 IDIs with District Education Officer • 3 IDIs with District Social Welfare Officer • 9 IDIs (3 teams per Region)
Tertiary Stakeholders	State/ District	• IDIs with NGOs/ CBOs/ organizations working in health domain like UNICEF, JHPIEGO, JSI, etc. • IDIs with local influential media personnel working for newspapers, radio channels, and local TV channels • IDIs with Faith-based organizations	• 5 IDIs based on availability • 5 IDIs based on availability • 3 IDIs based on availability

4.3.2 Review of Project Documents and Existing Communication Material:

In the next step, it will be important to gain an in-depth understanding of the existing status of the healthcare system in the State. This will give an idea about the communication needs and the ultimate outcomes that the communication activities should aim at achieving. This analysis will shed light on the performance of health systems and its key achievements, strengths and weaknesses of existing communication campaigns initiated any time earlier, etc. The review of existing project documents and the communication materials shall help us develop an understanding of ***'where do we wish to be in the future?'***.

4.3.2.1. Key Issues to Probe:

The key areas of inquiry that will be focussed on while reviewing the existing project documents and issues to probe are-

- An understanding of the existing healthcare scenario and health systems in the State
- The general positioning of the health system in the targeted community in terms of perceptions and beliefs of community members about the same
- What kind of changes are required for enhancing the uptake of health services
- Where and what kind of changes are needed in the "status quo"
- Role, skills and contribution of stakeholders, government departments, donors, NGOs, other major initiatives and the private sector in effective communication dissemination
- Communication initiatives to date, communication programme's achievements, constraints, lessons learned and challenges
- A list of all communication materials that have been produced so far - how they have been used and how effective they have been
- State response to IEC barriers or barriers in uptake of services under NHM

- Achievements, constraints, lessons learned and challenges.

4.3.2.2. Data Collection Instruments and Sources:

This exercise shall be based entirely on the review of secondary literature, project documents, reports and any other relevant communication material. The team shall review these documents and then conceptualize the overarching goals and objectives that the SBCC Strategy shall seek to achieve and develop the communication approach accordingly.

4.3.3 Need-Gap Analysis:

A comparison of ***'where do the we wish to be in future'***, based on interaction with key officials and review of related information, and ***'where we are'*** from the status of awareness and perception of the concerned stakeholders, will help identify the communication gaps that need to be addressed through the communication strategy. The "communication needs analysis" will help develop an understanding of the context in which the messages will be delivered. The data gathered from the preceding two exercises shall be thoroughly reviewed by the project team to study the trends and analysis around the healthcare delivery in the State and the key issues that the authorities want to be addressed in the future.

4.3.3.1. Key Issues to be Probed:

The key issues to be probed at this stage shall revolve around the following aspects –

- Review of status of healthcare systems in the State in terms of successes, failures, issues and problems, as well as the identification of those problems/ interferences that need to be overcome through communication interventions.
- Review of existing communication interventions and materials, listing of the objectives of information, education and communication materials and analysing the implications of the initiatives of the intended audience groups, as well as the results of previous communication efforts.
- Assessment of prevalent beliefs and perceptions about the economic and socio-political context in which the health systems and its stakeholders are placed, understanding underlying cultural values and norms, and studying the inter-relations between different stakeholder groups.
- Identification of communication gaps in terms of aspects that need to be promoted, the beliefs or practices that need to be discouraged or modified, the ideal practices or behaviours that the audience should be motivated to adopt, the ways in which the concerned audience groups can be positively influenced, the types of media most prevalent in different groups, and identification of influential figures.

The results of the analyses can be used to create a comprehensive communication strategy and also establish relevant indicators for subsequent monitoring and evaluation that, through this supportive environment, will help to achieve the communication programme objective.

CHAPTER 5

TECHNICAL APPROACH FOR DESIGNING THE SOCIAL BEHAVIOUR CHANGE COMMUNICATION (SBCC) STRATEGY

5.1 Designing the SBCC Strategy

SBCC strategy is a framework indicating direction and scope of communication activities. A communication strategy is the bridge between the situation analysis and the actual implementation of the SBCC program, including the creation and rollout of materials, products, and activities. The communication strategy will guide the intervention by providing direction and ensuring that the different products, materials, and activities all ultimately work well together and support each other toward change. In order to develop a robust strategy, the focus will be on – (i) target audiences, (ii) desired changes, barriers, facilitators, communication objectives by audience, (iii) strategic approach, (iv) positioning, (v) key content, and (vi) communication channels (e.g., mass media, mid-media, IPC), activities, and materials.

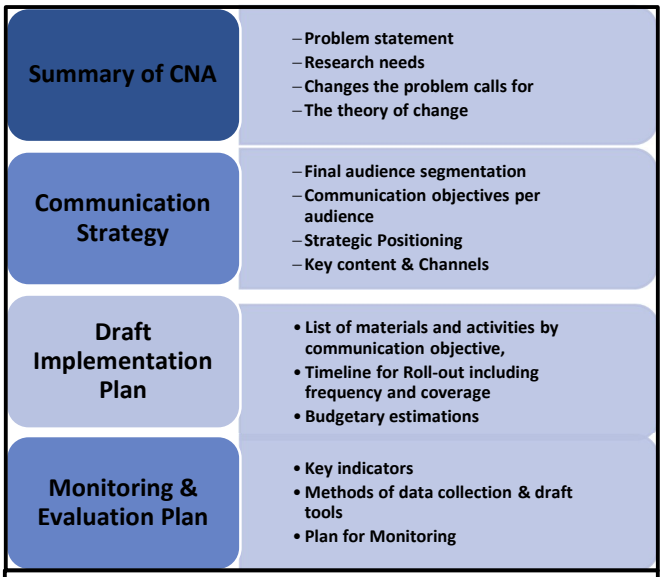


Figure 5.1: Components of SBCC Strategy

5.1.1 Detailed Framework for Designing the Strategy

The strategy will be designed against the framework given below. The issues to be probed under each section of the strategy document will be thoroughly **brainstormed** by experts. **Consultative workshops** will also be organized with the aim to garner the best possible expertise for the development of a robust strategy.

Table 5.1: Detailed Framework for Designing the SBBC Strategy

Sections of the Strategy Document	Issues to be probed/ answered
1. Summary of Communication Need Analysis	
Problem Statement	– Agree on a problem statement that summarizes the problem tree, population analysis, and context analysis.
Research Needs	– Identify other questions that still need to be answered through more research.

Table 5.1: Detailed Framework for Designing the SBBC Strategy	
Sections of the Strategy Document	**Issues to be probed/ answered**
Changes the Problem Calls for	– What changes (i.e., policy changes, services, products, social norms, and/or individual behaviours) would lessen the problem? – How can communication contribute to these changes through advocacy, social mobilization, and/or BCC? – What change would respond effectively to the current problem?
Theory of Change	– Explore all underlying assumptions about needed changes that have been identified, consulting SBCC theories about what will work and why, and indicating which strategies are likely to be most effective in the short, medium, and long term
2. Communication Strategy	
Final Audience Segmentation	– Which audiences (primary, secondary, tertiary) need to be addressed for these changes to occur? – Which audience segments are a priority and why?
Desired Changes	– What is the intended audience expected to change: knowledge, attitudes, beliefs, behaviours, skills, self-efficacy, access, perceived norms, sociocultural norms, policies, legislation, or something else? – Which theories and models contribute to an understanding of how these changes can happen?
Barriers	– What gets in the way of the changes that are needed? From the analysis, identify the main reasons why the audiences currently do not do this.
Communication Objectives	– For each audience segment, establish SMART communication objectives—specific, measurable, attainable, realistic, and time-bound— that address these key barriers.
Strategic Approach	– How are all communication objectives to be brought together into one approach or one activity platform to work toward change? – What is that platform called? – What will be the key strategy? – What will support it or link it to other strategies?
Positioning	– How will this approach stand out? – How will people be made to remember the program or campaign? – What distinctive logo or image will people associate with the program?
Key Content	– What is the key content to be communicated through each channel for each audience segment?
Channels, Activities & Materials	– Select channels, activities, or materials for each audience based on how to effectively reach a majority of them. – Consider how channels can reinforce each other to create an environment of change

Table 5.1: Detailed Framework for Designing the SBBC Strategy	
Sections of the Strategy Document	**Issues to be probed/ answered**
3. Implementation Plan	
Roll-out and communication dissemination plan	– Develop a plan that provides detail on each of the management considerations named below, as well as others deemed important to guide implementation. Name activities and materials to be created, keeping the budget in mind. ▪ List of materials and activities ▪ Implementers (including partners and allies) ▪ Resources ▪ Timeline
4. Monitoring & Evaluation Plan	
Monitoring & Evaluation System	– Think through reasons why the program should be monitored. Draft a monitoring design, name process and output indicators, and plan methods and tools for data collection.

Table 5.2: Supporting Guidelines for Developing the SBCC Strategy		
S. No.	**Sections of the Strategy Document**	**Supporting Guidelines for completing the section**
1	Audience Segments, Priorities, and Profiles: The first part of a communication strategy involves naming, segmenting, and prioritizing audiences.	
	Identifying the potential audience – Potential audiences shall be identified in using the concentric circles of C-Change's Socio-Ecological Model for Change.	– Answering the following questions can help in finalizing decisions about who should be the audiences for the SBCC program: primary (most affected), secondary (directly influencing), and tertiary (indirectly influencing). ○ Which group of people would be most important to reach to bring about change? ○ Which other groups play key roles in influencing them? ○ How do these different groups have an impact on the problem? What groups might provide the tipping point to motivate change? ○ What are the power relations between the groups?
	Segmenting – The identified audience can be segmented by dividing and organizing populations into smaller groups or audiences with similar	– Typically, audiences are segmented by geography, demographics, socio-cultural characteristics, and psychosocial issues. – Audiences can also be segmented according to what is called psychographics—personality, values, attitudes,

Table 5.2: Supporting Guidelines for Developing the SBCC Strategy		
S. No.	**Sections of the Strategy Document**	**Supporting Guidelines for completing the section**
	communication-related needs, preferences, and characteristics. – Each audience segment should be unique and relatively homogenous.	interests, level of readiness for change, and lifestyles (Senise 2007). – Audiences who identify with a particular lifestyle or group membership can also be segmented—e.g., religious sects, gay men, generation X— since this may override the usual segmentation categories. – Audiences can also be addressed by their self-efficacy to overcome certain barriers to – change.
	Prioritization – Once audience segments are drafted, they can be prioritized based on budget availability	Answers to the following questions help in prioritization – How many people are estimated to be in this group? – Does this group require specially prepared communication approaches or materials? – How important is addressing this group to achieve the objectives? – How likely is it that these audience members will change within the time frame of the program? – Does the program have the resources to address this group?
	Audience Profile	It is helpful to develop an **Audience profile** for each segment. This helps to personalize audience members and makes it easier to understand them during strategy development. The information to be included during profiling are: – geographic location, gender, age, occupation, literacy level, lifestyle, – where she or he gets information, – how he or she reacts to the health or development issue and related information, – the things he or she cares about or enjoys, and – if he – or she has anything at stake in the issue at hand
2	**Barriers**	
	Barriers: Individual or social change is not an easy thing to do and takes time.	The reasons people have for ignoring, fearing, or resisting change are grounded in strong beliefs or value systems. These have to be examined closely.

Table 5.2: Supporting Guidelines for Developing the SBCC Strategy		
S. No.	**Sections of the Strategy Document**	**Supporting Guidelines for completing the section**
		– Contextual or behavioral reason(s) for why the audience is not doing the desired behavior need to be identified and listed
3	**Communication Objectives**	
	Communication objectives **name ways to address barriers** to achieve desired change in policies, social norms, or behaviors. The objectives are **audience-specific**.	Strong communication objectives are developed by answering the following critical questions: – What do you want your audiences to change? – Why isn't this already happening (i.e., what are the barriers)? – Which of these barriers will you address with communication? – Which SBCC theory, model, or approach can help you?
4	**Strategic Approach and Positioning**	
	Strategic approach is the way a communication intervention is packaged or framed into a single program, campaign, or platform. – It holds together the different interventions, channels, and materials and combines them into a synergistic program: the whole is more than the sum of its – activities. – The strategic approach drives program coherence and describes how communication objectives will be achieved.	The approach shall be based on the three key strategies of advocacy, social mobilization and BCC. The planning for the SBCC implementation will be done by answering the following questions: – What needs to happen and where the program should focus. – Where is the tipping point for change that the program aims to affect? – What concepts are behind the assumptions? – How will the change happen? – What is the approach to change?
	Positioning means – Presenting an issue, service, or product so that it stands out from others and motivates certain reactions, changes, attitudes, and behaviors – Positioning creates a memorable cue for the audience to recognize program activities as part of an overall campaign or program.	– Does the positioning resonate with both male and female audiences? – What age group likes it? – Will it still resonate over time? – Is it different from the competition's positioning? – Does it represent something better or different than the known alternative? – Does it provide a benefit that is worth the cost or effort? – Can the program deliver the promise and/or benefit?

Table 5.2: Supporting Guidelines for Developing the SBCC Strategy		
S. No.	**Sections of the Strategy Document**	**Supporting Guidelines for completing the section**
	– It helps people to understand why they should adopt a certain policy, idea, value, or behavior and why they should advocate it to others.	
5	**Activity, Channel, and Material Mix**	
	To determine which activities or interventions will be used for each audience to achieve the communication objectives, as well as which channels and materials will support the activities and reach the audience.	– Before deciding what materials or activities to create, answers to the following questions should be considered carefully: o Which communication channels will best reach each intended audience? o Which channel/activity mix is best for the strategic approach? o Is the budget adequate for these choices? – The greatest impact will be achieved by **combining communication activities and channels** strategically. Within each category, multiple activities should be used. Ideally, different channels send mutually reinforcing messages.
	It might be helpful to think in terms of three basic intervention types	
	Interpersonal channels: One-to-one communication, such as provider-to-client, peer-to-peer, and partner-to-partner exchanges; social networks; training and skills building activities in small groups	Potential Benefits are: – Tailored communication – Interactive – Able to unpack complex information – Provides personalized assistance – Can build behavioral skills – Increases self-efficacy – Can increase intentions to act
	Community-based channels: Bulletin boards; community meetings and parent–teacher meetings; church and mosque notice boards; posters; drama groups, cultural events; community radio	Potential benefits are: – Can stimulate community dialogue – Can motivate collective solutions – Provides social support – Can increase intentions to act – Provides feedback to broader community
	Mass media and social media channels:	Potential benefits are: – Extensive reach

Table 5.2: Supporting Guidelines for Developing the SBCC Strategy		
S. No.	**Sections of the Strategy Document**	**Supporting Guidelines for completing the section**
	Television; radio; newspapers; billboards; transit advertising; web sites; Facebook; blogs; YouTube; videos; SMS; podcasts	– Efficient and consistent repetition of message – Have potential to mobilize youth effectively (social media)
	Factors that influence the choice of communication channels	
		Complexity of the issue: Although IPC is the most appropriate and effective communication for many situations, it is also the most labor- and cost-intensive communication channel. **Sensitivity of the issue**: Highly sensitive issues may not lend themselves to the use of mass media. **Literacy**: Low literacy levels rule out print materials with extensive text. **Desired reach**: Programs aiming at national or regional coverage often use mass media. **Prevailing social norms**: Localities and communities differ greatly in their openness and willingness to address certain issues. **Media habits and preferences of intended audiences**: Formative research needs to give answers to the question of access and habits to tailor programming to preferred listening times, favorites stations, programs, and media ownership. **Cost**: The cost of the many available communication channels and their combination vary by type and also by country. It is clearly a determining factor for strategy.

5.2 Development of Communication Materials

Communication materials will be developed for different aspects of the projects undertaken by MHSSP. The material (banners, posters, social media posts, mobile applications, etc.) developed will be focussed on motivating supply side stakeholders to adopt a quality focus in service delivery, and creating awareness amidst community to seek healthcare services. Under the purview of this activity, **effective communication products** - toolkits, facilitation manuals for group interaction, training manuals for counselling, job aids for service providers, websites, an interactive web-based process, TV or radio scripts, comic book or drama scripts, posters, brochures, and much more – **will be developed and tested**.

5.2.1 Process to be followed for Developing the Communication Materials

Step 1: Inventory of Existing Materials and Activities: Starting with an inventory of existing activities and materials can save enormous amounts of time. The existing resources are put to good use by complementing and/or adapting rather than recreating what is already out there. The existing resources can be analyzed using the matrix shown alongside.

Category of Communication Material	Activities and materials developed in the past	Ways to complement or adapt activities & materials already developed
Behavioral Change Communication		
Social mobilization		
Advocacy		

Step 2: Put together a Creative Brief: A **creative brief** is a short (one- or two-page) tool to guide the development of SBCC activities and materials. In general, each material or activity shall have its own creative brief, though a single brief may be developed for a set of activities or materials designed for the same audience(s) and with the same communication objective(s). The brief will be based on the communication strategy designed in the previous activity. The creative brief will have five broad categories:

- Goal and selected audience(s) for the activity or material(s)
- Desired changes, barriers, and communication objectives
- Message brief
- Key content and tone
- Media mix and other creative considerations

Detailed Framework for developing the Creative Brief:

Table 5.3: Framework for Developing the Creative Brief	
Category	**Guidance on Completing the Categories**
Overall Aim of the Communication - What are you trying to achieve with this activity or material	
Selected Audiences	– Primary: People most affected by the problem – Secondary: People who directly influence the problem primary audience, either positively or negatively – Tertiary: People who indirectly influence the primary and secondary audience—e.g., by shaping – Social norms, influencing policy, or offering – Financial and logistical support (access)
Communication Objectives: Directly address barriers to change	
Desired Changes	What changes do you want the audience to make?
Obstacles/ Barriers	– Why are people not doing what they should be doing?

Table 5.3: Framework for Developing the Creative Brief	
Category	**Guidance on Completing the Categories**
	– Would knowledge alone lead to their change in behavior or is something else missing? – Select a key barrier to adopting the desired change
Communication Objective	– Addresses the key barrier to the desired change
Message Brief: Formulated from an audience's point of view to guide writers, designers, and producers in designing and developing messages	
The Key Promise	– Provides a compelling, truthful, and relevant benefit that the audience anticipates receiving by taking the desired action
The Support Statement	– Convinces the audience they will actually experience the benefit; provides reasons why the key promise outweighs key barriers or alternative behaviors; often becomes the message
Call to Action	– Tells your audience what you want people to do or where to go to use the new product
Lasting Impression	– Focuses on what the audience will remember most after hearing or seeing the message and usually helps keep the message ideas on track
Perception of Someone Involved in the Change	– Describes what the audience thinks or believes about someone who is part of the change or who uses the product or service promoted.
Key Content and Tone: Should come from the communication strategy. If the strategy does not provide this detail, it is important to develop it here	
Key Content	– May be bullet points, grouped in the order they should appear in the material.
Tone or Appeal	– Helps convey the key promise. Content can be presented in different ways. – The feeling or personality your communication should have, based on the promise (e.g., humorous, logical, emotional, twisting, contrasting, ridiculous, visual, surprising, positive, or comic, or a combination thereof)
Creative Considerations: Describes how this activity or material relates to others you are creating and anything else you feel is important to keep in mind when creating, producing, or distributing this communication product	
Media Mix/ Activities	– Details on the campaign or series of activities to which this activity or material contributes

Table 5.3: Framework for Developing the Creative Brief	
Category	**Guidance on Completing the Categories**
Openings, Creative Consideration, Cost and Timing	– Openings: What opportunities (times and places) exist for reaching the audiences? – Creative considerations: Is there anything else the creative people need to know? Will the material or activity be in more than one language? What style and illustration type are preferred? How many local languages are needed? What are the reading levels of your audiences? Is there anything particular regarding style, layout, or visuals? What logos need to be used? How is this material branded? – Cost and timing: How much will the activities or materials cost, and when do they need to be ready? Do you have adequate funds to create everything? What could you cut, if necessary?

Step 3: Develop Effective Messages: A message is a brief, value-based statement that captures a positive concept and is aimed at an audience. The development of effective messages requires strategic thinking and nuanced insights about key populations. It is a matter of matching the intended audience's needs and motivations with the most compelling solution, which can outweigh (or at least address) the barriers the audience faces. Messages must be personally appealing and discuss only one or two key points. Care will be taken that the information being transmitted in these messages is new, clear, accurate, complete, and culturally appropriate. Messages shall include specific suggestions on actions people can take, and shall communicate key parts of the intervention. As messages will be drafted, their tone or appeal shall be kept in mind.

Framework for developing effective communication messages

The matrix given below, referred to as the Seven Cs of Communication, will be adopted while creating the communications materials/ messages.

Table 5.4: Seven Cs of Communication		
S. No.	**The Seven Cs of Communication**	**Questions to Ask and Things to Remember**
1	Command attention	– Does the message stand out? Does your audience think it does? – Focus will be on the following details: colors and fonts; images and graphics; sound effects; music; slogans; choosing innovative channel.
2	Clarify the message	– Is the message simple and direct? – The philosophy of “less is more” will be followed and focus will only be on what the audience needs to know.

3	Communicate a benefit	– What will the audience get in return for taking action? – A key benefit may not necessarily be a health benefit. Choosing an immediate benefit (instead of a long-term benefit) is typically more effective in bringing about immediate change.
4	Consistency counts	– Activities and materials convey the same message and become mutually supportive in creating recall and change. – Attention will be paid to the use of logos, colours, words, sounds, themes, images, and models.
5	Cater to the heart and the head	– Is it better to appeal to the audience's emotions, intellect, or both? Emotional appeals are often more convincing than facts.
6	Create trust	– Does your information come from a credible source? Who does the target audience consider to be credible? Is the source considered to be credible the same for men and women and for different age groups? Is there a celebrity who would impress your audience?
7	Call to action	– What do you want the audience to do after seeing the communication? What action is realistic as a result of the communication? – The call to action should focus on a concrete and realistic action and help achieve your objectives.

Step 4: Drafting Stories for Communication Materials: One way people communicate with each other is through **storytelling** and **narratives**.

- **Narratives** can include good stories, a gripping drama, oral history, personal experience, the experience of others, and fables or fairy tales. Narratives can be factual or fictional, told in the first, second, or third person. They can take different forms (e.g., conversations and dramas); they can be more or less interactive; and they can provide greater or lesser amounts of text versus pictures.
- **Stories** usually have a meaning. They offer learnings from the experience of the narrator or others, and these learnings are the message they promote.

A material or activity that incorporates a story shall be developed by the below-mentioned process:

- Write the script or text, **keeping literacy levels in mind**.
- Select **images for a storyboard**—a series of photos or illustrations that represent, scene-by-scene, what will appear on the screen or page. The words for each scene are written under each picture.

Step 5: Concept Testing: Concept testing concerns creative concepts that capture the essence of what is to be communicated. During concept testing, the main issues to be communicated are explored with members of intended audiences. Practitioners learn from them how they understand and speak about problems; the words and phrases they use and what is behind them; what moves, motivates, and interests them; and which creative ideas work for them. Before a material or activity is drafted, concept testing asks audience members what formats they prefer or what information they would like to see. After a material is drafted, concept testing explores which concept has the strongest appeal and potential for effect. At this point, concept testing also identifies confusing terms or concepts, language used by the intended audience, weaker concepts to be eliminated, and new concepts that should be developed. Draft concepts can be presented in drawings, mock-ups, skits that are acted out, and in other ways.

The agency will organize **consultative workshops** with language experts and key stakeholders/ informants from the community for the purpose of concept testing. Their inputs will be instrumental in drafting the messages and materials.

Step 6: Designing, Pre-Testing, and Finalization of Communication Material: The next step would involve converting all ideas and concepts into attractive and informative communication material. A mix of different types of communication materials would be required to convey relevant messages to different target audience based on their needs. It is proposed to use different kinds of media including mass media, print media, audio-visual media, social media networks, etc. to channelize the messages to different segments. It is proposed to provide 2 to 3 prototypes of each type of communication material, and use appropriate language depending on the need of target audience that the material is expected to cater to. The draft material shall be submitted to MHSSP for their review and feedback before finalizing.

Table 5.5: Indicative List of Communication Media and Material to be Prepared

Suggested Tools	Target Audience	Communication Objectives	Technical Specifications	Frequency/ Approach for Implementation
Mass Media Tools				
Newspaper Advertisement	Community (Mostly urban & Educated class)	Increase beneficiary knowledge of importance of various services and benefits offered under Govt. Health Systems, the ways of seeking these services, and the critical health behaviors that the project decides to	Advertisements to be developed targeting newspapers in English as well as Local dialects including Garo, Khasi, Jaintia, and Bengali. Preferably 400 Sq. Cm Advertisements to be prepared using appropriate softwares viz. Adobe InDesign, Illustrator, Photoshop or Corel Draw. The size and orientation of the advertisement can also be changed as per the space availability. These can either be in color or black and white. It will have a heading, pictures, infographics, logos of the concerned agencies like	The frequency of placement of advertisements and the geographical coverage can be decided based on when and in which area the project implements/ launches any special initiative, or organizes any event or campaign for promoting any health behavior, or records a significant achievement. It must be borne in mind that this media is accessed only by a limited set of educated population.

Table 5.5: Indicative List of Communication Media and Material to be Prepared				
Suggested Tools	**Target Audience**	**Communication Objectives**	**Technical Specifications**	**Frequency/ Approach for Implementation**
		promote in the community.	government department and world bank, etc. and a crisp and clear message.	
Articles for newspaper & magazines	Community (Mostly urban & Elite class)		500 to 1000 words articles depending on the content to be developed in English and local languages including Garo, Khasi, Jaintia, and Bengali on Microsoft Word document.	These will include detailed overview of the special initiatives undertaken by the project, the vision and objectives behind the initiatives, the actions or activities undertaken, and the expected value that it intends to add to the existing systems. It will also attempt to relay messages for promoting ideal healthcare and health seeking behavior in the community for various health issues prevalent in different regions of the State. These media are especially useful in reaching out to elite audience.
Press releases	Community (Mostly urban & Elite class)		500 to 1000 words articles depending on the content to be developed in English and local languages including Garo, Khasi, Jaintia, and Bengali on Microsoft Word document.	
Radio Clips/ Radio Spots/ Audio Clips	Community (Both Urban & Rural)		30 seconds jingles to be developed in English as well as in local dialects including Garo, Khasi, Jaintia and Bengali. The audios will be recorded by hiring trained and experienced professionals. MP3 formats of audio clips will be shared. It can be in the form of a musical or an announcement.	Short duration jingles with catchy tunes and lyrics for a good coverage across urban and rural areas alike. The messaging shall focus on ker health related issues, highlighting the need for adopting ideal health behavior and improve the uptake of healthcare services offered through the Government Health Systems in the State. Each jingle can be relayed 4 times day for 15 days during prime hours at a time interval of 2-3 months between each. The clips may be developed in Hindi as well as local dialects including Garo, Khasi, Jaintia and Bengali.

Table 5.5: Indicative List of Communication Media and Material to be Prepared				
Suggested Tools	**Target Audience**	**Communication Objectives**	**Technical Specifications**	**Frequency/ Approach for Implementation**
Audio/IVRS clips for voice calls	Community (Both Urban & Rural)		30 seconds Audio clips to be developed in English and then translated in local languages including Garo, Khasi, Jaintia and Bengali. The audios will be recorded by hiring trained and experienced professionals. MP3 or MPEG4 formats of audio clips will be shared. They can be in the form of a musical or an announcement.	Short duration audio clips may be used as caller tunes or IVRS response systems for toll-free numbers also have a wide reach in community. These clips may be designed to focus on critical health issues and relaying required advisory to deal with those issues. The messages may also focus on some important events or announcements that MHSSP wishes to make. Everytime a person calls in at the various toll-free numbers or Government helpline numbers or office landlines, they will hear this clip before they receive a response to the same. The clips may be developed in Garo, Khasi, Jaintia, and Bengali Languages.
Visual clips/ animated movies for video vans/ video walls at Health Facilities or to be displayed via mobile Vans travelling to difficult to reach areas	Community in Difficult to reach Rural areas and Users or visitors of health facilities		1 to 2 minutes video clips that can be used as commercials for mobile LED vans which can be used for the purpose of narrowcasting. May be developed in English and later translated into Garo/ Khasi/ Jaintia/ Bengali depending on the need. The same videos can be exhibited by installing video walls at prominent health facilities in the OPD areas or waiting halls. Videos will be produced by hiring trained professionals and technicians required for production of animated films. These videos will focus on the services being offered under the Government Health systems and potential ways of seeking these benefits.	Use of mobile vans mounted with LED screens and sound systems are effective media of communication, particularly in difficult-to-reach areas. These vans can be routed through areas with larger concentration of marginalized and deprived communities. It will involve hosting appealing videos communicating about programme interventions, messages promoting critical health behaviors, and about healthcare services being offered through Government health systems. These videos are expected to

Table 5.5: Indicative List of Communication Media and Material to be Prepared				
Suggested Tools	**Target Audience**	**Communication Objectives**	**Technical Specifications**	**Frequency/ Approach for Implementation**
				attract greater recall and retention about the programme amidst these communities. These can be disseminated through video vans/ video walls which can be created by installing video walls using high quality HD television screens, especially at places like OPD areas of health facilities or waiting halls not only enrich the look of the place but also engages audience very effectively. Some of the video content can be displayed through these video walls by looping it for repeat displays to cover audience that is likely to move in and move out of the place within a limited time period.
Print Material for Mass Communication				
Brochures	Supply side Stakeholders involved in health service delivery/ functionaries such as the Dorbar headed by the Rangbah Shnong, Village Health	Motivate Supply side stakeholders involved in service delivery to adopt a result-oriented behaviour. Build their communication skills and offer correct healthcare information they need to disseminate every time they organize sessions	The layout will be either 2- or 3-fold brochure in A5 size or A4 size respectively in English, and local languages including Garo, Khasi, Jaintia, and Bengali to be prepared using appropriate softwares viz. Adobe InDesign, Illustrator, Photoshop or Corel Draw. The content will have appealing pictures, infographics and details of the project, its objectives, the impact it has made and the future plans if any. It can be used to call for action, branding and promotion of the work done. It will also have logos of the supporting agencies like government department, world bank, etc. It	The materials like brochures, leaflets/ pamphlets, newsletters and handbills serve as effective and easy to manage tools of communication. These are usually effective in conveying short and focussed message. If designed with adequate use of infographics, these tools are likely to generate awareness even among the lesser educated population.

Table 5.5: Indicative List of Communication Media and Material to be Prepared				
Suggested Tools	**Target Audience**	**Communication Objectives**	**Technical Specifications**	**Frequency/ Approach for Implementation**
	Councils and Village Organizations/ Community	with frontline workers and families. Increase the commitment of community leadership to enhancing coverage and utilization of government health services, and to promote ideal health behavior in their community.	will be a multicolour communication material.	Posters and wall paintings capture attention of audience very effectively. The placement of these in the community should be very carefully decided. Having clutter free spaces with wide visibility are best suited to host this content. These methods are popular among the urban and rural communities alike.
Leaflets/ pamphlets			2 types of double-sided leaflets in A5 size layout in English and in local languages including Garo, Khasi, Jaintia, and Bengali to be prepared using appropriate softwares viz. Adobe InDesign, Illustrator, Photoshop or Corel Draw. The content will be crisp and will have appealing picture or pictures, infographics and short details of the project, its objectives and the impact it has made. It can be used to call for action, branding and promotion of the work done. It will also have logos of the supporting agencies like government Department, world bank, etc. It will be either two color or three color communication material.	
Posters			2 types of posters in A3 size layout in English and local languages including Garo, Khasi, Jaintia, and Bengali to be prepared using appropriate softwares viz. Adobe InDesign, Illustrator, Photoshop or Corel Draw. The content will be short and will have appealing picture or pictures, infographics, a heading and a few lines on the key healthcare related messages to be relayed. It can be used to call for action, branding and promotion of the work done. It will also have logos of the supporting agencies like government department, world bank, etc. It will be a multi color communication material.	

Table 5.5: Indicative List of Communication Media and Material to be Prepared				
Suggested Tools	**Target Audience**	**Communication Objectives**	**Technical Specifications**	**Frequency/ Approach for Implementation**
Newsletters/ handouts			2 types of Newsletters/ handouts in A4 size layout in English and local languages including Garo, Khasi, Jaintia, and Bengali to be prepared using appropriate softwares viz. Adobe InDesign, Illustrator, Photoshop, Corel Draw or Microsoft Word document. The content will have appealing pictures and details of the quarterly update of the work done, impact made, achievements and events organized. It can also have voices of the beneficiary or announcements if any. It can be used for promotion of the work done. It will also have logos of the supporting agencies like government department, world bank, etc. It will be a multicolour or three color communication material.	
Print Material for Interpersonal Communication				
Flipcharts	For Frontline functionaries active in the communities.	Frontline workers have useful aids and information and messages related to healthcare issues that they need to disseminate every time they organize sessions with families in the community to encourage uptake of services offered under the Government Health systems.	8 to 10 pager A3 size layout laminated flipcharts with infographic and pictorial content to facilitate ease of handling during interactive IPC sessions. These will be developed in and local languages including Garo, Khasi, Jaintia, and Bengali. It will also have logos of the supporting agencies like government department, world bank, etc. It will be a multicolour communication material.	To act as aids to facilitate focussed interaction with the target audience around different types of health related messages. These can be used for mobilizing frontline workers, or community level volunteers. These may also be used by the functionaries in turn during the interpersonal counselling sessions in the community.
Booklets			8 to 10 pager booklet, with a layout of A5 Size on programme features to be developed in English and in local languages including Garo, Khasi, Jaintia, and Bengali for	

Table 5.5: Indicative List of Communication Media and Material to be Prepared				
Suggested Tools	**Target Audience**	**Communication Objectives**	**Technical Specifications**	**Frequency/ Approach for Implementation**
			IPC sessions. It will also have logos of the supporting agencies like the government department, world bank, etc. It will be a multicolour communication material.	
Handbills			2 types of single pager double sided handbills in A5 Size layout with infographic information to be developed in English and in local languages including Garo, Khasi, Jaintia, and Bengali using Adobe InDesign, Illustrator, Photoshop or Corel Draw. It will also have logos of the supporting agencies like government department, world bank, etc. It will be a two color communication material.	
Print Material for Outdoor Publicity				
Hoardings **Banners** **Panels for Bus Stations/ Taxi stands/ community Sports grounds/ market places**	Community	To spread awareness about services and benefits offered under Govt. Health Systems and the unique advantages that the project brings for the communities. These media will also be used to promote critical healthcare behaviors as identified in the need assessment phase.	2 designs for each of these products shall be developed in English and local languages including Garo, Khasi, Jaintia, and Bengali depending on the project requirements using relevant softwares like Illustrator, Adobe-In Design, and AUTOCAD. The size will be decided as per the space available. It will also have logos of the supporting agencies like the government department, world bank, etc. It will be a multicolour communication material.	The outdoor publicity tools like Hoardings, Banners, Panels for bus stations, taxi stands, community sports grounds and market places. These will be put up in selected locations/sites with optimum footfall of targeted users.
Digital & Social Media/ Electronic/ Web-based Platforms				
Microblogs/ Infographic		To spread awareness about	10-15 designs to be developed using Adobe InDesign,	It is expected to leave a prominent digital footprint

Table 5.5: Indicative List of Communication Media and Material to be Prepared				
Suggested Tools	**Target Audience**	**Communication Objectives**	**Technical Specifications**	**Frequency/ Approach for Implementation**
Messages for Twitter, Instagram, Facebook and WhatsApp	Commu-nity	services and benefits offered under Govt. Health Systems and the unique advantages that it brings for the communities. To promote the special interventions taken under MHSSP to strengthen the quality of health services in the State. To promote critical healthcare behaviors and enhance healthcare seeking behavior of community	Illustrator, etc. in English and shall be translated in local languages including Garo, Khasi, Jaintia, and Bengali conveying different types of messages. JPEG files, CorelDraw	in the webspace, with the reach extending beyond the boundaries. It is expected to have repeated exposure of audience to the message without major cost implications.
Blogs for Web-based promotion			5 to 6 blogs to be written on different project themes. Blogs to be written in English and will be translated in local languages including Garo, Khasi, Jaintia, and Bengali. These will be hosted at relevant platforms in consultation with MHSSPP.	As in case of newspaper articles and press releases, the blogs and Vlogs/ podcasts also target at the elite set of audience. These will be usually developed by filming the interviews with key officials, functionaries or community. These media can be very useful to present complex and long messages or extensive information about a particular topic. This also has a good penetration, with reach extending beyond physical boundaries.
Vlogs/ Podcasts for You-tube and other Social media			5 to 6 Vblogs/ Podcasts to be developed depending on the types of messages to be conveyed. These may be developed in English and local languages including Garo, Khasi, Jaintia, and Bengali. These will be hosted at relevant social media platforms like youtube etc.in consultation with MHSSPP.	
Other material for Project Progress Promotion				
Backdrop Banners	Project Stakeholders including the Health systems functionaries, functionaries of other departments like Education, Social Welfare, etc. Tertiary stakeholders including media,	To generate awareness about project strategy and progress made in different interventions implemented under planned project components.	The designs for each of these products shall be developed in English and other langugaes as desired by Project officials. It will also depend on the schedule of events like seminars/ workshops/ meetings planned under the project. It will also have logos of the supporting agencies like government department, world bank, other agencies supporting the implementation of specific interventions, etc. It will have a multicolour, single color or two color scheme depending on the communication material.	These materials shall be developed as and when the project achieves certain milestones under different project interventions.
Standees				
Danglers/ table tops				
Signages for venue				

Table 5.5: Indicative List of Communication Media and Material to be Prepared				
Suggested Tools	**Target Audience**	**Communication Objectives**	**Technical Specifications**	**Frequency/ Approach for Implementation**
Press briefings/ conferences kits, etc.	prominent NGOs, etc.		The size of the backdrop and signages will be decided as per the space availability, standees will be of 6x3 feet dimension, danglers' size vary from 12– 48 inches as per the requirement.	

Step 7: Pre-Testing, and Finalization of Communication Material: The concepts will be pre-tested with groups or representatives of the target audience to test for cultural sensitivity and appropriateness, especially pictures, illustrations and other visual materials, which are easily misunderstood. At this stage, pretesting of draft communication materials will be conducted with at least 8-10 stakeholders from each of the categories identified in the preceding sections, and any new category of stakeholders that emerge during later stages in consultation with MHSSP team. Before piloting the tools, the Team Leader, Research Associates engaged in Need Assessment, and other members in the team will review each and every tool together to develop a thorough understanding of the concept, functionality, and the impact that the tool aims to create. The team will then develop questionnaires, interview guides, or agenda for the group meetings and feedback forms for different types of tools. The pre-testing shall be undertaken by adopting the following methods –

- **Review by partners and stakeholders** (officials from the State Health Department) will be organized through consultative meetings between core team before the pre-testing. Feedbacks and inputs from the stakeholders will ensure that the **content** of the messages and materials **is accurate**. It will also confirm **acceptance by the decision-makers**/ clients.
- **Field testing** helps to confirm whether the intended audience understood or liked the materials. In order to ensure its' efficacy in driving the message home, and in ensuring better recall and retention of messages, it will be prudent to test these tools among the same stakeholders for whom these tools have been devised. This will help capture the reaction of the audience about the appropriateness of the message, ease of understanding, and the effectiveness of the product to catch their attention and generate interest among them. Group meetings will be organized and individual feedback forms will be collected for different types of stakeholders to capture their feedback and suggestions on each tool. Testing will focus on five areas of assessment:

- **Comprehension**: Is the content of the material clearly understood by the audience? Is the visual presentation clear?
- **Attractiveness**: Does the material capture the audience's attention in a positive way?
- **Acceptance**: Is the content and presentation accepted as relevant to the audience?
- **Involvement**: Does the audience identify with the material? Do they feel it speaks to them and their experiences?

- **Relevance**: Does the material make the audience think and talk to others about change? Does it induce them to find more information or services and seek solutions?
- **Improvement**: Is there anything that can be done to improve the materials?

The tools shall be fine-tuned based on the pre-test results which will be shared with the client for their feedback and further suggestions. The tools thus finalized shall be submitted for approval by MHSSP before proceeding for the roll out.

CHAPTER 6

TECHNICAL APPROACH & STRATEGY FOR THE ROLL-OUT OF COMMUNICATION STRATEGY AND MONITORING & EVALUATION

6.1 Roll-out of Communication Strategy in Targeted Areas

After the finalization of the SBCC tools, the team shall undertake a few preparatory activities like preparing an implementation or roll-out strategy, develop training modules, and prepare a pool of State-level Master Trainers. The team shall offer active handholding support to these Master Trainers to facilitate state-wide roll-out of the SBCC package. The step-wise methodological approach proposed to be adopted is presented in the sub-sections ahead –

6.1.1 Preparing Implementation and Roll-out Strategy:

Based on the learnings drawn from the formative research and piloting of tools in the preceding phase, suitably responsive strategy will be developed for the proposed state-wide roll out of the SBCC Package. In addition to this, the core team members shall also identify various Government or private academic or training institutions, training resource centres under different associated departments, and other district and block level infrastructure and systems in place which may be capitalized on for organizing the district and block level trainings. The core team shall review all the information to design different components of the proposed Roll-out strategy, such as –

- Key stakeholders who can support roll-out of communication plan
- Roles and responsibilities of respective stakeholders
- Identified challenges/ competency gaps and measures to address these gaps
- Training approach & methodology, mode of delivery, duration and content
- Indicative training content and broad plan including a plan for scheduling the modules, materials required for each type of training, resource persons to be involved, etc.
- Work on an annual roll out plan which will include the schedule of release of different communication materials by location, logistic requirements for the same, and budgetary requirements.

The team shall then present this training strategy to the concerned officials of the Client team before finalizing the same. They will together review the strategy and training plan in terms of feasibility, efficiency of resource use, availability of required logistics and infrastructural requirements in the State, potential opportunities for convergence, and any clash with existing State level priorities, etc.

Based on joint review the training strategy shall be finalized and the same shall then be formalized for further action.

6.1.2 Preparing Training Modules:

The focus of training modules shall revolve around building the capacities of concerned stakeholders to use the given communication material, ability to ensure roll-out in their catchment areas as per roll out plan, competency to undertake routine monitoring to ensure efficacy of material developed. Based on the review of findings of formative research, and pre-test results, content of the training will be generated as per the information needs of different target audience. The team will ensure availability of requisite learning material for organizing the trainings as per plan. The content shall be customized based on mode of delivery, that is, face-to-face classroom-based training, workshops, self-instructional material available online, webinars, etc. or a combination of these.

6.1.3 Training the Pool of State level Master Trainers:

It is assumed that the State shall identify the number of persons that it proposes to deploy in the pool of State-level Master Trainers, who will be responsible for steering the state-wide rollout proposed under the project. Based on the current understanding of the requirements, it is estimated that a **minimum of 9 State-level Master Trainers** shall be trained in the first phase. Given the regional variations in language, it is proposed that there should be at least 3 trainers for each of the three regional languages. The calculation for working out the minimum requirement of the State-level Master Trainers is as follows:

No. of Local Languages other than English	No. of Master Trainers per Language	Total State Level Master Trainers
3 (Garo, Khasi, Jaintia)	3	9

The Core team members including Team Leader, Communication and Social Media Expert, and Design & Documentation Expert, shall serve as key trainers for training the pool of State-level Master Trainers. An intensive, 3-day classroom-based training shall be organized for these trainers. During this, the trainers will not only be exposed to the content to be delivered but also to the pedagogy of training various stakeholders for the dissemination of relevant messages the and use of different tools and material prepared for the same.

Design for Roll-out of State-wide Trainings of Functionaries:

Figure 6.1: Proposed Training Model

Once the pool of State-level master Trainers is trained, the trainings will be rolled out for concerned district and sub-district level officials of the Health Department. The training will primarily be provided in **Face-to-Face (F2F) mode.** However, if desired, online mode of training may also be considered for special circumstances.

Expected Number of Trainees:

Based on available secondary information from different Government sources, it is **estimated 10 district-level officials in each of the 11 districts of the State, and 780 Sub-district level functionaries**. The trainees to be included in the sub-district level trainings shall be decided in consultation with the PMU team. **Face-to-face training would need to be given to a total of 11 batches for District level trainees and 39 batches for sub-district level trainees over a period of 1.5 months**. The table alongside outlines the expected number of trainees at each level.

Table 6.1: Expected Number of Trainees under the Project

Trainee Groups	Expected no. of Trainees	No. of batches	Required No. of Training days	Available no. of days for training	Training Plan
District level Functionaries	110	1 batch per district	33 days (3 days per Batch including travel days)	12 days (2.5 weeks@5 days per week)	3 batch trainings shall be running simultaneously. Accordingly, 9 trainers shall be required
Block Level Functionaries	780	39 batches with about 20 trainees per batch	78 days (@2 days per batch)	18 (3 Weeks @ 5 days per week)	4-5 batch trainings shall be running simultaneously. Accordingly, 12-15 trainers shall be required

The above estimates are for classroom-based trainings. However, if desired, online mode of training may also be considered for special circumstances after discussion with the PMU team. This will help economize on both time and cost requirements. A schedule of trainings shall be shared well in advance to ensure participation of trainees. It can be facilitated through block-level PHCs to optimize on the resource and ensure adequate attendance and participation.

6.1.4 Offering Handholding Support for Roll-out of Communication Plan by Trained Functionaries:

Once all the key functionaries at various cadres have been trained, they will be required to steer and manage the roll-out of communication plan in their respective areas. This exercise shall be organized over **the remaining 4-year project duration**. To ensure effective planning, delivery, monitoring and

providing handholding support to the functionaries while they roll out these packages at community level, **3 full-time Project Coordinators will be deployed**. In view of the geographical terrain in the State and varying size of districts, each Project Coordinator shall be expected to **oversee conduct of the above activities in 3-4 districts in a phased manner**. The role of these project coordinators would be to –

- **Liaise between the Core Team and the District and Block Level Officials** to schedule roll out of community level interventions by integrating the activities in their scheduled activities.
- They will offer support to **District and Block level officials to make village-wise plan for scheduling these community level roll-outs**. The officials may seek support of frontline functionaries and plan the roll out and seek logistic support of Village administration functionaries such as the Dorbar headed by the Rangbah Shnong, Village Health Councils and Village Organizations.
- Offer **handholding support to district and block level functionaries for conducting audits and monitoring** of these communication activities for ensuring effective conduct and monitoring the performance of functionaries. Structured checklists and monitoring formats will be prepared for capturing the desired information.
- **Undertake routine monitoring** through **random site inspections** at the time of the scheduled session, **interact with functionaries** on their understanding of the message and their recall & retention rates, **visit a few beneficiary households and administer a short questionnaire** to capture their feedback on the efficacy of communication tools, and extent of recall and retention of messages shared. Android-enabled mobile-based application shall be developed for each of these monitoring components.

The core team members shall build the capacities of these Project Coordinators to undertake the desired functionaries. All monitoring information collected through Android-enabled mobile application shall be uploaded to the server, which will be integrated with an **MIS-based dashboard to offer real-time insights to all agency and client officials about the progress of work on the ground.** Based on information collected during healthcare facilities/ home visits, the feedback received from the target beneficiaries, quarterly progress reports shall be prepared and shared with the client as a key deliverable.

Further, **refresher training** may be provided to the functionaries during the four-year duration, if any performance gap or capacity gap is identified as a result of routine monitoring. These observations and feedback will also be shared with the District, and sub-district level functionaries so that they can identify the gaps in their understanding and interactions with the target beneficiaries and enhance their capabilities accordingly. The **best practices will also be shared will all functionaries** to boost their levels of comprehension and provide new ideas/ways of functioning.

6.2 Monitoring and Evaluation of Communication Strategy

6.2.1 Method of Monitoring & Evaluation:

In order to ensure achievement of intended results through the comprehensive media campaign, it is important to undertake routine periodic checks to assess if all is going as per plan. Further, to assess if the communication has been able to make the desired impact on the intended target audience, it will be desirable to rely on cross-sectional surveys at various time points in the project.

Monitoring of communication outcomes relies on tracking the release of inputs, the immediate outputs and intermediate outcomes so that adjustments can be made to the programme during implementation. Monitoring is usually limited to a broad set of easily observable indicators which can help draw quick insights about the mid-course corrections that need to be taken to enhance the reach and effectiveness of communication material. Routine monitoring can be carried out by collecting **secondary data** related to the project. The **HMIS** in itself is likely to yield very useful insights for tracking the project progress. Besides that, **internal monitoring reports**, and various types of **audits & evaluations** carried out as a routine function under the project can also serve as rich evidence for the purpose of monitoring. Further, dedicated **monitoring teams** can also be constituted that can perform the sole function of carrying out the **routine audit at a fixed frequency**.

6.2.2 Conceptual Framework for Monitoring & Evaluation:

The theory of change approach will be adopted to lay down the framework for monitoring and evaluation. While formulating the communication plan, efforts shall be made

to clearly lay down the indicators for each component of theory of change including – inputs, activities, outputs, outcomes, and impact.

Inputs usually denote the human and material resources that are deployed for carrying out the desired activities and functions. These include communication resources put into the project to support its implementation. The inputs largely constitute the assets such as personnel, finances, and equipment, as well as experience and expertise.

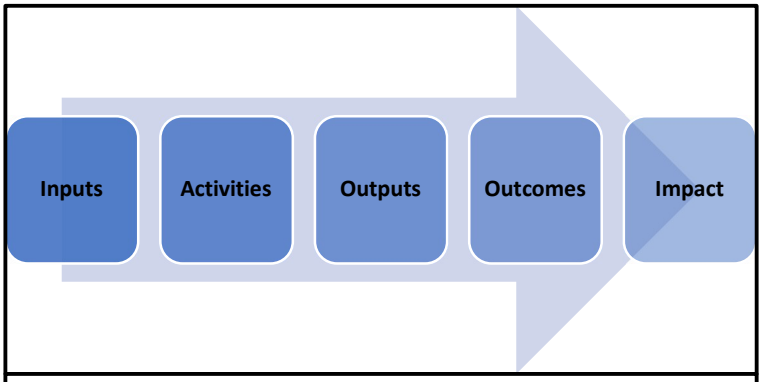


Figure 6.2: Logical Framework for Monitoring & Evaluation

Activities include activities performed under the ambit of communication plan to achieve the goals and objectives set forth in the planning stage. Activities include adapting messages to key audiences or creating messages, and materials, and facilitating their dissemination. These can be measured in terms of the number of posters disseminated, number of staff using the IPC material or Android-based applications developed for the purpose, or numbers of views and shares taking place on social media platforms.

Outcomes include second-level results that occur from communication outputs. These are usually in terms of changes in knowledge, attitudes, or behaviours of the target audiences based on exposure to the communication messages or materials relayed under UKHSDP. These changes are necessary to achieve the desired impact.

Impact refers to longer-term goals such as improved health-seeking behaviour of the community. These impacts require, but routinely transcend, communication inputs, activities, outputs or outcomes. The achievement of impacts is often influenced by the other local and environmental conditions like access to relevant infrastructure and resources etc. Any attempt to measure the impact and attribute it correctly to the project interventions must capture these details as well to assess the interdependencies with other factors.

An illustrative list of potential indicators to be considered for monitoring and evaluation of different types of media is presented in the matrix presented in Table 6.2 –

Table 6.2: Examples of key questions and Indicators

Questions	Indicators for Activities and Outcomes	Expected Impact
Reach of the tools	**Publications or blogs:** • Number of page views in a time period • Number of downloads in a time period • Clicks to download from the page • Compare with another time period to look at audience growth	• Access • Success of method
	Social media: • Number of shares or clicks to the output • Followers/Subscribers	Popularity and Reach of the programme
	Events: • Number of attendees • Number of online viewers • Compare with another time period to look at • audience growth • Type of attendee, including job type or sector • Drop-out rate	Popularity and Reach of the programme
	Email/Newsletter: • Number of subscribers • Open rate • Click rate • Unsubscribe rate	
Location of target audience	• Total web traffic by location	• The geographical extent of reach

Table 6.2: Examples of key questions and Indicators		
Questions	**Indicators for Activities and Outcomes**	**Expected Impact**
	• Percentage coverage as compared to expected in a particular region	• The spread of media coverage by geographic location
Interaction with indicator	• Time spent on app/website • Type of channel used the most	• Interest taken in advertisement • Outreach of each medium
Feedback from audience	• Comments received • Tweets and retweets • Formal and informal praises	Audience perception regarding potential mediums and the messages
Credibility of channels	• Number or percentage who state the content of the output/activity is useful • Number or percentage of users who report knowledge gained • Number or percentage of users who report their views have changed	• Provides an indication of how useful the output(s) is • Audience learning • Whether the information was internalized by the audience
Adapted from ODI CMEL Toolkit 2018		

Type of Monitoring & Evaluation Indicators to be Mapped

It is proposed to map some critical indicators for monitoring and evaluation of different types of tools or communication media proposed to be adopted as per the communication approach detailed in the preceding sections of this document. An indicative list of indicators to be used for the purpose of monitoring is presented in Table 6.3. This list is purely indicative in nature. Many more indicators can be worked out once the actual plan of implementation is finalized and when we get a thorough understanding of the availability of requisite data and resources in the system to operationalize the communication plan. The final roll out plan and actual resource deployment finalized at the project level will guide development of other critical indicators that can be looked at while developing the monitoring and evaluation tool kits.

Table 6.3: List of Potential Monitoring and Evaluation Indicators	
Tools	**Potential M&E Indicators**
Mass Media Tools	
Newspaper Advertisement	• Number of enquires raised in dedicated toll-free numbers/ helpline numbers like 14400, etc. as available in the State. • Social Surveys to test exposure to different media and recall & retention of messages relayed through these sources
Articles for newspaper & magazines	
Press releases	
Radio jingles	
Audio/IVRS clips for voice calls	

Table 6.3: List of Potential Monitoring and Evaluation Indicators	
Tools	**Potential M&E Indicators**
Visual clips for video vans or video walls at Health Facilities/ documentary for cinema spots	• Level of awareness about the project • Attitude and perception around the project initiatives Behaviour change of local community, • Support of local leaders, • Increase in utilization of facilities
Print Media to be Used for Mass Communication	
Brochures	• Number of enquires raised in dedicated toll-free numbers/ helpline numbers like 14400, etc. as available in the State. • Social Surveys to test exposure, recall and retention of messages relayed through these media • Level of knowledge, attitude and perception towards the project components • Behaviour change of local community, • Support rendered by local leaders and grassroots level functionaries • Increase in utilization of facilities
Leaflets/ pamphlets	
Posters	
Newsletters/ handouts	
Print Media to be Used for Interpersonal Communication	
Flipcharts	• Number of enquires raised in dedicated toll-free numbers/ helpline numbers like 14400, etc. as available in the State. • Social Surveys to test exposure, recall and retention of messages relayed through these media • Level of knowledge, attitude and perception towards the project components • Behaviour change of local community, • Support rendered by local leaders and grassroots level functionaries • Increase in utilization of facilities
Booklets	
Handbills	
Outdoor Publicity Material	
Hoardings	• Exposure to the concerned media • Attention span for the said media • Number of enquires raised in dedicated toll-free numbers/ helpline numbers like 14400, etc. as available in the State.
Banners	
Bus/ train panels	
Panels for Bus Stations and Railway Stations	
Illuminates Signages	

Table 6.3: List of Potential Monitoring and Evaluation Indicators	
Tools	**Potential M&E Indicators**
Wall Paintings	• Social Surveys to test awareness, Behaviour change of local community, Support of local leaders, Increase in utilization of facilities
Digital/ Social Media/ Electronic or Web-based platforms	
Microblogs/ Infographic Messages for Twitter, Instagram, Facebook and Whatsapp	• Number of followers, page views, retweets, clicks
Blogs for Web-based promotion	• Number of views, comments and time spent on page
Vlogs/ Podcasts for You-tube and other Social media	• Number of subscribers, views and comments

The sections ahead present an overview of the work plan for the proposed activities including timelines, phasing of activities, and other pertinent details on operationalization of the assignment.

CHAPTER 7

WORK PLAN

Altogether, the Meghalaya Health Systems Strengthening Project (MHSSP) is spread over a span of five years with five phases of the assignment. While the first year of the assignment includes the preparatory phase (1 month), execution of the Communications Need Assessment (2 Months), preparation of SBCC Strategy & Design, pretesting and finalization of communication tools & training of trainers (6 months), and facilitating roll out and monitoring & evaluation of the communication activities (3 months), the rest of the 48 months (4 years) are delegated towards the implementation/ roll out and monitoring phase. The activity time schedule for the proposed activities and deliverables has been annexed as Annexure 1 to this document. A description of each of the activities proposed in the schedule has been presented ahead –

7.1 Detailed Description of Activities

7.1.1 Preparation of the Inception Report (Week 1-4)

Step-1: Consultative Meetings with Project Officials: After the award of the assignment, the first week was spent making preparatory arrangements. The Team Leader along with some of the other Core team members undertook consultative discussions with MHSSP officials and concerned officials of the Health Department & World Bank to understand their expectations from the assignment. As a part of these discussions, two virtual meetings were attended on March 1, 2022 and March 9, 2022. Besides, the AMS Team also visited Shillong to attend an in-person meeting with the MHSSP officials on March 11, 2022 so as to get a clearer picture of what needs to be done. During the initial meeting, the project team jointly reviewed the terms of reference to achieve a common viewpoint for the requirements of the project. In these interactions, one other component of the assignment was also discussed- the roll-out of the Village Health Councils in the state which needs to be done in a month-time. As a part of this, AMS is expected to-

- **Generate & Disseminate IEC content for awareness on VHC in Media Dark areas and urban areas for all target groups; and,**
- **Work in a collaborative manner with line departments (H&FW, Social Welfare, Education, C&RD Departments) to generate content for VHC awareness**

Therefore, necessary communication materials will be developed in this regard based on the traditional frameworks, discussed in the previous sections, so as to ensure the promotion of these councils in the state.

Step-2: Obtaining Relevant Project Documents and Training Material: One of the preliminary steps of the assignment was to gain a thorough understanding of the training needs identified by project authorities. The Team Leader consulted with Client officials and obtained from them all relevant project documents, reports, guidelines, circulars, or manuals designed so far. Any kind of reports or secondary data the authorities feel relevant to gain an understanding of the requirements was also obtained for the purpose of internal review.

Step-3: Development and Submission of Inception Report: The project team reviewed the documents and literature obtained in the preceding step under the overall guidance of the team leader. Each member brought in their technical expertise to devise a pragmatic approach to be adopted for carrying out the given assignment. The consultative discussion held with concerned officials, and the review of the relevant literature made available provided an insight into the overall requirements. Based on this understanding, the team has drafted an inception report providing a detailed account of the technical approach, the steps involved, an indicative plan of activities to be undertaken, and the type of material to be developed under the project.

(The submission of the Inception Report constitutes the first deliverable of the assignment. Any suggestions offered by the client after review of the report shall be duly incorporated to finalize the document.)

7.1.2. Conducting the Communication Needs Assessment (Week 4 to 12)

As per the Terms of Reference, the agency will carry out a rapid need assessment study to map the different stakeholders and gain and in-depth insight into their beliefs, perceptions, knowledge, attitude and behavior related to the healthcare scenario in the State. As depicted in section A, a mixed-methods approach shall be adopted for capturing required information across 30 villages.

Step-1: Finalization of Tools: The feedback received from the client team on the draft tools submitted along with the inception report, shall be duly incorporated in the tools. They will then be translated into the regional languages. Thereafter, a rigorous review of the translated tools would be done to fine-tune the flow and language in close consultation with the client. This will allow us to check for any gaps, inconsistencies, ambiguities, etc., and other sources of bias & errors. In particular, the reviewing exercise will seek to assess the flow of questionnaires, clarity of questions asked, correctness of skip-patterns for ensuring continuity among different sections of the questionnaire, comprehensiveness in terms of information coverage, simplicity of the language used in framing questions.

Step-2: Sample Selection: An indicative approach for sample selection for needs assessment based on preliminary understanding of the project has been presented in the preceding section of this document. The actual sample design to be adopted shall be firmed up after review of project documents and in consultation with concerned authorities. Based on the approach finalized, the Team leader shall examine the secondary information to select the desired number of villages from each of the two blocks.

Step-3: Training of Field Staff: It is proposed to deploy a team of culturally conversant and suitably qualified and experienced staff to undertake the field-based data collection. It is proposed to deploy Field Supervisors and Research Investigators for carrying out the data collection. A **five-day orientation/ training** will be organized for the field team. During this they will be offered detailed understanding of the project background, need assessment objectives and methodology, the data collection protocol, and a thorough understanding of the tools to be used. This orientation will prepare them to undertake data collection using the guides and CAPI-based tools developed for the purpose.

Step-4: Data Collection: The trained team will then set out to the assigned sample locations to carry out the field-based data collection as per deployment plan. All structured questionnaire will be administered using CAPI-based questionnaire to allow near real-time access to data to the core team.

All qualitative data will be duly audio-recorded after seeking permission/ consent from the respondents. The audio recording will facilitate easy transcription of responses and will also ensure that no details of the conversation are missed out due to inability to capture notes. All these recordings will be shared with the agency headquarters where the transcription and translation shall be initiated at the backend.

Step-5: Data Analysis & Report Preparation: The Team Leader with the assistance of other team members, will review the data collection through primary and secondary sources to undertake a need gap analysis. The findings and observations from both the exercises will be collated in the form of a report. The field level data collected will be converted into soft format by in-house data entry operators, followed by verbatim transcription of all in-depth interview schedules and FGDs. The same will then be analyzed in a systematic and methodological manner, scrutinizing the text for its primary as well as latent content. All quantitative data shall be analyzed using statistical softwares like SPSS, STATA, R, etc. All qualitative data shall be subjected to content analysis using softwares like N-Vivo or Atlas-ti. The core team will prepare a detailed analytical report using the dataset and will share this report with the client for their review.

The findings that will emerge from the analyzed data will translate into recommendations for evidence-based design and draft of a communications plan and approach for improving the awareness and perception of various stakeholders about Government Health Systems in Meghalaya. These findings and their implications for the design of a communication campaign(s) will be documented in the form of a **Communication Need Analysis Report**. This report will be submitted to the concerned authorities for their review and feedback and will constitute **deliverable** 2 as per the schedule outlined in the TOR. The Team Leader may also make a presentation to the MHSSP officials on the key findings and their implications on the choice of communication approach, including messaging and media. A discussion based on the presentation and guidance offered by project authorities during the same will help the team firm-up the communication plan.

7.1.3 Designing & Developing the SBCC Strategy and Communication Tools & Material (Week 12-24 weeks)

Step-1: Preparing Communication Plan: Taking a lead from the findings of need assessment, the team will work out a detailed communication plan clearly outlining the type of media to be used, the content of messages to be designed, and the outline of communication tools/ material to be developed.

The core team, that comprises of the Team Leader and other key experts will brainstorm to develop a conceptual framework for the different tools that will be required for the campaign. To achieve this, they will first identify the target audience – the supply and demand side stakeholders of the project and then segment them according to their communication requirements. This will be followed by an extensive mapping of all the stakeholders engaged in the implementation which will be done based on consultations with concerned project officials along with review of secondary literature. The team will then identify the target behaviours for each stakeholder and then determine the communication objectives, and the communication components, and ultimately the most appropriate communication channel for delivery.

A draft outline of this strategy will be discussed and submitted to the MHSSP officials for their review and feedback. The Team Leader will undertake a consultative discussion with the concerned officials about the feasibility of approach proposed to be adopted for the communication campaign.

Step-2: Ideation and Development of Package: This stage will involve intensive engagement of the Communications Expert and Design and Documentation Expert. The various activities to be carried out in this phase will include –

- **Development of creative brief:** It is only after we receive a go-ahead from the MHSSP regarding the communication strategy will we engage our team to start developing the specific concepts for each communication component and tool. The designated team along with the content developer will develop creative briefs that will form the base for designing different types of tools as proposed in the preceding sections of this document.
- **Pre-testing the message concept:** To further ensure quality, salience and user-friendly communication tools, the message concepts will be pre-tested with a team of experts and the concerned project officials engaged in project implementation. The draft versions of concept will then be submitted to MHSSP for review and comments. As suggested in the preceding sections**, we will provide at least two to three concepts for each communication tool.**
- **Development of messages and materials:** Once the message concepts are approved by the MHSSP officials, we will begin developing the complete messages and materials with help of the dummy text, photos and logos provided by MHSSP, following the methodology proposed for the same earlier in the proposal. This task will be undertaken by under the guidance of Team Leader with several years of experience working on "communication for development" or "C4D"; and the other core team members.

Step-3: Pre-testing and Finalization of Communication Tools: The team of research associates will be engaged for the purpose of tool pre-testing with the targeted audience groups. The Research Associates will be offered an orientation on the pre-testing approach and methodology as detailed in the preceding section of this document. They will be offered an orientation on the checklists, feedback formats and discussion guides to be used for the purpose. After the orientation, they will be assigned the locations and samples on which they need to do the pre-testing.

They will record all the observations in the desired formats and share with the core team for their review. The core team will internally discuss the findings emanating from the pre-testing and will further work on fine-tuning or redesigning of tools based on the requirements and tastes of the targeted audience. The final set of tools shall be submitted to MHSSP to seek their approval before roll-out phase. The **comprehensive well documented SBCC Strategy** along with **final set of tools** shall constitute the **third deliverable** under the assignment.

Step-4: Preparation of Training Plan, Learning Material, and Conduct of Training of Trainers: Based on the tools finalized, the Team members shall start charting out the training plan for building capacities of concerned stakeholders to facilitate roll out of communication activities in their respective areas. Based on the competency assessment done during the Communication Needs Assessment, the team shall develop customized training curriculum and material for different types of stakeholders to be trained.

It is assumed that the Client will nominate a pool of State-level Master Trainers for the assignment. The agency will conduct the **face-to-face** and **online training** of this pool of master trainers. These trainers will be trained by the Core Team Members who would have developed these tools and are adept at conducting such trainings. It is proposed to train a pool of 9 master trainers at state level. Although no provision has been made so far for any residential trainings. If any of trainees needs to stay, decent arrangements shall be made for the same in close collaboration with the client team.

The pool of state-level master trainers will be ready to conduct the trainings for the district and sub-district level officials and functionaries to be engaged in programme implementation. The detailed approach of conducting these trainings has been presented in relevant section above. As depicted, a two-tier cascading model of training has been suggested based on estimated requirements from secondary data. The Core Team Members will offer handholding support to all State level master trainers for conducting these sessions in their respective districts. All district and block level officials will be trained at a centralized location in the district, to minimize the requirement of residential training and to ensure adequate participation and attendance. The achievement and performance of all training programmes conducted shall be reviewed by the core team. After **completion of trainings of all identified stakeholders, a comprehensive report of the same shall be collated and submitted to the client**.

7.1.4. Facilitating Roll out & Monitoring and Evaluation of SBCC Interventions

Step-1: Preparing Monitoring Checklists and Formats: As depicted in the methodology section, it is proposed to deploy Project Coordinators for supporting roll out of community level interventions by trained functionaries. For the purpose of effective conduct of these activities, it is offered to institutionalize a monitoring system. The core team shall develop various types of tools including – observation checklist to be filled by Project Coordinators during on-site visits, structured interview format for functionaries conducting the sessions, and structured questionnaire for beneficiary households. These will be developed in local language to ensure ease of administration.

Step-2: Orientation of Project Coordinators: The core team shall deploy suitably skilled professionals as Project Coordinators ensuring fluency in local language. They will offer them orientation on the programme and build their capacities to undertake the mandated roles and responsibilities, which includes facilitating preparation of quarterly roll-out plans at district level, supporting implementation, undertaking routine monitoring, and offering handholding support to functionaries to carry out their assigned roles effectively.

Step-3: Routine Monitoring and Feedback: The Project Coordinators shall roll out the sessions within the allocated districts in a phased manner. They will offer handholding support to the district and block level officials to plan and monitor the quality of community level interventions. They will also conduct visits to the randomly selected session sites to undertake monitoring of sessions, using the tools developed for the purpose.

The **field level data will be collected by CAPI method** using android-based phones and tablets. This will allow for the information to be readily available for viewing, reviewing and analysis. It is also proposed that a **regular dashboard will be maintained** by the Agency so that this information can be shared with the client on a real-time basis. This process shall continue throughout the remaining duration of the project. During this entire process, due diligence would be resorted to in order to

minimize the errors. **Quarterly Reports** shall be compiled on the basis of information gathered and will be shared with the client as **deliverable 4**. Any course corrections or modifications required in the tools as identified during monitoring exercise shall be undertaken by the core team in close consultation with MHSSP officials.

7.2 Deliverables

Final set of communication tools shall be submitted along with a completion report as the fifth deliverable in the last month of the assignment duration.

Table 7.1: List of Deliverables under the Project

S. No.	Description of Deliverable	Proposed Timeline
1	Submission of the Inception Report and Literature Review undertaken to inform comprehensive SBCC Strategy	Within 4 Weeks of Contract Signature
2	Repot of the baseline CNA survey on key stakeholders (including key findings, areas identified for interventions)	Within 3 months of Contract Signature
3	Submission of comprehensive SBCC strategy and its implementation including all finalized messages, tools, apps and materials after inputs from all stakeholders and completion of training of identified trainers	Within 9 months of contract signature
4	Submission of quarterly reports on the progress made and issues faced.	Total 17 quarterly reports at the end of every quarter
5	Submission of final progress report and all soft copies of messages, communication tools, reports, products, etc. as developed during the MHSSP tenure.	During the last month of contract period

CHAPTER 8

ORGANIZATION & STAFFING

The following section outlines the staffing of the personnel that will be engaged in the proposed assignment across all four phases of the project. Also presented are the details of roles and responsibility that they are expected to play in ensuring effective execution of tasks and activities outlined under the assignment.

8.1 Roles & Responsibilities of the Core Staff

The core team shall comprise of three key officials including the Team Leader, Communication & Social Media Expert & Design & Documentation Expert. The individual roles and responsibilities of each of the core team members is listed in the matrix presented in Table 8.1.

Table 8.1: Individual Roles & Responsibilities of Core Team Members

S. No.	Team Position	Detailed Tasks Assigned
1	Team Leader	– Liasoning with client team to obtain required secondary literature, information and desired permissions and authorization as required. – Overall planning, management and coordination of various activities under the assignment – Oversee preparation of inception report and detailed work plan – Prepare and finalize the study design and tools for formative research in collaboration with other members. – Oversee Training of the field teams for formative research – Undertake consultative discussions with key functionaries from State and district-level departments – Offer technical inputs for analyses of data and prepare analytical report and presentation on findings of formative research – Contribute towards development and design of SBCC Strategy & Communication tools, based on training needs identified in formative research – Oversee roll-out/ piloting of tools as per the plan. – Sharing findings of pre-test of communication material with client. – Prepare implementation strategy in collaboration with other team members. – Offer training to the team of Master Trainers at state level. – Oversee roll-out of communication plan and ensure concurrent monitoring of the same.

Table 8.1: Individual Roles & Responsibilities of Core Team Members		
S. No.	**Team Position**	**Detailed Tasks Assigned**
		– Sharing monitoring findings with key officials to further fine-tune the tools or implementation approach to suit the context.
2	Communication & Social Media Expert	– Assist Team Leader in undertaking all the mandated tasks as per their area of expertise. – Participate in all consultative meetings and discussions with client team and concerned state and district level officials. – Contribute to design, execution, analysis and documentation of the results of the formative research
3	Design & Documentation Expert	– Provide knowledge support in the design, implementation, monitoring and evaluation of the SBCC strategy – Offer technical inputs on design and development of Communication tools including print, audio-visual, and social media content. – Participate in piloting of tools and finalization of the same. – Assist with knowledge sharing efforts to disseminate project experiences and results – Provide communications expertise in the development and implementation of printed and online training material, websites, presentations, and any other collateral materials – Plan, develop, implement, and evaluate traditional and message strategies that meet project goals – Develop content for posting on various communication platforms for development, including ensuring consistency across communication channels and working within state requirements and guidelines – Ensure communication activities are based on accepted principles, methods, and best practices.

8.2 Roles & Responsibilities of the Non-Key Staff

The non-key staff proposed to be deployed include **one ICT Executive** and **3 Project Coordinators** to support roll-out and implementation phase. For the formative research phase, it is proposed to deployed 3 field supervisors and 14 research investigators. As presented in the preceding sections, a total of 30 clusters are to be covered and in each cluster 11 households will need to be interviewed. In addition, they will need to interview the frontline functionaries active in the areas, community leaders/ opinion makers and influencers, as well as with Village administration functionaries such as the Dorbar headed by the Rangbah Shnong, Village Health Councils and Village Organizations to capture their knowledge, attitude and behaviour towards healthcare scenario in the State. It is estimated that a team of 2 investigators shall be able to complete the data collection in one cluster,

within a time span of 3 days. Accordingly, if we plan to complete the field work in 2 weeks, a total of 14 research investigators shall be required. There will be 7 teams of investigators, and 3 Supervisors shall be deployed, each responsible for managing the work of 2-3 teams. The roles and responsibilities of non-key staff have been outlined in the Table 8.2 ahead–

Table 8.2: Individual Roles & Responsibilities of Non-Key Staff To Be Deployed

S. No.	Team Position	Detailed Tasks Assigned
	NON-KEY STAFF	
1	**ICT Executive**	– Develop software applications/ systems to support on-line roll out of training. – Prepare software for CAPI based data collection under formative research – Develop mobile applications for frontline functionaries for delivering content during community level interactions with target beneficiaries. – Create software that compiles and stores relevant field level monitoring information in the form of a MIS based Dashboard to facilitate near real time monitoring of project activities.
2	**Project Coordinators** *(Total 3 Coordinators to be Deployed. One for each 3 to 4 districts depending on regional requirements.)*	– Closely overseeing the coordination of roll out phase of the SBCC Campaign. – Coordinate with State, District and Block level officials of concerned departments to plan and organize roll out of community level dissemination of communication material. – Offer handholding support to District and Block Level officials of the Health Department to undertake routine monitoring and audit of the communication activities rolled out in their areas. – Undertake random field visits in the planned roll-out sites and obtain information on monitoring checklist prepared for the purpose by interviewing functionaries as well as the members exposed to the messages. – Offer handholding support and guidance to frontline functionaries for effective use of material and tools. – Prepare routine monitoring reports and upload them on the server so that the team can integrated the results with the MIS Dashboard developed for monitoring.
3	Field Supervisors ***(Total 3 Field Supervisors to Deployed)***	– Providing supportive supervision to Research Investigators during Formative Research – Grievance handling, problem resolution and motivation of field staff – Ensure timely completion of field survey as per the work plan – Collect relevant secondary data from key stakeholders – Ensure quality of enumerated data by undertaking spot-checks and random back-checks on sample basis during fieldwork – Checking of all (100%) filled-up questionnaires to check for consistency and possible omissions at the end of each day

Table 8.2: Individual Roles & Responsibilities of Non-Key Staff To Be Deployed		
S. No.	**Team Position**	**Detailed Tasks Assigned**
		– Undertaking in-depth interviews with key stakeholders including district and block level officials, and other tertiary stakeholders identified under the project.
4	Research Investigators ***(Total 14 Research Investigators to Deployed)***	– Conduct survey at the community level, undertake semi-structured interviews with frontline functionaries as well as other community level respondents – Audio Record/ transcribe the open-ended qualitative responses given by respondents

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Annexure 1: Work Schedule & Planning for Deliverable

Presented ahead is a detailed overview of proposed work schedule and plan for preparing the requisite deliverables.

N	Activities/ Deliverables	YEAR-1											
		Month-1	Month-2	Month-3	Month-4	Month-5	Month-6	Month-7	Month-8	Month-9	Month-10	Month-11	Month-12
Phase 1: Preparatory Phase (1 Month)													
	Consultative discussions with Officials of MHSSP												
	Collection of relevant Secondary data and Project Documents												
	Review of secondary literature for developing the Toolkit for Need Assessment												
D 1	**Preparation and Submission of Inception report containing approach to the assignment, objectives, detailed work plan and Draft tools for Communication Need Assessment**												
Phase 2: Communication Need Assessment (3 Months)													

N	Activities/ Deliverables	YEAR-1											
		Month-1	Month-2	Month-3	Month-4	Month-5	Month-6	Month-7	Month-8	Month-9	Month-10	Month-11	Month-12
	Finalizing the toolkit based on Feedback from MHSSP												
	Translation of tools in regional languages												
	Draw sample locations based on project information and in discussion with MHSSP officials												
	Orientation of Teams for Data collection for needs assessment												
	Undertaking primary data collection for Needs Assessment through consultation with different stakeholders												

N	Activities/ Deliverables	YEAR-1											
		Month-1	Month-2	Month-3	Month-4	Month-5	Month-6	Month-7	Month-8	Month-9	Month-10	Month-11	Month-12
	Review of Project Documents and Existing Communication Material												
	Analysis of Primary data and collation of findings from review of project documents and communication material												
D 2	**Submission of report on findings from Communication Needs Assessment**												
Phase 3: Preparation of SBCC Strategy & Design, Pretesting and Finalization of Communication Tools & training of Trainers (6 Months)													
	Preparing SBCC Strategy including details on stakeholder-wise media to be used, message content, frequency of exposure, etc.												

N	Activities/ Deliverables	YEAR-1																																								
		Month-1				Month-2				Month-3				Month-4				Month-5				Month-6				Month-7				Month-8				Month-9				Month-10				Month-11				Month-12			
	Ideation and development of tools																																													
	Pre-testing of communication tools on sample stakeholder groups																																												
	Consultative discussions with MHSSP team while finalizing communication strategy, draft tools, and sharing pre-test results to finalize the communication plan and tool design																																												
	Refinement and finalization of communication tools and sharing with MHSSP for approval and feedback																																												
	Preparation of Training Material & Tool Kit																																												

N	Activities/ Deliverables	YEAR-1											
		Month-1	Month-2	Month-3	Month-4	Month-5	Month-6	Month-7	Month-8	Month-9	Month-10	Month-11	Month-12
	Identification of Trainee stakeholders including officials and master trainers												
	Completion of Training of identified Trainers												
D 3	**Submission of Final SBCC Strategy, Communication Material and Details of Master Trainers Trained**												
Phase 4: Facilitating Roll out and Monitoring & Evaluation of the Communication Activities (3 Months)													
	Preparing quarterly Roll-out Plan in consultation with Project Officials												

N	Activities/ Deliverables	YEAR-1											
		Month-1	Month-2	Month-3	Month-4	Month-5	Month-6	Month-7	Month-8	Month-9	Month-10	Month-11	Month-12
	Handholding support to State for Implementation and Roll out of communication activities as per plan												
	Concurrent Monitoring of Activities using structured tools												
	Sharing results of monitoring with concerned officials and making course corrections by adjusting the strategy or tools as required.												
D4	**Submission of Quarterly Report**												

N	Activities/Deliverables	Year 2				Year 3				Year 4				Year 5			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Phase 4: Implementation/ Roll out and Monitoring Phase (4 Years)																	
	Preparing quarterly Roll-out Plan in consultation with Project Officials																
	Handholding support to State for Implementation and Roll out of communication activities as per plan																
	Concurrent Monitoring of Activities using structured tools																
	Sharing results of monitoring with concerned officials and making course corrections by adjusting the strategy or																

N	Activities/Deliverables	Year 2				Year 3				Year 4				Year 5			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	tools as required.																
D4	**Submission of Quarterly Reports**																
D5	**Submission of Final Report and all Communication tools and Material**																

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