Social and Behaviour Change Strategy
TO FIGHT UNDERNUTRITION
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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
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<tr>
<td>AWC</td>
<td>Anganwadi Centre</td>
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<tr>
<td>AWW</td>
<td>Anganwadi Worker</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
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<tr>
<td>DWCD</td>
<td>Department of Women and Child Development</td>
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<tr>
<td>GoI</td>
<td>Government of India</td>
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<tr>
<td>GoR</td>
<td>Government of Rajasthan</td>
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<tr>
<td>ICDS</td>
<td>Integrated Child Development Services</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IFA</td>
<td>Iron Folic Acid</td>
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<tr>
<td>IPC</td>
<td>Interpersonal Communication</td>
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<td>NFHS</td>
<td>National Family Health Survey</td>
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<tr>
<td>NGOs</td>
<td>Non-governmental Organisations</td>
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<tr>
<td>NHM</td>
<td>National Health Mission</td>
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<tr>
<td>NNM</td>
<td>National Nutrition Mission</td>
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<tr>
<td>NRLM</td>
<td>National Rural Livelihood Mission</td>
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<tr>
<td>PMMVY</td>
<td>Pradhan Mantri Matru Vandana Yojna</td>
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<tr>
<td>RMNCH+A</td>
<td>Reproductive, Maternal, Newborn, Child, and Adolescent Health</td>
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<tr>
<td>SBC</td>
<td>Social and Behaviour Change</td>
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<tr>
<td>SHG</td>
<td>Self Help Groups</td>
</tr>
<tr>
<td>THR</td>
<td>Take Home Ration</td>
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</table>
INTRODUCTION
The Government of Rajasthan (GoR) is committed to accelerated reduction in undernutrition in the state. This determination is guided by the National Nutrition Strategy and the National Nutrition Mission (NNM) which identifies nutrition as ‘central to the achievement of other National and Global Sustainable Development Goals’ and ‘the most important entry point for human development, poverty reduction and economic development’.

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

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

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

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

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

**How to use the Document**

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

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

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

Source: NFHS 3 and NFHS 4; RSoC data used for Low Birth Weight
Map 1: Stunting among children <5 years in Rajasthan in 2016, by district

Low prevalence (<20%)
Medium prevalence (20% to 30%)
High prevalence (30% to <40%)
Very high prevalence (≥40%)

Source: NFHS 4

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

Low prevalence (<20%)
Medium prevalence (20% to 40%)
High prevalence (40% to <60%)
Very high prevalence (≥60%)

Source: NFHS 4

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

Low prevalence (<5%)
Medium prevalence (5% to 10%)
High prevalence (10% to <15%)
Very high prevalence (≥15%)

Source: NFHS 4

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

Low prevalence (<5%)
Medium prevalence (5% to 10%)
High prevalence (10% to <15%)
Very high prevalence (≥15%)

Source: NFHS 4
Rajasthan has also shown improvements on various immediate determinants of nutrition between 2006 and 2016 (Figure 2). The proportion of women with low Body Mass Index (BMI<18.5 kg/m²) declined from 36.7 percent to 27 percent during 2006-2016. Although early initiation of breastfeeding increased from 13.3 percent to 28.4 percent during this period, less than a third of children are breastfed within one hour of birth. Of greatest concern is complementary feeding – timely introduction of complementary foods (between 6 and 8 months of age) declined over the last decade (from 38.7 percent to 30.1 percent) and in 2016, only 3.4 percent of children (between 6 and 24 months of age) received an adequate diet.

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

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

Source: NFHS-3 and NFHS-4;
Note: ARI= Acute respiratory infection.
Social and Behaviour Change Strategy TO FIGHT UNDERNUTRITION
VISION 2022
The NNM has set out a few national targets for accelerated nutritional results, particularly among children from 0 to 6 years, pregnant women and lactating mothers. Through its state nutrition strategy ‘Nourishing Rajasthan–Vision 2022’, GoR has adopted the targets set out by the NNM as its own, and reinforced its commitment to becoming a leader in the fight against undernutrition.

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

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

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

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

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

5. **Reduce low birth weight prevalence**
   - From 23.2 percent in 2016 to 20.88 percent (reduction of 2 percent per annum)
Target Versus Current Reduction

Stunting among children (0-6 years)

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

Low birth-weight prevalence

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

Anaemia among adolescents and women (15-49 years)

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

Anaemia among children (6-59 months)

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

Underweight prevalence in children (0-6 years)

Current AARR-reduction at 0.80% per annum
Target AARR-reduction at 2% per annum
This SBC framework highlights the need to understand and address several levels of influence so that specific interventions can be tailored to leverage them for fighting undernutrition. It aims to create a pro-nutrition environment to improve maternal dietary practices and infant and young child feeding for accelerated achievement of nutrition results.

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

Key components of the Framework include:

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

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

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

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

Improved health & nutrition outcomes

Strategic Use of Data

Decision Makers

Frontline Workers

Family & Community Influentials

Pregnant Women, Mothers, Caregivers

Mass communication

Outreach

Performance

Community mobilisation

Interpersonal communication

Partnership and Alliances in the Health System and Multiple Sectors for Scale and Sustainability

Improved knowledge, beliefs, skills & environment

Improved maternal nutrition, breastfeeding & complementary feeding practices
Community mobilisation
to engage husbands, mothers-in-law, community influentials such as sarpanch, religious leaders and local doctors to endorse and encourage improved behaviours.

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

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

This comprehensive framework utilises a variety of programme components and channels and each one has a different role: reaching different audiences, expanding beyond service delivery platforms, and reinforcing/reminding about priority actions.
Social and Behaviour Change Strategy
TO FIGHT UNDERNUTRITION
LIFE-CYCLE APPROACH
This SBC strategy is underpinned by a life-cycle approach that aims to focus on the current as well as the future generations of yet-to-be-born girls for overcoming the problem of undernutrition. Strategies that go beyond just pregnant and lactating women and improve nutritional behaviours at each step of the life-cycle – infants, adolescents and married but not yet pregnant women – are to be employed.

### SBCC Operational Strategy

<table>
<thead>
<tr>
<th>Married Couples Behaviours</th>
<th>Lactating Mother Behaviours</th>
<th>Pregnant Women Behaviours</th>
<th>Young Child Behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed pregnancy/contraceptives</td>
<td>Dietary Diversity</td>
<td>IFA consumption</td>
<td>Complementary feeding at 6 months (181 days)</td>
</tr>
<tr>
<td>Birth spacing</td>
<td>Colostrum feeding within one hour of birth</td>
<td>Adequate and diverse food consumption</td>
<td>Complete immunisation and deworming</td>
</tr>
<tr>
<td></td>
<td>No pre-lacteal/exclusive BF</td>
<td>Hygiene and sanitation practices</td>
<td>Continue breastfeeding for at least two years</td>
</tr>
<tr>
<td></td>
<td>Timely immunisation</td>
<td>Attending 4 ANCs</td>
<td>Dietary diversity</td>
</tr>
<tr>
<td></td>
<td>Hygiene and sanitation practices</td>
<td>Institutional delivery</td>
<td>Hygiene and sanitation practices</td>
</tr>
</tbody>
</table>

- **Adolescent Behaviours**
  - Developing life-skills to stop early marriage and early pregnancy
  - Completing quality school education; SRH
  - IFA consumption (girls)
  - Hygiene and sanitation practices

- **Young Child Behaviours**
  - Complementary feeding at 6 months (181 days)
  - Complete immunisation and deworming
  - Continue breastfeeding for at least two years
  - Dietary diversity
  - Hygiene and sanitation practices
The strategy aims to reach out to the audience at various stages in the life-cycle to disrupt the intergenerational cycle of undernutrition, which is often perpetuated with a high incidence of babies born with low birth weight, more susceptible to infections, more likely to experience growth failure, reflected in high levels of adolescent and maternal undernutrition and anaemia. It will be critical to improve nutritional behaviours across the life-cycle, to avert irreversible cumulative growth and development deficits that compromise maternal and child health and survival; and undermine the achievement of optimal learning outcomes in elementary education, impairing adult productivity and undermining gender equality.

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

1. Highlighting specific priority behaviours and actions for mothers, family members and community members.

2. Generating awareness and motivation among communities, families, individual women, mothers and caregivers.

3. Building demand for services to facilitate the adoption of practices.

4. Mobilising support from policy makers and programme authorities to relieve institutional and community constraints, provide a supportive environment and sustain momentum.

5. Convergence of operational elements to support individual behaviour change with effective service delivery and enabling policy environment.
Social and Behaviour Change Strategy
TO FIGHT UNDERNUTRITION
SOCIAL AND BEHAVIOUR CHANGE STRATEGY
The SBC strategy bases itself on a few key principles which have emerged from many years of programme experience and have shown significant effectiveness in improving nutritional behaviours:

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

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

<table>
<thead>
<tr>
<th>Priority Behaviour</th>
<th>Description</th>
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</table>
| **1. Pregnant women** | Consume one daily IFA supplement for 180 days  
Consume adequate amount of food to meet the caloric and protein needs throughout pregnancy  
Eat at least 5 defined types of foods daily throughout pregnancy  
Attend 4 ANCs  
Wash hands with soap before handling food |
| **2. Mothers of infants below 6 months** | Initiate breastfeeding immediately after delivery (within one hour)  
Do not feed pre-lacteal foods or liquids after delivery and feed only colostrum  
Breastfeed exclusively from birth through 6 months (180 days), do not give water (medicines and vitamins are permitted)  
Consume adequate amount of food to meet the caloric and protein needs of self and baby  
Timely Immunisation  
Wash hands with soap before eating and feeding their children |
Audience and Influencer Ecosystem

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

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

<table>
<thead>
<tr>
<th>Primary Audience</th>
<th>Priority Behaviours</th>
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</thead>
<tbody>
<tr>
<td>Mothers and caregivers of infants and young children from 6 to 24 months</td>
<td>Introduce feeding of semi-solid/solid complementary foods at 6 months (181 days)</td>
</tr>
<tr>
<td></td>
<td>Feed at least 4 defined types of foods daily to children 6 to 24 months</td>
</tr>
<tr>
<td></td>
<td>Immunisation and deworming</td>
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<tr>
<td></td>
<td>Handwashing with soap before preparing and feeding young children</td>
</tr>
<tr>
<td>Adolescent girls and boys</td>
<td>Consume IFA supplements (girls)</td>
</tr>
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<td></td>
<td>Develop life-skills to stop early marriage and early pregnancy</td>
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<tr>
<td></td>
<td>Complete quality school education</td>
</tr>
<tr>
<td></td>
<td>Follow appropriate hygiene and sanitation practices</td>
</tr>
<tr>
<td>Married couples</td>
<td>Use of contraceptives for delaying pregnancy</td>
</tr>
<tr>
<td></td>
<td>Birth spacing to ensure adequate care is given to a newborn, as well as to maintain her own health</td>
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</tbody>
</table>
Data from successful nutrition programmes and other SBC strategies shows that reaching these audiences with targeted messages using multiple channels accelerates the speed of Behaviour Change (Alive & Thrive, 2016). The following table summarises the influencer ecosystem that will be targeted to affect the behaviours for various primary targets.

<table>
<thead>
<tr>
<th>Primary audience</th>
<th>Influencer ecosystem</th>
</tr>
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<tbody>
<tr>
<td>Pregnant women (PW)</td>
<td>Husbands, Mother-in-law (MIL), Frontline Workers (FLW), Community Members, Doctor</td>
</tr>
<tr>
<td>Mothers of infants below 6 months</td>
<td>Husbands, MIL, FLW, Community Members, Doctor</td>
</tr>
<tr>
<td>Mothers and caregivers of infants and young children from 6-24 months</td>
<td>Husbands, MIL, FLW, Community Members</td>
</tr>
<tr>
<td>Adolescent girls and boys</td>
<td>FLW, Teachers, Peer Educators, Community Members</td>
</tr>
<tr>
<td>Married couples</td>
<td>Husbands, MIL, FLW</td>
</tr>
</tbody>
</table>

### Messaging and Communication Channels

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

- The person who is asked to change their behaviour, for example, pregnant women and mothers, must be clear about the specific “small doable action” to be carried out.
• They must believe in the benefits of Behaviour Change, consider those benefits relevant for them, and feel good about making the change (e.g. when a mother perceives that her child cries less and sleeps well when fed appropriately). Often behaviours are linked with outcomes that may have nothing to do with the health and nutrition goals, but the mother sees as immediately beneficial (e.g. the child sleeps better or is less demanding) or it is something she aspires (e.g. a well-educated child).

• Mothers and their families are confident that they can carry out the action without much difficulty. It is feasible, and they have the necessary skills, supplies and materials to act on the knowledge (e.g. improving dietary diversity by identifying a locally available affordable food that is usually in the home or adding an egg several times a week).

• Pregnant women and mothers believe other women in the community are doing the same, and influential family and community members will approve of the action (e.g. this may mean approval of husbands and mothers-in-law or endorsement of doctors for early initiation of breastfeeding).

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

Data from successful nutrition programmes and other SBC strategies shows that reaching these audiences with targeted messages using multiple channels accelerates the speed of Behaviour Change.
ELEMENTS OF SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION

MESSAGES
1. Regular consumption of IFA reduces tiredness and ensures baby’s development
2. Regular consumption of IFA reduces chances of preterm delivery and excess bleeding during delivery

PREFERRED BEHAVIOURS/ACTIONS

PRIMARY AUDIENCE

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

SECONDARY AUDIENCE

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

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

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

MEDIUM/CHANNELS

PRIMARY AUDIENCE

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

SECONDARY AUDIENCE

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

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

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

NON-CONSUMPTION OF IFA BY PREGNANT WOMEN

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

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

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

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

PREFERRED BEHAVIOURS/ACTIONS

PRIMARY AUDIENCE

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

SECONDARY AUDIENCE

HUSBAND
- Purchase defined foods
- Reminds wife for consumption

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

MEDIUM/CHANNELS

PRIMARY AUDIENCE

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

SECONDARY AUDIENCE

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

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

FLWs
- Training on specific messages and counselling techniques
- Appropriate job aids & tools
- Performance monitoring and performance based incentives
- Mobile phone based text messages
- Audio-video clips
- Mass Media
MESSAGES
1. Early reporting and regular check-ups ensure health and safety of the baby in the womb.
2. Preventive check-ups will avoid complications during delivery.

PREFERRED BEHAVIOURS/ACTIONS

PRIMARY AUDIENCE

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

SECONDARY AUDIENCE

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

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

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

MEDIUM/CHANNELS

PRIMARY AUDIENCE

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

SECONDARY AUDIENCE

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

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

FLWs
- Training on specific messages and counselling techniques
- Appropriate job aids & tools
- Performance monitoring and performance based incentives
- Mobile phone based text messages
- Audio-video clips
- Mass Media
INITIATING BREASTFEEDING IMMEDIATELY AFTER DELIVERY (WITHIN ONE HOUR)

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

PREFERRED BEHAVIOURS/ACTIONS

PRIMARY AUDIENCE

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

SECONDARY AUDIENCE

HUSBAND
- Can talk with their own mothers to ensure the family has a plan for early initiation of breastfeeding
- Can advocate for early initiation soon after delivery, whether it is at home or in the institution
- Handing over the baby to the mother immediately after delivery and encourage her to put the baby to the breast
- Refusing to give or allow pre-lacteals and encouraging the mother to give (and not discard) colostrum

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

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

MEDIUM/CHANNELS

PRIMARY AUDIENCE

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

SECONDARY AUDIENCE

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

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

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

SOCIAL AND BEHAVIOUR CHANGE STRATEGY 33
EXCLUSIVE BREASTFEEDING FOR FIRST 6 MONTHS (180 DAYS)

MESSAGES
1. Give exclusive breastfeeding to the child up to six months of age
2. Prelacteal feeds such as water, other liquids and foods can be a source of infection and interfere with breastfeeding
3. Till 6 months mother’s milk has enough water to satisfy the thirst even during hot weather.

PREFERRED BEHAVIOURS/ACTIONS

PRIMARY AUDIENCE

PLW
- To ensure that baby is not given other liquids, including animal milk and water, for the first 6 months
- To practice critical breastfeeding skills: proper positioning and attachment, giving enough time at each feed until baby leaves the breast, emptying both breasts and feeding frequently during the day and night (8 to 12 times based on baby’s age)
- To assess the supply of breast milk through checking the number of times the baby urinates and to maintain milk supply by frequent breastfeeds for the first 6 months

SECONDARY AUDIENCE

HUSBAND
- Can talk with their own mothers to ensure exclusive breastfeeding
- Help with chores to free up the mother’s time for breastfeeding and encouraging exclusive breastfeeding when facing concerns that breast milk may be insufficient
- Encourage their son to help with chores to protect the mother’s time for breastfeeding
- Serve as gatekeeper and stop others from giving animal milk or water
- Attend to older children or in other ways reduce the mother’s workload, allowing her to breastfeed

MIL
- Encourage pregnant women to have a plan for exclusive breastfeeding
- Ensure that during the first week mother and family members receive encouragement, information, and support for exclusive breastfeeding
- Explicitly advise against animal milk and water, even in summer
- Focused home visit as per schedule of home visits in first 6 months of life to counsel & support exclusive breastfeeding including addressing any difficulties

MEDIUM/CHANNELS

PRIMARY AUDIENCE

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

SECONDARY AUDIENCE

HUSBAND
- Community mobilisation events
- Directly addressed by FLW during home visits
- Community mobilisation events/religious gatherings
- SHG/women’s group meetings

MIL
- Directly addressed by FLW during home visits
- Community mobilisation events/religious gatherings
- SHG/women’s group meetings

FLWs
- Training on specific messages and counselling techniques
- Appropriate job aids & tools (possibly including audio or video pieces to play for families)
- Performance monitoring and performance based incentives
- Mobile phone based text messages
- Audio-video clips
- Mass Media
Complete immunisation saves the child from many deadly diseases throughout its life.

**Primary Audience**

- PLW
  - Completes her own TT vaccination during pregnancy
  - Ensures complete immunisation of the child till 2 years
  - Remember to carry Mamta Card to vaccination site

- HUSBAND
  - Accompanies wife and baby for vaccination

- MIL
  - Encourages son to accompany his wife for vaccinations
  - Accompanies the pregnant woman if her husband is not available

- FLWs
  - Do home visit 2-3 days before the vaccination day to remind and create awareness
  - Educate the mothers, husbands, MILs, and community leaders about all vaccines available and the protection offered by them
  - Remind parents and caregivers to bring their Mamta cards for immunisation session
  - Give out the 4 key messages to the parents and family members accompanying the child
  - Answer parents’ queries, respond to their doubts

**Secondary Audience**

- HUSBAND
  - Directly addressed by FLW during home visits
  - Community mobilisation events
  - Panchayat meetings
  - Mobile phones - SMS, Whatsapp, audio/video messages
  - TV/radio spots, newspaper

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

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

**Medium/Channels**

- PLW
  - IPC by FLWs before and during the immunisation sessions
  - Interpersonal communication by doctor/medical officer at the time of delivery
  - Prompts and reminders by husbands and MIL
  - Mid-media, nukkad naataks, regional songs
  - TV/radio spots
  - Print materials at AWCs

- HUSBAND
  - Directly addressed by FLW during home visits

- MIL
  - Directly addressed by FLW during home visits

- FLWs
  - Training on specific messages and counselling techniques
  - Appropriate job aids & tools
  - Performance monitoring and performance based incentives
  - Mobile phone based text messages
  - Audio-video clips
  - Mass Media
COMPLEMENTARY FEEDING (SPECIFIED FOOD GROUPS) AND DIETARY DIVERSITY

MESSAGE:
1. When the child starts crawling, it needs more than just mother’s milk (growing infant requires more food)
2. Diverse food will ensure adequate growth
3. Give one egg per day to the child after 6 months (180 days)
4. Include yellow/orange fruits/vegetables and dark green leafy vegetables daily in the food, after completion of 6 months.

PREFERRED BEHAVIOURS/ACTIONS

PRIMARY AUDIENCE
- To feed child with homemade mashed, semi-solid or solid food made from deep yellow/orange fruits/vegetables, thick lentils and dark green leafy vegetables daily, beginning at 7 months (at completion of 180 days)
- To feed child dairy products and eggs daily or as often as possible, beginning at 7 months
- To wash hands before feeding the child

SECONDARY AUDIENCE
- Purchase specific nutrient foods for children to eat
- Avoid buying harmful snacks from market and instead buy fruits or egg from market
- Encourage mothers to feed the children starting at 7 months (180 days), and prepare the foods or feed them
- During home visit, AWW can always inquire what the child is eating and recommend daily intake of these specific foods including addition of missing food groups
- Can coach and demonstrate preparation of these foods and help the mother to try feeding these to her child
- Help families come up with a plan for acquiring the foods that the child needs
- Monthly counselling and demonstration of dietary needs of each child from 6 months to 12 months during ‘Annaprashan Divas’ +6 (6-12 months approach)

MEDIUM/CHANNELS

PRIMARY AUDIENCE
- IPC at MCHND and home visits by FLWs
- By the doctor/mid-wife at the point of delivery
- TV/radio spots
- Print materials at AWCs

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

MEDIUM/CHANNELS
- Training on specific messages and counselling techniques
- Appropriate job aids & tools (possibly including audio or video pieces to play for families)
- Performance monitoring and performance based incentives
- Mobile phone based text messages
- Audio-video clips
- Mass Media
HAND WASHING THOROUGHLY WITH SOAP BEFORE PREPARING AND FEEDING FOOD

MESSAGES
Washing hands before cooking and eating will prevent infections and diarrhoea in children.

PREFERRED BEHAVIOURS/ACTIONS

PRIMARY AUDIENCE

PLW
- Wash both hands with soap and water before preparing food and before feeding infants and young children
- When the child learns to eat on his/her own, wash his/her hands with soap and water frequently

SECONDARY AUDIENCE

HUSBAND
- Purchase soap and ensure clean water supply
- Remind pregnant women and mothers to wash hands frequently

COMMUNITY/RELIGIOUS LEADERS
- Discuss the importance of handwashing before preparing and feeding children in regular community meetings
- Counsel mothers on the importance of hand washing
- Show pregnant women, mothers and family members correct hand washing techniques

FLWs
- Counsel mothers on the importance of hand washing
- Show pregnant women, mothers and family members correct hand washing techniques

MEDIUM/CHANNELS

PRIMARY AUDIENCE

PLW
- IPC and counselling during home visits by FLWs
- By the doctor
- TV/radio spots
- Print materials/posters at AWCs
- Melas/Haats

SECONDARY AUDIENCE

HUSBAND AND MIL
- Community mobilisation events
- Directly addressed by frontline workers during visits with pregnant women, religious gatherings
- SMS and audio/video clips
- TV spots, newspapers, national media campaign

COMMUNITY/RELIGIOUS LEADERS
- TV spots, newspapers, national media campaign
- Training on specific messages and counselling techniques
- Appropriate job aids & tools (possibly including audio or video pieces to play for families)
- Mobile phone based text messages
- Audio-video clips
- Mass Media
Social and Behaviour Change Strategy TO FIGHT UNDERNUTRITION
CONVERGENCE
The life-cycle approach that underpins the state SBC strategy also acts as a key catalyst for operational and programmatic convergence between various state departments and their flagship programmes. This SBC strategy will involve various departments within the state such as women and child development, health, food and public distribution, sanitation, drinking water, rural development, livelihoods, education and agriculture, among others to work together in a multi-sectoral nutritional response. Across the life-cycle, various programmes and their concerned departments will play an important role in addressing various determinants of nutrition through Behaviour Change interventions. The state nutrition strategy – ‘Nourishing Rajasthan – Vision 2022’ has already set out the mechanism for programmatic convergence, through the setting up of a state level convergence committee, and one of the key aims of the committee is to ensure the convergence through joint development of State/District Implementation Plans for ICDS, NHM and Swachh Bharat and others, addressing different determinants of undernutrition together.

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

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

**Department for Information and Public Relations**
- Information Campaigns
- Mass Communication Campaign

**Tribal Area Development Department**
- Swasthya Sahyoginis
- Sahramshala

**Rural Development and Panchayati Raj Department**
- Swachh Bharat Mission
- Rajivika SHGs

**PHED and Water Resource Department**
- National Rural Drinking Water Programme

**Food and Civil Supplies Department**
- PDS
- AnnapurnsBhandars
- Food Fortification

**NHM**
- Contraception education & supply
- Family planning support
- Mission Parivar Vikas

**Others**
- Skill Development
- NRLM

**Cross Cutting**

**DWCD**
- ICDS – IFA Supplementation
- ICDS – Take Home Rations (THRs)
- PMMVY – cash benefits
- Community events : God Bharai, MCHND
- Home Visits and counselling by Anganwadi Workers (AWWs)

**NHM**
- RMNCHA+A (VAD, Nutritional Anaemia, IDD)
- Janani Shishu Suraksha Yojana
- Ante Natal Check ups
- Home Visits and counselling by ASHA

**Department of Education**
- Mid-day Meal Scheme
- Nutrition education in curriculum

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

<table>
<thead>
<tr>
<th>Category of beneficiary</th>
<th>Indicators to be tracked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women</td>
<td>IFA consumption by pregnant mothers</td>
</tr>
<tr>
<td>Lactating women</td>
<td>% infants initiated breastfeeding within one hour of birth</td>
</tr>
<tr>
<td>Infants and children &lt; 5 years</td>
<td>% of infants with low birth weight</td>
</tr>
<tr>
<td>Adolescents</td>
<td>Number of adolescent girls consuming IFA supplements (girls) through WIFS</td>
</tr>
</tbody>
</table>
“To keep the body in good health is a duty, otherwise we shall not be able to keep our mind strong and clear”

Buddha