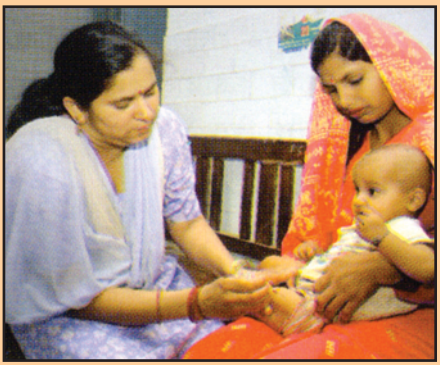
Social and Behaviour Change Communication (SBCC) Strategy for Routine Immunization in Rajasthan



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PREFACE

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Dr. M.L Jain
Director SIHFW

Communication is the core substance of every activity we experience in this world. The interaction between all living things starts with communication, from cradle to grave, from womb to tomb. Success of interaction depends on how strategically the message has been delivered and the communication has been established yielding desired outcome. Government programs also experience the same phenomenon and are required to go through the same test of effectiveness of the communication. Outcome of a planned activity is directly proportional to the effectiveness of the message which in turn depends on the strategy and ways adopted to deliver the information up to the beneficiary groups and individuals.

Under the GAVI-HSS supported partnership between SIHFW and UNICEF, Rajasthan, efforts are being made to strengthen communication strategy to improve Interpersonal Communication between service providers and the community to bring about the desired social and behavior changes promoting optimal utilization of services and resources.

In collaboration with UNICEF, SIHFW has developed a Social and Behavior Change Communication (SBCC) Strategy document on Routine Immunization. The document plans for optimum utilization of existing resources while developing Roll-Out Mechanism for the state, districts and block level plans in High Priority Districts. In particular, addressing components of Routine Immunization requires careful attention to selection of behaviours, messages, material and channels to support communication interventions and building capacities of the field functionaries such as ANM, ASHA and Anganwari workers.

All elements of Routine Immunization such as identification of determinants of left-out and drop-out community members as target beneficiaries, prioritizing those amenable to change and having the greatest impact on maternal and child health and survival, promoting set of messages in practices related to Routine Immunization, including newly introduced Pentavalent have been covered in the SBCC strategy. The document also emphasizes on importance of identifying the key stakeholders whose behaviors can impact full coverage of Routine Immunization.

The strategy document is also expected to be beneficial for policy makers, administrators, state and district level health and communication officials to understand what support is further required at various levels to yield indicator based outcomes.

The guidance and support of Shri Neeraj K. Pawan, Director IEC has been the main driving force in the development of this document. The inputs from multiple stakeholders including officials of Medical & Health Department, NHM, ICDS, UNICEF, UNFPA, Save the Children, NIPI, Jhepigo, IHBP, PSI, Global Health Strategies and of SIHFW have nourished each and every layer of this document.

Various communication approaches linked to key stakeholders at service and community levels have been identified in this document. This may not be exhaustive and the strategy document is open to amendments.

What we care the most is whether our work would inspire promotion and adoption of healthy behaviors among the targeted population; hence the document is open for valuable suggestions of the readers and users.

Sincerely yours,

(Dr. M. L. Jain)

Acknowledgement

The Social and Behaviour Change Communication (SBCC) Strategy for Routine Immunization in Rajasthan has been developed through a series of consultations with experts and key programme officers of the State Program Management Unit, State IEC bureau, Government of Rajasthan, State Institute of Health and Family Welfare and UNICEF Rajasthan.

We are thankful to the guidance and leadership provided by Principal Secretary Health, Mission Director, National Health Mission, Director IEC, Director RCH and Project Director Immunisation, who have guided and facilitated this process.

The proactive support and coordination of UNICEF in anchoring and developing the strategy is acknowledged. We are thankful to Representatives of Development Partners Dr Anil Agarwal, Health Specialist , UNICEF, Dr Apurva Chaturvedi and Ms Girija Devi – C4D Specialist UNICEF for developing the strategy. Mr. Sunil Thomas, Mr Rajnish Prasad –UNFPA, Mr. Pradeep Chaudhary NIPI, Mr. O.P. Singh, Save the Children, Mr. Bhaskar Pandya, PSI. We also appreciate hard work of Dr. Vishal Singh, Faculty, SIHFW, Ms Archana Saxena, Research Officer SIHFW, Ms. Priyanka Gupta, Consultant and members of SBCC Technical Working Group, Development partners, Core Group set up for development of this strategy.

There are many others who have contributed to this and naming all of them is not possible but their advice is sincerely acknowledged.

This strategy was developed under the overall guidance and unstinted support from Mr Samuel Mawunganidze , Chief, UNICEF Rajasthan and Dr M L Jain, Director SIHFW.

Dr Sanjaya Saxena
Registrar, SIHFW

Contributions

Technical Guidance and Support
Dr M. L. Jain , Director, SIHFW
Mr Samuel Mawunganidze, Chief, UNICEF Rajasthan

Partnership Execution & Co-ordination
Dr. Vishal Singh, Faculty, SIHFW
Ms. Girija Devi, Communication For Development Specialist, UNICEF

UNICEF
Dr.Anil Agarwal
Dr.Apurva Chaturvedi

UNFPA
Mr. Sunil Thomas
Mr. Rajnish Prasad

RMNCH + A Cell
Ms. Sibhumi
Mr. Sachin Kothari
Ms Vaidehi Agnihotri

Save The Children
Dr. O.P Singh
Mr.Hemant Acharya

Population Services International
Sh Bhaskar Pandya

IHBP
Dr.Meenakshi Singh

Global Health Strategies
Ms Sonica Sharma

State Programme Management Unit (SPMU)-National Health Mission
Dr J.P. Singhal
Dr.R.P.Jain
Sri Govind Pareek
Mr.Jagdish Varma
Ms.Varsha Tanu
Mr.Lalit Tiripathi

NIPI
Dr S.P. Yadav
Mr.Pradeep Choudhary

ICDS
Shri Mahesh Sharma

SIHFW Staff
Dr.Sanjaya Saxena
Dr.Mamta Chauhan
Dr. Richa Chaturvedy
Ms.Archana Saxena
Dr.Bhumika Talwar
Ms.Aditi Sharma

Freelance Consultants
Dr. Neetu Purohit
Ms.Priyanka Gupta

Abbreviations

AEFI	Adverse Effect Following Immunization
AHS	Annual Health Survey
ANM	Auxiliary Nurse Midwife
ARAVALI	Association for Rural Advancement through Voluntary Action and Local Involvement
AWC	Anganwadi Centre
AWW	Anganwadi Worker
ASHA	Accredited Social Health Activist
BCG	**Bacillus Calmette–Guérin**
BIO	Block Immunization Officer
CBO	Community Based Organizations
CCT	Cold Chain Technician
CCH	Cold Chain Handler
CEO	Chief Executive Officer
CES	Coverage Evaluation Survey
CHC	Community Health Centre
CMHO	Chief Medical and Health Officer
CSO	Civil Society Organization
CSR	Corporate Social Responsibility
CUG	Closed User Group
C4D	Communication for Development
DAP	District Action Plan
DHS	District Health Society
DICCG	District Immunization Communication & Coordination Group
DLHS	District Level Household Survey
DPM	District Program Manager
DPO	District Program Officer
DPT	Diphtheria, Pertussis anus Tetanus
DWCD	Department of Women and Child Health
FAQ	Frequently Asked Question

FIC	Fully Immunized Children
FBO	Faith Based Organization
FLW	Front Line Workers
GIVS	Global Immunization Vision & Strategy
GoI	Government of India
HPD	High Priority Districts
HRA	High Risk Areas
HW	Health Worker
IAP	Indian Association of Pediatrics
IEC	Information, Education & Communication
IMA	Indian Medical Association
IMR	Infant Mortality Rate
IPC	Inter Personal Communication
KAP	Knowledge, Attitude and Practice
LB	Live Births
LW	Link Worker
LMP	Local Medical Practitioners
MCHN	Maternal Child Health & Nutrition
MDG	Millennium Development Goal
MEIO	Monitoring Evaluation & Monitoring Officer
MO	Medical Officer
MPHW	Multi Purpose Health Worker
NFHS	National Family Health Survey
NGO	Non Government Organizations
NHM	National Health Mission
NID	National Immunization Day
NIPI	Norwegian India Partnership Initiative
NSS	National Social Service
NYKS	Nehru Yuva Kendra Sangh
PCTS	Pregnancy & Child Tracking System
PHC	Primary Health Centre
PIP	Project Implementation Plan
PPP	Public Private Partnership

PRI	Panchayati Raj Institution
RCHO	Reproductive Child Health Officer
RI	Routine Immunization
RMNCH+A	Reproductive Maternal Newborn and Child Health + Adolescent
RoD	Record of Discussions
SBCC	Social Behaviour Change Communication
SC	Sub Centre
SEAR	South East Asia Region
SICCG	State Immunization Communication & Coordination Group
SHG	Self Help Group
SMS	Short Message Service
SNID	Sub- National Immunization Day
SWOT	Strengths, Weaknesses, Opportunities and Threats
TBA	Traditional Birth Attendant
TIPS	Trial for Improved Practice
TV	Television
UIP	Universal Immunization Program
UNICEF	United Nation International Childs Fund
U5MR	Under 5 Mortality Rate
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee
VPD	Vaccination Preventable Disease
WHO-RIM	World Health Organization – Routine Immunization Monitoring

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1. Executive Summary

Rajasthan is among the few states in India that are facing a huge challenge of high Infant Mortality Rate (IMR – 60/1000 LB, AHS Bulletin 2011) and a high burden of Under Five Mortality Rate (79/ 1000 LB, AHS 2010-11). Immunization is an important cost effective intervention for reducing morbidity and mortality due to Vaccine Preventable Diseases (VPDs) and contributes towards reducing IMR and U5MR.

As per current UIP, immunization protects children against 7 killer diseases. Proportion of Fully Immunized Children (FIC) for Rajasthan is higher than the national average of 61% (Coverage Evaluation Survey 2009). As per the AHS 2011-12 data, FIC coverage of the state is 69.2%, which is slightly lower than the coverage of 70.8% in the previous year (AHS, 2010-11).

In Rajasthan, the scattered geography, population characteristics, hard to reach areas, rate of migration and proportion of tribal population has been a challenge in accelerating immunisation coverage. In the bottlenecks for improving immunisation coverage demand side issues have been very significant and needs special attention.

Year 2012-13 was celebrated as 'Year of Intensification of Routine Immunization' with focus on enhancing the immunization coverage in the state. As a follow up plan, the RI intensification efforts have been initiated with focus on communication and behavior change for RI. The RI communication strategy for year 2014-15 has been developed with technical support from UNICEF and in consultation with experts from various departments and sectors. Evidences from various data sources have informed the formulation and development of this strategy.

The Social and Behaviour Change communication Strategy (SBCC) strategy document aims to address demand side issues in order to :

- Accelerate Routine Immunization coverage and reduce drop out and left out rates by addressing communication barriers.

- Advocate for universalisation of Routine Immunization amongst the key stakeholders
- Develop the plan for key IEC/ SBCC interventions, monitor implementation and its outcome.

Situation Analysis clearly shows the current situation of RI in Rajasthan and indicates that there are 10 districts which fall in the High Priority category Districts viz Dholpur, Karauli, Sawai Madhopur, Tonk, Jhalawar, Bundi, Jalore, Sirohi, Barmer and Pali. The SBCC strategy would be focused in these districts to positively affect the overall FIC coverage in Rajasthan.

Challenges have been categorised in the context of demand (access, availability of services , its utilisation and quality) for RI .This has explained in the context of the Socio-Ecological Model of Communication which analyses interventions at various levels (such as individual, inter-personal, societal, institutional, public policy and physical environment) to create an enabling environment for SBCC. SWOT analysis of program environment, available communication channels, and stakeholders has been done to prioritise and strengthen key focus areas with the knowledge of existing strengths and available opportunities.

Stakeholders have been defined as Primary (mother, father, care giver), Secondary (Family members, relatives, Front line Workers, Supervisors etc.) and Tertiary (LMPs, Members of PRI, VHSC, CBOs, NGOs, FBOs, SHGs, Community leaders, Religious leaders, IAP, IMA, NSS, NYK, departments and development partners etc.)

Strategic SBCC planhas been based on four key approaches – Inter personal Communication (IPC), Mid- Media, Advocacy and Mass Media to facilitate SBCC for RI. However, to address the key demand side issues, IPC is of paramount importance and needs to be the key focus SBCC intervention in High Priority districts. Continued utilisation of RI services is the key to the SBCC strategy in the contest of the existing networks, stakeholders, schemes and programs and allocated resources. The strategy also endorses that we should adhere to the branding, tagline and appeal launched by GoI, ensuring utilisation of existing resources developed with

expert opinion and pre tested for results. There are few innovative activities proposed in the strategy to be adopted by the state and districts.

Keeping the National Communication, Operational and Technical guidelines for Intensification of RI, GOI the state SBCC strategy underlines the need for local innovations and customisation of popular advocacy campaigns.

This strategy document is aimed at providing all the necessary guidance for strengthening communication in areas of RI at state and district levels and how to operationalise it for a span of two years. It has been contextualised in the RMNCH+A life cycle approach framework with strong emphasis on intersectoral convergence.

2. Situation Analysis

2.1 Overview of Routine Immunization – India and Rajasthan

India has a major share of contribution to the global challenge of achieving complete immunization in children. And, India's Universal Immunization Programme (UIP) is one of the largest in the world in terms of quantities of vaccine used, number of beneficiaries, number of immunization sessions organized and the geographical spread and diversity of areas covered. The recent national figures for children fully immunized with the seven vaccines (tuberculosis, diphtheria, pertussis, tetanus, polio, measles and Hepatitis B) included in Universal Immunization Program (UIP) coverage shows only 61 percent (information source-CES 2009). Further, there is a marked variation in the coverage of different antigens in different states and different districts in the same state. While the southern states have generally reported higher coverage than northern and central states, it is believed that the coverage has been erratic and has been facing several challenges with regard to demand and supply that include supply chain systems.

Important Milestones in the National RI Programme:

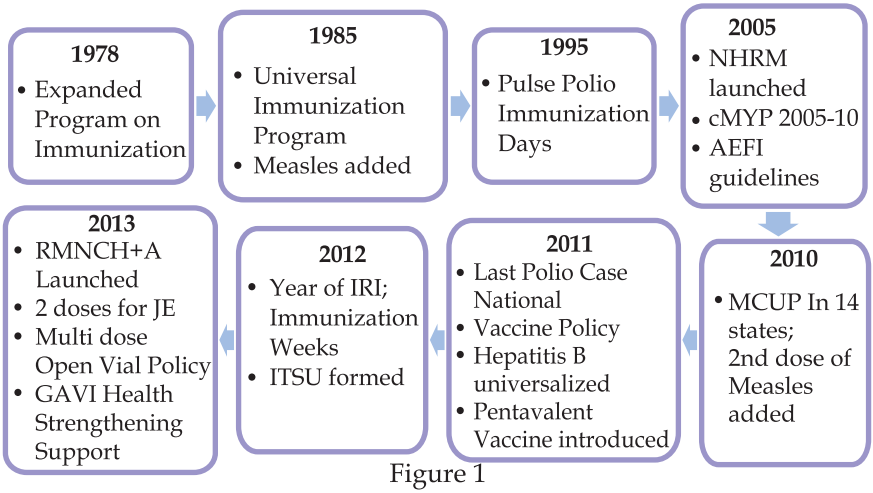


Figure 1

Routine Immunization is a highly cost effective means to improving child survival and presents immense opportunities to make substantial gains in health, bringing the countries closer to achieving the Millennium Development Goal -4 (MDG-4) for child mortality reduction. The program was introduced in 1978 in India. Investments in Immunization are almost risk free and have returns with remarkable gains that are tangible. MDG-4 provides a set of common targets to countries across the globe to achieve substantial and sustainable improvements in health. India's ability to achieve MDG 4 (reduction in child mortality) will in large measure depend on the child mortality indicators of its biggest state, Rajasthan.

Introduction of Pentavalent Vaccine in Rajasthan

Rajasthan is one of the twelve states in the country which is gearing up for the introduction of the prentavalent vaccine in first phase in October 2014 with the support of WHO , GAVI and UNICEF under Health Systems Strenghtening support to GOI and GOR.

The pentavalent vaccine, which is being used in 188 countries, is an important tool to reduce under-five mortality in India. Private practitioners in India have vaccinated lakhs of infants of the rich with this vaccine without any report of adverse effects. Its introduction in the public health domain will surely catapult the immunization drive

The pentavalent vaccine, which was recommended by National Technical Advisory Group on Immunization (NTAGI) in 2008 to be added to the UIP, has been introduced in a phased manner since 2011 in Kerala, Tamil Nadu, Karnataka, Puducherry, Goa, Gujarat, Haryana, Jammu & Kashmir Delhi and Rajasthan

- It is a single vaccine that protects children against five potentially fatal diseases: Tetanus, Diphtheria, Pertusis, Hepatitis B and Hib (Haemophilus Influenza Type B) with almost no side effects.
- Having five vaccines in one, is a real help for the health workers who are doing vaccination; they need fewer shots of vaccine to carry and administer, far less data to maintain for immunizing children; thus making them reach more children.

Rajasthan Profile:

Rajasthan is India's largest state in terms of geographical area and as it prides itself on a rich cultural heritage, the people here are known to value long-held beliefs, customs and traditions. Rajasthan constitutes 10.4 percent of the total geographical area of India and it accounts for 5.5 percent of population of India. Topographically, deserts in the State constitute a large chunk of the land mass, where the settlements are scattered and the density of population is quite low. Rajasthan has a population of 68,621,012 as per the 2011 census. The population growth over the last ten years has been around 21.44%. The sex ratio of Rajasthan is 926 per 1000 males.

Over the past decades, successive Governments in Rajasthan have shown commitment towards addressing developmental concerns in the state, especially that of children and women. Today almost 80% women are opting for delivering in hospitals and health centres. School Education has also seen a significant improvement in the last 10 years with over 80% children now enrolled in elementary education (DISE 2010-11). Increase in gender parity at the elementary level has been a particularly encouraging trend.

However, the rate of change and desired impact has not necessarily been equally distributed across geographical zones and social communities. Apart from the sheer size of opportunities, contrasts and challenges in the human capital of the state, the marked differences between geographical location (rural and urban), social groups (caste and religion), rich and poor and between sexes, is stark.

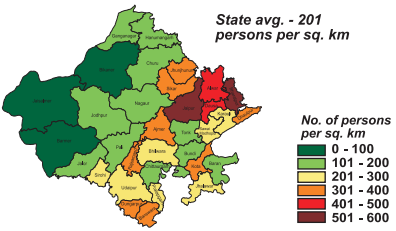
The tribal dominated districts of Banswara, Dungarpur and Udaipur, with difficult geographical terrain have consistently lagged behind on vital social development indicators. For instance, the mortality rates among rural children and children belonging to SC/ST groups remain much higher (SRS & AHS 2010-11 data).

Rajasthan : At a glance

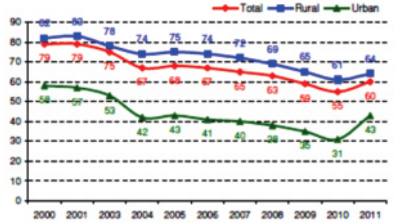
Socio - demographic profile

	Census 2001	Census 2011
Total Population	56,507,188	68,621,012
Population-0-6yr	10,651,002	10,504,916
Literacy Rate	60.4	67.1
Sex Ratop	921	926
Sex Ratop 0-6 yr	909	883

Population Density 2011

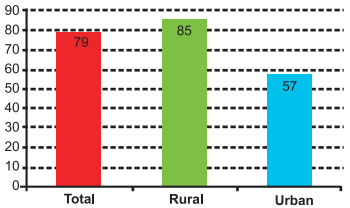


Infant Mortality Rate



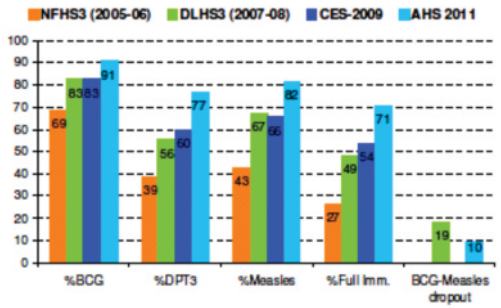
Date Source - SRS & AHS Bulletins

Under 5 Mortality Rate

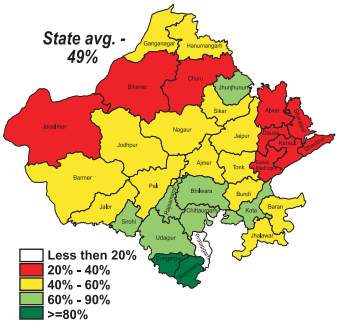


Date Source - AHS 2010-11

Immunization Performance

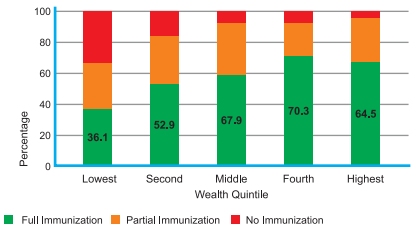


Full Immunization - DLHS3

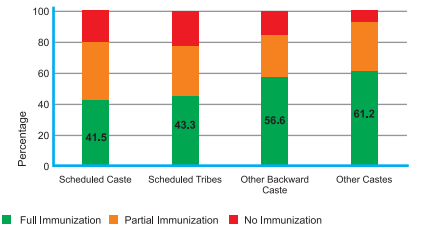


Immunization Coverage Evaluation Survey 2009

Immunization Status by Wealth Quintile



Immunization Status by Caste

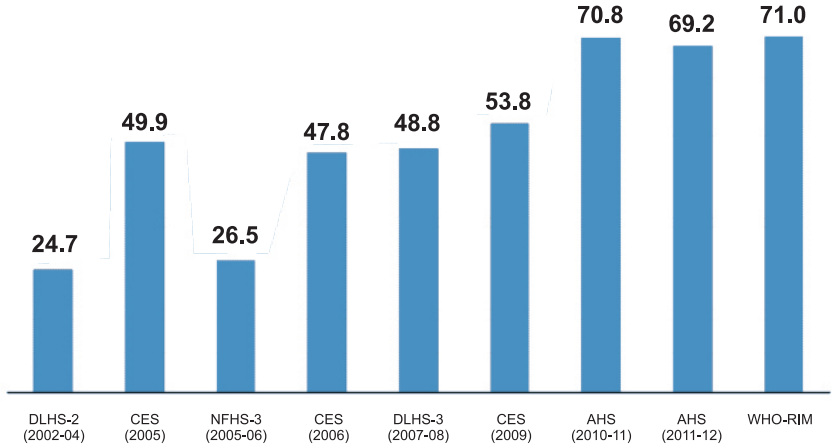


Status of Routine immunization:

Rajasthan is one of the 9 priority states catering to 1.7 million children and 1.9 million pregnant women. Full Immunization (FI) Coverage showed vast improvement in the recent health surveys and stands at 69.2% (AHS 2011-12) which is slightly less than the figure of AHS 2010-11 (70.8 %).

Coverage report of different surveys:Figure3

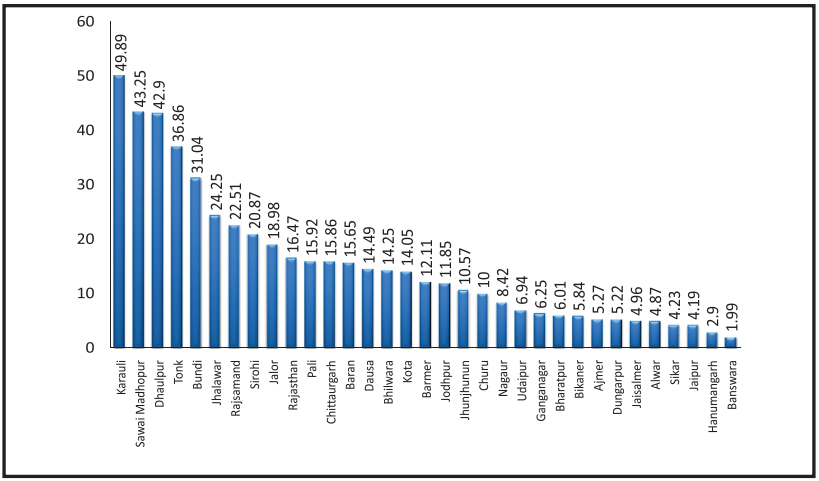
Fig 3 - Full Immunization Coverage of Rajasthan in Various Surveys



NFHS- National Family Health Survey | DLHS- District Level Household Survey | CES- Coverage Evaluation Survey | AHS- Annual Health Survey | WHO-RIM- WHO's RI Monitoring Data (March 2013 to Feb 2014),

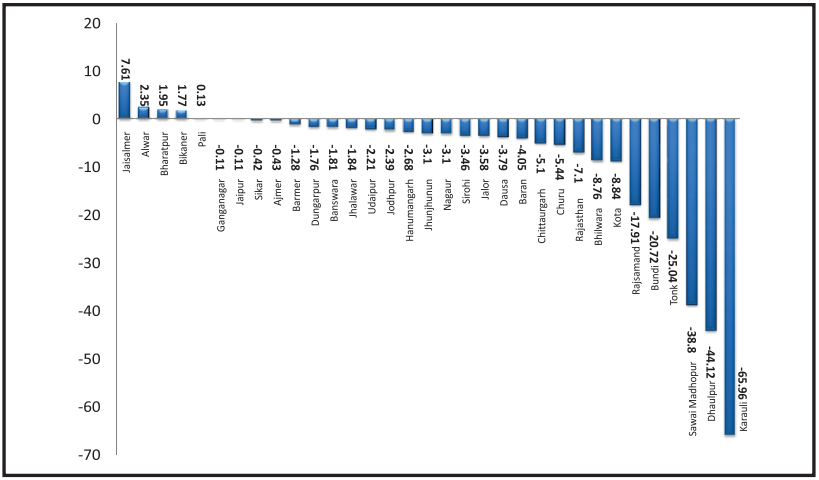
Though state has shown improvement in the last decade but there is wide inter district variation in FIC ranging from 41.5% in Dhaulpur to 95.9% in Hanumangarh. Of the 33 districts, 6 districts – Bundi, Dhaulpur, Jhalawar, Karauli, Sawai Madhopur and Tonk have less than 60% FIC.

Figure 4: Dropout rates between BCG to DPT3

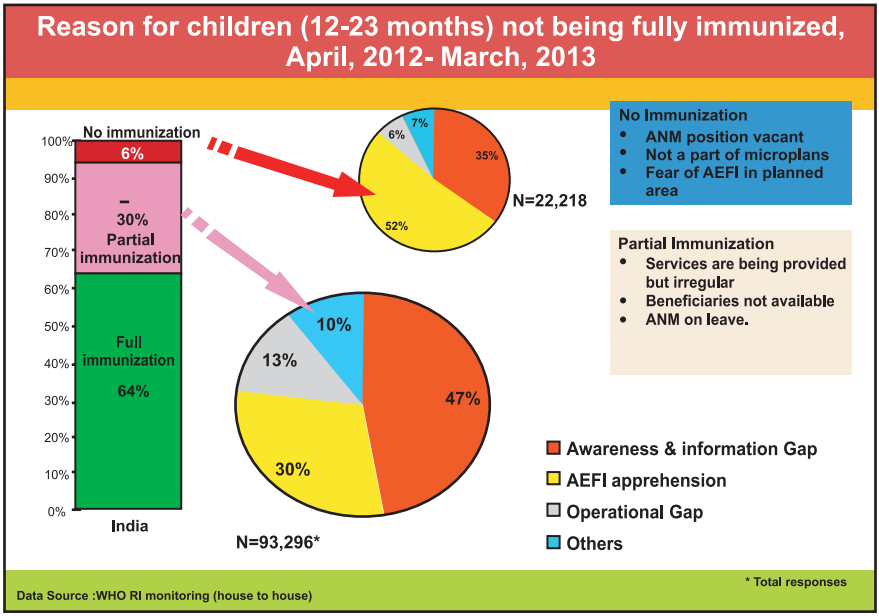


[1]Source – AHS 2010-11 and AHS 2011-12

Fig. 5: Dropout rates between DPT3 to Measles



The Figures show that there is a huge burden of drop out children between BCG-DPT3. The highest drop out for DPT and Measles vaccination clearly reflects upon the bottlenecks that exist in the outreach immunization service delivery with various demand and supply side issues for partial or no immunization of the children.



Reasons for not immunising Children in Rajasthan (CES 2009)

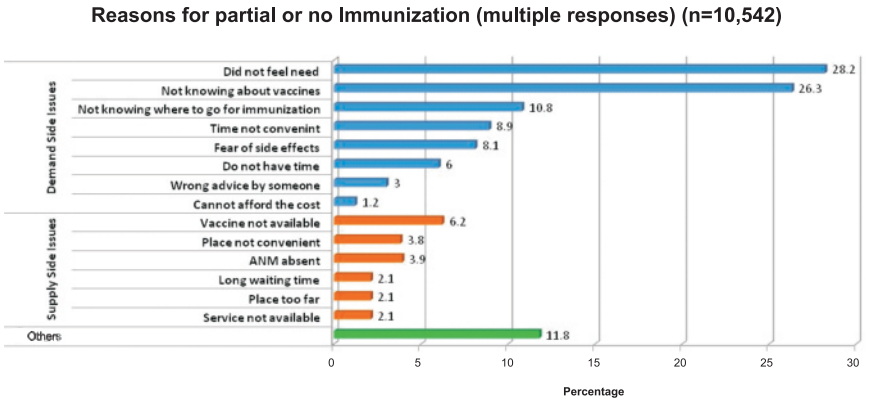
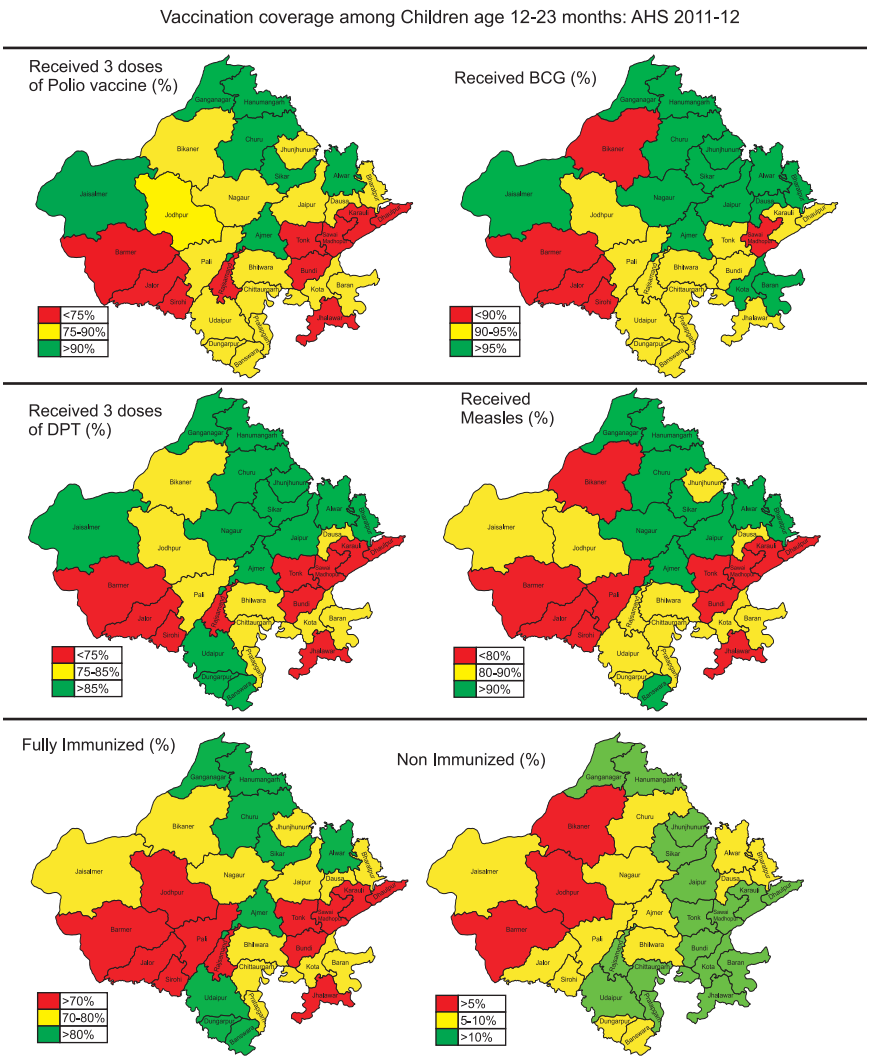


Figure 6

Figure 6 clearly shows that the major gap in demand side from the community is that they do not feel the need for immunizing their children and a close second is the non-awareness about the vaccines amongst the populace in general.

On the supply side, the gaps have not been very significant, clearly bringing out the need to strongly work towards creating a demand for immunization services amongst direct beneficiaries; to enhance the demand and thus uptake of services.

Fig 7 - Full Immunization Coverage Rajasthan (AHS 2011-12)



2.2 High Priority District Analysis - Rajasthan

AHS 2011-12 data in Figure 6 shows that 12 districts of Rajasthan (Dholpur, Karauli, Sawai Madhopur, Tonk, Jhalawar, Bundi, Jalore, Rajsamand, Sirohi , Barmer, Jodhpur and Pali) fall in the red category and have FIC below 70%. Further out of these 12 districts, 10districts have low DPT coverage except in Jodhpur and Pali; similarly 10 districts have low coverage of measles except in Jodhpur and Rajsamand. Thus, ten lowest performing districts will be considered as High Priority Districts for Routine Immunization (HPDs) for designing the strategy for enhancing Routine Immunization coverage.

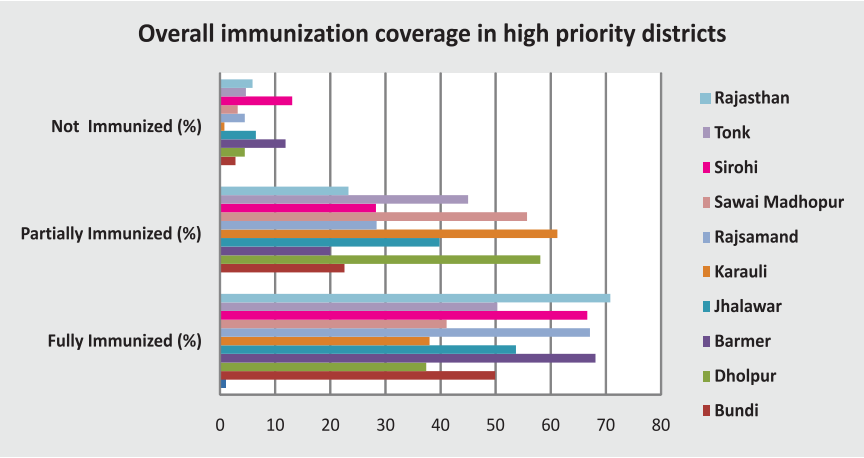
Table 1: Overall Immunization coverage in High Priority districts

Districts	Fully Immunized (%)	Partially Immunized (%)	Not Immunized (%)
Barmer	68.1	20	11.9
Bundi	49.9	22.6	2.8
Dholpur	37.4	58.1	4.5
Jalore	62.8	28	9.2
Jhalawar	53.7	39.8	6.5
Karauli	38	61.2	0.8
Rajsamand	67.1	28.4	4.5
S. Madhopur	41.1	55.7	3.2
Sirohi	66.6	28.3	13.1
Tonk	50.3	45	4.7
Rajasthan	70.8	23.3	5.9
Source: AHS 2011-12			

The full immunization coverage was found ranging from 67.1% for Rajasmand to 37.4% for Dholpur. The percentage of not immunized children ranged from 0.8% in Karauli district to 11.9% in Barmer district. Only 1 district has partial

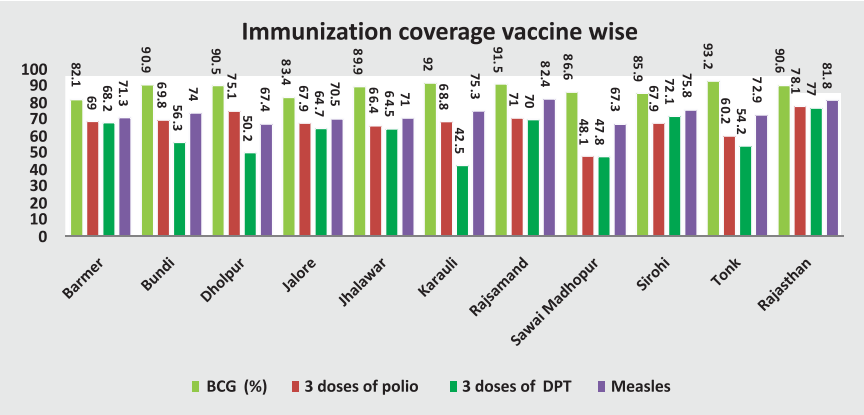
immunization coverage lower than the state average while 6 districts have non-immunization coverage higher than state coverage. Thus, Sawai Madhopur, Dholpur and Karauli are the districts lowest in full immunization coverage as well as the left out rate and the major concern for these districts is their dropout rates.

Figure 8: Immunization coverage in HPDs



Source: AHS 2011-12

Figure 9: Immunization coverage: vaccine-wise



Source: AHS 2011-12

Figure 8 shows the immunization coverage rates for each type of vaccination. According to the primary immunization schedule, the child should be fully vaccinated by the time he/she is 12 months old. BCG coverage is highest in all districts while DPT has lowest coverage in all districts except Sirohi which has lower polio coverage than DPT.

The dropout rates between BCG given in institutions when the child is delivered and the DPT-1 given at 6 weeks of the child's life indicates the break in services, lack of effective counselling by service providers during home visits or MCHN days and poor or no tracking of eligible children.

Why are there dropouts?

Dropout problems may involve access issues but are usually an indication of some other gap which is not being adequately addressed. It points to the fact that families have the knowledge are motivated to have accessed the services and started the vaccination for the child. Field level data from families, service providers have cited the following reasons for dropouts:

- Combined with the frustration of long queues, late openings, or even cancelled services on announced days, any ill-treatment by health worker can discourage return visits.
- Poor vaccination techniques can also cause anxiety in parents.
- If parents are not explained & reassured about possible reactions such as fever, then they may drop out.
- If parents cannot read, all the more reason that health workers counsel them properly. Many health workers do not fill out immunization cards, either because they're too busy or because they think parents cannot read them.

Why there are left outs?

Children being unreached by service providers and not availing services or left out point to problems involving access issues, both geographical and social.

- Inaccessible terrain, mountainous areas, or areas divided by natural barriers such as flooded streams.
- Migrant labourers and frequently shifting nomadic populations.
- Scattered populations based in locations far away from densely populated habitations and mining communities.
- Socially secluded communities based on caste or class.

- Improper tracking system.

2.3 Programme Environment and Key Challenges

Various surveys conducted in the country from time to time (DLHS, CES and AHS) indicate that the program of immunization is unable to reach the Global Immunization Vision and Strategy (GIVS) goals of 90% immunization coverage at the state level and more than 80% at the district level with strengthened health systems, access to quality vaccines, introduction of new vaccines, optimal sustainability of the entire program and focus on High risk areas (HRAs) where FI coverage is 54.7% (WHO field monitoring data during immunization weeks done in March 2014).

Though over the years, state has gradually improved in the Routine Immunization program, but still there are inter-district, intra-district challenges particularly in HRAs that need due attention and interventions. The challenges are related to gaps in immunisation services and its delivery coupled with limited or poor demand generation amongst the communities, particularly in hard to reach and migrant populations.

GAPS in IMMUNISATION SERVICES

- Cold chain, vaccines supply schedule and logistics management system
- VPD and AEFI surveillance systems
- Waste management systems
- Monitoring and supportive supervision structures
- HR issues related to positions of the ANMs and deployment of ANMs for other clinical duties
- Variable alternate vaccine delivery mechanism
- Optimum use of available VPD Surveillance data
- Inadequate supervision and monitoring
- Underutilization of Pregnancy and Child Tracking System (PCTS)

- Incomplete due list of beneficiaries
- Robust microplans

VACCINE SAFETY:

- AEFI apprehension in the community
- AEFI reporting mechanism
- Adverse news in media creating distrust in community
- AEFI management procedures

LACK OF INFORMATION AMONG COMMUNITY ABOUT:

- Awareness of need for vaccination
- Where and when to get the vaccination
- Little or no visibility of MCHN day
- Clarity over the AEFI case
- Poor communication and counselling
- Limited role of existing community structures /CBOs/ for social mobilisation and demand generation for RI

LESS/NO INVOLVEMENT OF CSO/NGOS IN THE PLANNING PROCESS FOR ROUTINE IMMUNIZATION

- Poor coordination between the local health system and CSOs/NGOs for RI
- Lack of clear message among the CSO/NGOs enabling them to strengthen RI

Communication Challenges

Communication is an integral element of public health practice, promotion and preparedness. While problems can be attributed to many factors, some of the most essential issues have to do with the gap between perceived risks and benefits of health, one-way communication, over dependence on mass media when its reach is limited in Rajasthan and lack of trained professionals for promoting effective BCC messages. The "one size fits all" formula has not been able to respond to the diverse geographical and regional needs of the state, so far.

Rajasthan has a diverse audience composition with the following –

- Pre-determined taboos and customs prevalent in many areas
- Scattered population
- High proportion of tribal areas
- High rate of migration
- Difficult and diverse geographical conditions; and
- Low literacy level amongst community esp. amongst women; and
- Inadequate SBCC efforts and lack of real time data cause a huge challenge to get desired outcomes

As per available data sources from CES 2009 and barrier analysis of NHM behaviors (state IEC Bureau/ Unicef, 2009-10), the communication challenges are mainly at three levels, as below:-

1. System

a. Diffused responsibilities of functionaries
b. Multiple massages delivered in an uncoordinated manner
c. Insufficient IPC skills of frontline workers
d. Sub optimal use of delivery points and MCHN days for knowledge and awareness building
e. Lack of focus of program managers on SBCC

2. Community

a. Immunization is not an "issue"
b. Insufficient information
c. Lack of awareness and motivation
d. Mid- media not adequately tapped
e. Reach to media dark villages or areas

3. Family members

a. Completion of full immunization within one year is a challenge

b. Insufficient knowledge of all vaccines and their key benefits
c. Fear and myths associated with immunization

Above communication challenges need to be addressed effectively for promoting routine immunization among various stakeholders including community and family members. To achieve better immunization coverage, we need to prepare evidence based communication plan which takes into account the various communication challenges at the family, community, outreach, facility levels of service delivery points. Various factors like individual, interpersonal, societal, institutional, public policy and physical environment plays a key role in behavior change. The various levels are important in ensuring enabling environment where behavior change can occur.

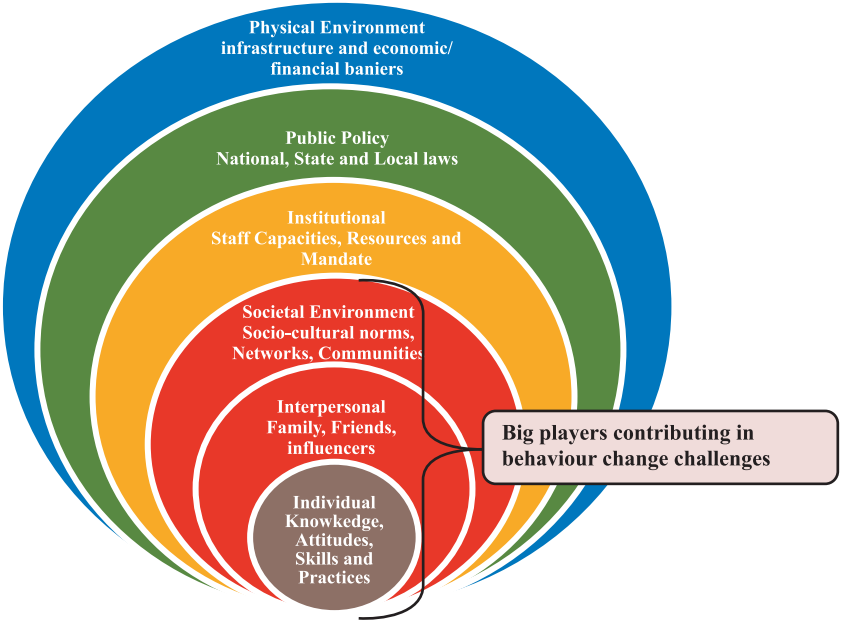


Figure 10 - Socio-Ecological Model

2.4 SWOT Analysis

Table 2: SWOT Analysis

Strengths	Opportunities
• Strong political commitment for strengthening health programs including RI • State gearing up for introduction of pentavalent vaccine in state from October 2014 leading to improved systems and services • Improved infrastructure for RI- cold chain supply points, EVM assessments , vaccine supply • State RI cell and IEC Bureau are in place to implement and monitor RI communication strategy • Availability of recent data on RI coverage, bottlenecks in communication and characteristics of audiences of RI, which can be used as a baseline for planning SBCC strategy. • Availability of various communication channels and tools with existing use in communication programs • Availability of skilled and trained human resource (vaccinators and social mobilisers) at grass root level for implementation. • More than 95% of the immunization sessions are held as per micro-plan	• 50,000 ASHA workers (one in every 40,000 villages) to be utilised as a very good resource for strengthening IPC in the communities to increase awareness, creating demand and active social mobilization for immunization • ASHA is given incentive of Rs. 150/- for mobilising families for RI at MCHN session • VHND days/ MCHN Days can be used as a very good platform to implement SBBC strategy. • VHSC committees at village level are formed and availability of committee fund allotted by government, committee members can be involved as implementers or facilitators for village level activities and funding can also be utilised for various SBBC activities. • Local Panchayat leaders as champions and drivers of SBCC in Gram Panchayats • Radio programmes across the state along with the FM channels can be used as a good resource for delivering RI communication messages to the community. • Good coverage and use of radio programmes at village level in the state • Launch of branding logo, tagline and tools for RI by GoI • Availability and use of folk groups

- Public health managers dedicated for RI and communication at block, district and state level
- Good technical support from development partners (UNICEF, WHO- NPSP) and forums of CSOs
- Branding of immunization by GoI with launch of RI logo RI communication material (posters, Radio and TV spots) which can be used for communication efforts and RI logo can be used in development of communication material or branding immunization program in the state
- Availability of funding in PIP for implementation
- Various communication channels like radio, TV, newspapers, mobiles and telephones, internet etc. are available.
- Piloting of effective innovations like E-ASHA with tablets uploaded with counselling messages from videos of Ammaji (Facts for Life – UNICEFInitiative) for real time tracking and monitoring of mothers and children.

promoted at district level by Field Publicity Units of Regional Song & Drama division of GOI and IEC Bureau

- Prioritising and supporting funding for strengthening RI communication and social mobilisation by GoI in high focus states, including Rajasthan
- Availability of mobiles (CUG connections) with Frontline Workers and Health Managers at all levels
- Mid-media activities at schools for RI awareness and motivational messages.
- Existence of leaders in well organised community structures (Jat Mahasabha, Gurjar community etc.), who can be sensitised and motivated to influence their community members on RI.
- Community based organisations (SHGs, Mahila Mandals, Kishori Mandal, Yuva Mandal etc.) and faith based organisation leaders can act as channels for SBCC on RI
- State, District and sub-district level NGOs and CSOs can act as partners for implementing and monitoring RI activities in the field.
- CSR initiatives are available and should be explored for bettering RI outcome.
- District IEC Coordinators and Block IEC Coordinators are appointed at district and block levels respectively, who can be used as good resource personnel

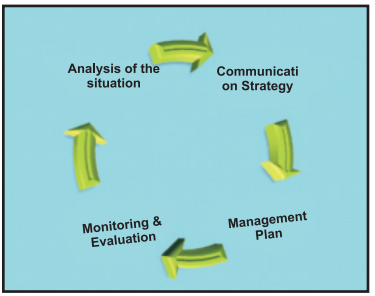
	• Convergence between Health department and DWCD department at the grass root level exists in the form of ASHA Sahyogini in Rajasthan. This convergence can be further strengthened to support the RI interventions in villages • Existence of diverse cultures and practices, community participation in Melas and other events, dependence on folk media for entertainment, varied festivals celebrated in parts of the state etc. offer great platforms to implement communication activities with maximum reach.

Weaknesses	Threats/ Challenges
• Poor SBBC/IEC efforts at the grass root level mainly in outreach areas, among migrant population, tribal areas, urban slums and peri-urban areas for RI • Lack of SBCC concept in activities and majority activities centered towards IEC at all levels. • Poor visibility of MCHN days in villages with little or no display of time and nature of services provided, little or no use of available counselling tools, IEC material and SBCC efforts for RI at session site and in the community. • State is able to reach the	• SBCC in migrant, hard to reach and tribal areas considering literacy level and availability of communication channels and use of the same • Dealing with unaware and unmotivated target population • Frequent change of management/ leadership at state level health departments including state RI cell. • Strengthening behaviour change efforts in resistant population • Lack of chapters/ subject on SBCC in ANM basic training curriculum • Lack of coordination amongst different departments and implementing agency of the SBCC activities • Weak capacity for planning and implementing SBCC programmes

already 'reached' population again and again for service delivery and also in matters of health communication but reaching the 'unreached' population (like hard to reach, migrant tribal, peri-urban areas and media dark villages) is inconsistent • Non optimal use of available IEC materials at all levels • Lack of use of modern technologies for spreading awareness through communication on RI • Lack of infotainment tools • Lack of proper monitoring of RI activities in the field • Scarcity of manpower at the village levels for mobilisation and follow up	• Weak community based SBCC inputs • Uncoordinated and unfocused mass media campaigns • Communication objectives to be achieved by the State IEC Bureau are not set. Performance is judged by inputs, for e.g. no. of video spots telecast, no. of posters, hoardings etc. • Trainings are not imparted based on any Training Need Assessment and neither any impact on job performance is assessed. • Over burden of tasks and reporting on frontline workers such as ANMs, ASHA hampers the quality as well as ownership towards work including RI. • Difficult geographical and climatic conditions in the desert part of the state pose a threat to access RI services

3. Framework for the SBCC Strategy on RI for HPDs : 2014-15

3.1 Introduction to SBCC strategy

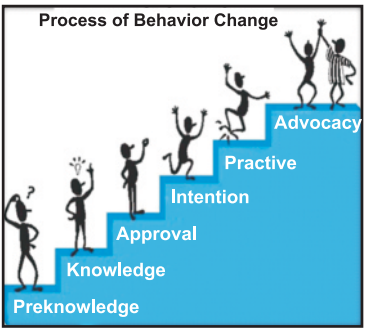


A sound and effective health communication strategy should be based on an overarching vision of what needs to be achieved to address a particular health issue. The strategy should be integrated, have a long-term focus; with short and medium term plans to monitor the process and make mid course corrections.

Basis of the Strategy for Social & Behavior Change Communication in Rajasthan is situational analysis presented earlier in this document, behavior and barrier analysis and existing capacities of the state to implement SBCC plans and resources. This will have to be viewed in the framework of Continuum of Care and Life cycle approach of the umbrella of RMNCH+A and NHM services with focus on integrated SBCC interventions to bridge the gap between availability, access, utilisation and demand for services

Process of Behavior Change

Communication intended to influence behavior change—is a process. People usually move through several intermediate steps in the behavior change process (Piotrow et al., 1997). In addition, there is typically a correlation between increases in behaviors, such as partner-to-partner



dialogue about child health and subsequent uptake of immunization services. Furthermore, people at different stages constitute distinct audiences. Thus, they usually need different messages and sometimes different approaches, whether through interpersonal channels, community channels, or mass media.

An audience can generally be described as:

Preknowledgeable—is unaware of the problem or of their personal risk.

Knowledgeable—is aware of the problem and knowledgeable about desired behaviors.

Approving—Is in favor of the desired behaviors.

Intending—intends to personally take the desired actions.

Practicing—Practices the desired behaviors.

Advocating—Practices the desired behaviors and advocates them to others.

SBCC Interventions

The Focus of RNCH+A strategy is on the continuum of care and life cycle approach and the same has to be considered for designing the SBCC strategy for RI. There are various levels (as shown in figure 13) according to which the strategy will need to be tailored.

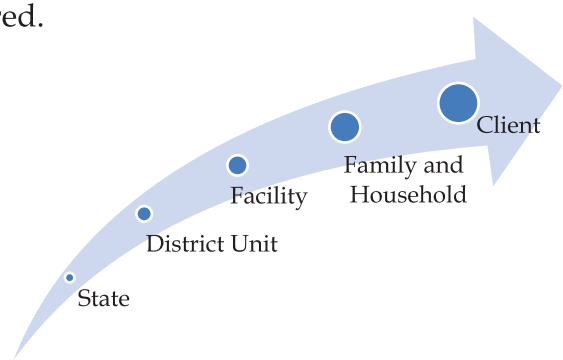


Figure 13: Various levels of SBCC Strategy

Client

The central focus in all the strategies is the clients, because the desired behavior is expected of them. Understanding of client among service providers including ASHA, ANM and AWW is essential to work out the Interpersonal Communication strategy and interventions.

Household/FamilyLevel– Inter Personal Communication (IPC)

IPC through home visits by ASHA and ANM; on MCHN day; during meetings with lactating women and influencers in decision making, including Mothers In law and other family members; are recommended. And especially designed IPC (interpersonal communication) tool on immunization is suggested to enable frontline workers to do need specific SBCC at the household level.

Theme based Village Contact Drive (VCD) and Trial for Improved Practice (TIPS) is another important strategy that can be helpful for mobilizing individuals and families for desired behavior Change. Quarterly theme based VCD Plan and Monthly TIPS Activity can be initiated on a pilot basis and replicated in the entire state.

Other household level BCC interventions include:

- Child to communityapproaches(Ongoing Swasthya Mitra Yojna can be helpful); and
- Promoting couple and family communication.

To ensure this intervention appropriate communication aids and tools to support the IPC by field worker is required along with enhancement of her capacities by organizing training on IPC.

Community Based SBCC Interventions

Community level SBCC interventions include:

- Group meetings, MCHN day, community notice boards,

use of mid media and mass media tools.

- Felicitation of good SBCC promoters (FLWs, PRI, Community influencers, volunteers SHG members, NGOs, Youth Mandal etc.)
- Community *"baithaks"* to review the work. The strategy proposes use of village level and household level monitors to track service provision and service utilization at the household level.

2 Days MCHN Day per month per AWC can be very effective where 1st day is used for reaching out to the beneficiaries, as per the due list for information on the immunization date (through home visits, announcements, rallies, ratri chuppals, community meetings etc.) and the 2nd day is the MCHN services implementation day as planned.

- Healthy baby shows, utilising various social and religious platforms for SBCC interventions viz local festivals, local melas, folk events, religious events etc.
- Creating champions for RI in communities like traditional healers faith based groups etc.
- An MCHN Day helpline is proposed and people can call the helpline to complain if the MCHN day is not held in the village as planned. VHSC will appoint a nodal person at the village regarding responses to the grievances
- The village notice board will have the monthly schedule for the MCHN day.

Facility/Institution

SBCC interventions at health facilities are equally important. Facilities should be equipped with a counsellor with audiovisual tools for counselling on immunization. In addition, "Badhai"kits to be given to every mother - on childcare including immunization on discharge from the institution. In this kit key behavioral change issues to be

covered with key messages followed by mother herself and her family members.

District level

At the district level, the DHS to review the SBCC activities on a regular basis; district specific interventions to be detailed out in the District SBCC plan. The district IEC Coordinator along with ASHA coordinator, Block ASHA Facilitator and PHC ASHA supervisor to be made responsible for the SBCC activities in the district as well as for doing training needs assessment and capacity enhancement as per need.

State Level

The interventions at the State level include facilitating and supporting the district SBCC plans and implementation of the intervention including monitoring and tracking of the planned outcomes. Airing TV, radio spots, health related serials etc., celebration of health days to reward the best performing Gram Panchayats/ blocks /districts, implementing village contact drives, use of alternate media such as mobile phones using SMS campaigns and contests, Political & Media Advocacy, use of outdoor media such as bus and autorickshaw panels, hoardings etc. are the key interventions.

3.2 Program and Communication Objectives

The SBCC strategy document intends to:

- Strengthen RI coverage and reduce drop out and left out rates by addressing communication barriers
- Advocate for universalisation of RI amongst the key stakeholders
- Develop the plan for key IEC/ SBCC interventions, monitor implementation and outcome of the same.

Programme objective:

By 2015, at least 90% of children are fully immunised in the state of Rajasthan.

Communication Objectives:

By 2015, % of mothers/ caregivers of children 0-5 years in Rajasthan –

A. Who is not aware about vaccines drops from 26.3% to < 10%

B. Who don't feel the need of immunization drops from 28.2% to < 10%

3.3 Key Strategies – Advocacy, Social Mobilisation and Inter-Personal Communication

Based on the variety of communication models, the communication approaches should be woven under three broad communication objectives and there should be good mix of different channels and media approaches like IPC, social mobilization, community dialogue, advocacy mass and mid media.

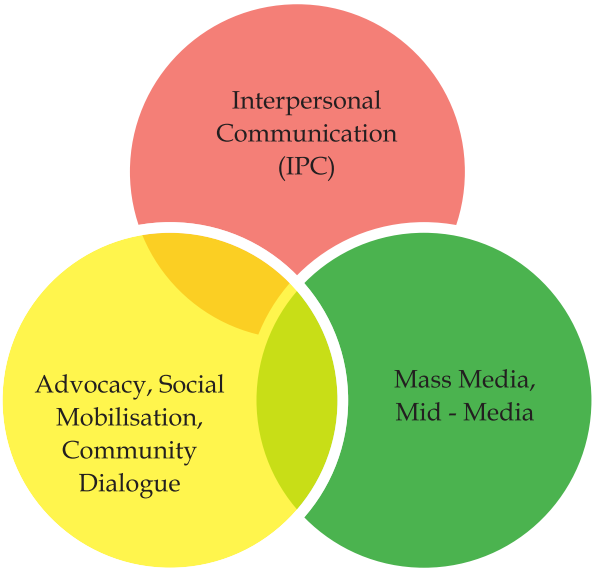


Figure 14: Communication Approaches

1. **Building mass awareness, making "immunization an issue"** – focus of this approach should be on general masses with special emphasis on women, family members, service providers, opinion makers etc. The ways and means will include mass and folk media, radio, TV, folk theatre, key newspapers, mid-media such as hoardings, tin plates, banners, posters etc. should be used to keep the message of immunization in "public eye".
2. **Mobilise Community**– here the focus should be on the secondary and tertiary target groups. The ways and means will include folk media, group discussions; local stakeholders (NGOs, SHGs etc.)while providing culture appropriate alternatives.
3. **Support mothers** – key focus should be mothers and family members. The ways and means will include repeated visits, meetings, counselling and activities at MCHN days, delivery points and ensuring community appropriate timing of MCHN days.

3.4 Communication Channels

In order to promote routine immunization in families and communities, a good mix of different media channels and activities is required. It is recommended to develop a branding for MCHN day and a cohesive message and material development activity should be put in place. The materials need to be designed also in sync with the branding logos and materials launched by GoI.

E – ASHA: A pilot initiative of Health Department and UNICEF

25 ASHA Sahyoginis of Jasol village in Barmer district of Rajasthan went Hi Tech, using Tablet PCs equipped with software to manage their day to day work. The software is fully equipped with all information on ante-natal and post-natal check-ups, all question-answers on newborns and immunisation list. The health workers have to upload the data once, then both the pregnant women and ASHAs get reminders for follow-up, check-ups and vaccinations through SMS. They also show infotainment videos for IPC.

Few strategic interventions are given below as examples:

1. **Interpersonal communication to focus for family and community.**

   Some examples are-

- Interpersonal communication during house to house visits
- Group IPC during Community meetings
- Make MCHN days educational. During MCHN days health workers and Aganwadi workers need to explain the key benefits of immunization displaying posters and flip book and other IEC material
- Sensitization meeting with women's group and SHG
- Social recognition to the families those who face completed full immunization of children in presence of Sarpanch/block medical officer/ CMHO
- Identify local influences to advocate for communication

2. **Outdoor and Mid-media** to focus on media dark villages -

Posters with key messages on RI are needed to inform and educate variety of audience. The posters primarily, are required for twin purposes:

- To convey the key service being rendered during MCHN days and
- To educate the primary/ secondary/ tertiary audiences about the RI schedule and key benefits of each vaccine

Hoardings/wall paintings: for the key locations- AWC, panchayat building, school, community centre, PDS shops at the district, block and small towns.

Tin panel: for all health facilities and key locations where the stakeholders like PRI members, SHG groups gather.

Banners/visibility: for identification of MCHN day sites

3. **Branding, Positioning and key messages:** RI is to be promoted by using the RI logo and package launched by GOI. The messages to be promoted
   - "Every child counts"
   - "Immunization is key to a healthy child"

Dominant colours: cyan Magenta- Yellow-black (C 50, M 100, Y 0 K 0) and the red green blue (R 154 G-39 B-143) colour percentages.

Key messages/tagline: "Bhul na Jaana Tikakaran Jaroor Karvana" (in Hindi)

"Do not forget vaccination your baby must get" {in English}

The brand line is accompanied by the visual of a large caricature of a happy syringe holding a happy baby in its arms. The development of this brand image was pretested in the communities in Bihar and found acceptable. The brand was used proactively and successfully in the immunization campaign called "Muskaan"of the Government of Bihar. With permission from UNICEF, Bihar, which developed the visual, it is now being widely used in all IEC material under UIP. It has to be remembered that barring polio drops, all other vaccines in the RI schedule are injectable. The image conveys this clearly. It also personifies the syringe and needle as a parent holding a baby in its arms, which is very happy and comfortable conveying the fact that injectable immunization is safe for the baby.

4. Mass Media

Radio: Radio programmes to support the MCHN days will be broadcast across the state in about 31 AIR and FM stations. Live phone-in programmes on FAQs of RI will be focussed. Key messages on AEFI and where to report in case of events will also be included.

Television: It is proposed to telecast select infotainment videos during evening time suitable for the women viewers.

Short duration spots on select barriers to complete immunization (see the Behavior Analysis matrix in table 3) should be aired.

Newspaper Advertisement : it is proposed to put newspaper advertisement in support of MCHN days and other health events from time to time. Special drive may be organised with intense media coverage and press advertisement. Radio and newspaper correspondents must be invited to MCHN days sessions and in special campaigns for immunization

Folk or traditional media: folk media have the advantage of familiarity and adaptability to the local reality. They are watched by both men and women and are inexpensive too. District wise drama troupes, local artistes registered with the Song and Drama Division and Field Publicity Units must be identified and commissioned to write hold performances. The performance must be monitored for audience participation and reaction. Field tested scripts are already available with State IEC bureau and may be used while incorporating cultural symbols according to the regions and locations.

3.5 Behavior Analysis Matrix (Barriers, Communication Messages/ Activities and Outcome Indicators)

The behavior analysis of individuals, families and communities in Rajasthan in the continuum of care based on studies and reports indicate that most behaviors are interlinked in the continuum from knowledge to action, from families in households to facilities and service providers of the health system.

A detailed analysis of behaviors at different levels of stakeholders (as mentioned above) in the realm of current health scenario and health seeking behavior is presented in the matrix below. Accordingly, key communication messages and activities along with expected outcomes, are laid out in the matrix.

Table 3: Behavior Change Analysis Matrix

Desirable Behaviours	Barriers to Desired Behaviours	Motivations and Support	Communication Themes/ Content of messages	Communication activities/ channels	Health behaviour outcomes/ indicators
Mothers/ Fathers and other primary caregivers					
• Bring their babies to immunization service delivery points at the ages recommended in the national schedule. • Always bring the child's health or vaccination card. • Treat any side effects as recommended. • Encourage relatives and friends to have their babies immunized on schedule. • Seek and/or accept tetanus immunizations for themselves. (This is applicable to mothers and other women of childbearing age.) • Take babies themselves for vaccinations at the	• Lack of knowledge about immunization • Low risk perception of diseases due to non-immunization • Lack of awareness of immunization schedule, place and date • Parents' concern with adverse events following immunization (AEFI) • Mothers don't know their baby's age and/or when their baby's next immunization is due • Poor access to closest health facility • Worry that mother and infant could get sick if she leaves the house too early • Husbands/part ners and/or other	• Immunization prevents serious child sickness • Support of other family members for the mother to take child for immunization • Understanding of family members that mild negative side effects from immunization is normal • Healthy baby show etc. for motivation through example • Immunization is free	• Only full immunization protects children from six life threatening diseases : a) Polio b) Diphtheria c) Whooping cough d) Tetanus e) Measles f) Tuberculosis • These diseases have already prevailed, you are lucky you did not get any of them. Do not take chance with your child. • Fully immunise your child All children are at equal risk of diseases; some are lucky, some are not. Do not take any chances. Immunize your child against all the six diseases • Full immunization of the child is the responsibility of every adult in the family, particularly the father • Every vaccine has different doses to protect the child • A child can become sick, physical handicapped or die if not fully vaccinated • Early dose of each vaccine is important for your child to be	• Media mix (choice of mid media and mass media) a) Video campaign in media dark villages b) TV as well as radio spots c) Folk based infotainment d) Mobile applications for reminders as well as immunization messages e) Awareness through print media, pamphlets, posters, hoardings, banners, wall paintings etc. f) Design IEC material of some daily utility for the rural household to ensure reinforcement of key RI messages (e.g. Glasses, pouches, carry bags, religious posters with RI messages, umbrellas etc.) g) Display boards to be maintained at AWC/ Sub-Center/ Panchayat on a daily	• Increase in the percentage of mothers and care givers reporting awareness of the six vaccine preventable diseases • Increase in the percentage of mothers and care givers reporting awareness of the risk of disease if the child is not fully immunised • Increase in the percentage of mothers, mothers in law, husbands reporting knowledge about Vaccine Preventable Diseases (VPDs), correct doses of immunization and immunization schedule • Decrease in the percentage of mothers dropping out due to missing a scheduled vaccination dose • Decrease in the percentage of women/

Desirable Behaviours	Barriers to Desired Behaviours	Motivations and Support	Communication Themes/ Content of messages	Communication activities/ channels	Health behaviour outcomes/ indicators
ages recommended in the national schedule, or encourage their mothers to do so. • Provide mothers with the money they need for transport or other expenses related to immunizing children eg. Loss of daily wages.	influencers don't want mothers to take babies for immunization because of time/lost labour, expense, and/or fear of side effects. • One has to pay for vaccine • Parents' refusal to have their children immunized due to religious beliefs. • Attitude of health staff unrespectable to caregivers • Lack of counselling by FLWs on immunization including the next immunization date • Occasional lack of vaccine or other essential supplies and equipment. • If a child misses a vaccine dose, then immunization is		fully protected against six diseases • Full immunization requires:- a) 1 BCG injection and polio drops at birth b) First DPT injection and polio drops when the child 1.5 months c) Second DPT injection and polio drops when the child 2.5 months d) Third DPT injection and polio drops when the child 3.5 months e) One measles injection when child is nine months • If you have missed a scheduled immunization day. • You do not have to start afresh. Do not stop immunization of the child. • Visit on the next immunization day and continue with the rest of the immunization schedule • Pustule and fever are sign of vaccine potency, which shows vaccine is working in the child's body • Side effects due to vaccination like pustule (BCG) and fever	basis with updated immunization status of the village. h) AWCs to be revamped and made attractive with IEC and other tools around key issues including RI, so as to attract more and more community members to avail services. Use of VHSC funds towards this is to be mandated i) Theme based village contact drives • IPC by frontline health workers particularly during ANC, contact and discharge from the facility after delivery • Reminders to women and family members about immunization dates by ASHAs and AWWs (especially for DPT 1 at 6 weeks as there is huge drop out between BCG and DPT 1; as community resists taking such a young child out of home) Village level private	mothers in law/ husbands due to fear of side effects as a reason for non immunization • Increase in the percentage of women/ mothers in law/ husbands receiving advice and treatment options from frontline health workers to manage side effects • Increase in the percentage of women/ mother in laws/ husbands reporting knowledge of the place of immunization • Decrease in the number of visits cancelled by the ANM on scheduled immunization day

Desirable Behaviours	Barriers to Desired Behaviours	Motivations and Support	Communication Themes/ Content of messages	Communication activities/ channels	Health behaviour outcomes/ indicators
	continued. • Lack of reliability of services • Lack of faith in immunization		are to be expected • Side effects are easily managed, ask your health worker how to manage side effects • Mild pain, discomfort and fever due to vaccination are to be expected, however this will ensure the protection of the child in future • There is a fixed immunization day in your AWC, SC,PHC and CHC • Ask your AWW and ASHA about the day, time and place of vaccination; confirm with your ASHA about the scheduled immunization day one day in advance • If your village does not have AWC/SC or the immunization session is not held in your village, go to the nearest village where immunization sessions are held and get your child immunised	practitioners to build awareness on immunization • Reinforce messages on immunization in special forums such as MCHN days • BCC material and counselling aids for use by Frontline Health Workers, SHGs, key partners (NGOs, CBOs) and other implementing stakeholders • Mobilization of school children to raise awareness on immunization among their parents • Awareness and sensitisation of adolescent population as well as newly married couples on the benefits of immunization (during pregnancy as well as for children) • Active participation mandated for PRI and VHSC members.	

Desirable Behaviours	Barriers to Desired Behaviours	Motivations and Support	Communication Themes/ Content of messages	Communication activities/ channels	Health behaviour outcomes/ indicators
Health workers who immunize					
• Perform all immunization service tasks correctly, including those that ensure safe vaccine handling and injections. • Treat mothers with respect (do not yell or criticize). • Give mothers and other caretakers the following essential information: when the next immunization is due and where to get it, what side effects are possible and what to do if any occur. • Proper maintenance of due cards, proper record keeping	• HW training does not provide skills or focus on importance of communicating with mothers. • There are real or perceived social, economic, class and possibly ethnic differences between HWs and clients. HWs lack time to give good counselling (because so many people are waiting for care). • Mothers don't expect to receive information and/or be invited to ask questions. • HWs and mothers do not speak the same language or dialect (in some settings).	• Trainings and skill development on immunization • Reminders according to due list with support of co-health workers • Timely reporting and supportive supervision • Timely replenishment and proper handling of vaccines • Acknowledgement and reward schemes for best performing health workers • Recruitment of adequate staff at all levels to ensure proper	• In case the scheduled immunization date is cancelled, announce in advance that the immunization day will not be observed • It is the responsibility of frontline health workers to inform and remind women and their families about immunization dates Responsible ANMs and health workers inform/ advise women about the next scheduled immunization date • Frontline health workers should maintain a list of all children due for vaccination and remind their parents to visit on the scheduled date for the next dose • A responsible ASHA/AWW knows that her counselling to parents on immunization could save many children from death or permanent disability • Remind parents and family members about immunization during your home visits • An effective and successful	• Media mix (choice of mid media and mass media) IPC, FGDs , advocacy events Sensitization meetings with mother's group and SHGs. • Social recognition to the mothers / families who have fully immunized their children in presence of key influencers of the community (e.g. rewards and felicitation, healthy baby show, testimonials etc.) • SBCC integrated training curriculum developed through Training Needs Assessment • Comprehensive and structured training modules and annual training calendar, with inbuilt refresher training sessions • Monitoring of communication skills and counselling through	• Decrease in the percentage of women and ASHAs reporting non-availability of the ANM as the reason for non-vaccination or drop out • Increase in the percentage of process variables like immunization in SHG meetings and involvement of local stakeholders in awareness raising campaigns • Increase in the percentage of ANMs/AWWs/ ASHAs who received information and have enhanced understanding on immunization during trainings. • Increase in the percentage of women/ mothers in law/ husbands who received information on the next scheduled immunization

Desirable Behaviours	Barriers to Desired Behaviours	Motivations and Support	Communication Themes/ Content of messages	Communication activities/ channels	Health behaviour outcomes/ indicators
and stocks maintenance • Timely and effective counselling to care givers on the adverse effects of immunization (AEFI). • Coordination with other field health workers for reinforcing availing of services as per due cards • Organize/reorganize immunization services to make them as convenient for and acceptable to mothers as possible. • Implement schemes to honour families whose children are fully immunized by age one.		reach as well as quality service provisioning; to avoid over burdening the existing manpower	ASHA uses communication and counselling aids to communicate messages	**On Job Performance Assessment.** • Mobile applications and softwares to be used for tracking due list, sending reminders, support in counselling sessions etc. • Development of Job aids to act as ready reckoners, interactive games, stories etc. • FLWs to be made responsible • Training on job aids, communication tools to improve RI coverage • Cross learning exposure for FLWs to other better performing areas/ sites to act as positive examples as well as for motivational purposes.	date • Increase in the percentage of women/ mothers in law/ husbands reporting that frontline health workers used counselling and communication aids to counsel them on immunization • Increase in the percentage of ASHAs/ ANMs/ AWWs using counselling aids on immunization

Desirable Behaviours	Barriers to Desired Behaviours	Motivations and Support	Communication Themes/ Content of messages	Communication activities/ channels	Health behaviour outcomes/ indicators
Policy-makers					
• Allocate sufficient financial and human resources to immunization and disease-control and eradication activities. • Demonstrate to the public and to the health staff their personal support for immunization and disease-control and eradication activities. • Efforts towards convergence amongst related departments for providing impetus to the drive of immunisation Micro level guidance and	• Not being able to visualise the implication of low immunization on the economic as well as health indicators of the state • Lack of convergence amidst related departments on the issue of immunization affects decision making and timely processes.	• Evidence based data be shared for accurate and timely decision making • Trends and progress through real time data of PCTS	• Immunization is a highly cost effective means to improving child survival and presents immense opportunities to make substantial gains in health, bringing the countries closer to achieving the Millennium Development Goal -4 (MDG-4) for child mortality reduction. • Investments in Immunization are almost risk free and returns with remarkable gains that are tangible.	• Advocacy meetings, workshops at different levels and cross-cutting departments Inter departmental as well intra departmental coordination meetings Setting up of State RI cell along with placement of IEC and SBCC personnel at all levels, as per mandate	• Rajasthan statehas aligned its RI strategy with the national immunization programme as guided by Global Immunization Vision and Strategy (GIVS) and SEAR Immunization Strategic Plan. • State level RI strategy developed. Translated further into District level as well as block level micro RI plans.

Desirable Behaviours	Barriers to Desired Behaviours	Motivations and Support	Communication Themes/ Content of messages	Communication activities/ channels	Health behaviour outcomes/ indicators
leadership to the immunization program • Develop strategic alliances to support innovations and efforts for achieving 100% immunization					
Key Influencers (Community leaders/ Religious leaders/ Traditional Healers/ Opinion Leaders/ Local Representatives etc.)					
• Explain to families the importance, benefits and safety of vaccination. • Ensure that families know when their child needs to get the next dose(s) of vaccine. • Motivate families to complete each child's basic immunizations in the first year of life. • Inform families	• Lack of knowledge on the importance and larger impact of non-immunization on the community, • Lack of active participation in mobilisation activities • Have limited perspective on growth/ development i.e. in terms of infrastructure rather than health, education etc	• Timely information through govt. functionaries about the plans and various schemes for enhancing their involvement • Appreciation and acknowledgement from all stakeholders for active involvement	• Only full immunization protects children from six life threatening diseases : g) Polio h) Diphtheria i) Whooping cough j) Tetanus k) Measles l) Tuberculosis • All children are at equal risk of diseases; some are lucky, some are not. Do not take any chances. Immunize your child against all the six diseases • Full immunization of the child is the responsibility of every adult in the family, particularly the father • Every vaccine has different	• Advocacy meetings, sensitization workshops at village level with ensured participation • Support in organising MCHN days and other communication activities on RI in their village • Felicitation of active key influencers in the field of RI. • Be positive carriers and facilitators of messages on the importance of RI during various community events, meetings and other platforms.	• Increase in awareness about RI amongst the community members • Increase in the number of immunized children as well as in pregnant women

Desirable Behaviours	Barriers to Desired Behaviours	Motivations and Support	Communication Themes/ Content of messages	Communication activities/ channels	Health behaviour outcomes/ indicators
about special immunization days such as NIDs, sub-national immunization days (SNIDs) and mobile brigade visits and about the introduction of new vaccines or other improvements in the immunization service. • Help mobilize community support for immunization activities • Advocating for provision of adequate immunization services for their community			doses to protect the child • A child can become sick, physical handicapped or die if not fully vaccinated • Early dose of each vaccine is important for your child to be fully protected against six diseases • Ask your AWW and ASHA about the day, time and place of vaccination; confirm with your ASHA about the scheduled immunization day one day in advance • If your village does not have AWC/SC or the immunization session is not held in your village, go to the nearest village where immunization sessions are held and get your child immunised		

3.6 Communication Approaches

Approach 1 – Interpersonal Communication (IPC)

Activity description	Timely and correct awareness and motivational messages and reminder to the parents of 0-5 years children through home contacts, meetings and other means: 1. Home visit and counseling on MCHN days 2. Parent meetings at each session site of rural and urban/peri-urban slum areas (one meeting/ 1000 population/ monthly) 3. FGDs with care givers (use of IPC tools, mobile apps. etc.) 4. Recognition of children with completion of full immunization during village meetings and provision of FIC certificate by village level community leaders 5. Felicitation of RI promoters during meetings and block/ district level events. 6. At village level the Village Health and Sanitation Committee is the core agency to provide the support and its key members ANM, ASHA and AWW can play the Role of catalyst in IPC.
Target audiences	• Parents of 0-5 years children • Mothers in Law • Community influencers
Implementers	• Front Line health Workers (FLWs) ANM,ASHA,AWW, MPHW,LWs(urban areas) TBAs, • Health supervisors, MOs • VHSC members, • SHGs, • NGO representatives • Health & IEC consultant (if any)
Steps of implementation	• Sector level meetings cum orientation (one day) of ANMs, MPHWs, ASHAs, AWWs, and village level volunteers, SHGs, VHSC members, NGO representatives. • District/ ward level training cum orientation of link workers, volunteers, NGO representatives, TBAs(urban areas) • Preparation of planning calendar for home visits, FGDs and parent meetings (ASHAs and ANMs will be facilitating all village level meetings of her catchment area • Home visits ,parent meetings and FIC certification to be conducted as per guidelines
Communication channels/ tools to be developed	• Pictorial pamphlets (especially designed for audience with low literacy level for rural areas) for all beneficiaries for mass education • Pictorial folders for all village level community leaders,

	opinion leaders including traditional healers • MCHN promotional material • Flipbook to be used for counseling (to convey key benefits of each vaccine and to ally fear and myths) • Infotainment games • Mobile Applications with IPC software IEC material of some daily utility for the rural household to ensure reinforcement of key RI messages (e.g. Glasses, pouches, carry bags, religious posters with RI messages, umbrellas etc.)
Existing communication channels/ tools	• MCHN days, home visits by FLWs • FAQ on RI
Monitoring mechanism	• Number of monthly meetings conducted by FLWs reported to the supervisor • District and sub-district level supervisors and external monitors (if any) to monitor the quality of parents' meeting, home visits and verification of FIC certification as per the checklist. (Annexure: Table 10) • Monitoring forms from supervisors to be submitted at district on weekly basis for analysis which will be reviewed in DICCG meetings and district progress reports on activities to be submitted to state on monthly basis as per reporting format. (Annexure: Table 11) • Monitoring from external monitors to be submitted at state level on monthly basis for analysis which will be reviewed in SICCG • Monitoring to be focused on performance of FLWs, quality implementation of activities and proper use of IEC material

Approach 2 – Advocacy

Activity description	1. State, divisional and district level media advocacy workshop 2. State and District level meeting of elected representatives 3. Advocacy through dissemination (of best practices, factsheets, survey etc.) workshops with policy makers 4. Persistent persuasion meetings with media, elected representatives and policy makers 5. Utilization of existing Alliance for Immunization in India (AII) and similar platforms for strengthening advocacy efforts towards immunization
Target groups	• Media personnel • Elected representatives (MPs, MLAs, PRIs etc.) • Policy makers

Implementers	• State RI cell, State IEC bureau, division and district health managers/ administrators and CBOs/ NGOs/ FBOs/Development Partners
Steps of implementation	• State level media advocacy workshop to be followed by divisional and then district level media advocacy workshop with key media personnel • Divisional and district level workshops with elected representatives to orient and advocate for strengthening RI and orientation on RI program • Convergence meetings with elected representatives, administrative bodies (viz. CEO, Zila Parishad, Collectors, SDMs etc.)
Communication channels/ tools to be developed	• Pamphlets • Advocacy leaflets • Quarterly newsletter • Documentary film on RI (if required as per state perspective)
Monitoring mechanism	• All SICC and DICC members, CSO/ CBO/ FBO partners, involved in the advocacy activities at district and state level to report on activities as per format given in table 11

Approach 3 - Mid Media

Activity description	1. Posters, hoardings, banners and public transport panels 2. Wall paintings 3. District level exhibitions; stalls during local fares and festivals 4. Folk drama in media dark villages 5. Mobile SMSs for tracking and sending reminders as per due list. 6. Rallies 7. School activities – quiz competition/ essay writing/ poster competition/ booklet containing RI messages 8. Healthy baby shows
	9. Felicitation of dedicated service providers
Target groups	Common masses with focused activity in media dark villages
Implementers	State RI cell, state IEC bureau, division and district health managers/ administrators and development partners, opinion and community leaders, FLWs and beneficiaries
Steps of implementation	• Planning/ designing the content/ material for each activity • Training of folk troupes on issue based drama • CUG plan for bulk SMS service
Communication channels/ tools to	• Posters, hoardings, banners and public transport panels • Wall painting layouts

be developed	IEC material for Exhibitions and stalls Standard reminder message application for mobile phones Script for folk dramas Certificates of appreciation for good FLWs
Monitoring mechanism	In each district supervisors will monitor the activity as per the checklist (Table 12.) and should be captured in district reporting (Table : 11) to be discussed in DICCG and SICCG meetings

Approach 4 – Mass media

Activity description	1. Newspaper advertisement / commissioned article/ interviews/ articles in various journals/ newsletters 2. Television program (interview/ drama/ special program etc.) 3. Radio and TV spots 4. Special programs on All India radio/ FM radio/community radio (drama, interview live phone in/ narrow casting etc.) 5. Audio visual awareness campaigns in districts 6. Celebrity engagement for endorsing full immunization as mass media campaign
Target groups	Common masses
Implementers	State RI cell, State IEC bureau, division and district health mangers/ administrators and development partners, opinion and community leaders, FLWs and beneficiaries
Steps of implementation	• Designing and development of key messages, radio jingles, audiovisual materials (short films, TV spots, dramas etc.) for use in mass media campaigns. • Development of broadcast plans in print, radio and TV media.
	• Development of plans of public campaigns. District wise preparation of plan (route chart, details of accompanying supervisors and folk troups) and supervision plan by block and district officials • CMHO to be designated as a nodal person for overall implementation and monitoring for the success of planned activities • Inauguration of public events by elected representatives and other district/ block level opinion leaders/ officers

Communication channels	Television Radio Newspapers Public awareness campaigns
Monitoring mechanism	In each district supervisors will monitor the activity as per the checklist (Annexure: Table 12) and should be captured in district reporting (Annexure: Table 11) to be discussed in DICCG and SICCG meetings SICCG and DICC member will be involved in advocacy activities at district and state level

4. Implementation and Management

4.1 Coordination Committees at State and District Level – Roles and Responsibilities

As per the national strategy for Routine Immunization, the formation and constitution of Immunization Communication Coordination Groups (ICCG) at state and district levels has been recommended to ensure effective and efficient implementation, supportive supervision, monitoring and evaluation of RI SBCC strategy.

Thus, the SICCG and DICCG should be formed in Rajasthan at state and district level, respectively. They are detailed out as under:

State Immunization Communication group (SICCG): The following are proposed to be the members of the group -

Innovations proposed for SBCC –

- *Proposing organising of 2 days MCHN activity; first day preparation, announcement social mobilisation events and 2nd day for service provisioning*
- *Felicitation of best performing FLWs and RI promoters at higher platforms (in the presence of community members, key influencers, govt. stakeholders etc.) through rewards and certificates*
- *Certification to Fully Immunised Children with photograph of the child on each*
- *M-health: use of mobile phones to send reminders to caregivers & to track due list as well as for counselling*
- *Equipping ASHAs with PC tablets with counselling messages and videos*
- *Engagement of schools for promotion of RI within their community*
- *Involving 'Connecters or Link persons' in planning, promotion, advocacy and monitoring of RI interventions within their community. Link persons would be the key influencers who are well connected with their community and the community is well connected with them (Community leaders, religious leaders, PRI members, teachers, CBOs etc.)*
- *CSO alliances for tracking and follow-up of missing children for RI*

District Immunization Communication Coordinator Group (DICCG): The following are proposed to be the members of the group -

Chairman: Mission Director, NHM

1. Director Immunization
2. Director IEC Bureau
3. Joint Director, Immunization
4. Director/ Joint Director, WCD
5. Deputy Director, Immunization
6. Deputy Director, IEC bureau
7. Director, RCH
8. State cold chain officer
9. Health Officer- UNICEF
10. C4D specialist –UNICEF
11. State RI coordinator
12. State Program Manager
13. RCHO (1)
14. District Monitoring Evaluation and Information Officer (MEIO)
15. Consultant IEC (NHM & State IEC Bureau)
16. Representative from NIPI, Save the Children, Aravali etc.
17. Representative from IMA/ IAP

Chairman: District Coordinator

1. CEO –Zila Parishad
2. CMHO
3. RCHO
4. DPM
5. MEIO
6. District CCT/ CCH
7. DPO
8. DAC
9. BAF
10. PHC ASHA Coordinator
11. Block Extension Educator
12. BIOs
13. District ASHA Coordinator
14. SMO-WHO/NPSP
15. Health or BCC consultant (UNICEF or any partner)
16. District VHSC representative
17. Representation of NYKS/NSS/CSOs

Roles and Responsibilities -

1. Conduct advocacy for inter-sectoral support, partnerships and collaboration at state
2. Facilitate the development of the state and district communication plans
3. Develop and implement capacity building activities for SICCG and DICCG members
4. Provide support for capacity building of frontline workers at the district
5. Oversee implementation of the communication activities at the state and district level
6. Strengthen media relations at the state level through appropriate media advocacy
7. Conduct state level mass-media activities supporting communication strategy
8. Develop and brand immunization; provide branding and communication tools to DICCG
9. Support financially for monitoring evaluation, documentation and utilization of data collected from the district
10. Make policy decision for offering incentives for specific communication activities
11. Oversee the Adverse Events Following Immunization (AEFI) committee
12. Update the immunization focal person at the Ministry of Health and Family Welfare, Government of India, about progress in communication and seek support if needed

Roles and responsibilities

1. Map human resources available in the district for developing and implementing the communication plan
2. Identify reporting structure at different levels in district, create focal points, develop reporting processes, assign responsibilities and ensure accountability

3. Conduct situation analysis vis-à-vis district coverage
4. Develop the District Communication Action Plan (DAP)
5. Advocate to mobilize resources from state and from within districts
6. Develop and implement capacity building activities at district level
7. Develop district specific communication tools if necessary
8. Implement communication activities as per the DAP
9. Monitor, evaluate, document communication activities
10. Hold regular meetings to analyze progress and do mid-correction
11. Promote inter-sectoral partnerships and collaborations at the district level
12. Establish media relation at district
13. Oversee the District AEFI Committee
14. Update the ICCG focal person at the state about progress in communication

Initially, the ICCG must meet once every fortnight till the development of communication strategy, moving to monthly meetings

Initially, the DCCG must meet once every week till the development of communication strategy, moving to fortnightly meetings

For preparatory meetings, have power point presentations to discuss the following:

- The process of developing the communication plan
- Individual responsibilities and team responsibilities
- A plan to review progress of tasks
- Timelines for submission of individual and team tasks
- Implementation plans

- Monitoring and evaluation plans
- Documentation and dissemination

Proposed partnerships to Strengthen RI at State Level:

1. UNICEF
2. WHO- NPSP
3. NIPI
4. IAP/IMA
5. CSO State Alliance for RI- RVHA
6. NSS
7. NYKS
8. SHGs

4.2 Timeline for Strategy Implementation

The implementation plan is depicted in the form of Gantt Charts below, clearly showing the activities and their roll out time during the two years of strategy implementation.

Table 4: Gantt Chart for activities under the strategy (2014-15)

	Year 1				Year 2			
Broad Activities	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4
Creation of State and District ICCG								
Development of RI Communication Strategy for districts								
Budgeting in PIP for 2014 - 2015								
Planning of activities								
Implementation and Monitoring								
Interim (process) evaluation								
End line (Impact) Evaluation								

	Year 1				Year 2			
Detailed Activities	Q 1	Q 2	Q3	Q 4	Q 1	Q 2	Q 3	Q 4
Home visits/ counseling at MCHN days								
Parents' meetings								
FGDs with care givers								
Recognition of fully immunized children (for FIC certification) – once every quarter								
Felicitation of RI promoters								
State level media advocacy workshops								
Divisional level media advocacy workshops								
District level media advocacy workshops								
Sensitisation workshop with IAP/ IMA representatives								
Persuasion meetings with media, elected representatives and policy makers								
Rallies, campaigns, marches etc. (as per district need)								
Identification of local level partners (CBOs/ NGOs/Faith based organizations (FBOs) etc.)								
Building local level partnerships (CBOs/ NGOs/ Faith based organizations (FBOs) etc)								
Development of Posters, hoardings, banners and public transport panels designs								
Placement of Posters, hoardings, banners and public transport panels								
Wall paintings								
District level exhibitions; stalls during local fairs and festivals								
Folk dramas in media dark villages								
Mobile SMSs for tracking and sending reminders as per due list								
Rallies								
School activities – quiz competition/ essay writing/ poster competition/ booklet containing RI messages								
Healthy baby shows								
Felicitation of dedicated service providers								
Mass Media								
Newspaper advertisement								
Commissioned article/Articles in various journals								
Interviews/ talk shows with eminent functionaries in the field of RI								
Television program (Interview/ drama/ special program etc.)								
TV spots								
Radio Spots								
Special programs on All India radio/ FM radio/ Community radio								
Community radio (drama, interview live phone in/ narrow casting etc.)								
Audio visual awareness campaigns in districts								
Celebrity engagement for endorsing full immunization								

4.3 Implementation Plan

SBCC strategy for RI has been woven around four key approaches of communication. These are, as mentioned earlier, IPC, Advocacy, Mid-Media and Mass Media. A detailed description of activities along with message tools for each approach, is being depicted in the tables below.

Table 5: Plan for IPC activities

Activity	Description	Message Strategy/ tools
Home visits & counselling sessions at MCHN days	All homes to be covered through home visits prior to immunization session as per updated due list. Counselling sessions to be held with caregivers at MCHN sites	Importance of immunization / Immunization awareness messages(mother and child care) Revised immunization schedule
Parents meetings/ FGDs	Meetings/ FGDs to be organised at MCHN days, health facilities, public places within the community	Immunization awareness messages, role of immunization in keeping baby healthy
Recognition of Fully Immunised Children (FIC)	Full immunization certificate (with a photograph of the child) to fully immunised children in presence of local key influencers	Immunization awareness messages, role of immunization in keeping baby healthy
Felicitation of RI promoters	Recognition of best performing FLWs in presence of key influencers (people representatives, district authorities, community leaders)	Awareness messages Role of FLWs in immunization How to overcome obstacle/ challenges

Table 6: Plan for Advocacy activities

Activity	Description	Message Strategy/ tools
State/ Divisional/ District level media advocacy workshops	Media workshops to be organised ensuring participation of all leading media houses.	Publication of articles and media coverage Awareness message in media
Sensitization workshop with IMA/IAP	Support IAP/IMA members in conducting studies and research, and to advice on improving RI program implementation. Identify and prepare a list of IAP/IMA members in the district and create networks.	how IAP/IMA members can support the immunization program IAP/IMA members supporting during unfortunate AEFI. IAP/IMA members are supporting for Supportive Supervision
Persuasion meetings with media	Regular and consistent follow up with media houses	Regular coverage on immunization in media

Table 7: Plan for mid media activities		
Activity	**Description**	**Message Strategy/ tools**
Posters/ hoardings/banners/ public transport panels	• Posters (3) Poster 1 : for wider display at health facilities and MCHN days Poster 2 : for wider display at MCHN days and public places • Poster 3 : for wider display at health facilities and MCHN days • Hoardings (2) – to be displayed at key public places (market places, bus stand and railway station, schools etc.) • Public transport panels: to be displayed over buses, autos, rickshaws etc.	• All focusing on the importance of immunization messages • Poster 1: revised immunization schedule • Poster 2: child curve poster • Poster 3: Mother and child curve launched by GoI • Hoarding 1: Displaying key immunization messages (mother and child curve, child curve poster) • Public transport panel 3: mother, father and child curve posters
Wall paintings	At MCHN days, health facilities, public places within the community	Clear message and slogans
District level exhibitions	• Exhibition should include:- • Posters and banners • TV spots and video messages • Drama • Video van • Leaflets for beneficiaries • Gifts for children • Exhibition need to be systematically arranged at proper identified places with all basic facilities for the beneficiaries (lunch /refreshment can be arranged for the beneficiaries for whole day exhibition) Inauguration to be done by opinion leaders/ influential person	Immunization awareness messages Slogans Film on RI
Folk drama in media dark villages	• Shows to be conducted in electricity / media dark villages/ areas (priority to very remote hamlets) • FLWs should be present with prior information in order to collect right information	• Awareness messages • Myths & clarification • Role of husbands in immunization • Gender discrimination for getting immunized • Like narrow casting use of discussion/ interaction should be promoted
Rallies	• Route map to be prepared for the rallies with pre preparation of slogans,boards, key advocacy messages and gathering participants	• Slogans and key advocacy messages
School activities (quiz/ poster/ slogan competition)	• Activities to be conducted in the schools in HPD in the presence of FLWs	• Awareness messages • Myths & clarification • Role of students/children for SBCC on RI and other health issues in their community.
Healthy Baby Show	• Health baby shows to be conducted at village level , all interested babies will participate in show and health baby will be selected on the basis of fully immunised and nutrition	• Awareness messages • Myths & clarification

Table 8: Plan for mass media activities		
Activity	**Description**	**Message Strategy/ tools**
Newspaper advertisement/ commissioned article/ interviews/ articles in various journals / newsletters	• Advertisement: one per Quarter • Commissioned articles: two per year • Interviews (with positive deviance families/ beneficiaries, opinion leaders, program managers, key influencers): one per month Articles in journals/ newsletters: in IMA/IAP newsletters and various public health journals with wide distribution amongst private providers	• Advantages and importance of immunization for healthy baby • Role of husbands in child immunization Promoting taglines for RI FAQs on immunization • Immunization schedule • Success stories
Television program (interview, drama & special program etc.)	One per quarter	• TV program should aim t generating awareness about vaccine, their importance and clarifying myths and believes
Radio and TV spots	10 days per quarter	• Spots which are developed by GoI
Special program on all 31 AIR and FM Radio Stations (drama, interviews, live phone- in, narrow casting etc.)	In sync with other mass media plan, the radio may have weekly program for 6 months	• The message strategy will remain as per radio program plan
Public awareness campaigns	Mobile van to be used for wide coverage through different routes to spread awareness on immunization issues	• Audio visual aids on RI Display of immunization messages on and in van

5. Monitoring & Evaluation

Baseline Evaluation: Data from AHS 2010-11 and CES 2009 will be considered as baseline for RI

Interim (Process) Evaluation: To be done at the end of one year

End line (Impact) Evaluation: To be done at the end of Two years and available data source to be worked out as a reference for end-line evaluation.

5.1 Monitoring and Reporting Plan

Table 9: Monitoring and Evaluation Matrix

Indicators/ Objective	Sources of Information	Data Value	Progressive Data Value	Frequency of reporting
Program Objective: By 2015, at least 90% of children would be fully immunized in Rajasthan.				
Communication Objective: In the span of 2 years, % of mothers/ care givers of children 0-5 years in Rajasthan: A. Who is not aware about vaccines drops from 26.3% to < 10% B. Who don't feel the need of immunization drops from 28.2% to < 10%				
Outcome Indicators	**Sources of Information**	**Data Value**	**Progressive Data Value**	**Frequency of reporting**
% of children fully immunized	AHS, DLHS, NFHS			End line evaluation
% reduction in BCG-DPT3 dropout rate	CES, Survey			End line evaluation
Output Indicators				
% beneficiaries who are aware about immunization	CES, Survey			End line evaluation
% beneficiaries who feel need for immunization	CES, Survey			End line evaluation
Process Indicators				
% of Parents' meetings conducted as per plan	State Reports			Quarterly
% of children certified with FIC certificate	State Reports			Quarterly
% of elected	State Reports			Quarterly

representatives participated in district meetings				
% of MCHN days and sessions where banner is displayed	State Reports			Quarterly
% of villages/ urban areas where wall paintings (with RI messages) done	State Reports			Quarterly
% of districts where exhibitions for RI put up	State Reports			Quarterly
% of villages where folk drama done as per plan	State Reports			Quarterly
% of villages/ urban areas where rallies conducted	State Reports			Quarterly
% of SICCG meetings conducted as per plan	State Reports			Quarterly
% of DICCG meetings conducted as per plan	State Reports			Quarterly
% of Dissemination meetings/ workshops conducted	State Reports			Quarterly
Number of CBOs/ NGOs/ FBOs partnered with at the state level	State Reports			Quarterly
Number of CBOs/ NGOs/ FBOs partnered with at the district level	State Reports			Quarterly
% of parents/ care givers reached through Mobile SMS service	State Reports			Quarterly
Number of FLWs felicitated for good work	State Reports			Quarterly
Number of Health Baby Shows organised	State Reports			Quarterly

% of schools involved in RI campaign	State Reports			Quarterly
% of activities conducted in schools	State Reports			Quarterly
% Advertisements placed in newspapers as per plan	State Reports			Quarterly
% TV programs broadcast as per plan	State Reports			Quarterly
% of Radio/ TV spots broadcast as per plan	State Reports			Quarterly
% of special programs relayed on AIR, Community Radio as per plan	State Reports			Quarterly
% of villages where public awareness campaigns conducted	State Reports			Quarterly

5.2 Monitoring and Reporting formats and checklists

Monitoring is used to measure if a communication intervention is progressing as planned, and to make changes if necessary. Evaluation is done to measure the expected outcomes (impacts) from an intervention. Indicators are evidence-based signals that help to measure the progress or achievement of a certain objective/activity.

There are three types of indicators:

- Process indicators: the processes to be followed to communicate the desired messages.
- Output indicators: the indicators in communication activities (such as IEC tools, mass-media products, etc.), to get the desired outputs.
- Outcome indicators: As a result of the efforts – process

followed and outputs used – the outcomes (impacts) expected (action on the part of the audience) achieved.

To record the progress of the intervention in an organised manner reporting formats have been developed (see **Annexure: Table 11**). Further to track the performance, a performance tracking tool (Monitoring Checklist) has been also developed (see **Annexure: Table 12**)

5.3 Documentation and Dissemination

Evidences from implementation of district and block plans in 10 HPDs for accelerated coverage of RI will have to be gathered by the State IEC bureau with support from coordinating development partners for lessons learnt on what has worked or not worked in the planned outcomes, pilots and demonstration of innovations for inputting back into the system for future programme sustainability. Based on the monitoring and evaluation framework and other real time as well as survey data sources, the evidence based analysis needs to be prepared for documenting outputs and outcomes of the implemented strategy. Purpose, methodology, activities, summary of processes, outputs, outcomes and the way forward or recommendations need to be captured in documentation.

Dissemination can be done in the following ways:

- Dissemination workshops for key stakeholders
- Through media workshops
- Sharing with visitors
- Putting up on website and in other publications
- Through mailing lists
- In meetings
- Flyers made available at strategic places
- Distribution at similar conferences
- Using email bulletins, etc.

6. Annexures

Annexure 6.1

Examples of campaign IEC material

Prototypes of the IEC material for JE, Measles 2nd catch-up, Polio, Immunization Weeks campaigns are available with the Immunization division, MoHFW. These prototypes have been widely circulated in all states. On demand, copies can be provided.

JE Campaign IEC




Measles Catch-up Campaign IEC


Polio



Immunization Weeks

Pentavalent Vaccine : Guide for Health Workers

(Produced by - Unicef for Immunization Division, MoHFW, GoI)

Immunization is one of the most well-known and effective methods of preventing childhood diseases. With the implementation of the Universal Immunization Programme (UIP) by the Government of India, significant achievements have been made in preventing and controlling vaccine-preventable diseases (VPDs). Introduction of pentavalent vaccine will further reduce the incidence of pneumonia and meningitis caused by *Haemophilus influenza* type b (Hib) bacteria.

This guide contains two parts: Part 1 focuses on key operational aspects on pentavalent vaccine; Part 2 gives answers to frequently asked questions on pentavalent vaccine. Key messages are listed on the back cover.

Part 1

The Government of India has decided to introduce pentavalent vaccine in the national immunization programme in selected states. Pentavalent vaccine provides protection to a child from 5 life-threatening diseases – Diphtheria, Pertussis, Tetanus, Hepatitis B and Hib. DPT (Diptheria +Pertussis + Tetanus) and Hep B are already part of routine immunization in India; Hib vaccine is a new addition. Together, the combination is called Pentavalent. Hib vaccine can prevent serious diseases caused by Haemophilus influenzae type b like pneumonia, meningitis, bacteremia, epiglottitis, septic arthritis etc. Giving pentavalent vaccine reduces the number of pricks to a child, and provides protection from all five diseases.

Important things to remember:

The pentavalent vaccine will replace the current Hepatitis B

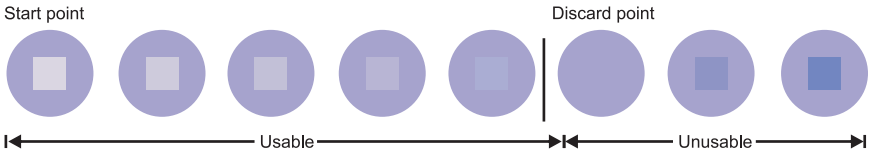
and DPT primary vaccination schedule in the immunization programme. Additionally, Hepatitis B birth dose will continue as before, in institutional birth within 24 hours of birth. Pentavalent Vaccine Guide for Health Workers with Answers to Frequently Asked Questions

DPT boosters at 16-24 months and 5-6 years will continue as before. The following is the revised immunization schedule:

Vaccine	Schedule
BCG, Hep B birth dose, OPV-O	At Birth
Pentavalent (DPT + Hep B + Hib), OPV	6 weeks, 10 weeks and 14 weeks
Measles and Vitamin A	9-12 months
DPT booster, OPV booster, Measles2*	16-24 months
DPT booster	5-6 years

*Measles2- 2nd dose or MMR (in a few selected states)

In UIP, pentavalent vaccine comes in a liquid form in a vial which contains 10 doses. Each dose is 0.5 ml to be given by intra muscular injection in anterolateral aspect of the mid-thigh using AD syringes. Discard injection waste as per guideline for immunization waste management. Pentavalent vaccine is a freeze sensitive vaccine, and should be stored and transported at +2 to +8 degree celsius in ice lined refrigerators and vaccine carriers with conditioned ice packs. Discard if vaccine is frozen or VVM reaches discard point.



Usable VVM – the color of the square is lighter than the circle.
Unusable VVM – the color of the square matches or is darker than the circle.

Advocacy and social mobilization is to be done to increase awareness and to generate demand. Cases of AEFI (minor or

major) will be reported as per existing Government of India AEFI reporting guidelines.

Part 2

FAQs (Frequently Asked Questions) on entavalent vaccine

What is Hib? What diseases does it cause?

Hib is the abbreviation for Haemophilus influenzae type b, a bacterium that causes severe infections, as listed below:

- Bacterial meningitis – inflammation of the membranes that cover and protect the spinal cord and brain. It is a serious infection.
- Pneumonia – inflammation of the lungs.
- Septicaemia – presence of pathogenic bacteria in the blood.
- Septic arthritis – inflammation of the joints.
- Epiglottitis – inflammation of the area around the vocal cords and obstruction of the airway.

Hib disease is not the same as hepatitis B (Hep B), which is a viral disease that affects the liver.

Why is Hib disease a public health problem?

Hib disease is a public health problem because it causes serious diseases that can result in hospitalization or death, including pneumonia (one of the major causes of death in children) and meningitis.

How does the Hib infection spread?

Hib bacteria are passed from child to child through droplets of saliva expelled when an infected child coughs or sneezes. Hib also spreads among children when they share toys and other things that they have put in their mouths.

Who can get Hib infections? Who is most at risk?

Hib mostly affects children under five years of age; children

between four months and 18 months of age are most at risk. By age of five years, most children have developed antibodies against the disease, hence serious diseases from Hib are uncommon in older children and adults.

Do antibiotics work against Hib infections?

Antibiotics are used for treatment of Hib disease, but they are not always effective. Even with antibiotics and the best medical care, 3% to 5% of meningitis patients die. Some strains of Hib are now resistant to antibiotics, making treatment even more difficult.

How can Hib infections be prevented?

Most Hib infections can only be prevented by Hib vaccine. A small proportion of cases can be averted by giving antibiotics to members of households where children have been infected, but at best, this amounts to only 1% to 2% of cases.

What are the limitations of Hib vaccine?

Hib vaccine protects only against diseases caused by the Hib bacterium. After Hib immunization, a child may still get pneumonia, meningitis, or flu caused by other bacteria and viruses.

Who should be immunized with Hib vaccine?

Generally, all children aged up to 1 year (after 6 weeks and less than 1 year) should receive Hib vaccine as part of routine immunization.

How many doses are needed? When should they be given?

Three doses are given. The first dose is given as pentavalent vaccine only after a child is 6 weeks old. The second and third doses are given at 10 and 14 weeks of age respectively also in the form of pentavalent vaccines. There is no booster dose recommended under UIP.

Why is Hib given as a pentavalent vaccine and not separately?

The schedule for DPT, Hep B and Hib is the same at 6, 10 and 14 weeks. Therefore, if these three vaccines are given separately, a child gets three pricks at the same time. Giving a pentavalent vaccine will reduce the number of pricks.Pentavalent Vaccine Guide for Health Workers with Answers to Frequently Asked Questions 6

A child who is 10 months old has not received any immunization. What are the vaccines that can be given to her?

The child should receive BCG, measles, and first dose of pentavalent vaccines with OPV drops, and Vitamin A syrup.

Till what age can pentavalent vaccine be administered?

Pentavalent vaccine can be given to any child aged more than 6 weeks and up to 1 year of age.

If a child comes unimmunized at completing 12 months of age, what vaccines would you give?

Give three doses of DPT and OPV at intervals of four weeks and a booster dose of DPT after six months. Also give measles vaccine and Vitamin A solution with the first dose of DPT.

What are the side effects of pentavalent vaccine?

Pentavalent vaccine has not been associated with any serious side effects. However, redness, swelling, and pain may occur at the limb site where the injection was given. These symptoms usually appear the day after the injection has been given and last from one to three days. Less commonly, children may develop fever for a short time after immunization.

Is there any reason why a child should not be given pentavalent vaccine?

Although serious side effects have not been reported, a child

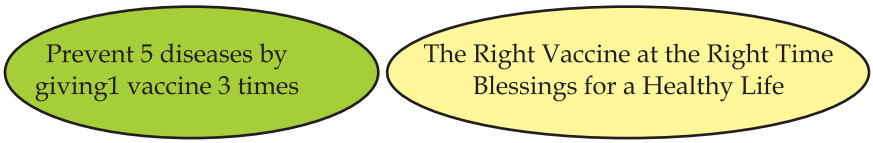
who has had a severe reaction to pentavalent vaccine earlier should not be given another dose.

What types of pentavalent vaccine are available?

The pentavalent vaccine is available in various forms of liquid and lyophilised. However, under the UIP in India, the vaccine will be available as a liquid formulation only.

Is it necessary to monitor pentavalent vaccine use, wastage, and immunization coverage? What records need to be kept?

Monitoring use, wastage, and coverage of pentavalent vaccine provides information about how effectively immunization targets have been met. Records also indicate how efficiently the pentavalent vaccine is being used. Therefore, all records need to be maintained as is done for any other UIP vaccine.



Key facts about Hib

1. Globally, Hib kills more than 370,000 children under five every year. Nearly 20% of these children die in India.
2. Hib disease survivors are often permanently paralysed, become deaf or get brain damaged.
3. Hib vaccine can prevent over a third of pneumonia cases and 90% of Hib meningitis cases.
4. The pentavalent vaccine protects against five potential killers – Diptheria, Tetanus, Pertusis, Hib, and Hepatitis B.
5. Giving a pentavalent vaccine will reduce the number of pricks to child.

IEC for Pentavalent Vaccine:

Poster

FAQ Booklet

How to Reconstitute and Administer Lyophilized DTP + Hib + Hepatitis B (Pentavalent) Vaccine

IMPORTANT FACTS TO CONSIDER

Lyophilized Hib + DTP + Hepatitis B vaccine comes in two separate vials:
- One vial contains liquid DTP + Hepatitis B vaccine (used as a diluent)
- The second vial contains a lyophilized (freeze-dried) Hib vaccine

- Only use the DPT-Hep B vaccine supplied with the lyophilized Hib vaccine
- Never use water or any other diluent to reconstitute the pentavalent vaccine
- Remember that the diluent IS the DTP-Hep B component of the vaccine

RECONSTITUTING

- Make sure you have both vials and 2 ml mixing (reconstitution) syringes
- Check the expiry date of the DTP + hepatitis B vaccine:
  - Discard vaccine that is too old or has been exposed to too much heat
- Use the shake test to determine if the DTP + hepatitis B vaccine has been frozen:
  - Do not use DTP + hepatitis B vaccine that has been frozen, or that you suspect has been frozen.
- Using the mixing syringe, draw up all of the DTP + hepatitis B vaccine (used as diluent). Inject it into the vial containing the lyophilized Hib vaccine.
- Remove the mixing syringe from the vaccine vial and shake the vial, or roll it between your palms, until the powder is fully dissolved and there are no visible particles in the vial

IMPORTANT: Discard any reconstituted Pentavalent vaccine after six hours, or at the end of each session, whichever comes first

ADMINISTERING

- Use a 0.5 ml syringe and needle (disposable or auto-disable), the same type of syringe and needle as are routinely used for DTP injections
- Draw 0.5 ml of reconstituted (mixed) vaccine into the injection syringe
- Administer as an intramuscular injection (IM) in the infant's outer mid-thigh*:

* NEVER give intramuscular injections in the buttock of infants as there is risk of damaging nerves in that area. Also, it will result in a reduction in immunogenicity, especially for the Hep B component of the vaccine.

NOTE: A sterile syringe and needle must be used for each injection and discarded in a safety box. The syringe and needle used for reconstitution should not be used for giving the injection

REMEMBER THE FOLLOWING PRECAUTIONS

To facilitate the adequate reconstitution of the pentavalent vaccine, always:
- Log the vaccines AND diluents in the stock inventory books
- Avoid keeping the lyophilized Hib vaccine and the DTP-Hep B vaccine (used as diluent) separated

During supervisory visits, supervisors must ensure the proper reconstitution and administration of the pentavalent vaccine by:
- Observing the reconstitution and injection process
- Ensuring the availability of the same number of lyophilized Hib and DTP-Hep B vials

ource: PATH (*Program for Appropriate Technology in Health*). Immunizing children against *Haemophilus influenzae* type b (Hib). A training module for vaccinators. Available t http://www.childrenvaccine.org/html/ip_clinical.htm#training

Table 10: House to House monitoring checklist										
House No.										
Name of beneficiary (Mother /Father)										
Whether beneficiary is aware about immunization	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial
Feels the need and importance of immunization	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial
Able to name diseases prevented by vaccine	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial
Able to name all the vaccine	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial
Able to tell immunization schedule	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial	Y/N/ partial
Able to tell immunization sites	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Able to tell immunization timings at session sites	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Able to name or knows the ASHA workers/link workers in the village/ urban semi urban areas	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Able to name or know the ANM/ vaccinator in the concerned village	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Participated/ watched events/ activities (parent meetings / folk drama/ awareness campaigns)	Y/N/ Don't Know	Y/N/ Don't Know	Y/N/ Don't Know	Y/N/ Don't Know	Y/N/ Don't Know	Y/N/ Don't Know	Y/N/ Don't Know	Y/N/ Don't Know	Y/N/ Don't Know	Y/N/ Don't Know
Source of information (mention numbers- multiple answers) 1. Home visits 2. Parents meetings 3. Folk drama 4. Newspaper 5. TV advertisement 6. Banner 7. Poster 8. Hoardings 9. Exhibitions 10. Rallies 11. Awareness campaign 12. TV or radio spots 13. Radio program 14. TV program 15. Wall paintings 16. Other (specify)										

Table 11: Reporting format (for block, district and division levels)				
S.N.	**Type of Activity**	**Process Indicator**	**Progress for current quarter**	**Cumulative progress till date**
1.IPC Activity				
1.1	Home visits/ counseling at MCHN days	Total no. of beneficiaries counseled through home visits Total no. of beneficiaries counseled at MCHN days Total no. of visits accompanied by supervisors		
1.2	Parent meetings	Total no. of parents meetings conducted Total no. of beneficiaries attended the meetings Total no. of meetings supervised by sector supervisors		
1.3	FGDs with care givers	Total no. FGDs conducted Total no. of beneficiaries participated in FGDs		
1.4	Recognition of fully immunized children (FIC certification)	Total No. of children provided FIC after proper verification by supervisors (sector, block and district level)		
1.5	Felicitation of RI promoters	Total no. of RI promoters felicitated		
2. Advocacy				
2.1	State level media advocacy workshop	Total no. of media houses and media personnel participated Total no. of print and digital media capturing the RI advocacy messages		
2.2	Divisional level media advocacy workshops			
2.3	district level media advocacy workshops			
2.4	Persuasion meetings with media, elected representatives and policy makers	No. of persuasion meetings held		
2.5	Rallies, campaigns, marches etc	No. of rallies, campaigns conducted No. of issues resolved after conducting rallies, campaigns		
2.6	Identification of local level partners (CBOs/ NGOs/ Faith based organizations (FBOs) etc)	No .of local partners identifies (district level, block level, village level)		
2.7	Building local level partnerships (CBOs/ NGOs/ Faith based organizations (FBOs) etc)	No. of CBOs/ NGOs/ FBOs involved in Monitoring of RI activities/ progress		
3.Mid Media				
3.1	Placement of Posters, hoardings, banners and public transport panels	No. of Posters, hoardings, banners and public transport panels containing immunization messages are placed No. of districts/ blocks placed Posters, hoardings, banners and public transport panels		

3.2	Wall paintings	No. of wall paintings done No of districts/ blocks/villages where wall paintings are done		
3.3	District level exhibitions; stalls during local fairs and festivals	No ,of district level exhibition done No. of stalls placed during local fairs and festivals Total no. of care givers visited exhibition Total no. of care givers visited stalls		
3.4	Folk dramas in media dark villages	Total no. of folk drama conducted for immunization Total no. of villages where folk dramas conducted		
3.5	Mobile SMSs for tracking and sending reminders as per due list	Total no. of parents received reminders for due immunization Total no. of service providers keeping track of immunization coverage		
3.6	Rallies	Total no. of rallies conducted for immunization Total no. of villages where rallies conducted for immunization		
3.7	School activities – quiz competition/ essay writing/ poster competition/ booklet containing RI messages	No .of school activities done No of schools where communication activities held No. of villages where communication activities held in schools		
3.8	Healthy baby shows	No. of healthy baby shows done No of villages where healthy baby show held No. of babies/ parents participated in healthy baby show		
3.9	Felicitation of dedicated service providers	No .of felicitation events conducted No. of service providers participated in felicitation event No of service providers		
		received felicitation No of villages / urban areas from where service providers received felicitation		
4.Mass Media				
4.1	Newspaper advertisement	No. of advertisement placed on RI		
4.2	Commissioned article	Total no. of commissioned articles published		
4.3	Interviews	No. of interviews held No. of interviews broadcasted		
4.4	Articles in various journals	No. of articles published in journals No. of journals captured RI		

4.5	Television program (Interview/ drama/ special program etc.)	No. of TV programs broadcasted on RI No. of TV channels which did broadcasting		
4.6	TV spots	No. of TV spots broadcasted on RI No. of TV channels which did broadcasting		
4.7	Radio Spots	No. of radio spots aired on RI		
4.8	Special programs on All India radio/ FM radio	No. of special programs broadcasted on radio		
4.9	Community radio (drama, interview live phone in/ narrow casting etc.)	Establishment of community radio Programs aired on community radio		
4.10	Audio visual awareness campaigns in districts	No of awareness campaigns done No. of villages covered through campaigns		
4.11	Celebrity engagement for endorsing full immunization	Celebrity endorsing full immunization		

Annexure 6.5

Table 12: Monitoring Checklist					
Activity	**Process/ Action for Supervisor/ Monitor**	**Components to be monitored**	**Findings/ Observations**	**Corrective Actions taken**	**Corrective Actions to be taken**
Inter Personal Communication					
Home visits and counseling at MCHN Days	Visit along with social mobilisers to observe process of communicatio	The messages were clear			
		The messages were in local language			
		Messages on RI awareness were given			
		Listening skill of workers			

Table 12: Monitoring Checklist					
Activity	**Process/ Action for Supervisor/ Monitor**	**Components to be monitored**	**Findings/ Observations**	**Corrective Actions taken**	**Corrective Actions to be taken**
	n of mobiliser	Discussion took place in comfortable environment			
		Understanding of the parents were ensured by the mobiliser			
Parents meeting at each session site of rural and urban/ peri-urban slum areas	Observe processes at meeting	Whether banner was displayed at meeting site			
		Home visits conducted the previous day for inviting for meeting			
		Whether key opinion leaders, community leaders, PRI members were present.			
		Whether ASHA present in the meeting			
		Whether ANM present in the meeting			
		No. of beneficiaries participated in the meeting			
		Whether meeting was participatory			
		Whether children were given gifts			
FGDs with care givers (use of IPC tools, mobile apps. etc.)	Observe process at FGD meetings	Whether ASHA and ANM present for the FGD session			
		No. of beneficiaries attending the FGD session			
		Discussion took place in comfortable environment			
		Understanding of the care givers was ensured by the mobilisers			
Recognition of children with completion of FIC during village meetings and provision of FIC certificate by village level community leaders	Observe processes at parents' meeting for FIC	Whether eligible children were given FIC			
		Total no. of children certified (write down figure) (check for accuracy in immunization card/ register/ history)			
		Mention whether ASHA received incentives no. of FIC children (write down figure)			
Mid Media					
Wall Paintings	Observe in the villages	Whether wall painting done in the concerned village			
		No. of wall paintings			

Table 12: Monitoring Checklist					
Activity	**Process/ Action for Supervisor/ Monitor**	**Components to be monitored**	**Findings/ Observations**	**Corrective Actions taken**	**Corrective Actions to be taken**
		observed			
		Write down the content of wall paintings			
	Ask beneficiaries (interview)	Total no. of beneficiaries read and understood wall paintings v/s total beneficiaries interviewed			
Posters, Banners and Hoardings	Visit to MCHN day sites	Whether banners on MCHN days displayed properly			
		Whether RI posters found at MCHN Days			
		Whether RI hoardings found in public places			
Folk drama in Media Dark villages	Visit along with folk troupes	Folk troupes conducted drama as per the agreed script with clear message delivery			
		No. Of villagers participated to see folk drama			
District level exhibitions; stalls during local fares and festivals	Visit during exhibitions	IEC material, banners, posters, and other mid media tools displayed nicely at the site.			
		Stalls to have interactive sessions along with take away IEC materials for visitors			
		Audio visual/ infotainment tools are run for visitors to see and are appropriately used.			
Mobile SMSs for tracking and sending reminders as per due list.	Ask beneficiaries (interview)	Total no. of beneficiaries received SMSs v/s total no. Of beneficiaries interviewed			
		No. Of beneficiaries who turned up on due date for immunization due to receiving the SMS v/s total no. Of beneficiaries interviewed			
	Check the mobile application of ASHA for latest update on due list and new beneficiaries	No. of ASHA with updated due list and added beneficiaries as per due list and list of beneficiaries available at AWC.			
Felicitation of dedicated service	Organise felicitation events or	No. of key participants who attended the felicitation event (PRIs, NGO/ CBO			

Table 12: Monitoring Checklist					
Activity	**Process/ Action for Supervisor/ Monitor**	**Components to be monitored**	**Findings/ Observations**	**Corrective Actions taken**	**Corrective Actions to be taken**
providers	utilise existing platforms for felicitation of service providers	reps, care givers, govt. Functionaries etc.)			
		No. Of service providers felicitated			
Rallies	Attend the rallies organised	No. of rallies organised			
		No. of participants attended the rally			
		No. of villages/ urban areas where rallies conducted			
		Whether key RI messages were conveyed during such rallies			
School activities – quiz competition/ essay writing/ poster competition/ booklet containing RI messages	Visit to schools during planned activities	No. of activities organised in schools for promoting RI			
		No. of schools covered for promoting RI through planned activities			
	Interviews with school authorities as well as students	No. of villages/ urban areas covered			
		Understanding of messages on RI and further communicated within peer groups and family.			
Healthy baby shows	Visit to the shows organised	No. of beneficiaries/ care givers attending the 'healthy baby show' v/s the eligible beneficiaries as per AWC list.			
		No. of children participated in the show (as per criteria) v/s those eligible under the AWC			
		No. of children who received gifts as part of the show.			
		No. of service providers/ FLWs present during the show			
		No. of villages where health baby shows organised			

Developed and Printed by :

State Institute of Health and Family Welfare (SIHFW), Rajasthan

Jhalana Institutional Area, South of Doordarshan Kendra, Jaipur (Raj.)

Phone : 0141-2706496, 2701938, Fax : 2706534

E-mail : sihfwraj@ymail.com

Website : www.sihfwrajasthan.com