INCEPTION REPORT

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Developing Social Behavioural Change Communication (SBCC) strategy for Meghalaya Health Systems Strengthening Project (MHSSP) Dept. of Health & Family Welfare, Govt. of Meghalaya

Submitted by:

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Submitted to:

Meghalaya Health Systems Strengthening Project
Department of Health and Family Welfare Meghalaya

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MEGHALAYA HEALTH SYSTEMS STRENGTHENING PROJECT

SACH
Society For Action In Community Health

List of contents

List of Abbreviations

Abbreviations	Full Form
ANC	Antenatal Care
CBOs	Community-Based Organizations
CEB	Child ever born
CHC	Community Health Centre
CNNS	Comprehensive National Nutrition Survey
COM-B	Capability (C), Opportunity (O), and Motivation (M)- Behaviour
D2C	Direct to Consumer
DoHFW	Department of Health and Family Welfare
FGD	Focus Group Discussions
FHI 360	Family Health International 360
GFR	Gross Fertility Rate
HRH	Human Resources for Health
ICDS	Integrated Child Development Services
IDI	In-depth interview
IEC	Information, Education, and Communication
INR	Indian Rupee
KAP	Knowledge, Attitude, and Practice
KPIs	Key Performance Indicators
MHSSP	Meghalaya Health Systems Strengthening Project
MICYN	Maternal, Infant and Young Child Nutrition
NCDs	Non-Communicable Diseases
NFHS-5	National Family Health Survey 5
NGO	Non-Governmental Organization
NHM	National Health Mission

List of Abbreviations

Abbreviations	Full Form
OOPE	Out-Of-Pocket Expenditure
PMU	Project Management Unit
ROSA	Regional Office for South Asia
SBCC	Social and Behaviour Change Communication
SACH	Society for Action in Community Health
SWOT	Strengths, Weaknesses, Opportunities, and Threats
SCEP	State Capability Enhancement Project
TOR	Terms of Reference
TB	Tuberculosis
UNICEF	United Nations International Children's Emergency Fund
VAD	Vitamin A Deficiency
VSM	Values Survey Module
WB	World Bank
WHO	World Health Organization

Glossary | Terminologies Explained

Cultural Competence	Strategy, materials and Interventions to be informed (and designed) by social and cultural norms and practices. Use of local folklore, deep entrenched mythologies and its interpretations and traditional belief systems.
Linguistically Apt	Interventions and material to be designed in local languages and dialects
Indigenous Design	Design of the overarching strategy, interventions and activities to be integrated with cultural and traditional practices, belief systems and social rituals of the tribal eco-system.
Social Symbolism	Intervention design and visual imagery of materials to be informed by social and familiar symbols and tribal rituals
Cultural Ecology of Diseases	To lay out the socio-cultural sources of health behavioural patterns towards the health topics of the targeted populations
Classic Intervention Continuum	Interventions for health topics that are a direct result of information asymmetry and require a knowledge provision only
Intensive Intensive Continuum	Intervention of health topics that require sustained periods of engagement, go beyond knowledge and information provision and are linked with deep social context and identity based issues.
Cognitive Style	Cognitive style, or thinking style, is a concept that describes how people process information, think, perceive, and remember. It's based on the idea that people have habitual ways of approaching situations and tasks
Neuro-Cultural Design	Cultural neuroscience is a field of research that focuses on the interrelation between a human's cultural environment and neurobiological systems. Materials, Interventions and engagement to be designed and informed through this new lens and insights.
User Centric Design	User-centered design (UCD) is a design philosophy and process that focuses on the needs of the user throughout the design process. So all interventions , materials and strategies to have this approach at the centre.

Additional Glossary l Terminology Explained.

Lifecycle Approach of Behaviour Change	Behaviour Change is a sustained process of various micro and macro interventions over a period of time- shifting the choice architecture of the targeted population towards a positive behaviour. Life Cycle approach means 360 degree methodology with materials, interventions, activities and engagement products to improve the health outcome
Habit Formation Design	Habit Formation is a process by which a behaviour becomes 'automatic' or a reflex. Recommendations for interventions will have a mix of materials, activities and other engagement products for positive health behaviour to become 'automatic' and an obvious choice.
Hyperlocal Approach	A region and district wise and more granular and targeted approach interventions for different social behaviours exhibited towards certain health topics in Meghalaya.
Participatory Design Mechanisms	To create recommendations which are embed within community for better adoption of interventions
Movement Like Model	To create a sustained list of activities and interventions that creates 'activism' around positive health behaviours. For instance- leveraging and creating incentivisation mechanism for local trusted local networks to become health influencers and ambassadors for positive health behaviour etc

1. Introduction

1.1. Background and context of the project

Meghalaya, located in the northeastern region of India, stands out for its predominantly rural population and its distinct tribal identity. Formed in 1972, the state was carved out of the United Khasi Hills, Jaintia Hills, and Garo Hills districts of Assam. Despite significant progress in health outcomes, Meghalaya's performance compared to the national average remains mixed, with notable rural-urban and inter regional disparities. While the state has seen improvements over time, it continues to grapple with legacy health issues and an increasing burden of non-communicable diseases (NCDs). Meghalaya ranks second in India for cancer prevalence among men, with 227.9 cases per 100,000 population, and 11th among women, with 118.6 cases per 100,000[1]. In recent years, immunization rates in Meghalaya have risen from 57% to 91%, and institutional deliveries have increased from 46% to 64%[2]. However, significant challenges remain in enhancing maternal and infant health coverage, particularly in rural areas.

Additionally, the state suffers from an acute shortage of healthcare professionals, with a doctor-to-patient ratio of 1:5000 and a nurse-to-patient ratio of 1:1700[3]. Meghalaya has the lowest rate of health workers in India, with just 2.5 health workers per 10,000 residents. This shortage is exacerbated by the state's geographical constraints, necessitating a better healthcare coverage ratio for effective service delivery.

Communication barriers further complicate health service delivery in Meghalaya, stemming from the state's diverse local languages, customs, and reliance on traditional and divine healers in indigenous health systems. Low health-seeking behaviour, coupled with low demand for services, highlights the need for strengthening healthcare institutions that are often understaffed. Despite allocating 7.4% of its fiscal year 2019-2020 budget to health, significantly higher than the national average of 3.9%, Meghalaya's healthcare system remains under pressure.

[1] *Our Reporter. (2022, February 5). Cancer cases on the rise in Meghalaya, shows data. The Shillong Times. https://theshillongtimes.com/2022/02/05/cancer-cases-on-the-rise-in-meghalaya-shows-data/*

[2] *Times of India. (2023, March 26). Rise in immunisation, institutional deliveries in Meghalaya, says data. The Times of India. https://timesofindia.indiatimes.com/city/shillong/rise-in-immunisation-institutional-deliveries-in-meghalaya-says-data/articleshow/99003407.cms*

[3] *The Shillong Times. (2021, October 13). Meghalaya struggles with doctor and nurse shortages. The Shillong Times. https://theshillongtimes.com/2021/10/13/meghalaya-struggles-with-doctor-and-nurse-shortages/*

The population relies heavily on government health services, but out-of-pocket spending continues to burden the poor. In 2017, the average out-of-pocket expenditure (OOPE) for hospitalization in a public hospital was INR 2,385, compared to INR 27,375 in private hospitals[4]. Rural-urban differences are stark, with OOPE in rural areas at INR 3,190 and INR 3,353 in urban public health facilities[5]. Meghalaya's healthcare system is affected by the "5A" issues: Availability, Accessibility, Affordability, Awareness, and Accountability (responsiveness). The low health-seeking behaviour is partly due to information asymmetry, highlighting the need for demand-side interventions.

Given these challenges, the Government of Meghalaya is committed to improving the health status of its citizens. To accelerate the progress, the Department of Health and Family Welfare (DoHFW), Government of Meghalaya with technical and financial support from the World Bank, is implementing 'Meghalaya Health Systems Strengthening Project' (MHSSP) in the state. The MHSSP intends to develop a well-designed Social Behaviour Change Communication (SBCC) strategy for addressing gaps in health awareness, promoting positive health behaviour, and strengthening the state's health system, particularly in its most vulnerable and hard-to-reach communities.

SBCC - Social and Behaviour Change Communication uses communication and engagement strategies that are based on behaviour science to positively influence knowledge, attitudes, and social norms among individuals, institutions and communities. SBCC proved to be an effective strategy for sustained behaviour changes.

[4] *World Bank. (2021, January 19). Project Information Document: Meghalaya Health Systems Strengthening Project (P173589). The World Bank Group. https://documents1.worldbank.org/curated/en/181211613721714068/Project-Information-Document-Meghalaya-Health-Systems-Strengthening-Project-P173589.docx*

[5] *World Bank. (2021, January 19). Project Information Document: Meghalaya Health Systems Strengthening Project (P173589). The World Bank Group. https://documents1.worldbank.org/curated/en/181211613721714068/Project-Information-Document-Meghalaya-Health-Systems-Strengthening-Project-P173589.docx*

2. Objectives of the Proposed Study

2.1. Primary objectives

- To Develop a comprehensive SBCC strategy
- To re-design or adapt the existing architecture and strategies
- Support the implementation of communication strategy in selected locations

2.2. Expected outcomes

- An SBCC strategy - integrating a 'Meghalaya specific approach and methodology' - for delivering health communication and engagement to enable behaviour change towards improving health seeking practices and generate a demand for health services to tackle the specific health issues.
- Revise existing materials and channels of communication for their effectiveness in behaviour change, with a mix of policy interventions, schemes, mass media, digital and technology products (to organize and leverage social networks) and community engagement events -depending on the existent health behaviour and responsive solutioning to a particular health issue.
- Pilot testing of the communication and engagement strategy to understand the field application of the SBCC strategy and its effectiveness.

3. Proposed Methodology

3.1. Study design and approach

The proposed Social and Behaviour Change Communication (SBCC) strategy development in Meghalaya is grounded in a study design informed by Hofstede's cultural model, along with the cultural-indigenous lens and a comprehensive situation analysis. The situation analysis will primarily look into three critical aspects –

1. being 'Culturally-Competent| Linguistically Apt'| 'Indigenous Design',
2. follow a Life Cycle Approach for Behaviour Change - 'Communication to Engagement and Habit Formation Design',
3. focus on Inter-Regional, Hyper Localized and Targeted Approach for Behaviour Change Interventions.
4. Rooting the proposed interventions in 'participatory design' mould

The primary objective of the study is to develop an SBCC strategy that addresses the unique socio-cultural dynamics of Meghalaya's predominantly rural and tribal population taking into consideration regional differences and disparities, ultimately improving the uptake of health services and fostering positive health behaviours.

3.2. Situation Analysis Plan

The situation analysis will be conducted through a combination of secondary and primary data collection methods:

- **Secondary Data (Desk Review):** Existing data sources, including government reports, health surveys, and academic literature, will be reviewed to understand the current health landscape in Meghalaya. This will include an analysis of demographic, socio-economic, and health indicators, with a particular focus on maternal and child health, non-communicable diseases (NCDs)- Cancer, Hypertension & Diabetes, and communicable diseases such as tuberculosis and HIV/AIDS.
- **Primary Data Collection / Information collection:** Where gaps exist in the secondary data, primary data collection will be undertaken. This will involve

qualitative research methods, largely Focus Group Discussions (FGDs) with key stakeholders and target populations. These FGDs will be designed to fill data gaps, offering insights into local health Knowledge, Attitude and Practices (KAP) that are not captured in existing data. The information collection will also focus on collecting information on their traditional belief systems influenced by folklore, mythology etc. of the three different tribes – Khasi, Bhois Garo and Jaintia.

- **Data collection:** The data collection tools for the focus group discussions (FGD) will be developed in close collaboration with the Department of Health, Government of Meghalaya, and the World Bank (WB). These tools will adhere to a unique survey operating protocol tailored for the behavioural study, ensuring that the questions are culturally relevant and contextually appropriate. Key issues probed during the FGDs will include:
  - **Barriers and Enablers:** Identifying the factors that hinder or facilitate the adoption of positive health behaviours.
  - **Health Service Awareness and Utilization:** Understanding the demand-side issues that impact the utilization of health services, especially among vulnerable populations.
  - **Cultural Practices:** Exploring traditional beliefs and practices , identity systems that influence or hinder health-seeking behaviour.
  - **Source and Channels of Health Information:** Understand about all different sources of health information, information and knowledge consumption patterns and identify the most preferred and viable channels of information specific to each stakeholder type and geography.
  - **Linguistic Patterns** - Familiar colloquial , responsive emotional spectrums and language typologies

3.3. Sampling strategy

The formative research will take place at three levels involving consultation with State-level stakeholders, district level stakeholders and the community level stakeholders. Since a baseline study has been done by the project, this assessment would focus on a minimal sample with most rigour.

Purposive sampling will also be used depending up on the exclusive nature of the

sample universe being derived for the study. Using the standard statistical formula, the required sample comes to 330, considering the fact that a 95% confidence interval will be used with a 7% margin of error, with a design effect of 1.3 (considering intra-cluster correlation coefficient of 0.05, and cluster size of 10). Taking an inflation of 10%, 330 respondents at the community level will be sampled. A three-stage sampling approach will be followed:

- **Selection of Study Districts:** 1 district from each of the three Hill regions (i.e., Garo, Khasi, & Jaintia) will be sampled to ensure adequate representation of the three key tribal communities using Simple Random Sampling approach.
- **Selection of Clusters/ Primary Sampling Units:** 30-cluster sampling approach will be used ensuring due representation of urban and rural areas. In each district, the urban area surrounding the District Hospital will constitute 1 urban cluster. Thereafter, the concerned district level Health Officials shall be consulted to stratify the CHCs present in the district into high, average, and poor performing facilities depending on some key performance criteria. Thereafter, 1 CHC shall be selected randomly from each performance category. Having all three CHCs will help uncover both the enablers and barriers to health-seeking behaviour of community and health service delivery by the supply side stakeholders. Thereafter, from the catchment area of each of the three facilities, 1 urban and 2 rural clusters shall be randomly selected to undertake a community-level survey. Accordingly, 10 clusters shall be sampled from each of the 3 study districts/regions.
- **Selection of Target Respondents:** The staff deployed at the sampled health facilities and frontline workers serving the catchment area for the same shall be the supply side stakeholders who will serve as the target respondents. At the community level, the households shall be sampled by adopting a systematic random sampling approach using random start method. The households to be included will be the ones that have at least one of the following respondent categories – parents or caregivers especially mothers of children under 2 years of age, adult male members of the household, and adolescent girls or boys.

3.4. Situational Analysis

The first step will be crucial to do a quick secondary review of the existing studies and gain an in-depth understanding of the existing landscape around the current

healthcare system in the state This will help to gain knowledge about what has been tried and tested previously, what worked and what are the learnings, and what are the current communication, advocacy and engagement needs and how best we could use the previous experiences to come up with a more robust and effective strategy that would address the current needs. This analysis will shed light on the performance of health systems and its key achievements, strengths and weaknesses of existing communication campaigns initiated previously.

The desk review will entail analysing the existing datasets, published peer-reviewed papers and monograph literature, government and non-governmental organizations (NGO) reports, and operational guidelines and regulations around services and schemes and will be used for data compilation, analysis and drawing conclusions from secondary analysis. The findings of the secondary analysis will be matched with the findings of the primary survey for ensuring scientific and transparent data analysis and reporting. Analyses will also focus on synthesizing key information related to the health topics mentioned in the TOR.

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

- Develop an understanding of the existing healthcare scenario, various health schemes and programs and its effectiveness in the State.
- The general positioning of the health system in the targeted community in terms of perceptions and beliefs of community members about the same.
- What have been the major barriers and deterrents in uptake of the health care service in the community.
- What kind of changes are needed to improve the uptake of health services.
- Role, skills and contribution of stakeholders, government departments, donors, NGOs, other major initiatives and the private sector in effective communication dissemination.
- Communication initiatives to date, communication programme's achievements, constraints, lessons learned and challenges.
- A list of all communication materials that have been produced so far - how they have been used and how effective they have been State response to IEC barriers or barriers in uptake of services under NHM.

3.5. SWOT analysis framework

Conducting a SWOT analysis for the proposed Social and Behaviour Change Communication (SBCC) strategy in Meghalaya will help identify the strengths, weaknesses, opportunities, and threats related to delivering health communication and engagement. This analysis is essential for refining the strategy to effectively enhance health-seeking behaviours and increase demand for health services among the Khasi, Garo, and Jaintia tribes.

SWOT Analysis for SBCC Strategy		
Strengths	A. Cultural Sensitivity	Hofstede model for cultural relevance.
		Strong local customs and language understanding.
	B. Existing Literature	Baseline reports and datasets (NFHS-5, CNNS, etc.) available.
	C. Focused Approach	Audience analysis and KAP assessments.
		Targeted strategy on key health issues (e.g., maternal health, NCDs).
Weaknesses	A. Geographical Challenges	Difficult terrain and dispersed population.
		Language diversity, connectivity issues, and indigenous systems.
	B. Cultural Barriers	Low health-seeking behaviour due to traditional beliefs.
		Resistance to modern health practices.
	C. Limited Workforce	Shortage of professionals affects engagement and implementation.
Opportunities	A. Leveraging Networks	Use traditional healers, influencers, and media channels.
		Access and utilize digital platforms.
	B. Partnerships	Engage religious institutions, NGOs, and local governments.
Threats	A. Sociopolitical Challenges	Political instability or priority changes may disrupt strategy.
		Risk of misinformation or cultural backlash.
	B. Competition with Traditions	Traditional practices may undermine modern health services.
		Resistance from traditional practitioners.

4. Implementation Plan and Approach

4.1. Duration

The project duration is three years, starting from August 2024 to July 2027. The implementation of the project is divided into the following:

4.2. Inception and Baseline Report

The team shall prepare an inception report which would detail out the proposed plan along with the approach and process that will be followed for developing the SBCC strategy. The inception report will present a blueprint of the plan and detail out the approaches to achieve each milestone along with timelines.

The team will leverage its experience working in Meghalaya and the insights gathered from both secondary data (desk review), as well as based on discussion(s) held with the MHSSP team and other relevant units within the Health & Family Welfare department to develop a comprehensive baseline report. Drawing on its expertise in conducting large-scale quantitative and qualitative assessments, the team will ensure early alignment on the study design and preliminary approach with the relevant MHSSP and relevant units and will facilitate the review of the draft baseline findings.

4.3. KAP Tool development and Pilot

To gather insights into the cultural disparity, local traditional and mythological practices and power dynamics, affecting health status of the population, will have to be explored and understood for which a detailed community-based knowledge, attitude and practice-based data / information will be collected. The team will conduct qualitative exploratory sessions across all the three tribal regions- Khasi, Garo and Jaintia to understand these cultural practices and differences. Appropriate tools will be developed for this purpose. These tools will be pre-tested to ensure they are fine-tuned and suitable for field execution.

4.4. SBCC Strategy Development

The team will design a SBCC strategy for delivering health communication and engagement that could enable behaviour change towards improving health seeking

practices and generate a demand for health services to tackle the specific health issues of:

- Birth Spacing (option-uptake and male participation)
- Cancer, Hypertension & Diabetes,
- Tuberculosis,
- Promotion of Exclusive Breastfeeding & Correct weaning (complementary feeding) practices,
- Male Participation in improving Maternal and Child Health, and
- Reducing the incidence of HIV/AIDS.
- Another 5 issues selected will be informed later.

The strategy would contain a suite of communication and engagement interventions, products and tools for each health issue/ bucket (10 topics of health as mentioned) followed by the corresponding channels, dissemination and outreach mechanisms for the target audience in different geographies. The strategy document will have sessions on program design, program implementation and monitoring and evaluation.

It will focus on redesigning or adapting the existing architecture and strategies, by reviewing existing materials and channels of communication for their effectiveness in behaviour change.

Development of guidelines for the adaptation of existing materials.

The engagement and communication tools should be multichannel - with a mix of policy interventions, schemes, mass media, digital and technology products(to organize and leverage social networks) and community engagement events - depending on the existent health behaviour and responses to a particular health issue.

Support the implementation of communication strategy in selected locations: Demonstration of field implementation of the communication strategy can help the government department to understand the field application of the SBCC strategy and its effectiveness. A prototype of a few communication materials can be developed and deployed in selected locations. The success of SBCC is not only dependent on the IEC materials developed, it involves the capacity of health care providers to communicate effectively at the beneficiary level.

Technical approach for SBCC Strategy: Guiding Principles

The approach to developing this strategy is informed by three-pronged design principles:

- Culturally-Competent| Linguistically Apt| Indigenous Design
- Life Cycle Approach for Behaviour Change - Communication to Engagement and Habit Formation Design
- Inter-Regional, Hyper Localized and Targeted Approach for Behaviour Change Interventions

Culturally-Competent| Linguistically Apt| Indigenous Design

As highlighted by the first of its kind, Tribal Health Report, released in 2021, tribal health in India shares a unique triple burden of diseases, while malnutrition and communicable diseases like TB continue to be rampant, rapid urbanization, environmental distress and altering lifestyles have also contributed to acceleration of non-communicable diseases like cancer, diabetes etc. And this is accentuated by the rising incidence of mental health issues, especially addiction.

It was also observed in the report that tribal health - due to its unique 'eco-social' dimension and its differentiated health needs- cannot be subsumed in rural healthcare and needs a slew of new national and 'hyperlocal' (as per different geographies and tribal societies) framework and roadmap for improving access, effectiveness, service delivery design, content , quality and utilization for ensuring tribal health security. The report stated that the health status of various tribal groups - despite a significant improvement in the last 25 years - is still lower than other social groups in the country. Apart from the deficiency in number, quality and resources, the report concluded that it suffers primarily from **'design problems'.**

Design problems will translate- in this context- as the absence of hyper-localism, indigenous and cultural ecology -resulting in lack of participation, low demand and health seeking behaviours amongst the indigenous population.

Keeping in view of the report findings and recommendation, it becomes a critical strategic need for the modern healthcare system to integrate 'cultural competence', emotional content and spiritual security along with its pure 'biomedical focus' in order to accelerate and achieve positive health outcomes for this social group.

The SBCC strategy design (health messaging, information and other interventions) for Meghalaya - will be designed with this integrative methodology and adopt the local linguistic patterns , social symbolism and lay out a cultural ecology of diseases to create 'familiar' formats for awareness, communication and health promotion for its indigenous population. The strategy will also integrate good and positive health practices- curated and interpreted- from local folklore, mythologies and indigenous belief/ knowledge systems of Meghalaya for ease of adoption.

For instance, a study -published in an international scientific journal on micronutrient deficiency like Vitamin A in Meghalaya demonstrates the efficacy of cultural competence strategy in quick adoption of positive health behaviours[6]. Deficiency of Vitamin A is a harsh reality amongst children in Meghalaya (Preschool- 2.49% and 5-15 years - 5.9% as opposed to the WHO global cut-off of 0.5%). In the research paper- studying the high prevalence of this disease in Meghalaya, researchers came across a word called 'Matiar' in Khasi language which meant 'hen eyes' and night blindness. Upon further inquiry, the condition was interpreted as the Vitamin A deficiency.

It was seen that 80% of the women were able to identify the Vitamin A Deficiency (VAD) condition in their children upon being presented with this information in local language and were also aware of the remedial measure -inscribed in the traditional knowledge system as beef liver (rich in Vitamin A). In the study area, the liver seems to be a good source of vitamin A, as the other good sources of vitamin A are oils of shark, cod or halibut or red palm oil are not available in the region. It is interesting to see the appropriateness of this home remedy which constitutes traditional knowledge of communities.

Global health expert Dan Buettner, the aging expert, who has studied blue zones for more than 20 years -in his eponymous book and a recent Netflix documentary has looked at 'social norms and cultural traditions as a big 'determinant' of care or health seeking journey and acknowledge it playing a critical part in extending life expectancy[7] as well as health seeking behaviours.

Therefore, with this new methodology, the SBCC strategy will have a 'rolodex' of culturally competent contexts, localized/indigenized health vocabulary and health

[6] *Nongrum, Melari & Kharkongor, Glenn. (2015). High prevalence of vitamin A deficiency among children in Meghalaya and the underlying social factors. Indian Journal of Child Health. 02. 59-63. 10.32677/IJCH.2015.v02.i02.005.*

[7] *Sullivan, L. (n.d.). Unlocking the secrets of Blue Zones: A blueprint for longevity and health. News Medical. Retrieved September 17, 2024, from https://www.news-medical.net/health/Unlocking-the-Secrets-of-Blue-Zones-A-Blueprint-for-Longevity-and-Health.aspx*

practices that could be integrated into the modern tool box for health communication and promotion.

Life Cycle Approach for Behaviour Change - Communication to Engagement and Habit Formation Design

Health behaviours and decision making is triggered by both rational brain and automatic processing parts (heuristics)- conscious and unconscious brain. And it is to be noted that behaviours are also influenced by a host of factors like contexts, choice architecture, identities and environments[8].

The SBCC study and strategy design for the recommended health topics will integrate new 'culture first' research frameworks like the Hofstede model to establish the 'causal' source along with the hyperlocal indigenous ecology of diseases (in this case, specific to Meghalaya).

It will, most significantly, create a marked segmentation between the health topics (ten topics as listed) that are driven by 'information and knowledge asymmetry' (classic intervention continuum) and those that are mired in deep social and cultural cognition style/contexts (intensive intervention continuum).

The former requires a steady state of attractive, engaging communication and information delivery over a sustained period of time to influence behaviours and drive positive outcomes. The latter requires much more than an information provision- a series of intensive engagement interventions to influence the positive health outcomes.

For example, while MICYN practices and exclusive breastfeeding requires a classic continuum intervention; cancer (with its grid of causes like smoking, alcoholism, genetic disposition, dietary habits, lack of exercise as the issues etc), teenage pregnancies and early pregnancies etc., may require intensive intervention strategies that can help affect choice environment.

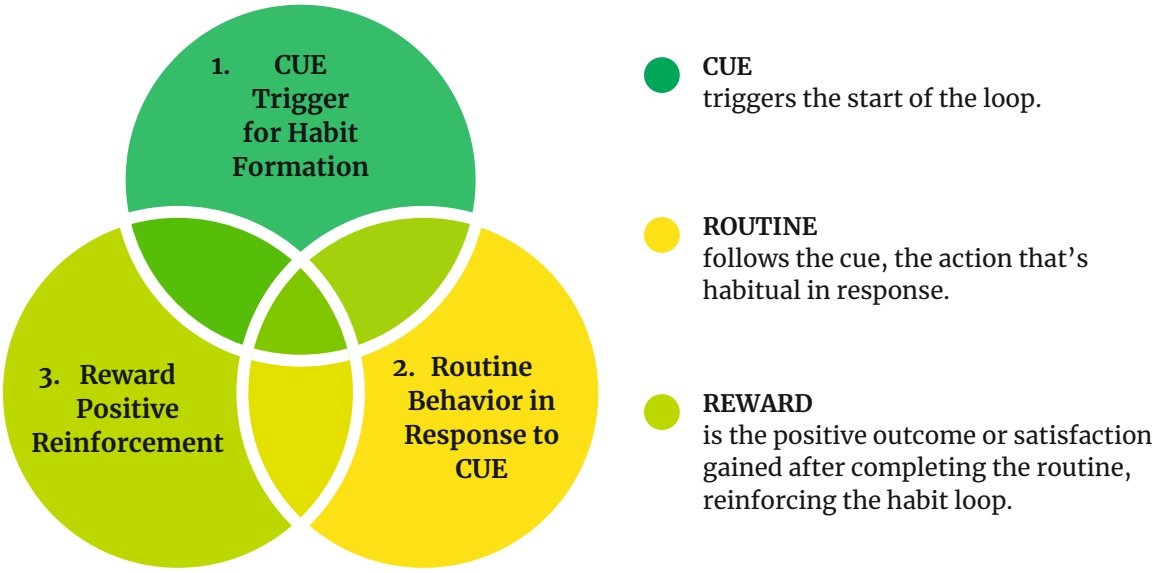
It is to be emphasized that communication (information and knowledge provision) is one of the first (necessary but not the only one) components amongst other strategic elements (contexts, identities, environments, choice architecture) in the toolkit to enable behaviour.

This approach will also expand the SBCC's scope of communication (from consumption of knowledge and information asymmetry) to include other strategic

[8] *Mulgan, G. (2010). Influencing public behaviour to improve health and wellbeing: An independent report. https://lx.iriss.org.uk/sites/default/files/resources/dh_111694.pdf*

components (beyond IEC materials) like engagement and habit formation techniques/methodologies in different formats and build a long tail 'engagement value chain' that can unlock agency, build intention and unleash the 'critical capacity' of people to act (choice architecture) and finally, aid in habit formation.

The Habit Loop



For instance, a recent report from FHI-360 and UNICEF Rosa[9] evaluated the quality of nutrition counselling in South Asian health systems and found the coverage to be significant but the early initiation of breastfeeding to be significantly late despite institutional birth delivery and ANC coverage. A counselling redesign framework- using the user centric approach- (conversational, localized dialect, culturally familiar responses, intrapersonal exchange as opposed to instructional tone and paper formats) ended up increasing the counselling uptake and resulted in improved health outcomes in breastfeeding initiation. This is a classic intervention continuum.

[9] *Bhanot A, Sethi V, Murira Z, Singh KD, Ghosh S and Forissier T (2023) Right message, right medium, right time: powering counseling to improve maternal, infant, and young child nutrition in South Asia. Front. Nutr. 10:1205620. doi: 10.3389/fnut.2023.1205620*
https://www.frontiersin.org/journals/nutrition/articles/10.3389/fnut.2023.1205620/full

In the case of NCDs or teenage pregnancies, a series of intensive engagement strategies will be developed to change the social cognitive style of the targeted audience. This will be an example of an intensive intervention continuum.

Inter-Regional, Hyper Localized and Targeted Approach for Behaviour Change Interventions

Data from several reports including the MHSSP draft report has brought up a clear insight of inter-regional/district dynamics in health behaviours of several target demographics.

For instance- household decision making in healthcare practices as reported by MHSSP report 2022, as far as the decision-making for a pregnant woman is concerned, in East Khasi Hills, a majority of the respondents answered that it was the mother who would take decisions regarding healthcare, followed by the spouse[10]. However, in West Garo Hills the targeted respondents mentioned that spouses take decisions regarding their health during pregnancy. Further, in the West Jaintia Hills, more than half of the targeted respondents preferred to make decisions regarding healthcare by themselves.

The decision-making process is influenced by a number of cultural factors and it is critical to further break this down to a more granular motivations factors.

Thus, it is critical to create a detailed, granular, targeted approach for addressing regional and inter-tribal dynamics and contextualize the messaging and engagement activity/intervention to the region.

Participatory Design in Health Literacy: Relationship Led Care Model Approach

Taking cues from SCEP model of Meghalaya[11],- that has used the Program Iterative Driven Approach to create a shift from 'curative model to preventative' model of healthcare in the state, the SBCC strategy's approach will also be designed to integrate the component of 'participatory design mechanisms' and create a 'low barrier activism' around positive health behaviours in the stakeholders (households and communities, individuals)[12].

It is to be mentioned that certain health topics like cancer, diabetes are lifestyle

[10] *TO DEVELOP AND ROLL- OUT SOCIAL BEHAVIOUR CHANGE COMMUNICATION (SBCC) STRATEGY FOR MEGHALAYA HEALTH SYSTEMS STRENGTHENING PROJECT, DRAFT COMMUNICATION NEED ASSESSMENT REPORT, Submitted to Project Director, Meghalaya Health System Strengthening Project. Prepared by AMS (Academy of Management Studies), Lucknow.*

[11] *World Economic Forum. (2023, March 1). An integrated approach is helping Meghalaya achieve universal health coverage in India. World Economic Forum. https://www.weforum.org/agenda/2023/03/integrated-approach-meghalaya-universal-health-coverage-india/*

[12] *Neuhauser, Linda. (2017). Integrating Participatory Design and Health Literacy to Improve Research and Interventions. Information Services & Use. 37. 153-176. 10.3233/ISU-170829. https://www.researchgate.net/publication/317634267_Integrating_Participatory_Design_and_Health_Literacy_to_Improve_Research_and_Interventions*

diseases and the sources of these behaviours are heavily influenced by 'networks and relationships' (peer to peer pressure, choice environments and preventive lifestyle behaviours). These are bound up in social 'identities' and therefore, it is critical to go beyond the communication, messaging and advocacy mechanism in these health buckets and build a more sustained, personalized, physical (phygital) influencing and activism mechanism within a community for behaviour change.

It may also require other strategic levers like policy, regulatory and other institutional interventions along with a 'movement like model'. This would mean reframing and re-modelling the SBCC strategy on certain health topics from a top down to bottom up approach for these health buckets by creating community led interventions and embed participatory mechanisms in its health literacy and behavioural interventions to facilitate the activation of 'a self-directed and self-managed, community for health promotion. This is explained in the figure below:

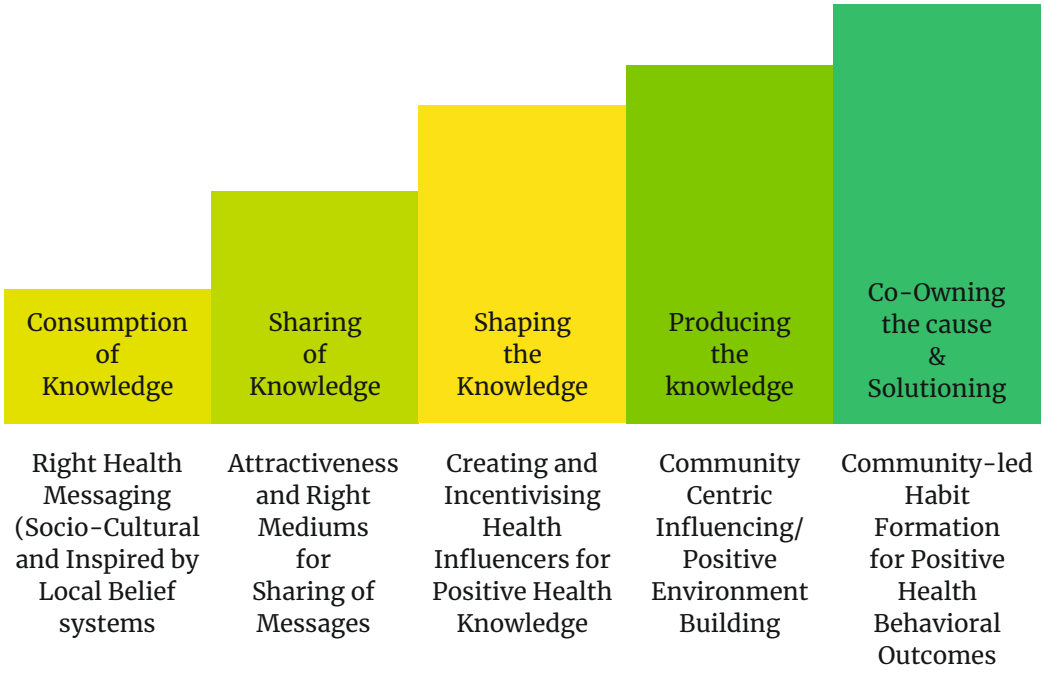


Fig. : Jeremy Heimans and Henry Timms - New Power [13]

The participatory mechanism will be used using the new power principles of shifting the power to crowds/communities and creating self-manageable, self-directed communities for positive health behaviours.

[13] *Heimans, J., & Timms, H. (2014, December). Understanding "new power." Harvard Business Review. https://hbr.org/2014/12/understanding-new-power*

For instance, Meghalaya has a coveted global biodiversity reputation with a vast repository of medicinal plants (75), a network of traditional healers who often act as first responders to the health crisis and are a more trusted source of health providers because of approachability, empathy, community, and connection.

MHSSP draft report, 2022- has also highlighted this reliance on these health managers of sorts.

"A dependency on traditional healers was also highlighted by the respondents across different groups owing to their easy availability. Pregnancy-related concerns, childcare, and ailments related to bone fractures were some of the health issues regarding which the community was mentioned to rely on traditional healers. In East Khasi Hills, a fear of modern medicines was also reported as a reason for seeking assistance from local healers".

Meghalaya's HRH Situation Analysis Report also highlighted the fact that various nokmas and communities in Garo Hills expressed their reliance on traditional healers and informal health providers like local pharmacists etc., for health information, health solutions and health care practices. It is critical to identify and create a mechanism to include these high value health influencers towards positive and inch them towards scientific modality of health solutions. The World bank in Sudan is working in collaboration with traditional healers to improve the health seeking behaviours of the population[14].

"Headmen are also considered - as suggested by MHSSP draft report 2022, to be important decision-makers in the health seeking journeys in Meghalaya. The speaker systems in the village are the reminders/alarm systems for the village. A reward and incentivisation (deeply cultural based on qualitative tribal knowledge mechanisms - trust deficit, dignity and environments based approach) would also be recommended to include them in the health management cadre."

The 'participatory' approach has been brought in -keeping the community led social fabric of the state and will be embedded in the methodology and design to activate these social networks for mass behaviour change.

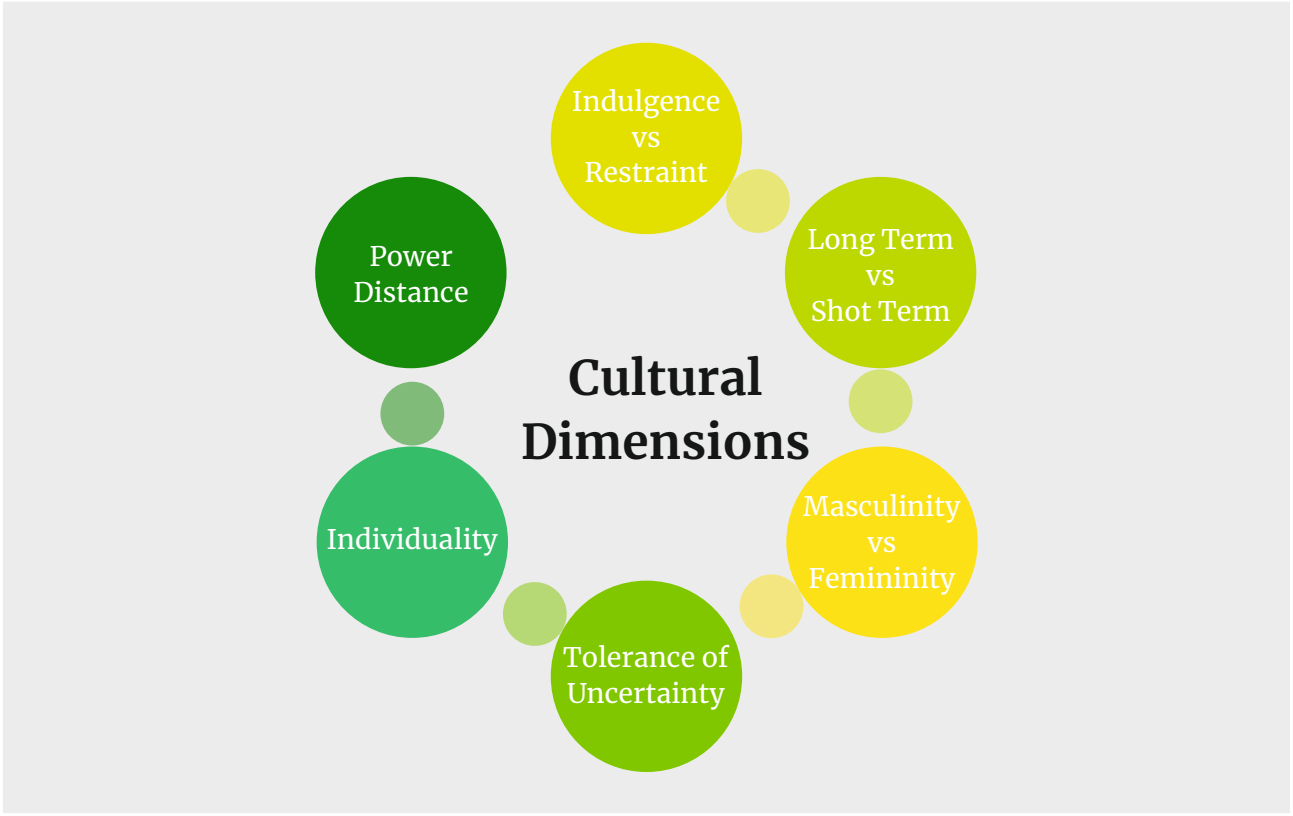
[14] *Sorketti EA, Zuraida NZ, Habil MH. Collaboration between traditional healers and psychiatrists in Sudan. Int Psychiatry. 2010 Jul 1;7(3):71-74. PMID: 31508045; PMCID: PMC6734982. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6734982/*

4.5 Research Framework : Survey Operating Protocol

The study design is informed by the Hofstede model of culture[15] to study the community responses to 10 health issues as mentioned in the TOR. Hofsteade's cultural model studies the effect of cultural attributes through five dimensions of the society on its members and provides an adequate framework to design an intercultural survey for analyzing the contextual behaviors of the target groups towards different health issues.

Hofstede model is usually used as an intercultural research framework to create culture and behavior first strategies. The five dimensions along which the cultural differences plotted are power distance, masculinity vs. femininity, long-term orientation vs. short- term thinking, individualism vs. collectivism, and uncertainty avoidance. The model is comprehensive and exhaustive in its treatment of cultural differences across cultures.

This key cultural aspects involved is illustrated in the Fig.1 below:



[15] *Worthy, L. D., Lavigne, T., & Romero, F. (2024, September 17). Hofstede's Cultural Dimensions – Culture and Psychology. Open Maricopa. https://www.maricopa.edu/degrees-certificates/culture-society*

To take the first dimension, **power distance measures the extent to which hierarchy dominates the societal environment and what are the multiple power structures within the household, community and individual level.**

Masculinity versus femininity analysis looks at the dominant societal/ community behaviors index. Meghalaya is a matrilineal society and the Hofstede model will help illustrate the extent of gender stereotypes/ ancestral conceptions perpetuating in the society.

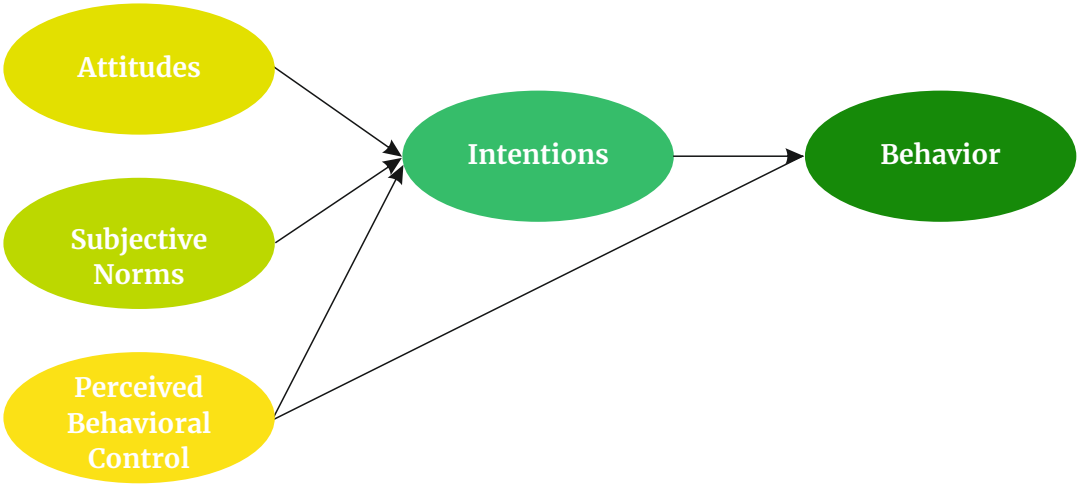
The third dimension of individualism vs. collectivism yields the result of societal values - which are collectivistic or individual as applied to communities, households and individuals' behavioral make-up. This can inform the nature of communication and engagement intervention - to be driven- for instance- by the government or community influencer?

The fourth dimension of long-term thinking vs. short-term thinking. Different cultures have evolved and wired to different geographical, cultural orientations and this will help inform and create' neuro-cultural nudges' and engagement strategies for behavior change for Meghalaya

Finally, the fifth dimension of uncertainty avoidance refers to the structured environment that judges the propensity or the degree to which people in a society are comfortable with risk, uncertainty, and unpredictable situations. People in high uncertainty avoidance societies tend to want to avoid uncertainty and unpredictability.

All these dimensions will be reviewed and contextualized within the local cultural and traditional fabric along with local belief systems and social symbolism.

2- This model will be juxtaposed with SBCC's Theory of Planned Behaviour to study the belief systems, attitudes of the target groups and create a new blueprint of insights related to health attitudes and health seeking behaviors -corresponding to the multiple health topics as mentioned. This is illustrated in the Fig.2 below: Health attitudes and health seeking behavior



The project aims at informing the development of a socio-cultural and behavior change communication (SBCC) strategy for the program with a Knowledge, Attitudes, and Practices (KAP) assessment, offering direction and insight into demand-side issues for the improved uptake of health services in the community. For the purpose of data collection for development of the SBCC strategy IDIs will be conducted across all the various stakeholder groups.

The IDI tools will be informed by the Value Survey Module of Hofstede model/Social Planner Behaviour Change and will be jointly used to create a new culturally informed, targeted and granular survey operating protocol and resulting in the following

Hofsteade Model at Work - Sample Case study on Family Planning and Contraceptive Uptake using Hofstede modeling and VSM

The MHSSP draft report highlighted the key point that *"On family planning methods, as per the MHSSP draft report, a striking 40% of respondents from East Khasi Hills reported that couples in the community consider using family planning methods as unnecessary. This underlines a critical lack of understanding of the implications of not practicing family planning. Further, a lack of willingness to use contraceptive measures was found to be the major reason (reported by 86% of the respondents) behind not using family planning methods in West Garo Hills. This was also mentioned by almost one-third of the respondents from West Jaintia Hills. In terms of urban-rural differential, the rural population seemed to face a lack of awareness as well as found it unnecessary to use these methods. However, it was the urban populace that, compared to their rural counterparts, showcased a higher unwillingness to use the products as well as a hesitance to purchase such products"*

The Hofstede Value Survey module will explore the institutional settings of the three tribes and sub tribes and regions in Meghalaya and the way reproduction and fertility preferences are controlled by the cultural and religious norms and how it shapes it. Power dynamic is explored here between matrilineal and patrilineal societies.

A recently published paper did a comparative study of fertility behaviors between khasi and krabi tribes in Assam and found interesting anecdotes. A sample testing found the mean CEB to be higher in a matrilineal system (Khasis) as compared to the patrilineal society (like Krabis in Assam). CEB represents the fertility performance of a particular populace and in a comparative paper[16], it was found that 112 and 79 babies were born to Khasi and Krabi women respectively, in the year preceding the survey. Based on these data the general fertility rates of the Khasis and the Karbis were estimated to be 280 and 207 per thousand women respectively. The GFR for non-converted Khasis (351 per thousand) was much higher than the GFR for converted Khasis (265 per thousand).

Interestingly, the educational levels of women had a significant influence on contraceptive use ($p < 0.05$). Improvement in the educational level of women by one unit decreased the odds of contraceptive use by a factor of 0.944 . This was particularly observed among the Khasis. The role of 14 recent movements of cultural revival, might provide a partial answer to this unexpected finding as educated Khasi women were more culture sensitive and were found to be strictly following the cultural taboos and norms. So , according to a published finding, the role of recent movement of cultural revival, might provide a partial answer to this unexpected finding as educated Khasi women were more culture sensitive and were found to strictly follow the cultural taboos and norms.

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The initial findings establish the fact that a high level of female autonomy does empower women in making decisions, especially decisions regarding reproduction and health, but it does not necessarily mean that these decisions will be anti-natalist. The higher level of female autonomy has allowed Khasi women to delay their marriage to the age of 21, but once they are married they do not want to delay the start of child bearing or to control the number of their births.

According to Khasi traditional belief or thought, the intrinsic value of the family is considered not only in terms of possessions, wealth and well being, but also in the numbers of children born and reared. The qualitative data from the focus group discussions and from

[16] *Saikia (n.d.). Culture, Religion and Reproductive Behaviour in Two Indigenous Communities of Northeastern India: A Discussion of Some Preliminary Findings. International Union for the Scientific Study of Population [IUSSP] https://iussp.org/sites/default/files/Brazil2001/s50/S50_02_Saikia.pdf*

in-depth interviews indicate that most Khasi women are still of the view that "that every child that comes into the world, comes with two hands and a bag of rice". The symbol of 'two hands' offers a pragmatic and utilitarian image relating directly to its inherent ability to enhance production. This traditional view means that God the Creator will always provide, and that in a short time a child will cater not only for his/her own needs, but also for the needs of others around him or her.

Even if teenage sexuality is not overtly accepted- for instance In the annual Nongkrem Dance which is also associated with fertility rituals and is one of the most sacred and revered ritual(s) of the Khasis, only virgin girls dance (Goswami 1996-98)[17]. the sentiments towards a teen-aged couple can change quickly once a pregnancy comes about, and the mother's family prepares for adjustment, either with or without the father's participation.Neither early marriage nor single motherhood is considered taboo — what is taboo, however, is any attempt to intervene in the natural flow of life, such as through contraception: kum ba ai u blei, life must flow.

Data on ideal family size show that almost 52% of the Khasi women want either four or more children. In contrast, 75% of the Karbi women do not want more than three children. Informal interviews with the village heads in the Khasi community revealed that they strongly encouraged the concept of a large family size in the face of the threat of becoming a minority. Khasi women, who enjoy a high level of autonomy in decision-making, appear to support the ongoing resurgence movement.

In an environment with pro-natalist social and cultural norms and a strong traditional society, high female autonomy may encourage women to produce more children. This paper has highlighted the reality of reproductive norms among these tribal groups in an attempt to emphasize the hypothesis that the perception of minority status and the adoption of a more defensive position vis-à-vis outside groups have impacted on fertility outcomes.

Therefore, on the Hofstede model values - femininity and high level of female autonomy is driving the high fertility rate and low uptake of contraceptives in Meghalaya. significantly. Coupled with this is the lack of khasi language around sexuality, the focus of communication has to change these social moorings through contextualized information and inter regionally.

And this value will then be used to choose a classic or intensive continuum and design communication and engagement strategy for the uptake of contraceptives.

[17] *Goswami, Roshmi. 1996-98. Insights: Documentation of Health Perspectives within Matrilineal Value Systems and Strategies for Action in the State of Meghalaya. Report submitted as MacArthur Fellow for Population Innovations 1996-98. http://dspace.cus.ac.in/jspui/bitstream/1/4018/1/Matriliny.pdf*

2) Audience Analysis - Behavioural Study with the cultural lens

The purpose is to identify relevant participant local/indigenous groups, their characteristics, the roles they play in the scheme of things, their existing awareness levels and underlying beliefs and perceptions about the existing health systems, services and the resources each group can access to bring about and maintain the desired behaviour change. This analysis will help us understand the localized perceptions, cultural ethos and attitude of the various stakeholder groups toward services provided under various programs and schemes.

The stakeholders of the project can be classified into three categories:

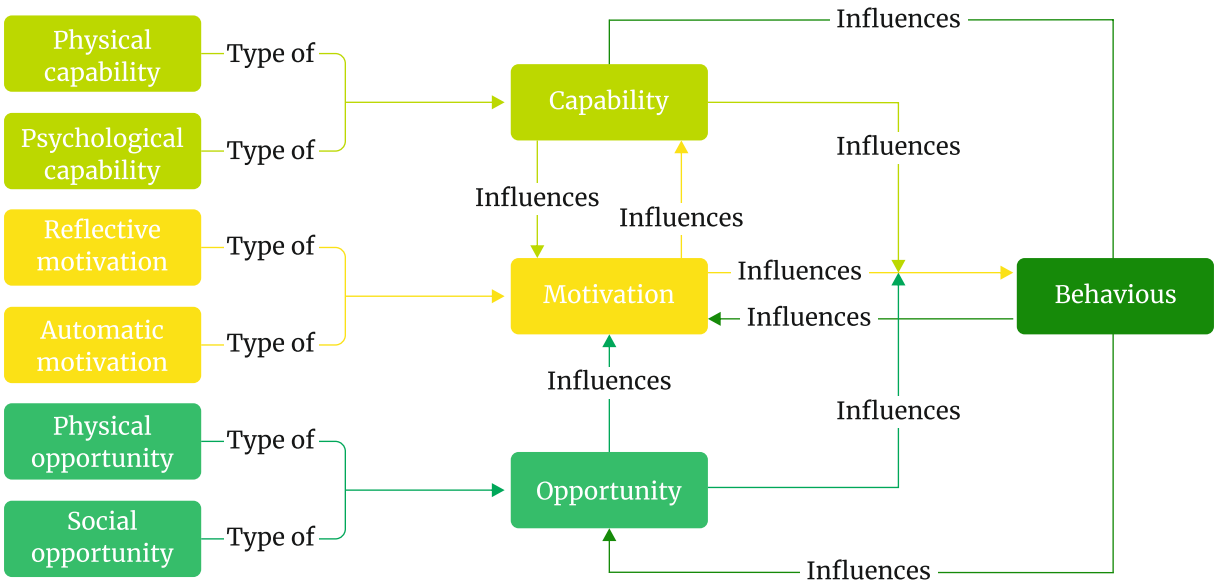
- Primary Stakeholders: These include the community actors (namely beneficiary population, gatekeepers, local leaders etc.) and the ultimate beneficiaries of the Health Department
- Secondary-Stakeholders: These stakeholders will include those who are directly engaged in service delivery, i.e., key state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

Audience Segmentation Methodology

Using our conceptual and research framework and survey operating protocols informed by desk review, following steps will be taken:

- Inter-Regional Behavioural Heatmap for Targeted Interventions- A granular inter regional behavioural heat map/dashboard will be developed for locking target behaviours of the primary, secondary and tertiary stakeholders- corresponding to the health topics mentioned.
- Stakeholders Analysis Based on Social Identity/Cognition Styles- Profiling of identified primary, secondary and tertiary stakeholders and targeted

behaviours- as per the region to the corresponding health topic will be listed as per the COM-B Model framework



The fine grain detail of motivation and psychological capacity will then be broken down in terms of external and intrinsic motivation drivers and social identity and cognitive styles.

- Indigenous Context of Target Behaviours- Root Cause Analysis and Cultural Ecology of Diseases. Contextualisation of these social cognitive styles in indigenous narratives, folklore and local linguistics patterns and social rituals. A tabular format of targeted response mechanisms of the stakeholders will be matched with references from existing belief systems, social practices and herd and personalized behaviours and existent lags and lapses in vocabulary. For instances- 'Doctor Sla' (Plant Doctors) as opposed to 'Doctor kot' (book doctors)- described a series of ailments like lait thied sohpet ka bih (toxin), jingshit ha kasnier (fever of the intestines), niañgsohpet (problem of childhood-indigestion), jakhlia (unwanted/impure substance) that enters the baby's mouth during birth etc., Khlamb - a word for pandemic already exist in their ancient vocabulary- all of these needs to be contextualized.
- Classic And Intensive Intervention Health Behaviours Segmentation - Categorisation of given health topics as the ones that are the result of information deficit behaviours (breastfeeding, MIYCN practices) and ones that are deep social behavioural patterns (early and teenage pregnancy, contraceptives uptakes, male participation, cancer, Diabetes)

- Interconnectedness Patterns of these diseases and behaviours to each other to establish causal behaviour patterns and source points (social or clinical determinants of health)

SBCC Communication and Development Framework

- Identification of community and engagement objectives- Identification of communication objectives for each target behaviour in familiar language, context.
- Communication and Advocacy Channels/ Formats– Region-wise and social cognition-wise breakdown of knowledge and information consumption patterns and preferences for communication, and engagement typology/formats for each stakeholder e.g. print, social media, physical and community Events, TV, personalized channels, immersive community games, digital products, folklore etc.
- Communication and Content Treatment: Neuro-Cultural Design- Matching the cultural pathology of diseases and identified behaviours with responsive emotional cues and arc (e.g-pathos, satire, role-modelling, aspirational identity, music, religious overtones), story-telling treatment, preferred visual imagery analysis for content styling. For instance- Inspirational Messaging/Role Modelling Story for cancer, Satire/Comedic Timing for Diabetes, church/ prophetic/ ancestral conception for teenage pregnancies, birth spacing etc.
- Multi-Channel/Format Integrative Campaign and communication Design and Dissemination Plan- Design a slew of interventions/activities/ campaigns/communication design with a multi-channel approach -using traditions, custom, local language / rituals, dialects, mass media, innovative community and social mobilization events, technology and digital products, entertainment, advocacy to craft an integrative, strategic, user centric communication programme. This can include campaigns, events, programmes and high-stake items like policies and schemes to deliver health positive messaging and positive health behaviour formation.
- Dissemination Platforms- Along with a dissemination plan which means a corresponding list of communication and engagement delivery platforms to be identified for proposed interventions for each target demographic. This may include creating an alternate technology product, designing a new phygital strategy for community engagement or a slew of brand new health influencer strategies for positive health messaging apart from digital channels.

- Rigorous testing of Intervention design/activities in the strategy with the government, target groups, influencers , health service providers to create an open- sourced strategy. Regular and broad consultations and co-designing or co-creation with key stakeholders will be a key guiding principle for the project from inception to scale up advocacy.

Development of Materials - This will be followed by designing of the materials- Training and D2C (Direct to Consumer) for Every Health Topic, Mass Media (Radio, Tv, Social Media, Traditional and Social Media items- Posters, Books, Pamphlets), Entertainment, Communication Events Campaign Design - Events Design With unique advocacy and Messaging Delivery Policy, legislation and schemes, Institutional Systems Design For High Level Mass Narratives for further engagement and habit formation.

COMMUNICATION DEVELOPMENT STRATEGY IN ESSENCE

Causal, Hyperlocal And Not Symptomatic Diagnosis: Identification of causal target behaviour (Hofstede Model)- Information deficit driven or Social and Cultural Norm Driven

Localized References, Speak and Feel- Behaviour specific communication familiar to the target demographic (localized cultural language and symbolism for ease of adoption

User Centric Design- Style and content of communication (Emotion Spectrum identification and Story-telling arc + attractiveness of the intervention for coverage

Barrier Free Modes of dissemination (print, social media, physical, phygital and in person(influencer) platforms for easy interaction - corresponding to the health topic)

High Frequency for High Coverage- Repeated frequency of that intervention and incentivisation for effective knowledge transfer and attention capture.

Repetition of Activity/Intervention Over Sustained Time- for knowledge to turn into a habit (a programmatic calendar over a sustained period to turn into an alternate belief system)

4.6. Support in Implementation and Roll Out

- **State Level dissemination workshop: Demo and Beta Testing**
  As part of gaining a comprehensive understanding of our new strategy, we propose organizing a dissemination workshop at the state and district level that will involve all relevant stakeholders. The primary objective of these workshops is to elucidate the distinguishing features of the new strategy, emphasize its enhanced effectiveness, and outline the forthcoming action plan. The demo testing and feedback is the guiding principle of this entire endeavour and will be rigorously tested with all stakeholders- beneficiaries, influencers, health representatives, health service providers and government officials.

- **Development of guidelines**
  In addition to the strategy document, we will develop a comprehensive program implementation guideline that provides detailed instructions for executing the program. This guideline will serve as a valuable resource for individuals at various levels, enabling them to gain a thorough understanding of the implementation process and their respective roles. The document will include detailed descriptions of each intervention, the target population, expected outcomes, and specific timelines. These program guidelines will serve as a reliable reference throughout the implementation phase.

- **Capacity building: Extensive Training Modules**
  Following the development of the strategy, capacity building will be structured in a cascading model. This approach involves training district-level officials and other stakeholders at the state level to familiarize them with the new strategy and its implementation. These trained individuals will then disseminate their knowledge by conducting training sessions at the district level and subsequently at lower levels. It is assumed that the State shall identify the number of persons that it proposes to deploy in the pool of State-level Master Trainers, who will be responsible for steering the state-wide rollout proposed under the project. This will also involve finalization of a training micro-plan with a progress tracker, support to training logistics and monitoring of training quality and interventions to address quality issues. Support for micro-planning of review meetings and accompany supportive supervision in a few selected sites and provide feedback.

- **Monitoring and Evaluation of the Strategy**
  A comprehensive monitoring structure will be intricately developed alongside the strategy document, incorporating key indicators and a meticulous

monitoring plan for both outcomes and outputs of the strategy. This structured approach will include delineated roles and responsibilities at each level of implementation. Moreover, the strategy document will encompass detailed monitoring tools, a robust data collection methodology, and an in-depth analysis plan. Quarterly and mid-year reviews will be conducted. At month four, a deeper analysis of monitoring data will be conducted to develop an initial report on implementation status for government stakeholders. In addition to providing an overview of the situation, the report will highlight implementation challenges, recommend adjustments, facilitate course correction decision making and ensure effective follow up on decisions. At month seven, a mid-year report will be developed to inform any broader course corrections needed. At both time points, working meetings will be conducted with government stakeholders to facilitate decision making on required course correction.

- **Leveraging External Resources| Enriching Government Resources | Fund Mobilisation**
  A comprehensive alternate fund mobilization strategy will also be drafted to assist the department through collaborations, viable partnerships, grant models to be able to leverage external financial resources for innovative interventions as recommended by the final SBCC strategy.

- **Assist in Inter Sectoral Convergence**
  Health is a multi-sectoral and an interconnected challenge and requires collaborative joint endeavour to achieve the optimum coverage and delivery of services. Inter sectoral alliances, unorthodox multi stakeholder consultations with ICDS, Jal Shakti Mission, State Rural Livelihood Mission etc- where community centric and high order federations are formed to drive the social change.

4.7. Monitoring Plan

To ensure the effective implementation of the SBCC strategy, the consultant team will develop a comprehensive monitoring plan. This plan will define Key Performance Indicators (KPIs) for each component of the strategy. The team will create the necessary monitoring tools and analyse data regularly to provide progress updates and feedback to the state team. Quarterly review meetings will be held to assess the strategy's effectiveness and make any necessary adjustments.

5. Workplan and Timelines

WORK SCHEDULE AND PLANNING FOR DELIVERABLES													
No.	Deliverables	Quarterly Timeline											
		Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12
D-1	Rapid Baseline Assessment (Formative Research- Qualitative Data)	■											
D-2	User Centric Design												
	Fine Tune Design Brief with Govt.	■	■										
	Cluster/Region-level consultations			■	■	■	■	■	■	■	■	■	■
	District-Level Consultations			■	■	■	■	■	■	■	■	■	■
	State level consultations			■	■	■	■	■	■	■	■	■	■
D-3	Development of Strategy Document- with clear methodolgy for SBCC for delivering envisaged health outcomes	■	■										
D-4	Development of revised tools based on approved strategy & IEC materials		■	■	■	■	■	■	■	■	■	■	■
D-5	Pilot- Pre-testing Tools			■									
D-6	Implementation Support and establishing learning loops			■	■	■	■	■	■	■	■	■	■
D-7	Monitoring, Evaluation and Learning			■	■	■	■	■	■	■	■	■	■
	Submission of the final comprehensive report												■

6. Risk and Mitigation

Key risks and mitigations for the SBCC strategy development are as follows:

Risk	Impact	Probability	Mitigation
Geographical and Logistical Challenges	Delays in strategy development and implementation due to difficult terrain and dispersed population.	High	Develop region-specific logistical plans, use technology for remote communication, and engage local partners familiar with the terrain.
Cultural Barriers	Resistance to modern health practices and low health-seeking behaviour due to reliance on traditional beliefs.	Medium	Integrate cultural competence into the SBCC strategy, engage traditional healers, and adapt messaging to align with local customs.
Limited Availability of Healthcare Workforce	Inadequate engagement with the community due to the shortage of healthcare professionals.	High	Train and deploy community health workers, leverage digital tools, and collaborate with NGOs and local organizations.
Sociopolitical Challenges	Disruptions in strategy development and implementation due to political instability or changes in government priorities.	Medium	Engage with multiple stakeholders, align the strategy with broader government goals, and secure commitments from key political figures.
Competition with Traditional Practices	The presence of traditional healing practices may undermine modern health services and SBCC efforts.	Medium	Collaborate with traditional practitioners, incorporate traditional practices into the modern health framework, and educate communities.

Field Offices

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D.N. Singh Road, Bhagalpur
Banka Dist. - 812002

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