SBCC STRATEGY FOR SYSTEM STRENGTHENING

Awareness to Action – Empowering Communities for a Healthier Meghalaya



Acknowledgement

We would like to express our heartfelt gratitude to all the individuals and organizations who have contributed their time, expertise, and support towards the development of this SBCC strategy document.

First and foremost, we extend our sincere thanks to Shri Sampath Kumar, IAS, Development Commissioner, for his leadership and unwavering commitment to improving the health sector in Meghalaya. We are equally grateful to Shri Ramkumar S, IAS, Mission Director, NHM, for his continuous support and vision in strengthening the state's healthcare systems.

We would also like to acknowledge Mr. Kmenbhalang Khongwir, Team Leader-MHSSP and Ms. Evanylla Marbaniang, Media & Communication Manager-MHSSP, whose strategic insights, dedication, and expertise were instrumental throughout the development of this strategy.

Our appreciation extends to the team leads and members of NHM and the Department of Health and Family Welfare, Government of Meghalaya, whose collaborative efforts and tireless work have been key to the success of this initiative. We are also deeply thankful to the team members of our development partners working in the state, whose support and contributions were invaluable during this process.

We would like to particularly thank all the staff members of NHM and the Health Department in the field who supported us during our visits. Their on-ground assistance, guidance, and cooperation made our work smoother and more effective.

We also express our gratitude to the field enumerators who assisted us in data collection and translation, ensuring that the information gathered was accurate and accessible.

With the support of all these dedicated individuals and teams, we have been able to successfully develop this SBCC strategy, which will contribute to enhancing public health awareness and outcomes in Meghalaya.

PREPARED BY

SACH and FirstBorn

PREPARED FOR

MHSSP, State of Meghalaya

Table of Contents

Abbreviations

Executive Summary

How to Use This Document
a. Part 1: Core SBCC Strategy
b. Part 2: Health Topic-Specific Strategies
c. Limitations

Introduction To The SBCC Strategy
Background
Current Health and SBCC Landscape in Meghalaya
Methodology and Approach

Assessment of Current SBCC Framework
Institutional Architecture Overview
Field Insights: KAPB and Cultural Assessments
Assessment of existing IEC Materials (strategy), Enablers, Challenges and Mitigation Strategy

Proposed SBCC Strategy
Macro and Micro Recommendations
Strengthened SBCC Institutional Framework
Innovative Channels and Materials: Benefits, Challenges, and Solutions
Target Audience Segmentation and Key Messages
Preferred communication channels by Audience
Integrated Strategic Approaches:
- Multi-sectoral Convergence with Roles & KPIs
- System Strengthening and Data-Driven Implementation
- Supportive Supervision

Theory of Change

Institutional Strengthening

Project Implementation Plan

Monitoring and Evaluation Framework

Sustainability Plan

Annexures
Glossary
Supporting Documents and Resources

List of Abbreviations

AIDS – Acquired immunodeficiency syndrome

ANC – Antenatal Care

ANM – Auxiliary Nurse Midwife

ASHA – Accredited Social Health Activist

AWW – Anganwadi Worker

AWC – Anganwadi Centre

B-CAP – Block Convergence Action Plan

BCG – Bacillus Calmette-Guérin

BPM – Block Program Manager

C&RD – Community and Rural Development Department

CB – Capacity Building

CBO – Community-Based Organizations

CDPO – Child Development Project Officer

CF – Complementary Feeding

CHC – Community Health Centre

CSR – Corporate Social Responsibility

DC – District Collector

D-CAP – District Convergence Action Plan

DCPC – District Child Protection Officer

DMHO – District Medical and Health Officer

DMM – District Mission Manager

DPO – District Project Officer

DSWO – District Social Welfare Officer

EBF – Exclusive Breast Feeding

EIBF – Early Initiation of Breastfeeding

FAQ – Frequently Asked Question

FGD – Focus Group Discussion

FHI – Family Health International

FLW – Frontline Worker

FP – Family planning

H&WC – Health and Wellness Centre

HBNC – Home Based Newborn Care

HBYC – Home Based Care for Young Child

HIV – Human immunodeficiency viruses

ICDS – Integrated Child Development Service

IEC – Information, Education, and Communication

IFPRI – International Food Policy Research Institute

IIPHS – Indian Institute of Public Health Shillong

IPC – Interpersonal Communication

KAP-B – Knowledge, attitudes, and practice behaviours

KMC – Kangaroo Mother Care

LM – Lactating Mother

M&E – Monitoring and Evaluation

MCH – Maternal and Child Health

MCP – Maternal and Child Protection

MDRTB – Multi Drug Resistant Tuberculosis

MHSSP – Meghalaya Health Systems Strengthening Project

MIS – Management Information System

MLHP - Mid-Level Health Providers

MoM – Minutes of Meeting

MO i/c – Medical Officer in Charge

MP – Male Participation

MSACS – Meghalaya State AIDS Control Society

MSRLS – Meghalaya State Rural Livelihoods Society

NCD – Non-Communicable disease

NFHS – National Family Health Survey

NGO – Non Governmental Organization

NHM – National Health Mission

PA – Primary Audience

PHC – Primary Health Centre

PHED – Public Health Engineering Department

PLWHA – People Living With HIV/AIDS

PMU – Project Management Unit

PNC – Postnatal Care

PPP – Public Private Partnership

PSU – Public Sector Undertaking

PTA – Parent Teacher Association

PW – Pregnant Women

PWD – Public Works Department

RBSK – Rashtriya Bal Suraksha Karyakram

RCH – Reproductive Child Health

S-CAP – State Convergence Action Plan

SBCC – Social and Behaviour Change Communication

SC – Sub Centre

SHG – Self Help Group

SRS – Sample Registration System

SUD – Strategic Use of Data

TB – Tuberculosis

UNICEF – United Nations Children's Fund

VEC – Village Education Committee

VHC – Village Health Council

VHIB – Village Health Information board

VHND – Village Health and Sanitation Day

WCD – Women and Child development

WHO – World Health Organization

WRA – Women in Reproductive age

Executive Summary

The Social and Behaviour Change Communication (SBCC) Strategy developed by the Society for Action in Community Health (SACH) for the Government of Meghalaya represents a robust, culturally sensitive framework aimed at transforming health behaviours across the state. Rooted in evidence-based practices and contextualised through in-depth field research, this strategy seeks to address critical health challenges by leveraging communication as a transformative tool.

The state of Meghalaya faces a unique set of public health challenges, including high maternal and child mortality rates, inadequate uptake of health services, and limited awareness of preventive health measures. Its diverse cultural fabric necessitates a nuanced approach to communication, ensuring messages resonate with various communities. Recognising this complexity, SACH adopted a participatory methodology to develop a comprehensive, hyperlocalized inclusive SBCC strategy. This methodology involved comprehensive field surveys and Focus Group Discussions (FGDs) across the three regions of Meghalaya, evaluation of existing Information, Education, and Communication (IEC) materials to identify gaps and opportunities, multi-stakeholder consultations to ensure alignment with state and national priorities, and collaboration with a multi-sectoral team comprising experts from health, education, communication, and community development to ensure a holistic and integrated approach.

The strategy is built on a unifying framework designed to integrate SBCC efforts across health topics while addressing systemic challenges. It provides tailored approaches to address key health priorities, including maternal and child health, nutrition, and communicable and non-communicable diseases. Findings from Knowledge, Attitudes, Practices, and Behaviours (KAPB) assessments, analysis of cultural dimensions using Hofstede's model, and community engagement have informed its development to ensure relevance and acceptance. Recommendations to enhance the SBCC institutional framework include capacity building, resource allocation, and strategic partnerships. Furthermore, innovative channels and locally adapted communication tools and platforms have been identified to effectively reach diverse audiences.

Findings

Field insights have revealed that deeply ingrained cultural beliefs, religious influences, and traditional practices significantly shape health behaviours and attitudes. There is a high reliance on traditional healers and community leaders for health guidance, alongside passive engagement from religious institutions, which underscores the need for culturally sensitive interventions. Collective social norms and stigma play a critical role in shaping decisions about healthcare, breastfeeding, family planning, and disease management.

Gender dynamics in health decision-making also present challenges. Sociocultural norms reinforce traditional gender roles, with women as primary caregivers and limited male participation in maternal and child health. Women's health decisions are influenced by

collaborative family structures but are constrained by traditional norms and limited resources. Additionally, significant misconceptions and gaps exist in understanding health practices, including breastfeeding, birth spacing, HIV/AIDS, TB, and non-communicable diseases (NCDs) like diabetes, hypertension, and cancer. Knowledge dissemination is inconsistent, often reliant on ASHAs, traditional leaders, or informal networks, with limited reach to hard-to-access areas.

Structural and systemic challenges exacerbate these issues. Inadequate health infrastructure, limited uptake of health services, and irregular screenings for diseases contribute to delayed diagnosis and treatment. Existing health campaigns and communication strategies are insufficient in addressing deep-rooted cultural and social barriers effectively. However, opportunities for community-centric interventions exist. Community networks and traditional structures, though underutilised, present significant potential for promoting health awareness and behaviour change. Leveraging trusted sources like traditional healers, religious institutions, and local influencers can enhance the effectiveness of health promotion strategies.

Recommendations and Strategic Approaches

The strategy outlines macro and micro recommendations, combining high-level policy interventions with community-level action plans to drive behavioural change. Specific messaging and channels have been designed for diverse demographic groups, including men and women, community stakeholders like village headman, elders, religious leaders and traditional healers. Collaborative efforts across departments, with clearly defined roles and Key Performance Indicators (KPIs), are emphasised to achieve multi-sectoral convergence. A results-oriented approach that integrates monitoring, evaluation, and adaptive learning through a well-defined theory of change is central to this strategy.

Sustainability and Monitoring

To ensure long-term impact, the strategy proposes strengthening local capacity for SBCC implementation, establishing supportive supervision mechanisms, and embedding SBCC practices into existing health systems and policies. The sustainability plan is focused on institutional strengthening and fostering community ownership of health initiatives.

Conclusion

This SBCC Strategy is a critical step toward achieving Meghalaya's public health goals. By addressing cultural, systemic, and behavioural factors, it provides a roadmap for sustained improvement in health outcomes. With strong institutional support and community engagement, this strategy has the potential to transform health communication and drive meaningful behavioural change across the state.



How to Use This Document





How to Use This Document

This document is designed to guide officials of Health Department and it's allied departments like Women and Child Development (Social Welfare), Education, Meghalaya State Rural Livelihood Society (MSRLS), Community & Rural Development (C&RD) at the state level and below in implementing a comprehensive and culturally attuned SBCC strategy in the state of Meghalaya. It provides a structured approach to address key health topics while fostering community engagement and inter-departmental coordination. The document is mainly divided into two parts- The Core Strategy document and Health Topic Based-Specific Strategy.

Part 1: Core SBCC Strategy

The strategy document serves as a foundational guide, clearly outlining its purpose and emphasizing key collaborative efforts. It provides an overarching framework for the SBCC strategy, identifying gaps in existing approaches and detailing actionable solutions to address them. Additionally, the document introduces innovative strategies and communication materials, offering clear recommendations to achieve its goals of fostering behaviour change, increasing community awareness, and improving health outcomes.

A significant focus is placed on the need for a collaborative and integrated approach across departments, highlighting interdependencies and defining roles and responsibilities with setting up accountabilities. The document advocates for the development of a unified work plan to ensure alignment on health-specific and health-sensitive interventions, with active contributions from all relevant departments.

Furthermore, the document emphasizes system strengthening, with detailed strategies to address human resource requirements, supportive supervision, data-driven decision-making, and capacity building. It also underscores the importance of community mobilization, calling for the involvement of key community structures such as Village Headmen, Village Health Committees (VHCs), Self-Help Groups (SHGs), and Religious Institutions. By integrating these elements, the document provides a holistic approach to achieving the strategy's envisioned health and wellness objectives.

Part 2: Health Topic-Based Specific Strategies

This section presents a comprehensive, topic-specific approach tailored to address individual health priorities effectively. Each health topic is structured to include targeted objectives and desired outcomes, audience-specific messaging and communication channels, and cultural and regional adaptations to ensure relevance and effectiveness across diverse settings. The document adopts a multi-level approach to enhance both

existing and new interventions by reviewing pre-existing communication materials and offering recommendations for improvement, as well as providing detailed guidance for designing new interventions. It emphasizes categorizing audiences into primary and secondary groups, developing key messages aligned with communication goals, identifying targeted behaviours for change across audience types, selecting appropriate channels and modes for effective dissemination, and formulating monitoring plans to track progress for each health topic.

The structure ensures a seamless transition from high-level planning to topic-specific implementation, enabling stakeholders to gain a holistic understanding of the SBCC framework and access actionable strategies for execution. Furthermore, the design highlights the importance of periodic reviews of resources and the development of micro-plans for interventions. This approach allows stakeholders to assess preparedness, identify necessary prerequisites, monitor participation, and systematically track progress, resulting in a clear, actionable roadmap that fosters effective planning, execution, and continuous improvement.

Limitations

This document is prepared based on the information gathered from across the state reflecting the current scenario, perspectives and experiences shared by officials, community level workers and community level stakeholders, and beneficiaries. This information should be viewed as representative rather than definitive or standardized for the entire state. Given the state's expanse and diversity, additional research may reveal further variations. However, the sample size provided a sufficient representation of diverse findings at this stage, allowing for an adequate assessment based on the reported data. The strategy and recommendations are primarily centred on the suggested health topics.

This document does not address how to develop and implement other social or behaviour change initiatives beyond communications. This document will not provide a one-stop solution to the health behaviours, but will aid in understanding the social and behavioural changes required and the related barriers to change in order to help design effective communication materials and interventions. Social and behaviour change is complex and difficult, requiring sufficient resources- time, funding, skills and expertise.



Introduction





Introduction To The SBCC Strategy

Meghalaya, the "Abode of Clouds," is a northeastern Indian state known for its stunning geography, deep cultural roots, and indigenous identity. Defined by the Khasi, Jaintia, and Garo Hills, its diverse terrain ranges from the world's highest rainfall areas to drier regions, influencing agriculture, water availability, and health outcomes.

The state is witnessing a 'transitioning paradox'. A uniquely cultural and socially networked society grappling to find a place for its own indigenous logic, social doctrines and collective cultural cognition (way of thinking) in a radically new world with its own crises and malaises. Public health and decision making in indigenous environments serves as a complex site for this 'transitioning cycle'. The socio-political climate with the ongoing upsurge of local nationalism, preservation of community identity and fear of cultural erosion -has further escalated this 'crisis of faith' in the public systems.

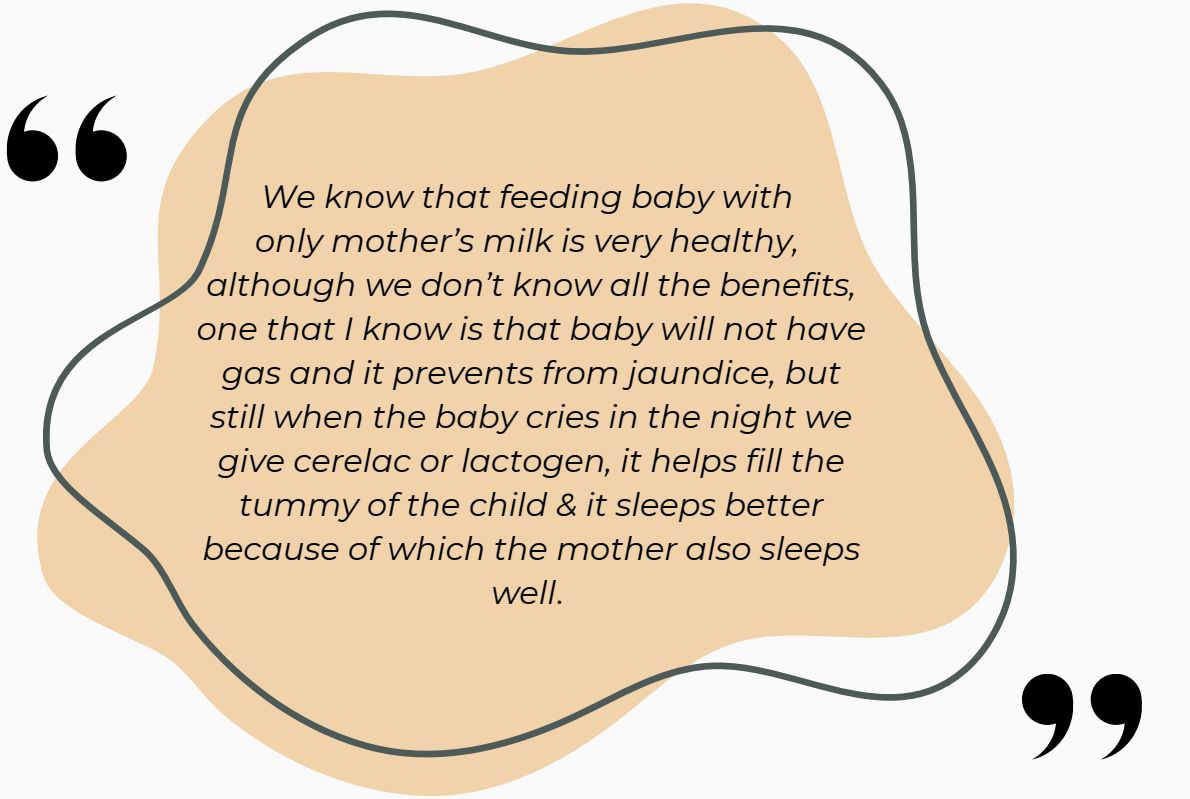
While access and infrastructure remain a massive challenge along with the underutilisation of existing health infrastructure, poor education status (high drop-out ratio post primary education) and acute information asymmetry about health conditions has caused the historical practices and some antiquated cultural norms to fill that void and have become an influential factor in decision making in health-related matters at the community level. The absence of a dedicated SBCC unit to oversee and coordinate communication activities has resulted in fragmented efforts and limited impact.

The IEC unit lacks a cohesive and structured framework hence often relying on ad hoc processes to largely meet the immediate requirement. Currently the focus is meeting the various program requirement and pushing IEC materials as received from ministry because of which the IEC materials are not adequately tailored to local contexts, and dissemination is irregular, largely confined to specific events. Furthermore, community involvement is minimal although the concept of VHCs has been introduced into the system it is yet to gather momentum as expected, and local media and mobilisation platforms remain underutilized for consistent engagement. The absence of mechanisms to gather community feedback and integrate it into campaigns further hampers effectiveness.

These gaps have further strengthened the persistent misconceptions and have limited the adoption of critical health behaviours, underscoring the urgent need for a dedicated SBCC unit and a comprehensive, culturally sensitive strategy to drive sustainable behaviour change in the state.

The proposed SBCC strategy aims to act as a service redesign framework - with active engagement and outreach design -as the first and foremost component - to support in establishing the ideal conditions for better health outcomes.

The strategy's goals and objectives establish the foundation and framework for sustainable social and behaviour change, focusing on promoting desired behaviours among target groups, creating an enabling environment for change, and equipping functionaries and stakeholders to deliver the strategy. The MHSSP team, in collaboration with the IEC wing of the health department, will lead this initiative in coordination with the allied departments to ensure effective and efficient implementation of this SBCC strategy across the state and across all levels.



Background

The state of Meghalaya shows a mixed performance across key health indicators, with sharp variations between rural and urban areas. While the state has made significant progress in reducing maternal and infant mortality rates and improving the performance of health facilities, it continues to struggle with a high fertility rate, low acceptance of family planning methods, poor infant care and feeding practices, high social acceptance of teenage pregnancies, and resistance to institutional maternal care.

Additionally, there is a dual burden of communicable and NCDs, with anaemia and malnutrition remaining endemic. The cultural and social factors play a significant role in influencing accepted behaviours and practices, which complicates the effectiveness of health services. Moreover, the low educational status among people of the indigenous groups reinforces negative social norms, further challenging the state health machinery's efforts to address these deeply rooted issues effectively.

Current Health and SBCC Landscape in Meghalaya

The state faces challenges like rural-urban disparities, inter-state & intra-state migration, limited healthcare access, and a rising burden of NCDs coupled with the burden of increasing malnutrition and existing burden of communicable diseases. Remote villages, scattered across rugged terrain, often lack infrastructure, while linguistic and cultural differences hinder effective communication and service delivery, making equitable healthcare delivery a persistent challenge.

In the state, birth spacing remains a critical issue with limited uptake of family planning options compounded by low male participation in reproductive health decisions. The state shows the lowest adoption of modern contraceptive methods among Northeastern states, at just 8.3%. Traditional methods remain prevalent, accounting for 39% of contraceptive users. Closely linked to this is the promotion of Exclusive Breastfeeding (EBF) and Complementary Feeding (CF) practices, which are essential for reducing infant mortality and preventing malnutrition, a risk factor that exacerbates other health conditions. Exclusive breastfeeding for children under six months improved from 35.8% in NFHS-4 (2015-16) to 42.7% in NFHS-5 (2019-20), reflecting enhanced awareness but requiring further efforts, especially in rural areas. Complementary feeding also improved, with children aged 6-8 months receiving solid or semi-solid food and breast milk rising from 51.6% to 62.9%. However, dietary diversity and minimum meal frequency remains critically low, with only 16.8% of children aged 6-23 months receiving an adequate diet in NFHS-5. Male participation in supporting these practices and broader maternal and child health efforts can create a supportive environment, fostering positive behavioural changes.

Currently, 58% of total births take place in a health facility (mostly government-run), while 41% occur at home. Institutional births have increased from 51% in NFHS-4 to 58% in NFHS-5, reflecting gradual progress.

The prevalence of anemia in Meghalaya is alarmingly high across all age groups. Among children aged 6-59 months, 45.1% are anemic, showing a marginal improvement from 48% (NFHS-4). Adolescents aged 15-19 years are similarly affected, with 52.5% of girls and 30.1% of boys found to be anemic. Among women of reproductive age (15-49 years), 53.8% are anemic, compared to 25.5% of men in the same age group.

In terms of antenatal care (ANC), 52.2% of pregnant women in Meghalaya received at least four ANC visits—below the national average of 58.1%. In urban areas, the figure is higher at 67.5%. However, this indicator has shown little improvement from 50% in NFHS-4. During their last pregnancy, 85% of mothers received iron and folic acid (IFA) tablets, but only 43% consumed them for 100 days, and a mere 21% completed the recommended 180-day course. While 82% of pregnant women were protected against neonatal tetanus, only 8% consumed deworming tablets.

Furthermore, the rising burden of NCDs like cancer, hypertension, and diabetes further strains the healthcare system, particularly as these conditions often coexist with communicable diseases. As per NFHS 5 report, 9.5 % of women and 13.9% of men above 15 years have high or very high levels of glucose in their blood.

The report also states that 18.7% of Women and 21.5 % of Men having elevated blood pressure. Meghalaya exhibits a unique cancer profile compared to other parts of the country. The Age-Adjusted Incidence Rate for cancer is 176.8 per 100,000 in males. Notably, approximately two-thirds (66.9%) of cancers in males and 43.1% in females can be attributed to tobacco use.

Tuberculosis (TB), for instance, continues to affect vulnerable populations, with co-morbidities such as diabetes compounding its impact. In 2022, Meghalaya recorded 4,974 TB case notifications, which decreased slightly to 4,812 cases in 2023. Public awareness about TB is moderate but fragmented. While 76% of respondents recognize the symptoms and 66% are aware of its transmission mode, only 52.6% believe the disease is preventable, and knowledge about the BCG vaccine is limited to 32%. Adding to the challenge is the prevalence of HIV/AIDS has emerged as a significant public health challenge, with the state reporting a prevalence rate of 0.43%, surpassing the national average of 0.21%. This represents nearly 9,589 registered cases of people living with HIV (PLWHA), a dramatic increase compared to previous years.

Addressing these interconnected issues through a cohesive SBCC approach offers an opportunity to tackle these challenges in an integrated manner, fostering healthier behaviours and improving health outcomes across the state.

The SBCC strategy for Meghalaya is designed to address the diverse cultural and social contexts of its three main indigenous communities: the Khasi, Garo, and Jaintia. Each community has distinct traditions, belief systems, and health-seeking behaviours influenced by their unique cultural frameworks and geographic settings.

Methodology and Approach

The strategy development process followed a phased approach, beginning with initial discussions held with the MHSSP PMU team and key officials from the NHM and the Department of Health & Family Welfare. These discussions outlined their vision and expectations for the assignment, providing clarity on the goals to be achieved. Following this, a state-level consultation was conducted, which laid the groundwork for detailed state profiling, literature review, and situation analysis. This comprehensive exercise established the objectives and approaches necessary to create a robust foundation and framework for sustainable social and behaviour change. The focus was on promoting desired behaviour changes among target groups and fostering an enabling environment to support these changes.

To further inform the strategy, an in-depth understanding of the current health landscape was undertaken, including an exploration of health-seeking practices, cultural factors, and awareness levels related to the proposed health topics. This was achieved through extensive field visits and systematic data collection efforts. The data collection and analysis were guided by the KAP-B framework, further enriched by Hofstede's cultural dimensions and anthropological approaches. This integration provided a deeper understanding of local behaviours, cultural determinants, and the factors influencing health-related decision-making.

State Profiling: The process involved analysing the profile of Meghalaya across key aspects such as geography, demography, economy, climate, and culture. This analysis highlighted the state's diversity, including regional and cultural variations, which are critical for understanding the behavioural determinants essential to shaping the strategy. Particular attention was given to understanding the media environment, patterns of communication channel consumption and preferences, which was examined at two levels: variations between tribes & their geography, and the other on gender-based preferences, ensuring a comprehensive approach to strategy development.

Literature Review and Situational Analysis: To understand the current situation across health topics, a literature review and situational analysis was conducted. This included a thorough review of existing literature, current statistics, and ongoing interventions by the health department and other stakeholders. A systems-thinking approach analyzed the interconnections among health topics. The comprehensive desk review referred to documents by MHSSP, MSRLS, IFPRI, WCD, the WISH Foundation, and other research papers, while data analysis used public sources like NFHS-4 & 5, Census 2011, SRS 2020, and newspaper archives. Discussions with the PMU MHSSP, Divisional Officers, the IEC team, various program teams, and partner organizations (UNICEF, WHO, IPE Global, WISH Foundation, IIPH-Shillong) gave insights into root causes of challenges, program effectiveness, communication barriers, and areas needing intervention.

Field Data Analysis (Qualitative Assessment): Based on the desk review and situational analysis, data collection tools were developed to identify and understand key challenges and barriers related to health-seeking practices, cultural dynamics, and awareness of the proposed health topics. These challenges were categorized into:

- Overarching Barriers: Factors influencing the broader environment necessary for decision-making among target audiences.
- Systemic Challenges: Issues at the administrative level impacting service delivery and outreach.
- Health Topic-Specific Barriers: Challenges specific to adopting desired health behaviours.

To capture these aspects, a KAP-B tool was designed for each health topic. This tool assessed awareness, perceptions, actions, and behavioural patterns within communities. Additionally, an anthropological survey tool was developed to understand cultural nuances, preferences, and differences among Meghalaya's three main indigenous groups. The tools incorporated components of the Hofstede Model to analyse cultural differences across regions, focusing on factors like power distance, individualism vs. collectivism, masculinity vs. femininity, uncertainty avoidance, long-term vs. short-term orientation, and indulgence vs. restraint influence behaviours, community dynamics, and decision-making. A score-based assessment was used to quantify these cultural dimensions. Another tool was deployed to map existing communication channels and materials, collecting information at both state and district levels.

<u>Process Undertaken:</u>

- Discussions with Officials and Stakeholders- consultations were conducted at the state level with officials from various health department verticals, including the State TB Cell, Megh-SACS, NHM-IEC division, RCH division, NCD unit, RBSK unit, and the NHM -State Program Manager.

- Group Discussions with Communities - Field visits were conducted in selected villages, involving interviews and group discussions with community members and stakeholders. Participants included:
  - Women aged 18–49 years (including pregnant and lactating women)
  - Adolescent girls
  - Women and men above 49 years
  - Male participants
  - ASHA workers and Anganwadi Workers

- Visits to Sub-centres / Health & Wellness Centres, and PHCs enabled interactions with healthcare staff.

Districts, blocks, and villages were selected based on discussions with state officials, considering accessibility, internet/mobile network connectivity, and performance. Fieldwork covered over 22 sites across the three regions, covering over 350 participants for focus group discussions and in-depth interviews.

Separate questionnaires were developed for women, men, and mixed groups, tailored to the context of each discussion.

Key Outcomes from Field Discussions focuses on the following

- Identified preferred communication channels to prioritize in the strategy.
- Highlighted key barriers and enablers influencing health behaviour adoption, varying by factors such as community type, village location, proximity to cities or neighbouring states, and women's education levels.
- Beneficiaries provided feedback on communication tools and approaches they found resonant and commonly used.

> *We only hear about pills and condoms when elders whisper. Nobody teaches us. We want to learn, but we don't know who to ask.*
>
> – a 15-year old adolescent boy, Nongchram Village, East Garo Hills District

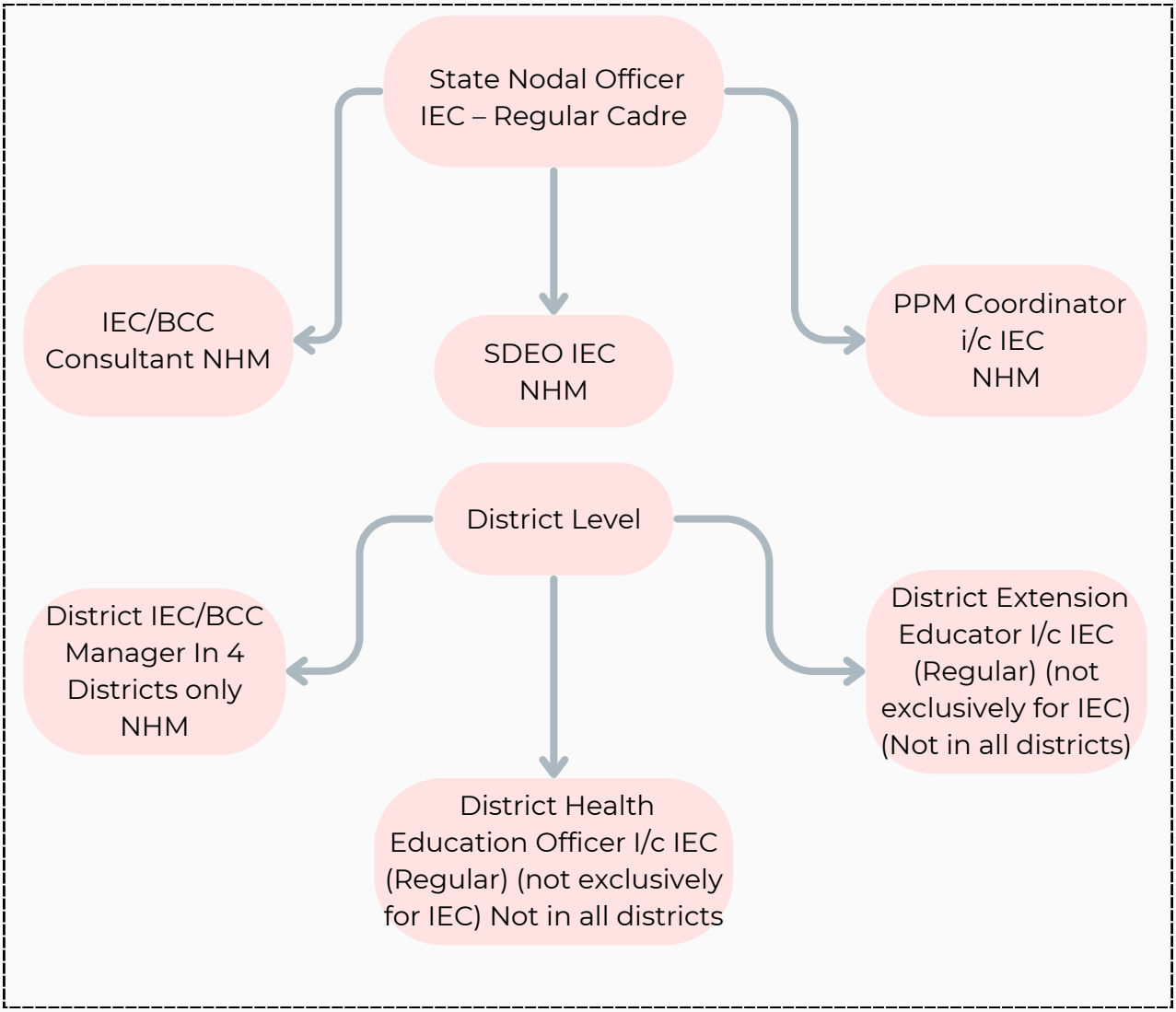


Assessment of Current SBCC Framework





Institutional Architecture Overview



Current institutional architecture

The IEC vertical of the State Health Department operates with a lean structure, characterized by role ambiguity and gaps in its functioning. At the state level, the vertical is led by the State Nodal Officer IEC , who is based in Shillong and supported by a team of three members i.e. IEC BCC Consultant NHM, PPM coordinator IEC NHM. and SDEO IEC NHM. In district level there are IEC/ BCC manager (only in 4 districts), District Health Education Officer (not in all districts) and District Extension Educator (Not in all districts).

The State Nodal IEC Officer is responsible for coordinating the development of IEC materials for various health programs and initiatives. Each program vertical submits its annual requirements for materials such as audio-visual, print, and digital content. The State Nodal IEC Officer ensures these materials are produced and dispatched to districts according to the plan.

At the district level, there are no dedicated District IEC Manager in many districts, except in four districts, the responsibility for IEC activities is managed by an officer in-charge. Few districts has got District Health Education Officer and few district have District Extension Educators. Further distribution of materials is carried out to blocks, PHCs, and HWCs, where the staff in charge of the respective facilities oversee their usage. These materials are either displayed or distributed, depending on their type and purpose. However, the absence of a structured and dedicated framework across levels often leads to inefficiencies.

Despite some level of functional coordination, the current system suffers from significant gaps. There is no robust mechanism to track the reach, usage, or effectiveness of IEC materials, making it difficult to assess their impact on the target population. The state also lacks a structured reporting and review process, which hampers the ability to identify usage patterns, assess needs, or recommend modifications to the materials. Moreover, the lean staffing and lack of defined roles further exacerbate these challenges, creating bottlenecks in the overall implementation of IEC activities. At the facility level, the usage of IEC materials is decentralized and ad hoc, with no standard guidelines governing their application.

> *Whenever the village people ask me about various diseases like sugar, BP, cancer and all I feel very embarrassed as being an ASHA I am unable to tell them anything about these kinds of diseases. I wish only if we got regular training and updates on these diseases, I could inform people when they approached me.*

– ASHA worker in Megonggre Village in Dadenggre block, West Garo Hills District

Field Insights: KAPB and Cultural Assessments

The findings presented in this section stem from a comprehensive field assessment and an in-depth review of secondary literature conducted as part of the SBCC strategy development for Meghalaya. The field assessment involved surveys and extensive interactions with key stakeholders, including community members, health workers, and local authorities, to capture grassroots insights and lived experiences. Simultaneously, the literature review examined existing policies, communication strategies, and behavioural patterns to provide a robust contextual framework.

The assessment highlights the intersection of social and cultural influences, which exacerbate hesitancy toward health services and emphasize the need for culturally sensitive interventions. Furthermore, the socio-political climate, characterized by the upsurge of local community identity and fears of cultural erosion, has intensified mistrust in public health systems and policies. This mistrust contributes to the low uptake of healthcare services and health-seeking behaviours in the state. Challenges such as limited access and poor educational attainment, including high dropout rates after primary and secondary education, further hinder the utilization of existing health facilities.

Below are the key findings categorized by the Hofstede Cultural Dimensions and anthropological inferences based on the KAPB assessment:

Macro-Findings: Cultural Dimensions

1. Major Beliefs and Social Order

Power Distance:

- The villages exhibit a high to moderate degree of power distance, where adherence to the authority of village heads or religious institutions is prominent.
- Approximately 90% of respondents reported refraining from actions disapproved by the church or religious institutions. Religion, traditional faith, and beliefs wield significant influence, with over 70% guided by spiritual, religious, and village institutions in health-related matters.
- Decision-making is driven by "community power structures" such as headmen, village elders, church authorities, and maternal uncles, emphasizing a hierarchy that influences health and family choices.

Gender Dynamics in Decision-Making:

- Sociocultural norms heavily influence reproductive health choices, including maternal health, birth spacing, breastfeeding, family planning, and male participation.

- While traditional norms dominate, resource constraints and aspirations have led to a slight positive shift in family size preferences, especially among the younger generation.
- Collaborative decision-making between spouses is common, though women remain the primary caregivers in 70% of households, responsible for elder, child, and extended family health matters.

2. Collectivism and Social Networks

High Collectivism:

- The Khasi and Jaintia communities exhibit slightly stronger collectivist traits than the Garos.
- Community engagement is a defining feature, with over 61% of the population showing a strong proclivity for adherence to social norms and practices.
- Social inclusion and collective responsibility underpin societal behaviour, while social stigma and communal anxieties significantly shape decision-making.

Knowledge Transfer and Social Networks:

- Dissemination of knowledge largely depends on trusted sources such as the church, traditional healers, and village headmen. These networks act as both the message and the medium for health communication.
- Despite their influence, institutions like the church have adopted a passive stance on critical health topics, inadvertently reinforcing traditional norms such as large family sizes and low contraceptive use.

3. Short-Term Orientation and Risk Perception

Present-Oriented Thinking:

- Only 40% of respondents reported saving for health emergencies, with most prioritizing short-term goals over long-term planning.
- Decision-making is predominantly tied to immediate needs, with limited emphasis on savings or future-oriented health preparedness.

4. Masculinity and Femininity Norms

Moderate Masculinity Norms:

- Meghalaya reflects a balanced approach to competitiveness and quality of life, with minimal gender conflicts.
- While 90% of respondents believe men are primarily responsible for financial contributions, financial roles are increasingly seen as shared responsibilities between partners.
- Women's autonomy in health decisions is viewed as a collaborative process influenced by socio-economic dynamics rather than authority or permission.

5. Socio-Cultural Inferences

Role of Traditional Healers:

- Traditional healers play a pivotal role as both medical practitioners and custodians of

collective identity and indigenous knowledge systems. They are often the first point of contact for common ailments like diarrhoea, fever, and cough.

- Their accessibility and integration into the cultural fabric position them as vital resources for addressing health challenges.

Stakeholder Engagement Gaps:

- Stakeholder engagement, particularly with non-traditional actors like pharmacists, local beauty salons, and weekly market vendors, remains poor. These spaces offer untapped potential for health awareness and communication interventions.

Role of the Church:

- Church is a highly influential institution but adopts a passive stance on critical health issues.

This passivity indirectly endorses traditional norms and behaviours, underscoring the need to engage religious institutions more actively in health promotion efforts.

Micro Findings: Topic-based findings

1. Exclusive Breastfeeding Practices

Cultural Beliefs and Practices:

- In all three regions, many mothers believe breast milk alone is insufficient for their baby's needs, especially at night. This misconception often leads to early complementary feeding before six months. In Khasi and Jaintia areas, rice broth, mashed rice, and bananas are common early foods, while Garo care-givers favour pre-lacteal feeds like cerelac and formula milk, believing these help babies sleep better.

Maternal Workload and Employment:

- Mothers across the region face challenges in practising EBF due to work and household responsibilities. Rural mothers working in farmlands or as daily labourers often lack support and turn to semi-solid foods or formula. Urban mothers face similar issues due to inadequate workplace breastfeeding facilities. Elder siblings or grandparents often introduce early feeding, and male partners provide limited support post-childbirth.

Knowledge and Misconceptions:

- While awareness of EBF benefits exists, gaps in understanding persist. Many mothers believe breastfeeding depletes their health or worry about insufficient milk production, leading to premature complementary feeding. Misinterpreting infant behaviours like crying as hunger also reinforces these misconceptions.

Traditional Practices and Societal Influence:

- Family traditions strongly influence feeding practices. Elders often advocate early complementary feeding, believing breast milk is insufficient. Foods like mashed rice and rice broth are introduced as early as one month, with societal pressure compelling mothers to follow these practices despite knowing the guidelines.

Health System Barriers:

- Lactating mothers primarily rely on ASHAs and ANMs for guidance, but counselling is often inconsistent or incomplete. Limited postnatal support and counselling undermine mothers' confidence in EBF and the timely initiation of complementary feeding.

2. Birth Spacing Practices

Cultural Beliefs and Practices:

- In Meghalaya, a strong belief that children are divine blessings discourages planned family decisions, as intervening is seen as interfering with God's will. Religious institutions, such as churches, remain neutral on family planning, offering no collective guidance. As a result, decisions on family size and spacing are influenced by personal beliefs, cultural norms, and individual discretion.

Traditional Norms and Ideal Family Size:

- Among younger women, the ideal family size is 3–5 children, reflecting financial challenges. In contrast, older women consider 5–8 children ideal, aligning with traditional norms. Younger women are more likely to support 2–3 years of spacing between births for better maternal and child health, though societal expectations often prioritise lineage continuation over strategic planning.

Economic and Practical Constraints:

- Families with limited financial resources cite high education and healthcare costs as reasons to limit family size. However, the desire for a girl child often leads to larger families. Traditional support systems, such as older siblings assisting with caregiving, are common. Limited access to contraceptives is also a significant barrier to family planning.

Awareness of Family Planning Methods:

- Awareness of contraceptive options like pills (Mala D/N), injections (Antra), and Copper-T exists but is often basic and inconsistent. ASHA workers, nurses, and occasional health campaigns are the primary sources of information, which rarely reach remote areas comprehensively. Knowledge gaps about birth spacing and effective contraceptive use persist.

3. Low Male Participation in Maternal and Child Health Care

Inconsistent Support:

- *Male involvement across the Khasi, Garo, and Jaintia regions varies, with many men providing support only in emergencies, lacking consistent engagement.*

Low Prioritization:

- *Despite recognising their role, men often view maternal and child health as a low priority, leaving women to manage independently.*

Peer and Societal Pressure:

- *Cultural norms discourage male participation, with fear of judgement deterring active involvement.*

Traditional Gender Roles:

- *Caregiving is largely seen as a woman's responsibility, limiting men's engagement.*

Regional Variations:

- *In the Garo region, men often take decision-making roles, while in the Khasi region, women are left to manage healthcare, reflecting cultural differences.*

Knowledge Gaps:

- *Men lack awareness and sensitisation on how to contribute effectively.*

Few Role Models:

- *Absence of male examples reinforces the belief that maternal health is a woman's duty.*

Economic Pressures:

- *Men prioritise earning over health involvement, especially as primary breadwinners.*

Institutional Gaps:

- *Health systems lack structured initiatives to encourage male participation.*

4. Incidence of HIV/ AIDS

Limited Understanding of HIV/AIDS Transmission:

- During the FGDs, it was revealed that while most participants, both men and women, identified sexual intercourse as the primary route of HIV transmission, there was minimal knowledge about other pathways, especially mother-to-child transmission. Awareness gaps, including some knowledge of needle sharing, can inadvertently increase the risk of transmission.

Cultural Terminology and Perceptions:

- In the Khasi community, HIV/AIDS is referred to as "Khniang Mynrain," meaning a disease of private parts, which may shape how the disease is understood. Although this term acknowledges the disease, it carries social and cultural connotations that can stigmatise it, limiting open discussions and preventive actions.

Stigmatization:

- Participants noted that HIV/AIDS is often associated with "carelessness" in relationships, particularly among young people, reflecting a moralistic view. People living with HIV/AIDS are perceived as having "poor morals," which can discourage individuals from seeking information, testing, or treatment, potentially contributing to higher incidence rates.

Low Engagement with Awareness Campaigns:

- Although some people recalled HIV/AIDS awareness programs by health authorities and NGOs, many had limited knowledge, and the content from these programs was often poorly retained. The lack of engaging, frequent, and culturally relevant education contributes to ongoing gaps in awareness and preventive behaviours.

Limited Community Involvement in Health Campaigns:

- *Some groups suggested involving the VHC more in organizing HIV/AIDS awareness campaigns, noting that community-based education is insufficient. In some areas, people do not personally know anyone with HIV/AIDS, leading to indifference towards further learning. However, participants acknowledged that communities should actively engage in awareness campaigns if individuals are living with HIV/AIDS.*

Minimal Perception of Risk:

- *Many respondents did not feel the need for more information about HIV/AIDS as they did not know anyone affected within their community or family. This misconception of low risk leads to complacency, increasing the likelihood of transmission.*

Integrated Campaigns:

- *Some participants suggested that HIV/AIDS information is often mixed with other health issues, such as tuberculosis, which dilutes the focus on HIV. This overlap may prevent people from fully understanding the significance of HIV and its impact on public health.*

5. Incidence of TB

Cultural Norms and Practices:

- In the Khasi, Garo, and Jaintia regions, many communities turn to traditional medicine as their first treatment option, delaying formal medical diagnosis and care. This cultural preference, coupled with limited understanding of tuberculosis (TB) prevention and treatment, contributes to delays in intervention, worsening the disease control efforts.

Awareness and Education Gaps:

- While some respondents could identify prolonged cough as a TB symptom, few recognized weight loss or weakness. Knowledge of TB's full range of symptoms and its transmission—such as droplet infection—was limited. Misunderstandings about TB transmission and treatment, combined with insufficient knowledge among ASHA workers, delay medical help-seeking. Although health campaigns have raised awareness, they often lack depth, particularly in high-prevalence, hard-to-reach areas.

Stigma and Perception Challenges:

- While TB stigma is generally low, misconceptions about the disease's curability and preventability remain widespread. These false beliefs hinder early detection and treatment, discouraging patients from seeking medical help or completing their treatment, negatively affecting public health outcomes.

Role of Health Workers and Infrastructure:

- ASHA workers, who are over-reliant for patient follow-up in remote areas, face challenges due to limited resources. This hampers timely diagnosis and treatment. Additionally, there is unequal access to diagnostic and treatment facilities, particularly in hard-to-reach areas, further obstructing effective disease management and control.

6. Incidence of NCDs (Diabetes/Hypertension/Cancer)

Awareness Levels:

- Field interactions revealed that while there is some awareness of diabetes and hypertension, it remains superficial, focused mainly on basic causes like stress, smoking, and alcohol use. Awareness of cancer is significantly lower, with many misconceptions and incomplete understanding.

Knowledge Gaps:

- People have limited knowledge about the symptoms, prevention, and management of diabetes, hypertension, and cancer. Diabetes awareness includes symptoms like sweet urine and weight loss, whereas little is known about hypertension or cancer. Cancer is often misunderstood, with misconceptions such as radiation from mobile towers or the smell of burnt plastics as causes.

Screening Practices:

- Diabetes and hypertension screenings are irregular, mainly attended by older individuals, while younger people often skip them due to misconceptions. Cancer screenings are rarely conducted, highlighting a gap in preventive measures.

Cultural Perceptions and Local Terminology:

- Local terms for diseases like "andime" for hypertension, meaning "blood turning black and reaching the brain," and "Bampong" for cancer, show that these conditions are recognized within the community. Cultural perceptions, such as "sweet urine attracting ants" for diabetes, provide culturally relevant entry points for awareness efforts.

Community Beliefs and Misconceptions:

- Cancer is viewed as untreatable and equated with certain death. There is little understanding of hereditary or lifestyle-related risk factors for NCDs.

Sources of Information:

- Information is primarily accessed through health staff (ASHA workers and health camp officials), friends, family, and sometimes social media or tobacco warning labels. Posters and IEC materials have limited recall, indicating a need for more effective dissemination. There is also a lack of structured, sustained awareness campaigns, especially for cancer.

7. Quality ANC

Awareness Levels:

- Awareness of ANC services is fairly widespread, though the term itself may not be locally recognized. Communities understand it as routine pregnancy check-ups, with local terms helping convey the concept. Younger women are more aware, and most information is shared through ASHAs, ANMs, and family members.

Traditional Beliefs and Practices

- Traditional beliefs still influence pregnancy practices, especially in Garo Hills. Food taboos and spiritual concerns, such as fears of witchcraft, shape behaviours. In contrast, such practices have declined in Khasi and Jaintia Hills with increasing trust in formal healthcare.

Role of Traditional Healers and Birth Attendants

- Traditional healers are consulted mainly for spiritual issues, particularly in Garo Hills. While modern healthcare is generally preferred for deliveries, a blend of traditional and modern practices continues, especially in remote areas. Reliance on traditional healers is much lower in Khasi and Jaintia regions.

Attitudes and Family Decision-Making

- Families view ANC as important, with supportive roles from husbands, elders, and even religious leaders. Women are increasingly taking decisions on their own, though in areas with poor access, traditional methods still dominate.

Utilization and Practices of ANC Services

- ANC services are accessed through Sub-Centres and PHCs. However, supply of supplements like IFA and calcium is irregular, particularly in Garo Hills. Visit frequency varies across regions, and ANC days are more structured in Khasi and Jaintia Hills than in Garo.

Barriers and Health System Challenges

- Access challenges persist, especially in remote areas where institutional deliveries are rare and awareness is low. While Khasi and Jaintia regions report better infrastructure, emergency services remain limited. Communities suggest improving local facilities and emergency care availability.

8. Institutional Delivery

Awareness and Preferences

- In Khasi Hills, institutional delivery is widely accepted, and most women now prefer hospital births. This transition is driven by greater awareness, ASHA engagement, and experiences with previous complications. In Garo Hills, institutional births are increasingly favoured, especially C-sections, which are perceived as safer and less painful. However, in Jaintia Hills, although understanding is growing, many women, especially older ones, still prefer home births due to comfort and fear of medical procedures.

Decision-Making and Cultural Influences

- Across all regions, women increasingly make autonomous decisions about delivery, often supported by husbands and family. In Garo Hills, decisions are taken by the maternal family (Mahari), while in Khasi Hills, women have strong individual agency. Traditional beliefs in Khasi Hills, such as those held by Niam Khasi followers, see childbirth as sacred but do not influence delivery location. In Jaintia Hills, religious leaders have minimal influence. TBAs are rarely involved, though in some Garo and Khasi areas, they assist with massages or basic care and refer complicated cases to health facilities.

Health Infrastructure and Access

- PHCs serve as the primary contact point in all regions but face challenges like staff shortages and limited operational days, particularly in Khasi Hills. Transport has improved with CMSMS vehicles, though poor roads and restricted timings persist. In Garo and Jaintia Hills, physical distance, high transport costs, and difficult terrain continue to restrict access to institutional care despite the availability of free services.

Utilization of Government Schemes

- Garo Hills shows high awareness and usage of MHIS cards, helping reduce out-of-pocket costs. However, monetary incentive schemes like JSY, PMMVY, and CMSMS are poorly understood across all regions. In Khasi and Jaintia Hills, some women are registered under these schemes but report not receiving benefits. Superstitions—such as associating Aadhaar with bad omens—also affect enrolment in Khasi Hills. ASHAs and village meetings remain the main sources of information, but outreach varies in consistency and effectiveness, with limited digital engagement or health camps.

9. Prevalence of Anemia

Terminology and Local Understanding

- Anemia is not widely recognized by its clinical name across Meghalaya. However, when explained in local dialects, the concept gains familiarity. In Khasi and Jaintia Hills, it is referred to as *Jingduna Snam* (lack of blood), while in Garo Hills, terms like *An.chi ko.mia, Bolsuta*, and *At.Ch.Dosa* denote weakness or low blood. Across all regions, anemia is broadly perceived as a condition of tiredness, low energy, and vitality. The use of local language in health messaging significantly improves understanding.

Symptoms and Perceived Causes

- Commonly mentioned symptoms include fatigue, dizziness, pale or yellowish skin, swelling, headaches, back pain, numb knees, and poor eyesight. Region-specific signs include cough and peeling skin in Garo and Khasi Hills respectively. Poor diet and irregular eating habits are consistently cited as key causes. Worm infestation is more commonly linked to anemia in Khasi and Jaintia Hills than in Garo. Other cited causes include early marriage, physical overwork, illness, and low blood pressure. Misconceptions—such as anemia being hereditary, communicable, or linked to soap consumption—were noted, especially in Garo Hills. Some communities associate anemia with mental confusion or spiritual possession.

Prevention and Dietary Practices

- There is widespread understanding of food-based prevention. Commonly mentioned foods include leafy greens like mustard, pumpkin, spinach, local gourds (Lau, Megong, Me.bitchi), sweet potato leaves, fruits like pomegranate, apples, and grapes. Meat is valued but consumed infrequently due to cost. In the Garo region, local chicken soups with green papaya or ginger are considered effective for building blood. While food is widely seen as the primary preventive method, affordability limits consistent intake of iron-rich items.

Iron and Folic Acid (IFA) Supplementation

- The term "IFA" is largely unfamiliar. Supplements are generally called "vitamin tablets." In Khasi and Jaintia Hills, awareness is moderate and often linked to ANMs and health facility visits. In Garo Hills, awareness is low and tablets are sometimes confused with calcium supplements. Side effects such as bitter taste, drowsiness, and frequent urination lead to irregular usage. Once explained, communities show openness toward using iron tablets. The major issue reported across regions is irregular or insufficient supply of IFA and calcium tablets.

Deworming Awareness and Practices

- Awareness of deworming is higher than IFA across all regions. In Khasi and Jaintia Hills, a stronger connection is made between worms and anemia. In Garo Hills, this link is weaker and not readily understood without explanation. Worms are commonly referred to as Krimi jo.ong in Garo. Children are usually given deworming tablets through schools or ASHA outreach. However, misconceptions—such as combining deworming and IFA causing illness—lead to parental resistance, especially in Garo communities.

Traditional vs. Modern Medicine

- A dual approach to health is common across regions. In Khasi Hills, people often combine traditional healing with dietary advice from elders or healers. In Jaintia Hills, herbal remedies like soup made from boiled leaves are popular. In Garo Hills, strong reliance on traditional healers (Ojas) persists. Remedies include plant saps, tree bark infusions, and herbal applications. While traditional methods are trusted, communities remain open to modern treatments when they are accessible and clearly beneficial.

Sources of Information and Communication Gaps

- Primary sources of information are ANMs, ASHAs, Anganwadi workers, health sub-centres, and health camps. However, most community members could not recall anemia-specific posters or campaigns. Visuals related to HIV, TB, and malaria are better remembered. Health camps are well-attended when treatment is involved, but less so when focused only on awareness. Religious and cultural institutions have no significant role in shaping beliefs or practices around anemia.

Screening and Health Services Uptake

- Regular anemia screening is reported in Khasi Hills, with good community participation. In Jaintia Hills, there have been no recent anemia-specific screening camps, though community willingness is high. In Garo Hills, screening practices are not commonly known, and general awareness of anemia is low. Across regions, access and regularity of screening remain key challenges.

School and Community Interventions

- Participation in school-based IFA and deworming programs is inconsistent. Some recall annual distributions, while others say ASHAs or AWWs manage them in the community. In Garo Hills, parental resistance to IFA tablets in schools is notable, based on fears that these may cause illness. Community support improves significantly when health workers clearly explain the benefits of supplementation and deworming.

10. Prevalence of Teenage Pregnancy

Awareness and Knowledge Gaps

- Across all three regions, adolescents face a significant lack of access to accurate and age-appropriate reproductive health education. In the absence of structured sex education in schools, most young people rely on informal sources such as peers, social media, or occasionally frontline health workers like ASHAs and ANMs. Discussions led by elders or religious institutions tend to focus on morality, avoiding practical topics such as contraception, sexually transmitted infections (STIs), or reproductive rights. This knowledge gap is particularly stark among girls from poorer or less-educated families, making them more vulnerable to early pregnancy. As one teenager from Garo Hills put it.

Cultural and Social Norms

- Cultural expectations and evolving adolescent attitudes are in constant negotiation across these communities. Although early marriage is officially discouraged, societal pressures and economic constraints still drive some families—particularly in Garo and Jaintia Hills—to marry off their daughters early. Teenage pregnancy, especially outside of wedlock, is widely perceived as a source of shame and moral failure, often resulting in social exclusion, family embarrassment, and school dropouts. Religious teachings generally condemn teenage pregnancy, and in some cases, churches even suspend pregnant teens from participation. At the same time, religious leaders are seen as influential voices who, if engaged, could play a pivotal role in changing perceptions and promoting responsible behaviour among youth.

Health Risks and Access Barriers

- There is an awareness within communities of the health risks associated with early pregnancy, such as delivery complications, uterine weakness, and excessive blood loss. However, this awareness is not matched by access to or utilisation of health services. Many teenage girls refrain from seeking medical assistance due to fear of social judgement, lack of privacy, and the unavailability of adolescent-friendly services. In Garo Hills, home deliveries are still common, not just due to tradition but as a deliberate attempt to conceal pregnancies from the community and avoid institutional scrutiny. This secrecy is compounded by fear of legal repercussions, especially in cases where the girl is underage. One community elder candidly shared.

Family and Community Response

- Responses to teenage pregnancy vary widely among families and communities. In many cases, families prefer to handle the matter discreetly to avoid shame or further emotional harm to the girl. Some families quietly support the young mother, while others express disappointment or even disown her temporarily. The responsibility of childcare frequently falls on mothers or grandmothers, and the involvement of young fathers is inconsistent—ranging from supportive to completely absent. In Khasi Hills, participants noted a decline in traditional forms of guidance, such as storytelling and wisdom-sharing by elders, further widening the generational communication gap around sexual and reproductive health.

Communication Gaps and Hesitations

- A deep-rooted discomfort in discussing reproductive health persists among parents, elders, and even teachers. While adolescents express a strong desire for open and respectful dialogue, such channels are rarely available. The reach of frontline health workers like ASHAs and ANMs is uneven, leaving many adolescents without trusted sources of guidance. Teens across all regions emphasised the need for structured, friendly counselling spaces in schools and communities, where they can access reliable information without judgement. Peer educators, too, were highlighted as a promising avenue for facilitating meaningful conversations about reproductive health.

Contraceptives: Stigma and Access Issues

- Although contraceptives are generally accepted for use within marriage, adolescent access remains limited and heavily stigmatised. There is low awareness of contraceptive options—such as condoms, pills, or emergency contraception—and many misconceptions continue to circulate. In Garo Hills, for instance, teenage pregnancy is often seen as a moral failure rather than a public health issue. Families tend to conceal the situation, avoiding medical documentation, police involvement, or community exposure. This leads to coping strategies like sending girls away, opting for home deliveries, or suppressing the matter entirely. Discussions around contraception or sexual health are rare, even though adolescents—particularly boys—are visibly curious and in need of correct information.

Shifting Awareness Amidst Persistent Stigma

- In Khasi Hills, there is a noticeable shift in awareness levels, especially among school-going adolescents in urban areas. These youths are generally more informed and likely to delay sexual activity or pregnancy. However, teenage pregnancy continues to carry strong social stigma, particularly among rural and economically weaker groups. While parents still hesitate to discuss reproductive topics, some adolescents have begun seeking information from ASHAs and ANMs. Traditional sources of advice, like grandparents or elders, have become less influential due to changing lifestyles and the rise of digital media. One young mother shared during an FGD that she only learned about contraception after becoming pregnant, through interactions with an ASHA—underscoring the urgent need for early, proactive education.

Structural Challenges and Community Shifts

- Teenage pregnancy in Jaintia Hills is strongly linked to structural issues such as poverty, early marriage, and lack of educational opportunities. Peer influence and limited parental supervision—often due to economic hardship—also contribute. Adolescents tend to get their information from friends, TV, and social media rather than from parents or frontline workers. Teenage mothers frequently face gossip, isolation, and are forced to leave school. Nevertheless, there are emerging signs of community support for preventive education. Teachers and ASHAs are respected and increasingly seen as key figures in promoting sex education. One teacher shared that a joint session with ASHAs led to a noticeable increase in contraceptive queries from students, showing the potential impact of culturally sensitive outreach. Platforms like school workshops, street theatre, and involvement of religious leaders are gaining traction as effective tools for awareness.

Review of existing IEC materials

The review of existing IEC materials and delivery modalities reveals that the recall value of these materials ranges from "poor" to "average" in most cases. Overall, the communication approach remains largely passive, failing to engage users effectively.

Key Observations:

- High Recall for Posters: Among the existing IEC materials, posters demonstrate the highest recall value, followed by videos. However, other resources register a poor impact due to a lack of user-centric design.
- Fragmented Messaging: Health messaging is currently delivered with low frequency and is often sporadic and fragmented.
- Transactional Nature of IEC Materials: The content primarily focuses on the "transaction of information" rather than being experiential, participatory, or rewards-centric—factors critical for influencing behaviour loops.

Infotainment and Phygital Model: The Emergent Medium

- One of the standout findings from the field assessment is the widespread penetration and consumption of digital media, even in geographically remote areas. Most of the population prefers infotainment as a medium for understanding complex real-life scenarios related to health decision-making.

Digital Media Trends:

- Videos: With entertainment videos being the most-watched format, sustained video-based health messaging can have a significant impact.
- YouTube: YouTube is the preferred platform, as mobile phones increasingly replace televisions. Instagram, Facebook, and WhatsApp groups are also key communication channels.
- Digital Ads: Given low ad-free subscriptions and minimal ad-blocking, compulsory digital ads present an effective space for repetitive health messaging.

Phygital Communication: Integrating Physical and Digital Media

- The review also highlights the importance of integrating cultural storytelling into physical environments (phygital communication). The current lineup of health events and activities lacks cultural relevance and storytelling, leading to poor attention and engagement from the target audience.

Cultural Preferences:

- Drama and Storytelling: Physical event trends among the Khasi indicate a preference for drama, performance, and satirical storytelling as effective infotainment genres.
- Song and Dance: Among the Garo, traditional song and dance performances resonate more strongly.
- Modern Packaging of Cultural Traditions: Combining traditional cultural elements with modern packaging can create impactful health communication campaigns that captivate and sustain audience attention.

Assessment of existing IEC Materials (strategy), Enablers, Challenges and Mitigation Strategy

This section outlines the key components of the SBCC operational framework, with a primary focus on the assessment of existing IEC materials and strategies. This critical step involves a thorough evaluation of current resources and approaches to determine their effectiveness, cultural relevance, and ability to address community needs. By identifying both the enablers within the current context and the challenges that hinder their impact, the framework emphasizes refining and adapting these materials to enhance their utility and resonance, rather than discarding or unnecessarily reinventing them. This approach ensures that existing strengths are leveraged while addressing gaps through practical, context-specific solutions, thereby making the communication efforts more effective and impactful.

Platform	Existing Materials	Enablers	Challenges	Mitigation Strategy
Accredited Social Health Activist (ASHA)	Limited to MCP cards and flipbooks	Strong community trust	Limited resources and materials available for ASHA workers and the community	Enhance training programs and update materials for cultural relevance
		Accessibility and personal connection of ASHA workers with the community	Insufficient training, affecting ASHA workers' effectiveness	Integrate digital resources for wider outreach
		Willingness for information uptake, ensuring active participation in health initiatives	Underinformed and under-performing ASHA workers	Further training and skill developme nt for ASHAs

Platform	Existing Materials	Enablers	Challenges	Mitigation Strategy
Accredited Social Health Activist (ASHA)	Limited to MCP cards and flipbooks	ASHAs are trusted messengers due to their local knowledge and relationships	Lack of awareness and clarity about roles and responsibilities	Capacity building through regular workshops and refresher training sessions
			Need for awareness of other field-level functionaries for better convergence	Develop a TOR (Terms of Reference) and JD (Job Description) for ASHA workers to provide clarity on their roles
				Implement mentorship and peer support systems to reduce burnout
				Regular feedback and evaluation mechanisms to assess training effectiveness and improve interventions

Platform	Existing Materials	Enablers	Challenges	Mitigation Strategy
Sub-centre/Heal-th & Wellness Centre	Pamphlets, posters, flipbooks, handbooks, hoardings	Accessibility to basic healthcare services at the community level	Limited resources for comprehensive diagnosis and treatment	Improve infrastructure for basic diagnosis and services
		Acts as a first point of contact for rural health issues	Inequitable access to services, especially in hard-to-reach areas	Provide ANMs and ASHAs with training on specific health conditions like TB and NCDs
		Staffed by ANMs and supported by ASHAs	Over-reliance on ANMs with limited capacity for follow-up	Update IEC materials to reflect local languages and contexts
		Infrastructure available for health campaigns	Inadequate IEC materials for NCDs, TB, and male participation, especially	Introduce mobile health units for hard-to-reach areas
		Equipped for basic maternal and child health services	Poor cultural relevance of materials in some areas	Enhance the use of IEC tools like MCP cards and flipbooks during counselling
			Infrequent counselling sessions by ANMs and Medical Officers	
			Low use of tools like MCP cards for structured sessions	

Platform	Existing Materials	Enablers	Challenges	Mitigation Strategy
Village Health Committees (VHC)	VHC IEC handbooks, flipbooks, posters, banners, and village health information boards	Strong community engagement through local leaders, elders, and SHG members	Irregular meetings and low motivation among members	Conduct regular training for VHC members on key health topics
		Platform for grassroots health awareness campaigns and discussions	Minimal use of IEC handbooks during sessions	Improve the utilization of IEC handbooks and posters during VHC meetings
		Useful for monitoring child and maternal health practices and discussing general health-related practices	Limited awareness of health topics like EBF and TB and NCDs among members	Foster stronger collaboration with ASHAs and ANMs to amplify awareness
		Existing handbooks provide guidance for awareness sessions	Weak coordination with ASHAs and frontline workers.	Schedule community monitoring activities and campaigns to boost motivation and impact.
		A platform where religious leaders can also engage and contribute	Weak coordination with ASHAs and frontline workers.	Suggest to the moderators and leaders of the meeting to engage with and include religious leaders and utilise their positive influence for shaping health-related behaviours

Platform	Existing Materials	Enablers	Challenges	Mitigation Strategy
Primary Health Centre (PHC)	MCP cards, posters, flipbooks, VHC/IEC handbooks, wall paintings, hoardings, ASHA tabs with videos and animations	Acts as a referral hub for SCs	Overburdened staff due to high patient load	Strengthen staffing with additional Medical Officers and paramedics
		Staffed by Medical Officers and paramedics	Inconsistent stock of medicines and diagnostic kits	Conduct regular stock audits to ensure medicine and material availability
		Provides diagnostic and treatment services for TB, EBF, and other health concerns	Lack of structured counselling sessions for EBF and complementa-ry feeding	Establish structured counselling protocols during ANC and PNC visits
		Regular platform for antenatal care and health counselling sessions	Poor display and use of IEC materials	Enhance the use of posters, videos, and digital tools at PHCs
		Regular platform for antenatal care and health counselling sessions	Limited outreach to hard-to-reach populations	Extend outreach through mobile units or satellite PHCs in remote areas



Proposed SBCC Strategy





Macro and Micro Recommendations

This framework provides a comprehensive blueprint for developing an effective SBCC strategy by addressing existing gaps while building on current strengths. It begins with an assessment of existing materials, highlighting their enablers within the current context and identifying challenges that hinder their impact. Instead of discarding or unnecessarily recreating these resources, the framework emphasizes refining them through targeted suggestions, making them more effective and impactful. Simultaneously, it proposes the introduction of innovative channels and materials, detailing their advantages, anticipated challenges, and practical solutions to optimize their utility. A key feature of the framework is topic-wise audience segmentation, which focuses on specific targeted behaviours to be changed and the development of key messages tailored to these behaviours. These messages serve as the foundation for crafting focused hyper-localized communication content, disseminated through carefully selected channels and materials. By proactively addressing challenges with well-defined and innovative solutions, the framework ensures effective SBCC intervention implementation. It integrates health actors such as ASHAs, ANMs, community leaders, and grassroots groups, delivering tailored, culturally relevant content to enhance community engagement and ownership of health practices. Through strategic execution, the framework aspires to foster sustainable health behaviour changes deeply embedded in the community's cultural and social fabric.

Macro Recommendations

These macro-level recommendations aim to strengthen healthcare policy initiatives, enhance multisectoral collaboration, and create an enabling environment conducive to sustained behaviour change. Below are the detailed strategies under various themes:

I. Policy Development and Promotion

Well-being of Future Generations Act

- Establish a legislative framework that mandates all government policies and programs to consider long-term sustainability and intergenerational equity.
- Integrate key social determinants of health, such as climate adaptation, affordable housing, income security, early childhood development, sustainable employment, and food security, into this act.
- Form a convergence body led by the Department of Health & Family Welfare to ensure coordinated efforts across departments, including Education, Community & Rural Development, Public Works Department (PWD), Public Health Engineering Department (PHED), Forest and Environment, and Food, Civil Supplies & Consumer Affairs.

Social Credit Program for Health Behaviours

- Leverage community governance systems like *Nokmas*, *Himas*, and *Dorbar Shnong* to foster pro-social health behaviours through a social credit system.
- Define measurable metrics such as regular health checkups, reduced alcohol/tobacco use, contraceptive adoption, and environmental contributions.
- Offer rewards like scholarships, improved village infrastructure, livelihood opportunities, and free passes to cultural events to incentivize positive behaviours.

Integrated State-Level Action Plans

- Develop culturally relevant, state-specific action plans targeting key health priorities such as maternal and child health, family planning, HIV/AIDS, TB, and NCDs.
- Advocate for workplace policies like crèche facilities, breastfeeding-friendly environments, and gender-sensitive health guidelines.
- Allocate sufficient resources and forge partnerships with development agencies, NGOs, and private entities to ensure effective implementation.

II. Technology, Media Campaigns, and Outreach

Infotainment-Driven Health Messaging

- Design state-wide multimedia campaigns using local languages and culturally sensitive content to address health misconceptions and promote positive behaviours.
- Incorporate testimonials and stories of positive deviations to build trust and relatability.

Voice Bot: 'Alexa for Maternal Health'

- Develop an AI-powered voice assistant (similar to that of 'Alexa' but with a local name) tailored for Khasi, Garo, and Pnar populations.
- Features may include real-time counselling during critical hours, nutritional reminders, menstrual tracking, and baby name suggestions.
- Ensure regular updates to incorporate local feedback and emerging maternal health issues.

'SWIPE' for Health

- Create a mobile application with a swipe-based interface to educate youth on sexual and reproductive health.
- Include AI-powered chatbots, culturally relevant content, and gamified learning modules to combat stigma and misinformation.

Phygital and Cultural Storytelling

- Combine traditional storytelling methods (e.g., drama, song, dance) with digital platforms for impactful health communication.
- Train local artists and performers to embed health messages into their work.

III. Capacity Development

Training and Skill Development

- Conduct periodic, standardized training for state and district health officials, program managers, and field staff.
- Develop a trainer pool with defined roles, annual training calendars, and SOPs.
- Use refresher training modules to ensure continuous reinforcement of knowledge and skills

Automating Frontline Health Tasks

- Introduce AI-driven tools for frontline health workers to automate repetitive tasks such as data entry, inventory management, and report generation.
- Free up capacity for critical interventions like counselling and patient care.

IV. Monitoring and Accountability

Community Scorecards

- Implement participatory scorecards to measure program effectiveness and identify service gaps.
- Conduct regular review meetings with VHCs, SHGs, and community representatives.

Feedback Mechanisms

- Establish structured systems for collecting and addressing community grievances through VHCs and frontline health workers.
- Use digital surveys and assessments to evaluate behaviour change and program impact.

Recognition Programs

- Celebrate milestones such as increased adherence to breastfeeding, family planning uptake, and successful TB/NCD management.
- Recognize high-performing communities and health workers through awards, public ceremonies, and media coverage.

V. Sustainability and Resource Mobilization

Sustained Awareness Campaigns

- Develop an annual State Health Campaign Calendar aligned with global health observances with clear action-plans along with accountability matrix.
- Collaborate with local influencers and NGO partners for year-round engagement.

Resource Partnerships

- Mobilize funds through CSR initiatives, PSUs, international donors, and local development partners for health campaigns, training, and infrastructure.
- Explore Public-Private Partnership (PPP) models to strengthen service delivery.

Strengthening Infrastructure

- Enhance diagnostic and treatment facilities in underserved areas through partnerships with corporate and development agencies.
- Prioritize telemedicine and mobile health units for remote locations.

Micro Recommendations

These micro-level recommendations aim to improve implementation and service delivery at the grassroots level by fostering community engagement, improving awareness, and addressing systemic barriers. The strategies focus on empowering individuals and groups to actively participate in health initiatives and promoting culturally relevant practices.

I. Community Mobilization and Engagement

Engage Community Leaders:

- Sensitize village headman, elders, and traditional healers to promote health practices like breastfeeding, birth spacing, HIV prevention, and NCD management.

- Partner with religious leaders and institutions to deliver health messages during gatherings, addressing cultural sensitivities and aligning messages with community values.

Leverage Community Platforms:

- Use VHCs, SHGs, and youth organizations to disseminate health information and mobilize the community.
- Train local influencers, SHG leaders, and male champions as peer educators to address misconceptions and promote health behaviours.

Promote Male Participation:

- Conduct father-to-father campaigns and peer discussions led by respected male figures, emphasizing shared responsibilities in family health.
- Organize dedicated health sessions for men during VHNDs, focusing on FP, MCH, and other health topics.

Empower Community Members:

- Train mothers, survivors of diseases, and individuals managing chronic conditions to serve as role models and community champions.
- Establish mother-to-mother and male peer support groups to facilitate shared learning and experiences.

II. Awareness Campaigns and Local Media

Culturally Adapted Messaging:

- Develop region-specific, culturally sensitive communication materials in local languages using relatable visuals and terminology.
- Incorporate storytelling, folklore, and real-life testimonials to enhance community connection and retention.

Interactive and Engaging Campaigns:

- Use local festivals, community events, and cultural gatherings as platforms for promoting health messages.
- Conduct interactive activities like quizzes, role plays, and street plays to improve participation and understanding.

Mass and Digital Media:

- Utilize WhatsApp, Facebook, and Instagram to share videos, infographics, and stories targeting youth and other demographics.
- Equip influencers with simple, relatable messages to amplify campaigns and address myths.

III. Addressing Community-Level Barriers

Myth-Busting and Education:

- Work with traditional healers to dispel misconceptions and encourage timely medical interventions.
- Highlight the benefits of health behaviours like breastfeeding, birth spacing, and NCD management through positive framing (e.g., "healthy mother, healthy child").

Accessible Services:

- Provide mobile health units for screenings and testing in remote areas.

- Integrate health services like NCD screenings with existing community health events for improved accessibility.
- Incentives and Recognition:
- Offer small incentives for participation in screenings and health camps.
- Recognize villages, groups, and individuals achieving health milestones to motivate broader engagement.

IV. Capacity Building and Training

Enhanced Training for Frontline Workers:

- Train ASHAs and ANMs to use the MCP card and ASHA Tabs as effective interpersonal communication tools.
- Conduct targeted training sessions on NCDs, including diabetes, cancer, and hypertension, as well as HIV, TB, and improving male participation for MCH.
- Strengthen HBNC and HBYC visits to counsel mothers on breastfeeding, complementary feeding, and family planning.

Role Clarity for ASHA Workers:

- Provide clarity on the shift of ASHAs' roles from mobilizers to skilled communicators with defined responsibilities.
- Introduce performance-based incentives linked to behaviour change outcomes.
- Update the job description of ASHAs and ANMs for clarity and delineation of roles.

Training Infrastructure Improvements:

- Establish district-level training teams to eliminate inefficiencies of the cascade model.
- Maintain a comprehensive database to track training participation and evaluate skill enhancement.
- Increase VHC training frequency with revised IEC material for effective community dissemination.

V. Communication Platforms and Tools

Community-Based Communication Spaces:

- Designate community spaces for health communication, managed by VHCs.
- Display updated posters, IEC materials, and digital kiosks for ongoing awareness.

Hotlines for Support and Awareness:

- Establish dedicated, toll-free hotlines for NCDs, TB, and HIV to provide real-time counselling and information.
- Ensure operational efficiency and user-friendly interfaces for callers.

VI. System Strengthening and Accountability

Improved IEC Delivery and Monitoring:

- Use participatory scorecards to measure the reach and impact of SBCC interventions.
- Regularly assess frontline workers' performance and incorporate community feedback for program refinement.

VII. Village-Level Recommendations

Community-Led Monitoring and Support:

- Empower VHCs and SHGs to monitor health activities and promote adherence to health programs.
- Establish peer-led initiatives such as male and youth champions to drive community campaigns.

Door-to-Door Outreach:

- Enhance ASHAs and ICDS workers' visits with comprehensive counselling on key health issues like breastfeeding, birth spacing, male participation and NCD prevention.

Integration with Local Events:

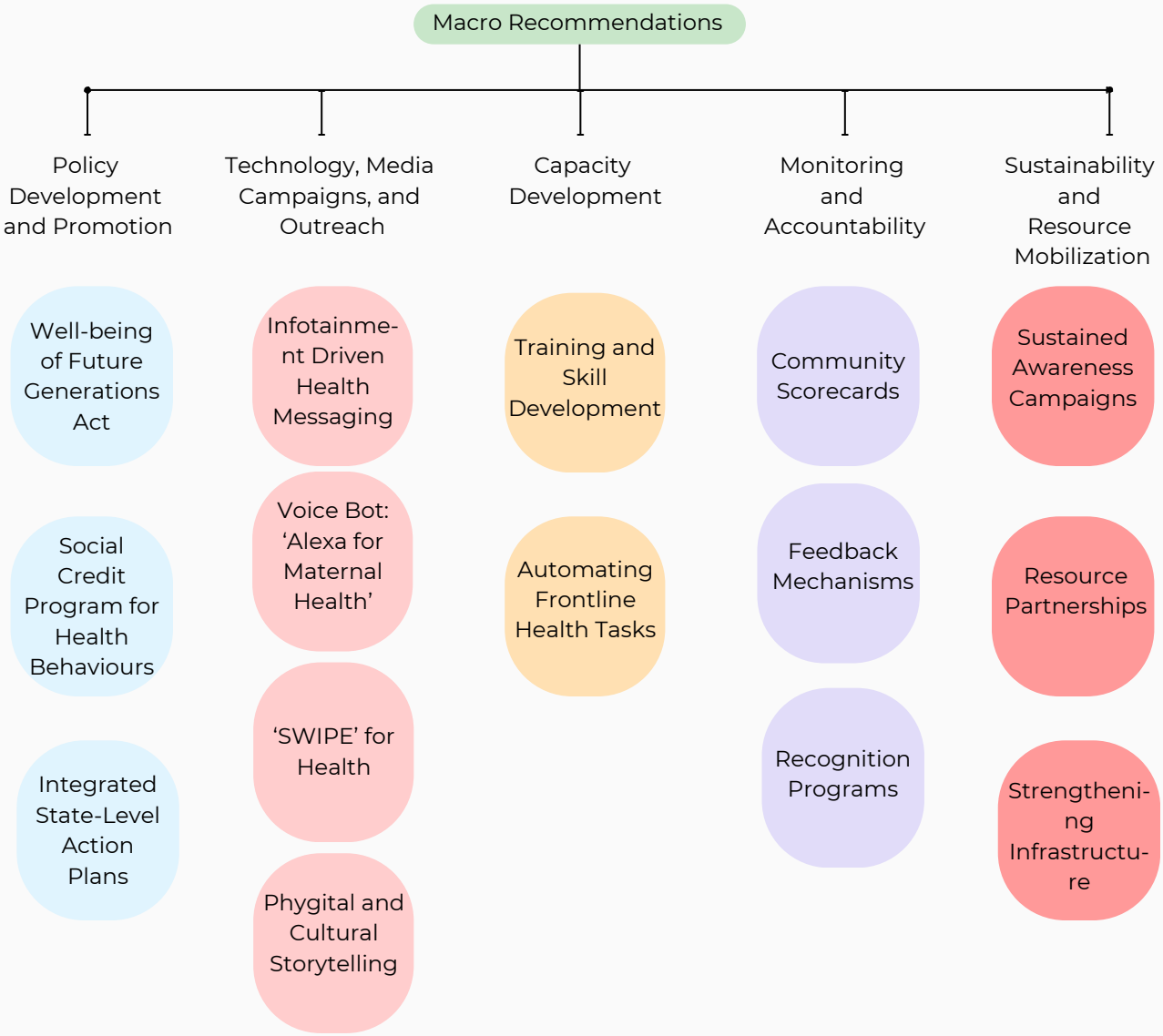
- Utilize village festivals, health camps, and cultural gatherings for health screenings and awareness campaigns.

Culturally Relevant IEC Materials:

- Develop pictorial and video-based IEC materials in local languages, focusing on health literacy and behavioural change.

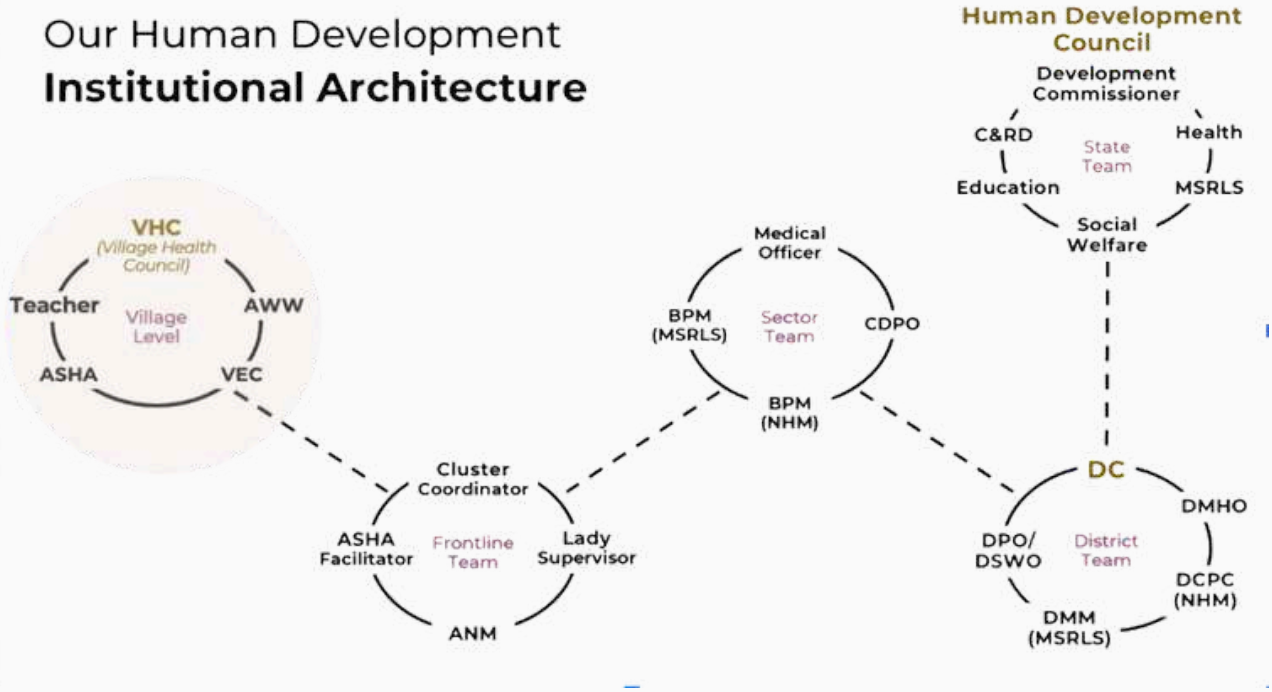
Recognition and Incentives:

- Introduce recognition programs for villages and individuals showing significant improvements in health metrics.



Strengthened SBCC Institutional Framework

The proposed HR Architecture is taken as proposed by MHSSP for Meghalaya. This model encompasses a multi-tiered structure integrating state, district, sector, and village-level teams to implement the SBCC strategy effectively. Each level plays a critical role in ensuring seamless communication, convergence, and execution of health promotion activities tailored to the state's socio-cultural context.



Given below are the expected roles played by each team across different levels:

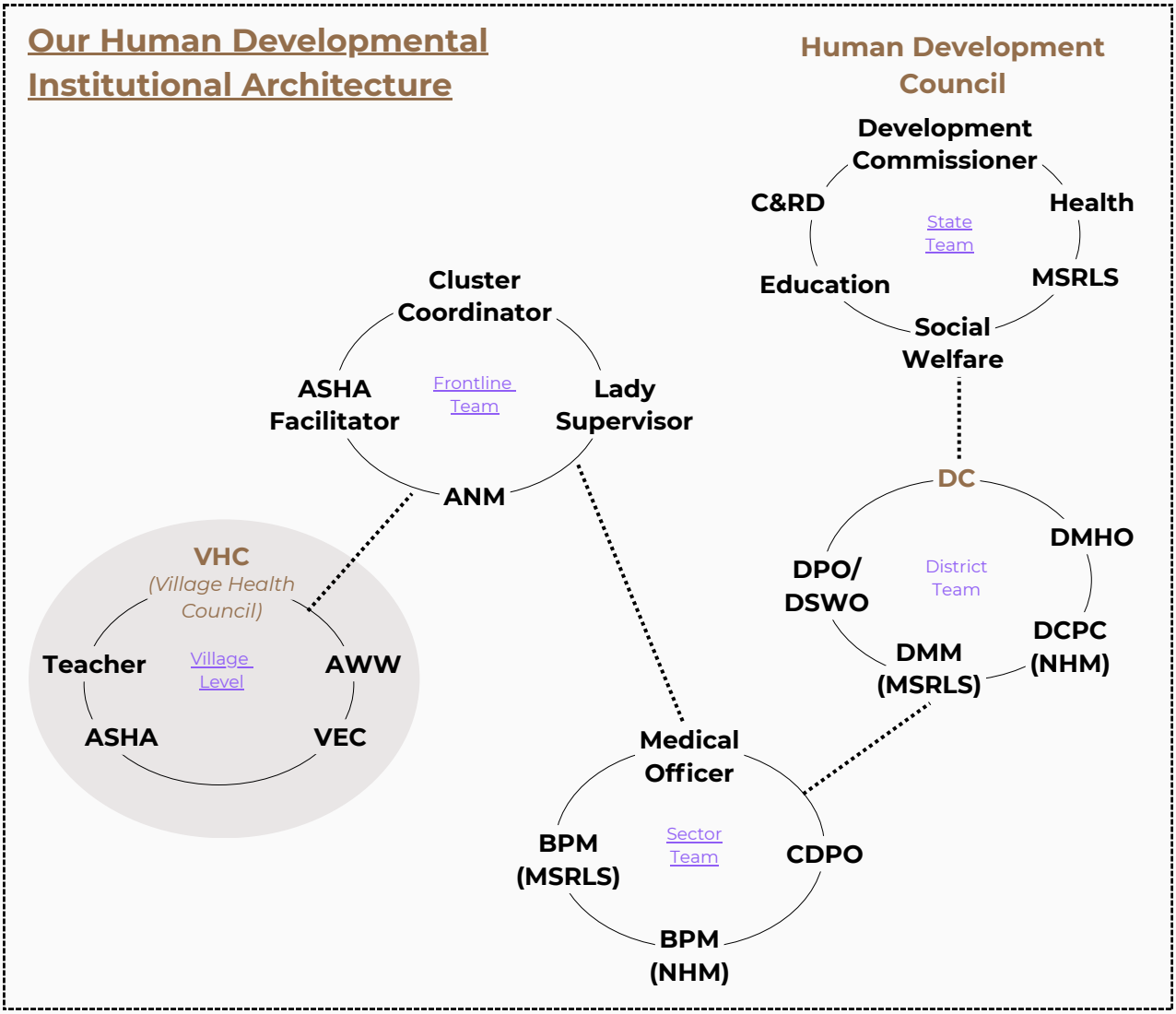
State Level: Human Development Council - the Human Development Council, led by the Development Commissioner, comprises key stakeholders from Health, Education, Social Welfare, MSRLS and C&RD departments.

Expected Roles:

- Policy and Strategy Development: Provide overarching guidance on the SBCC framework and ensure alignment with state health priorities.
- Resource Allocation: Facilitate funding, infrastructure, and workforce allocation for SBCC initiatives.
- Capacity Building: Develop state-level training modules and conduct workshops for district and sector teams.
- Monitoring and Evaluation: Establish KPI and review the program's impact periodically (refer to the convergence section and M&E framework).

Strengthened SBCC Institutional Framework

The proposed HR Architecture is taken as proposed by MHSSP for Meghalaya. This model encompasses a multi-tiered structure integrating state, district, sector, and village-level teams to implement the SBCC strategy effectively. Each level plays a critical role in ensuring seamless communication, convergence, and execution of health promotion activities tailored to the state's socio-cultural context.



Given below are the expected roles played by each team across different levels:

State Level: Human Development Council - the Human Development Council, led by the Development Commissioner, comprises key stakeholders from Health, Education, Social Welfare, MSRLS and C&RD departments.

Expected Roles:

- Policy and Strategy Development: Provide overarching guidance on the SBCC framework and ensure alignment with state health priorities.
- Resource Allocation: Facilitate funding, infrastructure, and workforce allocation for SBCC initiatives.
- Capacity Building: Develop state-level training modules and conduct workshops for district and sector teams.
- Monitoring and Evaluation: Establish KPI and review the program's impact periodically (refer to the convergence section and M&E framework).

District Level: District Team - At the district level, the team is led by the DC and includes representatives such as DPO/DSWO, DMHO, DCPC and DMM (MSRLS).

Expected Roles:

- Program Coordination: Coordinate activities across departments to ensure integration of SBCC activities.
- Local Adaptation: Customize the SBCC strategy to district-specific cultural and demographic needs.
- Supportive Supervision: Supervise the performance of sector teams and provide necessary handholding support and feedback on real-time basis.
- Monitoring and Review: Based on KPI and accountability matrix, review the progress of implementation periodically and report to state team.

Sector Level: Sector Team - the sector team comprises the Medical Officer, BPM from NHM and MSRLS, and CDPO.

Expected Roles:

- Implementation Oversight: Oversee the rollout of SBCC activities within their sector.
- Health Topic Segmentation: Identify and prioritize health topics and target audiences based on local health indicators and community needs.
- Support Frontline Workers: Train and guide frontline teams in delivering SBCC messages effectively.
- Feedback Mechanism: Collect field-level feedback and share insights with the district team for iterative improvement.

Frontline Level: Frontline Team - the frontline team includes ASHA facilitators, ANMs, Lady Supervisors, and Cluster Coordinators.

Expected Roles:

- Direct Community Engagement: Conduct focus group discussions, one-on-one counselling, and health awareness campaigns.
- Message Dissemination: Use innovative channels and culturally relevant materials to promote SBCC messages.
- Behaviour Monitoring: Observe and document changes in community health-seeking behaviour.
- Supportive Supervision: Act as a link between sector teams and village-level stakeholders.

Village Level: VHC - VHC comprises ASHAs, AWW, teachers, and VEC.

Expected Roles:

- Community Mobilization: Foster participation from community members in health promotion activities.
- Localized Messaging: Tailor SBCC messages to align with village-specific traditions, beliefs, and practices.
- Feedback Collection: Provide real-time data on community responses and challenges to the frontline team.
- Sustainability: Encourage local ownership of health initiatives to ensure long-term impact.

Television is outdated!

A significant shift in media consumption behaviour has been observed in Meggongre village in Garo region, where villagers no longer watch television as most of their time is now spent on mobile phones engaging with social media platforms and messaging apps. While villagers use mobile phones extensively, they rarely watch health-related videos, indicating an underutilization of this platform for health awareness.

Innovative Channels and Materials: Benefits, Challenges and Solutions

This section outlines the key components of the SBCC operational framework, emphasizing the proposal of new and innovative channels and materials designed to address specific health communication needs. These recommendations highlight the advantages of adopting novel approaches including use of technology and out-of-box thinking, while acknowledging potential challenges and providing practical solutions to overcome them, ensuring their effective implementation. These messages are further to-be-refined to create focused communication strategies using appropriate channels and materials. By integrating health actors across the levels from state to district and at grassroot level such as ASHAs, ANMs and community players such as village headman, VHC & SHG members, religious leaders, and traditional healers, the framework ensures the delivery of tailored, culturally relevant content that resonates with diverse communities and their health practices, contributing to sustained behaviour change health practices, contributing to sustained behaviour change.

Proposed Channels and Materials with Detailed Description for Channel: IPC				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
ASHA Tab	ASHAs in the state are equipped with mobile tablets for reporting and information dissemination. These compact devices, loaded with user-friendly SBCC materials, replace bulky paper-based IEC tools.	Multi-Utility: Supports reporting, awareness sessions, activity documentation, and photo capturing.	ASHA Skills: Non-tech-savvy ASHAs, especially in remote areas, may struggle with using Tabs.	ASHA Skills: Provide regular training and support to non-tech-savvy ASHAs; phase out those unable to adapt over time.

Proposed Channels and Materials with Detailed Description for Channel: IPC				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
ASHA Tab	ASHAs in the state are equipped with mobile tablets for reporting and information dissemination. These compact devices, loaded with user-friendly SBCC materials, replace bulky paper-based IEC tools.	Compact: Easily portable, unlike bulky paper-based IEC materials.	Training Quality: Poor training on Tabs and SBCC materials can defeat the purpose.	Quality Training: Establish regional/district trainers with IT and SBCC expertise using an interactive, fit-for-purpose training module.
	The content, including animation, real-life stories, edutainment, and influencer videos, will educate and motivate beneficiaries with relatable, engaging examples to promote positive health behaviours.	Ample Storage: Stores SBCC materials for multiple health topics.	Field Support: Lack of handholding and supervision may hinder effective use.	Field Support: Supervisors must offer hands-on training and support to enhance ASHA performance.
		Easy Updates: New content can be downloaded online or from health centres.	Monitoring: Inconsistent reporting and monitoring can render Tabs ineffective.	Reporting & Monitoring: Implement robust reporting and periodic monitoring to ensure effective use of SBCC/IEC materials.

Proposed Channels and Materials with Detailed Description for Channel: IPC				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
ASHA Tab	The content, including animation, real-life stories, edutainment, and influencer videos, will educate and motivate beneficiaries with relatable, engaging examples to promote positive health behaviours.	Simple Sharing: Content can be shared via WhatsApp, Facebook, Instagram, and YouTube.	Maintenance: Regular updates and maintenance are crucial for optimal performance.	Updates & Maintenance: Schedule regular updates and maintenance sessions at health facilities with IT staff support.
Compact Handbook	ASHAs and ANMs should be provided with a compact, durable pocket-sized handbook containing FAQs and acting as a ready reference during fieldwork.	Quick Access: The handbook will serve as a ready-reckoner with FAQs for easy access to accurate information.	Literacy: Non-literate ASHAs may face challenges using the handbook.	Illustrations: Includes visuals to assist ASHAs with limited literacy.
	It will cover key health topics, including MCH (focusing on EBF, timely initiation of CF, and birth spacing), male roles in MCH, HIV/AIDS prevention, and managing TB and NCDs like diabetes, hypertension, and cancer.	Backup Support: It acts as a reliable backup during counselling sessions, especially if the Tab malfunctions.	Willingness: Some ASHAs may resist carrying it, preferring Tabs instead.	Awareness: Educate ASHAs on its purpose and importance as a quick-reference tool.

Proposed Channels and Materials with Detailed Description for Channel: IPC				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
Compact Handbook	The handbook will serve as backup SBCC/IEC material during home visits and VHNDs, offering quick access to accurate information and addressing common beneficiary queries. Made with lightweight, laminated paper, it will be durable and easy to carry.	Lightweight & Compact: Its portable design ensures easy carrying in a bag.	Durability: Careless handling could damage the handbook, reducing its usability.	Durability: Made with high-quality laminated material for long-lasting use.

> *Our first point of access is the Oja so we go to them, they are available day & night. And why will not we go to them, they have been treating us for ages now for all different types of ailments!"*

– a participant from the FGD in Sakalgre, West Garo Hills District, when asked if they go to Traditional Healers for treatment

Proposed Channels and Materials with Detailed Description for Channel: Mid Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
Posters	Posters will be developed in Khasi and Garo languages to address gaps in health topics, and displayed in multiple locations. They will be made of laminated, durable material for reuse, with holes and strings for hanging instead of sticking to surfaces. This design allows for easy removal and extended reuse. Since the posters will be used beyond health facilities and on different health days, their portability and storage ease are crucial for effective deployment.	Recall Value: Posters had the highest recall value among all IEC materials.	Poor Utilization: Posters need to be visible and understandable to be effective for beneficiaries.	Ineffective Utilization: Designated spaces for different topics, especially in health facilities, are needed for proper poster display.
		Attract Attention: Well-designed, hyper-localized posters capture attention and interest.	Non-localized Content: Posters must relate to the local context to attract attention and improve recall.	Non-localized Content: Posters should be hyper-localized, with culturally sensitive images and messages in the local dialect to connect with the community.
		Easy to Use and Replace: Wall-hanging posters are easy to replace, ideal for using specific posters on celebratory days.	Old Approach: Paper posters stuck haphazardly lose attention and effectiveness.	Old Approach: Use durable, reusable materials and hanging posters with holes and strings for easy storage and use.
			Limited Reach: Posters are mostly confined to health facilities, limiting the visibility of health messages.	Limited Reach: Posters should be displayed in locations beyond health facilities to increase visibility and impact.

Proposed Channels and Materials with Detailed Description for Channel: Mid Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
Village Health Informa-tion Board (VHIB)	This approach ensures broader community penetration of health information.	Durable posters: Reusable laminated plastic-coated posters, designed with holes and threads for easy hanging, will outlast paper posters.	Low community interest: Without awareness of the VHIB's purpose, people may show little interest in the information displayed.	Community interest: Regular sensitization sessions will be held with beneficiaries and stakeholders to raise awareness of SBCC materials and their use.
IEC Handb-ook (VHC)	The VHC IEC handbook is a valuable resource at the village level. It is proposed to update it and distribute it to other platforms like SHGs, religious leaders, schools, and traditional healers, renaming it the "Health Handbook." This handbook will cover key health topics, including managing TB, NCDs (Diabetes, Hypertension, Cancer), reducing HIV/AIDS, MCH (EBF, CF), birth spacing, and MCH.	Uniform Messaging: Standardized content ensures consistent messaging.	Technical Competency Gaps: Stakeholders from diverse backgrounds may struggle with understandi-2ng technical content, so it should be simple and clear.	Technical Competency: High-quality, simple training will be provided to all users. The handbook will use clear, minimal text with relevant visuals, finalized through iterations with community stakeholders and vetted by real users.
		Reference Material for Stakeholders: Provides high-quality, easy-to-use resources for all stakeholders.	Lack of Interest: A lack of interest in using the resource could undermine its purpose.	Interest: Regular follow-ups, refresher training, and handholding support will ensure stakeholders stay engaged.

Proposed Channels and Materials with Detailed Description for Channel: Mid Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
IEC Handb-ook (VHC)	It will serve as a reference guide with FAQs for easy access. The handbook will be made from high-quality laminated paper with spiral binding for durability and ease of use.	Support for Traditional Healers: The handbook will help traditional healers provide accurate, timely information to patients.	Clarity in Use: Ambiguity in how and when to use the content may lead to the dissemination of incorrect or unclear information. Different stakeholders may have varied usage contexts, adding to the confusion.	Clarity in Use: The handbook will include a section outlining expectations for each stakeholder, detailing how, when, and on which platforms to use the content for effective dissemination.
		Resource for Schools: Useful for both teachers and students, offering a handy reference for various health conditions.		
Events	Busking and Karaoke Tour: "Awareness to Action"	Collaborate with Grassroots Cultural Projects and music agencies to release health-focused videos and host statewide music tours	Coordinating statewide tours across various regions can be complex and resource-intensive.	Develop a detailed event calendar and establish partnerships with local organisations to manage logistics.
		Music and performance art have a universal appeal, making them powerful tools for engaging diverse audiences.	Ensuring the content aligns with the cultural and traditional values of diverse communities.	Involve local cultural experts and community leaders in content creation and approval processes to ensure cultural sensitivity.

Proposed Channels and Materials with Detailed Description for Channel: Mid Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
Events	Busking and Karaoke Tour: "Awareness to Action"	The tour creates widespread awareness about health issues by using a culturally relevant and entertaining medium.	Maintaining momentum and engagement beyond the initial tour phase.	Establish follow-up activities such as workshops to reinforce health messages and provide actionable steps.
		Partnering with local artists and agencies fosters community involvement and strengthens ties with grassroots organisations. Live performances and video content ensure health messages reach even remote areas with limited media penetration.	Securing adequate funding for the tour and video production.	Engage corporate sponsors under CSR initiatives and explore government grants for health awareness campaigns.
	Cosplay	Collaborate with influencers like Zacky D and Reuben Hnamte to integrate cosplay formats into HIV/AIDS messaging.	High costs of production and influencer partnerships.	Explore sponsorships and crowdfunding to cover costs.
		Develop Meghalaya's first anime or cosplay character for aspirational role modelling.	Limited familiarity with cosplay in some regions may reduce immediate resonance.	Conduct awareness campaigns about cosplay before the event to build interest.

Proposed Channels and Materials with Detailed Description for Channel: Mid Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
Events	Cosplay	Leverage the growing popularity of anime and cosplay among youth to deliver impactful messages. Influencers bring credibility and reach, ensuring a broader audience. An anime or cosplay character can serve as a long-term symbol of awareness and positive behaviour.	Ensuring the messaging aligns with health communicati on objectives.	Involve health communication experts to guide content creation and align messaging with health objectives.
	Travelling Folk Theatre for Men/Women	Revive local performance traditions like Bamphalar and Jabulo to engage older male audiences with storytelling on gender norms.	Lack of performers skilled in traditional art forms.	Collaborate with local cultural groups to train new performers and document traditional forms.
		Preserve and revitalise cultural heritage while addressing critical social issues.	Difficulty in measuring the direct impact of storytelling on behaviour change.	Pair performances with interactive sessions to evaluate audience reception and impact.

Proposed Channels and Materials with Detailed Description for Channel: Mid Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
Events	Travelling Folk Theatre for Men/Women	Folk theatre has a deep emotional appeal, encouraging audience reflection and dialogue.	Resistance to discussing sensitive topics like gender norms.	Engage community leaders to foster acceptance of sensitive topics and influence people to motivate them to attend the performances.
		Targets a demographic often excluded from modern health campaigns.	There may be a lack of interest in people to attend and engage with folk theatre.	
	Angling Competitions	Leverage the popularity of angling to promote male involvement in maternal health through community events.	Risk of health messages being overshadowed by the competitive nature of the event.	Embed health messages within competition rules or announcements.
		Utilises an existing recreational activity to engage men in health conversations.	Limited participation if angling is seasonal or region-specific.	Schedule events during peak angling seasons and involve local angling clubs.

Proposed Channels and Materials with Detailed Description for Channel: Mid Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
Events	Travelling Folk Theatre for Men/Women	Folk theatre has a deep emotional appeal, encouraging audience reflection and dialogue.	Resistance to discussing sensitive topics like gender norms.	Engage community leaders to foster acceptance of sensitive topics and influence people to motivate them to attend the performances.
		Targets a demographic often excluded from modern health campaigns.	There may be a lack of interest in people to attend and engage with folk theatre.	
	Angling Competitions	Leverage the popularity of angling to promote male involvement in maternal health through community events.	Risk of health messages being overshadowed by the competitive nature of the event.	Embed health messages within competition rules or announcements.
		Utilises an existing recreational activity to engage men in health conversations.	Limited participation if angling is seasonal or region-specific.	Schedule events during peak angling seasons and involve local angling clubs.

Proposed Channels and Materials with Detailed Description for Channel: Mid Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
Events	Angling Competitions	Builds a sense of community while subtly integrating health messaging.	Ensuring health messaging is relevant and engaging without seeming forced.	Offer prizes that align with maternal health themes (e.g., family wellness kits).
		Encourages male participation in maternal health, traditionally seen as a women-focused area.		
	Teer Counters and Livestreams	Uses this widely followed cultural activity to disseminate health messages to a captive male audience.	Risk of audiences perceiving the messages as intrusive or unrelated to the activity.	Collaborate with teer organisers to ensure seamless integration of health messages.
		Capitalises on a popular and trusted community activity and Low-cost dissemination with potential for high reach.	Ethical consideratio-ns in targeting gambling spaces.	Ensure messages align with ethical standards by promoting health and well-being without exploiting the audience's engagement with teer.
		Allows for repetitive messaging, reinforcing health campaigns over time.	Difficulty in creating impactful yet concise messages for live-stream formats.	Focus on brief, engaging, and visually appealing content.

Proposed Channels and Materials with Detailed Description for Channel: Mid Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
Van mount-ed digital screen with 'Ask-The-Machine' (ATM) and vending machine	In Meghalaya, technological advancements contrast with deeply rooted cultural traditions, leaving many remote areas disconnected. To bridge this gap, a mobile SBCC/IEC unit called the "Mobile Health ATM" (Ask-The-Machine) has been proposed. This unit features an interactive screen with voice and touch support, offering a comprehensive health information repository. Users can ask questions or navigate the screen for information. At the end of the session, topic-specific leaflets or pamphlets are provided.	Innovative Solution: This first-of-its-kind SBCC product could make Meghalaya the first state in India to launch such a mobile health unit, serving as a case study for national and international platforms.	As a first-of-its-kind product, a clear concept note is needed, and finding the right mix of experts will be challenging.	Concept Design: A team of health, communication, automobile (modification), and IT specialists, led by the MHSSP team with consultant guidance, will develop the design and technical specifications. The team will handle vehicle modifications and integrate equipment, with IT setting up the interactive screen and health/comms specialists guiding content and presentation.

Proposed Channels and Materials with Detailed Description for Channel: Mid Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
Van mounted digital screen with 'Ask-The-Machine' (ATM) and vending machine	The unit will also feature mounted screens for AV communication materials and, potentially, a vending machine offering free sanitary pads and condoms (if culturally accepted).	Comprehensive Information & Services: The unit will provide both health information and basic services (sanitary pads, condoms) in one place.	Procurement & Maintenance: Since this is an innovative product, procurement and ongoing maintenance of vehicles, screens, and vending machines may face apprehensions. A PPP or CSR model could mitigate risks. Resource allocation for maintenance and upgrades will be crucial for success.	Procurement & Maintenance: Procurement and maintenance can be approached through a PPP model with equal partnership or through CSR initiatives, where a firm provides resources and maintenance while the government handles implementation.
	The unit can be deployed at large events, schools, busy locations, and remote villages.	Access in Hard-to-Reach Villages: The mobile unit brings health information and services to remote areas, showing educational videos in communities, schools, and religious places.	Without sufficient publicity, people may mistake the unit for a mobile bank ATM, leading to low usage and awareness challenges.	A strong campaign using social media influencers, along with a state and district-level launch, will generate awareness and increase usage.

Proposed Channels and Materials with Detailed Description for Channel: Mid Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
Digital wall mount-ed (signag-e) screen	Install digital screens in health facility waiting areas, IP wards, and maternity wards to play health awareness videos continuously.	Maximize resource utilization: Enables regular use of the department's digital health awareness content.	Operational challenges: Common issues include ensuring electricity, regularly using screens, following content schedules, and addressing minor issues like replacing remote control batteries. Repair management: Lack of clear SOPs often leads to neglect and eventual discarding of malfunctioni-ng equipment.	Operational challenges and maintenance: A detailed SOP with a clear responsibility matrix must be established and followed. Monthly reporting and district/state SBCC team visits should ensure effective resource utilization. Accountability must be set and regularly reviewed.

Proposed Channels and Materials with Detailed Description for Channel: Mid Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
Digital wall mount-ed (signag-e) screen	Content will follow a scheduled calendar, tailored to the local language of the region, and include diverse topics to maintain interest (as detailed in the topic-wise strategy).	Engage in-patients: Keeps patients informed and entertained with relevant and engaging video content.	Content updates: A system is needed to regularly update content to maintain beneficiary interest.	Content updates: The state/district SBCC team must ensure timely updates of newly released content on all relevant systems, with accountability and regular reviews resolving any delays.
	These screens can also be used for health-related public announcements, such as new schemes or upcoming events.	Broader audience reach: Engages family members accompanying patients, extending health awareness to a larger audience.	Content monotony: Officials may hesitate to play repetitive content, reducing its utilization.	Health facility staff should be reminded that the content is for beneficiaries, not for them. Their focus should remain on keeping screens operational and playing content as per the schedule.
			Beneficiary awareness and interest: Lack of awareness or interest among beneficiaries highlights the need for better communicat-ion about the content's purpose and benefits.	

Proposed Channels and Materials with Detailed Description for Channel: Mass/Digital Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
Digital Hoardi-ng (Solar power-ed)	It is proposed to set up solar-powered digital hoardings in busy locations of major cities and towns to display health-related digital content developed by the state. Solar power will reduce electricity dependency and costs. These hoardings can be established under CSR initiatives, with corporates handling maintenance and the state department managing content.	Engaging Information Sharing: Digital screens offer an attractive way to disseminate health information, sparking curiosity and excitement among the public.	High Setup Costs: Establishing large digital hoardings can be expensive.	CSR Collaboration to Reduce Costs: Partnering with corporates under CSR reduces government expenses and ensures long-term maintenance of assets.
		Innovative Solar-Powered Solution: Solar panels ensure a consistent power supply, addressing electricity challenges effectively.	Maintenance Challenges: Regular upkeep of solar panels and digital boards is essential to prevent malfunctions.	Maintenance: Engage the same corporates providing CSR support for upkeep.
		Utilization of Digital Health Products: This approach maximizes the use of existing digital health information resources.	Content Updates: Frequent updates are necessary to maintain public interest and fulfil the hoardings' purpose.	Content Updates: The state and district SBCC teams will handle content updates, monitor performance, and ensure accountability through regular reviews.

Proposed Channels and Materials with Detailed Description for Channel: Mass/Digital Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
Voice Bot for Health	Develop an AI-powered voice assistant (similar to that of 'Alexa' but with a local name) tailored for Khasi, Garo, and Pnar populations.	The AI-powered voice assistant will make maternal health information accessible to Khasi, Garo, and Pnar populations in their local languages, improving engagement and understanding.	There may be limited access that could reduce the reach of voice bot	The voicebot for health should be designed to be installed in any smart phone with internet access and should take less space. Wide publicity through health workers and VHC can increase the reach.
	Features may include real-time counselling during critical hours, nutritional reminders, menstrual tracking, and baby name suggestions.	Real-time counselling during critical hours can provide support to pregnant women and new mothers, enhancing maternal health outcomes.	User may lack familiarity with voice bot technology which could hinder the adoption	FLWs to be trained on how to support beneficiaries to use voice bot
	Ensure regular updates to incorporate local feedback and emerging maternal health issues.	Nutritional reminders and menstrual tracking will help users manage their health more effectively and also enable FP.	Challenge in ensuring the voice bot effectively understand and respond to regional dialects and accents	Voice bot to be trained with different dialects and accents. Regular feedback from the community members to be collected about the effectiveness and clarity of response and modification to be made accordingly

Proposed Channels and Materials with Detailed Description for Channel: Mass/Digital Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
SWIPE for Health	Create a mobile application with a swipe-based interface to educate youth on sexual and reproductive health.	The swipe-based interface and gamified learning modules will make the app engaging and easy to navigate for youth.	Limited access to smartphones or the internet in rural areas could hinder widespread use of the app.	Develop offline functionality or integrate the app with low-data modes to cater to users with limited internet access.
				Partner with local organizations to promote app access in rural areas.
	Include AI-powered chatbots, culturally relevant content, and gamified learning modules to combat stigma and misinformation.	The mobile application will provide convenient access to sexual and reproductive health information anytime, anywhere. Chatbots powered by AI will provide personalized responses to queries, ensuring a reliable source of information and guidance.	Resistance to discussing sexual and reproductive health openly could limit app adoption, especially in more conservative regions.	Collaborate with local community leaders to ensure content is culturally appropriate.

Proposed Channels and Materials with Detailed Description for Channel: Mass/Digital Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
SWIPE for Health		Tailoring content to the local culture will improve acceptance and increase the likelihood of behaviour change. The app can challenge stigmas and correct misconceptions by providing accurate, science-based information in an accessible format.	Ensuring continuous funding and content updates to keep the app relevant and functional over time could pose a challenge.	Conduct focus groups to adapt language, imagery, and messaging to local norms. Seek funding through partnerships with health organizations, CSR initiatives, and government grants. Regularly update content and introduce new features to maintain user engagement.
Health Memes: Introducing health as satire	Health memes are humorous, shareable images, videos, or text that convey important health messages in an engaging and easily digestible format, addressing a wide range of health topics.	Increased Engagement: Memes have the potential to capture attention quickly, especially among youth and online communities, making them an effective tool for spreading health messages.	Misinformation: If not carefully crafted, health memes could spread incorrect or misleading information, potentially harming the public's understanding of critical health issues.	Ensure Accuracy: Work with health experts to ensure that the health messages conveyed through memes are accurate, scientifically sound, and evidence-based.

Proposed Channels and Materials with Detailed Description for Channel: Mass/Digital Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
Health Memes: Introducing health as satire	Memes are designed to be culturally relevant, relatable, and visually appealing to different target audiences, especially younger demographics.	Wide Reach: With their shareable nature, memes can reach a large audience across different demographics, especially if shared by influential individuals or groups.	Cultural Sensitivity: Memes need to be culturally sensitive and tailored to the target audience, as humour that works in one community may be inappropriate or offensive in another.	Cultural Customization: Involve local influencers, and cultural experts to design memes that resonate with specific audiences and are culturally appropriate.
	They can be shared widely on social media platforms, mobile apps, and community-based messaging systems.	Breaking Stigma: Humorous and relatable content can help break down social barriers and stigma related to sensitive health topics, making it easier for people to engage in discussions about their health.	Over-simplification: Health issues, especially complex topics, may be oversimplified in meme format, leading to the risk of trivializing serious concerns.	Strategic Targeting: Use data analytics to identify and target specific demographic groups, such as youth or high-risk populations, through social media platforms and mobile apps to ensure the widest impact.

Proposed Channels and Materials with Detailed Description for Channel: Mass/Digital Media				
Material	**Description**	**Advantages**	**Potential Challenges**	**Proposed Solutions**
Health Memes: Introducing health as satire		Cost-Effective: Creating and distributing memes is a low-cost strategy compared to traditional media, allowing for frequent updates and targeting a broad audience without significant financial investment.	Saturation and Fatigue: Overuse or over-saturation of memes can lead to fatigue among the audience, reducing their effectiveness over time.	Monitor and Adapt: Regularly monitor the effectiveness of the memes through engagement metrics (shares, likes, comments) and adjust the content to prevent over-saturation and keep it fresh and engaging.
		Viral Potential: Memes have the potential to go viral, dramatically amplifying the reach and impact of health messages.		Hybrid Approach: Combine digital meme campaigns with offline strategies, such as community events or health talks, to reach populations with limited access to digital media.

Target Audience Segmentation and Key Messages

The operational framework of the SBCC strategy emphasizes topic-wise audience segmentation to ensure tailored interventions that address specific health issues, align with cultural contexts, and resonate with diverse community groups. For each identified health topic, the primary and secondary audiences are carefully segmented based on demographics, socio-cultural factors, and roles within the community. Targeted behaviours to be changed are identified for each audience. Key messages are developed to address these behavioural gaps using culturally relevant and easy-to-understand language, leveraging traditional beliefs and practices where appropriate. These messages are disseminated through strategic channels, including interpersonal communication by ASHAs and ANMs, SHG meetings, community gatherings, and multimedia tools, ensuring alignment with the preferences and accessibility of each audience segment. This tailored approach ensures that SBCC interventions are precise, impactful, and responsive to the unique needs of the states varying geography.

Target Audience Segmentation and Key Messages for Birth Spacing		
Audience Type		**Targeted Behaviour**
Primary Audience	Women in Reproductive age group & their male partners / Eligible Couples	• Ensuring women and their male partners actively plan and maintain a minimum spacing of 3 years between births to safeguard maternal and child health. • Both partners seek information from frontline health workers and adopt modern contraceptive methods suited to their needs. • Male partners actively engage in discussions and decisions regarding family planning and health needs, fostering a supportive environment.
Secondary Audience 1	Immediate family members – Wife / Female Partner, Mother, Maternal Uncle etc.	• Family members encourage birth spacing, respecting the couple's decision while providing emotional and logistical support.Relatives positively influence and endorse the use of modern contraceptives by reducing stigma and misinformation.

Target Audience Segmentation and Key Messages for Birth Spacing		
Audience Type		**Targeted Behaviour**
Secondary Audience 2	FLWs	• Proactively providing accurate, culturally sensitive, and tailored counselling on birth spacing and family planning options to couples, ensuring both women and men are equally engaged in discussions. • Actively encourage male participation by addressing their questions and concerns about family planning, emphasizing their role as supportive partners in reproductive health decisions. • Consistently follow up with families to ensure the adoption and sustained use of family planning methods, addressing any challenges or misconceptions encountered by the couple or family.
Secondary Audience 3	VHC members / SHG members / Religious Leaders / Traditional Healers	• Actively engage communities with accurate information on birth spacing and its health benefits through meetings, counselling, and cultural events. • Ensuring men are sensitized on their critical role in family planning and dispel traditional norms that limit male involvement. • Supporting in addressing and combating cultural and religious beliefs that hinder the uptake of family planning options, ensuring messages align with community values.

Key Messages for Birth Spacing option uptake and male participation

Plan 2-3 years between births to protect the health of mothers and children and strengthen family well-being

Modern family planning options are safe and accessible. Consult health workers to choose what's best for you.

Support your partner in family planning decisions and lead the way to a healthier family.

Target Audience Segmentation and Key Messages for EBF and CF		
Audience Type		**Targeted Behaviour**
Primary Audience	Lactating Mothers	• Ensuring that the baby is not given any other food item including rice broth with sugar, any pre-lacteals, water or animal milk for the first 6 months. • Ensuring proper positioning and attachment to the breast, giving enough time at each feed until baby leaves the breast, emptying both breasts and feeding frequently during the day and night. • Assess the supply of breast milk by checking the number of times the baby urinates and maintain breastfeeding frequently ensuring each breast is completely emptied (to ensure baby gets the fore-milk & hind-milk) for the first 6 months.
Secondary Audience 1	Husband / Partners	• Help with household chores to free up time for mothers to practice exclusive breastfeeding frequently especially when facing concerns that breast milk may be insufficient. • Talk with their mother and other elders living in the family about the need for EBF and how they should support the lactating mother to ensure EBF is done.
Secondary Audience 2	Mother & Family Elders- Maternal Uncle, Grandparents etc.	• Encourage the son/partner to help with household chores to ensure that the lactating mother gets enough time and space for practising EBF till 6 months of age of the child. • Help the lactating mother by attending to other children and also helping in reducing the workload so that she can practice EBF.

Target Audience Segmentation and Key Messages for EBF and CF		
Audience Type		**Targeted Behaviour**
Secondary Audience 3	FLWs	• Encourage pregnant women, especially in the last trimester, to plan for Early Initiation of Breastfeeding and also for EBF till 6 months. • Ensure that the mother and the family members receive correct and complete information about EIBF and EBF. • Emphasize that during the first six months of life, no food or liquids other than the mother's milk should be given to the child. • Ensure timely and planned home visits in the first six months to counsel and support the mother for EBF and correct CF practices.
Secondary Audience 4	VHC members / SHG members / Religious Leaders / Traditional Healers	• Sensitize and encourage husbands/partners of lactating women regarding helping with household chores to provide time and space for the mother for EBF till 6 months of age of the child. • Sensitize community members especially husband/partner, Mother and immediate family members regarding the need and advantages of EBF and correct weaning practices. • Sensitize and encourage Mother and other family elders to share household chores and to take care of other children in the family to provide time and scope for the mother to do EBF till 6 months of the age of the child. • Encourage community members to share information on correct weaning practices focusing on timing of initiation, meal frequency and diet diversity using locally available food items with lactating mothers and their family members.

Key Messages for Promotion of Exclusive Breast Feeding and complementary Feeding Practices

Give Exclusive Breastfeeding to the child up to six months of age.

Pre-lacteal feeds such as rice broth with sugar, water, other liquids and foods can be a source of infection and interfere with breastfeeding.

Mother's milk has enough nutrition and water to meet all the requirements of the child up to 6 months of age.

Baby's tummy is very small and requires very little quantity of milk again and again.

Target Audience Segmentation and Key Messages for Male Participation in MCH		
Audience Type		**Targeted Behaviour**
Primary Audience	Male Partners	• Ensure providing support to female partner / wife by accompanying for Healthcare Visits especially during ANC, PNC visits, for child's immunization and during the time sickness. • Supporting EBF by encouraging and assisting female partner / wife in practicing exclusive breastfeeding for six months by reducing maternal workload by contributing in household chores. • Ensure Complementary Feeding (weaning) is initiated for the child starting six months, by making other family members understand the advantages and benefits, and ensuring till then no other feeds including pre-lacteals are given. • Sharing Household Responsibilities to reduce physical strain on pregnant or breastfeeding mothers, allowing them to focus on their health and the child's well-being.

Target Audience Segmentation and Key Messages for Male Participation in MCH		
Audience Type		**Targeted Behaviour**
Secondary Audience 1	Family Elder, including Husbands mother	• Encouraging Positive Behaviours by support the couple in attending healthcare visits and practicing EBF, and discourage cultural practices or advice that conflict with recommended maternal and child health practices. • Creating a supportive environment by reducing the burden of traditional roles and expectations placed on mothers, allowing them to prioritize health
Secondary Audience 2	FLWs	• Engage Male Partners during outreach activities targeting to educate them on maternal and child health and provide culturally tailored counselling for men on supporting EBF and supporting in CF. • Building Community Awareness through facilitating group discussions during ANC / PNC visits or village meetings (during VHC or PTA meetings) to share success stories and address barriers to male involvement.
Secondary Audience 3	VHC members / SHG members / Religious Leaders / Traditional Healers	• Sensitize community members especially male partners and the village elders on gender equality in maternal and child caregiving and endorse & appreciate male participation in maternal and child health during community gatherings or religious sermons. • Promoting Cultural Acceptance by addressing cultural taboos or traditional beliefs that discourage male involvement in caregiving roles and encourage family-centred health practices as part of communal values.

Key Messages For Increasing Male Participation in Improving Maternal And Child Health

Encouraging men to share household responsibilities, provide emotional support during pregnancy, and ensure reduced physical burden for mothers.

Encouraging men to accompany their partners during ANC, understand the importance of balanced nutrition during pregnancy, and support breastfeeding and postnatal care.

Promoting male involvement in ensuring maternal and child care especially for seeking timely healthcare during illnesses of mother or child, and supporting in child care practices like accompanying during vaccinations, participating and supporting during initiation of CF.

Target Audience Segmentation and Key Messages for Reducing the Incidence of HIV/AIDS		
Audience Type		**Targeted Behaviour**
Primary Audience	General Population	• Ensuring individuals undergo regular HIV testing and know their status, especially among high-risk groups. • Ensuring individuals are aware of HIV/AIDS and its modes of transmission and attend screening program for early & timely detection of HIV/ AIDS
Secondary Audience 1	People Living with HIV/AIDS (PLWHA)	• PLWHA consistently adhere to antiretroviral therapy (ART) for improved health and reduced transmission risk. • People living with HIV/AIDS understand and continue with regular ART to suppress the viral load and prevention of progression to AIDS. • Ensure People living with HIV/AIDS make necessary lifestyle modifications to ensure a healthy living.

Target Audience Segmentation and Key Messages for Reducing the Incidence of HIV/AIDS		
Audience Type		**Targeted Behaviour**
Secondary Audience 2	Immediate family members of PLWHA	• Families and caregivers to provide emotional, physical, and logistical support to PLWHA, such as accompanying them to medical appointments and ensuring treatment adherence. • Families to prevent isolation and discrimination, and promote acceptance.
Secondary Audience 3	FLWs	• Encourage and ensure pregnant women undergo HIV and STI testing as part of their 'Essential Investigations' during pregnancy. • Provide necessary information to address stigma, promote testing, and facilitate access to ART and relevant support services. • Advocate for safer sexual behaviours especially among younger population, including creating awareness and pushing for condom use and reduced multiple sexual partnerships, through culturally sensitive messaging. • Engage religious leaders and village headmen to champion awareness campaigns and foster collective action against stigma.

Key Messages For Increasing Reducing the Incidence of HIV/AIDS

Regular HIV testing and early detection are vital for protecting your health and preventing transmission, especially for at-risk population.

Consistently follow ART to suppress viral load, prevent progression to AIDS, and live a healthy, fulfilling life.

Families and communities play a crucial role by offering emotional and logistical support to PLWHA while combating stigma and discrimination.

Practice safer sexual behaviours, including consistent condom use and reducing multiple partnerships, to prevent HIV and other STIs.

Target Audience Segmentation and Key Messages for Addressing Tuberculosis		
Audience Type		**Targeted Behaviour**
Primary Audience	Stakeholder – TB Patient	• Ensuring timely action is taken for early testing if experiencing symptoms like prolonged cough, fever, night sweats, or weight loss. • Ensure complete course of TB medication is adhered to as prescribed, even if symptoms improve, understanding that discontinuation of medication before completing the regimen could cause multi-drug resistance and reoccurrence of TB. • Ensure hygiene practices like covering the mouth while coughing and using personal utensils to prevent transmission is practiced till TB is completed treated and ensure eating nutritious food.
Secondary Audience 1	Immediate Caretakers / Family members	• Providing Emotional and Practical Support to the patient to complete treatment and attend follow-up appointments. • Developing necessary understanding about prevention of transmission to reduce fear and stigma, ensuring isolation and hygiene as needed to facilitate healthy and effective recovery.
Secondary Audience 2	FLWs	• Proactively identify and refer TB suspects promptly for testing and follow up on treatment adherence. • Providing effective counselling by being empathetic and provide clear communication about TB diagnosis, treatment, and prevention measures, giving confidence that TB is completely treatable and to follow all instructions as informed. • Facilitate effective community engagement by conducting awareness sessions and ensure accessibility of government schemes for TB patients.

Target Audience Segmentation and Key Messages for Addressing Tuberculosis		
Audience Type		**Targeted Behaviour**
Secondary Audience 3	VHC members / SHG members / Religious leaders	• Promoting TB awareness, emphasizing its curability and the importance of timely detection and complete treatment during community events, gatherings etc. • Actively create community support system through community discussions and mobilization for supporting TB patients and their families.
Secondary Audience 4	Traditional Healers	• Ensuring early referral as soon as a suspected TB case is found, to formal health facilities for testing and treatment. • Work collaboratively with health workers to reinforce accurate TB-related information in communities and patients that come for consultations.

Key Messages for Addressing Tuberculosis

Identifying TB and the Need for Timely Screening / Testing

Importance of Completing TB Treatment to prevent Multi-Drug Resistance

Breaking Stigma and Building Support in community and within family

Target Audience Segmentation and Key Messages for NCDs		
Audience Type		**Targeted Behaviour**
Primary Audience 1	General Population	• Get screened for diabetes, hypertension, and cancer regularly, especially after the age of 30, to detect these diseases early and manage them effectively. • Reduce risk factors by quitting tobacco, limiting alcohol consumption, eating a balanced diet, and exercising regularly.

Target Audience Segmentation and Key Messages for NCDs		
Audience Type		**Targeted Behaviour**
Primary Audience 1	General Population	• Understand and recognize the signs of diabetes, hypertension, and cancer (e.g., frequent urination, chest pain, unexplained weight loss) to seek timely medical help. Sometimes the disease may be asymptomatic, requires regular screening. • Participate in community health campaigns that educate about the importance of early detection and lifestyle changes in preventing NCDs.
Primary Audience 2	People with NCDs	• Follow prescribed medication regimens and attend regular check-ups to manage diabetes, hypertension, and cancer effectively. • Make lifestyle changes such as reducing salt, sugar, and unhealthy fats in the diet, quitting smoking, and increasing physical activity to manage the disease and improve quality of life. • Regularly check blood sugar, blood pressure, and undergo cancer screenings as advised by healthcare providers to avoid complications and improve long-term health outcomes. • Involve family members and community leaders in supporting health decisions and adhering to treatment plans.
Secondary Audience 1	Immediate Family Members / Caretakers	• Help loved ones with NCDs adhere to their medication and treatment schedules, and assist in making healthier lifestyle choices, such as preparing nutritious meals and encouraging physical activity. • Foster an environment that reduces stress and encourages regular health check-ups and medication adherence for those with NCDs. • Learn about the risks and symptoms of diabetes, hypertension, and cancer, and advocate for early detection and prevention within

Target Audience Segmentation and Key Messages for NCDs		
Audience Type		**Targeted Behaviour**
Secondary Audience 2	FLWs	• Encourage regular screenings for diabetes, hypertension, and cancer during home visits and in community meetings. • Educate patients and their families about the importance of timely medical treatment, medication adherence, and healthy lifestyle practices to manage NCDs. • Assist individuals with NCDs in setting goals for lifestyle modifications (e.g., diet, exercise) and provide ongoing support and counselling
Secondary Audience 3	Traditional Healers	• Educate and inform patients about the risks of diabetes, hypertension, and cancer, and refer them to medical professionals for proper screening and treatment. • Encourage patients for lifestyle modification like diet control and exercise along with medical supervision. • Help reduce the stigma surrounding NCDs by providing culturally sensitive care and supporting individuals in their health journey.
Secondary Audience 4	VHC members, SHG members, Religious Leaders	• Use platforms such as community gatherings or religious services to spread awareness about NCDs and promote healthy lifestyles. • Support the community in understanding the importance of early detection and regular check-ups for diabetes, hypertension, and cancer. • Advocate for families to support members with NCDs, particularly in managing their conditions and fostering an environment conducive to health.

Key Messages For Improving Awareness, Prevention And Management Of Non-communicable Diseases (diabetes, Hypertension And Cancer)

Identifying diabetes, hypertension, and cancer early through regular screening can save lives and prevent complications.

Adhering to prescribed treatments and making lifestyle changes like healthy eating, regular exercise, and stress management ensures better control of NCDs.

Addressing risk factors such as tobacco use, poor diet, and inactivity is essential to prevent the onset of these diseases.

Breaking myths and stigma around NCDs helps foster understanding and support within families and communities.

Routine check-ups and vaccinations, like HPV for cervical cancer, empower individuals to take charge of their health and prevent severe outcomes.

Specific Risk factors for NCDs to shed light on, Tobacco use in any form, Physical inactivity, Unhealthy diet (high salt, sugar, and saturated fats), Harmful use of alcohol, Stress, and Obesity

Target Audience Segmentation and Key Messages for Anemia		
Audience Type		**Targeted Behaviour**
Primary audience 1	Pregnant Women (15–49 years)	• Daily IFA tablet intake; increased consumption of iron- and folate-rich foods; regular ANC check-ups including hemoglobin testing; seeking timely treatment.

Target Audience Segmentation and Key Messages for Anemia		
Audience Type		**Targeted Behaviour**
Primary audience 2	Adolescent Girls and Boys (10–19 years)	• Weekly IFA tablet intake; understanding signs/symptoms of anemia; consuming iron-rich foods; adopting healthy hygiene practices
Primary audience 3	Mothers and Primary Caregivers	• Ensure iron-rich diets for children and themselves; monitor children's health; encourage family IFA intake.
Secondary audience 1	Men (Husbands & Fathers)	• Encourage IFA intake; support healthy diets and checkups; recognize anemia signs.
Secondary audience 2	Teachers and School Staff	• Promote WIFS actively; include anemia education in school activities.
Secondary audience 3	Community Leaders and Traditional Healers	• Endorse IFA and dietary changes; refer people to services.
Secondary audience 4	Frontline Health Workers (ASHAs , ANMs, AWWs)	• Actively counsel on anemia; track IFA adherence; promote diet change.

Key Messages For Prevention and Management of Anemia

Consumption of IFA tablets, 180 tablets Antenatal period and 180 tablets post delivery

Provision and consumption of deworming tablets by pregnant women, as per recommended guidelines, to reduce the prevalence of intestinal worm infestations

Conducting regular and periodic testing for anaemia in target populations, such as women and children, to facilitate early detection and timely intervention

Consumption of WIFS tablets and de-worming tablets by Adolescents

Talk about adopting healthy lifestyle measures, increase iron levels in the body and taking healthy diet rich in iron, protein and vitamin C.

Timely referral of identified anaemic cases, particularly severe cases, to higher-level health facilities for comprehensive medical evaluation and care.

Target Audience Segmentation and Key Messages for Quality Ante-natal Care		
Audience Type		**Targeted Behaviour**
Primary audience	Pregnant Women	• Register pregnancy early (within 12 weeks) • Complete 4 ANC visits on time • Accept all components: IFA, calcium, BP check, abdominal check, Hb test, ultrasound, TT, counselling • Report warning signs and adhere to referrals
Secondary audience 1	Husbands/Part-ners	• Encourage and accompany wife to ANC visits Support in nutrition, rest, and IFA adherence
Secondary audience 2	Mother, Mothers-in-law / Elder Women	• Encourage early registration and facility visits Promote complete ANC care
Secondary audience 3	Traditional Birth Attendants (TBAs)/ Traditional Healers	• Refer early to facilityWork with ASHAs to promote ANC servicesEncourage use of formal health care alongside cultural practices
Secondary audience 4	Religious Leaders / Village Elders	• Encourage early care and healthy practices from the pulpit Support ANC in public messages
Secondary audience 5	Health System Stakeholders (PHC/Sub-centre staff, Supervisors)	• Provide respectful, complete ANC services Strengthen FLW coordination and follow-upEnsure supplies, training, and quality monitoringRecognize and support FLWs and community outreach

Target Audience Segmentation and Key Messages for Quality Ante-natal Care		
Audience Type		**Targeted Behaviour**
Secondary audience 6	Frontline Health Workers (ASHAs, ANMs, AWWs)	• Conduct home visits and counsel family too Follow-up for each ANC schedule and danger signs

Key Messages For Quality Ante-natal Care

Promoting early registration for ANC within the first trimester to facilitate timely initiation of essential antenatal services

Emphasizing the crucial role of antenatal care services and consistent attendance at scheduled visits in the prevention of complications and promotion of a healthy pregnancy.

Ensuring that pregnant women are fully informed about the comprehensive package of services received through ANC, tailored to their individual needs

Establishing clear protocols for the identification of danger signs during ANC visits and ensuring prompt and efficient referral of women requiring specialized care

Counseling pregnant women on the importance of balanced nutrition, sufficient rest, and consistent intake of IFA and calcium tablets as prescribed by healthcare providers

Implementing effective counseling strategies using the MCP card to promote informed decision-making and empower women to actively participate in their own care

Ensuring that ANC services are provided in a manner that respects a woman's autonomy, upholds her rights, and addresses her emotional and psychological well-being

Target Audience Segmentation and Key Messages for Institutional Delivery		
Audience Type		**Targeted Behaviour**
Primary audience	Pregnant Women	• Plan and choose institutional delivery well in advanceRegister for ANC and understand birth preparedness stepsVisit nearby PHC/CHC for check-ups and delivery
Secondary audience 1	Husbands	• Accompany and support wife in birth planningArrange transport earlyKnow danger signs and act swiftly
Secondary audience 2	Mothers/Mothe-rs-in Law/Elders	• Support institutional deliveries as safer optionEncourage daughters-in-law to go for ANC & PHC visits
Secondary audience 3	Community Leaders / Village Council Members	• Publicly endorse institutional deliveries Mobilize emergency transport and local support
Secondary audience 4	Traditional Healers / Dais / TBAs	• Encourage hospital births, refer high-risk casesBecome part of early identification and preparedness
Secondary audience 5	Youth & School Teachers	• Include reproductive health in school discussionsEncourage adolescent girls to seek ANC if needed
Secondary audience 6	ASHAs/FLWs	• Track high-risk pregnancies early

Key Messages For Promotion of Institutional Delivery

Why institutional delivery is important

Importance of birth prepared-ness and emergency transport system

Support of husbands and family members

Dignity and respect during child birth

Target Audience Segmentation and Key Messages for Teenage Pregnancy		
Audience Type		**Targeted Behaviour**
Primary audience 1	Adolescent Girls (10-19 years)	• Delay marriage and pregnancy until at least 20 years of age.Seek accurate information about menstruation, contraception, and reproductive health. • Access adolescent-friendly health services (AFHS) when needed.Build confidence to say "no" to early sex or unsafe relationships.
Primary audience 2	Adolescent Boys (10–19 years)	• Take shared responsibility in preventing early pregnancy. • Avoid risky sexual behaviour and understand consequences. • Support peers in respecting girls' choices and rights. • Engage positively in discussions around reproductive health and gender equality.
Secondary audience 1	Parents & Guardians	• Initiate open, non-judgmental conversations with children about puberty, sex, and relationships. • Support adolescents' education and delay in marriage/pregnancy. • Encourage use of health services without stigma or shame.
Secondary audience 2	Teachers and School Staff	• Provide accurate, age-appropriate reproductive health information. • Create a supportive school environment for adolescents. • Identify and refer at-risk adolescents for counselling or support.
Secondary audience 3	Community and Religious Leaders	• Publicly support delay in marriage and pregnancy. • Promote gender-equitable norms and youth education in sermons/discourses. • Encourage families to seek help rather than hiding pregnancies.

Target Audience Segmentation and Key Messages for Teenage Pregnancy		
Audience Type		**Targeted Behaviour**
Secondary audience 4	Peers and Friends	• Promote healthy, respectful relationships. • Support each other in accessing health information and services. • Counter peer pressure and normalize saying no to early sexual activity.
Secondary audience 5	ASHAs, ANMs, and Other FLWs	• Provide confidential, adolescent-friendly counselling and referrals. • Proactively engage with boys and girls to dispel myths about sex and contraception. • Educate families about health risks of teenage pregnancy.

Key Messages For Addressing Teenage Pregnancy

Advocating for the postponement of marriage and pregnancy until the age of 20 or later, emphasizing the benefits for girls' education, empowerment, and overall well-being

Fostering healthy and respectful relationships between girls and boys through comprehensive sexuality education that promotes gender equality, communication skills, and violence prevention

Expanding access to and utilization of services provided by Adolescent Friendly Health Clinics, including sexual and reproductive health care, mental health support, and nutritional counseling

Ensuring that adolescents are aware of and have access to various family planning methods, including emergency contraception, within a supportive and confidential environment

Consumption of WIFS tablets and de-worming tablets by Adolescents

Talk about adopting healthy lifestyle measures, increase iron levels in the body and taking healthy diet rich in iron, protein and vitamin C.

Timely referral of identified anaemic cases, particularly severe cases, to higher-level health facilities for comprehensive medical evaluation and care.

> *VHC is a good platform for health information dissemination, but the current officials cannot communicate with the members effectively on health topics as that is not their area of expertise. Good to have designated people who are experts in health can do this. More training to be given for VHC officials as currently they were given one day training only*

– Village Headman of Moknoor village, Saipung, East Jaintia Hills District

Preferred Communication Channels by Audience

The following are the recommended preferred communication channels of different audience types in different geographies:



General population/ high risk group

Urban 'Voice-Bot for Health(Alexa type); Posters in hospitals and busy community / public places; Social media - WhatsApp, YouTube, Health memes; Hoarding; Travelling Folk Theatre; Religious institutions; Schools; Sensitisation programs attached to events & gatherings; Wall paintings

Rural 'Voice-Bot for Health(Alexa type); Posters in hospitals and village health information board; Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; VHC meetings; 'Ask the mechine' van Religious institutions; Schools; Sensitisation programs attached to Melas; Wall paintings'



Persons impacted directly

Urban Hosptial and Home based counselling by Healthcare providers; posters in hospitals and public places; Social media - WhatsApp, YouTube, Health memes; Voice-Bot for Health(Alexa type); Wall paintings

Rural Hosptial and Home based counselling by Healthcare providers; posters in hospitals and village health information board; Social media - WhatsApp, YouTube, Health memes; VHC meetings, SHG meetings, 'Ask the Mechine' Van; Voice-Bot for Health(Alexa type); Wall paintings



Family members of persons impacted directly

Urban Hosptial and Home based counselling by Healthcare providers; posters in hospitals and public places; Social media - WhatsApp, YouTube, Health memes; Voice-Bot for Health(Alexa type); Wall paintings

Rural Hosptial and Home based counselling by Healthcare providers; posters in hospitals and village health information board; Social media - WhatsApp, YouTube, Health memes; VHC meetings, SHG meetings, 'Ask the Mechine' Van; Voice-Bot for Health(Alexa type); Wall paintings



Community Based Organisations (VHC, SHG etc)

Urban and Rural Specific training programs; Sensitisation sessions by health providers; Handbook on Health



Religious Leaders / Teachers/ Social Leaders

Urban and Rural Specific training programs; Sensitisation sessions by health providers; Handbook on Health



Frontline Workers

Urban and Rural Training on how to use different communication tools (ASHA tab, flip chart handbook, VHC IEC Book; Training on communication & counselling

Integrated Strategic Approaches

Multi-sectoral convergence with Roles & KPIs – The need

The emerging health landscape across all the three regions of Meghalaya presents with rather complex challenges, where there is an increasing burden of NCDs like diabetes, cancer, and hypertension, communicable diseases such as TB and HIV/AIDS, couple with alarming health and nutrition practices like low rate of EBF and high rates of child malnutrition and limited male participation in MCH care. These challenges demand a multisectoral approach leveraging the strengths of the Health Department, ICDS, Education Department, and C&RD (SHG). There are platforms like the VHC, SHG, PTA, VHSND etc existing at the community level which can facilitate the ease of convergence.

Strengthening VHCs a crucial step for effective SBCC Implementation

VHCs play a pivotal role in ensuring the success of SBCC strategies at the grassroots level. Strengthening VHCs is essential to establish them as facilitators, implementers, and monitors of health initiatives.

Empowered VHCs can bridge the gap between policy and community action, fostering ownership and accountability for health outcomes.

The primary goal of this concept of convergence is to provide a comprehensive and effective service to the populace in an integrated manner which is influenced by multiple health and social attributed and platforms.

Key responsibilities of VHCs include planning, executing, and monitoring activities as per an annual calendar of events tailored to local health priorities.

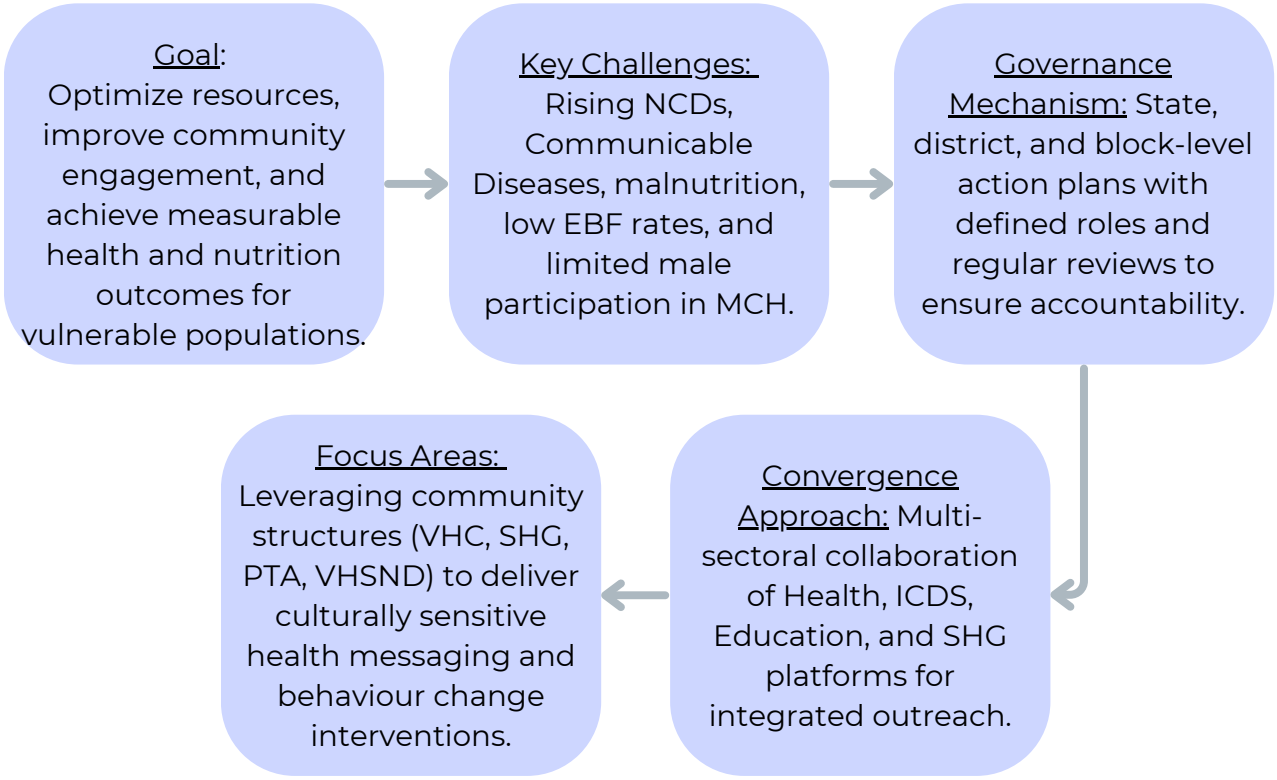
This structured approach ensures consistent messaging and effective resource utilization while promoting community participation.

VHCs can act as a platform for disseminating culturally sensitive health information, organizing events like health camps and awareness drives, and addressing community-level barriers to behaviour change.

The philosophy of the convergence strategy is to work together for the benefit of all especially the vulnerable and marginalized. Convergence among these stakeholders and effective utilization of these platforms can help optimize resources, improve community engagement, and achieve shared health goals. The main objective of convergence is to enhance the utilization of the system through provision of a common platform for availability of and access to all relevant information pertaining the expected behaviour change around various existing health practices.

Effective institutional mechanism for convergence of health care and awareness services with other government run schemes for health determinants is critical considering the massive burden on the department and the population.

The Multi-Sectoral Convergence Approach:



For effective convergence across different departments, it is important that convergence plans are developed across all levels – State, Districts and Block levels. It is proposed that S-CAP should be developed, implemented and bi-annually reviewed under the Chairmanship of Chief Secretary with Principal Secretary- Health and Family Welfare being the nodal officer, involving secretaries of all relevant departments namely Social Welfare Department (WCD / ICDS), C&RD Department, Department of Education and CEO-SMMU, MSRLS.

By integrating VHCs into the SBCC strategy, activities such as door-to-door outreach, community mobilization, and monitoring of frontline workers' performance can be streamlined. Additionally, regular capacity-building efforts, coupled with access to tools like participatory scorecards and updated IEC materials, will enable VHCs to deliver measurable and sustainable results.

At the District level, the convergence action plan will be developed under the Chairmanship of the District Collectors where Deputy Commissioner would be nodal officer for coordination, other members would be DM&HO, DPO – WCD/ICDS, DEO and DPM-DMMU/MSRLS.

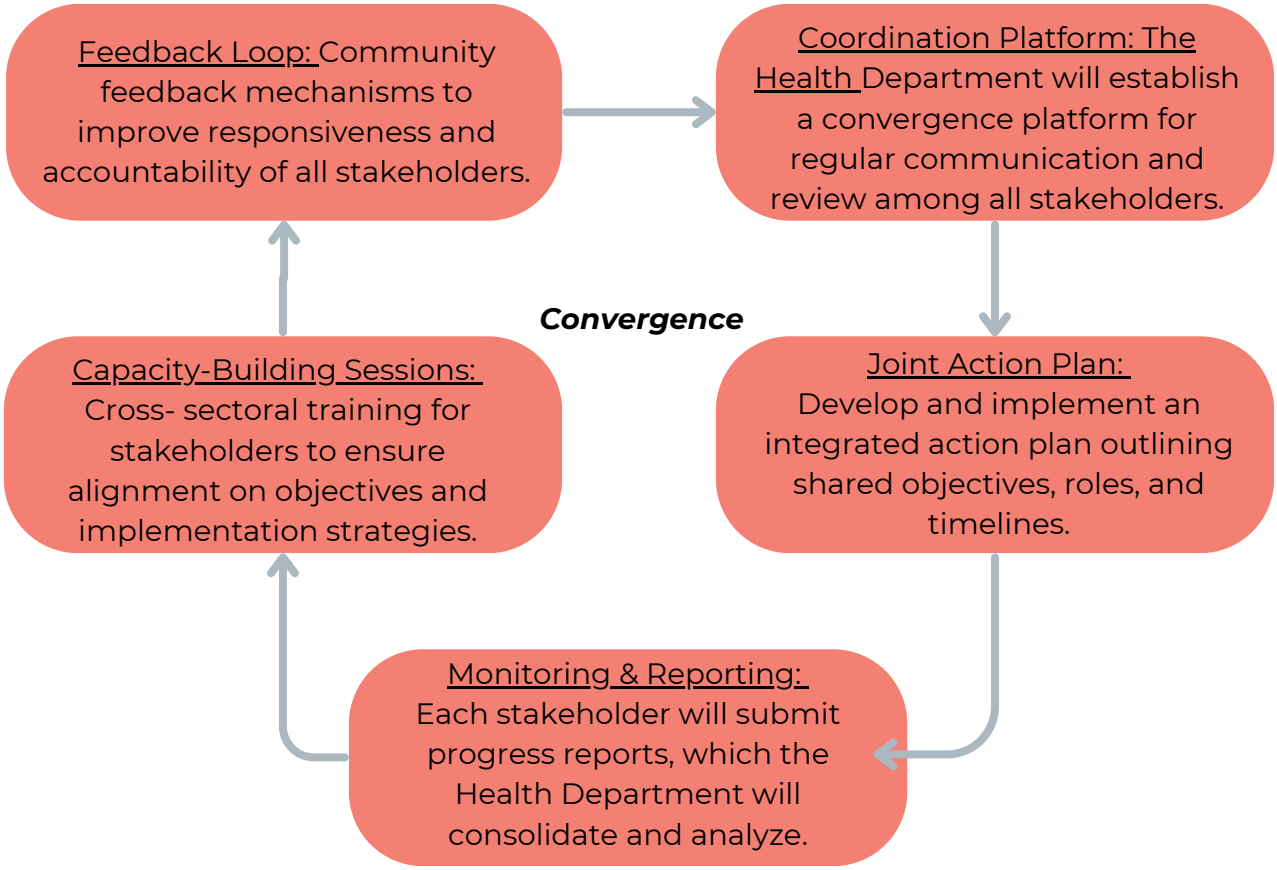
At the block level, the process of convergence would be led by Block Development Officer along with other block level officials namely the BMO, CDPO, BEO and BPM-BMMU/MSRLS. The process of CAP document development will be a consultative process with lead official / department taking responsibility of development, implementation, review and reporting on a mutually agreed timeline.

In summary, strengthening VHCs is a critical step in creating a community-driven, locally relevant, and accountable health communication ecosystem that ensures the successful implementation of the proposed SBCC strategy.

The SBCC convergence plan involves the coordinated efforts of multiple departments—H&FW, WCD/ICDS, Education, C&RD and MSRLS—to address health & associated social challenges comprehensively. This plan ensures the integration of tailored messaging across platforms and institutions to tackle issues such as NCDs – Diabetes/ Cancer / Hypertension; communicable diseases like TB, HIV-AIDS; need for promotion of EBF and correct weaning (complementary feeding) practices; uptake of Birth spacing options, and male participation in maternal and child healthcare.

It focuses on streamlining roles, building capacity, and leveraging existing community structures for impactful outreach. Each stakeholder plays a defined role, for example frontline workers delivering community-based structured counselling to schools promoting adolescent health education (& sensitizing parents), while SHGs ensuring reaching out to family members (including male members) on various health messages, ensuring uniformity and efficiency in messaging. The approach emphasizes collaboration, capacity building, culturally sensitive communication strategies, and systematic monitoring to achieve measurable improvements in health outcomes.

Operational Mechanisms



Roles and Responsibility / Accountability Matrix with KPIs of each department for SBCC Convergence

Accountability Matrix for SBCC Convergence – State Level

Department/ Agency	Roles and Responsibilities	KPIs	Process Activities
Health and Family Welfare (H&FW) / NHM	Lead the development of S-CAP; ensure interdepartmental coordination; oversee SBCC messaging integration and capacity building of state-level trainers.	S-CAP developed and reviewed biannually; number of state-level trainings conducted; proportion of SBCC content integrated.	Chair State Convergence Committee meetings; approve guidelines; coordinate SBCC dissemination.
Women & Child Development (ICDS)	Ensure inclusion of EBF, CF practices, and maternal health in SBCC content; provide ICDS platform for messaging dissemination.	Integration of maternal and child health messages into ICDS services; quarterly progress report submissions.	Participate in S-CAP planning; coordinate capacity building for ICDS workers; monitor implementati-on.
Education Department	Facilitate adolescent and parental health education campaigns; ensure SBCC materials are available in schools.	Number of school campaigns conducted; proportion of students sensitized on SBCC health topics.	Plan education campaigns; integrate health messages into curriculum; track school engagement.
Community & Rural Development (C&RD)	Support SHGs and VHCs in awareness drives; integrate SBCC messages into rural outreach activities.	Percentage of SHGs trained on SBCC; number of VHC-driven community meetings conducted.	Mobilize SHGs; review community awareness drives; link SHG outcomes to district plans.

Accountability Matrix for SBCC Convergence – State Level

Department/ Agency	Roles and Responsibilities	KPIs	Process Activities
Meghalaya State Rural Livelihood Society (MSRLS)	Engage SHGs for family and male member sensitization; support SBCC dissemination through rural networks.	Number of families reached through SHGs; male participation in SBCC activities measured through surveys.	Provide SBCC content to SHGs; ensure SHGs report outcomes to district officials.

Accountability Matrix for SBCC Convergence – District Level

Department/ Agency	Roles and Responsibilities	KPIs	Process Activities
Health and Family Welfare (H&FW) / NHM	Coordinate D-CAP; monitor district-level SBCC implementation; facilitate training of ANMs and ASHAs.	Finalized D-CAP; number of training sessions; percentage of ANMs and ASHAs trained.	Convene District Convergence Committee; ensure district health reviews.
Women & Child Development (ICDS)	Integrate SBCC messages into AWWs' activities; monitor community awareness sessions on EBF and weaning.	SBCC sessions by AWWs or no. of beneficiaries covered; quarterly progress reports.	Align AWW outreach with SBCC; ensure monitoring of field activities.
Education Department	Conduct adolescent and parental sensitization programs; integrate health education into school activities.	Number of schools engaged in SBCC campaigns; attendance in health sessions.	Plan sensitization sessions; review teacher involvement in SBCC.

Accountability Matrix for SBCC Convergence – District Level

Department/ Agency	Roles and Responsibilities	KPIs	Process Activities
MSRLS	Mobilize SHGs for health outreach; ensure timely reporting on SBCC activities.Provide infrastructural support for SBCC campaigns; align health themes with community projects.	Percentage of SHGs implementing SBCC; proportion of families reached through campaigns.SBCC themes included in 70% of projects; number of awareness drives conducted.	Track SHG activities; support district-level SBCC reporting.Coordinate health awareness drives.

Accountability Matrix for SBCC Convergence – Block Level

Department/ Agency	Roles and Responsibilities	KPIs	Process Activities
Health and Family Welfare (H&FW)	Ensure B-CAP aligns with D-CAP and S-CAP; lead capacity building for frontline workers; conduct health camps.	Number of ASHAs trained; health camp participation rates; community feedback analysis.	Organize B-CAP implementation workshops; oversee health camp outcomes.
Women & Child Development (ICDS)	Facilitate AWWs in delivering SBCC; monitor home visits and community sessions.	Proportion of AWWs trained in SBCC; number of home visits conducted; number of community sessions conducted.	Coordinate block-level workshops; support field worker engagement.
Education Department	Promote SBCC through block-level schools; conduct teacher training on SBCC integration.	Percentage of schools implementing SBCC; number of teachers trained.	Monitor school outreach; ensure student-parent participation in health sessions.

Accountability Matrix for SBCC Convergence – Block Level

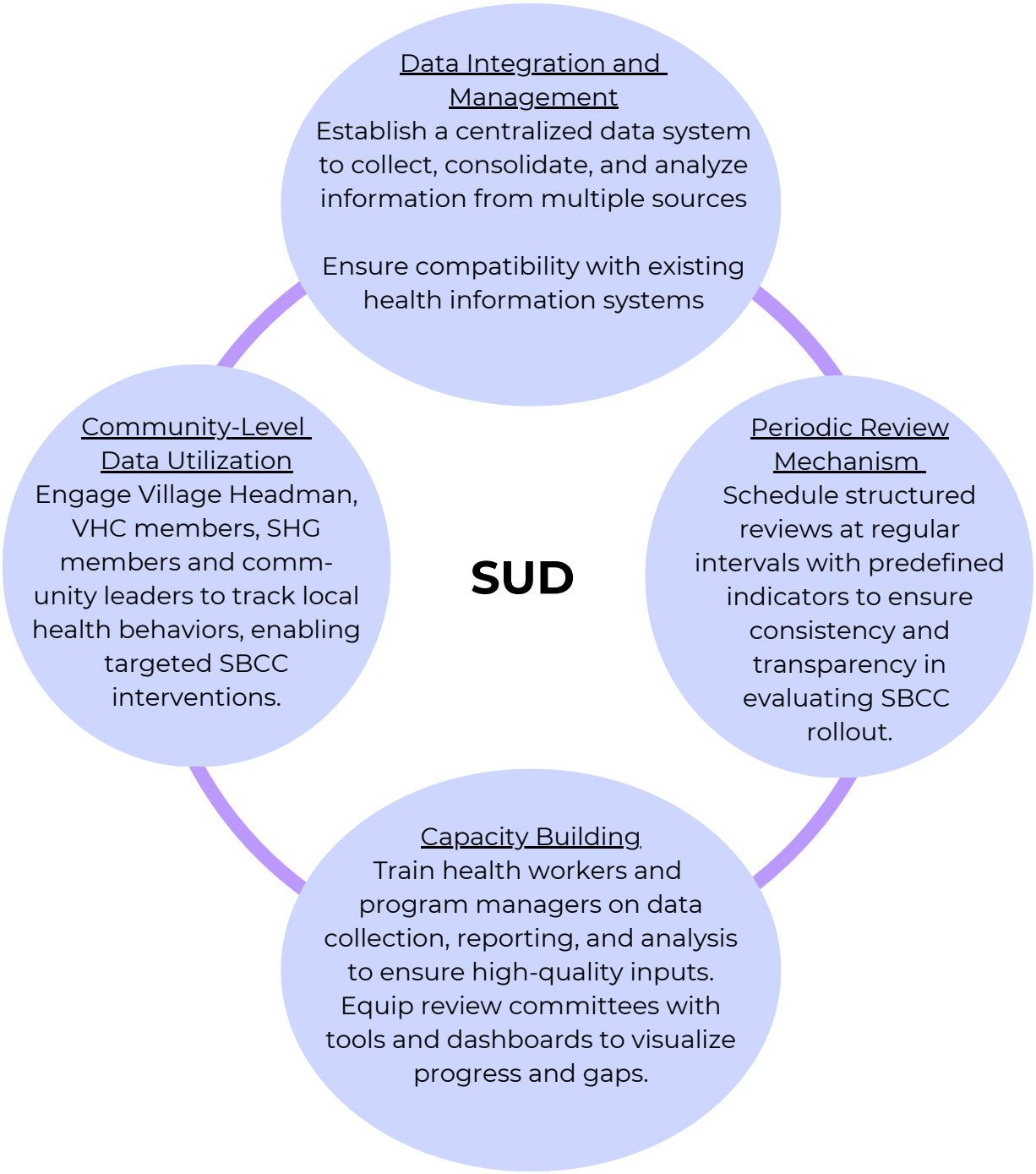
Department/ Agency	Roles and Responsibilities	KPIs	Process Activities
MSRLS	Build SHG capacity for SBCC activities; track no. of household engagement done. Support SHGs in delivering health messages; involve male members in health programs.	Number of block-level SHG campaigns conducted; percentage of target families engaged. Number of SHG-driven events; percentage of male participation in awareness campaigns.	Facilitate resource provision; coordinate block-level SBCC activities. Conduct capacity building sessions for SHGs; track male involvement.



System Strengthening and Data Driven Implementation

Strategic Use of Data (SUD) for Effective Rollout of SBCC Strategy

Strategic use of data is imperative for the successful rollout of the SBCC strategy in Meghalaya. Data-driven decision-making can enable the Health Department to prioritize interventions, monitor progress, and recalibrate strategies based on real-time insights for improving coverage and quality of services. A robust review mechanism with focus on processes, embedded at all levels—State, District, Block, and PHC / SC—is essential for tracking implementation effectiveness, ensuring accountability, and achieving desired health outcomes.



Review based on SUD Indicators across various Levels – State, District and Block

Level	Indicators	Review Activities	How to review
State	Percentage of districts with functional D-CAPs.	Bi-annually state-level review chaired by Chief Secretary the Principal Secretary (H&FW).	Use a consolidated MIS from districts; maintain MoM for action points and timelines.
	Proportion of districts submitting timely and accurate reports.	Analysis of district data for trends, gaps, and best practices.	Review submission timelines and validation accuracy using MIS. Share comparative dashboards over ppt.
	State-level campaign coverage and participation rates.	Develop and share data-driven recommendations with all districts.	Analyse MIS data, conduct spot checks, and use survey reports for participation validation.
District	Number of blocks with active SBCC activities aligned to D-CAP.	Monthly district SBCC review chaired by the District Collector.	Verify activity logs submitted by blocks; prepare MoM for monthly progress and challenges.
	Participation rates in SBCC campaigns (segmented by community groups).	Cross-check data with frontline worker feedback.	Conduct FGDs with community groups; compare feedback with campaign data from the field and MIS reports.
	Timely training completion rates for ASHAs, ANMs, and SHGs.	Share district progress reports with the state.	Validate training attendance using signed attendance sheets and digital MIS records.
Block	Proportion of PHCs and sub-centres submitting complete and timely data.	Monthly block-level meetings led by the Block Development Officer (BDO).	Cross-verify PHC and sub-centre reports with data in the district MIS. Prepare actionable insights in MoM.

Review based on SUD Indicators across various Levels – State, District and Block

Level	Indicators	Review Activities	How to review
Block	Number of SBCC community sessions conducted per month.	Verify frontline worker attendance and coverage reports.	Use attendance sheets and field visit records; ensure triangulation with random spot checks.
	Feedback from community members on campaign relevance and clarity.	Compile block-level insights for district reports.	Conduct FGDs and short surveys; consolidate qualitative feedback with trends from field staff reports.
PHC/Sub-Centre	Number of households covered during community outreach sessions.	Bi-weekly review meetings with PHC medical officers.	Use frontline workers' reports validated by random household surveys and GPS tracking for outreach coverage.
	Counselling session coverage rates by ASHAs and AWWs.	Validate field data through random household surveys.	Cross-check session attendance registers with family reports during surveys and MIS analysis.
	Feedback on message comprehension and behavioural changes from families and male participants.	Prepare PHC-level data summaries for block-level review.	Conduct household surveys for feedback; integrate findings into qualitative and quantitative block-level data.

Supportive supervision

Supportive supervision is critical to ensuring that the SBCC strategy is understood, implemented as designed, sustained and adapted effectively to meet local needs. A robust supervision system provides frontline workers and their supervisors with the tools and guidance necessary to address challenges, maintain fidelity to the strategy, and achieve desired behaviour change outcomes.

Key Features of Supportive Supervision

Dual Approach: In-Person and Remote (hard-to-reach areas)

- In-Person Support: Supervisors conduct planned joint field visits to observe and guide frontline workers, providing real-time feedback and hands-on training as required.

- Remote Supervision: Leveraging technology, remote support can be provided via smartphones, internet connectivity, and dedicated apps (e.g., the SAHYOG app developed by FHI and adopted by the Ministry of Women and Child Development)

Structured Process

- Planned Joint Visits: Supervisors schedule regular field visits, either virtually or physically, to monitor implementation, answer queries, and address barriers in real-time.
- On-Job Support: Hands-on guidance is provided to strengthen worker confidence and skill application during their routine activities.
- Debriefing Sessions: After each session, supervisors and workers review activities, appreciate successes, and identify areas needing improvement.
- Identification of field level issues and resolution: Issues are identified during the debriefing sessions which based on the level of resolution is escalated in real-time; issues which can be resolved instantly are resolved during the debrief, while others which require escalation to the next level are either escalated using the app or through field visit reporting.

Real-Time Tracking and Reporting

- A dashboard integrates data from supervisory visits, enabling higher authorities to monitor support efforts across levels and ensure accountability.
- Insights from the dashboard inform decision-making, ensuring timely intervention and addressing systemic challenges.

Capacity Building

- Supportive supervision fosters continuous learning by reinforcing workers' knowledge of the SBCC strategy, improving their counselling skills, and enabling adaptive problem-solving.

> *The IEC Handbook is quite good and quite informative but it could have been much simpler as many of us do not really understand the terminologies in it.*
>
> - VHC members in Ganol Apal, West Garo Hills.



Theory of Change





Theory of Change

The proposed TOC for the SBCC strategy in Meghalaya outlines a comprehensive pathway to achieve improved health outcomes by addressing key behavioural and systemic barriers. Rooted in an evidence-based approach, this framework highlights the critical role of capacity building, community mobilization, stakeholder engagement, and policy advocacy in fostering sustained behaviour change and promoting health-seeking behaviours.

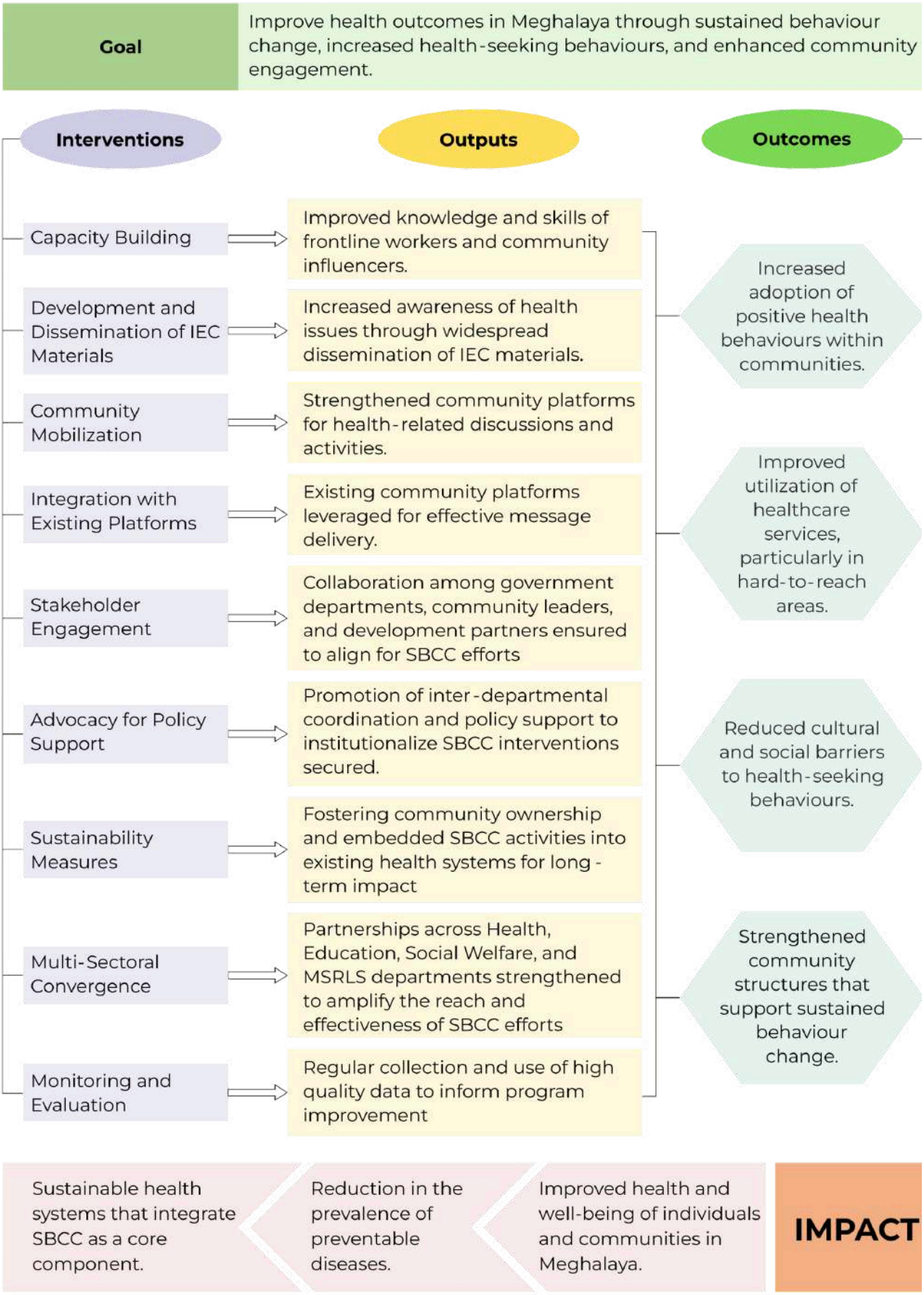
The strategy leverages existing community platforms, such as VHCs, SHG meetings, and religious gatherings, as conduits for delivering culturally appropriate health messages. By engaging influential community members—such as religious leaders, traditional healers, and SHG leaders—it aims to build trust and support for health initiatives. To ensure long-term impact, the strategy emphasizes the integration of SBCC interventions into existing health systems and multi-sectoral collaboration among key departments like Health, Education, and Social Welfare.

A robust M&E framework underpins the TOC, ensuring real-time tracking of progress, identification of challenges, and data-driven decision-making. This framework also incorporates sustainability measures to encourage community ownership and ensure continuity of efforts beyond the program lifecycle.

The ultimate goal of the proposed TOC is to achieve measurable improvements in health behaviours, increased utilization of healthcare services, and a reduction in preventable diseases, contributing to the overall health and well-being of Meghalaya's population.

> *I was told by the houseowner where I work as a maid that steel scrub used for washing dishes causes cancer, so we have stopped using that!*
>
> – 31 years old FGD participant in Laitmawpen, Mawplang, West Khasi Hills District, when asked about causes of cancer.

Theory of Change





Institutional Strengthening





Institutional Strengthening

The effective implementation of the SBCC strategy hinges on the strength and preparedness of the institutional structures outlined in Meghalaya's Human Development Institutional Architecture. Each level, from state to village, plays a pivotal role in ensuring that SBCC interventions are tailored, culturally relevant, and impactful. However, to achieve the desired health behaviour changes, these structures require targeted capacity-building efforts to address knowledge gaps, enhance technical skills, and foster collaboration.

It is proposed to have two-pronged training plan with one focussing on the proposed HR architecture covering officials of Health Department and its allied departments as clearly stated above in the HR section and proposed in the Convergence Action Plan section.

Capacity Building for State, District, Sector and Frontline Structures in SBCC Strategy Implementation

Key Areas of Capacity Building – State, District, Sector and Frontline level

Level	Areas of Capacity Building
State Level - Human Development Council	Policymakers and department heads need training on SBCC design, strategic planning, and monitoring tools.Enhanced capacity to integrate SBCC principles with existing policies and interdepartmental coordination for cohesive implementation.
District Level - District Team	District leaders require skill development in data analysis, local adaptation of strategies, and operational management.Focus on fostering partnerships and engaging community stakeholders.
Sector Level – Sector Team	Capacity enhancement in program implementation, resource optimization, and use of innovative communication channels.Training in supervising and mentoring frontline workers.
Frontline Level - Frontline Team	FLWs (ASHAs, ANMs) and Cluster Coordinators need hands-on training in interpersonal communication, counselling, and mobilizing communities.Building their ability to monitor behaviour change indicators and relay actionable insights.

Capacity Building Plan

Level	Training Focus	Participants	Methods	Duration
State Level	Strategic SBCC planning, inter-departmental convergence, monitoring, and review	Development Commissioner, key department heads (Health, Education, MSRLS, Social Welfare), and concerned state officials from all relevant departments	High-level workshops for sensitization on SBCC strategy, CAP and role of each partner department	Annual
District Level	District-specific adaptation of SBCC strategies, inter-departmental convergence, monitoring, and review	DC, DPO/ DSWO, DMHO, DCPC, DMM, and all relevant district officials	Interactive training modules Convergence Action Plan and role of each partner department	Bi-annual workshops (1-2 days each)
Sector Level	Supervising frontline teams, effective communication for program coordination, stakeholder engagement and utilizing innovative SBCC tools	MOs, BPMs (NHM and MSRLS), CDPO, all relevant block level officials	Sector-level training camps Role-play and scenario-based exercisesToolkits for resource optimization	Bi-annual workshops (2 days each)
Frontline Level	Interpersonal communication, counselling techniques, community mobilization, and data documentation	ASHAs, ANMs, Lady Supervisors, Cluster Coordinators	Hands-on practical sessions Mobile-based learning applications Community simulations	Quarterly with refresher sessions (1–2 days)

Capacity Building for Village level Structures in SBCC Strategy Implementation

The successful rollout of the SBCC strategy in Meghalaya requires strengthening the capacity of various institutional and community structures. The gaps identified during primary data collection highlight the need for targeted capacity-building initiatives, periodic refresher training, and robust engagement with key stakeholders to ensure the sustained and effective dissemination of SBCC messaging.

Key Areas of Capacity Building – Village level

Platform	Areas
VHC	VHCs act as a critical communication platform at the village level, bringing together ASHAs, ANMs, and social representatives.Despite the one-day orientation currently provided, there is a need for in-depth engagement to:Build awareness about their roles.Enhance their capacity to implement health activities, including SBCC rollout.Strengthen their role as a bridge between service providers and beneficiaries.
Religious Leaders	Religious leaders are influential community members who can integrate health messages into religious counselling sessions and gatherings.Periodic sensitization is essential to equip them with the knowledge to promote health-related information passively and actively during their sessions.
Traditional Healers	In remote and hard-to-reach areas, traditional healers remain primary points of contact for health-related issues.Sensitizing them to align their practices with basic health awareness and disseminate SBCC messages can leverage their influence effectively.
SHG Members	SHG meetings are informal yet impactful forums where health topics can be introduced passively.Sensitizing SHG leaders can help cascade health messages to their members, enhancing community-level awareness.
Frontline Workers (ASHAs, ANMs, Cluster Coordinators)	Although these workers attend various training programs, periodic refresher courses are necessary to:Keep their knowledge up-to-date.Strengthen interpersonal communication skills.Improve their use of SBCC materials for effective community engagement.

Capacity Building Plan for SBCC

Training Framework

Training Frequency

- Refresher Trainings – every two years for all key stakeholders
- Regular Sensitization / Orientation – quarterly or bi-annually depending on the target group

Training Level

- State Level TOT - state-level team will train district-level trainers
- District-Level Trainings*- District teams will conduct training for frontline workers and community leaders.

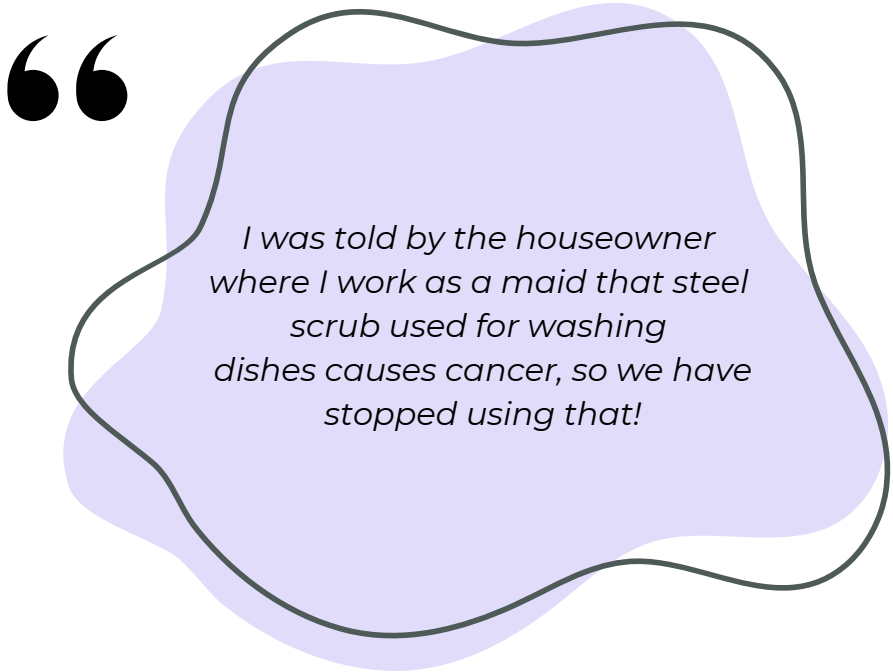
** Each district will have a 5-member training team, including one coordinator.*

These teams will - develop detailed annual training plans, facilitate all SBCC-related trainings, maintain a database of training activities and progress for ASHAs, ANMs, and other health actors, address challenges in training during district review meetings.

Capacity Building Activities

Stakeholder	Training Topics	Mode of Delivery	Frequency	Stakeholder
VHC Members	Roles and responsibilities, SBCC messaging, health activity implementation	Workshops, Interactive Discussions	Quarterly	VHC Members
Religious Leaders	Health awareness, integrating messages into religious gatherings	Sensitization Meetings, Toolkits	Bi-annual	Religious Leaders
Traditional Healers	Awareness of key health issues, collaboration with medical systems, referral protocols	On-site Workshops, Case-based Discussions	Quarterly	Traditional Healers

Stakeholder	Training Topics	Mode of Delivery	Frequency	Stakeholder
SHG Leaders	Basic health knowledge, SBCC messaging, passive health information dissemination methods	Community-level Sessions, Visual Aids	Bi-annual	SHG Leaders
Frontline Workers	Advanced communication skills, SBCC material utilization, data documentation	Refresher Training, Role-Playing Exercises	Quarterly	Frontline Workers



-31 years old FGD participant in Laitmawpen, Mawplang, West Khasi Hills District, when asked about causes of cancer.



Project Implementation Plan







Monitoring and Evaluation





Monitoring and Evaluation

A robust Monitoring and Evaluation (M&E) framework is essential for the effective implementation of the SBCC strategy, ensuring it achieves its intended outcomes and long-term impact. Such a framework facilitates systematic data collection, analysis, and utilization to track progress, identify challenges, and support evidence-based decision-making. Integrity in reporting and timely data flow are fundamental to building trust, ensuring transparency, and fostering accountability among stakeholders. By converting field data into actionable insights, the framework enables regular program reviews and timely interventions to address gaps and enhance performance. A critical component of the framework is capacity building, which ensures data quality through training stakeholders in accurate collection, reporting, and analysis. This approach supports continuous improvement while fostering collaboration among all stakeholders. Additionally, an effective M&E framework measures long-term behavioural and social impacts, aligning SBCC interventions with broader health and development goals, and promoting engagement through feedback mechanisms that drive collective learning and improvement.

SBCC strategy – Objectives, Monitoring Indicators & Evaluation Indicators

Objectives, Monitoring Indicators & Evaluation Indicators for EBF and CF		
Objectives	**Monitoring Indicators**	**Evaluation Indicators**
• Educate mothers, families, and male partners on EBF for the first 6 months and proper CF practices, including timely initiation, meal frequency, and diet diversity. • Raise awareness among mothers of under-2 children on EBF, timely CF, diet diversity, and meal frequency.	• % of public locations displaying breastfeeding/complementary feeding posters • % of mothers and family members informed about exclusive breastfeeding during HBNC • % of mothers and family members informed about timely initiation of complementary feeding, minimum diet diversity and meal frequency during HBYC	• % of mothers of children <6 months aware of EBF • % of mothers of children <6 months aware of CF initiation at 6 months • % of mothers of children <1 year receiving counselling on EBF/CF from ASHA/ANM • % of mothers satisfied with the EBF/CF counselling from ASHA/ANM

Objectives, Monitoring Indicators & Evaluation Indicators for EBF and CF		
Objectives	**Monitoring Indicators**	**Evaluation Indicators**
• Equip stakeholders (FLWs, VHC, SHG members, traditional healers) to promote EBF and proper CF practices.	• % of mothers informed about exclusive breastfeeding post-delivery at the hospital • % of ASHA & ANM trained on topics related to Breastfeeding, Complementary feeding and use of MCP card as a communication tool, in last 3 years	• % of mothers of children 6-23 months aware of diet diversity and meal frequency • % of mothers informed on breastfeeding and CF through any source

Objectives, Monitoring Indicators & Evaluation Indicators for Birth Spacing		
Objectives	**Monitoring Indicators**	**Evaluation Indicators**
• To raise awareness on birth spacing by promoting FP uptake and encouraging male involvement. • To educate eligible couples, women of reproductive age, and their male partners about the importance of birth spacing and available FP options.	• % of couples provided counselling related to family planning methods when they attend immunisation day at community. • % of communities/ public locations have displayed posters related to birth spacing in designated spaces • % of mothers provided information about family planning during HBYC visits by ASHA worker • % of couples provided counselling on family planning methods while discharge from hospitals after delivery • % of ASHA & ANM received training related to Birth spacing and use of MCP card as communication tool for Family planning in last 3 years	• % of currently married males recalling different FP methods • % of currently married females recalling different FP methods • % of community members understanding the importance of a 3-year birth spacing • % of mothers and fathers receiving birth spacing information through any source

Objectives, Monitoring Indicators & Evaluation Indicators for Male participation in MCH		
Objectives	**Monitoring Indicators**	**Evaluation Indicators**
• To raise awareness on the importance of male participation in MCH for better health outcomes of mothers and children. • To engage community members, including social and religious leaders, to promote male involvement in MCH.	• % of public locations displaying posters on importance of male participation in MCH • % of husbands counselled on the MCP card during ANC check-ups at VHND • % of male family members counselled on the MCP card during HBNC visit • % of male family members counselled on the MCP card during any of the HBYC visits • % of ASHA & ANM trained on improving men's participation in last 3 years	• % of fathers of children under one year recalling counselling session details • % of fathers accompanying their wives for hospital delivery • % of fathers present during ASHA's HBNC visits • % of fathers attending children's immunisation sessions • % of fathers acknowledging the importance of supporting mothers and caring for the child • % of fathers of children under one year receiving information on male participation in MCH through any source

Objectives, Monitoring Indicators & Evaluation Indicators for HIV/AIDS		
Objectives	**Monitoring Indicators**	**Evaluation Indicators**
• Raise community awareness on HIV/AIDS, focusing on risk reduction (condom use, uninfected partner) and dispelling misconceptions.	• % of public locations in the community displaying posters in designated spaces • % ASHA & ANM using FAQ Booklet for counselling	• % of individuals undertaking HIV test voluntarily • % of pregnant women undertaking HIV test voluntarily

Objectives, Monitoring Indicators & Evaluation Indicators for HIV/AIDS		
Objectives	**Monitoring Indicators**	**Evaluation Indicators**
• Promote HIV testing among reproductive-age individuals by increasing awareness, reducing stigma, and encouraging proactive health-seeking behaviours.	• # of persons reached through digital platforms (YouTube, Instagram and other social media) • % of schools reached through school-based events on HIV/AIDS • % ASHA and ANM trained on HIV and communication in last 3 years	• % of individuals with comprehensive HIV/AIDS knowledge • % of community members receiving HIV information through any source

Objectives, Monitoring Indicators & Evaluation Indicators for Tuberculosis		
Objectives	**Monitoring Indicators**	**Evaluation Indicators**
• Raise awareness on TB signs, symptoms, transmission, prevention, and management to promote timely detection and treatment completion. • Foster community support for TB patients by encouraging screening, treatment adherence, and rehabilitation. • Improve TB patients' and families' understanding of the importance of completing treatment.	• % of public locations in community displaying TB posters in designated spaces • % of ASHAs using videos to counsel high-risk groups and community members on TB • % of ASHAs and ANMs using reference materials on TB. • % of Salons who have received and are using reading or reference materials on TB. • # of persons reached through digital platforms (YouTube, Instagram and other social media) for TB messaging • % of ASHA and ANM trained on counselling on TB in last 3 years	• % of community members aware of TB signs, symptoms and the need for screening • % of TB patients aware of the need for completion of treatment • % of TB patients' family members aware of the importance of TB testing • % of community members receiving TB information through any sources

Objectives, Monitoring Indicators & Evaluation Indicators for NCDs		
Objectives	**Monitoring Indicators**	**Evaluation Indicators**
• Raise awareness on risk factors, prevention, and management of NCDs (Diabetes, Hypertension, Cancer). • Increase awareness of the importance of early detection and screening for NCDs.	• % of public locations in community displaying NCD posters in designated spaces • # of persons reached through digital platforms (YouTube, Instagram and other social media) about information related to NCDs • % of ASHAs and ANMs using reference materials on NCDs. • % of Salons who have received and are using reading or reference materials on NCDs • % of ASHA using videos to counsel high risk group and people affected with NCDs • % of ASHA and ANM trained on diabetes, hypertension and cancer in last 3 years •	• % of people aware of screening programs for diabetes, hypertension, and cancer • % of people aware of NCD risk factors, signs, and symptoms • % of NCD patients receiving appropriate treatment • % of community members receiving NCD information from any sources

Objectives, Monitoring Indicators & Evaluation Indicators for Anemia		
Objectives	**Monitoring Indicators**	**Evaluation Indicators**
• Increase awareness and understanding of anemia using locally relevant terminology and culturally appropriate messaging.	• % of ASHA and ANMs using MCP card to counsel pregnant women on anemia • % of ASHA using videos to counsel pregnant, lactating women and adolescent girls on anemia	• Percentage of adolescents have knowledge about anaemia (prevention and management) • ·Percentage of pregnant women have knowledge about anaemia (prevention and management)

Objectives, Monitoring Indicators & Evaluation Indicators for Anemia		
Objectives	**Monitoring Indicators**	**Evaluation Indicators**
• Promote regular consumption of iron-rich foods and consistent use of IFA and deworming tablets by addressing misconceptions and side effects. • Strengthen community trust and participation in anemia-related health services, including screenings, school programs, and frontline worker outreach	• % of ASHAs and ANMs using reference materials on anemia. • % of Salons who have received and are using reading or reference materials on anemia • % of public locations having displayed posters, wall paintings related to anemia in designated spaces • # of persons reached through digital platforms (YouTube, Instagram and other social media) • % of ASHA & ANM trained on anemia and MCP card use in last 3 years	• Percentage of community members understand the importance of consuming IFA tablets and deworming tablet • Percentage respondents received information about anaemia through sources like campaigns, VHC, ASHA, ANM, WhatsApp videos, posters, ask the machine, saloons, schools and religious institutions

Objectives, Monitoring Indicators & Evaluation Indicators for Quality ANC		
Objectives	**Monitoring Indicators**	**Evaluation Indicators**
• Promote early registration for antenatal care (ANC) within the first trimester among pregnant women by increasing awareness of its importance through culturally appropriate SBCC approaches.	• % of ASHA and ANMs using MCP card to counsel pregnant women on ANC • % of ASHA using videos for counselling pregnant women on ANC • % of ASHAs and ANMs using reading or reference materials on ANC • % of Salons who have received and are using reading or reference materials on ANC	• % of pregnant women have knowledge about ANC services • % of family members of pregnant women have knowledge about ANC services • % of community members understand the importance of ANC services

Objectives, Monitoring Indicators & Evaluation Indicators for Quality ANC		
Objectives	**Monitoring Indicators**	**Evaluation Indicators**
• Encourage completion of all recommended ANC visits, including uptake of key services such as screening, counselling, and supplementation, by addressing behavioural and socio-cultural barriers. • Foster positive perceptions and demand for quality ANC services by engaging pregnant women, their families, and communities through multimedia campaigns, interpersonal communication, and community-based platforms.	• % of public locations displaying posters, hoardings, wall paintings on ANC in designated spaces • # of persons reached through digital platforms (YouTube, Instagram and other social media) about information related to ANC • % of ASHA & ANM trained on effective use of communication tools in last 3 years	• % of pregnant women have knowledge about ANC services • % of family members of pregnant women have knowledge about ANC services • % of community members understand the importance of ANC services • % respondents received information about ANC through sources like campaigns, VHC, ASHA, ANM, WhatsApp videos, posters, ask the machine, saloons and religious institutions.

Objectives, Monitoring Indicators & Evaluation Indicators for Teenage Pregnancy		
Objectives	**Monitoring Indicators**	**Evaluation Indicators**
• Improve adolescents' understanding of sexual and reproductive health, including the risks of	• % of ASHA using videos to counsel adolescent girls and boys	• % of adolescent boys and girls have knowledge about importance of prevention of teenage pregnancy and how to prevent it

Objectives, Monitoring Indicators & Evaluation Indicators for Teenage Pregnancy		
Objectives	**Monitoring Indicators**	**Evaluation Indicators**
• early pregnancy and the benefits of delaying childbearing. • Promote open, respectful communication on reproductive health within families, schools, and communities, breaking the culture of silence and stigma. • Support adolescents—especially out-of-school youth—to access age-appropriate, confidential information and services, including contraceptives and counselling. • Mobilize parents, teachers, religious leaders, and community influencers to become advocates for adolescent health and delay of early pregnancy through culturally sensitive messaging.	• % of ASHAs and ANMs using reading or reference materials on Teenage pregnancy • % of Salons who have received and are using reading or reference materials on Teenage pregnancy • % of public locations displaying posters, hoardings, wall paintings on teenage pregnancy in designated spaces • % of adolescents reached through school and other community-based events • # of persons reached through digital platforms (YouTube, Instagram and other social media) about information related to Teenage pregnancy • % of ASHA & ANM trained on addressing teenage pregnancy in last 3 years	• % of family members of pregnant women have knowledge about prevention of early marriages and importance of sex education • % of community members understand the importance of prevention of early marriages and importance of sex education • % of respondents received information about teenage pregnancy through sources like campaigns, VHC, ASHA, ANM, WhatsApp videos, posters, ask the machine, saloons, schools and religious institutions.

Objectives, Monitoring Indicators & Evaluation Indicators for Institutional Delivery		
Objectives	**Monitoring Indicators**	**Evaluation Indicators**
• Enhance awareness among pregnant women, families, and communities about the benefits and safety of institutional delivery, and the risks associated with home births, using culturally sensitive, locally resonant communication. • Identify and counter traditional beliefs, fears, and social norms that discourage institutional delivery, through storytelling, community influencers, and culturally appropriate messaging tailored to specific tribal communities. • Promote awareness and clarity on government schemes, birth preparedness, free transport, and facility-based support services, ensuring timely registration and utilization through frontline workers and community-based communication platforms	• % of ASHA and ANMs using MCP card to counsel on institutional delivery and danger signs during pregnancy • % of ASHA using videos to counsel pregnant women and their families on importance of institutional delivery • # of ASHAs and ANMs using reading or reference materials on institutional delivery • % of Salons provided and using reading or reference materials on institutional delivery • % of public locations have displayed posters, hoarding, wall paintings related to institutional delivery in designated spaces • # of persons reached through digital platforms (YouTube, Instagram and other social media) about information related to institutional delivery • % of ASHA & ANM training on counselling and promotion of institutional delivery in last 3 years	• % of pregnant women have knowledge about importance of institutional delivery • % of family members of pregnant women have knowledge about importance of institutional delivery • % of community members understand the importance of institutional delivery • % of respondents received information about importance of institutional delivery through sources like campaigns, VHC, ASHA, ANM, WhatsApp videos, posters, ask the machine, saloons and religious institutions.

Levels of monitoring

SBCC system monitoring should be an integral part of health system monitoring. Indicators of SBCC to be reviewed during the quarterly review meetings at block level, district level and state level. The indicators belonging to each health topic to be complied and presented before the meeting by the respective IEC officer or the program manager.

Data compilation and Reporting

The data flow can be along with the existing reporting structure by adding additional indicators to the existing reports. Data compilation can be done at block level by Block Data Manager and at the district level the district data manager. Reports for the review can be prepared by the program managers at respective levels.

The agony!

Sakalgre village, a remote settlement at the end of a deteriorating road, faces an ongoing struggle for basic healthcare services. The village is isolated, with no functioning health center or Village Health Committee (VHC). While a VHC was once established, it has since become defunct, leaving the villagers without any local healthcare support. The nearest Primary Health Centre (PHC) is in Asanang, approximately 26 kilometers away, making it difficult for residents to access timely medical care.

The closest health facility, a Sub Centre in Durakalakgre village, is around 5 kilometers away but remains non-functional as it has yet to be inaugurated. The residents of Sakalgre are in dire need of accessible healthcare. Their collective plea is for the authorities to expedite the inauguration and functioning of the Durakalakgre Sub Centre. For a community already grappling with isolation and poor infrastructure, this health center represents a lifeline that could significantly improve their access to essential health services.



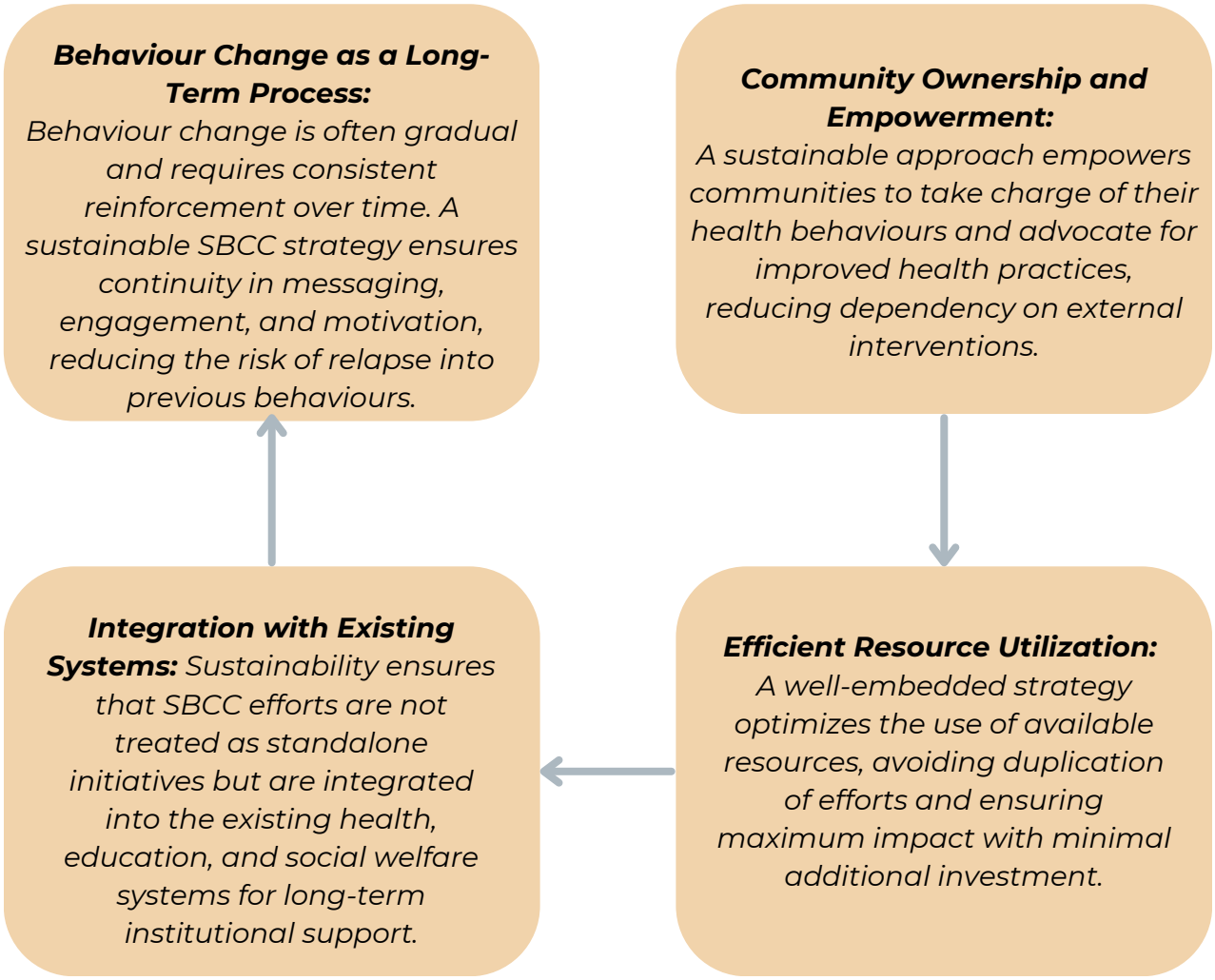
Sustainability Plan





Why Sustainability Matters

The proposed SBCC strategy for Meghalaya aims to bring about transformative changes in health behaviours across diverse communities. However, for the strategy to achieve its intended long-term impact, it is crucial to embed sustainability in its design, along with implementation, and monitoring. Ensuring sustainability will not only maintain the momentum of behaviour change but also institutionalize the processes and mechanisms developed under the strategy, leading to a self-sustaining ecosystem of health promotion and communication.



Recommendations to Ensure Sustainability

- Community-Centric Approaches:
  - Strengthen community structures like VHCs, SHGs and traditional networks such as religious leaders and healers, making them the primary drivers of SBCC initiatives.
  - Ensure periodic capacity-building and refresher training for these groups to keep them informed and motivated.

- Institutionalization within Governance Systems:
  - Integrate the SBCC strategy into existing government programs like the NHM and MSRLS to ensure dedicated support and resources.
  - Mandate SBCC activities in the roles of frontline workers such as ASHAs, ANMs, and Lady Supervisors, linking their performance to measurable SBCC outcomes.

- Culturally Sensitive and Locally Relevant Messaging:
  - Develop locally tailored communication materials that resonate with the cultural beliefs, languages, and practices of Khasi, Garo, and Jaintia communities.
  - Use traditional platforms such as festivals, religious gatherings, and community events to deliver health messages, ensuring higher acceptance and uptake.

- Technology-Enabled Interventions:
  - Leverage mobile-based applications and digital platforms for continuous engagement, training, and real-time data collection.
  - Promote community-led social media campaigns to amplify health messaging.

- Stakeholder Collaboration:
  - Foster inter-departmental coordination among health, education, social welfare, and rural development sectors to pool resources and expertise for SBCC activities.
  - Engage private sector players, NGOs, and academic institutions to co-create innovative SBCC tools and approaches.

- Robust Monitoring and Evaluation:
  - Establish a strong M&E framework to track progress, measure impact, and identify areas for improvement.
  - Regularly disseminate success stories and best practices to motivate stakeholders and showcase the value of SBCC interventions.

- Policy Advocacy:
  - Advocate for policies that prioritize SBCC as a core component of health and social development programs.
  - Ensure budget allocations for SBCC activities in state and district health plans.



Annexure





Glossary

- Age-adjusted incidence rate – A statistical measure that compares cancer incidence rates across groups of people while accounting for age distribution differences.
- Andime – Garo term for hypertension.
- Angling – A fishing technique that involves using a hook, line, and rod to catch fish. In Meghalaya, angling is a significant part of the local culture, economy, and ecology.
- Bampong – Pnar term for cancer which roughly means "blood turning black and reaching the brain".
- BCG vaccine - The BCG (Bacillus Calmette-Guérin) vaccine is to protects against Tuberculosis (TB).
- Birth spacing – The time between giving birth and getting pregnant again.
- Busking - To sing or play music in public places as a street performance.
- Collective Cultural Cognition – Collective cultural cognition is the idea that people's cultural values and beliefs influence how they interpret information and make decisions.
- Complementary feeding – The process of introducing semi-solid foods and liquids in addition to breast milk to an infant at the age of six months.
- Cosplay - A performance art activity where participants, known as cosplayers, dress up as particular characters from different movies/TV shows/video games/comics, using clothing and accessories.
- Exclusive breastfeeding – The practice of feeding a baby only breast milk for the first six months of life. It's a key part of a child's health and survival.
- Hofstede's Cultural Dimensions - Hofstede's Cultural Dimensions is a framework for understanding how cultural values influence behaviour, communication, and decision-making in different societies. It identifies six key dimensions that vary across cultures; Power Distance, Individualism vs Collectivism, Masculinity vs Femininity, Uncertainty Avoidance, Long-term vs Short-term Orientation, Indulgence vs Restraint
- Hyper-localization – The process of customizing products, services, or content to meet the needs of a specific local audience. It involves tailoring the service to the local culture of the target audience
- IEC - Information, Education, and Communication (IEC) materials are a variety of tools used to convey information to a target audience. They are used to promote positive behaviours and support public health messaging

- Individualism vs Collectivism - One of the dimensions of Hofstede's cultural framework. The degree to which individuals are integrated into groups, focusing on personal independence versus group cohesion
- Indulgence vs Restraint - One of the dimensions of Hofstede's cultural framework. The degree to which societies allow or suppress gratification of desires and the pursuit of happiness.
- Infant mortality - The death of a baby that occurs between the time it is born and 1 year of age
- Kangaroo Mother Care – A technique that involves placing a newborn in skin-to-skin contact with a caregiver
- KAPB - Knowledge, Attitude, Practices, and Behaviour survey is a research method used to assess a population's level of understanding (knowledge), opinions (attitude), actions (practices), and overall Behaviour related to a specific topic or issue, often used in public health research to design targeted interventions and evaluate their effectiveness
- Long-term vs Short-term Orientation - One of the dimensions of Hofstede's cultural framework. The focus on future-oriented virtues like perseverance and thrift (long-term) versus past and present values like tradition and social obligations (short-term).
- Malnutrition - Deficiencies or excesses in nutrient intake, imbalance of essential nutrients or impaired nutrient utilization.
- Masculinity vs Femininity - One of the dimensions of Hofstede's cultural framework. The preference for achievement, competition, and material success (masculinity) versus cooperation, caring for others, and quality of life (femininity). This should not be confused with matriarchal vs patriarchal traits.
- Meme – An amusing or interesting item (such as a captioned picture or video) or genre of items that is spread widely online especially through social media.
- Phygital – A term that describes the blending of physical and digital worlds to create a more immersive consumer/audience experience. It's a combination of the words "physical" and "digital".
- Power Distance – One of the dimensions of Hofstede's cultural framework. The extent to which less powerful members of a society accept and expect unequal distribution of power.
- Public Private Partnership (PPP) – An arrangement between a government /statutory entity/Government owned entity on one side and a private sector entity on the other, for the provision of public assets and/or public services, through investments being made and/or management being undertaken by the private sector.

- SBCC - A collection of communication strategies known as Social and Behaviour transformation Communication (SBCC) seeks to encourage constructive social and personal transformation. SBCC employs a range of communication strategies, such as interpersonal communication, mainstream media, and social media.
- Situational analysis – A comprehensive assessment of the current context and environment surrounding a research topic, examining both internal and external factors that could influence the study, including relevant trends, challenges, opportunities, and key stakeholders, essentially providing a detailed understanding of the "situation" before launching a research project.
- Theory of Change – A textual or graphic depiction of how a series of actions will result in desired outcomes is called a Theory Of Change (TOC). It is a tool for social change planning, assessment, and decision-making.
- Traditional healers – Individuals who practice healing methods rooted in cultural, spiritual, and community traditions, often using indigenous knowledge, herbal remedies, rituals, and other techniques passed down through generations. Traditional healers include Khasi, Garo, and Jaintia practitioners who hold a significant role in providing primary healthcare within rural communities.
- Uncertainty Avoidance - One of the dimensions of Hofstede's cultural framework. How comfortable a culture is with ambiguity, risk, and unstructured situations.
- Voice bot - An artificial intelligence (AI)-powered virtual assistant that uses voice recognition, natural language processing, and speech synthesis to interact with users and perform tasks. Examples include Alexa, Siri, and Google Assistant, which can answer questions, control smart devices, provide information, and facilitate various services through spoken commands.

Local Words and Terminologies

Khasi:

- ANC – ka jing check– up ha kapor ba armet
- Anemia – Jing duna snam
- Body change – ka jingpher ha ka met
- Careless behaviour – ka jinglong bym husiar
- Delivery – ka por ba kha khun
- First wife – ka lok nyngkong
- Local medicine applied on fore head for anemia – u dawai khasi ba tah ha shyllang na ka bynta ka jing duna snam
- Person who goes around in the village making announcements – u nong pyrta Shnong
- Pregnant – armet
- Pregnant lady – ka kynthei ba armet
- Relative – bahaing
- Second wife – ka lok ba ar
- TBA – ka nong pynkha khun
- Teenage pregnancy – ka jing armet khynnah
- Thank giving after delivery – ka jing ai khublei hadien ba la dep kha
- Worm infestation – ka jing don palat ki wieh

Pnar:

- ANC – check-up-punkhon
- Anemia – Duna snam
- Body changes – Jingkylla ka met
- Careless behaviour (wrt teenage pregnancy) – wym em kheiñkor iei Armet dang khynnah
- Delivery – Kha khon
- Girl having baby without father – Kynthai em khon khlem pa
- Local medicine applied on forehead for Anemia – Kombirait
- Original/first wife – ka long wa nyngkong
- Person who goes around in the village making an announcement – nong pynbna Chnong

Local Words and Terminologies

Pnar:

- Pregnancy – Armet
- Pregnant lady – Kynthai punkhon
- Relative – Wa ha iung ha sem
- Second wife – lok wa ar
- TBA – Nong pynkha khon ha iung
- Thanks giving after delivery – jing ei ngut
- Worm infestation – Kjit snam u wieh

Garo:

- ANC – An·no donggipana simsakani
- Anemia – anchi komia (blood weakness); Bolsuta (low blood) [especially in North Garo]
- Body Changes – Bimang (body- Chehera)
- Careless Behaviour (wrt Teenage Pregnancy) – Simsaka komia
- Delivery – atchia
- Girl having baby without father – Depatchi
- Local medicine applied on fore-head for anemia – Poron
- Original / First wife – Jikmongma
- Person who goes around in the village making announcement – Kotiar / Dakora
- Pregnancy – anno
- Pregnant Lady – Anno donggipa mechik
- Relatives – Mahari
- Second wife – Jikgite
- TBA – Kamar / Mite tata
- Thanks giving after delivery – Doma rima
- Witchcraft by which the foetus is eaten inside – Katil cha.a
- Worm infestation – Krimi jo·ong



This document is prepared for MHSSP by:

SACH
Society For Action In Community Health

253, 2nd Floor, Shahpur Jat, New Delhi - 110049
Tel.: +91 11 4056 2549, 4611 4888
Email: contactus@sachindia.org
www.sachindia.org

Firstborn Collective LLP
55, 2nd Floor, Lane no. 2, Westend Marg
Saidulajab, South Delhi - 110030

Strategy For Quality Ante-Natal Care

Project submitted by
SACH
Society For Action In Community Health

Strategy For Quality Ante-Natal Care

1. Introduction

Antenatal care (ANC) is a critical component of maternal health services, ensuring the well-being of both mother and child during pregnancy. In Meghalaya, a state with a predominantly tribal population and challenging terrain, the quality and accessibility of ANC services remain areas of concern. Despite efforts by the government and healthcare providers, gaps persist in the delivery of comprehensive ANC services, particularly in rural and remote areas.

According to the National Family Health Survey-5 (NFHS-5, 2019-21) , 52.2% of pregnant women in Meghalaya received at least four ANC visits, which is below the national average of 58.1%.The percentage of pregnant women in urban area who received four ANC visits is 67.5%. There is no significant increase in the indicator from NFHS 5 which was 50 %. In coverage of 4 Antenatal checkup for pregnant women, West Khasi Hills (64%), South West Khasi Hills (63%) and Ri-Bhoi (61%) are the top 3 districts where as South West Garo Hills (29%), East Garo Hills (26%) and North Garo Hills (24%) are having less coverage. Pregnant women who have received ANC in the first trimester is 53.9%. Among the registered pregnancy, 93% received Mother and Child Protection (MCP) Card.[1]

In the last birth, 85% of mothers receive IFA tablets. Only 43% consumed for 100 days and only 21% consumed for 180 days during ANC period. Pregnant women protected against neo natal tetanus is 82% and only 8% consumed deworming tablets. Related to guidance by health worker on pregnancy care, among those who met with a health worker in the last 3 months of delivery, 89% got information about importance of keeping baby warm and importance of institutional delivery, 88% received advice on breast feeding, 72% on cord care and 85% on family planning. In Meghalaya, more than 90 percent of women who received antenatal care for their last birth received each of the services needed to monitor their pregnancy: having their blood pressure measured (99%), having their weight taken (98%), having their abdomen examined

[1] International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS-5), India, 2019-21: Meghalaya. Mumbai: IIPS

(95%), having a urine sample taken (93%), and having a blood sample taken (92%). An ultrasound test was performed during 49 percent of pregnancies in the five years preceding the survey.

In a study conducted in South West Garo Hills (2018-2020)[2], More than half (59.4%) of women were reluctant to attend antenatal care as government services seem not ideal in terms of services and behaviour of health providers. Attitude of not attending ANC due to absence of health problems need to be corrected (9.4%). 3.1% did not attend antenatal as age definition seems to prevent from seeking health care. 5.9% of pregnant women have reported that they have never attended the antenatal checkups, the reasons were the following: Not all ANC available therefore don't want to go (40.6%), Distance and less transport (28.1%), Health workers are rude (18.8%), No Health problems (9.4%) and Afraid of the law as I'm teenager (3.1%). Women education, financial independence and mobility of women has a positive influence in utilisation of ANC services.[3], [4]

2. The Current Landscape

The current landscape of antenatal care (ANC) in Meghalaya reveals a mixed but gradually improving picture across the Garo, Khasi, and Jaintia Hills. While awareness of ANC services has significantly increased, especially among younger women, traditional beliefs and limited health literacy continue to influence utilization patterns, particularly in remote areas. Accredited Social Health Activists (ASHAs), Auxiliary Nurse Midwives (ANMs), and Anganwadi Workers play a pivotal role in raising awareness and facilitating access to ANC services. Cultural taboos and dietary restrictions during pregnancy persist in some communities, particularly in the Garo Hills, where reliance on traditional healers and birth attendants remains more pronounced. In contrast, Khasi and Jaintia communities show greater acceptance of modern medical care, supported by proactive community leaders and better access to health facilities. Despite these gains, gaps remain in knowledge about the full scope of ANC services, regularity of visits, and the need for system strengthening to address infrastructural and quality-related challenges—underscoring the importance of a culturally sensitive and community-driven SBCC strategy.

Mentioned below are the major findings regarding quality ANC from the FGDs conducted across the three regions of Meghalaya:

---

[2] Marwein, N., & Rao, P. S. Barriers and Facilitators for Utilization of Antenatal Care services in Meghalaya state, India. Health, 9, 28-1.
[3] Gogoi, M. (2014). Women Empowerment and Maternal health care utilisation in North-East India. Journal of North-East India studies, 4(2), 69-80.
[4] Lalmalsawmzauva, K. C. (2014). Developmental Factors Influencing Utilization of Antenatal Care in Meghalaya. People and Health in North-East India, New Delhi: Mittal Publications, 31-45.

Awareness and understanding of ANC Services

While the term "ANC" is not commonly recognized in local dialects, community members understand it as regular check-ups during pregnancy. Local terms like “ano donggipa mechikna sum sakani” in Garo, “por armet” in Khasi and “punkhon” in Jaintia regions help communicate the concept Most women are aware of the services provided through Sub-Centres, PHCs, and outreach by ASHAs and ANMs. Younger women (<40 years) have better awareness than older generations. Key services recognized include iron/folic acid supplements, TT vaccination, BP monitoring, and sometimes massages. Information is mostly received through ASHAs, ANMs, and family elders. Posters and media have limited recall.

Traditional Beliefs and Practices

Garo communities observe different kinds of food taboos during pregnancy, like for example pregnant women are not supposed to eat snakes - child may have a snake-like tongue / eating honey- may cause shivering, and baby may be “slimy” / not eat porcupine- as baby may be born with stretch marks / not eat monkey meat - baby may become hyperactive or “like a monkey” / not eat Pura (pounded rice flour) - baby would have powder coating on its body / local gourd (Lau) during sickness - believed to increase blood pressure / Do not eat eggs, milk, pineapple, ginger (especially in high BP) as it creates heat in the body, and no chilly if there's stomach pain. Cultural restrictions involve Tearing clothes during pregnancy is believed to cause a baby to be born with a cleft palate / pregnant women are forbidden from visiting sacrificial sites or walking through other villages at night due to fear of witchcraft / Tabeez (amulets) and potions from Ojas are used if signs of witchcraft appear (e.g., nightmares or stomach aches) / Colocasia (Yam) is believed to repel witchcraft, eaten raw 2-3 times for about 3 days. It is believed that women develop stomach ache if under the spell of witchcraft, and the foetus is eaten from inside. In Khasi and Jaintia Hills, traditional practices have significantly declined post-2000 with increased reliance on institutional care.

Role of Traditional Healers and Birth Attendants

Traditional healers (Ojas) are usually consulted only when spiritual causes are suspected, mainly in Garo Hills. - Modern healthcare is trusted more for safe delivery and pregnancy complications, although in parts of Garo there is a 50-50 trust split between modern and traditional medicine. Sometimes, traditional beliefs contradict doctors' advice, but supportive husbands override traditional restrictions to prioritize their wives' care. Kamal (TBA) assist in home deliveries, especially in remote areas, though most are now formally trained. After delivery, traditional medicines are often used to restore strength. If ASHA’s medicines don’t work, Oja’s remedies are sought. In Garo, the local medicine for easier delivery is known as “Babra ka. laka”.

In Khasi and Jaintia Hills, reliance on traditional healers has decreased significantly.

Attitudes and Family Decision-Making

ANC is valued as important for the mother and unborn child's health. In all regions, husbands and family members (especially girl's parents in Garo) support ANC visits. Decision-making is either collective or increasingly autonomous for women. Religious leaders are supportive and aid in reducing stigma and reinforcing modern care, usually do not interfere with ANC practices. In certain pockets of Garo region where access to ASHA and health care services are difficult people have minimal ANC visits and depend on Ojas remedies and medicines during ANC.

Utilization and Practices of ANC Services

Pregnant women typically attend Sub-centres, PHCs, and CHCs. Services received (not all services all times) include BP checks, IFA tablets, TT shots, and general health monitoring. IFA and Calcium supply was found to be very erratic especially in Garo region and adherence was also found to be low. Some pregnant women were found to be confused between IFA and calcium tablets (referring iron tablets as white tablets). Frequency of visits varies—many believe 3-4 visits are adequate, though some women attend more predominantly in Khasi and Jaintia regions while in part of Garo 2-3 visits were the average. MCP cards are commonly held and regularly updated during check-ups. ANC check-ups are commonly done on fixed days (e.g., Mondays and Fridays), supported by VHNDs in Khasi and Jaintia regions, while in Garo, VHND days are not fixed and are conducted based on ANMs and ASHAs decision which they inform the women before coming to the village.

Barriers and Health System Challenges

In remote villages of Garo Hills, institutional deliveries are rare and ANC understanding is poor. Women in these areas primarily rely on Kamals and receive minimal services. Jaintia and Khasi regions report good accessibility but note that emergency care is often unavailable locally. Some health staff behaviour was noted as rude but did not deter service use. Recommendations from communities include strengthening local facilities and improving emergency care access.

Case Study: A Tale of Two Pregnancies: The Power of Antenatal Care

In the quiet hills of West Khasi Hills, two women from the same village embarked on parallel but contrasting journeys of pregnancy; each shaped profoundly by access to and acceptance of antenatal care (ANC) services.

Ripalyne, 26, was expecting her second child when she noticed the early signs of pregnancy. Without delay, she approached her local ASHA, who guided her to the nearest sub-centre for confirmation. Once her pregnancy was confirmed, Ripalyne enrolled herself for routine ANC check-ups. With support from her husband and mother, she made regular visits for health monitoring, vaccinations, IFA and calcium supplementation, and vital blood and urine tests. She was well-informed about the importance of these services, and her family took shared responsibility for her well-being—her partner ensured she was always accompanied to the health centre, while her mother helped with household chores.

Just a few houses away, 28-year-old Gloria was preparing to give birth to her fifth child. Though she was no stranger to pregnancy, her path diverged sharply from Ripalyne's. Deeply influenced by traditional beliefs and family superstitions, Gloria's family discouraged her from attending ANC check-ups. They feared that blood samples taken during tests could be used for witchcraft, putting the mother and unborn child in danger.

Additionally, there was a widespread misconception that regular intake of modern medicines, including IFA tablets, would make the baby "unnaturally dark-skinned." As a result, Gloria's pregnancy remained largely unmonitored. She missed critical screenings and supplementation, and her nutritional needs went unmet. While Ripalyne was being actively tracked for her haemoglobin levels, blood pressure, and foetal growth, Gloria navigated her pregnancy without medical oversight.

By the final trimester, the outcomes of these contrasting approaches became starkly evident. Ripalyne went into labour at full term and safely delivered a healthy baby girl at the sub-centre, with minimal complications. Her pregnancy had been closely managed, and her body was well-prepared for the process. In contrast, Gloria's labour began prematurely around the seventh month. She experienced heavy bleeding, prompting the family to rush her to the hospital. There, it was confirmed that she was severely anaemic and undernourished, both conditions that could have been detected and treated through regular ANC services. Her newborn was underweight and required immediate neonatal intensive care.

This illustrates the critical role that antenatal care plays not only in promoting safe deliveries but also in empowering families with the knowledge and tools to make informed decisions. Ripalyne's story is a testament to the success of early engagement with the health system, while Gloria's highlights how misinformation and fear can become life-threatening barriers.

3. Objectives

Objective 1

Promote early registration for antenatal care (ANC) within the first trimester among pregnant women by increasing awareness of its importance through culturally appropriate SBCC approaches.

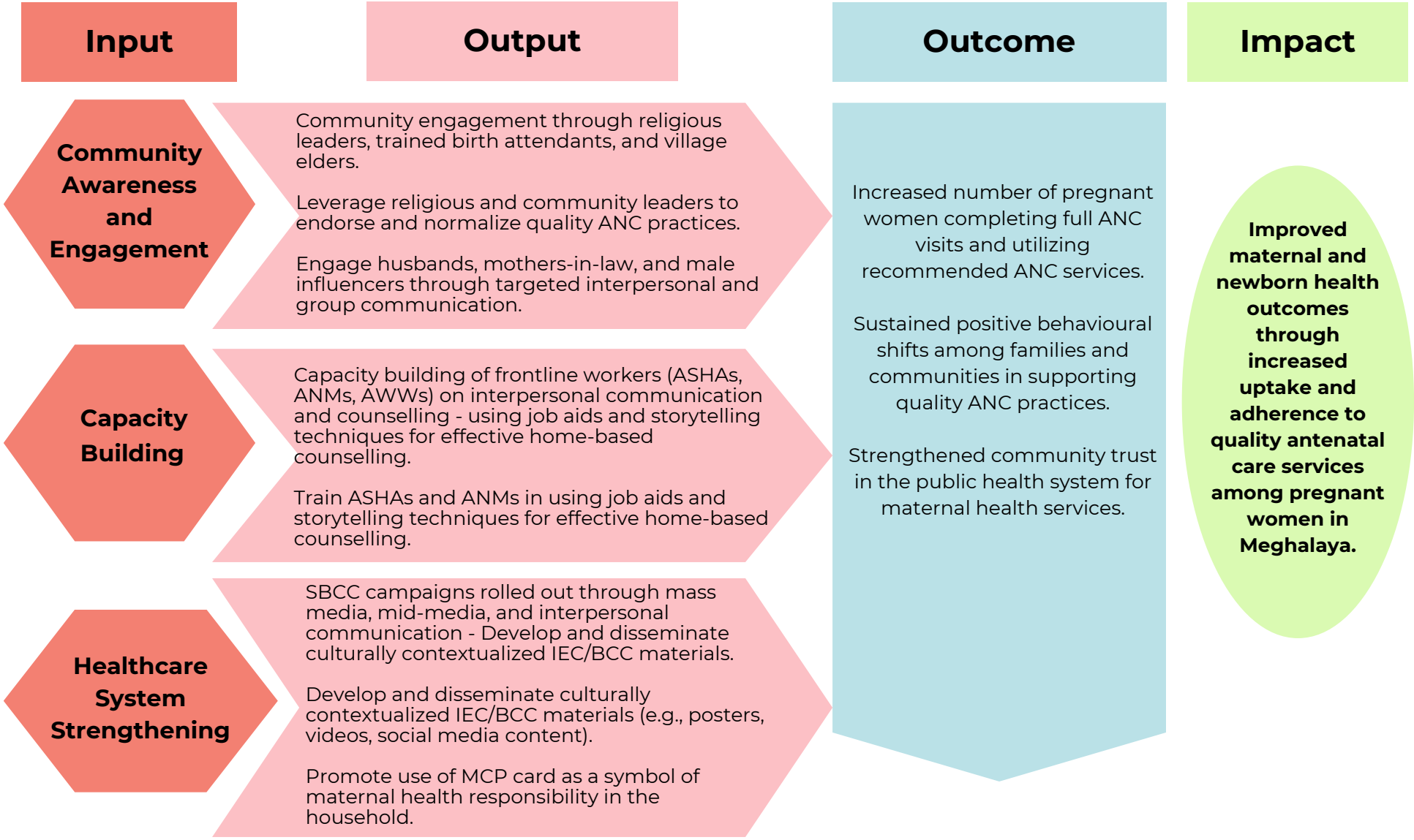
Objective 2

Encourage completion of all recommended ANC visits, including uptake of key services such as screening, counselling, and supplementation, by addressing behavioural and socio-cultural barriers.

Objective 3

Foster positive perceptions and demand for quality ANC services by engaging pregnant women, their families, and communities through multimedia campaigns, interpersonal communication, and community-based platforms.

4. Theory of Change



5. Current Communication tools available

5.1 Current IEC materials and their status in the channel: **IPC**					
Modes	**List of materials**	**Platform**	**Audience**	**Recall**	**Reach (of modes/materials)**
Counselling during Home visit	MCP Card*	Home visit	Pregnant women and their male partner	Poor, no recall of having seen message or heard message on various services under ANC in the MCP card or remember any messages from the MCP card.	Poor
		VHND (AWC) SC (H&WC) PHC			

** MCP Card provides all relevant information related to various MCHN schemes, messages related to care during the ANC period /pregnancy, PNC period, immunization, newborn care, growth, and development, Family Planning methods etc.*

5.2 Current IEC materials and their status in the channel: **MID MEDIA**					
Modes	**List of materials**	**Platform**	**Audience**	**Recall**	**Reach (of modes/materials)**
Posters	Poster on Antenatal examination	SC (H&WC) PHC CHC	Pregnant women and their male partner Women of reproductive age, their male partners and adolescents.	Average, can recall having seen posters on TB, HIV etc but cannot recall having seen on ANC posters.	Average

5.3 Current IEC materials and their status in the channel: <u>DIGITAL/MASS MEDIA</u>					
Modes	**List of materials**	**Platform**	**Audience**	**Recall**	**Reach (of modes/materials)**
Instagram	Instagram posts on VHAM initiatives and awareness for maternal health	Mobile Phone	General population	Average, only some people could recall having seen Instagram reels but could not specifically remember having seen this one.	Average

"I didn't know what ANC meant in the past. Now I know it means being watched over—so that both I and my baby are safe."

–27 years-old, Nongchram, East Garo Hills

5.4 Current IEC materials and their status in the channel: **OTHERS**					
Modes	**List of materials**	**Platform**	**Audience**	**Recall**	**Reach (of modes/materials)**
Handbook	IEC Handbook	VHC meetings	VHC members	The IEC handbook is not used effectively to share any information during meetings or otherwise.	Poor

6. Suggested Changes for Improving IEC Materials and their Usage

6.1 Suggested changes for improving IEC Materials and their usage in the channel: <u>IPC</u>				
Modes	**List of materials**	**Platform**	**Responsible person**	**Suggestions for Improvement**
Counselling during Home visit	MCP Card	Home visit	ASHA / ANM	Change / Improve the image depicting PW in the ANC card for local contextualization.
Counselling during PNC visit		VHND (AWC) SC (H&WC) PHC	ANM MLHP	Conduct structured group counselling sessions with PW and women of reproductive age and counselling eligible couples.

6.2 Suggested changes for improving IEC Materials and their usage in the channel: **MID MEDIA**				
Modes	**List of materials**	**Platform**	**Responsible person**	**Suggestions for Improvement**
Posters	Poster on Antenatal examination	SC (H&WC) PHC CHC	ANM MLHP MO i/c	Display the poster in the local language at places of prominence and clear visibility in Facilities. Inform eligible couples/women of reproductive age and their male partners about the various posters and their relevance to them and their family members.

6.3 Suggested changes for improving IEC Materials and their usage in the channel: **DIGITAL/MASS MEDIA**				
Modes	**List of materials**	**Platform**	**Responsible person**	**Suggestions for Improvement**
Instagram	Instagram posts on VHAM initiatives and awareness for maternal health	Mobile Phone	State / District SBCC Officer	Dubbing the existing Reels in other local languages and sharing in WhatsApp groups of beneficiaries created by ASHA/AWW/SHGs at the village level.

6.4 Suggested changes for improving IEC Materials and their usage in the channel: **OTHERS - VHC**				
Modes	**List of materials**	**Platform**	**Responsible person**	**Suggestions for Improvement**
Handbook	IEC Handbook	VHC meetings / other community gatherings	ASHA ANM VHC members	ASHA/ANM to ensure VHC members use the IEC Handbook during VHC meetings to sensitize on various topics including anemia. ASHA/ANM along with the VHC office bearers develop a calendar for sharing & discussing various health topics.

7. Suggested New Additions to Tools and Platforms

7.1 Suggested new additions to tools and platforms in the channel: **IPC**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Counselling during Home visit	ASHA Tab	Home visit	ASHA	Digital content in Khasi, Garo and Pnar regarding care provided by skilled healthcare providers to pregnant women, which consists of a minimum of 4 ANC visits, early pregnancy registration, regular physical examination, identification and referral for danger signs, consumption of at least 100 days of IFA tablets, essential lab investigations (for Hb, STIs etc), tetanus toxoid injection, and counselling: - Create real-life stories - Animation videos - Influencer videos - Edutainment videos
	Compact Handbook			Compact Handbook is like a ready-reckoner with FAQs with specific illustrations covering aspects consisting of a minimum of 4 ANC visits, early pregnancy registration, regular physical examination, identification and referral for danger signs, consumption of at least 100 days of IFA tablets, essential lab investigations (for Hb, STIs etc), tetanus toxoid injection, and counselling, and the role of the male partner in supporting their partner / spouse.

7.1 Suggested new additions to tools and platforms in the channel: **IPC**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Individual Counselling	Digital content as Ready Reckoner	Salon	ASHA ANM VHC members	The salons would act as a hub of information for PWs, WRAs and adolescent girls about various health matters including importance of ANC during pregnancy, and the need to follow-up on all services during ANC for the better health of mother and baby. The information to be shared with clients visiting the salon will be developed as a digital tool which will be used using mobile phones. The content will be short and to the point acting as a "ready reckoner" and will also have a list of FAQs. The salon worker shall also act as a referral agent in case they come across any person who needs medical intervention. Salon workers shall refer such patients to the nearest health centre or health worker.

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Print material	Poster	Facility - - Waiting area - Maternity ward	ANM MLHP	Develop posters in Khasi and Garo with translation in Hindi: regarding minimum of 4 ANC visits, early pregnancy registration, regular physical examination, identification and referral for danger signs, consumption of at least 100 days of IFA tablets, essential lab investigations (for Hb, STIs etc), tetanus toxoid injection, and counselling, and the role of the male partner in supporting their families.
		Community - - Market place - Salon - Community meeting halls - Bus stop	VHC members ASHA	
	IEC Handbook	SHG meetings	SHG members ASHA	Adapt the VHC IEC Handbook to develop a common Handbook for use across multiple platforms, which should include sections on the following: - minimum of 4 ANC visits, early pregnancy registration, regular physical examination, identification and referral for danger signs, consumption of at least 100 days of IFA tablets, essential lab investigations (for Hb, STIs etc), tetanus toxoid injection, and counselling, and the role of the male partner in supporting their families.
		Religious meetings / Gatherings (Sunday mass/prayer)	Religious leaders	
		Traditional Healers Counselling during Treatment	Traditional Healers	

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Mobile Information Unit	Van-mounted digital screen with 'Ask-The-Machine' (ATM) and vending machine	At crowded sites like festivals, events, competitions (fishing etc), market places and tourist sites	District SBCC / Officer	The van would have the following features: • Ask-The-Machine(ATM): Interactive information screen with voice-enabled support or touchscreen-based information repository. The machine would be equipped with providing an information leaflet once the session is completed for the user to refer later or share further. The ATM shall provide information regarding minimum of 4 ANC visits, early pregnancy registration, regular physical examination, identification and referral for danger signs, consumption of at least 100 days of IFA tablets, essential lab investigations (for Hb, STIs etc), tetanus toxoid injection, and counselling, and the role of the male partner in supporting their families. • Vending machine (free of cost): Users can use the vending machine to get family planning materials like condoms, OCP and Sanitary Pads. • Digital Display Screen: The digital content could be common as mentioned above.

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Digital screen	Develop digital content	In facility – PHC/CHC: • Waiting areas • Maternity wards	State/District SBCC Officer	The digital content could be common / standard to be used across all channels, as mentioned above.
Wall Paintings	Pictorial content	Community: • Hard-to-reach villages • Marketplace • Community meeting halls • Bus stop	District SBCC Officer Block SBCC Officer	Develop wall paintings on: • minimum of 4 ANC visits, early pregnancy registration, regular physical examination, identification and referral for danger signs, consumption of at least 100 days of IFA tablets, essential lab investigations (for Hb, STIs etc), tetanus toxoid injection, and counselling, and the role of the male partner in supporting their families.
Folk Theatre	Folk Play/Street Play/Performances	• Events • Market Place • Community • meetings • Institutions	District SBCC Officer Block SBCC Officer	The script of the folks play/street play would convey important messages related to minimum of 4 ANC visits, early pregnancy registration, regular physical examination, identification and referral for danger signs, consumption of at least 100 days of IFA tablets, essential lab investigations (for Hb, STIs etc), tetanus toxoid injection, and counselling, and the role of the male partner in supporting their families.

7.3 Suggested new additions to tools and platforms in the channel: <u>DIGITAL/MASS MEDIA</u>				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Hoarding	Pictorial content	Community- Market places, Bus stops	State / District SBCC officer	Develop picture-based hoarding capturing information: • Minimum of 4 ANC visits, early pregnancy registration, regular physical examination, identification and referral for danger signs, consumption of at least 100 days of IFA tablets, essential lab investigations (for Hb, STIs etc), tetanus toxoid injection, and counselling, and the role of the male partner in supporting their families.
Digital Hoardings	Develop digital content	Community – - Bus stop - Popular (busy) locations	State /District SBCC Officer	The digital content could be common/standard to be used across all channels, as mentioned above.
Instagram	Post / Story	Mobile phone	State IEC officer	

7.3 Suggested new additions to tools and platforms in the channel: <u>DIGITAL/MASS MEDIA</u>				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
YouTube	Videos Songs – Traditional and New Age	Mobile phone	State IEC officer	The digital content could be common / standard to be used across all channels, as mentioned above.
WhatsApp	-Video Snippets -GIF messages		State / District SBCC / IEC officer	The content would focus on: • minimum of 4 ANC visits, early pregnancy registration, regular physical examination, identification and referral for danger signs, consumption of at least 100 days of IFA tablets, essential lab investigations (for Hb, STIs etc), tetanus toxoid injection, and counselling, and the role of the male partner in supporting their families.
YouTube	Videos Songs – Traditional and New Age		State IEC officer	The digital content could be common / standard to be used across all channels, as mentioned above.

7.3 Suggested new additions to tools and platforms in the channel: **DIGITAL/MASS MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Voice-bot /assistant (similar to Alexa)	Voice-enabled information provision	Mobile Phones	State SBCC officer	Develop a Voice-bot (similar to Alexa) with a detailed repository of possible queries/questions in the local language (Khasi, Garo, Pnar) related to minimum of 4 ANC visits, early pregnancy registration, regular physical examination, identification and referral for danger signs, consumption of at least 100 days of IFA tablets, essential lab investigations (for Hb, STIs etc), tetanus toxoid injection, and counselling, and the role of the male partner in supporting their families.

7.4 Suggested new additions to tools and platforms in the channel: **OTHERS**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Village-level Display Board	Posters	Village Health Information Board	VHC members ASHA	Posters to be developed: • minimum of 4 ANC visits, early pregnancy registration, regular physical examination, identification and referral for danger signs, consumption of at least 100 days of IFA tablets, essential lab investigations (for Hb, STIs etc), tetanus toxoid injection, and counselling, and the role of the male partner in supporting their families.
Drone Services	Leaflet / Pamphlet	Direct dropping to Village (hard-to-reach)	State SBCC Officer	The leaflet would cover information pictorially on: • minimum of 4 ANC visits, early pregnancy registration, regular physical examination, identification and referral for danger signs, consumption of at least 100 days of IFA tablets, essential lab investigations (for Hb, STIs etc), tetanus toxoid injection, and counselling, and the role of the male partner in supporting their families.

SUGGESTED / PROPOSED KEY MESSAGES

This section highlights a few samples of new, innovative messages, aiming to present fresh perspectives that enhance audience engagement with the communication material. These are just a few samples of perspectives that can be explored further, showcasing how different angles can make communication more accessible, relevant, and impactful for diverse audiences.

Encourage women to ensure early ANC registration for timely identification and management of potential risks.



Ensure completion of the full ANC schedule for safe pregnancy and positive outcomes.



Encourage daily consumption of supplements – IFA & Calcium and nutritious food to prevent anemia and support foetal development.



Reinforce the role of family and frontline workers in ensuring continued ANC attendance and emotional support.



8. Types of Audience and Targeted Behaviour

Audience Type

Primary Audience

Pregnant women

Suggested Behaviours

- Ensuring timely / early registration of pregnancy in the first trimester and attending the recommended four ANC visits.
- Ensure regular intake of IFA and calcium supplements and ensure adequate dietary intake and rest during pregnancy.
- Male partners support their pregnant wife during ante-natal care period and ensure appropriate nutrition and supplement intake.

- Partners and family members actively ensure early registration and regular ANC checkups for pregnant women.
- Partners and family members remind and support adherence to IFA and calcium supplementation throughout pregnancy.
- Family members and partners accompany or encourage pregnant women to visit health facilities for ANC.

Suggested Behaviours

Secondary Audience

Partners / Spouse, immediate family members

Audience Type

Secondary Audience

FLWs

Suggested Behaviours

- FLWs provide consistent, respectful, and culturally appropriate counselling on ANC, danger signs, nutrition, and rest.

- Religious leaders and traditional healers endorse timely care-seeking and discourage harmful traditional practices that delay institutional care.

Suggested Behaviours

Audience Type

Secondary Audience

Religious and traditional leaders

Audience Type

Secondary Audience

Teachers

Suggested Behaviours

- Teachers and educators integrate maternal health information in school settings and promote intergenerational awareness.

9. Audience-wise Suggested Channels and Materials

Primary Audience



Pregnant women

Urban 'Voice-Bot for Health(Alexa type); Home visits by FLWs (counselling); Posters at Health Centre; Digital Hoarding; Social media - WhatsApp, YouTube, Insta post, Health memes; SWIPE for Health (App); Community Events.

Rural Voice-Bot for Health (Alexa type); Home visits by FLWs (counselling); Posters at Health Centre;
Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; Village Health Information Board; Community Events.

Urban Voice-Bot for Health (Alexa type); Community events; Home visits by FLWs (counselling); Posters at Health Centre; Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; Digital Hoarding; SWIPE for Health (App); Wall painting

Rural Home visits by FLW (counselling); Voice-Bot for Health (Alexa type); Posters at Health Centre; Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; Village Health Information Board; Community Events; Wall painting



Husbands

Secondary Audience

Secondary Audience



Religious leaders, Teachers

Urban and Rural Posters/ Hoardings; Sensitisation meetings; information booklets; Wall painting

Urban and Rural Trainings on ASHA Tabs videos to use during Home visits by FLWs (counselling);
Compact Handbook during home visits by FLWs (counselling); Community Events



FLWs

Secondary Audience

10. Dissemination Channels and Sample Messages

SBCC Strategy Meghalaya - Detailed implementation plan

Topic: Antenatal care

Expected change: More number of people are aware of importance of registering pregnancy in first trimester, attending minimum of ANC in regular intervels, PMSMA program and nutrition during pregnancy.

Messgae focus

Health benefits of registering pregnancy in first trimester (Early ANC registerations)
Health Benefits of attending ANC (Completion of 4 ANC visits-appropriate gaps between ANC visits)
Nutrition care during pregnancy

SBCC tool	Term	Description	Implementation steps	Responsibility	Dissemination Channels	Target Audience	Location Focus	# of Materials	Training Component	Calendar – Pre-prod.	Calendar – Prod.	Calendar – Dissemination	Accountability Indicators (for the dept. to follow)
Development of new posters	Short term	New Posters with attractive design aesthetics and elements based on user centered approach for improved recall	Finalisation of messages to be conveyed and types of posters to be developed	SACH	Village Health Information Board and Health Facilities	General Public	PHCs, SCs and other Facilities/Public spaces- information boards etc	To be finalised in consultation with the dept	No	Jul-25	Jul-25	Sept-Oct 2025	Field use, poster surveys
			Development of poster design, testing the recall, finalisation of design based on feedback from primary audience & translation	SACH									
			Estimation of the number of posters to be printed	Health Dept.									
Compact Hand book/FAQ	Short term	Compact hand book to have curated list of Frequently Asked Questions related to Quality ANC emphasising on the services, need for early registrations, etc. This will be a digital tool and will be used by ASHA and ANM in their Tablets. This digital version will be also shared at Salons and Religious institutions. **Develop this in a magazine like print-ready format for Salons in case if department decides to provide printed copies to salons.**	Developing a curated list of questions that could arise from the field and their correct answers.	SACH & Health Dept.	FLW outreach/Home visits, VHND events	Pregnant & Lactating women; caregivers	Households, SCs, VHND sites	1 Print version- to be finalised by MHSSP / Health dept	Yes (FLW orientation)	Jun-25	Jul-25	Sept-Oct 2025	FLW usage logs, end-user knowledge assessment
			Designing the Handbook	SACH									
			Orientation of all stakeholders particularly FLWs on the use of hand book	Health Dept.									
Digital Content: Short Videos Formats (GIFs, etc)	Short term	Silent - self explanatory video content for sharing through digital platforms like WhatsApps, ad inserts on youtube etc. and to be played in (loops) in the waiting areas of facilities (H&WC, PHC CHC etc) and public digital screens.	Development of short video scripts	SACH & Health Dept.	Waiting areas, YouTube, InstaGram, WhatsApp, ASHA Tab	Pregnant women & accompanying persons, general public	Health facilities (SC /H&WC, PHC, CHC etc); Online	10–12 videos	No	Jun-25	Jul-25	Aug–Oct 2025	Video reach analytics, engagement metrics, field staff feedback
			Onboarding of video agency and development of videos										
			Dissemination of content through Digital platforms including public screen and to health facilities; Identification of public digital screens (across the state) & facilities with availability of digital screens, where unavailable facilitating procurement of digital screens.	Health Dept.									
Digital Content: Instagram Reels	Short term	Reels by local influencers on importance of ANC. **Smaller reels can also be produced from the content of the long format videos**	Identification of popular Instagram stars	SACH & Health Dept.	Instagram, community sharing	Pregnant Women; General Public	Online + event displays		Yes (Influencer onboarding)	Jun-25	Jul-25	Aug–Oct 2025	View count, field staff user feedback, reach metrics
			Providing themes/scripts (based on the focal areas identified) for reels	SACH & Health Dept.									
			Dissemination of videos	Health Dept.									
Digital Content: YouTube Videos	Short term	Story-based YouTube videos / songs on Quality ANC and its importance **Short snippets of these can be developed into short video formats and reels**	Development of scripts / songs for YouTube videos and translation to local language	SACH	YouTube, ASHA tabs, VHC meetings	Pregnant women; General public	Online + digital sessions		Yes (ASHA)	Jun-25	Jul-25	Aug–Sept 2025	Views, shares, qualitative feedback
			Onboarding of video agency and development of videos	Health Dept.									
			Dissemination of videos	Health Dept.									
Village Health Information Board (Community display of posters)	Medium term	Currently the posters are located mainly at hospitals and the premise of hospital, only those who visit can only see it. The village information board will be located in a common place. Posters will be displayed based on event calendar specific for each month. VHC members and ASHA willl be responsible for display of posters as per calendar.	Setting-up of village health information board	Health Dept./Village Committess	Health boards	Entire community	Centre of the village or an areas within the village with maximum visibility	Village information boards (at pilot sites)	No	Oct-25	Dec-Jan-25	Sep 2025–Mar 2026	Poster refresh logs, FLW checklists
			Event calender with details of posters to be displayed	SACH & Health Dept.									
			Orientation of VHC members	Health Dept.									
			Implementation, monitoring & reporting	Health Dept.									
Hoardings (Non-Digital)	Medium term	Hoardings placed in public places can provide information to public	Development of prototype of hoarding (Convert digital content into static hoarding style content)	SACH	Markets, highway turns, CHC walls	General travelers, commuters/General Public	Entry/exit points of towns, rural highways	Pre-owned hoardings of NHM can be used immediately to insert	No	Oct-25	Jan-Feb-25	Sept–Nov 2025	Visibility count, monthly inspection
			Event calender with details of hoarding message to be displayed										
			Identification of locations	Health Dept.									
			Changing / Replacing hoarding on periodic basis	Health Dept.									
Voicebot assistant (Alexa type)	Long term	A mobile phone app which can provide answers to the doubts and provide more information about the health topic	Identification of implementing agency	Health Dept.	Mobile app	Pregnant & Lactating women; Family members & Caregivers	Online	N/A	No	TBD	TBD	TBD	App downloads, usage rate
			Development of script of all possible questions and answers in different languages	SACH & Health Dept.									
			Development of AI software and algorithm	SACH & Health Dept.									
			Voice recording according to the script	Health Dept.									
			Training of AI software to answer the queries based on language	Health Dept.									
			Establishing technical support	Health Dept.									
			Purchasing server space	Health Dept.									
			Getting all statutory approvals	Health Dept.									
			Placing the app in play store	Health Dept.									
			Encourage people to download and use the app.	Health Dept.									

SBCC tool	Term	Description	Implementation steps	Responsibility	Dissemination Channels	Target Audience	Location Focus	# of Materials	Training Component	Calendar – Pre-prod.	Calendar – Prod.	Calendar – Dissemination	Accountability Indicators (for the dept. to follow)
Ask the Machine	Long term	People can get information from the machine in their local language. The machine is placed on a vehicle so that it can be moved to different location and people in remote location also can access the service of this machine.	Detailing of project requirement and plan for implementation	SACH and Health Dept.	On-ground locations	General public and population attending events	Towns and selected rural areas with higher population and at event sites	1-2 units per district	Yes (for FLWs/drivers on SoPs)	TBD	TBD	TBD	Machine logs, reach tracking, community feedback
			Hiring technical agency for development of software and hardware	Health Dept.									
			Development of detailed script for health queries and related answers and translation of these queries into local language	SACH and Health Dept.									
			Training of AI software to answer the queries based on language	Health Dept.									
			Hiring and training the team for implementation	Health Dept.									
			Purchase of vehicle and alteration for fixing the vehicle	Health Dept.									
			Route plan and program implementation	Health Dept.									

11. Monitoring and Evaluation plan

Monitoring Framework for ANC			
Process Indicators (Assesses the implementation of activities)			
Indicator	**Data Source**	**Frequency**	**Responsibility**
Number of registered pregnant women provided with MCP cards	Report from IEC department	Bi annually	In charge IEC Department
Number of posters, wall painting and hoarding prototypes planned and developed on quality ANC care			
Number of videos related to ANC care planned for different platforms (long videos, short videos and reels) and developed			
Number of print materials on ANC care for reading and referencing planned and developed			
Number of digital apps planned and developed with ANC information			
Number of health related events planned and implemented with information on ANC			
Number of training programs planned and implemented related to ANC			

Monitoring Framework for ANC					
Output Indicators					
Monitoring Indicator	**Primary source**	**Responsible person**	**Frequency**	**Pilot phase**	**Denominator**
% of ASHA and ANMs using MCP card to counsel pregnant women on ANC	VHND report	ANM	Monthly	30%	# ANM & ASHA
% of ASHA using videos for counselling pregnant women on ANC	Field report	ASHA		20%	# ASHA
% of ASHAs and ANMs using reading or reference materials on ANC	Field report	ASHA		60%	# ANM & ASHA
% of Salons who have received and are using reading or reference materials on ANC	Field report	ASHA		20%	# Salon
% of public locations displaying posters, hoardings, wall paintings on ANC in designated spaces	Field report	ASHA		20%	# of communities with VHC
# of persons reached through digital platforms (YouTube, Instagram and other social media) about information related to ANC	IEC department report	Head IEC Department		Based on user analytics	# viewers/ subscribers
% of ASHA & ANM trained on effective use of communication tools in last 3 years	Training report	Training organiser	When training is organised	30%	# ANM & ASHA

Monitoring Framework for ANC				
Outcome Indicators				
Indicator	**Data Source**	**Frequency**	**Target (5 years)**	**Responsibility**
Percentage of pregnant women have knowledge about ANC services	Sample survey	Yearly	90%	M&E Department
Percentage of family members of pregnant women have knowledge about ANC services			90%	
Percentage of community members understand the importance of ANC services			60%	
Percentage respondents received information about ANC through sources like campaigns, VHC, ASHA, ANM, WhatsApp videos, posters, ask the machine, saloons and religious institutions.			60%	

12. Recommendations: A multi-pronged approach

The SBCC strategy for promoting quality ANC in Meghalaya must address cultural norms, traditional practices, and structural barriers while leveraging opportunities for community mobilization, inter-departmental convergence, and system strengthening across the Khasi, Garo, and Jaintia regions. Given below are multi-pronged specific recommendations across levels-Government System Strengthening – State, District & Block and Village level; Inter-Departmental Convergence Approaches, Community Mobilization and Engagement.

12.1. GOVERNMENT SYSTEM STRENGTHENING	
STATE LEVEL	• Integrate Quality ANC into state-level SBCC and RMNCH+A communication strategies. • Allocate dedicated budget and human resources for SBCC activities promoting ANC. • Develop standard SBCC toolkits (audio-visuals, print, IPC tools) and localize them to Meghalaya's tribal contexts. • Build capacity of health officials and program managers on strategic communication and behaviour change approaches. • Strengthen supportive supervision systems to ensure quality of counselling and respectful maternity care during ANC visits

12.1. GOVERNMENT SYSTEM STRENGTHENING	
DISTRICT & BLOCK-LEVEL	• Conduct periodic orientation and refresher trainings for FLWs on ANC counselling and communication skills. • Monitor the reach and quality of community-level SBCC activities related to ANC through Health Management Information Systems (HMIS) and supportive supervision. • Identify and promote local champions (ASHA, ANMs, Anganwadi Workers) who demonstrate good ANC promotion practices.
12.2. VILLAGE-LEVEL ENGAGEMENT AND LOCAL LEADERSHIP:	
VILLAGE LEVEL	• Mobilize Gram Sabhas and Village Health Committees (VHCs) to prioritize ANC awareness and service access. • Ensure active engagement of Panchayat members in tracking ANC service uptake and addressing barriers. • Develop and display village-specific maternal health dashboards (with visuals/icons) showing ANC uptake trends. • Promote community-level surveillance and follow-up of pregnant women by ASHAs with support from VHSNCs.

12.3. INTER-DEPARTMENTAL CONVERGENCE APPROACHES

- Strengthen collaboration between Health, ICDS, Education, Panchayati Raj, and Tribal Affairs departments.
- Jointly organize VHNDs and ANC outreach days, with active roles from ICDS and Health functionaries.
- Utilize school health programs to promote awareness among adolescents about maternal and child health, including the importance of ANC.
- Coordinate with SHGs under NRLM to include ANC messaging in livelihood group meetings.
- Leverage the communication networks of the Tribal Affairs department to culturally adapt and disseminate ANC messages.

12.4. COMMUNITY MOBILIZATION AND ENGAGEMENT

- Involve traditional leaders, religious heads, and community elders as messengers of ANC promotion in culturally appropriate ways.
- Organize community health days and street theatre activities on ANC during local festivals and market days.
- Create and promote community-level birth preparedness plans involving families, FLWs, and community leaders.
- Facilitate peer-group platforms to share positive experiences and build social norms around complete ANC.
- Recognize and reward villages and FLWs showing improvement in ANC indicators to build motivation and community ownership.

12.5. ADDRESSING COMMUNITY LEVEL BARRIERS:

Lack of Awareness and Knowledge of ANC Importance

- Use local dialect-based audio-visual content (radio spots, folk songs, puppet shows) to communicate the benefits of early and regular ANC.
- Promote positive deviant stories of mothers who followed all ANC protocols and had safe deliveries.
- Organize pregnancy clubs or women's groups where information on ANC is shared regularly by FLWs and peer educators.

Cultural Beliefs and Traditional Norms

- Involve traditional healers, religious leaders, and community elders as influencers to endorse ANC practices through community meetings and religious gatherings.
- Frame ANC practices as complementary to traditional care, not in opposition, using culturally respectful narratives.
- Use community theatre and street plays incorporating local folklore to debunk harmful myths (e.g., about dietary taboos or frequent check-ups).

Gender Norms and Lack of Family Support

- Engage husbands and mothers-in-law through special "family ANC sessions" led by ASHAs and ANMs at VHNDs and home visits.
- Organize male involvement campaigns using role models, posters, and local champions to encourage husbands' support during pregnancy.
- Introduce family health pledges during community events, where men publicly commit to supporting ANC for their partners.

12.5. ADDRESSING COMMUNITY LEVEL BARRIERS:

Physical Inaccessibility and Transport Constraints

- Collaborate with local Panchayats to develop village-level transport plans (e.g., mapping nearby ANC centres, community vehicle pools).
- Schedule mobile ANC clinics in hard-to-reach hamlets on fixed days with advance community mobilization.
- Display ANC visit calendars in common places (e.g., ration shops, Anganwadi centres) with FLW contact details.

Distrust or Low Perceived Quality of Services

- Facilitate dialogues between service providers and communities to address concerns about behaviour, waiting time, or facilities.
- Promote respectful maternity care practices among FLWs through soft skill training and regular supportive supervision.
- Establish feedback boxes at sub-centres and health facilities and encourage community-based monitoring.

Competing Priorities (Workload, Agriculture, Family Care)

- Schedule ANC services during community-preferred hours/days and align them with market days or festivals.
- Provide reminder messages and home-visit scheduling by ASHAs and peer leaders.
- Advocate for village-level birth preparedness plans to reduce last-minute burden and ensure timely ANC compliance.

List of Abbreviations

AIDS – Acquired immunodeficiency syndrome

ANC – Antenatal Care

ANM – Auxiliary Nurse Midwife

ASHA – Accredited Social Health Activist

AWW – Anganwadi Worker

AWC – Anganwadi Centre

B-CAP – Block Convergence Action Plan

BCG – Bacillus Calmette-Guérin

BPM – Block Program Manager

C&RD – Community and Rural Development Department

CB – Capacity Building

CBO – Community-Based Organizations

CDPO – Child Development Project Officer

CF – Complementary Feeding

CHC – Community Health Centre

CSR – Corporate Social Responsibility

DC – District Collector

D-CAP – District Convergence Action Plan

DCPC – District Child Protection Officer

DMHO – District Medical and Health Officer

DMM – District Mission Manager

DPO – District Project Officer

DSWO – District Social Welfare Officer

EBF – Exclusive Breast Feeding

EIBF – Early Initiation of Breastfeeding

FAQ – Frequently Asked Question

FGD – Focus Group Discussion

FHI – Family Health International

FLW – Frontline Worker

FP – Family planning

H&WC – Health and Wellness Centre

HBNC – Home Based Newborn Care

HBYC – Home Based Care for Young Child

HIV – Human immunodeficiency viruses

List of Abbreviations

ICDS – Integrated Child Development Service

IEC – Information, Education, and Communication

IFPRI – International Food Policy Research Institute

IIPHS – Indian Institute of Public Health Shillong

IPC – Interpersonal Communication

KAP-B – Knowledge, attitudes, and practice behaviours

KMC – Kangaroo Mother Care

LM – Lactating Mother

M&E – Monitoring and Evaluation

MCH – Maternal and Child Health

MCP – Maternal and Child Protection

MDRTB – Multi Drug Resistant Tuberculosis

MHSSP – Meghalaya Health Systems Strengthening Project

MIS – Management Information System

MLHP - Mid-Level Health Providers

MoM – Minutes of Meeting

MO i/c – Medical Officer in Charge

MP – Male Participation

MSACS – Meghalaya State AIDS Control Society

MSRLS – Meghalaya State Rural Livelihoods Society

NCD – Non-Communicable disease

NFHS – National Family Health Survey

NGO – Non Governmental Organization

NHM – National Health Mission

PA – Primary Audience

PHC – Primary Health Centre

PHED – Public Health Engineering Department

PLWHA – People Living With HIV/AIDS

PMU – Project Management Unit

PNC – Postnatal Care

PPP – Public Private Partnership

PSU – Public Sector Undertaking

PTA – Parent Teacher Association

List of Abbreviations

PW – Pregnant Women

PWD – Public Works Department

RBSK – Rashtriya Bal Suraksha Karyakram

RCH – Reproductive Child Health

S-CAP – State Convergence Action Plan

SBCC – Social and Behaviour Change Communication

SC – Sub Centre

SHG – Self Help Group

SRS – Sample Registration System

SUD – Strategic Use of Data

TB – Tuberculosis

UNICEF – United Nations Children's Fund

VEC – Village Education Committee

VHC – Village Health Council

VHIB – Village Health Information board

VHND – Village Health and Sanitation Day

WCD – Women and Child development

WHO – World Health Organization

WRA – Women in Reproductive age

This document is prepared for MHSSP by:

SACH
Society For Action In Community Health

253, 2nd Floor, Shahpur Jat, New Delhi - 110049
Tel.: +91 11 4056 2549, 4611 4888
Email: contactus@sachindia.org
www.sachindia.org

Firstborn Collective LLP
55, 2nd Floor, Lane no. 2, Westend Marg
Saidulajab, South Delhi - 110030

Strategy For Prevention and Management of Anemia

Project submitted by
SACH
Society For Action In Community Health

Strategy For Prevention and Management of Anemia

1. Introduction

Anemia remains a significant public health concern in Meghalaya, affecting various demographic groups, including children, adolescents, and women of reproductive age. The condition, characterized by a deficiency of red blood cells or hemoglobin, is primarily caused by iron deficiency, poor nutrition, and inadequate healthcare access. The cultural and social factors play a significant role in influencing accepted behaviours and practices, which complicates the effectiveness of health services. Moreover, the low educational status among various indigenous groups reinforces negative social norms, further challenging the state health machinery's efforts to address these deeply rooted issues effectively.

According to the National Family Health Survey-5 (NFHS-5, 2019-21), the prevalence of anemia in Meghalaya is alarmingly high across all age groups. Among children aged 6-59 months, 45.1% are anemic, a slight improvement from 48% in NFHS-4 (2015-16). Adolescents (15-19 years) also show high anemia rates, with 52.5% of girls and 30.1% of boys affected. Women of reproductive age (15-49 years) have a prevalence rate of 53.8%, while men in the same age group have a lower rate of 25.5%. These figures highlight the persistent gender disparity in anemia prevalence, with women and girls being disproportionately affected.

As per NFHS 5, anemia among children is seen higher in South West Khasi Hills (61.3%) followed by West Khasi Hills (56.2%) and West Jaintia Hills (54.6%). Anemia among women in reproductive age group is seen higher in South West Garo Hills (62.5%) and Ri-Bhoi (62.4%) followed by South West Khasi Hills (58.9%) and North Garo Hills (58.4%). Anemia among adolescent girls is found to be higher in South West Garo Hills (67.3%) followed by North Garo Hills (65.2%) and South Garo Hills (65%).

The Government of Meghalaya has implemented several initiatives to combat anemia, including the distribution of IFA tablets and the WIFS

program. The NFHS 5 shows that mothers consuming 180 IFA tablets for 6 months is 20.6% on which the consumption is least in East Garo Hills (7%) and North Garo Hills (7.9%) followed by South West Garo Hills (11%). AMB (Anemia Mukt Bharat) index defined as a simple average of IFA supplementation coverage across the seven beneficiary groups. According to AMB Index estimated for 2019-20 Meghalaya stands at 17.1 where the country average is 41.2[1]

The diets consumed by the indigenous women in Meghalaya are high in starchy staples but largely lacking in green leafy vegetables, orange-coloured vegetables and fruits, other fruits, nuts and seeds, and eggs, which may be a contributing factor to the micronutrient deficiency found in Meghalaya among children and women.[2] Pregnant, under nutritious, and poorest women are at high risk of anemia. Urban women are also at high risk; however, higher educated women are at low risk of anemia. The habit of cigarette smoking/pan/bidi/gutka etc. also increases the risk of anemia [3]

2. The Current Landscape

Understanding anemia across Meghalaya reveals a complex interplay of language, local beliefs, and health behaviours. While the clinical term "Anemia" is largely unfamiliar, it gains clarity when translated into local dialects—such as Jingduna Snam (Khasi), An.chi ko.mia or Bolsuta (Garo), and At.Ch.Dosa in South Garo—where it is broadly associated with fatigue, weakness, and a perceived reduction in blood or vitality. Recognition of symptoms such as tiredness, dizziness, pale skin, and even unique localized experiences like "jing khoh snieh" (peeling skin) in Khasi communities, suggests a general awareness, though gaps remain in understanding causes and management. The condition is often linked to poor diet, overwork, early marriage, and worm infestations, though misconceptions persist, particularly in the Garo Hills, where spiritual and supernatural explanations are sometimes invoked. Across the state, prevention is most commonly associated with diet, with local greens, fruits, and occasional meat seen as beneficial. However, challenges like irregular IFA supplementation, misconceptions about tablets, and reliance on traditional healers persist. Health messaging, while primarily disseminated by frontline workers such as ASHAs and ANMs, struggles with limited recall and cultural resonance. Though screening and school-based programs are in place in some areas, participation and awareness vary, underscoring the need for more localized, language-sensitive, and culturally rooted interventions.

---

[1] Joe W; Rinju; Patel N, Alambusha R, Kulkarni B, Yadav K, Sethi V. Coverage of iron and folic acid supplementation in India: progress under the Anemia Mukt Bharat strategy 2017-20. Health Policy Plan. 2022 May 12;37(5):597-606. doi: 10.1093/heapol/czac015. PMID: 35257147; PMCID: PMC9113188

[2] Chyne, D. A. L., Meshram, I. I., Rajendran, A., Kodali, V., Getti, N., Roy, P., ... & Longvah, T. (2017). Nutritional status, food insecurity, and biodiversity among the Khasi in Meghalaya, North-East India. Maternal & child nutrition, 13, e12557.

[3] Dey, S., Goswami, S., & Goswami, M. (2010). Prevalence of anaemia in women of reproductive age in Meghalaya: a logistic regression analysis. Turkish Journal of Medical Sciences, 40(5), 783-789.

Mentioned below are the major findings regarding anemia from the FGDs conducted across the three regions of Meghalaya:

Terminology and Local Understanding of Anemia

Across Meghalaya, the term Anemia is widely unfamiliar in its clinical form but gains recognition when explained in local dialects:

- Khasi Hills and Pnar: Referred to as “Jingduna Snam” (lack of blood)
- Garo Hills: Known as “An.chi ko.mia” (blood weakness), in North Garo Hills, also as “Bolsuta” (low blood in body) and in South Garo known as “At.Ch.Dosa” (meaning low blood).

In all regions, Anemia is broadly understood as a condition of weakness, fatigue, and reduction in blood or vitality. Awareness deepens only when health messages are delivered in the local language.

Awareness of Symptoms and Causes

Across the three regions, commonly mentioned symptoms include weakness, tiredness, dizziness, and pale/yellowish skin, swelling, headaches, poor eyesight, back pain, numb knees, and cough (Garo) and peeling of skin (jing khoh snieh in Khasi).

The perceived causes of anemia largely include - poor diet and irregular eating habits, widely seen as the main causes. Worm infestation is understood better in Khasi and Jaintia regions; in Garo Hills, it's not commonly linked to anemia until explained. Early marriage, physical overexertion, low blood pressure, and illness were also cited, especially in Garo Hills. While some misconceptions exist, such as anemia being hereditary or communicable (Garo, Jaintia) and some believe that sodium in soap (Garo) causes anemia. Some believe that anemia leads to mental confusion, hallucinations, or is caused due to spiritual possession/associated with witchcraft (Garo).

School and Community Interventions

Mixed understanding and participation in school-based IFA and deworming programs, some say tablets are distributed in schools annually while others say only ASHA or AWWs give them in community settings. In case of WIFS, in Garo it was seen was that many parents discourage their children from consuming IFA tablets given in the school thinking that it was cause diseases. Parental support is stronger when health workers explain the benefits clearly.

Perceptions about Prevention and Treatment

People across all regions recognize the role of food in preventing and managing anemia, they informed green leafy vegetables like mustard leaves (lai patta), pumpkin leaves, spinach, local gourds (Lau), Megong, and Me. bitchi (Garo local green vegetables), sweet potato leaves, fruits like pomegranate (dalim), apples, and grapes.

Meat is not regularly consumed due to financial constraints—often once a week or less, local preparations like soup made of local chicken with green papaya and soup made of local chicken with ginger (in Garo region) are believed to help anemia.

Iron and Folic Acid (IFA) Supplementation

Term “IFA” is not widely recognized; supplements are called “vitamin tablets”. In Khasi and Jaintia Hills levels of awareness is moderate and main source is through ANM, and during visits to health facilities.

The level of awareness was found to be low in Garo regions and interestingly IFA tablets were often referred to as ‘vitamin’ – white coloured tablets,confused with calcium. In Garo regions, people use them irregularly and at their own discretion citing side effects such as frequent urination, drowsiness, and bitter taste.
Once understood, communities across regions view iron tablets as beneficial and did not mention of any side effects as such. The major challenges found were erratic or insufficient supply of IFA and calcium tablets

Deworming Awareness

Better understood than IFA across regions; community link between worms and anemia is stronger in Khasi and Jaintia; weaker in Garo. Commonly referred to as “Krimi jo.ong” (worms in the stomach) in Garo.

Children are often encouraged to take deworming tablets in schools or via ASHA workers.

Although in Garo it was found that many parents do not encourage consumption of both IFA and deworming tablets thinking that it causes diseases.

Traditional Practices vs. Modern Medicine

- Khasi Hills: People often use both traditional and modern medicine. For example, a healer from Assam used a thread-tying ritual and dietary advice (curd, green vegetables) for treatment.
- Jaintia Hills: Herbal remedies such as boiling leaves into soup are common; effectiveness varies.
- Garo Hills: Strong reliance on traditional healers (Ojas) and herbal remedies like sap from Mari Bitchi (a local plant vine), potion made out of the bark of dugrak and dumegong trees. Treatment also include 'Poron' for applying on the forehead.

Across all regions, there is a trust in traditional medicine, though communities are open to medical interventions when accessible and effective.

Screening and Health Services Uptake

In Khasi Hills region, regular anemia screenings by the health department occur twice a year; general willingness to undergo testing, though a few still hesitate.

In Jaintia Hills no recent anemia-specific screening camps reported, but high willingness to attend if conducted.

Additionally, in Garo Hills region there was no mention of screenings for anemia and general awareness was found to low.

Deworming Awareness

Better understood than IFA across regions; community link between worms and anemia is stronger in Khasi and Jaintia; weaker in Garo. Commonly referred to as "Krimi jo.ong" (worms in the stomach) in Garo.

Children are often encouraged to take deworming tablets in schools or via ASHA workers.

Although in Garo it was found that many parents do not encourage consumption of both IFA and deworming tablets thinking that it causes diseases.

Case Study: A Silent Deficiency: How Anemia Stole a Life

In the remote hills of East Garo, 28-year-old Chanchina (name changed) cradles her one-year-old son—her sixth child—but behind her tired smile lies the trauma of a previous pregnancy that ended in the stillbirth of her fifth baby. The cause? A silent, undiagnosed condition that many women like her unknowingly carry: severe anemia.

During her fifth pregnancy, Chanchina struggled with persistent fatigue, dizziness, and visible weight loss—symptoms she thought were normal during pregnancy. It wasn't until a routine ANC check-up, which included blood tests, that she learned she had An.chi.ko.mia—a term used locally to describe a condition similar to anemia. Although prescribed Iron-Folic Acid (IFA) tablets, her intake was irregular due to erratic supply at the health sub-centre and a lack of clear instructions on proper usage. Dietary adjustments were ineffective, and no tailored nutritional counselling was offered. Her anemia continued to worsen unnoticed.

By the time she reached her third trimester, her hemoglobin had dropped to a dangerously low level of 2.5 g/dL. Such a level posed a grave threat to both mother and child, warranting urgent referral to a higher facility. The attending health worker advised immediate transfer to the district hospital in Tura. However, her husband, burdened by financial worries, refused.

Left with no choice, Chanchina delivered at the local sub-centre. She recalls being administered fluids through an IV, but was unaware of what treatment she was receiving. The outcome was devastating—her baby was stillborn. The loss was later attributed to complications arising from severe maternal anemia, a preventable condition that had gone untreated for too long.

Chanchina's story is a stark reminder of how anemia—an invisible but life-threatening condition—remains one of the leading causes of maternal and neonatal mortality in rural regions. It exposes the gaps in early detection, uninterrupted supply of supplements, community awareness, and health-seeking behavior that must be addressed to save lives.



3. Objectives

Objective 1

Increase awareness and understanding of anemia using locally relevant terminology and culturally appropriate messaging.

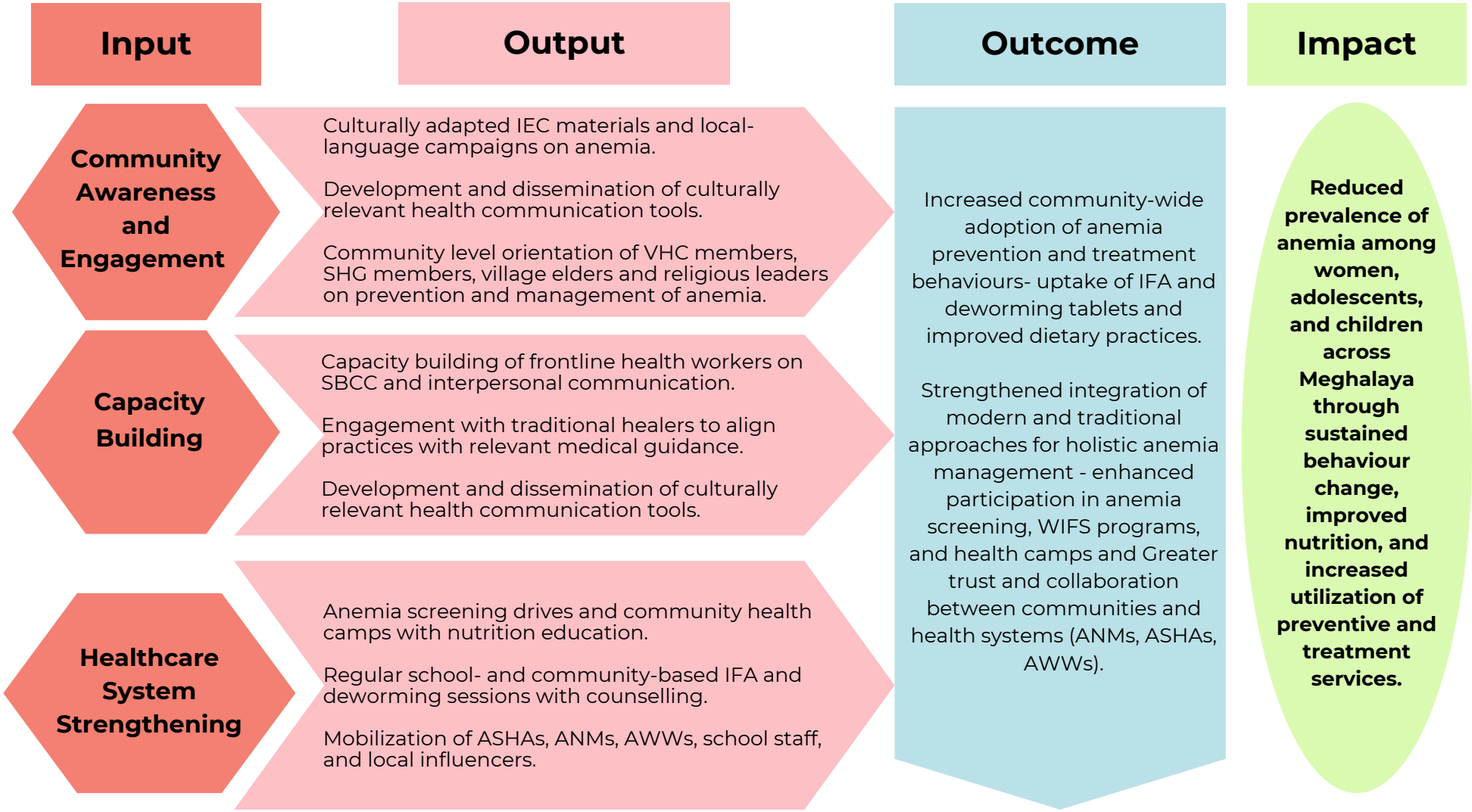
Objective 2

Promote regular consumption of iron-rich foods and consistent use of IFA and deworming tablets by addressing misconceptions and side effects.

Objective 3

Strengthen community trust and participation in anemia-related health services, including screenings, school programs, and frontline worker outreach.

4. Theory of Change



5. Current Communication tools available

5.1 Current IEC materials and their status in the channel: **IPC**					
Modes	**List of materials**	**Platform**	**Audience**	**Recall**	**Reach (of modes/materials)**
Counselling during Home visit	MCP Card*	Home visit	Pregnant women and their male partner	Poor, no recall of having seen message or heard message on anemia the MCP card or remember any messages from the MCP card.	Poor
Counselling during PNC visit		VHND (AWC) SC (H&WC) PHC	Mother of children up to 2 years of age	Poor, no recall of anemia posters but have heard about it through ASHA/ANM and at SCs.	

** MCP Card provides all relevant information related to various MCHN schemes, messages related to care during the ANC period /pregnancy, PNC period, immunization, newborn care, growth, and development, Family Planning methods etc.*

5.1 Current IEC materials and their status in the channel: **MID MEDIA**					
Modes	**List of materials**	**Platform**	**Audience**	**Recall**	**Reach (of modes/materials)**
Posters	Poster on Do's and Don'ts of Anemia Poster on Iron rich foods to combat anemia	SC (H&WC) PHC CHC	Women of reproductive age, their male partners and adolescents. Other Community members like Elders, Village Headman, VHC members, Traditional Healers etc.	Average, can recall having seen posters on TB, HIV etc but cannot recall having seen anemia posters.	Average

5.2 Current IEC materials and their status in the channel: <u>DIGITAL/MASS MEDIA</u>					
Modes	**List of materials**	**Platform**	**Audience**	**Recall**	**Reach (of modes/materials)**
Instagram	Reels on anemia awareness and health camps	Mobile Phone	General population	Average, only some people could recall having seen Instagram reels but could not specifically remember having seen this one.	Average
Video	Video on POSHAN in Ri-Bhoi in English by MWCD			Poor; no recall of having seen the video.	Poor

5.3 Current IEC materials and their status in the channel: **OTHERS**					
Modes	**List of materials**	**Platform**	**Audience**	**Recall**	**Reach (of modes/materials)**
Handbook	IEC Handbook	VHC meetings	VHC members	The IEC handbook is not used effectively to share any information during meetings or otherwise.	Poor

"I know that anemia is very dangerous for pregnant women it basically dries-up the blood in the body and the lady will die, but I don't the treatment so we go to Ojas for medication."

– FGD participant in her mid-30s in Chachinat Village, North Garo Hill.

6. Suggested Changes for Improving IEC Materials and their Usage

6.1 Suggested changes for improving IEC Materials and their usage in the channel: IPC				
Modes	**List of materials**	**Platform**	**Responsible person**	**Suggestions for Improvement**
Counselling during Home visit	MCP Card	Home visit	ASHA / ANM	Change / Improve the image depicting PW in the ANC card for local contextualization.
Counselling during PNC visit		VHND (AWC) SC (H&WC) PHC	ANM MLHP	Conduct structured group counselling sessions with PW and women of reproductive age and counselling eligible couples.

6.2 Suggested changes for improving IEC Materials and their usage in the channel: **MID MEDIA**				
Modes	**List of materials**	**Platform**	**Responsible person**	**Suggestions for Improvement**
Posters	Poster on Do's and Don'ts of anemia Poster on Iron rich foods to combat anemia	SC (H&WC) PHC CHC	ANM MLHP MO i/c	Display the poster in the local language at places of prominence and clear visibility in facilities. Inform eligible couples/women of reproductive age and their male partners about the various posters and their relevance to them and their family members

6.3 Suggested changes for improving IEC Materials and their usage in the channel: **DIGITAL/MASS MEDIA**				
Modes	**List of materials**	**Platform**	**Responsible person**	**Suggestions for Improvement**
Instagram	Reels on anemia awareness and health camps Instagram posts on VHAM initiatives and awareness for maternal health	Mobile Phone	State / District SBCC Officer	Dubbing the existing Reels in other local languages and sharing in WhatsApp groups of beneficiaries created by ASHA/AWW/SHGs at the village level.

6.4 Suggested changes for improving IEC Materials and their usage in the channel: **OTHERS - VHC**				
Modes	**List of materials**	**Platform**	**Responsible person**	**Suggestions for Improvement**
Handbook	IEC Handbook	VHC meetings / other community gatherings	ASHA ANM VHC members	ASHA/ANM to ensure VHC members use the IEC Handbook during VHC meetings to sensitize on various topics including anemia. ASHA/ANM along with the VHC office bearers develop a calendar for sharing & discussing various health topics.

7. Suggested New Additions to Tools and Platforms

7.1 Suggested new additions to tools and platforms in the channel: <u>IPC</u>				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Counselling during Home visit	ASHA Tab	Home visit	ASHA	Digital content (include separate Tabs for all different topics): • Create real-life stories, representing Khasi, Jaintia and Garo regions for sharing personal stories of anemia was detected, managed and prevented. • Stories should capture the real-life situation and provide all relevant information for others to learn about their experiences. • Animation on various aspects of anemia starting from causes, symptoms, screening / testing, impact on women's health and its intergenerational impact, and effective management. • Influencer videos on how anemia can be identified, managed and prevented effectively through diet and IFA medication. • Edutainment videos for school children (adolescents) on causes, symptoms, screening / testing, impact on women's health and its intergenerational impact, and effective management in Khasi, Garo and Pnar.
	Compact Handbook			Compact Handbook is like a ready-reckoner with FAQs and specific illustrations covering all aspects related to anemia- causes, symptoms, screening / testing, impact on women's health and its intergenerational impact, and effective management, do's & don'ts of IFA consumption, and the role of the male partner in supporting their families.

7.1 Suggested new additions to tools and platforms in the channel: **IPC**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Individual Counselling	Digital content as Ready Reckoner	Salon	ASHA ANM VHC members	The salons would act as a hub of information for women and young girls about various health matters including anemia. The information to be shared with clients visiting the salon will be developed as a digital tool which will be used using mobile phones. The content will be short and to the point acting as a "ready reckoner" and will also have a list of FAQs. The salon worker shall also act as a referral agent in case they come across any person who needs medical intervention. Salon workers shall refer such patients to the nearest health centre or health worker.

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Print material	Poster	Facility - - Waiting area - Maternity ward	ANM MLHP	Develop posters in Khasi and Garo with translation in Hindi: regarding anemia- causes, symptoms, screening / testing, impact on women's health and its intergenerational impact, and effective management, do's & don'ts of IFA consumption, and the role of the male partner in supporting their families.
		Community - - Market place - Salon - Community meeting halls - Bus stop	VHC members ASHA	

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Print material	IEC Handbook	SHG meetings	SHG members ASHA	Adapt the VHC IEC Handbook to develop a common Handbook for use across multiple platforms, which should include sections on the following: • Anemia- causes, symptoms, screening / testing, impact on women's health and its intergenerational impact, and effective management, do's & don'ts of IFA consumption, and the role of the male partner in supporting their families.
		Religious meetings / Gatherings (Sunday mass/prayer)	Religious leaders	
		Traditional Healers Counselling during Treatment	Traditional Healers	

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Mobile Information Unit	Van-mounted digital screen with 'Ask-The-Machine' (ATM) and vending machine	At crowded sites like festivals, events, competitions (fishing etc), market places and tourist sites	District SBCC / Officer	The van would have the following features: Ask-The-Machine (ATM): Interactive information screen with voice-enabled support or touchscreen-based information repository. The machine would be equipped with providing an information leaflet once the session is completed for the user to refer later or share further. The ATM shall provide information regarding anemia- causes, symptoms, screening / testing, impact on women's health and its intergenerational impact, and effective management, do's & don'ts of IFA consumption, and the role of the male partner in supporting their families. Vending machine (free of cost): Users can use the vending machine to get family planning materials like condoms, OCP and Sanitary Pads. Digital Display Screen: The digital content could be common / standard to be used across all channels, suggestions are as follows: -Create real-life stories, representing Khasi, Jaintia and Garo regions for sharing personal stories of anemia was detected, managed and prevented. Stories should capture the real-life situation and provide all relevant information for others to learn about their experiences. -Animation on various aspects of anemia starting from causes, symptoms, screening / testing, impact on women's health and its intergenerational impact, and effective management. -Influencer videos on how anemia can be identified, managed and prevented effectively through diet and IFA medication. -Edutainment videos for school children (adolescents) on causes, symptoms, screening / testing, impact on women's health and its intergenerational impact, and effective management in Khasi, Garo and Pnar.

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Digital screen	Develop digital content	In facility – PHC/CHC: • Waiting areas • Maternity wards	State/District SBCC Officer	The digital content could be common / standard to be used across all channels, suggestions are as follows: -Create real-life stories, representing Khasi, Jaintia and Garo regions for sharing personal stories of anemia was detected, managed and prevented. Stories should capture the real-life situation and provide all relevant information for others to learn about their experiences. -Animation on various aspects of anemia starting from causes, symptoms, screening / testing, impact on women's health and its intergenerational impact, and effective management. -Influencer videos on how anemia can be identified, managed and prevented effectively through diet and IFA medication. -Edutainment videos for school children (adolescents) on causes, symptoms, screening / testing, impact on women's health and its intergenerational impact, and effective management in Khasi, Garo and Pnar.
Wall Paintings	Pictorial content	Community: • Hard-to-reach villages • Marketplace • Community meeting halls • Bus stop	District SBCC Officer Block SBCC Officer	-Develop wall paintings on: Anemia- causes, symptoms, screening / testing, impact on women's health and its intergenerational impact, and effective management, do's & don'ts of IFA consumption, and the role of the male partner in supporting their families.

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Folk Theatre	Folk Play/Street Play/Performances	Events Market Place Community meetings Institutions	District SBCC Officer Block SBCC Officer	The script of the folks play/street play would convey important messages related to Anemia- • it's major causes, common symptoms • importance of testing • impact on women's health • its intergenerational impact • effective management • do's & don'ts of IFA consumption • the role of the male partner in supporting their families in Khasi, Garo and Pnar.

7.3 Suggested new additions to tools and platforms in the channel: **DIGITAL/MASS MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Hoarding	Pictorial content	Community - Market places, Bus stops	State / District SBCC officer	Develop picture-based hoarding capturing information: Anemia- causes, symptoms, screening / testing, impact on women's health and its intergenerational impact, and effective management, do's & don'ts of IFA consumption.
Digital Hoardings	Develop digital content	Community – - Bus stop - Popular (busy) locations	State /District SBCC Officer	The digital content could be common / standard to be used across all channels, suggestions are as follows: -Create real-life stories, representing Khasi, Jaintia and Garo regions for sharing personal stories of anemia was detected, managed and prevented. Stories should capture the real-life situation and provide all relevant information for others to learn about their experiences. -Animation on various aspects of anemia starting from causes, symptoms, screening / testing, impact on women's health and its intergenerational impact, and effective management. -Influencer videos on how anemia can be identified, managed and prevented effectively through diet and IFA medication. Edutainment videos for school children (adolescents) on causes, symptoms, screening / testing, impact on women's health and its intergenerational impact, and effective management in Khasi, Garo and Pnar.
Instagram	Post / Story	Mobile phones	State IEC officer	

7.3 Suggested new additions to tools and platforms in the channel: **DIGITAL/MASS MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
YouTube	Videos Songs – Traditional and New Age	Mobile phones	State IEC officer	The digital content could be common / standard to be used across all channels, as mentioned above.
WhatsApp	-Video Snippets -GIF messages	Mobile Phones	State / District SBCC / IEC officer	The content would focus on: Anemia- causes, symptoms, screening / testing, impact on women's health and its intergenerational impact, and effective management, do's & don'ts of IFA consumption

7.3 Suggested new additions to tools and platforms in the channel: <u>DIGITAL/MASS MEDIA</u>				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Voice-bot /assistant (similar to Alexa)	Voice-enabled information provision	Mobile Phones	State SBCC officer	Develop a Voice-bot (similar to Alexa) with a detailed repository of possible queries/questions in the local language (Khasi, Garo, Pnar) related to Anemia- it's major causes, common symptoms, importance of testing, impact on women's health and its intergenerational impact, and effective management, do's & don'ts of IFA consumption, and the role of the male partner in supporting their families.
Health Meme	Post	Mobile Phone	State SBCC officer	Develop interesting, attractive and catchy meme posts with appropriate images on Anemia- it's major causes, common symptoms, importance of testing, do's & don'ts of IFA consumption and the role of the male partner in supporting their families.

"Anaemia is caused due to witch-craft, it is believed that it will suck the blood out of the person and person will die. No medicine will be effective unless some remedial rituals are done this was a popular belief about anaemia in some parts of Khasi region"

– ANM, Mawlai, East Khasi Hills district

7.4 Suggested new additions to tools and platforms in the channel: **OTHERS**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Village-level Display Board	Posters	Village Health Information Board	VHC members ASHA	Posters to be developed: • Anemia- it's major causes, common symptoms, importance of testing, impact on women's health and its intergenerational impact, and effective management, do's & don'ts of IFA consumption, and the role of the male partner in supporting their families.
Drone Services	Leaflet / Pamphlet	Direct dropping to Village (hard-to-reach)	State SBCC Officer	The leaflet would cover information pictorially on: • Anemia- it's major causes, common symptoms, importance of testing, impact on women's health and its intergenerational impact, and effective management, do's & don'ts of IFA consumption, and the role of the male partner in supporting their families.

SUGGESTED / PROPOSED KEY MESSAGES

This section highlights a few samples of new, innovative messages, aiming to present fresh perspectives that enhance audience engagement with the communication material. These are just a few samples of perspectives that can be explored further, showcasing how different angles can make communication more accessible, relevant, and impactful for diverse audiences.

Encourage routine prevention; eat iron-rich foods and take iron tablets regularly.



Iron and deworming tablets are safe and effective; talk to your health worker about how to prevent and manage anemia better.



Support your family's health by encouraging regular check-ups, nutritious (iron rich) meals, and timely anemia treatment.



Healthy mothers, strong children; prevent and treat anemia for a brighter tomorrow.



8. Types of Audience and Targeted Behaviour

Audience Type

Primary Audience

Pregnant women

Suggested Behaviours

- Ensure regular consumption of IFA tablet (& de-worming tablet) during ante-natal period and post-natal period.
- Promote consumption of iron-rich foods daily.

- Ensure adolescent girls adopt weekly IFA consumption and do deworming periodically; adolescents understand the value of iron in diet and consume regularly.

Suggested Behaviours

Audience Type

Primary Audience

Adolescent girls

Audience Type

Primary Audience

mothers and children, male partners and immediate family members

Suggested Behaviours

- Both parents prioritize iron-rich meals as part of family diet, support and encourage children to take IFA tablet intake.
- Male partners support women and children in nutrition and supplement intake.

Audience Type

Secondary Audience

FLWs
School Teachers & school staff

Suggested Behaviours

- Frontline workers deliver consistent, culturally resonant messages on anemia; ensure follow-ups during visits.
- School teachers and FLWs support delivery of IFA and deworming on a regular basis, while creating safe spaces for discussion and provide counselling for ensuring consumption.

- Influential community leaders endorse and support good and positive health practices for anemia by providing necessary assurances.

Suggested Behaviours

Audience Type

Secondary Audience

Religious and traditional leaders

9. Audience-wise Suggested Channels and Materials

Primary Audience



Pregnant women

Urban
'Voice-Bot for Health(Alexa type); Home visits by FLWs (counselling); Posters at Health Centre; Digital Hoarding; Social media - WhatsApp, YouTube, Insta post, Health memes;
SWIPE for Health (App); Community Events.

Rural
Voice-Bot for Health (Alexa type); Home visits by FLWs (counselling); Posters at Health Centre;
Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; Village Health Information Board; Community Events.

Urban
'Voice-Bot for Health(Alexa type); Home visits by FLWs (counselling); Posters at Health Centre; Digital Hoarding; Social media - WhatsApp, YouTube, Insta post, Health memes;
SWIPE for Health (App); Community Events.

Rural
Voice-Bot for Health (Alexa type); Home visits by FLWs (counselling); Posters at Health Centre;
Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; Village Health Information Board; Community Events.



Adolescents

Primary Audience

Primary Audience



Mothers of children less than 5 years

Urban
'Voice-Bot for Health(Alexa type); Home visits by FLWs (counselling); Posters at Health Centre; Digital Hoarding; Social media - WhatsApp, YouTube, Insta post, Health memes;
SWIPE for Health (App); Community Events.

Rural
Voice-Bot for Health (Alexa type); Home visits by FLWs (counselling); Posters at Health Centre;
Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; Village Health Information Board; Community Events.

Secondary Audience



Husbands

Urban Voice-Bot for Health (Alexa type); Community events; Home visits by FLWs (counselling); Posters at Health Centre; Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; Digital Hoarding; SWIPE for Health (App); Wall painting

Rural Home visits by FLW (counselling); Voice-Bot for Health (Alexa type); Posters at Health Centre; Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; Village Health Information Board; Community Events; Wall painting

Urban Voice-Bot for Health (Alexa type); Community events; Home visits by FLWs (counselling); Posters at Health Centre; Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; Digital Hoarding; SWIPE for Health (App); Wall painting

Rural Home visits by FLW (counselling); Voice-Bot for Health (Alexa type); Posters at Health Centre; Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; Village Health Information Board; Community Events; Wall painting



Family elders

Secondary Audience

Secondary Audience



Religious leaders, Teachers

Urban and Rural Posters/ Hoardings; Sensitisation meetings; information booklets; Wall painting

Urban and Rural Trainings on ASHA Tabs videos to use during Home visits by FLWs (counselling);
Compact Handbook during home visits by FLWs (counselling);
Community Events



FLWs

Secondary Audience

10. Dissemination Channels and Sample Messages

SBCC Strategy Meghalaya - Detailed implementation plan

Topic: Anaemia

Expected change: Increased number of pregnant women and adolescent girls testing for anaemia; Increased number of people attending T3 camps; Improved awareness regarding consumption of IFA tablets and Deworming tablets

Messgae focus

What is anemia, it's symptoms and ways to prevent.
Importance of doing blood test - know about T3 campaign - [Test, Treat & Talk]
Importance of consuming IFA tablets and de worming tablets

SBCC tool	Term	Description	Implementation steps	Responsibility	Dissemination Channels	Target Audience	Location Focus	# of Materials	Training Component	Calendar – Pre-prod.	Calendar – Prod.	Calendar – Dissemination	Accountability Indicators (for the dept. to follow)
Jingles	Short term	Jingles in local language covering Anemia symptoms, testing, prevention, and treatment and T3 campaigns	Development of the concept and script with translations	SACH	Not to limit to radio. Broadcasted during major events or functions. Micing during events and public	General public	Marketplaces, Village meetings, PHCs, bus/Taxi stands	2	No	Jun-25	Jul-25	Sep-25	% recall in post-jingle survey, airing logs
			Development of Jingles with appropriate agency and broadcasting	Health Dept.									
Development of new posters	Short term	New Posters with attractive design aesthetics and elements based on user centered approach for improved recall	Finalisation of messages to be conveyed and types of posters to be developed	SACH	Village Health Information Board and facilities	General Public, Pregnant & Lactating women and Adolescent girls	PHCs, SCs and other Facilities/ Public spaces-information boards etc	(To be finalised in consultation with the dept for the print version)	No	Jul-25	Jul-25	Sept-Oct 2025	Field use, poster surveys
			Development of poster design, testing the recall, finalisation of design based on feedback from primary audience, & translation	SACH									
			Estimation of the number of posters to be printed	Health Dept.									
Compact Hand book/FAQ	Short term	Compact hand book to have curated list of Frequently Asked Questions related to Anemia symptoms, testing, prevention, and treatment and T3 campaigns. This will be a digital tool and will be used by ASHA and ANM in their Tablets. This digital version will be also shared at Salons and Religious institutions. **Develop this in a magazine like print-ready format for Salons in case if department decides to provide printed copies to salons.**	Developing a curated list of questions that could arise from the field and their correct answers.	Both SACH and Health Dept.	FLW outreach/Home visits, VHND events	Pregnant & Lactating women & their caregivers, Adolescent girls	Households, SCs, VHND sites	2000* (To be finalised in consultation with the dept)	Yes (FLW orientation)	Jun-25	Jul-25	Sept-Oct 2025	FLW usage logs, end-user knowledge assessment
			Design Handbook	SACH									
			Orientation of all stakeholders particularly FLWs on the use of hand book	Health Dept.									
VHC IEC Hand book (Digital Version)	Short term	Update the VHC IEC Handbook with topics related T3 testing, and convert into digital version to be shared with SHG groups, Traditional healers, religious leaders, salons, schools. The same will be uploaded on the ASHA tabs as well.	Development of the content of the hand book	Both SACH and Health Dept.	WhatsApp groups - Schools, Salons, Religious Institutions, SHGs, ASHA Tablets	General Public, Pregnant & Lactating women and Adolescent girls	Community/VHC meetings/Salons/Religious Institutions	Digital copies	No	Jul-25	Jul-25	Sept-Oct 2025	# leaders using handbook, orientation logs
			Translation, Printing and distribution of hand book	Health Dept.									
			Database of Salons/Religious Institutions/Schools/SHG groups, etc										
Digital Content: Short Videos Formats (GIFs, etc)	Short term	Silent - self explanatory video content for sharing through digital platforms like WhatsApps, ad inserts on youtube etc. and to be played in (loops) in the waiting areas of facilities (H&WC, PHC CHC etc) and public digital screens.	Development of short video scripts	SACH & Health Dept.	Waiting areas, YouTube, InstaGram, WhatsApp, ASHA Tab	General public, Pregnant and Lactating women & their caretakers	Hospitals, PHCs, common areas, Online	10–12 videos	No	Jun-25	Jul-25	Aug–Oct 2025	Video reach analytics, engagement metrics, field staff feedback
			Installation/identification of availability of digital screens	Health Dept.									
			Onboarding of video agency and development of videos										
Digital Content: Instagram Reels	Short term	Reels by local influencers **Smaller reels can also be produced from the content of the long format videos**	Identification of popular Instagram stars	SACH & Health Dept.	Instagram, community sharing	Youth including adolescent girls, young WRA	Online + event displays		Yes (Influencer onboarding)	Jun-25	Jul-25	Aug–Oct 2025	View count, field staff user feedback, reach metrics
			Providing themes/scripts for reels	SACH & Health Dept.									
			Dissemination of videos	Health Dept.									
Digital Content: YouTube Videos	Short term	Story-based YouTube videos **Short snippets of these can be developed into short video formats and reels**	Development of scripts / songs for YouTube videos and translation to local language	SACH	YouTube, ASHA tabs, VHC meetings	Youth including adolescent girls, young WRA	Online + digital sessions		Yes (ASHA)	Jun-25	Jul-25	Aug–Sept 2025	Views, shares, qualitative feedback
			Identification of agency for development	SACH & Health Dept.									
			Development and dissemination of videos	Health Dept.									
MCP card inclusion of additional information on anaemia	Medium term	Information about importance of prevention and management of anemia and T3 campaign among pregnant and lactating women and children	Content development and translation	SACH	ANC visits	Pregnant/lactating women	Health facilities	N/A	No	Aug '25	Sep '25	Oct '25 onwards	MCP update logs
			Printing and dissemination	Health Dept.									
Village Health Information Board (Community display of posters)	Medium term	Currently the posters are located mainly at hospitals and the premise of hospital, only those who visit can only see it. The village information board will be located in a common place. Posters will be displayed there based on the specific months. VHC members and ASHA can ensure the display of posters relevant to that month	Allocation of funds to establish village health information board	Health Dept./Village Committess	Health boards	Entire community	Centre of the village or an areas within the village with maximum visibility	Village information boards (at pilot sites)	No	Oct-25	Dec-Jan-25	Sep 2025–Mar 2026	Poster refresh logs, FLW checklists
			Content update calender: What posters go when	SACH & Health Dept.									
			Orientation of VHC members	Health Dept.									
			Implementation and monitoring	Health Dept.									
			Development of prototype of hoarding (Convert digital content into static hoarding style content)	SACH									
			Content update calender: What content goes when										

SBCC tool	Term	Description	Implementation steps	Responsibility	Dissemination Channels	Target Audience	Location Focus	# of Materials	Training Component	Calendar – Pre-prod.	Calendar – Prod.	Calendar – Dissemination	Accountability Indicators (for the dept. to follow)
Hoardings (Non Digital)	Medium term	Hoardings placed in public places can provide information to public	Identification of locations	Health Dept.	Markets, highway / main roads, CHC premise	General travelers, commuters / General Public	Entry/exit points of towns, rural highways	Pre-owned hoardings of NHM can be used immediately to insert	No	Oct-25	Jan-Feb-25	Sept–Nov 2025	Visibility count, monthly inspection
			Program implementation	Health Dept.									
Voicebot assistant (Alexa type)	Long term	A mobile phone app which can provide answers to the doubts and provide more information about the health topic	Identification of implementing agency	Health Dept.	Mobile app	Youth, Pregnant & Lactating women; Adolescent Girls; Family members & Caregivers	Online	N/A	No	TBD	TBD	TBD	App downloads, usage rate
			Development of script of all possible questions and answers in different languages	Both SACH & Health Dept.									
			Development of AI software and algorithm	SACH & Health Dept.									
			Voice recording according to the script	Health Dept.									
			Training of AI software to answer the queries based on language	Health Dept.									
			Establishing technical support	Health Dept.									
			Purchasing server space	Health Dept.									
			Getting all statutory approvals	Health Dept.									
			Placing the app in play store	Health Dept.									
			Encourage people to download and use the app.	Health Dept.									
Ask the Machine	Long term	People can get information from the machine in their local language. The machine is placed on a vehicle so that it can be moved to different location and people in remote location also can access the service of this machine.	Detailing of project requirement and plan for implementation	Both SACH and Health Dept.	On-ground locations	General public and population attending events	Towns and selected rural areas with higher population and at event sites	1-2 units per district	Yes (for FLWs/drivers on SoPs)	TBD	TBD	TBD	Machine logs, reach tracking, community feedback
			Hiring technical agency for development of software and hardware	Health Dept.									
			Development of detailed script for health queries and related answers and translation of these queries into local language	Both SACH and Health Dept.									
			Training of AI software to answer the queries based on language	Health Dept.									
			Hiring and training the team for implementation	Health Dept.									
			Purchase of vehicle and alteration for fixing the vehicle	Health Dept.									
			Route plan and program implementation	Health Dept.									

11. Monitoring and Evaluation plan

Monitoring Framework for Anemia			
Process Indicators (Assesses the implementation of activities)			
Indicator	**Data Source**	**Frequency**	**Responsibility**
Number of registered pregnant women provided with MCP cards	Report from IEC department	Bi annually	In charge IEC Department
Number of anemia poster, wall painting and hoarding prototypes planned and developed			
Number of videos related to anemia planned for different platforms (long videos, short videos and reels) and developed			
Number of print materials on anemia for reading and referencing planned and developed			
Number of digital apps planned and developed with anemia information			
Number of health related events planned and implemented with information on anemia			
Number of training programs planned and implemented			

Monitoring Framework for Anemia					
Output Indicators					
Monitoring Indicator	**Primary source**	**Responsible person**	**Frequency**	**Pilot phase**	**Denominator**
% of ASHA and ANMs using MCP card to counsel pregnant women on anemia	VHND report	ANM	Monthly	30%	# ANM & ASHA
% of ASHA using videos to counsel pregnant, lactating women and adolescent girls on anemia	Field report	ASHA		20%	# ASHA
% of ASHAs and ANMs using reference materials on anemia	Field report	ASHA		60%	# ANM & ASHA
% of Salons who have received and are using reading or reference materials on anemia	Field report	ASHA		20%	# Salon
% of public locations having displayed posters, wall paintings related to anemia in designated spaces	Field report	ASHA		20%	# of communities with VHCs
# of persons reached through digital platforms (YouTube, Instagram and other social media)	IEC department report	Head IEC Department		Based on user analytics	# viewers/ subscribers
% of ASHA & ANM trained on anemia and MCP card use in last 3 years	Training report	Training organiser	When training is organised	30%	# ANM & ASHA

Monitoring Framework for Anemia				
Outcome Indicators				
Indicator	**Data Source**	**Frequency**	**Target (5 Years)**	**Responsibility**
Percentage of adolescents have knowledge about anemia (prevention and management)	Sample survey	Yearly	80%	M&E Department
Percentage of pregnant women have knowledge about anemia (prevention and management)			80%	
Percentage of community members understand the importance of consuming IFA tablets and deworming tablets			60%	
Percentage respondents received information about anemia through sources like campaigns, VHC, ASHA, ANM, WhatsApp videos, posters, ask the machine, saloons, schools and religious institutions.			60%	

12. Recommendations: A multi-pronged approach

The SBCC strategy for promoting prevention and management of anemia in Meghalaya must address cultural norms, traditional practices, and structural barriers while leveraging opportunities for community mobilization, inter-departmental convergence, and system strengthening across the Khasi, Garo, and Jaintia regions. Given below are multi-pronged specific recommendations across levels-Government System Strengthening – State, District & Block and Village level; Inter-Departmental Convergence Approaches, Community Mobilization and Engagement

12.1. GOVERNMENT SYSTEM STRENGTHENING	
STATE, DISTRICT & BLOCK LEVEL	• Integrate anemia-specific SBCC planning into existing state and district health communication strategies. • Ensure regular supply and uninterrupted availability of IFA, deworming tablets, and screening kits across all health facilities. • Build capacity of health personnel (ANMs, ASHAs, AWWs, CHOs) on interpersonal communication, local dialects, and addressing myths and misconceptions. • Use data from HMIS and WIFS to identify low-coverage areas and guide focused communication interventions.

12.1. GOVERNMENT SYSTEM STRENGTHENING

VILLAGE LEVEL

- Support VHNSCs to lead awareness efforts at the community level with tailored messaging.
- Strengthen frontline workers with job aids and visual tools in local languages for one-on-one and group sessions.
- Establish village anemia champions (youth, teachers, religious leaders, traditional healers) to support dialogue and reinforce messages.

12.2. INTER-DEPARTMENTAL CONVERGENCE APPROACHES

- Health & Education: Strengthen WIFS and deworming programs in schools through joint planning, training of teachers, and parent engagement sessions.
- Health & Social Welfare: Leverage Anganwadi platforms (ICDS) to disseminate consistent messages to mothers and caregivers, integrating with nutrition and early childhood development.
- Health & Agriculture/Horticulture: Promote home gardening and use of iron-rich local crops through demonstration plots, local food festivals, and nutrition fairs.

12.3. COMMUNITY MOBILIZATION AND ENGAGEMENT

- Leverage Traditional Structures: Work with village durbars, Nokmas, and faith leaders to legitimize and promote anemia-related health behaviours.
- Engage Traditional Healers: Recognize and involve herbalists, Ojas, and other community healers as allies, while sensitizing them about evidence-based practices and referrals.
- Culturally Rooted Campaigns: Use local festivals, markets, and cultural events to host street plays, folk songs, and wall paintings using familiar language and symbolism.
- Peer Education & Testimonials: Use real-life stories from women, adolescents, and elders who benefited from anemia management to motivate others—through videos, reels, or community meetings.

12.4. ADDRESSING COMMUNITY LEVEL BARRIERS:

Overcoming Low Awareness & Misconceptions

- Use Local Language & Familiar Terms: Develop and disseminate materials using terms like Jingduna Snam, An.chi ko.mia, Bolsuta, etc. to improve community understanding.
- Community Myths-Busting Campaigns: Use local influencers and trusted community figures to debunk myths (e.g., anemia is caused by soap or spiritual possession) through stories, folk media, and real-life videos.
- Interactive Health Sessions: Organize “Talk with ASHA/ANM” days in villages for open Q&A sessions where people can ask about IFA, deworming, food habits, etc.

Enhancing Acceptance and Usage of IFA & Deworming Tablets

- Normalize and De-stigmatize Supplements: Conduct community demos showing the correct way to take IFA tablets; include testimonials addressing mild side effects.
- Mother and Youth Groups: Form or engage existing women/youth groups to monitor and encourage regular tablet intake and dietary changes.
- Family Counselling Approach: Engage fathers and elders to support women and children in IFA adherence by emphasizing family well-being.

12.4. ADDRESSING COMMUNITY LEVEL BARRIERS:

Addressing Cultural Preference for Traditional Healers

- Engage and Train Traditional Healers: Respectfully include traditional healers in orientation sessions, share basic anemia information, and build referral pathways to the public health system.
- Bridge the Gap Strategy: Promote messages that combine traditional dietary practices with medical advice—"Our herbs + health worker care = stronger families."

Improving Dietary Practices Despite Economic Constraints

- Promote Low-Cost Local Foods: Create seasonal calendars and visual guides showing affordable iron-rich local vegetables and fruits (e.g., mustard leaves, me. bitchi, green papaya, dalim).
- Cooking Demonstrations: Conduct sessions at Anganwadi centres or health camps showing how to prepare iron-rich meals using local ingredients.
- Link with Nutrition Schemes: Integrate messaging into ration distribution, PDS, or agriculture extension efforts to promote nutrient-rich local crops.

Increasing Participation in Screening and School Programs

- Incentivized (non-monetary) Screening Days: Link anemia screening camps to other popular services (e.g., immunization, child check-ups) to increase footfall.
- Engage Schools & PTAs: Ensure schools involve parents through meetings that explain the value of WIFS, build trust in tablets, and encourage children to participate.
- Use Community Champions: Identify and support respected individuals (e.g., teachers, midwives, elders) to lead by example and spread the message.

List of Abbreviations

AIDS – Acquired immunodeficiency syndrome

ANC – Antenatal Care

ANM – Auxiliary Nurse Midwife

ASHA – Accredited Social Health Activist

AWW – Anganwadi Worker

AWC – Anganwadi Centre

B-CAP – Block Convergence Action Plan

BCG – Bacillus Calmette-Guérin

BPM – Block Program Manager

C&RD – Community and Rural Development Department

CB – Capacity Building

CBO – Community-Based Organizations

CDPO – Child Development Project Officer

CF – Complementary Feeding

CHC – Community Health Centre

CSR – Corporate Social Responsibility

DC – District Collector

D-CAP – District Convergence Action Plan

DCPC – District Child Protection Officer

DMHO – District Medical and Health Officer

DMM – District Mission Manager

DPO – District Project Officer

DSWO – District Social Welfare Officer

EBF – Exclusive Breast Feeding

EIBF – Early Initiation of Breastfeeding

FAQ – Frequently Asked Question

FGD – Focus Group Discussion

FHI – Family Health International

FLW – Frontline Worker

FP – Family planning

H&WC – Health and Wellness Centre

HBNC – Home Based Newborn Care

HBYC – Home Based Care for Young Child

HIV – Human immunodeficiency viruses

List of Abbreviations

ICDS – Integrated Child Development Service

IEC – Information, Education, and Communication

IFPRI – International Food Policy Research Institute

IIPHS – Indian Institute of Public Health Shillong

IPC – Interpersonal Communication

KAP-B – Knowledge, attitudes, and practice behaviours

KMC – Kangaroo Mother Care

LM – Lactating Mother

M&E – Monitoring and Evaluation

MCH – Maternal and Child Health

MCP – Maternal and Child Protection

MDRTB – Multi Drug Resistant Tuberculosis

MHSSP – Meghalaya Health Systems Strengthening Project

MIS – Management Information System

MLHP - Mid-Level Health Providers

MoM – Minutes of Meeting

MO i/c – Medical Officer in Charge

MP – Male Participation

MSACS – Meghalaya State AIDS Control Society

MSRLS – Meghalaya State Rural Livelihoods Society

NCD – Non-Communicable disease

NFHS – National Family Health Survey

NGO – Non Governmental Organization

NHM – National Health Mission

PA – Primary Audience

PHC – Primary Health Centre

PHED – Public Health Engineering Department

PLWHA – People Living With HIV/AIDS

PMU – Project Management Unit

PNC – Postnatal Care

PPP – Public Private Partnership

PSU – Public Sector Undertaking

PTA – Parent Teacher Association

List of Abbreviations

PW – Pregnant Women

PWD – Public Works Department

RBSK – Rashtriya Bal Suraksha Karyakram

RCH – Reproductive Child Health

S-CAP – State Convergence Action Plan

SBCC – Social and Behaviour Change Communication

SC – Sub Centre

SHG – Self Help Group

SRS – Sample Registration System

SUD – Strategic Use of Data

TB – Tuberculosis

UNICEF – United Nations Children's Fund

VEC – Village Education Committee

VHC – Village Health Council

VHIB – Village Health Information board

VHND – Village Health and Sanitation Day

WCD – Women and Child development

WHO – World Health Organization

WRA – Women in Reproductive age

This document is prepared for MHSSP by:

SACH
Society For Action In Community Health

253, 2nd Floor, Shahpur Jat, New Delhi - 110049
Tel.: +91 11 4056 2549, 4611 4888
Email: contactus@sachindia.org
www.sachindia.org

Firstborn Collective LLP
55, 2nd Floor, Lane no. 2, Westend Marg Saidulajab,
South Delhi - 110030

Strategy For Addressing Teenage Pregnancy

Project submitted by
SACH
Society For Action In Community Health

Strategy For Addressing Teenage Pregnancy

1. Introduction

Teenage pregnancy is a significant public health and social issue in Meghalaya, reflecting broader challenges related to adolescent health, education, and socio-economic development. Early pregnancies not only pose health risks for young mothers and their babies but also perpetuate cycles of poverty and inequality. As per NFHS 5 report[1] , in Meghalaya teenage pregnancy is contributing to increase in infant mortality, Infant mortality is 48 per 1,000 live births for teenage mothers and 36 per 1,000 live births for mothers age 30-39, compared with 26 per 1,000 live births for mothers age 20-29. This shows that Children born to mothers under age of 20 are more likely to die during infancy than children born to mothers in the prime childbearing age (20-29 years). Teenage pregnancies are not only a public health issue, it is a social issue as well, Young parents are unable to take up the responsibility that comes with parenthood and this leads to several undesirable socio-emotional outcomes. In Meghalaya, a state with a predominantly tribal population and unique socio-cultural dynamics, teenage pregnancy remains a pressing concern.

According to the National Family Health Survey-5 (NFHS-5, 2019-21), 7.2% of women aged 15-19 years in Meghalaya had begun childbearing, which includes those who were either pregnant or had already given birth. This is higher than the national average of 6.8 % and remains a cause for concern given the state's small population and limited healthcare resources. The top 4 districts for this indicator is East Jaintia Hills (14.4%), South West Khasi Hills (13.2%), West Khasi Hills (12.9) and West Jaintia Hills (12.9). Good performing districts include West Garo Hills (1%), South Garo Hills (1.1%) and East Garo Hills (2.2%). The percentage of girls got married before the age of 18 years is 16.9%, there is no significate difference happened between NFHS 4 (2015-16) in this indicator. Early marriage is significantly higher is rural areas (19.1%) when compared to urban areas (9.1%). Among the districts with early marriage happening West Khasi Hills (30.3%), East Jaintia Hills (25.3%) and South West Khasi

[1] International Institute for Population Sciences (IIPS) and ICF. 2021. National Family Health Survey (NFHS-5), India, 2019-21: Meghalaya. Mumbai: IIPS

Hills (21.6%) are in the top 3 districts. The adolescent fertility rate in Meghalaya as per NFHS 5 is 49 and there is a visible difference in rural and urban area where rural area is 58 and urban area is 18.

A study conducted in South West Garo Hills among adolescent school girls highlighted the importance of education related to sexual health and HIV/AIDS. Another qualitative study among young mothers in Meghalaya revealed that many of them expressed happiness about their motherhood. This sentiment may stem from low life aspirations and a perception that motherhood signifies progress, achievement, or growth in life—areas where education plays a crucial role. High school dropout rates are a significant influencing factor, often linked to the low educational attainment of parents.

The study also presented a case of a 16-year-old young mother, Ms. X, who lived with her single mother and four siblings. Her father did not take any responsibility for the children. Ms. X's mother had to work long hours to support the family, leaving her daughter at home to care for her younger siblings. As a result, Ms. X dropped out of school. In the absence of adult supervision, she began spending time in the neighbourhood and eventually entered into a relationship with a young man who worked as a driver. The relationship led to pregnancy. Although the boy's family initially offered some support, Ms. X now continues to live with her mother and contributes to the household income by working as a domestic helper.

This case underscores the need to instil higher aspirations among adolescents through sustained school and college education, coupled with comprehensive reproductive health education and awareness. These measures could significantly help in reducing the incidence of teenage pregnancies.

2. The Current Landscape

Teenage pregnancy in Meghalaya, while declining in visibility, remains a significant concern across the three tribal regions; Khasi, Garo, and Jaintia Hills, due to a complex interplay of socio-cultural, economic, and systemic factors. Though the specific manifestations vary, common themes emerge around stigma, lack of information, weak communication channels, and inadequate youth-friendly services.

This section synthesizes the insights gathered through Focus Group Discussions with adolescents, parents, community elders, health workers, and religious leaders, offering a nuanced understanding of current attitudes, practices, challenges, and emerging opportunities for adolescent sexual and reproductive health in the region.

Awareness and Knowledge Gaps

Across all three regions, there is limited access to accurate, age-appropriate reproductive health education. Most teenagers rely on peers, social media, and occasionally frontline workers for information. Formal sex education in schools is absent or sporadic, and while churches and elders speak on morality, discussions on contraception, STIs, or reproductive rights are largely avoided. Girls from poorer or less-educated families are especially vulnerable due to low awareness.

"We want to know these things in school or community meetings, but nobody really talks to us openly." – Teenager, Garo Hills

Cultural and Social Norms

There is a cultural tug-of-war between traditional expectations and evolving attitudes. While early marriage is discouraged officially, societal pressures and economic constraints still push some families toward marrying off girls early, especially in Garo and Jaintia Hills. Teenage pregnancy—especially outside of marriage—is seen as shameful across all three communities, leading to stigma, family embarrassment, and sometimes school dropouts.

Religious beliefs do not condone teenage pregnancy, and in some cases, churches may suspend or stigmatize pregnant teenagers. However, religious leaders are also recognized as influential actors who can promote change.

Health Risks and Access Barriers

Communities are aware of the physical health risks associated with early pregnancy, such as weak uterus, excessive blood loss, and delivery complications. Despite this awareness, teenage girls are often reluctant to seek medical help due to fear of social judgement, lack of privacy, and poor access to youth-friendly services. In Garo Hills, home deliveries are common as a means to conceal the pregnancy.

"We keep quiet because some girls try to take their lives. It's happened before." – Community Elder, Garo Hills

Family and Community Response

Reactions vary significantly—some families quietly support the girl to avoid shame and mental health consequences, while others express anger or disown the child temporarily. The burden of care often falls on the mother or grandmother. Young fathers, if present, are either supportive or absent. Teenage pregnancies are rarely reported to authorities or institutions.

Khasi Hills communities noted that traditional support systems like storytelling and elder guidance have weakened over time, widening the generational gap in reproductive health discussions.

Communication Gaps and Hesitations

There is a deep discomfort among parents and elders in discussing reproductive health. While ASHAs and ANMs are trusted to some extent, their reach is inconsistent. Teens in all three regions expressed a desire for more open and respectful communication channels through schools, friendly counselling spaces, and peer educators.

Contraceptives: Stigma and Access Issues

Though contraception is viewed positively for married couples, access remains restricted for adolescents. In all regions, there's low awareness of options like condoms, pills, or emergency contraceptives, and misconceptions about their use abound.

"Yes, it helps the mother, makes the family strong. But it's only for married people." – Female respondent, Garo Hills

Khasi Hills Region

There is a visible shift in awareness, especially among school-going youth and urban populations.

While teenage pregnancy is still considered taboo, there is a growing openness in acknowledging that it happens and needs to be addressed sensitively.

- School-going adolescents are better informed and more likely to delay pregnancy.
- Teenage pregnancy is more common among school dropouts or those in rural and economically weaker sections.
- There is hesitancy among parents to speak openly about reproductive health, but some adolescents rely on ASHAs and ANMs for information.

Jaintia Hills Region

Teenage pregnancy is closely tied to structural issues like poverty, lack of education, and early marriage practices.

Peer pressure and personal choices also contribute, especially when parental supervision is limited due to financial pressures.

- Adolescents often get information from friends, social media, and TV rather than parents or FLWs.
- Early marriage is more common among poor families where girls are expected to contribute economically.
- Stigma around teenage pregnancy is high—teen mothers face social exclusion, gossip, and school dropouts.
- Despite this, there is growing community support for sex education and preventive awareness programs.

Garo Hills Region

Teenage pregnancy is not just a health concern but a deeply emotional and social dilemma. The community views it as a moral issue, often associating it with shame and family dishonour.

As a result, families tend to manage such situations discreetly, often hiding the pregnancy from neighbours and extended relatives. Several coping strategies include:

- Sending the girl away to live with relatives to avoid community scrutiny.
- Opting for home deliveries to avoid hospital visits and documentation that could expose the situation.
- Avoiding legal or institutional interventions, fearing police complaints due to the girl being underage.

Khasi Hills Region

- Traditional sources of guidance like grandparents and elders have diminished in influence due to modern lifestyles, urbanization, and media exposure.

For example: In one FGD, a young mother shared that she did not know about contraception before marriage because her parents never spoke about it, and only learned about options through an ASHA after becoming pregnant.

Though religious beliefs do not support teenage pregnancy, young girls are rarely abandoned. Families, though embarrassed, often support them. However, the stigma remains strong, and some churches reportedly suspend young girls who become pregnant outside of marriage.

Jaintia Hills Region

For example: A teacher from a semi-urban high school shared that the students in her school had responded positively to reproductive health sessions conducted jointly by ASHAs and school staff, leading to increased contraceptive inquiries by adolescents.

Teachers and ASHAs are respected figures in the community and are trusted for delivering age-appropriate information. Parents are becoming more open to conversations, albeit slowly.

Efforts like street theatre, school workshops, and religious leader involvement are seen as promising platforms to reach adolescents with culturally sensitive messages

Garo Hills Region

For example: During the FGD, a participant shared that they avoided hospital care for their teenage daughter's delivery because of fear of legal implications and opted for a home birth attended by a traditional birth attendant.

Discussions on sexual and reproductive health are minimal. While the health risks of early pregnancy are acknowledged—such as excessive bleeding and physical complications—the preventive approach is more social than medical.

Adolescents, especially boys, are curious and confused, often lacking access to correct information. Formal sex education is absent, and while churches promote morality, they do not talk about contraceptives or reproductive health

Case Study: Too Young, Too Soon: Rishina's Story from Jaintia Hills

In a quiet hamlet nestled in the hills of Jaintia, 14-year-old Rishina (name changed) had already taken on responsibilities far beyond her years. The eldest of four siblings, she became the default caregiver after her father abandoned the family and her mother working long hours as a daily wage labourer struggled to make ends meet.

School had once been a place Rishina loved. But when food became a bigger priority than books, she had no choice but to drop out. While caring for her siblings and managing the household, her world shrunk to the limits of her home and village pathways. It was during this time that she formed a close bond with a boy from her village, a relationship that offered her comfort, companionship, and the illusion of being seen.

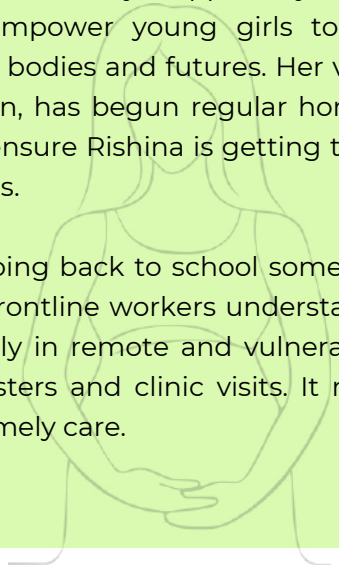
What Rishina didn't have, however, was access to the right information. No one had ever spoken to her about reproductive health, about consent, or about the life-altering consequences of early pregnancy. At 15, she discovered she was pregnant.

Afraid of being judged by her neighbours and shamed by society, her family chose silence. With no antenatal check-ups, no medical supervision, and little understanding of the dangers involved, Rishina delivered the baby at home with only her mother to support her. Her body, still not ready for motherhood, gave birth to a premature baby. She had been anemic and malnourished, and the complications during delivery nearly cost her life.

Today, her child is an additional mouth to feed in an already struggling household. And while Rishina now shoulders even more responsibility, her story is not one of hopelessness, it is one of urgency.

Her experience shines a harsh light on the need for adolescent health education, community support systems, and strong interventions that empower young girls to make informed decisions about their bodies and futures. Her village ASHA, now aware of the situation, has begun regular home visits, not just for the baby, but to ensure Rishina is getting the postnatal care she desperately needs.

Rishina dreams of going back to school someday. But for now, her story is helping frontline workers understand why reaching adolescents, especially in remote and vulnerable communities must go beyond posters and clinic visits. It requires listening, trust-building, and timely care.



3. Objectives

Objective 1

Improve adolescents' understanding of sexual and reproductive health, including the risks of early pregnancy and the benefits of delaying childbearing.

Objective 2

Promote open, respectful communication on reproductive health within families, schools, and communities, breaking the culture of silence and stigma.

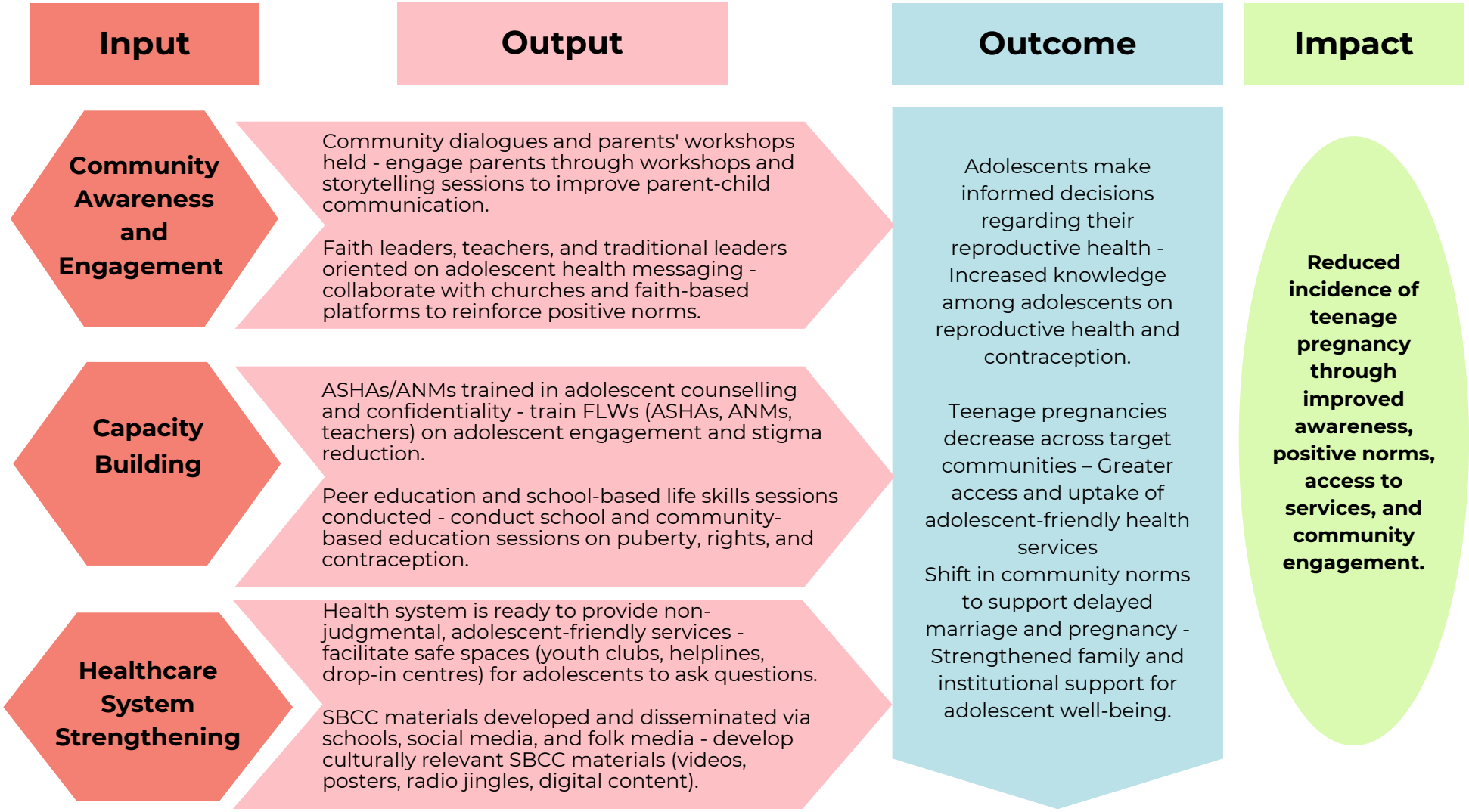
Objective 3

Support adolescents—especially out-of-school youth—to access age-appropriate, confidential information and services, including contraceptives and counselling.

Objective 4

Mobilize parents, teachers, religious leaders, and community influencers to become advocates for adolescent health and delay of early pregnancy through culturally sensitive messaging.

4. Theory of Change



5. Current Communication tools available

5.1 Current IEC materials and their status in the channel: MID MEDIA					
Modes	**List of materials**	**Platform**	**Audience**	**Recall**	**Reach (of modes/materials)**
Posters	English poster on Teenage pregnancy	SC (H&WC) PHC CHC	Adolescent girls and boys; Parents and family elders.	Poor, have no recall of having seen any poster.	Poor

5.2 Current IEC materials and their status in the channel: DIGITAL/MASS MEDIA					
Modes	**List of materials**	**Platform**	**Audience**	**Recall**	**Reach (of modes/materials)**
YouTube Videos	My girlfriend got pregnant' Teenage pregnancy YouTube sketch by Chi iung YouTube Music Video on Teen pregnancy awareness () - KiDo AlpH - Re·atkuna Sal (Official Music Video) News report of awareness campaign on teenage pregnancy.	Mobile Phone	Adolescent girls and boys; Parents and family elders; General population.	Average, only some people could recall having seen Instagram reels, mostly in urban pockets.	Average

5.2 Current IEC materials and their status in the channel: <u>DIGITAL/MASS MEDIA</u>					
Modes	**List of materials**	**Platform**	**Audience**	**Recall**	**Reach (of modes/materials)**
Instagram	Music Video on Teen pregnancy awareness () - KiDo AlpH - Re•atkuna Sal Instagram post on awareness campaign organised by a CHC	Mobile Phone	Adolescent girls and boys; Parents and family elders; General population.	Average, only some people could recall having seen Instagram reels, mostly in urban pockets.	Average
Facebook	Informative video by Meghalaya health on teenage pregnancy in English and Khasi			Average, only some people could recall having seen Facebook videos, mostly in urban pockets.	
Podcast	Hato Ka Jingarmet Khynnah Ka Long Kaba Bha? | #EP041 Ft. Flourish & Evanylla by HA Shillong			Average, only some people could recall having heard/seen the podcast.	

6. Suggested Changes for Improving IEC Materials and their Usage

6.2 Suggested changes for improving IEC Materials and their usage in the channel: **MID MEDIA**				
Modes	**List of materials**	**Platform**	**Responsible person**	**Suggestions for Improvement**
Posters	English poster on Teenage pregnancy	SC (H&WC) PHC CHC	ANM MLHP MO i/c	Display the poster in the local language at places of prominence and clear visibility in Facilities. Inform youth (young population)/ adolescent girls of reproductive age and their male partners about the various posters and their relevance to them and their family members.

"Teenage pregnancy is mostly happening among school dropout girls. They do not have much aspirations and soon fall in love affairs which can result in pregnancy."

- ASHA worker, Mynska village in West Jaintia Hills

6.2 Suggested changes for improving IEC Materials and their usage in the channel: <u>DIGITAL/MASS MEDIA</u>				
Modes	**List of materials**	**Platform**	**Responsible person**	**Suggestions for Improvement**
Instagram and Facebook	Video by Selco Foundation on Accessing quality maternal and child healthcare Video on High risk pregnant woman being for Institutional Delivery by NHM Video by Deputy Commissioner East Garo Hill to encourage institutional delivery Video - An encouraging and successful story from Marngar PHC #RiBhoi	Mobile Phone	State / District SBCC Officer	Dubbing the existing Reels in other local languages and sharing in WhatsApp groups of beneficiaries created by ASHA/AWW/SHGs at the village level.
YouTube	My girlfriend got pregnant' Teenage pregnancy YouTube sketch by Chi iung YouTube Music Video on Teen pregnancy awareness () - KiDo AlpH - Re•atkuna Sal (Official Music Video)			All videos to be made available in all local languages – Khasi, Garo, Jaintia. Sharing the content through WhatsApp up to beneficiaries through FLWs (ASHA/AWW/SHGs) based on a set calendar.

7. Suggested New Additions to Tools and Platforms

7.1 Suggested new additions to tools and platforms in the channel: **IPC**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Counselling at AFHC	Booklet	Centre visit	ARSH Counsellor	A mini booklet in Khasi, Garo and Pnar, containing information with relevant illustrations regarding delayed marriage and pregnancy till at least 20 years of age; avoid risky sexual behaviour (unprotected sex, multiple partners); build assertiveness and confidence to say "no" to early sex; proactively seek accurate information about menstruation, contraception, puberty, and reproductive health from trusted sources like ASHAs, ANMs, AWW & teachers; respect girls' boundaries, rights, and decisions, rejecting peer pressure or harmful gender norms; pursue education, skills training, or personal goals as pathways to independence and delayed pregnancy; parents to initiate open, non-judgmental conversations with children about puberty, relationships, and reproductive health; signs of emotional distress or risky behaviour and seek timely support for adolescents; parents avoid pressuring daughters into early marriage or motherhood due to societal or economic reasons; parents & elders to encourage both sons and daughters to pursue education and personal goals over early family formation.

7.1 Suggested new additions to tools and platforms in the channel: **IPC**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Counselling of adolescents	ASHA Tab	Community meeting / gathering	ASHA	Develop digital content covering- delayed marriage and pregnancy till at least 20 years of age; avoid risky sexual behaviour (unprotected sex, multiple partners); build assertiveness and confidence to say "no" to early sex; proactively seek accurate information about menstruation, contraception, puberty, and reproductive health from trusted sources like ASHAs, ANMs, AWW & teachers; respect girls' boundaries, rights, and decisions, rejecting peer pressure or harmful gender norms; pursue education, skills training, or personal goals as pathways to independence and delayed pregnancy; parents to initiate open, non-judgmental conversations with children about puberty, relationships, and reproductive health; signs of emotional distress or risky behaviour and seek timely support for adolescents; parents avoid pressuring daughters into early marriage or motherhood due to societal or economic reasons; parents & elders to encourage both sons and daughters to pursue education and personal goals over early family formation.

7.1 Suggested new additions to tools and platforms in the channel: **IPC**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Individual Information sharing	Digital content as Ready Reckoner	Salon	Salon Worker ASHA	The salons would act as a hub of information for Adolescent Girls and youths about various health matters including harmful effects of Teenage Pregnancy. The information to be shared with clients visiting the salon will be developed as a digital tool which will be used using mobile phones. The content will be short and to the point acting as a “ready reckoner” and will also have a list of FAQs. The salon worker shall also act as a referral agent in case they come across any person who needs medical intervention. Salon workers shall refer such patients to the nearest health centre or health worker.

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Print material	Poster	Facility - - Waiting area - Maternity ward	ANM MLHP	Develop posters in Khasi and Garo with translation in Hindi: delayed marriage and pregnancy till at least 20 years of age; avoid risky sexual behaviour (unprotected sex, multiple partners); build assertiveness and confidence to say "no" to early sex; proactively seek accurate information about menstruation, contraception, puberty, and reproductive health from trusted sources like ASHAs, ANMs, AWW & teachers; respect girls' boundaries, rights, and decisions, rejecting peer pressure or harmful gender norms; pursue education, skills training, or personal goals as pathways to independence and delayed pregnancy; parents to initiate open, non-judgmental conversations with children about puberty, relationships, and reproductive health; signs of emotional distress or risky behaviour and seek timely support for adolescents; parents avoid pressuring daughters into early marriage or motherhood due to societal or economic reasons; parents & elders to encourage both sons and daughters to pursue education and personal goals over early family formation.
		Community - - Market place - Salon - Community meeting halls - Bus stop	VHC members ASHA	

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Print material	IEC Handbook	SHG meetings	SHG members ASHA	Adapt the VHC IEC Handbook to develop a common Handbook for use across multiple platforms, which should include sections on the following: • delayed marriage and pregnancy till at least 20 years of age; avoid risky sexual behaviour (unprotected sex, multiple partners); build assertiveness and confidence to say "no" to early sex; proactively seek accurate information about menstruation, contraception, puberty, and reproductive health from trusted sources like ASHAs, ANMs, AWW & teachers; respect girls' boundaries, rights, and decisions, rejecting peer pressure or harmful gender norms; pursue education, skills training, or personal goals as pathways to independence and delayed pregnancy; parents to initiate open, non-judgmental conversations with children about puberty, relationships, and reproductive health; signs of emotional distress or risky behaviour and seek timely support for adolescents; parents avoid pressuring daughters into early marriage or motherhood due to societal or economic reasons; parents & elders to encourage both sons and daughters to pursue education and personal goals over early family formation.
		Religious meetings / Gatherings (Sunday mass/prayer)	Religious leaders	

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Print material	Board Game	School and Home	State/District SBCC Officer ASHA	The School & Home setting introduces Board Games for Better Relationship Building, a dynamic and discussion-based simulation tool designed to help adolescents navigate relationships with confidence and care. Through physical board games and mobile-friendly versions, players take on diverse roles and scenarios that spark conversations around emotional regulation, dating norms, and personal responsibilities. Facilitated by school educators, NGO teams, and even during PTMs, the game makes learning about healthy relationships engaging and age-appropriate. With messages like “Healthy love is learned” and “Play it safe. Date smart,” this tool creates a safe, interactive space for teens to explore complex emotions and decisions in a supportive, low-pressure environment.

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Mobile Information Unit	Van-mounted digital screen with 'Ask-The-Machine' (ATM) and vending machine	At crowded sites like festivals, events, competitions (fishing etc), market places and tourist sites	District SBCC / Officer	The van would have the following features: Ask-The-Machine (ATM): Interactive information screen with voice-enabled support or touchscreen-based information repository. The machine would be equipped with providing an information leaflet once the session is completed for the user to refer later or share further. The ATM shall provide all relevant information pertaining to teenage pregnancy. The ATM shall provide very specific information regarding delayed marriage and pregnancy till at least 20 years of age; avoid risky sexual behaviour (unprotected sex, multiple partners); build assertiveness and confidence to say "no" to early sex; proactively seek accurate information about menstruation, contraception, puberty, and reproductive health from trusted sources like ASHAs, ANMs, AWW & teachers; respect girls' boundaries, rights, and decisions, rejecting peer pressure or harmful gender norms; pursue education, skills training, or personal goals as pathways to independence and delayed pregnancy; parents to initiate open, non-judgmental conversations with children about puberty, relationships, and reproductive health; signs of emotional distress or risky behaviour and seek timely support for adolescents. Vending machine (free of cost): Users can use the vending machine to get family planning materials like condoms, OCP and Sanitary Pads. Digital Display Screen: The digital content could be common as mentioned above.

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Digital screen	Develop digital content	In facility – PHC/CHC: • Waiting areas • Maternity wards	State/District SBCC Officer	The digital content could be common / standard to be used across all channels, as mentioned above.
Wall Paintings	Pictorial content	Community: • Hard-to-reach villages • Marketplace • Community meeting halls • Bus stop	District SBCC Officer Block SBCC Officer	Develop wall paintings on: • delayed marriage and pregnancy till at least 20 years of age; avoid risky sexual behaviour (unprotected sex, multiple partners); build assertiveness and confidence to say "no" to early sex; proactively seek accurate information about menstruation, contraception, puberty, and reproductive health from trusted sources like ASHAs, ANMs, AWW & teachers; respect girls' boundaries, rights, and decisions, rejecting peer pressure or harmful gender norms; pursue education, skills training, or personal goals as pathways to independence and delayed pregnancy; signs of emotional distress or risky behaviour and seek timely support for adolescents.

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Folk Theatre	Folk Play/Street Play/Performances	Events Market Place Community meetings Institutions	District SBCC Officer Block SBCC Officer	The script of the folks play/street play to cover the following- delayed marriage and pregnancy till at least 20 years of age; avoid risky sexual behaviour (unprotected sex, multiple partners); build assertiveness and confidence to say "no" to early sex; proactively seek accurate information about menstruation, contraception, puberty, and reproductive health from trusted sources like ASHAs, ANMs, AWW & teachers; respect girls' boundaries, rights, and decisions, rejecting peer pressure or harmful gender norms; pursue education, skills training, or personal goals as pathways to independence and delayed pregnancy; signs of emotional distress or risky behaviour and seek timely support for adolescents.
Community & Urban Events	Experiential learning conventions	Village and city community halls	District SBCC Officer Block SBCC Officer	The Community & Urban Events initiative uses experiential learning and gamification to spark open, engaging conversations around wellness, mental health, and sexual education among adolescents and young people. Through aspirational pop-ups and wellness mixers hosted in both urban and rural settings, the events create safe and vibrant spaces for learning and self-expression. Participants interact with curated event kits that include branded tokens, story cards, and journaling zines, encouraging personal reflection and peer dialogue. Activities such as sex ed games, self-love journaling, and mental health Q&As are designed to be inclusive, fun, and educational. Driven by urban youth teams, NGO partners, influencers, and schools, these events aim to break stigma and inspire confidence, all while amplifying key messages like “Wellness is cool,” “Healing can be fun,” and “Your story matters.”

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Community & Urban Events	Inter-generational workshops	Village and city community halls	District SBCC Officer Block SBCC Officer	The Community/Village-based initiative focuses on nurturing open, respectful, and emotionally supportive communication between adolescents and their caregivers through intergenerational workshops. Branded as "Communoholics: Parent-Teen Dialogue Circles," these sessions use interactive tools such as storytelling decks, conversation cards, and emotional cue charts to break down barriers and encourage honest dialogue on sensitive topics like puberty, values, and emotional wellbeing. Facilitated by Village Health Committees (VHCs), ASHAs, and trained “Super Parents,” the workshops aim to strengthen family bonds and equip both generations with essential communication and listening skills. The initiative promotes messages of unity and empathy, such as “Let’s grow together,” “Talk builds trust,” and “Caring means listening,” fostering an environment where adolescents feel heard and supported.

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Community & Urban Events	Faith-based Youth Fellowships	Church	State / District SBCC Officer	In Faith-Based Institutions, the initiative Faith-based Youth Fellowships offers a values-aligned space for open conversations on adolescent wellness. Through peer fellowship and sermon-style talks, young people engage with sermon toolkits, devotional diaries, and interactive ice-breaker activities that bridge spiritual teachings with real-life challenges. Led by church youth leaders and faith champions, these gatherings promote respect, values-based sexuality education, and compassion-building, reinforcing the idea that caring for one's body and mind is part of spiritual integrity. Core messages like "Faith and health go together" and "Your body is sacred" help foster self-worth, empathy, and informed choices grounded in belief and belonging.

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Community & Urban Events	Cafés, Libraries, and Youth Hubs	Cafes Libraries Community Halls	State / District SBCC Officer SRH Counsellor	In Cafés, Libraries, and Youth Hubs, the initiative Safe Love Certification & Mental Health Cafés transforms everyday spaces into inclusive, informative wellness zones for young people. Through certification programmes, branding, and content hosting, venues display Safe Space signage, IEC kits, and training manuals, signalling openness to sensitive discussions around sexual and mental health. Led by café owners, youth mentors, and SRH educators, these hubs host dialogue sessions, poetry slams, and info corners, offering gentle entry points for awareness and connection. Core affirmations like “This is a no-judgement zone” and “Here, you’re safe to feel” help establish trust, comfort, and community support in informal settings.

7.3 Suggested new additions to tools and platforms in the channel: **DIGITAL/MASS MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Instagram	Post / Story	Mobile phones	State IEC officer	The digital content could be common / standard to be used across all channels, as mentioned above.
YouTube	Videos Songs – Traditional and New Age	Mobile phones	State IEC officer	
WhatsApp	-Video Snippets -GIF messages	Mobile Phones	State / District SBCC / IEC officer	The content would focus on: delayed marriage and pregnancy till at least 20 years of age; avoid risky sexual behaviour (unprotected sex, multiple partners); build assertiveness and confidence to say "no" to early sex; proactively seek accurate information about menstruation, contraception, puberty, and reproductive health from trusted sources like ASHAs, ANMs, AWW & teachers; respect girls' boundaries, rights, and decisions, rejecting peer pressure or harmful gender norms; pursue education, skills training, or personal goals as pathways to independence and delayed pregnancy; signs of emotional distress or risky behaviour and seek timely support for adolescents.

7.3 Suggested new additions to tools and platforms in the channel: **DIGITAL/MASS MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Voice-bot /assistant (similar to Alexa)	Voice-enabled information provision	Mobile Phones	State SBCC officer	Develop a Voice-bot (similar to Alexa) with a detailed repository of possible queries/questions in the local language (Khasi, Garo, Pnar) related delayed marriage and pregnancy till at least 20 years of age; avoid risky sexual behaviour (unprotected sex, multiple partners); build assertiveness and confidence to say "no" to early sex; proactively seek accurate information about menstruation, contraception, puberty, and reproductive health from trusted sources like ASHAs, ANMs, AWW & teachers; respect girls' boundaries, rights, and decisions, rejecting peer pressure or harmful gender norms; pursue education, skills training, or personal goals as pathways to independence and delayed pregnancy; signs of emotional distress or risky behaviour and seek timely support for adolescents.
Health Meme	Post	Mobile Phone	State SBCC officer	Develop interesting, attractive and catchy meme posts with capturing appropriate and relevant information pertaining to teenage pregnancy.

7.3 Suggested new additions to tools and platforms in the channel: **DIGITAL/MASS MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
SWIPE	App	Mobile phones	State IEC officer	Dynamic, youth-focused digital platform designed to support adolescents in Meghalaya through interactive, confidential, and engaging tools. It offers mood trackers for emotional self-awareness, quizzes to make learning about sexual and reproductive health (SRH) fun and informative, confessional threads for anonymous peer sharing, e-stories that reflect real-life challenges and victories, and peer training modules to build a supportive adolescent community. Developed by the SBCC team in collaboration with adolescent peer influencers and a tech partner, SWIPE aims to empower young users with accurate SRH information, mental health check-ins, and peer counselling tips. Through a safe, stigma-free space, the app promotes wellness and self-expression, reinforcing messages like “You're not alone,” “Ask anything, safely,” and “Wellness is power.”

7.3 Suggested new additions to tools and platforms in the channel: **DIGITAL/MASS MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Broadcast & Online stream	Online stream	Mobile phones	State IEC officer	The Broadcast & Online stream leverages the power of drama and authentic storytelling to spark meaningful conversations around adolescent experiences. Through TeenTV: Confessions & Dramas, student creators, guided by the Hello Meghalaya team and the SBCC unit, produce engaging content like audio dramas, scripted videos, and satirical reels that dive into relatable themes—teenage love, heartbreak, friendships, and sexual and reproductive health (SRH) rights. With access to scripts, audio equipment, and creative production support, adolescents take the lead in sharing raw, real narratives that reflect their world. Centred on the messages “Real teens. Real talk.” and “Your choices, your voice,” the platform ensures that youth voices are not only heard but celebrated, helping normalise difficult topics in an entertaining and empowering way.

7.4 Suggested new additions to tools and platforms in the channel: **OTHERS**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Village-level Display Board	Posters	Village Health Information Board	VHC members ASHA	Posters content to be similar as mentioned above.
Drone Services	Leaflet / Pamphlet	Direct dropping to Village (hard-to-reach)	State SBCC Officer	The leaflet would cover information pictorially on: delayed marriage and pregnancy till at least 20 years of age; avoid risky sexual behaviour (unprotected sex, multiple partners); build assertiveness and confidence to say "no" to early sex; proactively seek accurate information about menstruation, contraception, puberty, and reproductive health from trusted sources like ASHAs, ANMs, AWW & teachers; respect girls' boundaries, rights, and decisions, rejecting peer pressure or harmful gender norms; pursue education, skills training, or personal goals as pathways to independence and delayed pregnancy; signs of emotional distress or risky behaviour and seek timely support for adolescents.

SUGGESTED / PROPOSED KEY MESSAGES

This section highlights a few samples of new, innovative messages, aiming to present fresh perspectives that enhance audience engagement with the communication material. These are just a few samples of perspectives that can be explored further, showcasing how different angles can make communication more accessible, relevant, and impactful for diverse audiences.

Focus on enabling girls to make informed life choices through education, self-confidence, and supportive environments.



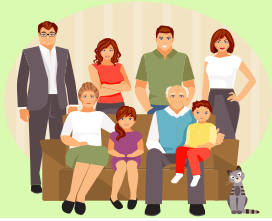
Encourages open communication between adolescents and trusted adults (parents, teachers, FLWs) about puberty, relationships, and reproductive health.



Promotes the importance of age-appropriate decisions related to marriage and childbearing to ensure healthier outcomes for girls.



Highlights the vital role of families, communities, and influencers in protecting adolescents from early pregnancy and supporting their growth.



8. Types of Audience and Targeted Behaviour

Audience Type

Primary Audience

Adolescent girls

Suggested Behaviours

- Delay marriage and pregnancy until at least 20 years of age, recognizing the health, educational, and personal benefits.
- Proactively seek accurate information about menstruation, contraception, puberty, and reproductive health from trusted sources like ASHAs, ANMs, teachers, or health sessions.
- Build assertiveness and confidence to say "no" to early sex or relationships that feel unsafe, uncomfortable, or pressured.
- Pursue education, skills training, or personal goals as pathways to independence and delayed pregnancy.

- Share responsibility in preventing teenage pregnancy, including understanding how choices and actions impact partners and families.
- Avoid risky sexual behaviour (unprotected sex, multiple partners) and understand the consequences for both self and others.
- Respect girls' boundaries, rights, and decisions, rejecting peer pressure or harmful gender norms.
- Positively engage in conversations about puberty, sexuality, gender, and reproductive health in schools or community forums.
- Challenge myths and support friends in making respectful, informed decisions—becoming peer champions for cha

Suggested Behaviours

Audience Type

Primary Audience

Adolescent boys

Secondary Audience

Immediate family members

Suggested Behaviours

- Initiate open, non-judgmental conversations with children about puberty, relationships, and reproductive health.
- Recognize signs of emotional distress or risky behaviour and seek timely support for adolescents.
- Avoid pressuring daughters into early marriage or motherhood due to societal or economic reasons.
- Encourage both sons and daughters to pursue education and personal goals over early family formation.
- Actively support adolescent girls to access health services and counselling when needed.

- Integrate age-appropriate sexual and reproductive health (SRH) education into school activities.
- Create a safe and supportive school environment for adolescents to ask questions and seek help.
- Identify at-risk students (especially school dropouts) and connect them with support networks.
- Collaborate with local health authorities for awareness sessions, AFHS camps, or counselling referrals.
- Address gender-based teasing, bullying, or harassment on school grounds to protect adolescent dignity

Suggested Behaviours

Audience Type

Secondary Audience

School Teachers

Secondary Audience

FLWs

Suggested Behaviours

- Deliver adolescent-focused counselling sessions that include menstruation, contraception, STIs, and relationships.
- Conduct regular community outreach on teenage pregnancy prevention and SRH education.
- Encourage adolescent visits to AFHCs or health sub-centres without fear or judgment.
- Be sensitive to stigma and confidentiality concerns of adolescents during home visits or counselling.
- Support parents and teachers with culturally appropriate SRH education tools and resources.

- Publicly endorse delay of marriage and pregnancy until the age of 20+ for girls.
- Speak against child marriage and promote education for girls during sermons, meetings, and local forums.
- Support SRH awareness events (like street plays, church youth clubs, school sessions) without moral judgement.
- Actively reduce community stigma around adolescent pregnancy by promoting empathy, confidentiality, and care.
- Engage families in re-integrating adolescent girls who become pregnant, encouraging education continuation

Suggested Behaviours

Audience Type

Secondary Audience

Community Leaders

9. Audience-wise Suggested Channels and Materials

Primary Audience



Adolescent girls and boys

Urban

'Voice-Bot for Health(Alexa type); Home visits by FLWs (counselling); Posters at Health Centre; Digital Hoarding; Social media - WhatsApp, YouTube, Insta post, Health memes; SWIPE for Health (App); Community Events; Podcast; Messages from saloon workers Adolescent friendly health clinics; Cafe library Youth hubs; Faith based youth fellowships, Experiential learning conventions

Rural

Voice-Bot for Health (Alexa type); Home visits by FLWs (counselling); Posters at Health Centre;
Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; Village Health Information Board; Community Events; Adolescent friendly health clinic

Urban

Voice-Bot for Health (Alexa type); Community events; Home visits by FLWs (counselling); Posters at Health Centre; Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; Digital Hoarding; SWIPE for Health (App), Podcast; Messages from saloon workers
Wall painting, Intergenerational workshops

Rural

Home visits by FLW (counselling); Voice-Bot for Health (Alexa type); Posters at Health Centre;
Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; Village Health Information Board; Community Events; Podcast; Messages from saloon workers; Wall painting, Intergenerational workshops



Family members

Secondary Audience

Secondary Audience



Religious leaders, Teachers

Urban and Rural Posters/ Hoardings; Sensitisation meetings; information booklets; Wall painting

Secondary Audience



FLWs

Urban and Rural Trainings on ASHA Tabs videos to use during Home visits by FLWs (counselling);
Compact Handbook during home visits by FLWs (counselling);
Community Events

10. Dissemination Channels and Sample Messages

SBCC Strategy Meghalaya - Detailed implementation plan

Topic: Teenage pregnancy

Expected change: Improved awareness among adolescents about teenage pregnancy and it's impact on their health and lives.

Messgae focus

Puberty and associated physical & mental changes
Psychological, social and health impacts of early pregnancy and how to prevent
Importance of setting life goals and achieving it (Selling aspirations)
Informed decision making

SBCC tool	Term	Description	Implementation steps	Responsibility	Dissemination Channels	Target Audience	Location Focus	# of Materials	Training Component	Calendar – Pre-prod.	Calendar – Prod.	Calendar – Dissemination	Accountability Indicators (for the dept. to follow)
Development of new posters	Short term	New Posters with attractive design aesthetics and elements based on user centered approach for improved recall	Finalisation of messages to be conveyed and types of posters to be developed	SACH	Village Health Information Board; important location in village with visibility; AWC	Adolescents, young people	Health centers, AWCs, VHCs	2 to 3	No	Jul-25	Jul-25	Sept-Oct 2025	Field use, poster surveys
			Development of poster design, testing the recall, finalisation of design based on feedback from primary audience & translation	SACH									
Compact Hand book/FAQ	Short term	Compact hand book to have curated list of Frequently Asked Questions related to Adolescent health on puberty and associated physical & mental changes; psychological, social & health impacts of early pregnancy and how to prevent, important of setting life goals and achieving it and on informed decision making. This will be a digital tool and will be used by ASHA and ANM in their Tablets. This digital version will be also shared at Salons and Religious institutions. **Develop this in a magazine like print-ready format for Salons in case if department decides to provide printed copies to salons.**	Development of the technical content in the hand book	SACH and Health Dept.	FLW outreach / Home visits, VHND events	Adolescents & young people and their Families	Households, SCs, VHND sites	(To be finalised in consultation with the dept for the print version)	Yes (FLW orientation)	Jun-25	Jul-25	Sept-Oct 2025	FLW usage logs, end-user knowledge assessment
			Design of Handbook	SACH									
			Orientation of all related health care staff on hand book	Health Dept.									
VHC IEC Hand book (Digital Version)	Short term	Update the VHC IEC Handbook with topics about Adolescent health on puberty and associated physical & mental changes; psychological, social & health impacts of early pregnancy and how to prevent, important of setting life goals and achieving it and on informed decision making, and converting it to digital version to be shared with SHG groups, Traditional healers, religious leaders, salons, schools. The same will be uploaded on the ASHA tablets.	Development of the content of the hand book	SACH and Health Dept.	WhatsApp groups, Tablets	Adolescents & young people and their Families and general public	Community / VHC meetings / Salons / Religious Institutions	Digital copies	No	Jul-25	Jul-25	Sept-Oct 2025	# leaders using handbook, orientation logs
			Translation, Printing and distribution of hand book	Health Dept.									
Digital Content: Short Videos Formats (GIFs, etc)	Short term	Silent - self explanatory video content for sharing through digital platforms like WhatsApps, ad inserts on youtube and public digital screens.	Development of short video scripts	SACH & Health Dept.	InstaGram, Youtube, WhatsApp, ASHA Tab	Adolescents & young people and general public	Hospitals, PHCs, common areas, Online	10–12 videos	No	Jun-25	Jul-25	Aug–Oct 2025	Video reach analytics, engagement metrics, field staff feedback
			Installation/identification of availability of digital screens	Health Dept.									
			Onboarding of video agency and development of videos										
Digital Content: Instagram Reels	Short term	Reels by local influencers **Smaller reels can also be produced from the content of the long format videos**	Identification of popular Instagram stars	SACH & Health Dept.	Instagram, community sharing	Adolescents and Youth	Online + event displays		Yes (Influencer onboarding)	Jun-25	Jul-25	Aug–Oct 2025	View count, field staff user feedback, reach metrics
			Providing themes/scripts for reels	SACH & Health Dept.									
			Dissemination of videos	Health Dept.									
Digital Content: YouTube Videos	Short term	Story-based YouTube videos **Short snippets of these can be developed into short video formats and reels**	Development of scripts / songs for YouTube videos and translation to local language	SACH	YouTube, ASHA tabs, VHC meetings	Adolescents & Youth, general public	Online + digital sessions		Yes (ASHA)	Jun-25	Jul-25	Aug–Sept 2025	Views, shares, qualitative feedback
			Identification of agency for development	SACH & Health Dept.									
			Development and dissemination of videos	Health Dept.									
Digital Content: Short video series covering topics like HIV/AIDS, Teenage pregnancy and Male participation	Medium term	A story based video series (netflix format) covering key contours of HIV/AIDS, Male Participation and Teenage Pregnancy (Can be screened on platforms like Hello! Meghalaya)	Development of scripts for the series	SACH & Health Dept.	Online- Instagram, Hello! Meghalaya, YouTube	Adolescents & Youth, general public	Online (with rural coverage)	12-15 videos *this includes multi-topic videos	No	Aug-25	Oct-Feb-26	Oct-Feb-26	Views, shares, qualitative feedback
			Onboarding of video agency and development of videos	Health Dept.									
			Dissemination of videos	Health Dept.									
ASHA Tab short videos (Tutorial videos- Puberty and adolescence) 30sec-1 min formats	Medium term	Counselling / education based on short videos during home visits and small gathering	Development of script and story board	SACH	Home visits, adolescents / out-of-school adolescents girl meetings	adolescents & youth and their families	Home Visits with focus on high teenage pregnancy sites / locations	3–5 videos	TOT + ASHA usage demo	Aug '25	Oct '25	Oct–Nov '25	# videos played per visit
			Hiring agency for the development	Health Dept.									
			Development of videos in different languages	Health Dept.									
			Installation of videos	Health Dept.									
School-Based Quiz & Drawing Competitions	Medium term	Adolescent Health awareness activities integrated into schools	Quiz/Drawing Competition toolkit development	SACH & Health Dept.	Schools	Adolescents	Middle & High Schools	Digital toolkit	Yes- Teachers	Oct-25	Jan-Feb-25	Sep 2025–Mar 2026	School reports
			Coordination with Edu Dept.	Health Dept.									
Wall painting competitions at schools	Medium term	Messages through paintings in schools, where the message focal points and contours are shared with the schools by the department	Development of wall painting topic contours/competition layout	SACH & Health Dept.	Boundary walls, schools, PHC walls	General public	Villages, Schools, PHC walls	50 walls	No	Oct-25	Jan-Feb-25	Sept–Oct 2025	# walls painted, photo documentation
			Identification of locations for wall painting	Health Dept.									
			Implementation of school event	Health Dept. & Schools									
Health information board (Community display of posters)	Medium term	Currently the posters are located mainly at hospitals and the premise of hospital, only those who visit can only see it. The village information board will be located in a common place. Posters will be displayed there based on the specific months. VHC members and ASHA can ensure the display of posters relevant to that month	Allocation of funds to establish village health information board	Health Dept./Village Committess	Health boards, VHND days	Entire community	VHND sites, select village locations, Gram Sabhas	Village information boards (at pilot sites)	No	Oct-25	Dec-Jan-25	Sep 2025–Mar 2026	Poster refresh logs, FLW checklists
			Content update calender: What posters go when	SACH & Health Dept.									
			Orientation of VHC members	Health Dept.									
			Implementation and monitoring	Health Dept.									
Hoardings (Non Digital)	Medium term	Hoardings placed in public places can provide information to public	Development of prototype of hoarding (Convert digital content into static hoarding style content)	SACH	Markets, Main roads / highway	General travelers, commuters/General Public	Entry/exit points of towns, rural highways	Pre-owned hoardings of NHM can be used immediately to insert	No	Oct-25	Jan-Feb-25	Sept–Nov 2025	Visibility count, monthly inspection
			Content update calender: What content goes when										
			Identification of locations	Health Dept.									
			Program implementation	Health Dept.									
Health memes	Long term	Development of Health memes on Teenage pregnancy	Development of health meme	SACH & Health Dept.	Instagram, whatsapp	Youth	Online (with rural coverage)	5 to 10	No	TBD	TBD	Rolling	Share counts, reactions, user metrics
			Detailing of project requirement and plan for implementation	Both SACH and Health Dept.									

SBCC tool	Term	Description	Implementation steps	Responsibility	Dissemination Channels	Target Audience	Location Focus	# of Materials	Training Component	Calendar – Pre-prod.	Calendar – Prod.	Calendar – Dissemination	Accountability Indicators (for the dept. to follow)
Ask the Machine	Long term	People can get information from the machine in their local language. The machine is placed on a vehicle so that it can be moved to different location and people in remote location also can access the service of this machine.	Hiring technical agency for development of software and hardware	Health Dept.	On-ground locations	General public and population attending events	Towns and selected rural areas with higher population and at event sites	1-2 units per district	Yes (for FLWs/drivers on SoPs)	TBD	TBD	TBD	Machine logs, reach tracking, community feedback
			Development of detailed script for health queries and related answers and translation of these queries into local language	Both SACH and Health Dept.									
			Training of AI software to answer the queries based on language	Health Dept.									
			Hiring and training the team for implementation	Health Dept.									
			Purchase of vehicle and alteration for fixing the vehicle	Health Dept.									
			Route plan and program implementation	Health Dept.									
Swipe for health	Long term	Mobile phone app to get information about health topic	Identification of implementing agency	Health Dept.	Mobile App	General public	Online (with rural coverage)	1	No	TBD	TBD	TBD	App usage analytics
			Development of script of all possible questions and answers in different languages	Both SACH and Health Dept.									
			Development of AI software and algorithm	Health Dept.									
			Establishing technical support	Health Dept.									
			Purchasing server space	Health Dept.									
			Getting all statutory approvals	Health Dept.									
			Placing the app in play store	Health Dept.									
			Encourage people to download and use the app.	Health Dept.									
AFHC Cafes	Long term	Place where adolescents can meet and talk	Development of the concept	SACH	AFHCs	Adolescents	Pilot blocks	1 per AFHC	Orientation for counselors	TBD	TBD	TBD	Footfall, satisfaction feedback
			Implementation	Health Dept.									

11. Monitoring and Evaluation plan

Monitoring Framework for Teenage Pregnancy			
Process Indicators (Assesses the implementation of activities)			
Indicator	**Data Source**	**Frequency**	**Responsibility**
Number of posters, wall painting and hoarding prototypes planned and developed on Teenage pregnancy	Report from IEC department	Bi annually	In charge IEC Department
Number of videos related to Teenage pregnancy care planned for different platforms (long videos, short videos and reels) and developed			
Number of print materials on Teenage pregnancy for reading and referencing planned and developed			
Number of digital apps planned and developed with information related to teenage pregnancy			
Number of health related events planned and implemented with information on Teenage pregnancy			
Number of training programs planned and implemented related to Teenage pregnancy			

Monitoring Framework for Teenage Pregnancy					
Output Indicators					
Monitoring Indicator	**Primary source**	**Responsible person**	**Frequency**	**Pilot phase**	**Denominator**
% of ASHA using videos to counsel adolescent girls and boys	Field report	ASHA	Monthly	10%	# ASHA
% of ASHAs and ANMs using reading or reference materials on Teenage pregnancy	Field report	ASHA		60%	# ANM & ASHA
% of Salons who have received and are using reading or reference materials on Teenage pregnancy	Field report	ASHA		20%	# Salon
% of public locations displaying posters, hoardings, wall paintings on teenage pregnancy in designated spaces	Field report	ASHA		20%	# of communities with VHCs
% of adolescents reached through school and other community-based events	Field report	ASHA/RKSK worker		30%	# Adolescents
# of persons reached through digital platforms (YouTube, Instagram and other social media) about information related to Teenage pregnancy	IEC department report	Head IEC Department		Based on user analytics	# viewers/ subscribers
% of ASHA & ANM trained on addressing teenage pregnancy in last 3 years	Training report	Training organiser	When training is organised	30%	# ANM & ASHA

Monitoring Framework for Teenage Pregnancy				
Outcome Indicators				
Indicator	**Data Source**	**Frequency**	**Target (5 years)**	**Responsibility**
Percentage of adolescent boys and girls have knowledge about importance of prevention of teenage pregnancy and how to prevent it	Sample survey	Yearly	70%	M&E Department
Percentage of family members of pregnant women have knowledge about prevention of early marriages and importance of sex education			60%	
Percentage of community members understand the importance of prevention of early marriages and importance of sex education			50%	
Percentage of respondents received information about teenage pregnancy through sources like campaigns, VHC, ASHA, ANM, WhatsApp videos, posters, ask the machine, saloons, schools and religious institutions.			60%	

12. Recommendations: A multi-pronged approach

The SBCC strategy for stopping teenage pregnancy in Meghalaya must address cultural norms, traditional practices, and structural barriers while leveraging opportunities for community mobilization, inter-departmental convergence, and system strengthening across the Khasi, Garo, and Jaintia regions. Given below are multi-pronged specific recommendations across levels-Government System Strengthening – State, District & Block and Village level; Inter-Departmental Convergence Approaches, Community Mobilization and Engagement.

12.1. GOVERNMENT SYSTEM STRENGTHENING	
STATE LEVEL	• Develop a State Action Plan on Prevention of Teenage Pregnancy, integrating health, education, WCD, and youth affairs departments. • Ensure dedicated state budget lines for Adolescent Health (RKSK - AFHC), School Health & Wellness Day, Nutrition& Health Day and Menstrual Hygiene Management. • Organize Training of Trainers on adolescent SRH, gender, and communication skills for nodal officers and master trainers. • Integrate adolescent pregnancy indicators into HMIS and promote use of disaggregated data (age, marital status, schooling status) for evidence-based planning. • Strengthen AFHCs with trained counsellors, IEC materials, and outreach through mobile health vans for out-of-school adolescents or school-based health check-ups.

12.1. GOVERNMENT SYSTEM STRENGTHENING

DISTRICT & BLOCK LEVEL	• Activate/establish District and Block Adolescent Health Committees to plan, review, and coordinate TP prevention efforts. • Strengthen AFHCs in all districts and sub-district level to cater to both out-of-school and in-school adolescents. • Joint micro-planning involving Health, Education, ICDS, and Panchayati Raj departments to identify vulnerable clusters and design targeted interventions. • Institutionalize platforms like “Adolescent Health Clubs” or Faith based Youth groups’ at the block level for young people to voice concerns and access services. • Conduct refresher training for teachers on SRH education and for ASHAs/ANMs on adolescent counselling, AFHS referrals, and gender-responsive outreach.

12.2. VILLAGE-LEVEL ENGAGEMENT AND LOCAL LEADERSHIP

- Include teenage pregnancy and early marriage as agenda points in VHC meetings and SHG meetings.
- Encourage local resolutions to discourage child marriage and promote school retention for girls.
- Support ASHAs, AWWs, and Peer Educators with toolkits and training to counsel adolescents especially out-of-school adolescents and families on delaying pregnancy.
- Create local adolescent support groups linked with ASHAs and SHGs for information-sharing, confidence building, and redressal of risks.

12.3. INTER-DEPARTMENTAL CONVERGENCE APPROACHES

- Collaborative campaigns between Health (RKSK-AFHC), Education (Samagra Shiksha), WCD (ICDS & Mission Vatsalya), and Youth Affairs (Nehru Yuva Kendra).
- Combine School Health & Wellness Days (every Tuesday), with Nutrition & Health days at AWCs, VHNDs, and Poshan Abhiyan days to include teenage pregnancy prevention sessions, SRH counselling, and parent-adolescent sessions.
- Establish clear referral protocols between schools, FLWs, AFHCs, and Child Protection Units for adolescents at risk.
- Link Education Management Information System with RMNCH+A tracking systems to follow up with school dropouts and provide preventive outreach.

12.4. COMMUNITY MOBILIZATION AND ENGAGEMENT

- Empower peer educators with culturally contextual tools and scripts to facilitate discussion on gender equality, SRH, and resisting peer pressure.
- Organize Parent-Adolescent Dialogues in community spaces to build trust and equip caregivers to discuss reproductive health openly.
- Collaborate with religious institutions and tribal leaders to build culturally sensitive narratives against early marriage and pregnancy.
- Leverage street theatre, busking, cosplay, and storytelling formats to spark community-wide conversations on teenage pregnancy and adolescent aspirations.
- Engage women's groups in identifying at-risk girls, supporting school re-entry, and conducting neighbourhood-level awareness drives.

12.5. ADDRESSING COMMUNITY LEVEL BARRIERS:

Cultural Taboos Around Sexual and Reproductive Health (SRH) Discussions

- Use trusted community influencers (e.g., teachers, ASHAs, religious/traditional leaders) to initiate culturally appropriate conversations.
- Conduct intergenerational dialogue sessions where parents and adolescents are supported in communicating more openly.
- Introduce safe community spaces (like youth clubs, health and wellness rooms, or peer educator corners) for adolescents to ask questions without fear or stigma.

Normalization of Early Marriage and Early Childbearing

- Work with Village Councils (Dorbar Shnong, Rangbah Shnong, Sirdarships, Nokmas) and SHGs to pass community resolutions against child marriage.
- Showcase positive role models (girls who pursued higher education, delayed marriage) through posters, community events, and local media.
- Link eligible adolescent girls with scholarship schemes and vocational training programs to reinforce alternate aspirations.

Lack of Adolescent-Friendly Health Services and Poor Utilization

- Improve visibility of AFHCs through outreach, school announcements, and IEC materials.
- Train ASHAs and ANMs to offer non-judgmental, confidential counselling and referrals.
- Involve peer educators to promote AFHS and accompany adolescents who are hesitant to visit clinics.

12.4. ADDRESSING COMMUNITY LEVEL BARRIERS:

Peer Pressure and Myths Around Contraception

- Strengthen peer education programs with interactive, accurate, and youth-friendly materials.
- Use edutainment tools (e.g., street plays, community radio dramas) to bust myths and present facts about contraception and SRH.
- Encourage youth-led campaigns like “My Body, My Right” or “Dreams First, Baby Later” to challenge risky norms in a relatable tone.

Limited Parental and Community Support for Adolescent Decision-Making

- Facilitate parenting workshops focused on adolescent development, communication, and support.
- Create adolescent support groups in villages (linked to AFHCs or peer networks) to build confidence, life skills, and decision-making.
- Engage men and boys, especially fathers and brothers, through community sessions to create a more supportive home environment.

Social Stigma Around Teenage Pregnancy

- Work with local leaders to promote non-discriminatory norms and support systems for young mothers (education continuation, health services).
- Document and share stories of change—communities that have successfully supported pregnant adolescents or prevented early marriage.
- Link pregnant adolescents with social protection schemes (like PMMVY, ICDS support) to ease access to health and nutrition services.

Inadequate Role of Men and Boys

- Involve boys and young men through sports clubs, youth forums, and targeted IEC that emphasizes responsibility, respect, and gender equality.
- Train male peer educators to lead change in their peer circles.
- Conduct community dialogues that challenge traditional masculinity and promote healthy relationships.

List of Abbreviations

AIDS – Acquired immunodeficiency syndrome

ANC – Antenatal Care

ANM – Auxiliary Nurse Midwife

ASHA – Accredited Social Health Activist

AWW – Anganwadi Worker

AWC – Anganwadi Centre

B-CAP – Block Convergence Action Plan

BCG – Bacillus Calmette-Guérin

BPM – Block Program Manager

C&RD – Community and Rural Development Department

CB – Capacity Building

CBO – Community-Based Organizations

CDPO – Child Development Project Officer

CF – Complementary Feeding

CHC – Community Health Centre

CSR – Corporate Social Responsibility

DC – District Collector

D-CAP – District Convergence Action Plan

DCPC – District Child Protection Officer

DMHO – District Medical and Health Officer

DMM – District Mission Manager

DPO – District Project Officer

DSWO – District Social Welfare Officer

EBF – Exclusive Breast Feeding

EIBF – Early Initiation of Breastfeeding

FAQ – Frequently Asked Question

FGD – Focus Group Discussion

FHI – Family Health International

FLW – Frontline Worker

FP – Family planning

H&WC – Health and Wellness Centre

HBNC – Home Based Newborn Care

HBYC – Home Based Care for Young Child

HIV – Human immunodeficiency viruses

List of Abbreviations

ICDS – Integrated Child Development Service

IEC – Information, Education, and Communication

IFPRI – International Food Policy Research Institute

IIPHS – Indian Institute of Public Health Shillong

IPC – Interpersonal Communication

KAP-B – Knowledge, attitudes, and practice behaviours

KMC – Kangaroo Mother Care

LM – Lactating Mother

M&E – Monitoring and Evaluation

MCH – Maternal and Child Health

MCP – Maternal and Child Protection

MDRTB – Multi Drug Resistant Tuberculosis

MHSSP – Meghalaya Health Systems Strengthening Project

MIS – Management Information System

MLHP - Mid-Level Health Providers

MoM – Minutes of Meeting

MO i/c – Medical Officer in Charge

MP – Male Participation

MSACS – Meghalaya State AIDS Control Society

MSRLS – Meghalaya State Rural Livelihoods Society

NCD – Non-Communicable disease

NFHS – National Family Health Survey

NGO – Non Governmental Organization

NHM – National Health Mission

PA – Primary Audience

PHC – Primary Health Centre

PHED – Public Health Engineering Department

PLWHA – People Living With HIV/AIDS

PMU – Project Management Unit

PNC – Postnatal Care

PPP – Public Private Partnership

PSU – Public Sector Undertaking

PTA – Parent Teacher Association

List of Abbreviations

PW – Pregnant Women

PWD – Public Works Department

RBSK – Rashtriya Bal Suraksha Karyakram

RCH – Reproductive Child Health

S-CAP – State Convergence Action Plan

SBCC – Social and Behaviour Change Communication

SC – Sub Centre

SHG – Self Help Group

SRS – Sample Registration System

SUD – Strategic Use of Data

TB – Tuberculosis

UNICEF – United Nations Children's Fund

VEC – Village Education Committee

VHC – Village Health Council

VHIB – Village Health Information board

VHND – Village Health and Sanitation Day

WCD – Women and Child development

WHO – World Health Organization

WRA – Women in Reproductive age

This document is prepared for MHSSP by:

SACH
Society For Action In Community Health

253, 2nd Floor, Shahpur Jat, New Delhi - 110049
Tel.: +91 11 4056 2549, 4611 4888
Email: contactus@sachindia.org
www.sachindia.org

Firstborn Collective LLP
55, 2nd Floor, Lane no. 2, Westend Marg
Saidulajab, South Delhi - 110030

Strategy For Promotion of Institutional Delivery

Project submitted by
SACH
Society For Action In Community Health

MEGHALAYA HEALTH SYSTEMS STRENGTHENING PROJECT

Strategy For Promotion of Institutional Delivery

1. Introduction

Institutional delivery, defined as childbirth in a healthcare facility under the supervision of trained healthcare professionals, is a key indicator of maternal and neonatal health. In Meghalaya, a state with a predominantly tribal population and challenging geographical terrain, institutional delivery rates have improved over the years but remain below the national average. Disparities exist across regions, particularly in the Khasi, Jaintia, and Garo Hills districts, due to varying levels of healthcare access, cultural practices, and socio-economic factors.

According to the National Family Health Survey-5 (NFHS-5, 2019-21), Meghalaya Fifty-eight percent (58%) of total births take place in a health facility (mostly a government facility) and a little over two-fifths (41%) take place at home. The percentage of births in a health facility increased in the 4 years from 51 percent (NFHS-4) to 58 percent (NFHS-5). Institutional births are more common among women who have received an antenatal check, women with 12 or more years of schooling, women who are having their first birth, and living in urban areas. It is also seen that there is a significant disparity between urban and rural areas where close to 83% of urban have adopted institutional delivery and in rural area 54.3% are adopting institutional delivery. Lowest institutional delivery rates are seen in South West Khasi Hills (41.7%), West Khasi Hills (41.7%) and West Jaintia Hills (42.2%). The high performing districts include West Garo Hills (89.6%), South Garo Hills (88.3%) and Southwest Garo Hills (83.7%). In all the districts public health facilities are well utilized for institutional delivery.

In a study conducted in 3 North Indian states shows that ANC visits, parity and consumption of IFA tablets are associated with higher rates of Institutional delivery[1] . Studies specific to Meghalaya shows determinants to choose home delivery over institutional delivery include financial constraints, fear of out-of-pocket expenditure, ignorance of available schemes, unavailability of transport, bad roads, and distant hospitals.

[1] Roy, M. P. (2018). Determinants of institutional delivery in three North Indian states: Evidence from DLHS 4. Journal of Dr. YSR University of Health Sciences, 7(1), 8-12.

Home delivery apparently offered the women privacy and the opportunity to attend to their household chores and older children[2]. Another study conducted at South Garo Hills [3] shows that the reasons for choosing home delivery includes Bad road condition, Steep slope area (22.6%), Not comfortable delivery in institution (21.3%), No health complications (7.5%), Available of Traditional Birth Attendant & quack doctors (14.2), Scared of C-section (7.1%), Dislike the behaviour of health workers (1.7%), No delivery facility in health centres (2.9%), Lack of vehicle (20.1%), No money for transport (2.5%). In a study to understand the barriers for the utilization of Obstetric Care Services (OCS) in India shows that lack of knowledge and awareness and less family support in availing the required OCS were key individual and interpersonal barriers. Negative social and cultural practices, such as belief in traditional herbs/healers, dietary restrictions, and discarding colostrum were frequently reported barriers, especially in rural settings. Poor economic status and high health service costs were the most often cited barriers to low institutional delivery and delayed ANC services. Long distances to health facilities and poor road conditions were the most frequently reported logistical barriers. On the provisioning side, poor quality of treatment, shortage of drugs and equipment, and non-cooperative attitude of health professionals were the most significant barriers .

2. The Current Landscape

This chapter presents a comprehensive overview of community perceptions, practices, and health system factors influencing institutional deliveries across the three major tribal regions of Meghalaya—Khasi Hills, Garo Hills, and Jaintia Hills.

Drawing insights from focused group discussions and community interactions, the findings highlight the evolving landscape of maternal health-seeking behaviour in these regions. While there is an encouraging shift toward institutional deliveries driven by increased awareness and the efforts of frontline health workers, significant regional disparities persist.

These variations are shaped by cultural beliefs, decision-making dynamics, infrastructure gaps, and access to information about government schemes. Understanding these nuances is essential for designing culturally appropriate, locally responsive interventions to improve maternal health outcomes across the state.

---

[2] Sarkar, A., Kharmujai, O. M., Lynrah, W., & Suokhrie, N. U. (2018). Factors influencing the place of delivery in rural Meghalaya, India: A qualitative study. Journal of Family Medicine and Primary Care, 7(1), 98-103
[3]Marwein, N., & Rao, P. S. Barriers and Facilitators for Utilization of Antenatal Care services in Meghalaya state, India. Health, 9, 28-1.
[4] Singh, S., & Rajak, R. (2024). Barriers in utilization and provisioning of obstetric care services (OCS) in India: a mixed-methods systematic review. BMC Pregnancy and Childbirth, 24(1), 16.

Khasi Hills Region

Institutional deliveries are widely accepted in the Khasi Hills, with most women now preferring hospital births over home deliveries. This shift is largely influenced by increased awareness, the presence of ASHAs, and past experiences with complications during home births.

Community Perceptions and Decision-Making

- Institutional delivery is now viewed as essential—even when no complications are present—marking a clear shift from earlier practices of going to the hospital only in emergencies.
- Women often make their own decisions about where to deliver, with strong support from husbands.

Jaintia Hills Region

In Jaintia Hills, while understanding of the benefits of institutional deliveries is increasing, a significant proportion of women still opt for home births due to comfort, fear, and systemic barriers.

Community Perceptions and Decision-Making

- Many families now believe that hospital deliveries are safer, but home births remain common—particularly among older women or those with a fear of medical procedures.
- Decisions about the place of delivery are often made by the pregnant woman herself, sometimes with ASHA support.
- TBAs are no longer active in most villages.

Garo Hills Region

Garo Hills demonstrates a strong shift toward institutional deliveries, driven by concerns for safety, trust in government hospitals, and wide usage of MHIS cards. However, disparities persist between remote and connected villages.

Community Perceptions and Decision-Making

- Institutional deliveries are increasingly favoured, particularly C-sections, which are perceived as quicker, safer, and less painful than natural births.

-As one respondent stated: "C-section is better. Natural birth is painful and dangerous."

- Cultural respect for natural birth as a sign of strength persists, especially among elders, but younger families are more inclined toward hospital births.

Khasi Hills Region

Community Perceptions and Decision-Making

- Traditional beliefs still exist, particularly among followers of Niam Khasi (traditional Khasi religion), where childbirth is seen as a sacred event and a blessing from U Blei (God). Naming ceremonies are culturally significant but do not typically influence delivery location.

- TBAs are still occasionally involved for massages or basic care but refer cases with complications to PHCs.

Health Infrastructure and Access

- PHCs are the first point of contact, but many function intermittently, with doctors available only on specific days.

- There is a reported shortage of staff and equipment in some PHCs.

Jaintia Hills Region

Community Perceptions and Decision-Making

- Religious leaders do not strongly influence childbirth decisions.

Health Infrastructure and Access

- Physical distance to health centres and hospitals is a major barrier, with high transportation costs and poor road conditions limiting access.

- Free government services exist but are underutilized due to these logistical constraints.

Awareness and Use of Schemes

- Awareness of government schemes (JSY, PMMVY, CMSMS, MHIS) is low and inconsistent.

- Many respondents are unsure how to apply or what benefits they are entitled to.

Garo Hills Region

Community Perceptions and Decision-Making

- Decision-making typically lies with the Mahari (wife's relatives), including the husband, parents, and elder siblings. Maternal uncles are not involved.

- In culturally conservative or remote villages, home births are still common, supported by trained or experienced Kamars (traditional birth attendants).

Health Infrastructure and Access

- Access to government hospitals is appreciated for free services and trusted staff.

- Despite MHIS coverage, financial concerns remain, especially related to transportation and incidental expenses.

- Fear of rude hospital staff and past negative experiences discourage some families from seeking institutional care.

Khasi Hills Region

Health Infrastructure and Access

- Transport access has improved due to the CMSMS vehicle service, though some villages still face poor road conditions and limited transport hours.

Awareness and Use of Schemes

- Mixed awareness of schemes like PMMVY, JSY, MHIS, and CMSMS.
- Some respondents are registered but have not received benefits; others avoid Aadhaar registration due to superstitions (e.g., associating the number 666 with Aadhaar).
- Information dissemination through village meetings and ASHAs is preferred, though effectiveness varies with community participation.

Jaintia Hills Region

Awareness and Use of Schemes

- ASHAs and village meetings are primary sources of health information. However, digital platforms are rarely used, and regular health outreach (like camps) is lacking.

Garo Hills Region

Awareness and Use of Schemes

- High awareness and usage of MHIS smart cards; most families rely on them to reduce out-of-pocket expenses.
- Very limited knowledge about monetary incentive schemes like JSY, PMMVY, or CMSMS.
- Most women are only aware of the free food program, ambulance services, and insurance—monetary benefits are rarely discussed or understood.

Case Study: A Step Towards Safer Births: Sakani's First Glimpse into Institutional Delivery

Sakani, a 24-year-old mother from a remote village tucked deep in the hills, vividly remembers the time she set foot in a health facility for the birth of her second child. It was her ASHA worker who encouraged her to consider institutional delivery—citing the benefits of skilled care, access to emergency support, and the overall safety it ensured for both mother and child. Encouraged by these conversations and wanting a better experience than her previous home birth, Sakani agreed.

However, the journey to the nearest health centre was far from easy. The travel was long, physically taxing, and financially burdensome for the family. Understanding the distance and approaching due date, the ASHA arranged for Sakani to reach the facility a few days in advance to help her settle in and get ready for a safe delivery.

At the centre, Sakani was provided with basic care—meals, a clean space to rest, and regular monitoring. But despite the physical care she received, the experience wasn't without emotional discomfort. Her slightly low haemoglobin levels and mild anemia drew criticism from the attending staff. Rather than offering gentle guidance or encouragement, Sakani recalls being spoken to in a curt, dismissive manner. She felt ashamed and confused.

"I had followed what the ASHA said... I thought they would explain things, but instead they scolded me," she quietly shared. Her baby was delivered safely, and both mother and child returned home healthy. However, the emotional sting of the experience lingered. Feeling unwelcome and judged, Sakani chose not to return to the health facility for her next two deliveries. Instead, she turned back to the familiar hands of the traditional birth attendant in her village—a choice rooted not in rejection of modern care, but in a longing for dignity and kindness. Yet, her story is not one of failure—it is one of learning.

Sakani's experience reflects how powerful a role frontline health workers can play in building trust, and how crucial it is for facility-based care to be not just clinically sound, but also compassionate. Her safe delivery at the centre remains a reminder that institutional care can offer life-saving services, but for many women like Sakani, respectful care matters just as much as medical expertise.

Today, through strengthened community health dialogues and more empathetic training for facility staff, such stories are shaping how institutional delivery services evolve—ensuring they are not only accessible, but also welcoming to every woman who walks through their doors.



3. Objectives

Objective 1

Enhance awareness among pregnant women, families, and communities about the benefits and safety of institutional delivery, and the risks associated with home births, using culturally sensitive, locally resonant communication.

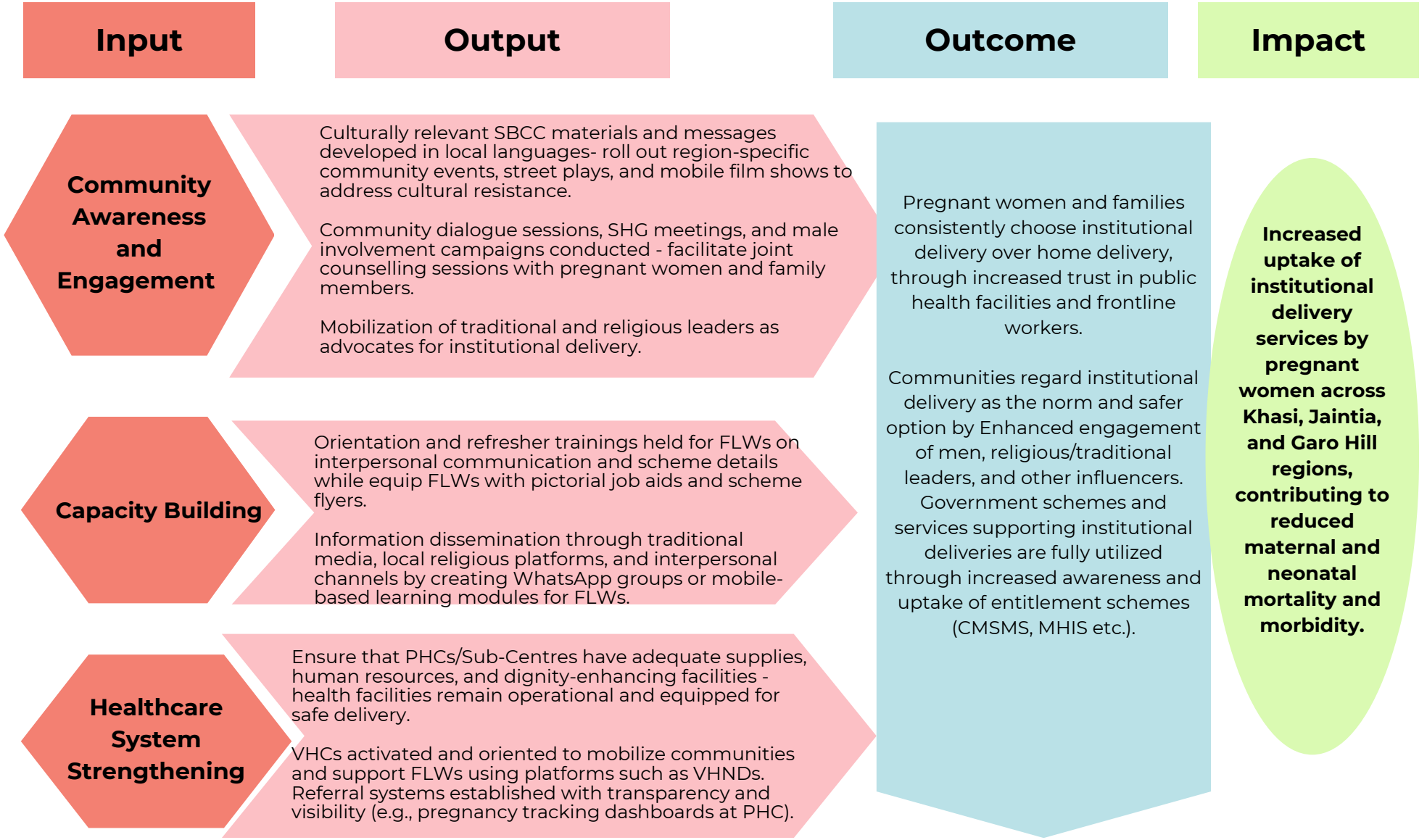
Objective 2

Identify and counter traditional beliefs, fears, and social norms that discourage institutional delivery, through storytelling, community influencers, and culturally appropriate messaging tailored to specific tribal communities.

Objective 3

Promote awareness and clarity on government schemes, birth preparedness, free transport, and facility-based support services, ensuring timely registration and utilization through frontline workers and community-based communication platforms

4. Theory of Change



5. Current Communication tools available

5.1 Current IEC materials and their status in the channel: **IPC**					
Modes	**List of materials**	**Platform**	**Audience**	**Recall**	**Reach (of modes/materials)**
Counselling during Home visit	MCP Card*	Home visit	Pregnant women and their male partner	Poor, no recall of having seen message or heard message on various services under ANC in the MCP card or remember any messages from the MCP card.	Poor
Counselling during facility visit (VHND		VHND (AWC) SC (H&WC) PHC			

** MCP Card provides all relevant information related to various MCHN schemes, messages related to care during the ANC period /pregnancy, PNC period, immunization, newborn care, growth, and development, Family Planning methods etc.*

5.1 Current IEC materials and their status in the channel: **MID MEDIA**					
Modes	**List of materials**	**Platform**	**Audience**	**Recall**	**Reach (of modes/materials)**
Posters	Poster in Khasi on Institutional Delivery	SC (H&WC) PHC CHC	Women of reproductive age, their male partners and adolescents.	Average, can recall having seen posters on TB, HIV etc but cannot recall having seen ANC or Institutional delivery posters.	Average

5.2 Current IEC materials and their status in the channel: **DIGITAL/MASS MEDIA**					
Modes	**List of materials**	**Platform**	**Audience**	**Recall**	**Reach (of modes/materials)**
Instagram	Video by Selco Foundation on Accessing quality maternal and child healthcare	Mobile Phone	General Population	Average, only some people could recall having seen Instagram reels but could not specifically remember having seen this one.	Average
Facebook	Video on High risk pregnant woman being for Institutional Delivery by NHM Video by Deputy Commissioner East Garo Hill to encourage institutional delivery Video - An encouraging and successful story from Marngar PHC #RiBhoi			Poor to average, only some people could recall having seen Facebook videos but could not specifically remember having seen these.	

5.2 Current IEC materials and their status in the channel: <u>DIGITAL/MASS MEDIA</u>					
Modes	**List of materials**	**Platform**	**Audience**	**Recall**	**Reach (of modes/materials)**
YouTube	Video on Chief Minister's Safe Motherhood Scheme, a Govt. of Meghalaya initiative	Mobile Phone	General Population	Poor to average, only some recall of having seen the video	Poor to average

"Because of good treatment and facilities, we prefer sending our partners to the sub-centre in Nongchram, we are happy with the service we get there!"

– a male FGD participant in his late-20s in Nongchram village, in East Garo Hills District.

5.3 Current IEC materials and their status in the channel: **OTHERS**					
Modes	**List of materials**	**Platform**	**Audience**	**Recall**	**Reach (of modes/materials)**
Handbook	IEC Handbook	VHC meetings	VHC members	The IEC handbook is not used effectively to share any information during meetings or otherwise.	Poor

6. Suggested Changes for Improving IEC Materials and their Usage

6.1 Suggested changes for improving IEC Materials and their usage in the channel: IPC				
Modes	**List of materials**	**Platform**	**Responsible person**	**Suggestions for Improvement**
Counselling during Home visit	MCP Card	Home visit	ASHA / ANM	Change/Improve the image and information on Institutional Delivery.
Counselling during PNC visit		VHND (AWC) SC (H&WC) PHC	ANM MLHP	Conduct structured group counselling sessions with PW and women of reproductive age and counselling eligible couples.

6.2 Suggested changes for improving IEC Materials and their usage in the channel: **MID MEDIA**				
Modes	**List of materials**	**Platform**	**Responsible person**	**Suggestions for Improvement**
Posters	Poster in Khasi on Institutional Delivery	SC (H&WC) PHC CHC	ANM MLHP MO i/c	Display the poster in the local language at places of prominence and clear visibility in facilities. Inform eligible couples/women of reproductive age and their male partners about the various posters and their relevance to them and their family members

6.3 Suggested changes for improving IEC Materials and their usage in the channel: **DIGITAL/MASS MEDIA**				
Modes	**List of materials**	**Platform**	**Responsible person**	**Suggestions for Improvement**
YouTube	Video on Chief Minister's Safe Motherhood Scheme, a Govt. of Meghalaya initiative	Mobile Phone	State / District SBCC Officer	Converting the videos as small ad plug-ins which will pop-up in between videos

6.3 Suggested changes for improving IEC Materials and their usage in the channel: DIGITAL/MASS MEDIA				
Modes	**List of materials**	**Platform**	**Responsible person**	**Suggestions for Improvement**
Instagram and Facebook	Video by Selco Foundation on Accessing quality maternal and child healthcare Video on High risk pregnant woman being for Institutional Delivery by NHM Video by Deputy Commissioner East Garo Hill to encourage institutional delivery Video - An encouraging and successful story from Marngar PHC #RiBhoi	Mobile Phone	State / District SBCC Officer	Dubbing the existing Reels in other local languages and sharing in WhatsApp groups of beneficiaries created by ASHA/AWW/SHGs at the village level.

6.4 Suggested changes for improving IEC Materials and their usage in the channel: OTHERS - VHC				
Modes	**List of materials**	**Platform**	**Responsible person**	**Suggestions for Improvement**
Handbook	IEC Handbook	IEC Handbook	ASHA ANM VHC members	ASHA/ANM to ensure VHC members use the IEC Handbook during VHC meetings to sensitize on various topics including anemia. ASHA/ANM along with the VHC office bearers develop a calendar for sharing & discussing various health topics.

7. Suggested New Additions to Tools and Platforms

7.1 Suggested new additions to tools and platforms in the channel: **IPC**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Counselling during Home visit	ASHA Tab	Home visit	ASHA	Digital content, in Khasi, Garo and Pnar, emphasizing on the need for regular ANC check-ups, identification of danger signs during pregnancy, birth planning & preparedness, benefits of institutional delivery for mother and newborn, issues and challenges of home delivery, challenges in managing complication during delivery at home, highlighting availability of free government services (ambulance, medicines, food, incentives), dispelling myths and address fears related to hospital deliveries: • Create real-life stories • Animation videos • Influencer videos • Edutainment videos
	Compact Handbook			Compact Handbook consists of FAQs with specific illustrations covering aspects emphasizing on the need for regular ANC check-ups, identification of danger signs during pregnancy, birth planning & preparedness, benefits of institutional delivery for mother and newborn, issues and challenges of home delivery, challenges in managing complication during delivery at home, highlighting availability of free government services (ambulance, medicines, food, incentives), dispelling myths and address fears related to hospital deliveries, and the role of the male partner & family in ensuring delivery at institution.

7.1 Suggested new additions to tools and platforms in the channel: **IPC**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Individual Counselling	Digital content as Ready Reckoner	Salon	ASHA ANM VHC members	The salons would act as a hub of information for PWs, WRAs and adolescent girls about various health matters including benefits of institutional delivery for mother and newborn, issues and challenges of home delivery, challenges in managing complication during delivery at home, highlighting availability of free government services (ambulance, medicines, food, incentives). The information to be shared with clients visiting the salon will be developed as a digital tool which will be used using mobile phones. The content will be short and to the point acting as a "ready reckoner" and will also have a list of FAQs. The salon worker shall also act as a referral agent in case they come across any person who needs medical intervention. Salon workers shall refer such patients to the nearest health centre or health worker.

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Print material	Poster	Facility - - Waiting area - Maternity ward	ANM MLHP	Develop posters in Khasi and Garo with translation in Hindi: emphasizing on the need for regular ANC check-ups, identification of danger signs during pregnancy, birth planning & preparedness, benefits of institutional delivery for mother and newborn, issues and challenges of home delivery, challenges in managing complication during delivery at home, highlighting availability of free government services (ambulance, medicines, food, incentives), dispelling myths and address fears related to hospital deliveries, and the role of the male partner & family in ensuring delivery at institution.
		Community - - Market place - Salon - Community meeting halls - Bus stop	VHC members ASHA	
	IEC Handbook	SHG meetings	SHG members ASHA	Adapt the VHC IEC Handbook to develop a common Handbook for use across multiple platforms, which should include sections on the following: • emphasizing on the need for regular ANC check-ups, identification of danger signs during pregnancy, birth planning & preparedness, benefits of institutional delivery for mother and newborn, issues and challenges of home delivery, challenges in managing complication during delivery at home, highlighting availability of free government services (ambulance, medicines, food, incentives) • dispelling myths and address fears related to hospital deliveries, and the role of the male partner & family in ensuring delivery at institution.

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Print material	IEC Handbook	Religious meetings / Gatherings (Sunday mass/prayer)	Religious leaders	Adapt the VHC IEC Handbook to develop a common Handbook for use across multiple platforms, which should include sections on the following: • emphasizing on the need for regular ANC check-ups, identification of danger signs during pregnancy, birth planning & preparedness, benefits of institutional delivery for mother and newborn, issues and challenges of home delivery, challenges in managing complication during delivery at home, highlighting availability of free government services (ambulance, medicines, food, incentives) • dispelling myths and address fears related to hospital deliveries, and the role of the male partner & family in ensuring delivery at institution.
		Traditional Healers Counselling during Treatment	Traditional Healers	

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Mobile Information Unit	Van-mounted digital screen with 'Ask-The-Machine' (ATM) and vending machine	At crowded sites like festivals, events, competitions (fishing etc), market places and tourist sites	District SBCC / Officer	The van would have the following features: • Ask-The-Machine (ATM): Interactive information screen with voice-enabled support or touchscreen-based information repository. The machine would be equipped with providing an information leaflet once the session is completed for the user to refer later or share further. The ATM shall provide information emphasizing on the need for regular ANC check-ups, identification of danger signs during pregnancy, birth planning & preparedness, benefits of institutional delivery for mother and newborn, issues and challenges of home delivery, challenges in managing complication during delivery at home, highlighting availability of free government services (ambulance, medicines, food, incentives), dispelling myths and address fears related to hospital deliveries, and the role of the male partner & family in ensuring delivery at institution. • Vending machine (free of cost): Users can use the vending machine to get family planning materials like condoms, OCP and Sanitary Pads. • Digital Display Screen: The digital content could be common as mentioned above.

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Digital screen	Develop digital content	In facility – PHC/CHC: • Waiting areas • Maternity wards	State/District SBCC Officer	The digital content could be common / standard to be used across all channels, as mentioned above.
Wall Paintings	Pictorial content	Community: • Hard-to-reach villages • Marketplace • Community meeting halls • Bus stop	District SBCC Officer Block SBCC Officer	Develop wall paintings on: • emphasizing on the need for regular ANC check-ups, identification of danger signs during pregnancy, birth planning & preparedness, benefits of institutional delivery for mother and newborn, issues and challenges of home delivery, challenges in managing complication during delivery at home, highlighting availability of free government services (ambulance, medicines, food, incentives) • dispelling myths and address fears related to hospital deliveries, and the role of the male partner & family in ensuring delivery at institution.

7.2 Suggested new additions to tools and platforms in the channel: **MID MEDIA**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Folk Theatre	Folk Play/Street Play/Performances	Events Market Place Community meetings Institutions	District SBCC Officer Block SBCC Officer	The script of the folks play/street play would convey important messages related to • emphasizing on the need for regular ANC check-ups • identification of danger signs during pregnancy • birth planning & preparedness • benefits of institutional delivery for mother and newborn • issues and challenges of home delivery • challenges in managing complication during delivery at home • highlighting availability of free government services (ambulance, medicines, food, incentives) • dispelling myths and address fears related to hospital deliveries, and the role of the male partner & family in ensuring delivery at institution.

7.3 Suggested new additions to tools and platforms in the channel: <u>DIGITAL/MASS MEDIA</u>				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Hoarding	Pictorial content	Community- Market places, Bus stops	State / District SBCC officer	Develop picture-based hoarding capturing information: emphasizing on the need for regular ANC check-ups, identification of danger signs during pregnancy, birth planning & preparedness, benefits of institutional delivery for mother and newborn, issues and challenges of home delivery, challenges in managing complication during delivery at home, highlighting availability of free government services (ambulance, medicines, food, incentives), dispelling myths and address fears related to hospital deliveries, and the role of the male partner & family in ensuring delivery at institution.
Digital Hoardings	Develop digital content	Community – - Bus stop - Popular (busy) locations	State /District SBCC Officer	The digital content could be common / standard to be used across all channels, as mentioned above.

7.3 Suggested new additions to tools and platforms in the channel: <u>DIGITAL/MASS MEDIA</u>				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Instagram	Post / Story	Mobile phones	State IEC officer	The digital content could be common / standard to be used across all channels, as mentioned above.
YouTube	Videos Songs – Traditional and New Age	Mobile phones	State IEC officer	
WhatsApp	-Video Snippets -GIF messages	Mobile Phones	State / District SBCC / IEC officer	The content would focus on: emphasizing on the need for regular ANC check-ups, identification of danger signs during pregnancy, birth planning & preparedness, benefits of institutional delivery for mother and newborn, issues and challenges of home delivery, challenges in managing complication during delivery at home, highlighting availability of free government services (ambulance, medicines, food, incentives), dispelling myths and address fears related to hospital deliveries, and the role of the male partner & family in ensuring delivery at institution.

7.3 Suggested new additions to tools and platforms in the channel: <u>DIGITAL/MASS MEDIA</u>				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Voice-bot /assistant (similar to Alexa)	Voice-enabled information provision	Mobile Phones	State SBCC officer	Develop a Voice-bot (similar to Alexa) with a detailed repository of possible queries/questions in the local language (Khasi, Garo, Pnar) related to emphasizing on the need for regular ANC check-ups, identification of danger signs during pregnancy, birth planning & preparedness, benefits of institutional delivery for mother and newborn, issues and challenges of home delivery, challenges in managing complication during delivery at home, highlighting availability of free government services (ambulance, medicines, food, incentives), dispelling myths and address fears related to hospital deliveries, and the role of the male partner & family in ensuring delivery at institution.
Health Meme	Post	Mobile Phone	State SBCC officer	Develop interesting, attractive and catchy meme posts with appropriate images on emphasizing on the need for regular ANC check-ups, identification of danger signs during pregnancy, benefits of institutional delivery for mother and newborn, issues and challenges of home delivery, challenges in managing complication during delivery at home, highlighting availability of free government services (ambulance, medicines, food, incentives) & dispelling myths and address fears related to hospital deliveries.

7.4 Suggested new additions to tools and platforms in the channel: **OTHERS**				
Modes	**Suggested/ Proposed materials**	**Platforms**	**Responsible Persons**	**Suggested / Proposed Content**
Village-level Display Board	Posters	Village Health Information Board	VHC members ASHA	Posters to be developed: • emphasizing on the need for regular ANC check-ups • identification of danger signs during pregnancy • birth planning & preparedness • benefits of institutional delivery for mother and newborn • issues and challenges of home delivery • challenges in managing complication during delivery at home • highlighting availability of free government services (ambulance, medicines, food, incentives) • dispelling myths and address fears related to hospital deliveries • the role of the male partner & family in ensuring delivery at institution.
Drone Services	Leaflet / Pamphlet	Direct dropping to Village (hard-to-reach)	State SBCC Officer	The leaflet would cover information pictorially on: emphasizing on the need for regular ANC check-ups, identification of danger signs during pregnancy, birth planning & preparedness, benefits of institutional delivery for mother and newborn, issues and challenges of home delivery, challenges in managing complication during delivery at home, highlighting availability of free government services (ambulance, medicines, food, incentives), dispelling myths and address fears related to hospital deliveries, and the role of the male partner & family in ensuring delivery at institution.

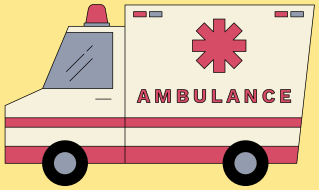
SUGGESTED / PROPOSED KEY MESSAGES

This section highlights a few samples of new, innovative messages, aiming to present fresh perspectives that enhance audience engagement with the communication material. These are just a few samples of perspectives that can be explored further, showcasing how different angles can make communication more accessible, relevant, and impactful for diverse audiences.

Giving birth at a hospital ensures the health and safety of both mother and baby, with access to skilled care and emergency support.



Free ambulance services, medicines, food, and financial incentives are available for pregnant women in government health facilities.



Support from husbands, mothers-in-law, elders, and community leaders encourages safer choices for childbirth.



Trust your local ASHA and frontline workers—they guide, support, and ensure timely care for safe delivery.



8. Types of Audience and Targeted Behaviour

Audience Type

Primary Audience

Pregnant women

Suggested Behaviours

- Prefer and plan for institutional delivery as the first choice
- Understand and trust the benefits of safe childbirth in a health facility
- Proactively register and utilize CMSMS, MHIS, PMMVY schemes
- Make informed and timely decisions regarding ANC checkups and delivery location

- Partner to actively support and participate in decision-making around ANC and institutional delivery
- Partner & family members prioritize financial and logistical support for institutional delivery
- Spouse to help their partners register and access scheme benefits and entitlements

Suggested Behaviours

Audience Type

Secondary Audience

Male partners and immediate family members

Audience Type

Secondary Audience

FLWs

Suggested Behaviours

- FLWs to provide culturally relevant, persuasive counselling on institutional delivery
- Health workers to actively facilitate registration and ensure follow-up for maternity schemes
- FLWs to actively engage entire household including men and elders in conversations on safe delivery

- Community leaders actively champion institutional delivery at the community level
- Community leaders and elders coordinate with health systems to ensure timely access and services

Suggested Behaviours

Audience Type

Secondary Audience

Community leaders

9. Audience-wise Suggested Channels and Materials

Primary Audience



Pregnant women

Urban: 'Voice-Bot for Health(Alexa type); Home visits by FLWs (counselling); Posters at Health Centre; Digital Hoarding; Social media - WhatsApp, YouTube, Insta post, Health memes; SWIPE for Health (App); Community Events.

Rural: Voice-Bot for Health (Alexa type); Home visits by FLWs (counselling); Posters at Health Centre; Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; Village Health Information Board; Community Events.

Urban: Voice-Bot for Health (Alexa type); Community events; Home visits by FLWs (counselling); Posters at Health Centre; Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; Digital Hoarding; SWIPE for Health (App); Wall painting

Rural: Home visits by FLW (counselling); Voice-Bot for Health (Alexa type); Posters at Health Centre; Social media - WhatsApp, YouTube, Health memes; Travelling Folk Theatre; Village Health Information Board; Community Events; Wall painting



Husbands

Secondary Audience

Secondary Audience



Religious leaders, Teachers

Urban and Rural: Posters/ Hoardings; Sensitisation meetings; information booklets; Wall painting

Urban and Rural: Trainings on ASHA Tabs videos to use during Home visits by FLWs (counselling); Compact Handbook during home visits by FLWs (counselling); Community Events



FLWs

Secondary Audience

10. Dissemination Channels and Sample Messages

SBCC Strategy Meghalaya - Detailed implementation plan
Topic: Institutional Delivery

Messgae focus

Importance of all deliveries to be conducted at hospital
High risk pregnancies- signs & symptoms
Various schemes related to institutional delivery and how to avail it

Expected change: Increased number of women opt for institutional delivery
Number of women aware about the importance of birth preparedness

SBCC tool	Term	Description	Implementation steps	Responsibility	Dissemination Channels	Target Audience	Location Focus	# of Materials	Training Component	Calendar – Pre-prod.	Calendar – Prod.	Calendar – Dissemination	Accountability Indicators (for the dept. to follow)
Compact Hand book/FAQ	Short term	Compact hand book to have curated list of Frequently Asked Questions related to Institutional Deliveries emphasising on its importance, signs & symptoms of high risk pregnancies, brief about various schemes etc. This will be a digital tool and will be used by ASHA and ANM in their Tablets. This digital version will be also shared at Salons and Religious institutions . **Develop this in a magazine like print-ready format for Salons in case if department decides to provide printed copies to salons.**	Developing a curated list of questions that could arise from the field and their correct answers. Designing the Handbook Orientation of all stakeholders particularly FLWs on the use of hand book	SACH & Health Dept. SACH Health Dept.	FLW outreach/Home visits, VHND events	Pregnant women & their caregivers	Households, SCs, VHND sites	1 Print version- to be finalised by MHSSP / Health dept	Yes (FLW orientation)	Jun-25	Jul-25	Sept-Oct 2025	FLW usage logs, end-user knowledge assessment
VHC IEC Hand book (Digital Version)	Short term	Update the VHC IEC Handbook with information on various schemes and other necessary details and the digital version of it to be shared with SHG groups, Traditional healers, religious leaders, salons, schools. The same will be uploaded on the ASHA tabs and shared with FLWS as well.	Development of the content of the hand book Translation, Printing and distribution of hand book Database of Salons/Religious Institutions/Schools/SHG groups, etc	SACH and Health Dept. Health Dept.	WhatsApp groups - Schools, Salons, Religious Institutions, SHGs etc, ASHA Tablets	Pregnant women & their caregivers	Community/VHC meetings/Salons/Religious Institutions	Digital copies	No	Jul-25	Jul-25	Sept-Oct 2025	# leaders using handbook, orientation logs
Digital Content: Short Videos Formats (GIFs, etc)	Short term	Silent - self explanatory video content for sharing through digital platforms like WhatsApps, ad inserts on youtube etc. and to be played in (loops) in the waiting areas of facilities (H&WC, PHC CHC etc) and public digital screens.	Development of short video scripts Onboarding of video agency and development of videos Dissemination of content through Digital platforms including public screen and to health facilities; Identification of public digital screens (across the state) & facilities with availability of digital screens, where unavailable facilitating procurement of digital screens.	SACH & Health Dept. Health Dept.	Waiting areas, YouTube, Instagram, WhatsApp, ASHA Tab	Pregnant women & accompanying persons, general public	Health facilities (SC /H&WC, PHC, CHC etc); Online	10–12 videos	No	Jun-25	Jul-25	Aug–Oct 2025	Video reach analytics, engagement metrics, field staff feedback
Digital Content: Instagram Reels	Short term	Reels by local influencers on importance of institutional deliveries, signs of high risk pregnancies, information about schemes **Smaller reels can also be produced from the content of the long format videos**	Identification of popular Instagram stars Providing themes/scripts (based on the focal areas identified) for reels Dissemination of videos	SACH & Health Dept. SACH & Health Dept. Health Dept.	Instagram, community sharing	Pregnant Women; General Public	Online + event displays		Yes (Influencer onboarding)	Jun-25	Jul-25	Aug–Oct 2025	View count, field staff user feedback, reach metrics
Digital Content: YouTube Videos	Short term	Story-based YouTube videos / songs on Institutional deliveries, high risk pregnancies, information about schemes **Short snippets of these can be developed into short video formats and reels**	Development of scripts / songs for YouTube videos and translation to local language Onboarding of video agency and development of videos Dissemination of videos	SACH Health Dept. Health Dept.	YouTube, ASHA tabs, VHC meetings	Pregnant women; General public	Online + digital sessions		Yes (ASHA)	Jun-25	Jul-25	Aug–Sept 2025	Views, shares, qualitative feedback
MCP card inclusion of additional information on Schemes in Meghalaya	Medium term	Information to the added to MCP card about benefits of each schemes	Content development and translation Printing and dissemination	SACH & Health Dept Health Dept.	ANC visits	Pregnant/lactating women	Health facilities	N/A	No	Aug '25	Sep '25	Oct '25 onwards	MCP update logs
ASHA Tab short videos on Institutional Delivery- High Risk Deliveries (Signs & Symptoms) 30sec-1 min formats	Medium term	Counselling / education based on short videos during home visits and small gathering on high risk pregnancies, institutional deliveries and available schemes	Development of script and story board Hiring agency for the developing videos Development of videos in different languages -Khasi / Garo / Pnar Dissemination and timely installation of videos	SACH Health Dept. Health Dept. Health Dept.	Home visits, mother meetings	Pregnant & lactating women; family members	Home Visits (especially of pregnant women)	3–5 videos	Yes	Aug '25	Oct '25	Oct–Nov '25	# videos played per visit
Village Health Information Board (Community display of posters)	Medium term	Currently the posters are located mainly at hospitals and the premise of hospital, only those who visit can only see it. The village information board will be located in a common place. Posters will be displayed there based on the specific months. VHC members and ASHA can ensure the display of posters relevant to that month	Allocation of funds to establish village health information board Content update calender: What posters go when Orientation of VHC members Implementation and monitoring	Health Dept./Village Committess SACH & Health Dept. Health Dept. Health Dept.	Health boards	Entire community	Centre of the village or an areas within the village with maximum visibility	Village information boards (at pilot sites)	No	Oct-25	Dec-Jan-25	Sep 2025–Mar 2026	Poster refresh logs, FLW checklists
Hoardings (Non-Digital)	Medium term	Hoardings placed in public places can provide information to public	Development of prototype of hoarding (Convert digital content into static hoarding style content) Event calender with details of hoarding message to be displayed Identification of locations Changing / Replacing hoarding on periodic basis	SACH SACH & Health Dept. Health Dept. Health Dept.	Markets, highway turns, CHC walls	General travelers, commuters/General Public	Entry/exit points of towns, rural highways	Pre-owned hoardings of NHM can be used immediately to insert	No	Oct-25	Jan-Feb-25	Sept–Nov 2025	Visibility count, monthly inspection
Development of new posters	Long term	New Posters with attractive design aesthetics and elements based on user centered approach for improved recall	Finalisation of messages to be conveyed and types of posters to be developed Development of poster design, testing the recall, finalisation of design based on feedback from primary audience & translation Estimation of the number of posters to be printed	SACH SACH Health Dept.	Village Health Information Board and Health Facilities	General Public	PHCs, SCs and other Facilities/Public spaces- information boards etc	To be finalised in consultation with the dept	No	TBD	TBD	TBD	Recall survey; poster visibility audit

SBCC tool	Term	Description	Implementation steps	Responsibility	Dissemination Channels	Target Audience	Location Focus	# of Materials	Training Component	Calendar – Pre-prod.	Calendar – Prod.	Calendar – Dissemination	Accountability Indicators (for the dept. to follow)
Voicebot assistant (Alexa type)	Long term	A mobile phone app which can provide answers to the doubts and provide more information about the health topic	Identification of implementing agency	Health Dept.	Mobile app	Pregnant & Lactating women; Family members & Caregivers	Online	N/A	No	TBD	TBD	TBD	App downloads, usage rate
			Development of script of all possible questions and answers in different languages	SACH & Health Dept.									
			Development of AI software and algorithm	SACH & Health Dept.									
			Voice recording according to the script	Health Dept.									
			Training of AI software to answer the queries based on language	Health Dept.									
			Establishing technical support	Health Dept.									
			Purchasing server space	Health Dept.									
			Getting all statutory approvals	Health Dept.									
			Placing the app in play store	Health Dept.									
			Encourage people to download and use the app.	Health Dept.									
Ask the Machine	Long term	People can get information from the machine in their local language. The machine is placed on a vehicle so that it can be moved to different location and people in remote location also can access the service of this machine.	Detailing of project requirement and plan for implementation	SACH & Health Dept.	On-ground locations	General public and population attending events	Towns and selected rural areas with higher population and at event sites	1-2 units per district	Yes (for FLWs/drivers on SoPs)	TBD	TBD	TBD	Machine logs, reach tracking, community feedback
			Hiring technical agency for development of software and hardware	Health Dept.									
			Development of detailed script for health queries and related answers and translation of these queries into local language	SACH & Health Dept.									
			Training of AI software to answer the queries based on language	Health Dept.									
			Hiring and training the team for implementation	Health Dept.									
			Purchase of vehicle and alteration for fixing the vehicle	Health Dept.									
			Route plan and program implementation	Health Dept.									

11. Monitoring and Evaluation plan

Monitoring Framework for Institutional Delivery			
Process Indicators (Assesses the implementation of activities)			
Indicator	**Data Source**	**Frequency**	**Responsibility**
Number of posters, wall painting and hoarding prototypes planned and developed on institutional delivery	Report from IEC department	Bi annually	In charge IEC Department
Number of videos related to institutional delivery planned for different platforms (long videos, short videos and reels) and developed			
Number of print materials on institutional delivery for reading and referencing planned and developed			
Number of digital apps planned and developed with information about institutional delivery			
Number of health related events planned and implemented with information on institutional delivery			
Number of training programs planned and implemented on communication related to institutional delivery			

Monitoring Framework for Institutional Delivery					
Output Indicators					
Monitoring Indicator	**Primary source**	**Responsible person**	**Frequency**	**Pilot phase**	**Denominator**
% of ASHA and ANMs using MCP card to counsel on institutional delivery and danger signs during pregnancy	VHND report	ANM	Monthly	30%	# ANM & ASHA
% of ASHA using videos to counsel pregnant women and their families on importance of institutional delivery	Field report	ASHA		20%	# ASHA
# of ASHAs and ANMs using reading or reference materials on institutional delivery.	Field report	ASHA		60%	# ANM & ASHA
% of Salons provided and using reading or reference materials on institutional delivery.	Field report	ASHA		20%	# Salon
% of public locations have displayed posters, hoarding, wall paintings related to institutional delivery in designated spaces	Field report	ASHA		20%	# of communities with VHCs
# of persons reached through digital platforms (YouTube, Instagram and other social media) about information related to institutional delivery	IEC department report	Head IEC Department		Based on user analytics	# viewers/ subscribers
% of ASHA & ANM training on counselling and promotion of institutional delivery in last 3 years	Training report	Training organiser	When training is organised	30%	# ANM & ASHA

Monitoring Framework for Institutional Delivery				
Outcome Indicators				
Indicator	**Data Source**	**Frequency**	**Target (5 years)**	**Responsibility**
Percentage of pregnant women have knowledge about importance of institutional delivery	Sample survey	Yearly	90%	M&E Department
Percentage of family members of pregnant women have knowledge about importance of institutional delivery			90%	
Percentage of community members understand the importance of institutional delivery			80%	
Percentage respondents received information about importance of institutional delivery through sources like campaigns, VHC, ASHA, ANM, WhatsApp videos, posters, ask the machine, saloons and religious institutions.			80%	

12. Recommendations: A multi-pronged approach

The SBCC strategy for promoting Institutional Deliveries in Meghalaya must address cultural norms, traditional practices, and structural barriers while leveraging opportunities for community mobilization, inter-departmental convergence, and system strengthening across the Khasi, Garo, and Jaintia regions. Given below are multi-pronged specific recommendations across levels- Government System Strengthening – State, District & Block and Village level; Inter-Departmental Convergence Approaches, Community Mobilization and Engagement.

12.1. GOVERNMENT SYSTEM STRENGTHENING	
STATE LEVEL	• Integrate SBCC strategy for institutional delivery into state RMNCH+A action plans. • Develop a uniform message bank and IEC/BCC materials in local languages (Khasi, Garo, Pnar). • Train district officials and communication focal points on SBCC planning, implementation, and monitoring. • Strengthen the state IEC / SBCC cell to track reach, feedback, and impact. • Partner with local radio, cable TV, influencers, and digital platforms to amplify key messages.

12.1. GOVERNMENT SYSTEM STRENGTHENING

DISTRICT & BLOCK LEVEL	• Conduct regular convergence meetings of NHM, ICDS, Education, and Panchayati Raj departments to plan joint outreach. • Provide FLWs (ASHAs, ANMs) with flipbooks, FAQs, and audiovisual aids for counselling. • Map transport options and referral facilities; ensure dissemination of CMSMS ambulance numbers at community level. • Strengthen and effectively utilise WhatsApp support groups for FLWs and pregnant women for referral and advice.

12.2. INTER-DEPARTMENTAL CONVERGENCE APPROACHES

- Ensure clear signage, clean surroundings, and friendly staff behaviour at sub-centres and PHCs to improve trust and acceptability.
- Intensify interpersonal counselling through ASHAs and ANMs, with early identification and engagement of pregnant women.
- Create community displays (wall paintings/posters) on schemes like CMSMS, PMMVY, MHIS etc. benefits and how to access them

12.3. INTER-DEPARTMENTAL CONVERGENCE APPROACHES

- Effectively collaborate with ICDS for VHNDs, home visits, and adolescent outreach; include ANCs and birth preparedness in joint planning.
- Sensitize school teachers to promote adolescent awareness on teenage pregnancy, maternal health and create peer role models.
- Involve traditional heads, religious groups including traditional healers in addressing myths and cultural barriers around institutional delivery.

12.4. COMMUNITY MOBILIZATION AND ENGAGEMENT

- Leverage SHGs, VHC, and other CBOs / FBOs to discuss benefits of hospital births.
- Involve religious leaders, traditional healers, traditional birth attendants (TBAs), and village elders as change agents.
- Use real-life stories through posters, videos, and street plays to build emotional connect and trust.
- Develop messages that respect local rituals and promote positive / good health behaviours, while reinforcing safe practices.

12.5. ADDRESSING COMMUNITY LEVEL BARRIERS:

Addressing Myths, Misconceptions, and Fears

- Community Dialogues & Storytelling: Use community-led storytelling, street plays, and real-life testimonials to bust myths (e.g., fear of injections, pain of C-sections, hospital stigma).
- Faith-Based Engagement: Involve religious and traditional leaders to counter superstitions and reinforce positive norms using respected platforms (church sermons, community / tribal gatherings).

Cultural Sensitivity & Traditional Beliefs

- Respect & Integration of Traditions: Encourage hospital staff to be polite and inclusive, while respecting traditional rituals, maternal roles, or blessings, so that women do not feel culturally excluded.
- Bridging with Traditional Birth Attendants (TBAs): Where TBAs are still active, train and incentivize them to refer women to institutions rather than conducting deliveries themselves.

Enhancing Male & Family Engagement

- Husband and Family Counselling: Conduct sessions during VHC meetings or during VHNDs and during home visits that target husbands and other immediate family members to build their support for hospital deliveries.
- Male Champions: Identify and train local male champions to speak about benefits and remove any gendered barriers

Improving Trust in Public Health Facilities

- Respectful Maternity Care Campaigns: Promote awareness of women's rights during childbirth and train healthcare staff on respectful care, addressing past negative experiences.
- Testimony-Based Confidence Building: Use posters, videos, and radio stories of local women who had positive hospital experiences.

12.4. ADDRESSING COMMUNITY LEVEL BARRIERS:

Improving Awareness of Schemes and Services

- IEC in Local Languages: Distribute posters, videos, and messages in Khasi, Garo, and Jaintia languages, with simplified visuals.
- Scheme Demonstration Camps: Organize registration drives to support beneficiaries to access CMSMS, PMMVY, MHIS benefits.
- Aadhaar Myths Clarification: Address fear of Aadhaar through trusted community figures.

Strengthening Community Platforms

- Use of SHGs, VHCs, and other faith based organizations: Regularly engage these groups in promoting institutional delivery norms and monitoring pregnant women.
- Village Recognition Systems: Celebrate villages achieving 100% institutional deliveries with awards, certificates, or social recognition.

Transportation and Access Issues

- Community Transport Mapping: Work with Panchayats to develop emergency transport plans using local vehicles.
- Awareness of CMSMS: Ensure pregnant women and families are aware of free ambulance numbers and procedures through wall paintings and cards.

List of Abbreviations

AIDS – Acquired immunodeficiency syndrome

ANC – Antenatal Care

ANM – Auxiliary Nurse Midwife

ASHA – Accredited Social Health Activist

AWW – Anganwadi Worker

AWC – Anganwadi Centre

B-CAP – Block Convergence Action Plan

BCG – Bacillus Calmette-Guérin

BPM – Block Program Manager

C&RD – Community and Rural Development Department

CB – Capacity Building

CBO – Community-Based Organizations

CDPO – Child Development Project Officer

CF – Complementary Feeding

CHC – Community Health Centre

CSR – Corporate Social Responsibility

DC – District Collector

D-CAP – District Convergence Action Plan

DCPC – District Child Protection Officer

DMHO – District Medical and Health Officer

DMM – District Mission Manager

DPO – District Project Officer

DSWO – District Social Welfare Officer

EBF – Exclusive Breast Feeding

EIBF – Early Initiation of Breastfeeding

FAQ – Frequently Asked Question

FGD – Focus Group Discussion

FHI – Family Health International

FLW – Frontline Worker

FP – Family planning

H&WC – Health and Wellness Centre

HBNC – Home Based Newborn Care

HBYC – Home Based Care for Young Child

HIV – Human immunodeficiency viruses

List of Abbreviations

ICDS – Integrated Child Development Service

IEC – Information, Education, and Communication

IFPRI – International Food Policy Research Institute

IIPHS – Indian Institute of Public Health Shillong

IPC – Interpersonal Communication

KAP-B – Knowledge, attitudes, and practice behaviours

KMC – Kangaroo Mother Care

LM – Lactating Mother

M&E – Monitoring and Evaluation

MCH – Maternal and Child Health

MCP – Maternal and Child Protection

MDRTB – Multi Drug Resistant Tuberculosis

MHSSP – Meghalaya Health Systems Strengthening Project

MIS – Management Information System

MLHP - Mid-Level Health Providers

MoM – Minutes of Meeting

MO i/c – Medical Officer in Charge

MP – Male Participation

MSACS – Meghalaya State AIDS Control Society

MSRLS – Meghalaya State Rural Livelihoods Society

NCD – Non-Communicable disease

NFHS – National Family Health Survey

NGO – Non Governmental Organization

NHM – National Health Mission

PA – Primary Audience

PHC – Primary Health Centre

PHED – Public Health Engineering Department

PLWHA – People Living With HIV/AIDS

PMU – Project Management Unit

PNC – Postnatal Care

PPP – Public Private Partnership

PSU – Public Sector Undertaking

PTA – Parent Teacher Association

List of Abbreviations

PW – Pregnant Women

PWD – Public Works Department

RBSK – Rashtriya Bal Suraksha Karyakram

RCH – Reproductive Child Health

S-CAP – State Convergence Action Plan

SBCC – Social and Behaviour Change Communication

SC – Sub Centre

SHG – Self Help Group

SRS – Sample Registration System

SUD – Strategic Use of Data

TB – Tuberculosis

UNICEF – United Nations Children's Fund

VEC – Village Education Committee

VHC – Village Health Council

VHIB – Village Health Information board

VHND – Village Health and Sanitation Day

WCD – Women and Child development

WHO – World Health Organization

WRA – Women in Reproductive age

This document is prepared for MHSSP by:

SACH
Society For Action In Community Health

253, 2nd Floor, Shahpur Jat, New Delhi - 110049
Tel.: +91 11 4056 2549, 4611 4888
Email: contactus@sachindia.org
www.sachindia.org

Firstborn Collective LLP
55, 2nd Floor, Lane no. 2, Westend Marg
Saidulajab, South Delhi - 110030