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Sishu O Matru Suraksha

A Social and Behaviour Change Intervention for Child and Maternal Health in **Odisha**

Globally, about 800 women die every day of preventable causes related to pregnancy and childbirth – 20 percent of whom are from India[1]. Though the Maternal Mortality Rate (MMR)[2] reduced from 212 in 2007 to 178 in 2012, there remains scope to save more children and mothers.

Underlying reasons for a relatively high MMR and Infant Mortality Rate (IMR) include social norms relating to health and nutrition, and low demand and access for the same.The intervention led by the Government of Odisha is supported by UNICEF, and aims at strengthening community-based institutions through Social and Behaviour Change Communication (SBCC), leading to better access and utilisation of Reproductive, Maternal, Newborn, Child, and Adolescent health (RMNCH+A) services in the region. Local Non-Governmental Organisations – My Heart and *Parivartan* – implemented the programme in extremely vulnerable sub-centres of Koraput and Malkangiri districts. An enabling environment was created to promote change by leveraging already existing community institutions and events, and improved interpersonal communication tools such as Facts for Life (FFL) videos, storytelling, Mother and Child Protection cards – for adult learning, leading to enhanced knowledge and behaviour change communication skills of key actors. As a result, there has been an increase in the knowledge and communication skills of community influencers, inclusion of women and children from hard-to-reach areas, and an increased involvement of community members for demand and utilisation of health services. Interlinkages between government departments have been established, and capacities of partners involved in this programme have been developed.

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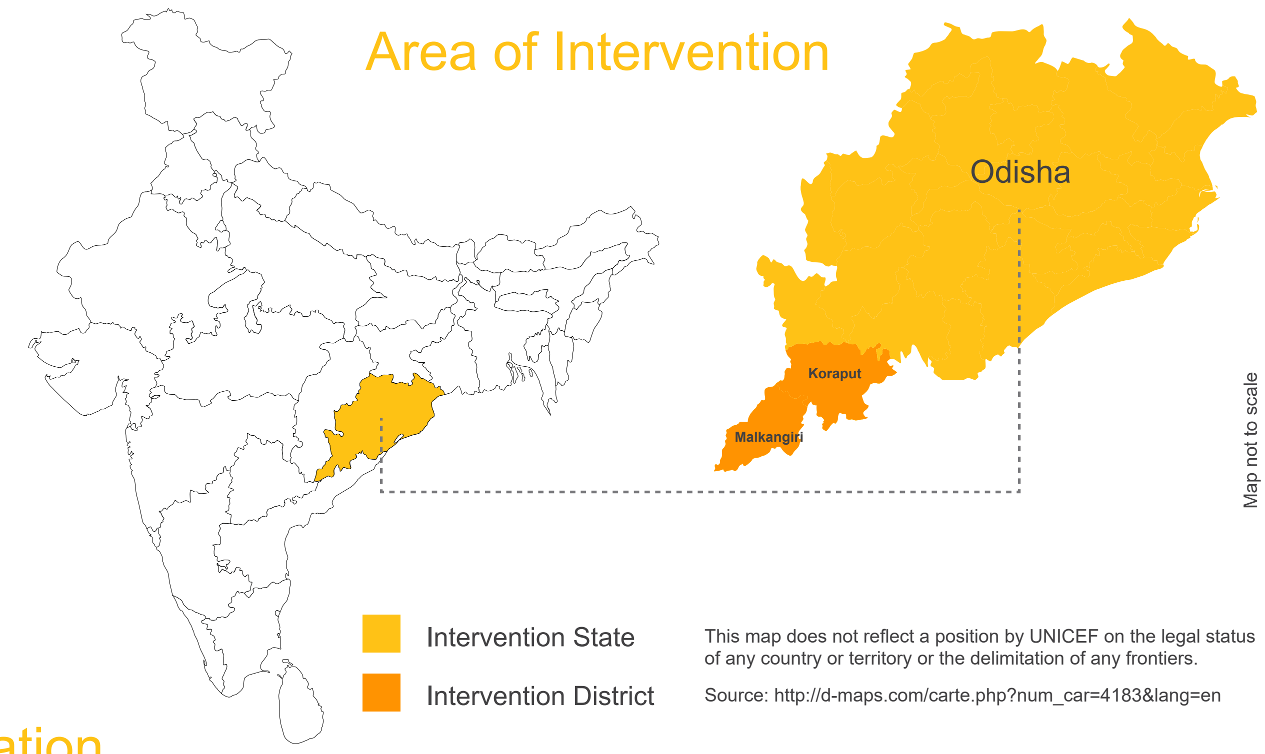


Situation

Odisha is an Indian state located on the south-eastern coast. It ranks low in the Human Development Index (HDI) – 17th in 2011[3]. The IMR[4] and the MMR[5] in Koraput and Malkangiri districts are significantly behind the national average, institutional delivery, and full immunisation coverage.

Table 1: Reproductive and Child Health indicators

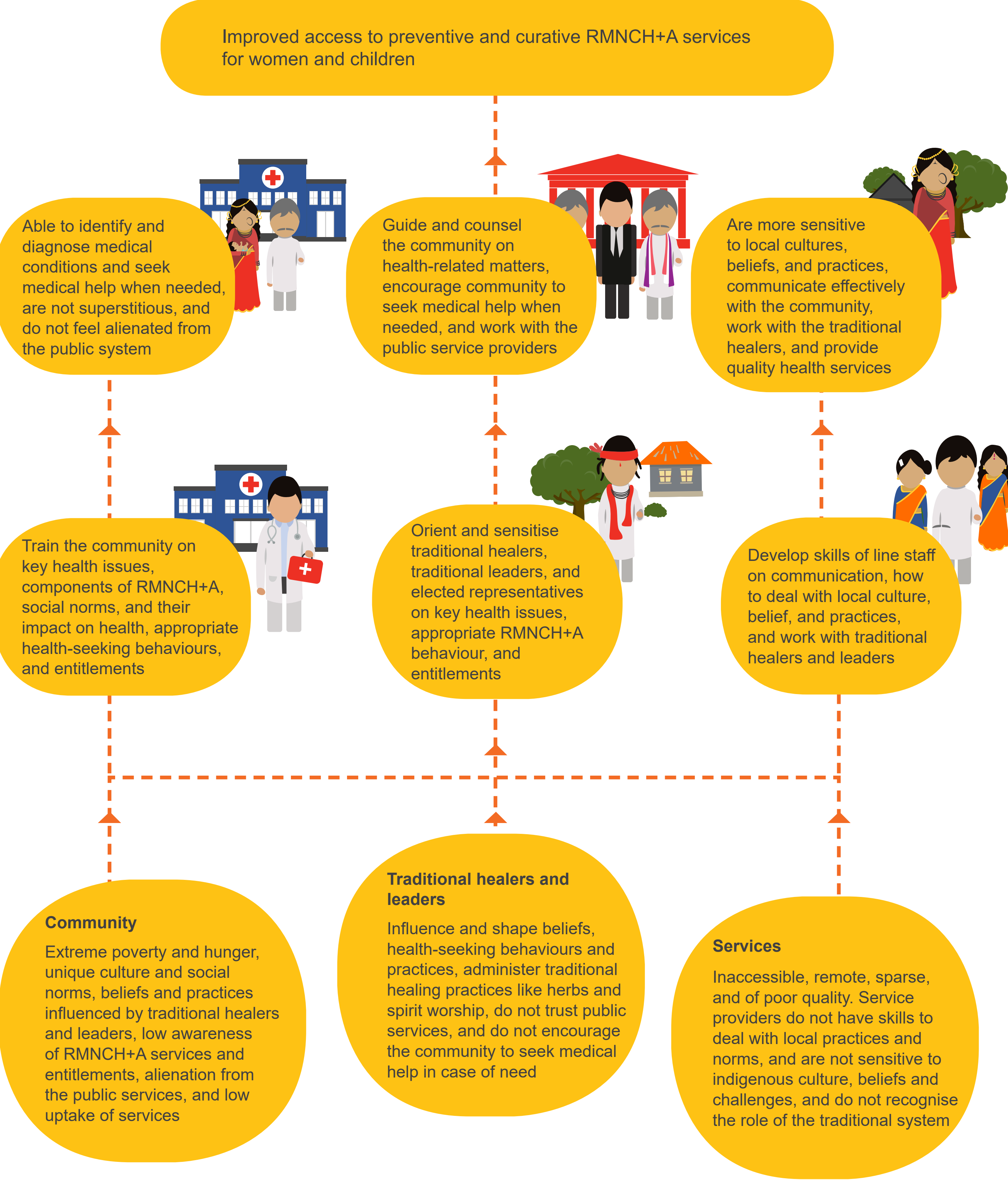
Indicator (2013)[9]	India	Odisha	Koraput	Malkangiri
IMR*	42	53	48	48
MMR**	178	235	245	245
Institutional delivery (%)	78.5	80.8	53.4	52.6
Full immunisation coverage (%)	53.5	68.8	51.6	29.6

Source: Annual Health Survey, 2012-13

*per 1,000 live births
**per 1,00,000 live births

Sishu O Matru Suraksha was based on a partnership between UNICEF, *ASHA* workers, and local NGOs.

Theory of Change



The western region of the state in which these districts are located, is geographically difficult to reach due to underdeveloped infrastructure and Left-Wing Extremist (LWE) groups. These factors make it difficult to deliver public services like healthcare.

The state government has taken steps to improve health infrastructure and delivery, and accessibility of healthcare services in the state. It has classified the government health sub-centres[6] into four categories **(V-1, V-2, V-3, V-4)**[7] based on degree of inaccessibility, presence of LWEs, and characteristics of the service area. Other issues specific to the two districts were:

- Low awareness on the need and availability of RMNCH+A health services among the community. Members of local self-governing and community-based institutions like *Panchayati Raj* Institutions (PRI)[8] and *Gaon Kalyan Samiti* (GKS)[9] lacked adequate understanding about RMNCH+A.
- Cultures, beliefs, and norms guiding health-seeking behaviours of the population. Institutional health workers were not sensitive to the traditional practices related to healthcare. They did not recognise the role of traditional healers (known as *desharis*) within the community, who are the first point of contact for community members.
- Frontline Workers (FLWs) such as Accredited Social Health Activists (*ASHA*)[10] and *anganwadi workers*[11] come from the same communities they serve, with similar beliefs and norms influencing their interactions with the community.

Deshari counseling a mother about her child.

Deshari carrying out routine check up for a child.

Method

To address the above challenges, UNICEF Communication for Development (C4D) and their Nutrition and Health Department complemented the efforts of Government of Odisha and implemented an intervention on Social and Behaviour Change Communication (SBCC). It focused on strengthening service delivery of Maternal and Child Healthcare through demand generation. My Heart and *Parivartan* were the partner organisations (already working with the government) who implemented the programme in Koraput (48 V-4 sub-centres) and Malkangiri (40 V-4 sub-centres) districts respectively in 2014-15. This intervention incorporated learnings from the implementation of a European Civil Protection and Humanitarian Aid Operations (ECHO)[12] funded humanitarian action project, which aimed at increasing institutional deliveries, coverage of full immunisation, and improving management of childhood illnesses.

Learnings from the ECHO project were:

- Frontline Workers (FLWs)[13] require training on behaviour communication skills for service delivery and awareness generation for RMNCH+A services.
- It is important to build capacities of traditional healers and members of self-governing institutions about preventive and curative maternal and child healthcare services and entitlements.
- Need to use adult learning methods to train the identified stakeholders.
- There was low demand from the community due to low awareness about need for health services.

The specific objective of the programme was to improve access to quality health services for women and children by promoting health-seeking behaviour.
In particular, it aimed to:

- Create awareness within the community on RMNCH+A related health services, social norms and their impact on maternal and child health, and their health entitlements.
- Orientation and training of traditional healers and leaders about RMNCH+A related health services, behaviours, and entitlements.
- Develop interpersonal skills of FLWs to improve their service delivery skills.

The community was mobilised through different participatory methods to build rapport and gain support. The programme made use of innovative tools to enhance knowledge and behaviour communication skills of primary stakeholders. These included FFL videos[14] projected using Pico Projectors[15] or shared as Mobisodes[16], and Mother and Child Protection Cards[17] for interpersonal communication. The community was engaged through focus group discussions on healthcare practices for pregnant and lactating mothers and children.

Bimla Bhumia with her son Nabin from the district of Malkangiri.

Action

UNICEF identified and sensitised **community influencers**[18] and tapped them to build upon existing human capital, rather than create a new community of workers. Further, *panchayats*, *Gaon Kalyan Samiti*, Self Help Groups, Village Health Nutrition Day (VHNDs), and Fixed Immunisation Day (FIDs) were utilised as platforms to facilitate maternal and child health related activities and develop other programmes for the village in general.

- More than 4000 traditional healers in Koraput and Malkangiri districts were trained to mobilise and promote healthy behaviour among community members. They were also sensitised to the importance of institutional deliveries, routine immunisation, and proper nutrition among mothers and children, and encouraged to promote the availing of formal medical care during times of ill health.

- FFL videos were used to build behaviour change communication skills in around 6,500 FLWs across the two districts and train them on methods to work along with *desharis* and the local culture. In turn, FLWs also used FFL videos during their home visits to increase knowledge of common childhood illnesses, underlying behavioural issues, and life-saving practices.

- More than 3,000 quarterly GKS meetings were facilitated as a part of the programme. The *panchayat* encouraged families to attend VHNDs and FID, and monitored the actions of the community during these events. Further, community health workers used the FFL videos to disseminate health and nutrition related knowledge.

- GKS and PRI members were sensitised towards their roles and responsibilities related to maternal and child health. They were provided training focused on building their skills to update village health registers and health information boards, schedule and draft village health plans and annual health reports, and better utilise funds. They were also asked to encourage community members to seek formal healthcare.

24-year-old Dalimba Pujari and her 9-month-old son have been supported by UNICEF's MCH programme.

Results

A joint effort by UNICEF C4D and Government of Odisha, the programme has been successful in reaching disadvantaged women, children, key caregivers, and community influencers. Formal and informal health service providers have contributed to the creation of an enabling environment to influence SBCC in health practices[19].

- **Increased knowledge and communication skills of health service providers:** The intervention has helped improve knowledge and communication skills of FLWs and traditional healers. They are now able to communicate with their patients effectively and counsel them on child and maternal health. FLWs are able to deliver their services with support from community influencers. In hard-to-reach areas, traditional healers have started following up with pregnant and lactating mothers and their families, and ensure that they receive appropriate healthcare facilities.

Tulabadi Mahanandia, *ASHA* worker

"Earlier, whenever I used to counsel during trainings, no one paid attention to what I said. Now, they are engaged and there is improved interaction between us because of entertaining videos educating them about maternal and child health. There is better understanding among villagers about it now. We discuss topics like sanitation, diseases like Malaria, facilities like emergency 108 number, etc. Earlier, we used to work alone, but now others like 'desharis' and ward members also support us. 'Desharis' sent us villagers who need help with improving their health. We make plans, conduct regular meetings for GKS and maintain cleanliness in the village. We also give money to people during emergencies and refer pregnant women to hospitals".

- **Building agency of women**: With participation in community activities like GKS and SHG meetings, awareness among women about health practices and services has increased. Women are able to discuss their health issues with formal health service providers, improving health-seeking behaviours and increasing the utilisation of formal health services among them.
- **Increased knowledge of traditional healers:** The programme has increased knowledge and awareness about reproductive, maternal, and child health issues, and healthcare practices among traditional healers. They are also informed of the rights and entitlements of the mother and child, so that they encourage the community to avail these entitlements.
- **Capacity development of partners:** Partner organisations have been able to increase their understanding of the technical aspects of maternal and child health. Their communication skills have become more effective, and they now understand the criticality of SBCC and how to use it to increase programme effectiveness.
- **Interlinkages between government departments:** The programme has leveraged funds, infrastructure, and human resources of various state departments and central government schemes. This includes Department of Health and Family Welfare, Department of Women & Child Development, Department of *Panchayati Raj* Institutions, and Rural Development Department[20].

Radhika Pujari has been with the MCH project for the last three years.

Transformative Change

- **Increased community involvement leading to generation of demand for health services:** Institutions like GKS and PRI have started providing an interactive platform to the villagers to step forward and ask questions, clarify doubts, and present the village's problems. Closer engagement between GKS, PRIs, and the community has also helped to develop an informal monitoring and feedback mechanism. These regular reviews and monitoring have helped establish a system of social accountability at the PRI level. There is now an increase in the number of GKS meetings held, from 89 percent to 94 percent in Koraput and from 65 percent to 80 percent in Malkangiri district. Fund utilisation by GKS has increased from 55 percent to 80 percent in Koraput and 51 percent to 80 percent in Malkangiri district, during the programme cycle 2014-16[21].
- **Referrals to formal institutions and creation of an enabling environment for participants**: Traditional healers motivate villagers to seek help from FLWs who, if needed, refer them to Primary Health Centres (PHCs) for treatment. This has created an enabling environment, thereby increasing the effectiveness of health workers, leading to fewer casualties in the district. Pregnancies registered have gone up drastically, with an increase from 35 percent to 84 percent in Koraput and 50.5 percent to 73.4 percent in Malkangiri[22].
- **Building continuity and consistency into the system**[23]: Ensuring sustainability through transfer of knowledge and practices to the government, the project has been successful in mainstreaming the communication strategy into ongoing government programmes such as National Rural Health Mission (NRHM)[24], Integrated Child Development Services (ICDS)[25], *Sarva Shiksha Abhiyaan* (SSA)[26], *Swachh Bharat Abhiyan,* and actively involving other implementers at the district level. Communication tools and strategies developed by UNICEF C4D such as FFL videos have been adopted by the government in these health schemes.

In Summary

UNICEF C4D, in partnership with the Government of Odisha and local NGOs, facilitated an intervention in Koraput and Malkangiri districts of Odisha. This was done in order to improve the utilisation of RMNCH+A services in the region. Since then, there has been an increase in knowledge and communication skills of community influencers, and greater involvement of community members for demand and utilisation of health services.

Results

Transformative Change

The intervention has successfully mainstreamed the communication strategy into ongoing government schemes, ensuring the sustainability of the project.

References

[1] http://unicef.in/Whatwedo/1/Maternal-Health

[2] the number of maternal deaths per 100,000 live births

[3] http://www.in.undp.org/content/dam/india/docs/orissa_factsheet.pdf

[4] Infant mortality refers to deaths of young children, typically those less than one year of age. It is measured by the infant mortality rate (IMR), which is the number of deaths of children under one year of age per 1,000 live births.

[5] Maternal Mortality Rate (MMR) is defined as the number of maternal deaths per 1,00,000 live births due to causes related to pregnancy or within 42 days of termination of pregnancy, regardless of the site or duration of pregnancy.

[6] In India, Primary Health Centres(PHCs) are the basic first-line units providing primary health care. Each PHC has five or six sub-centres staffed by health workers for outreach services such as immunisation, basic curative care services, and maternal and child health services and preventive services.

[7] V-1-Less vulnerable, V-2-Moderately vulnerable, V-3-Highly vulnerable and V-4-Extremely vulnerable.

[8] The *Panchayati Raj* is a South Asian political system found mainly in India, Pakistan, Bangladesh,Sri Lanka,Trinidad and Tobago, and Nepal. It is the oldest system of local government in the Indian subcontinent and form the third tier of governance.

[9] *Gaon Kalyan Samiti* (GKS) is structured to help the village promote health activities, improve environmental and sanitation standards, seek support for emergency healthcare services, conduct social audits, and set up regular meeting.

[10] Accredited social health activists (ASHAs) is community health workers instituted by the government of India's Ministry of Health and Family Welfare (MoHFW) as part of the National Rural Health Mission (NRHM).

[11] *Anganwadi* workers work for rural mother and child care centre in India in *anganwadi* centres. They were started by the Indian government in 1975 as part of the Integrated Child Development Services programme to combat child hunger and malnutrition.

[12] Headquartered in Brussels, through ECHO, The European Commission aims to save and preserve life, prevent and alleviate human suffering and safeguard the integrity and dignity of populations affected by natural disasters and manmade crises.

[13] The first point of contact among formal health service providers in rural India such as ASHA and ANM.

[14] Series of Facts For Life videos.

[15] Portable, hand held projector which helped to conveniently project videos in remote areas.

[16] Mobisode is a short episode of Fact For Life videos made specifically for viewing on the screen of a mobile phone.

[17] Mother and Child Protection cards are

[18] This includes traditional healers, traditional leaders and members of the self governing bodies.

[19] Based on key informant interviews with stakeholders and programme documents.

[20] The Ministry of Rural Development, a branch of the Government of India, is entrusted with the task of accelerating the socio-economic development of rural India. Its focus is on health, education, drinking water, housing and roads.

[21] DPMU Endline Survey Report

[22] DPMU Endline Survey Report

[23] Based on key informant interview with Odisha UNICEF C4D state representative and programme document.

[24] NRHM is an initiative undertaken by the government of India to address the health needs of underserved rural areas.

[25] Integrated Child Development Services (ICDS) is an programme which provides food, preschool education, and primary healthcare to children under 6 years of age and their mothers.

[26] *Sarva Shiksha Abhiyan* (Education for All Movement), or SSA, is an Indian Government programme aimed at the universalisation of elementary education "in a time bound manner", as mandated by the 86th Amendment to the Constitution of India making free and compulsory education to children between the ages of 6 to 14, a fundamental right.

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