

POSHAN Abhiyaan

Social and Behaviour Change Communication: What is the status one year later?



Surveyor with
mother in
rural Bihar

BACKGROUND

Social and Behaviour Change Communication (SBCC) in nutrition has undergone an exciting journey under Poshan Abhiyaan, India's flagship nutrition programme. One year ago, in September 2018, Poshan Maah was launched as a month-long intensive *Jan Andolan* campaign (or people's movement) with the aim of energizing mothers and communities to practice healthier nutrition behaviours. In March 2019, Poshan Pakhwada was conducted as a two-week intensive campaign to celebrate the anniversary of Poshan Abhiyaan. In addition to these campaigns, Poshan Abhiyaan has made a concerted effort to regularly push behaviour change communication through the year via existing platforms.

Social and behaviour change communication is central to POSHAN Abhiyaan. The current scale of national SBCC programming means that a number of messages are being disseminated through a variety of platforms. This presents an opportunity to refine the SBCC strategy through the collection of evidence on platform/message reach and quality, such that the strategy is even more focused on the right platforms and messages that will most effectively improve knowledge and practice of nutrition behaviours.

This current Brief describes evidence generated for the Ministry of Women and Child Development on SBCC in November 2018 ('Phase I') and in July 2019 (referred to as 'Phase II'). Phase I was conducted across 27 Aspirational Districts across eight states. The objective was to inform programming post Poshan Maah. Phase II was conducted in four states (Andhra Pradesh, Bihar, Gujarat, Madhya Pradesh) with the objective to inform the second Poshan Maah in September 2019, as well as inform long-term programming.

Overall, the results have highlighted that patterns are similar across geographies, but also that there are varying levels of key SBCC indicators across states. This Brief will focus on survey Phase II findings, and where useful, draw comparisons to Phase I.



SUMMARY OF KEY FINDINGS

- **Platform Reach:** Platforms with highest reach are Home Visits, Television, Village Health Sanitation & Nutrition Days, Community-Based Events, and Posters/wallpaintings.¹
- **Recall from Platforms:** Recall of nutrition-related messages is highest from Home visits, Health facilities, and Television. Recall of messages from Community-Based Events and Village Health Sanitation and Nutrition Days is still relatively low.
- **Knowledge and Practices:** Complementary feeding and child dietary diversity knowledge and practices are low.
- **State Variation:** The pattern of effective platforms across states is similar. Each state is at a different level and needs to make varying levels of effort to improve.
- **Counseling Quality:** Frontline health workers are mainly telling women what behaviours to practice. They do not convey the “how” and “why” and sufficient time is often not given.

SUMMARY OF EMERGING RECOMMENDATIONS

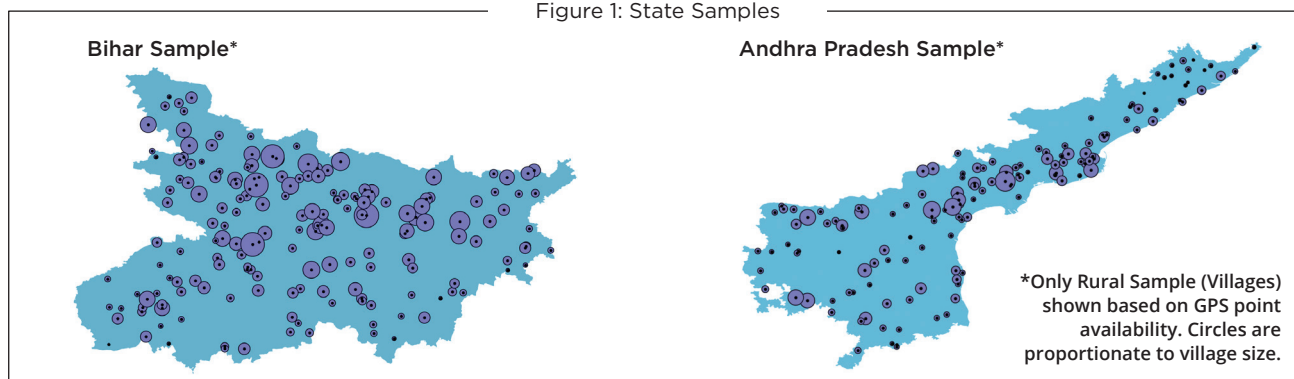
- **Right Platforms:** Prioritise Home Visits, Television, Community-Based Events, and Village Health Sanitation and Nutrition Days in terms of frequency and nutrition message dissemination.
- **Right Messages:** Intensify complementary feeding, child dietary diversity, and hygiene messages.
- **Right Quality:** Improve the quality of nutrition messaging in Community-Based Events and Village Health Sanitation and Nutrition Days (VHSNDs). Emphasise counseling of the “how” and “why” for behaviours by frontline health workers (FHW) across all high reach platforms, including health facilities.
- **Right Targeting:** Increase access of SBCC platforms to poorer, less educated women. Because these disadvantaged women have lower exposure to non-interpersonal communication platforms, the importance of high quality of interpersonal counseling is even greater.

PHASE II SURVEY METHODOLOGY

Objective: In November 2018 a survey was conducted under Phase I and represented 27 Aspirational Districts across eight states in India as a unit. In July 2019 under Phase 2, the survey covered non-Aspirational areas as well and a variety of geographic regions across India. The Phase II findings represent four states as a unit and individually: Andhra Pradesh, Gujarat, Bihar, and Madhya Pradesh. Criteria for state selection included selecting states with relatively high Poshan Maah intensity in order to better determine the effectiveness of platforms, as well as to focus on geographical diversity.

Sampling Design: In each state, 600 pregnant or lactating women (recent mothers of children aged 1 to 24 months) were surveyed residing in approximately 200 villages or wards which are spread across the state (see *Figure 1*)². First, 200 clusters of villages (in rural areas) or wards (urban areas) were randomly selected with the probability of selection proportional to village or ward population. In each village or ward cluster, one ASHA or Anganwadi worker was randomly selected out of all those who serve the cluster. Lastly, three women out of the list of pregnant and lactating women who are registered with the selected FHW were randomly selected and interviewed. Sampling weights, which adjust for disproportionate selection probabilities in the last two stages (ASHA/AWW selection and pregnant and lactating women selection), are applied to all estimates.

Figure 1: State Samples



1. The reach of self-help groups was also measured and further analysis is currently being conducted and can be shared upon request.
2. 5 villages in flooded areas in Bihar were excluded during data collection.



Sample Representativeness: The final sample is representative of pregnant women and mothers of children 1-24 months who are registered on ASHA or Anganwadi lists in each state. The characteristics defining this population may differ from the general population of women targeted by SBCC (which include those not registered with ASHA or AWW). Compared to the general population (NFHS), the population in this study includes a lesser proportion of first trimester pregnant women and a higher proportion of third trimester pregnant women. This population also has higher TV ownership and higher completion of primary and secondary education. As such, some of our point estimates may differ from the general population - this is particularly true in dense urban areas, where registration with frontline workers is less common. Nevertheless, FHW-registered women represent a large and policy relevant group: 70 percent of pregnancies across the four states are registered with a frontline health worker, according to NFHS 2015-16. As such, their experiences with nutrition messaging may serve as a useful benchmark to understanding the reach of these messages.

KEY FINDINGS

1. The top 5 platforms that reach women are: Home visits, Television, Village Health Sanitation and Nutrition Days, Community-Based Events, and Posters. While the relative ranking of platforms are consistent across survey phases as well as across rural and urban geographies, the levels of platform reach differ by large margins.

The very first step in encouraging behavior change through social and behaviour change communication is ensuring the target audience has access to or has interacted with the SBCC platform. The Jan Andolan strategy for Poshan Abhiyaan employs a variety of platforms, ranging from interpersonal and community engagement, mass and digital media, to mid media platforms. The reach of 19 platforms was measured, defined as whether the respondent had been exposed to the platform at least once in the last five months (see Figure 2).

The top 5 platforms with the highest reach were Home visit (81%), Television (69%), Village Health Sanitation and Nutrition Day (66%), Community-Based Event (60%), and Posters, hoardings, or wall paintings (59%). Several other interpersonal communication platforms had high reach as well, such as health facilities (84%) and ASHA mothers' meetings (44%). The bottom 5 platforms were community radio (8%), radio (11%), Facebook (21%), Nukkad natak (24%), and WhatsApp (29%).

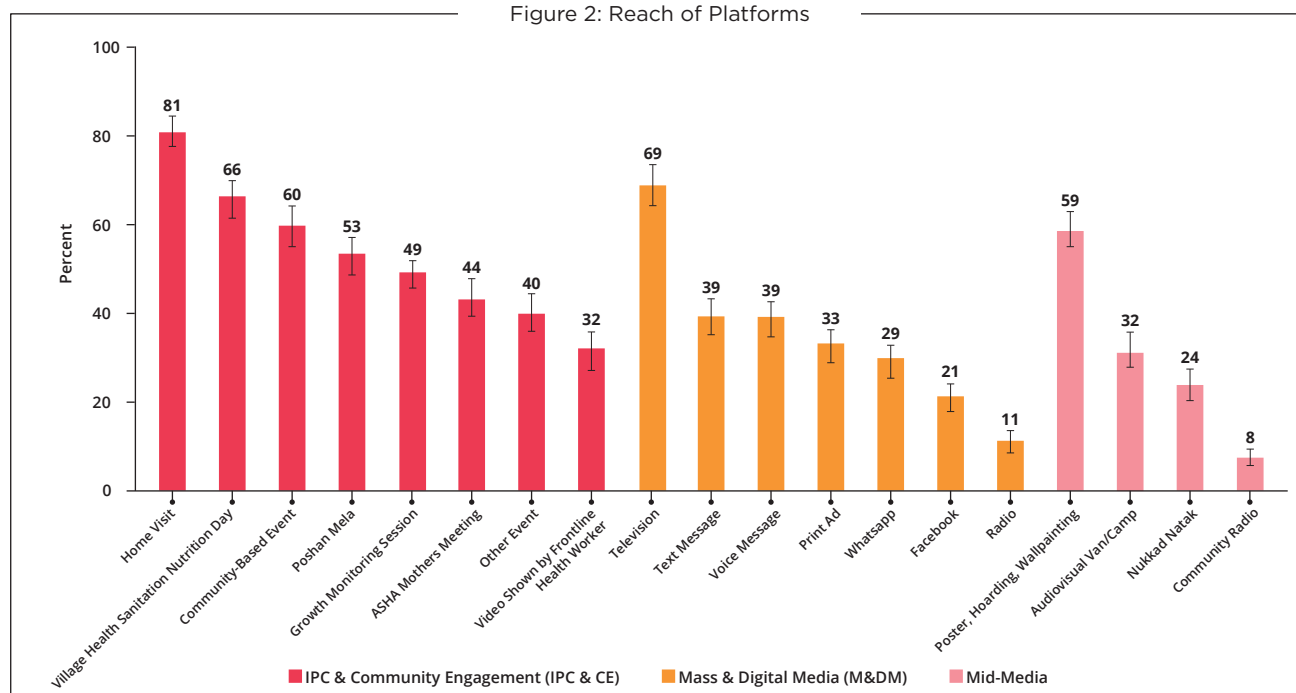


Overall, the top platforms include mass media, mid-media and interpersonal communication approaches. Most of the top platforms are within the category of interpersonal communication, highlighting its importance in reaching women. In comparison to Phase I, the top and bottom platforms are largely the same. Previously, home visits, television, Village Health Sanitation and Nutrition Days, and Community-Based Events were also top platforms and digital and social media platforms were also bottom platforms. Interestingly, posters have a relatively higher reach in Phase II. One possibility for this could be that women in our Phase I survey who reside in aspirational districts are poorer and may miss the posters if posters tend to be placed in busier and relatively less poor town areas. This may also reflect more intensive efforts to increase the reach of posters during Poshan Pakwada.

Overall, certain platforms pushed during Poshan Abhiyaan, such as Community-Based Events, have attained notably high reach. However, others, such as radio or nukkad natak are not well-accessed by the targeted audience of pregnant and lactating women. To some extent these may be determined by varying levels of implementation, but also by technology access or the frequency with which women tend to leave the house. For example, 34 percent of mothers did not own their own mobile phone and 16 percent left their house less than once a month. The large difference in levels of reach of platforms indicate that certain platforms (e.g. home visit) may be more capable of reaching mothers than others.

Of note is that the top and bottom platforms are similar in urban and rural areas and across states. However, among women registered with frontline health workers, urban areas have higher reach of the majority of platforms, especially mass media and digital platforms. Please see figures in Appendix.

Figure 2: Reach of Platforms



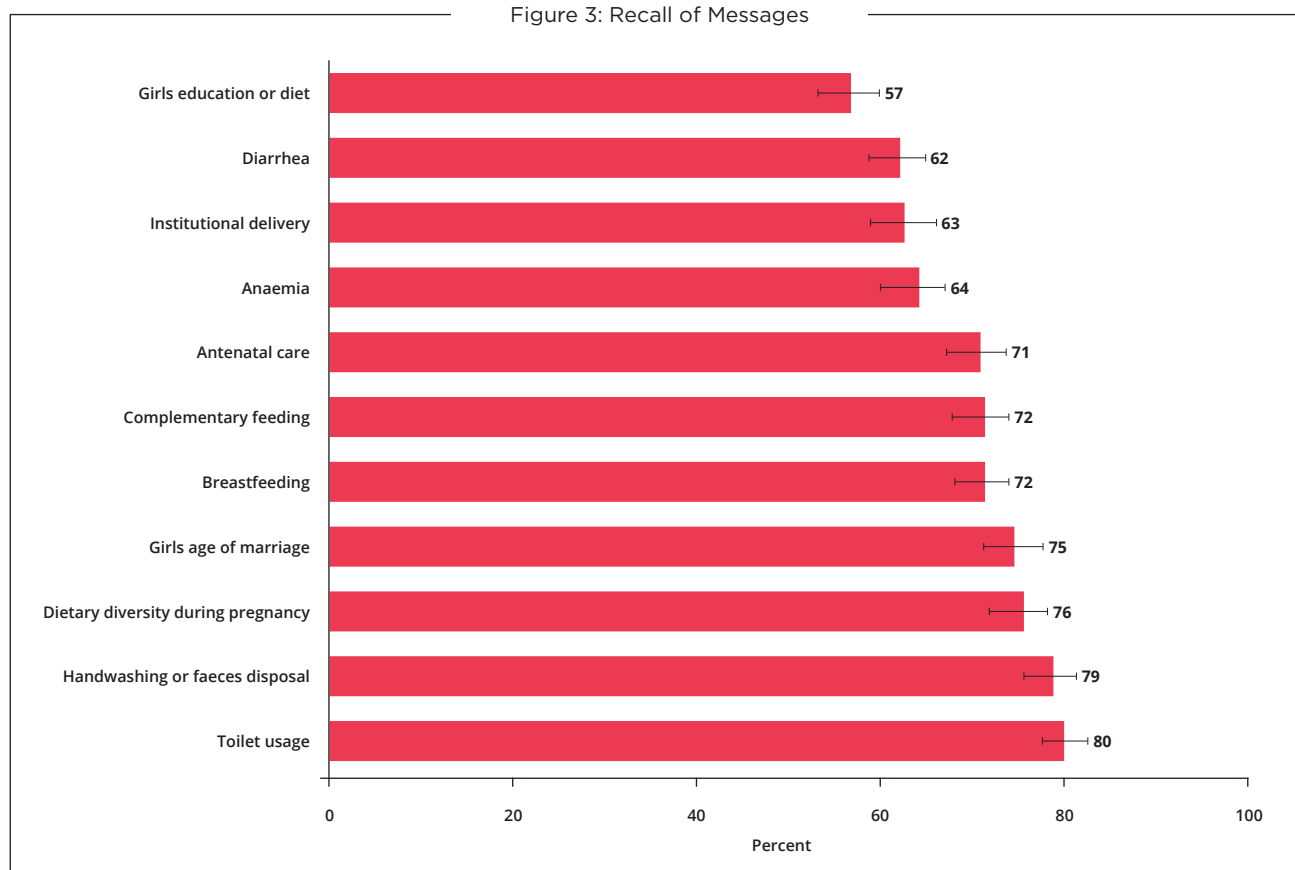
2. Recall levels of nutrition messages are above 50 percent and are comparable to sanitation messaging.

The next step in encouraging behavior change through social and behaviour change communication is ensuring the target audience has recalled nutrition-related messages from SBCC platforms. The Jan Andolan strategy promotes several nutrition-related themes as messages. The recall of 11 messages was measured, defined as whether the mother recalled hearing anything about the topic from any source at least once in the last five months (see Figure 3).

The recall of messages ranged from 57 to 80%. Similar to Phase I, the recall of sanitation messages is still the highest. However, the recall levels of several nutrition messages (such as breastfeeding, complementary feeding, and dietary diversity) have nearly caught up to sanitation messaging. It is important to note that states differ in terms of the extent of recall of messages. For example, in Andhra Pradesh the recall levels of messages range from 70 to 94 percent whereas in Bihar the recall levels range from 43 to 73 percent. Overall, across states the reach of nutrition-messaging is catching up to sanitation messaging, but states differ in terms of the extent of improvement in recall levels needed.



Figure 3: Recall of Messages



3. Platforms vary by recall rate levels - home visits and television have highest recall rates of nutrition-related messages. Overall platform strategy should be informed by their reach and recall rates.

In addition to exposure to platforms, it is important to assess the quality of platforms in delivering nutrition-related messages. It has already been shown that a high proportion of women attending a VHSND suggests that VHSND is a “high-reach” platform capable of reaching targeted women. Yet another key question is whether the platforms are effectively delivering messages. In other words, whether women recall hearing messages specifically from the platform they were exposed to. This was assessed by estimating message “recall rate” of 19 platforms, defined as the percentage of women who recalled hearing at least one nutrition-related message from the platform in the last five months out of the women who had been reached by that platform (see *Figure 4*).

Home visits and television had high recall rates. Out of those reached by home visits, 66 percent recalled hearing at least one nutrition-related message from home visits. Additional platforms that had high recall rates were health facilities and Anganwadi centres.

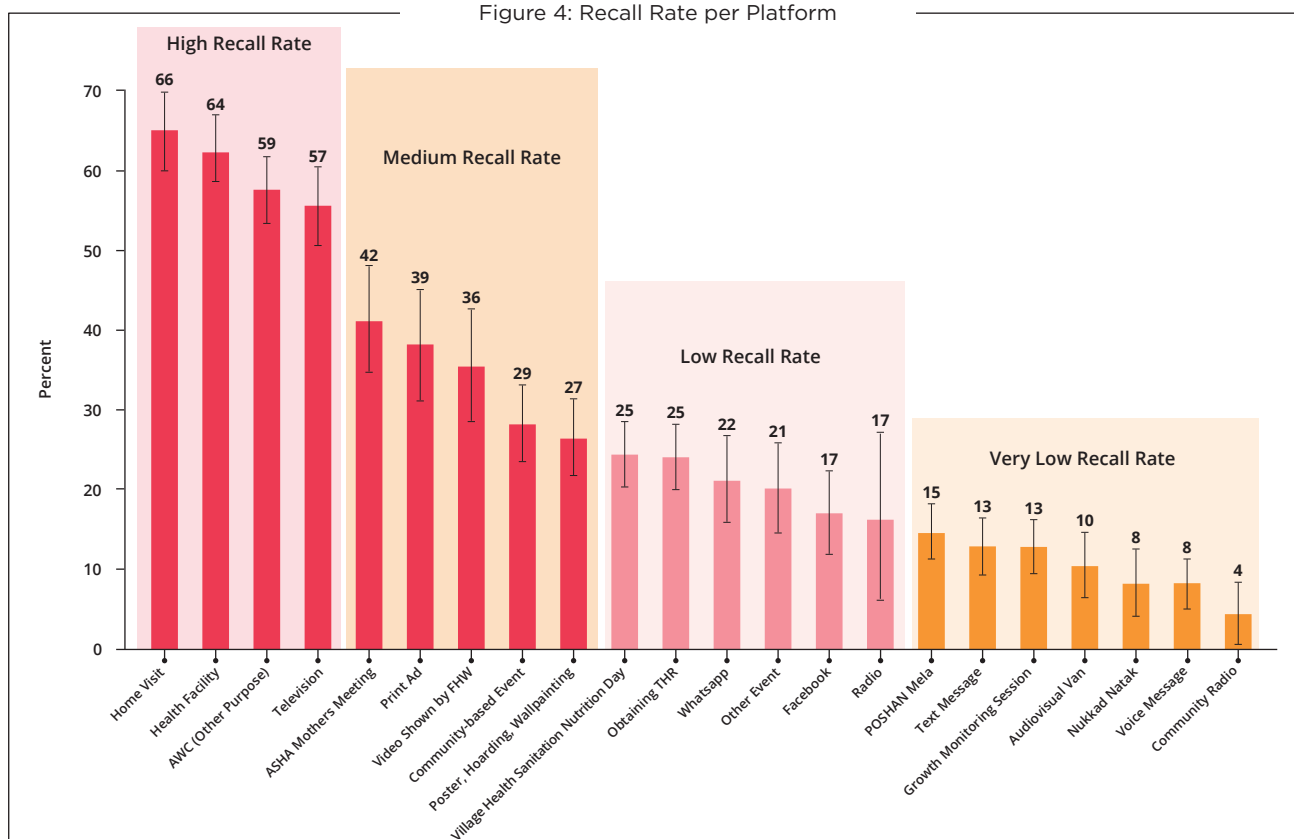
To note is that Community-Based Events and Village Health Sanitation and Nutrition Days had relatively low recall rates at 29 percent and 25 percent respectively. This indicates a missed opportunity in messaging given their high reach. Furthermore, improving the quality of Community-Based Events should particularly be stressed given their primary purpose as a social and behaviour change communication platform for nutrition and increasing reach.

Similar to Phase I, home visits and television have high recall rates. Phase I and Phase II both indicate that the effectiveness of Community-Based Events and Village Health Sanitation and Nutrition Days still needs to be improved, especially given their high reach.

Overall, when considering platforms to prioritise and strategy, it is important to not only consider reach but also the recall rate (see *Table 1*). Platforms designed for nutrition messaging, such as community-based events, with a low recall rate indicate a clear need for quality improvement. Other platforms, such as community radio



Figure 4: Recall Rate per Platform



and nukkad natak may have low recall rates due to several factors, such as implementation levels for nutrition programming as well as effectiveness in generating message recall. However, reach of platforms may be harder to change than quality of platforms. For example, it may be infeasible to increase the reach of digital and social media as mobile phone ownership and internet access are determined by economic factors outside the scope of SBCC programming. Cost-effectiveness of implementing other platforms at scale such as nukkad natak and community radio will also have to be considered. Therefore, the quality of high reach interpersonal communication platforms and other platforms (such as television) may be more amenable to improvement.

Table 1: Reach and Recall Rate of Platforms
Platforms are ranked by reach

| Platform | Reach (%) | Recall Rate (%) |
|---|-----------|-----------------|
| Health Facility | 84 | 64 |
| Home Visit | 81 | 66 |
| Television | 69 | 57 |
| Village Health Sanitation Nutrition Day | 66 | 25 |
| Community-based Event | 60 | 29 |
| Poster, Hoarding, Wallpainting | 59 | 27 |
| Poshan Mela | 53 | 15 |
| Growth Monitoring Session | 49 | 13 |
| ASHA Mothers' Meeting | 44 | 42 |
| Other Event | 40 | 21 |
| Text Message | 39 | 13 |
| Voice Message | 39 | 8 |
| Print Ad | 33 | 39 |
| Audiovisual Van/Camp | 32 | 10 |
| Video Shown by FHW | 32 | 36 |
| WhatsApp | 29 | 22 |
| Nukkad Natak | 24 | 8 |
| Facebook | 21 | 17 |
| Radio | 11 | 17 |
| Community Radio | 8 | 4 |

■ High Reach, High Recall Rate
 ■ High Reach, Low Recall Rate
 ■ Very Low Reach, Very Low Recall Rate

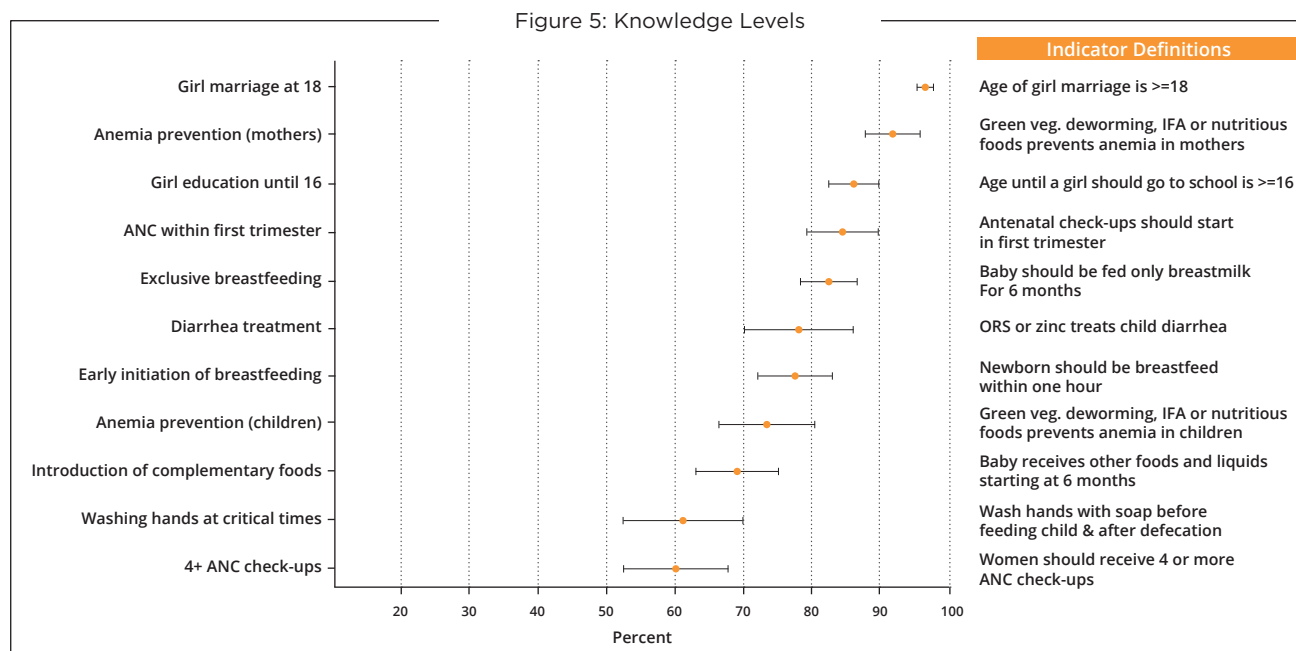




4. Knowledge and practice levels of complementary feeding and child dietary diversity are both low.

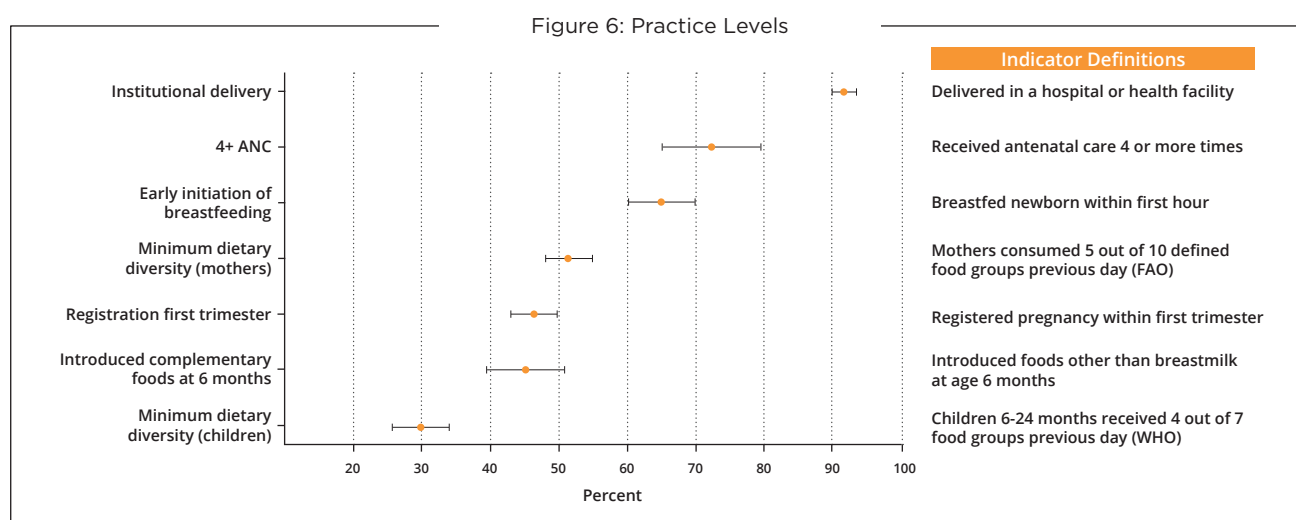
Understanding the current levels of knowledge surrounding the correct practice of behaviors is critical to both assess whether or not SBCC has scope to further improve knowledge as well as highlight which behavior areas are most lacking in knowledge. Knowledge levels of several behaviours were measured (see *Figure 5*), defined as whether the respondent expressed correct knowledge of how to practice the behaviour (e.g. for how many months to only give a child breastmilk). This differed from measuring recall, which only indicated whether the respondent had heard about a general topic such as breastfeeding.

Overall, mothers possessed higher knowledge of behaviours such as girls' issues, antenatal check-ups within first trimester, breastfeeding practices and anemia prevention in mothers. To note is that mothers had substantially higher



knowledge of ways to prevent anemia for themselves than for their children. Mothers possessed lower knowledge of behaviours such as anemia prevention in children, introduction of complementary foods at age six months and handwashing. Overall, the sequencing of knowledge levels from greatest to least is very similar to Phase I and timely introduction of complementary feeding still has low relative knowledge.

Behavior practice among mothers was also measured (see *Figure 6*), defined as whether the mother reported correct practice of the behaviour. Across the behaviors SBCC messaging aims to improve, the



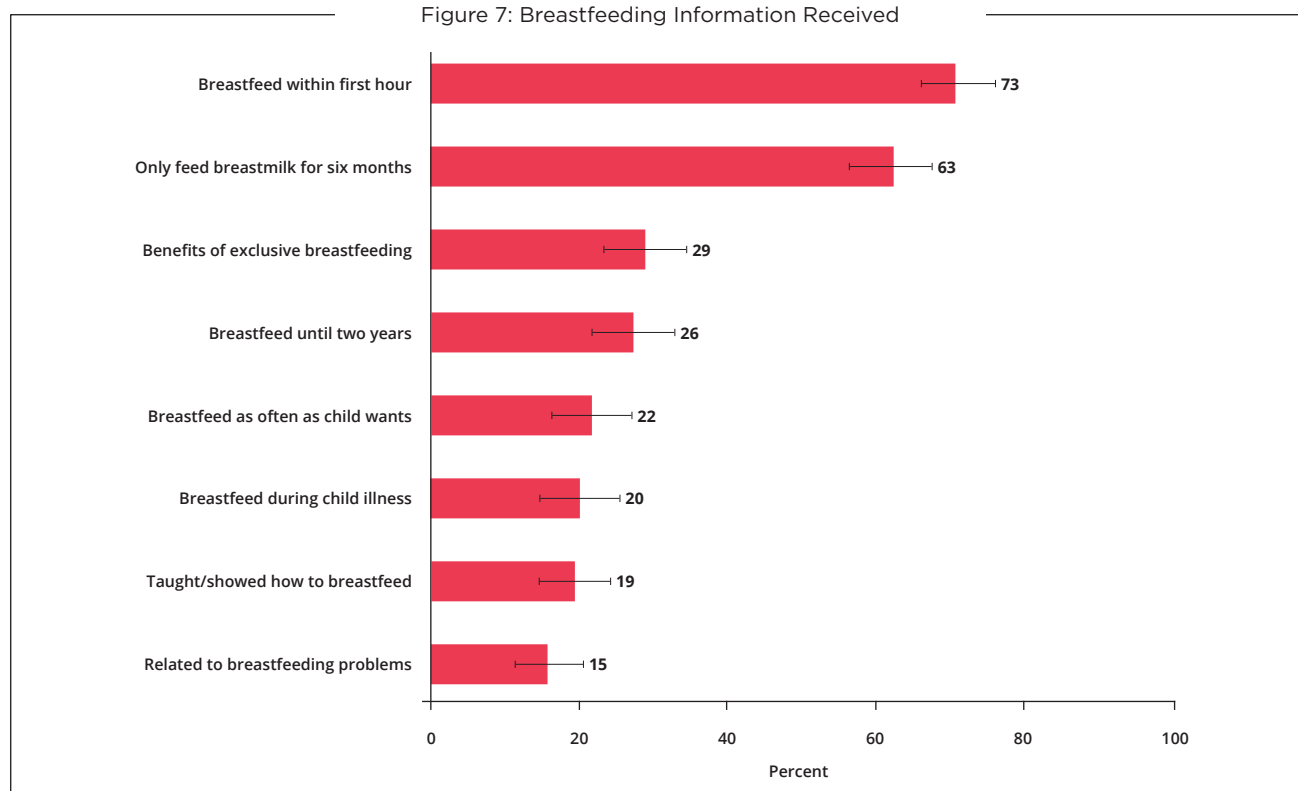


timely introduction of complementary feeding and child minimum dietary diversity have the lowest practice levels.

5. Frontline health workers are mainly telling women how to practice behaviours, but not how or why.

Effective social and behaviour change communication requires quality counseling from frontline health workers. To gauge the quality of FHW counseling, women who had heard about breastfeeding or complementary feeding from frontline health workers were asked about the kinds of information they recalled receiving (see *Figure 7 and 8*). A high percentage of these women were informed by FHW about the behaviours they should be practicing, such as early initiation of breastfeeding, exclusive breastfeeding, or introducing complementary foods at age 6 months.

Figure 7: Breastfeeding Information Received



Counseling messages respondents recall receiving out of those who received breastfeeding counseling from frontline healthworkers



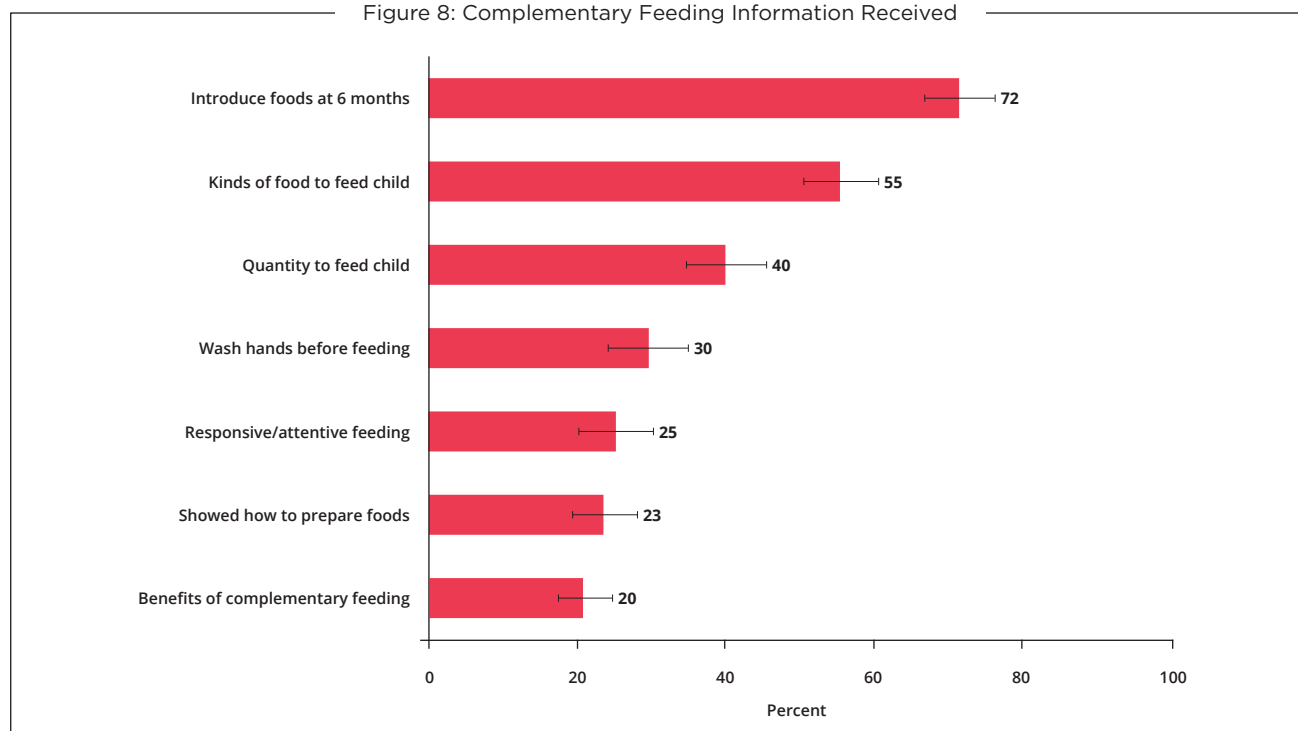
Field Manager
Debendra surveying
an ASHA worker



However, a lower percentage of these women recalled hearing the benefits of these practices. Additionally, a low percentage of women recalled hearing messages related to responsive child feeding and few have been shown how to breastfeed or prepare complementary foods. In order to promote behaviour change, it is important for mothers to not only understand the correct behaviours, but also the importance of these behaviours and how they can practice them.

Furthermore, 39 percent of mothers indicated that they only sometimes/seldom get time to ask frontline health workers their questions and 36 percent of mothers indicated that frontline health workers do not take the time to understand their family or personal context before counseling. Hence, the reason women are not getting all the support they need may be the lack of time frontline health workers are able to spend with them.

Figure 8: Complementary Feeding Information Received



Counseling messages respondents recall receiving out of those who received complementary feeding counseling from frontline healthworkers

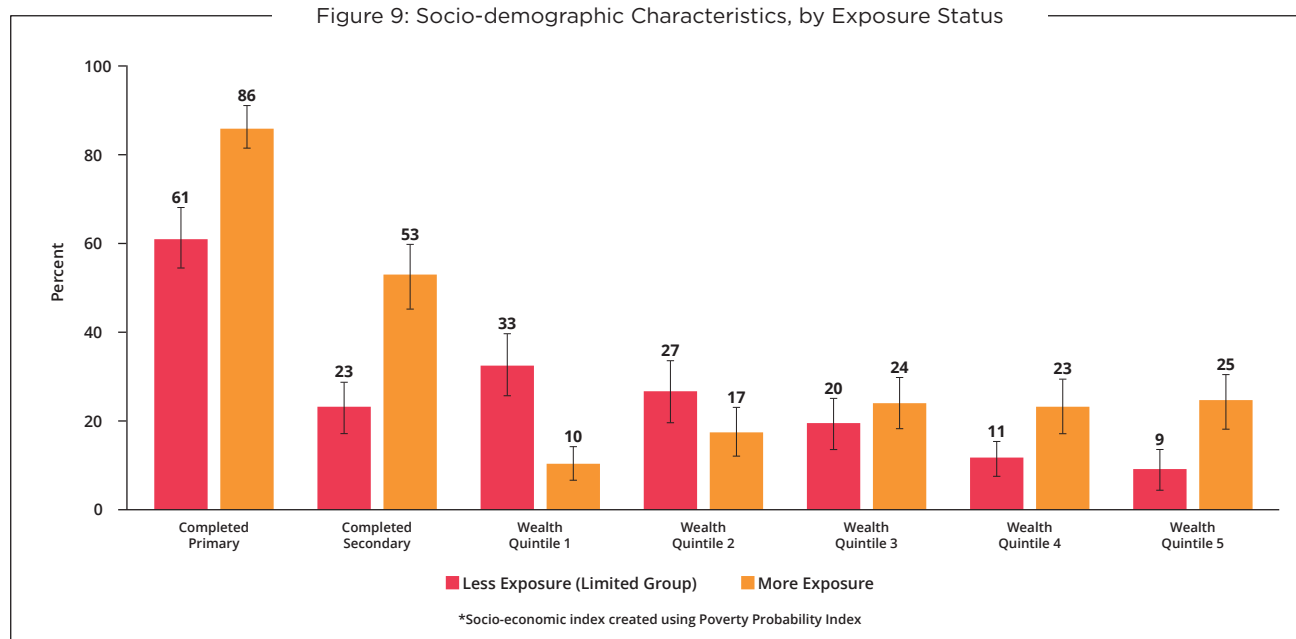


6. Women with less exposure to social and behaviour change communication messaging tend to be poorer and less educated.

Mothers varied in their exposure to social and behaviour change communication programming. Hierarchical cluster analysis, an exploratory statistical technique, was used to identify groupings of women based on similarities or differences in their exposure to the 19 SBCC platforms. Three cluster groupings were found: 46 percent of women on the ASHA or AWW lists belong to the “limited” cluster; these women had limited exposure to the majority of platforms, with the exception of home visits and Village Health Sanitation and Nutrition Days. 31 percent of women had high exposure to interpersonal communication platforms, but low exposure to most digital platforms. 23 percent of women had moderate exposure to interpersonal communication and mobile platforms.³

As compared to women with more exposure, women in the group with less exposure tended to be poorer and less educated (see *Figure 9*). Hence, even within ASHA and AWW lists, women that are poorer and/or less educated have less exposure to these platforms even though the right messaging and support may be more critical for them.

Figure 9: Socio-demographic Characteristics, by Exposure Status



RECOMMENDATIONS FOR POSHAN MAAH AND BEYOND

1. Right Platforms - Prioritise Home Visits, Television, Community-Based Events, and Village Health Sanitation and Nutrition Days in terms of frequency and nutrition message dissemination.

The right platforms should be determined based on both high reach and recall levels. Interpersonal communication platforms (home visits, Community-Based Events, and Village Health Sanitation and Nutrition Day) and Television have high reach. Home visits and television have shown high recall rates of nutrition-related messages. Hence, the recommendation would be to select a few platforms to intensify efforts.

Another recommendation would be to potentially reconsider the strategy of using social and digital media, radio, and nukkad natak. Factors to consider would include the cost-effectiveness and right audience for these platforms. For example, given that household reach of radio is low, this might mean that further investing in mass media platforms such as television would be the more cost-effective approach. Furthermore, although social and digital media have shown low use by pregnant and lactating women, these platforms potentially have higher engagement from frontline health functionaries and may be a prime target audience to focus efforts.

At the national or state level, suggestions for platform operationalisation include incorporating more Poshan Abhiyaan content in television. At the district and block level, activity calendars should allot more frequency to high reach platforms, especially home visits in order to reach as many women as possible.

3. High - > 80 percent; Moderate - 50-80 percent; Low - <50 percent



2. Right Messages – Increase the intensity of complementary feeding, child dietary diversity, and hygiene messages.

Behaviours related to timely introduction of complementary feeding, child dietary diversity, and appropriate handwashing practices still have low knowledge or practice levels. It has been consistently shown that in comparison to breastfeeding practices, the right knowledge and practice of complementary feeding practices is relatively worse off.

For operationalisation, additional content on complementary feeding and child dietary diversity can be added in frontline health worker job aids and the media. Frontline health workers can be trained on emphasising these messages to beneficiaries.

3. Right Quality – Improve the quality of nutrition messaging in Community-Based Events and Village Health Sanitation and Nutrition Days. Emphasise counseling of “how” and “why” for behaviours across all high reach platforms, including health facilities.

Community-Based Events and Village Health Sanitation and Nutrition Days still have lower recall rates of nutrition-related messages. Given their high reach and regular frequency, it is a missed opportunity for disseminating key messages to pregnant and lactating women. Furthermore, in addition to emphasizing the “what” in terms of practicing behaviours such as breastfeeding and complementary feeding. Frontline health workers should also aim to increase mothers’ understanding of the “how” and “why” behind these behaviours. Increased training can also be given to health facility functionaries on nutrition counseling given the high reach of health facilities.

Prior to Poshan Maah, frontline health functionaries can be trained on how to conduct Community-Based Events and delivering counseling. Emphasis should not only be placed on holding these events and calling beneficiaries, but also on the kinds of messages delivered during these events and connecting well with the beneficiaries.

4. Right Targeting – increase access of SBCC platforms to poorer, less educated women.

Poorer and less educated women have less exposure to most SBCC platforms, with the exception of exposure to home visits and Village Health Sanitation and Nutrition Days.

In order to ensure that nutrition messages are reaching these women, frontline health workers should prioritise delivery of messages through home visits. The fact that poorer and less educated women are reached much more through home visits and Village Health Sanitation and Nutrition Days suggests that these platforms are even more important for high quality interpersonal counseling towards certain segments of women. Furthermore, better training and monitoring of participation at all platforms where frontline workers are present could be useful. Frontline health workers can be trained on the importance of targeting less educated and poorer women, and participation of women from lower socio-economic groups can be separately included in monitoring reports.



Surveyor with a lactating mother in rural Andhra Pradesh

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Surveyor with a mother in Uttar Pradesh, Phase I

APPENDIX

Figure 1: Reach of Platforms in Urban vs Rural - Among Women in FHW Lists

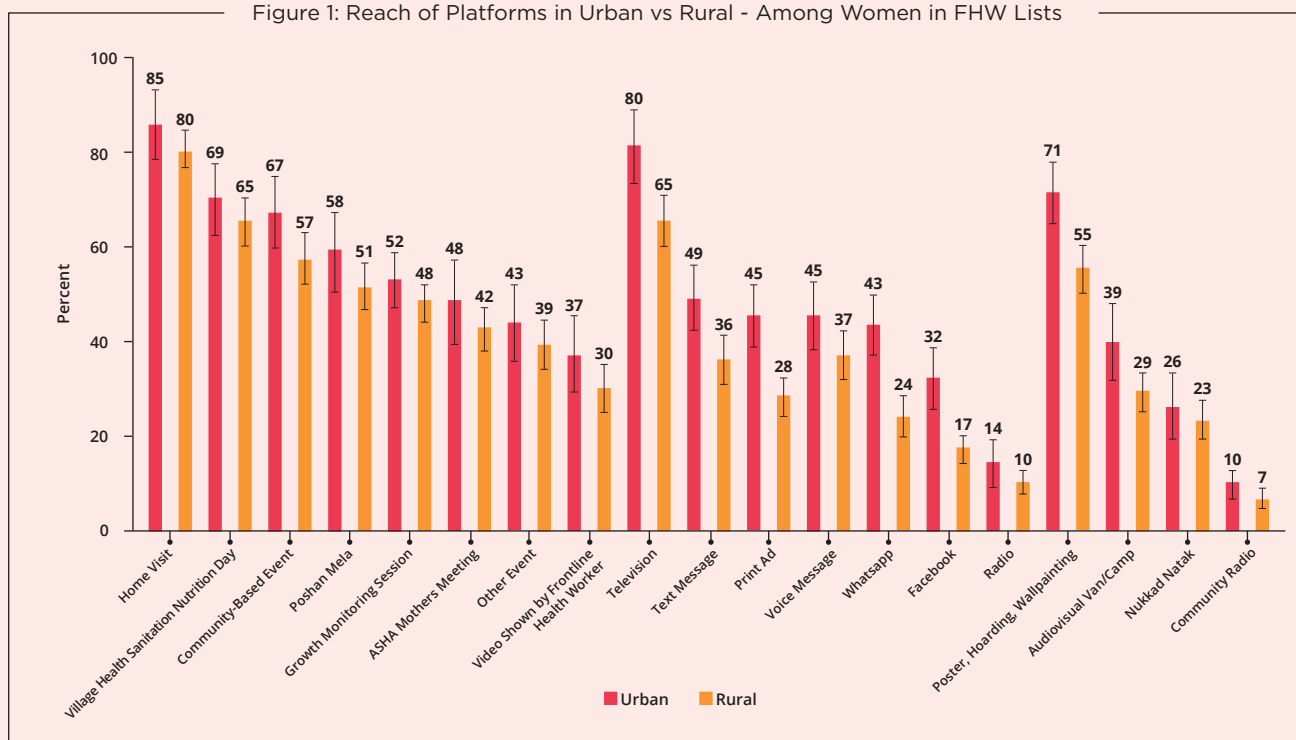


Figure 2: Rank of Platforms by Reach in Each State, Out of 19 Platforms

| | Home Visit | TV | VHSND | CBE | Poster, Hoarding, Wall Painting | Poshan Mela | Growth Monitoring Session | ASHA Mothers Meeting | Other Event | Text Message | Voice Message | Print Ad | Audio Visual Van or Camp | Video Shown by FHW | Whats App | Nukkad Natak | Facebook | Radio | Community Radio |
|----------------|------------|----|-------|-----|---------------------------------|-------------|---------------------------|----------------------|-------------|--------------|---------------|----------|--------------------------|--------------------|-----------|--------------|----------|-------|-----------------|
| Bihar | 1 | 3 | 2 | 6 | 5 | 7 | 9 | 10 | 11 | 8 | 4 | 15 | 12 | 17 | 14 | 13 | 16 | 18 | 19 |
| Madhya Pradesh | 1 | 3 | 2 | 4 | 7 | 5 | 6 | 9 | 8 | 10 | 15 | 12 | 11 | 16 | 14 | 13 | 17 | 18 | 19 |
| Gujarat | 1 | 3 | 5 | 4 | 2 | 8 | 6 | 7 | 13 | 9 | 10 | 14 | 11 | 16 | 12 | 15 | 17 | 18 | 19 |
| Andhra Pradesh | 2 | 1 | 6 | 3 | 5 | 4 | 10 | 9 | 8 | 12 | 13 | 11 | 15 | 7 | 14 | 17 | 16 | 19 | 18 |

■ Higher Reach (1-7) ■ Medium Reach (8-14) ■ Lower Reach (15-19)