OPERATIONAL GUIDELINES FOR BEHAVIOR CHANGE COMMUNICATION (BCC)

1. Background and Introduction

Malaria is a public health problem in India but is preventable and curable. Controlling/eliminating malaria would immensely contribute to alleviate poverty, improve equity and overall development. Interplay of numerous biological, ecological, socio-economic and behavioral factors determines the intensity of disease transmission; who is infected; who gets sick and who dies. Malaria is referred as both a disease of the poor and a cause of poverty since the marginalized, poorer sections, in hard to reach rural areas, with low socio-economic status, limited access to quality health care, communication, other basic facilities, are often the worst sufferers. The difficult terrain, ethnic diversity with a wide-ranging socio-cultural traditions & institutions, migrant and mobile populations as well as problems relating to socio-political situation (like ethnic conflicts, insurgency), etc. complicate the situation. At the same time, the individual, the family and the community at large in these areas are yet to be entirely empowered with knowledge and mobilized for responsive behaviour.

Recognizing the fact partnerships remain one of the key strategic steps towards malaria elimination, the National Vector Borne Diseases Control Programme (NVBDCP) – the nodal organization in the fight against malaria of the Directorate General of Health Services, Ministry of Health & Family Welfare, Government of India, encouraged and fostered partnerships with civil society under the Global Fund (GF) supported Intensified Malaria Control Project-II (IMCP-II) [2010-15]. A civil society consortium led by Caritas India expressed their commitment and passion to achieve common goals & objectives and initiated service delivery from 2011, majorly in difficult-to-reach areas in seven northeastern states, complementing the efforts of the NVBDCP and the State Vector Borne Disease Control Programmes. Tribal population predominantly inhabits the coverage areas (up to 98%) that are also fraught with constraints particularly relating to yet to be optimal health care delivery systems, basic amenities, communications, socio-political scenario & variable health seeking behavior.

Further support by the Global Fund as well as continued domestic investments launched Intensified Malaria Control Project-3 (IMCP-3) in north eastern states and Odisha for the period 2015-17 to consolidate the response to malaria control towards elimination as envisioned in the National Strategic Plan for Malaria Control 2012-17. Caritas India was conferred an approval by the Global Fund and India-Country Coordinating Mechanism (CCM) for implementation of IMCP-3 in seven NE states as well as Odisha as continuing Principal Recipient (PR) in partnership and coordination with the NVBDCP, State VBDCPs. The Caritas India Consortium has FBOs, NGOs, as Sub Recipients (SRs), Sub-Sub-recipients (SSRs). In addition, community networks, Village Health Sanitation & Nutrition Committees, Tribal Councils, PRIs, Gram Kalayan Samitis, Self Help Groups, women/youth groups, amongst others, who are also partners for supporting specific interventions at community level in difficult-to-reach areas.

The IMCP-3 aims to reduce malaria related mortality by at least 50% and morbidity by at least 50% in project areas (in 08 states) by 2017 as compared to 2012 and contribute to achievement of national goals and Sustainable Development Goals (SDGs).

Expected impact:

- Confirmed malaria cases (microscopy or RDT) per 1000 persons (API) per year declining by at least 50% by 2017 relative to baseline in 2012.
- Number of confirmed malaria deaths declining by at least 50% by 2017 relative to baseline in 2012.
- Total positivity rate (microscopy + RDT) declining by at least 50% by 2017 relative to baseline in 2012.

The objectives are to: 1) achieve near universal coverage (80%) by 2017 by effective preventive intervention (Long Lasting Insecticidal Net-LLIN) for population living in high risk project areas (API>1); 2) achieve near universal coverage (80%) of fever cases by correct, affordable and appropriate parasitological diagnosis; and prompt, effective treatment according to the national drug policy in project areas by 2017; 3) achieve 100% coverage in project areas by appropriate BCC activities to improve knowledge, awareness and responsive behaviour regarding effective preventive and curative malaria control interventions by 2017; 4) strengthen surveillance and M&E, program planning and management, and coordination and partnership development to improve service delivery in project areas by 2017; and 5) strengthen health systems, community systems through capacity building (training) to improve service delivery in project areas by 2017.

Expected outcome:

- Proportion of population that slept under an insecticide-treated net the previous night.

- Proportion of children under five years old who slept under an insecticide-treated net the previous night.
- Proportion of pregnant women who slept under an insecticide-treated net the previous night.
- Proportion of persons reporting fever within last two weeks, who have obtained a test result (RDT/microscopy) within 24 hours of reporting to health care system/provider.
- Proportion of people who know about the cause of, symptoms of, treatment for and preventive measures of malaria.

Target Groups/Beneficiaries: The focus of IMCP-3 continues in areas with high disease burden, problems of accessibility, ethnic diversity, and socio-political challenges. Caritas India Consortium is covering approx. four million people in 46 districts (out of 119 districts northeast states and Odisha). Details of coverage are presented in Table-1 below.

	# of State	# of dist.	# of block	# of village	Male	Female	Total Population
NE states	7	40	178	5718	13,03,082	12,51,981	25,55,063
Odisha	1	6	21	2000	5,25,557	5,04,946	10,30,503
IMCP-3 Total	8	46	199	7718	18,28,639	17,56,927	35,85,566

The target group/beneficiaries include marginalized groups, tribal population, and women and children and other key population like Jhum cultivators (shifting cultivators); forest workers; & migrant and mobile populations (especially in border areas). Most malaria cases and deaths probably occur among these key populations, as malaria transmission is intense in areas inhabited/frequented by them. Hence, they remain central in the fight against malaria.

An outline of strategy, prioritized modules and interventions with related performance indicators (coverage/output), activities as per the IMCP-3 performance framework under above-mentioned objectives is presented below.

Objective 1: To achieve near universal coverage (80%) by 2017 by effective preventive intervention (LLIN) for population living in high risk project areas (API>1).

Strategy: Vector control; Module: Vector control

Interventions:
- Long-lasting insecticidal nets (LLIN) – Mass campaign

Expected coverage/output:
- Number of long-lasting insecticidal nets distributed to at-risk populations through mass campaigns.

Activities:
- Support to PR1 in household survey; Coordination & micro-planning; Receipt of LLINs from District VBDCP, Storage, transportation, distribution, pre- & post-distribution BCC, recording/reporting, continued monitoring to ensure use

Objective 2: To achieve near universal coverage (80%) of fever cases by correct, affordable and appropriate parasitological diagnosis; and near universal coverage (80%) of malaria cases by prompt, effective treatment according to the national drug policy in project areas by 2017; &
Objective 3: To achieve 100% coverage in project areas by 2017 by appropriate BCC activities to improve knowledge, awareness and responsive behaviour regarding effective preventive and curative malaria control interventions.

Strategy: Early diagnosis and complete treatment; Module: Case management

Interventions:
- IEC/BCC.
- Private sector case management
- Other

Expected output/coverage:
- Proportion of reported fever cases suspected of malaria that received a parasitological test at community level (CHV level)

- Proportion of confirmed malaria (Pf positive) cases that received ACT according to national policy at community level by non government community health volunteers (CHVs)

Additional expected output/coverage:
- Number of health camps held in selected hard to reach areas in the districts of PR2.
- Number of villages covered by infotainment activity.
- Number of villages covered by public announcements (miking) activity.
- Number of villages covered by community consultation and message dissemination activity.
- Number of people reached through community consultation and message dissemination activity.
- Number of local schools covered by activities.
- Proportion of private health care service providers trained/re-trained on national malaria treatment guidelines and reporting by PR2.

Activities:
- Use of RDT/slide for diagnosis and antimalarials including ACT-AL for treatment (per national guidelines)
- Pharmaceutical & health product management (PHPM) - Receipt of RDT/slide, antimalarials from District VBDCP, maintenance of stock registers at district, FS levels, simple stock record at CHV level
- Health camp in selected hard to reach areas prior to/during transmission season
- BCC and community mobilization
- Mapping & training of private healthcare service providers followed by case reporting; Updating & dissemination of curriculum/modules
- Support to NVBDCP in QA of RDTs through NIMR/WHO

Objective 4: To strengthen surveillance and M&E, program planning and management, and coordination and partnership development to improve service delivery in project areas by 2017.

Strategy: Surveillance and M&E; Module: Health Information Systems and M&E

Interventions:
- Routine reporting.
- Analysis, review and transparency.
- Other

Additional expected output/coverage:
- Proportion of routine reporting units - villages submitting monthly reports (M1 Form) to identified Reporting Units per set timelines (through M4 by Field Supervisor).
- Proportion of Field Supervisors submitting completed FS Reporting Form monthly to the DPMU per set timelines
- Proportion of DPMUs submitting monthly completed district wise MIR & MLR as a single report to (respective) RPMU/SPMU per set timelines
- Number of supervisory visits monthly by District Project Officer to community level (village level) and report submitted to (respective) RPMU (Regional Project Manager) or SPMU (State Project Coordinator)
- Number of supervisory visits monthly by Field Supervisor to community level (village level) and report submitted to (respective) DPMU
- Number of FSs participating in monthly planning and review meeting held by DPMU per set timelines
- Number of CHVs participating in quarterly planning and review meeting held by FS per set timelines
- Proportion of village (CHV) MIS forms - M1 forms including 'nil' report uploaded on Project MIS by DPMU (as submitted by FS) per set timelines

Activities:
- Surveillance and M&E
    - Management of MIS – web based/paper based
    - Submission of monthly data from village to identified Reporting Units (PHC/CHC/Hospital) for integration under national HMIS; analysis & synthesis
- Review and planning: Joint reviews, workshops with NVBDCP, State/District VBDCPs/PHC & CHC, partners, others
- Impact evaluation

Strategy: Technical guidance, programme management; Multi sectoral collaboration; Module: Program management; Coordination and partnership building

Interventions:
- Policy, planning, coordination and management.
- Grant management.

Activities:
- Stakeholder consultations, engagement
- Cross border meetings
- Reports, newsletters
- Technical inputs; programme management (including SR management); management of TA to NVBDCP

Objective 5: To strengthen health systems, community systems through capacity building (training) to improve service delivery in project areas by 2017.

Strategy: Institutional strengthening & capacity building; Module: Health and community workforce

Interventions:
- Health and community workers capacity building.

Expected output/coverage:
- Number of ASHAs/CHVs trained/re-trained

Activities:
- Training/re-training of ASHA/Community Health Volunteers
- Updating & dissemination of curriculum/modules
- Training of trainers

Overall, IMCP-3 structures are as under:
- 7,718 Community Health Volunteers (CHVs) [with SRs & SSR per 01 village].
- 500 Field Supervisors (with SRs & SSR per 16-25 villages & per 1-16 identified Reporting Units, namely, Sub centre, PHC/CHC/District).
- District PMUs (with SRs & SSR per 1-5 districts)
- State PMUs (SPMU) [01 SPMU with SR - SSSS & 01 SPMU with SR-Lepra Society).
- Regional PMUs (RPMUs) [PR2-Caritas India for in NE states – Guwahati, Shillong]; [01 RPMU with SR-VHAI – Guwahati].
- Central Project Management Unit (PMU) [PR2-Caritas India - New Delhi]; [01 Central PMU with SR-VHAI – New Delhi]

2. Behaviour Change Communication (BCC)

Behaviour Change Communication (Behaviour Change Communication) is a systematic process that motivates individuals, families, communities, to change inappropriate or unhealthy behaviour or to continue appropriate or healthy behaviour. BCC as a supportive strategy is an integral part of the National Vector Borne Disease Control Programme (NVBDCP) of the Government of India, towards bringing behavioural change through enhanced awareness and empowering people with correct information and encouraging them for responsive behaviour within an enabling environment.

Behaviour Change Communication (BCC) is defined as research-based, consultative process of addressing knowledge, attitudes, and practices through identifying, analyzing, and segmenting audiences and participants in programs and by providing them with relevant information and motivation through well-defined strategies, using an appropriate mix of interpersonal, group and mass-media channels, including participatory methods.[1]

BCC thus, is about understanding the communities, contexts and environments in which behaviours occur. The BCC activities uses dialogue, messages, persuasion, interpersonal and group communication as a means of exchanging information, ideas, skills and values aimed at bringing about behaviour change or adoption of

[1] Neill McKee, Erma Manoncourt, Chin Saik Yoon, Rachel Carnegie. Ed. 2000. Involving People, Evolving Behaviour. Co-published by Southbound, Penang and UNICEF, New York.

safe behavior. The BCC activities also emphasize on identifying and deconstructing the myths and misconceptions (if any) and provide complete and correct information about the disease to the community.

In malaria control/elimination domain, BCC is employed to ensure universal access to appropriate, accurate, timely and socio-culturally and other context-specific information about malaria control and its management in a manner coordinated across partners, so that effective behaviour change is achieved at the individual, family and community level. A strategic approach with a blend of advocacy, communication and social mobilization guide the multifaceted activities under IMCP-3 towards realization its goal, objectives.

Under IMCP-3, locale- and context-specific channel-mix would be attempted with special emphasis on inter-personal communication, mid media programmes focused on community outreach (group communication). The operational guidelines here would majorly focused on key BCC activities included in the project.

Purpose of BCC operational guidelines: The purpose of this dynamic document is to describe opearational guidelines for BCC activities for the Principal Recipient 2 (PR2) consortium comprising Caritas India and SRs, SSR. The guidelines would provide clarity on conduct of BCC activities.

2.1 Guiding Principles

- BCC activities play an important role in making the project/programme a success. BCC would inculcate participatory approaches to foster ownership, self monitoring and ensure sustainable end results.
- Evidence-based planning and implementation by understanding situation, barriers and influences, responding to concerns, emphasizing benefits of the desired behavior; the needs of individuals, families, communities, care providers.
- BCC objectives would be aligned with program objectives.
- BCC enhances knowledge and awareness about LLIN and promote usage, uptake of Indoor Residual Spraying (IRS) and early diagnosis and complete treatment.
- Each BCC activity - Infotainment, Public announcements (miking) and Community Consultation & Message Dissemination (CCMD), should be conducted in each village once in a year.
- In each district, 10 schools would be covered for sensitization & creating change agents.
- Advance micro-plan for BCC activities to ensure maximum community participation.
- BCC activities should be conducted within a minimum gap of one week in the same village. No two activities should be conducted together in one village.
- Communication would be carried out through umbrella campaign; focused localized campaign, and routine activities on ground initiatives. Emphasis would be on:
  - Providing a steady flow of information on priority behaviour through locale- and context-specific channel-mix targeted to the right audiences and using the right tools and channels at right times.
  - Ensuring continuity, which is critical for recall.
  - Assigning higher weights before and during transmission season.
  - Sustaining a positive message in front of key audiences and countering negative messages/stories.
  - Publicizing achievements and success stories.
  - Targeting key population viz. women and children, as critical audience.
  - Clarity regarding: five Ws: 1) What: the specific behaviour/action aimed at; 2) Who: the target - care taker/care provider/policy maker; 3) When: the time frame; 4) Where: the site; and 5) Why: the overall purpose. In addition, “how” or the approach/mode would also be an inherent component.
- In all the activities, CHVs should be introduced as supportive hand of ASHA, ANM for providing services in the community.
- Messages should be drafted keeping in mind the local context and dialect/language. Messages should be simple, clear and effective targeting specified behavioral outcomes [with special emphasis on dynamics of communities, key populations (“high-risk” population sub-sets) - pregnant women, children under 5, school going children, farmers staying in the field, persons moving within and outside country that are often most at risk; and care givers].
- All scripts for infotainment/miking should be ready before activities and appropriate endorsement should be taken.
- Use appropriate BCC materials (flip books, puzzles, games, etc.) as aids.
- Field Supervisor should be part of the BCC activities at all levels from planning till its execution.
- CHVs and FSs should be trained to take proper signatures, thumb prints of the participants. S/He should be well acquainted with all the BCC Input forms and must know how to fill these forms.
- BCC Input Forms and supporting documents must bear the certification from the school authority/principal/village headman/village leader, etc. (sign and seal).

- Proper documentation of the BCC activities should be done – a brief report highlighting the experiences and case studies accompanied by good quality pictures.
- M&E would be part and parcel of the BCC activities. A logical framework (Input-Process-Output-Outcome-Impact) would be applied. Set output/coverage indicators should be tracked. Outcome indicators would be gauged through survey.
- Caritas India Consortium teams would work closely with: NVBDCP—the PR1, to harmonize approaches and methodologies, work plans, activities; share learning, best practices, innovations.

2.2 Target Audience

Target audience segmentation corresponding to those to whom the messages would be targeted disaggregated by demographic/political/socio-cultural/economic profile, is critical. An overview of target audience that would be reached is presented in Table-2 below.

Audience	Description
Primary	People to whom BCC is targeted and within whom responsive behaviour is expected. a) Individual, family; emphasis on pregnant women, migrant and mobile worker; b) Schools (Children, Teachers); [Same groups may constitute the secondary audience depending on the target behaviour, messages].
Secondary	People who directly relate to the primary audience through frequent contact and who may either influence or impede behaviour change amongst the primary audience. BCC would target these people directly for expected changes in the primary audience. a) Leaders/influencers at various levels of implementation (including Village Chief, Leaders, NGOs, FBOs, support groups, AWW, ANM, ASHA, PRI members b) Media persons c) Pharmacies, shops and other sellers of medicines d) Traditional Healers, Birth attendants e) Private health care service providers [Same groups may constitute the primary audience depending on the target behaviour, messages].
Tertiary	People, groups, individuals, institutions, who may either influence or impede behaviour change in a community or area, by permitting/sanctioning or restraining an intervention. Socio-political, legal environment, decision-making processes, policy and guidelines, resource allocation, technical support, etc. are greatly influenced by them. a) Politicians, Administrators, other leaders b) Development Partners, other organization playing roles c) Other Health programmes, institutions; other government institutions/department (non-health) d) Media

2.3 Messages

Messages would focus on motivating behaviour change amongst the target audience instead of giving information only. While designing:

- Messages would draw from knowledge about target audiences. Messages would be tailored to the context - socio-cultural, geographic, gender sensitivity, etc.
- Messages would capture the attention of target audiences; appeal to their hearts and minds (may range from positive, humorous, sensitive, to serious, fear-based etc. as appropriate). A mix of logic-based and emotion-based messages would be used.
- Messages would be relevant and relate to real life situation.
- Messages would focus on benefits, barriers, motivators.

Messages for programme components would focus on the following (Table-3)

Programme Component	Needs/Gaps/barriers
Case Management	• Awareness of signs and symptoms of malaria • Early treatment seeking behaviour by patients • Correct treatment as per national policy • Importance of completing treatment

	• Belief in test results by CHV/ASHA/HF • Importance of pregnant women attending early to ANC clinics • Appropriate referral, if signs & symptoms of malaria
Prevention	• Daily and correct use of LLIN, with special attention to use by pregnant women and children under five • Acceptance of Indoor Residual Spraying (IRS) • Awareness, involvement and participation in larviciding activities, environmental manipulation and modifications, etc.

3. BCC activities under IMCP-3

3.1 Infotainment (information dissemination through entertainment)

Responsibility: SRs

Unit cost: INR 470/- per performance for the local group in addition to INR 200/- per performance incentive for the CHV (yearly escalation cost would be applicable, upon approval by PR)

Information through entertainment is powerful medium. The music/dance performances (often using the traditional/folk media) with information dissemination/education of the key players as well as the community at large would be priority. This channel is important on account of reach, credibility, and ability to adapt performances to the standardized messages. The focus and venue of the show are to be selected with care, keeping in mind the socio-cultural environment of the area and target audience. The following aspects would also be kept in mind: scripts of the plays/shows would be sensitive to community, would be in local language, religious and socio-cultural values, norms; groups/troupes/individuals that are known to the audience would be engaged; orientation of the performers is a key necessity to sensitize them on the messages/their delivery, especially to weave the messages into compelling and entertaining scripts. There would be element of interaction between audience and performers. The performer would elicit feedback from the audience to involve them and also gauge their level of interest and retain attention. Sometimes dummy performers may be placed in the audience and at the appropriate moment, he/she may be included in the play. Since the show is set in a market, village and since the performers are familiar with the setup, it is expected to lend a lot of credibility to the messages being disseminated. In this way, the audience trusts the performers to the extent that they are willing to take their advice on the services being promoted. The scripts can be designed to explore every issue of concern like prevention as well as EDCT. Successful performances are those whose scripts are flexible and open to on the spot improvisations, to suit local context.

- In each year one infotainment activity would be conducted once in a village (at community level).
- A standardized infotainment messages would be disseminated in all the villages to ensure that correct and complete information on malaria prevention and control are provided to the community. The messages would be in line with the national programme strategies and interventions.
- Infotainment activities would be emphasized before transmission season/during Anti- Malaria Month/World Malaria Day/LLIN distribution/IRS, etc. alternating with other BCC activities, as locally appropriate. May need to synchronize timing especially with rounds of IRS/LLIN distribution, etc. that are at times variable across states depending on the transmission season and local circumstances and hence the activities may be conducted at different times in a year.
- Identified local group would perform infotainment activity (drama/music/skit/puppetry, etc.) at the village level in local language/dialect with the support of CHV. The Field Supervisor would oversee the activities in his/her assigned areas.
- In each infotainment activity at community level (village) would have the attendance of approx. 25 people including specific target groups like women, children, tribal & marginalized groups, mobile & migrant population, etc.
- Community should be informed well in advance. Audience should be encouraged to ask questions related to malaria and should be answered appropriately by FS/CHV.
- For documentary evidence, feedback form would be administered to at least 3-5 audience and signature/thumb impression of Panchayat/village headman/chief/village council or any other community leader would be taken upon completion of the event certifying that the event has been conducted in the village.
- Local group would be paid for the infotainment performance.
- The BCC input form would be filled by CHV & FS and transmitted to DPMU for uploading on project MIS and necessary reporting.

- IMCP-3 finance guidelines should be followed for booking expenses.

3.2 Public Announcements (Miking)

Responsibility: SRs

Unit cost: INR 470/- per session in addition to INR 200/- per performance incentive for the CHV (yearly escalation cost would be applicable, upon approval by PR)

- In each year one miking activity would be conducted once in a village (at community level)
- Miking activities would be emphasized before transmission season/during Anti- Malaria Month/World Malaria Day/LLIN distribution/IRS, etc. alternating with other BCC activities, as locally appropriate. May need to synchronize timing with rounds of IRS/LLIN distribution, etc. that are at times variable across states depending on the transmission season and local circumstances and hence the activities may be conducted at different times in a year.
- Standardized messages would be disseminated in all the villages to ensure that correct and complete information on malaria prevention and control are provided to the community. The messages would be in line with the national programme strategies and interventions.
- Always use local language/dialect
- Miking should be conducted when community people are present in the village
- Messages should be announced clearly and audibly.
- Payment would be made to the person(s) conducting the miking for which payment receipt is required.
- The BCC input form would be filled by CHV & FS and transmitted to DPMU for uploading on project MIS and necessary reporting.
- IMCP-3 finance guidelines should be followed for booking expenses.

3.3 Community Consultation and Message Dissemination (CCMD) Session

Responsibility: SRs

Unit cost: INR 470/- per session in addition to INR 200/- per performance incentive for the CHV (yearly escalation cost would be applicable, upon approval by PR)

Participatory Community consultations/meetings would be held at village level and focus on orientation/sensitization of local leaders/influencers and stakeholders towards community level linkages, collaboration and coordination for adoption of responsive behaviour regarding EDCT, personal protection, environmental management. Script or slides and/or AV capsules may be used in addition to flipbooks, leaflets, etc. to assist CCMD sessions and trigger discussions.

- In each year one Community Consultation & Message Dissemination (CCMD) activity would be conducted once in a village (at community level).
- Each session at community level (village) would have the attendance of approx. 20 people. Activity would be carried out village with participation of VHSNC, ASHA, AWW, ANM, PRI member, other field level health worker, Village Head, teachers, other stakeholders including specific target groups like women, children, tribal & marginalized groups, mobile & migrant population, etc.
- CCMD sessions would be emphasized before transmission season/during Anti- Malaria Month/World Malaria Day/LLIN distribution/IRS, etc. alternating with other BCC activities, as locally appropriate; or as inception activity in new geo scope. May need to synchronize timing with rounds of IRS/LLIN distribution, etc. that are at times variable across states depending on the transmission season and local circumstances and hence the activities may be conducted at different times in a year.
- CHV would facilitate this activity with the supportive supervision of Field Supervisors.
- The agenda and discussion points should be prepared before the CCMD session. Inform the participants well in advance about the agenda, date, time and venue.
- The BCC input form would be filled by CHV & FS and transmitted to DPMU for uploading on project MIS and necessary reporting. BCC Input forms would include the signature/thumb impression of each participant with the date. Follow-up actions to be noted in brief.
- IMCP-3 finance guidelines should be followed for booking expenses.

3.4 Local School Activity

Responsibility: SRs

Unit cost per school: INR 800/- including INR 200/- per CHV (yearly escalation cost would be applicable, upon approval by PR)

School-based initiatives being critical in creating change agents in the short- to long term, various programmes would continue. Child-to-Child/Child-to-Family communication for dissemination of messages has proven impact in fostering knowledge and awareness and responsive behavior among peer groups and family.

- 10 local schools to be reached with school activity in each district. Each activity would have the attendance of approx. 30 school children in a school.
- In each school, the initiatives would create at least one change agent for dissemination of messages to foster knowledge and awareness and responsive behaviour [in the critical context of number of children reached, change agent created and benefiting community level sensitization by knowledge transfer to peer groups (child-to-child), parents/relatives (child-to-family), etc.].
- Activity to be conducted by CHV and FS in coordination with school authorities.
- Depending on local circumstances the activities may be conducted at different times in a year. Activities may be emphasized before transmission season/during Anti- Malaria Month/World Malaria Day, etc., as locally appropriate.
- The preferred activity layout (competitions, debate, presentation, games, quiz, rally, etc.) would be devised in consultation with school principals/teachers. Lectures should be avoided while interactive sessions should be encouraged interaction, although conducting classroom sessions on how to spread messages on prevention and control of malaria would be priority. From time to time, messages dissemination during morning assembly would be done. Necessary demonstration of preventive and curative measures would be planned too.
- Display of BCC materials would be undertaken, wherever possible in coordination with health authorities.
- All school children and teachers should be encouraged to participate in the activities.
- The amount budgeted should be used for conducting the aforementioned activities e.g. for purchasing chart papers, color paints, prizes, etc.
- For documentary evidence, BCC Input Forms would be completed with signature of principal/teacher or any other school authority would be taken.
- The BCC input form would be filled by CHV & FS and transmitted to DPMU for uploading on project MIS and necessary reporting.
- IMCP-3 finance guidelines should be followed for booking expenses.

3.5 Interpersonal Communication (IPC)

Interpersonal communication with patients/household members is effective and works best when there is one-on-one contact between the CHV/FS and the person whose behaviour is to be changed to adopt new knowledge, practices for the welfare of their families and children. IPC would require training and other aids to implement. Over a period of time, if done consistently, IPC can result in adoption of appropriate practices on a sustainable basis through mutual trust building at community level between CHV/FS and target group - individual/family. IPC draws from openness and approachability, leaning attitude, appropriate eye contact, pleasing personality. IPC aids include: Flip book/Fact sheets, etc.

3.6 Wall Painting

- Wall painting should to be done under each Sub-Centre. Prior approval from the Sub-Centres/PHC/CHC would be required. Places where Sub-Centres do not have proper plastered walls, the paintings could be done at the community centre, primary schools or any other visible place of public gathering.
- The walls that are to be painted must be frontal and prominent, to attract attention of maximum viewers. The size of the wall painting should be at least 4 ft. by 7 ft.
- The painting should preferably be 2-3 feet above the ground to avoid damage such a pan spit, scribbling, etc. by people. The colour scheme should preferably be red, blue and yellow.
- Use only the standard sample/prototypes shared by the PR: (a) what is malaria and its effects, (b) early diagnosis and correct & complete treatment and (c) malaria prevention—sleeping under nets-LLIN, IRS and source reduction. Choose from among these and ensure a district has these 3 different paintings.
- Messages need to be translated into local language by the respective SRs. Use English only where necessary.

- The unit cost is INR 1500/- per painting. This includes the entire cost including the travel cost of the painter. Preferably engage a painter/agency to do the paintings, who has experience of undertaking the activity for SVBDCP/DVBDCP, National Health Mission, etc. Necessary approval needs to be taken from PR.
- Logos of Caritas India, NVBDCP and the implementing organization along with IMCP Fight Against Malaria symbol should be featured on the wall paintings.
- IMCP-3 finance guidelines should be followed for booking expenses.

3.7 World Malaria Day, Anti Malaria Month

World Malaria Day

Every year, 25th April marked as World Malaria day is significant as it is observed as a campaign to create mass awareness and rallying multi-sectoral response to fight against malaria. It is also a day to share and learn from the past, discuss the present/current situation and plan for the future, highlighting the need for continued commitment from all stakeholders for collective action as well as investment in the journey to malaria elimination. Therefore the events at the national, state, district and village level should be conducted in a campaign mode together with the NVBDCP, State & District VBDCPs and others, ensuring maximum participation and visibility as per well defined plan specifying the level of implementation, target audience, activity planned, person responsible, necessary budget and desired output/outcome.

The PR, SRs should mobilize the masses, for which various events like marathon, rallies, street plays, musical shows, quiz competition, banner displays, tableau road shows, sports competition group discussions, sessions on malaria, and mass signature campaigns, etc. should be organized. Through various events, signature campaign and pledge to "Join the Fight Against Malaria", should be fostered.

Advocacy being a key aim, observance of World Malaria Day should ensure active participation and contribution by the Government officials, medical fraternity, paramilitary forces, local entrepreneurs, church networks, community leaders, educational institutions, National Cadet Corps (NCC), community based organizations, media and the public in huge numbers. Additional resources may be mobilized at local level through sponsorship and contribution in kind. The prizes/ gifts for the competitions, if any, should be in kind, no cash payments should be made. Appropriate IEC/BCC materials should be disseminated. Wide coverage by media and capturing high-resolution photographs, video clips and feed back from the audience should be priority.

Anti Malaria Month

Likewise, anti Malaria Month is also observed in the month of June every year. The specific objectives of the Anti Malaria Month campaign are as under:

- Enhance awareness regarding source and transmission risk reduction, EDCT, availability of services at different levels
- Promote attitudinal and value changes among target audiences leading to informed decisions, modified behaviour, desirable practices at individual and societal level
- Stimulate increased and sustained demand for quality prevention and care services and optimal utilization of available health care services
- Build support across inter-sectoral partner organizations, influential sectors of society (corporate houses, political representatives, social activists, media, civil society organizations, etc.) and health care service providers and elicit commitment for action.

Anti Malaria month should also be conducted in coordination and collaboration with the NVBDCP and State/District VBDCPs and other stakeholders and activities should reach out to maximum people. Appropriate advocacy (political, administrative, media) at national, state and district and sub district levels should be done.

A report incorporating these details should be generated and submitted to the PR. The PR would generate and disseminate a consolidated report. IMCP-3 finance guidelines should be followed for booking expenses.

4. M&E

Responsibility: SRs

Timeline: As per IMCP-3 implementation plan, M&E Plan

Monitoring is a regular, systematic process of measuring performance against set targets and benchmarks in a programme, while it is ongoing. Evaluation periodically assesses current versus desired performance standards and seeks to analyze whether the needs are met as envisaged and any gap, bottleneck so as to improve further performance in similar or different contexts.

M&E of BCC would be an integral component of overall M&E Plan towards:

- ensuring BCC activities are on track and providing opportunities for mid-course corrections;
- demonstrating that particular channel/approach/medium reached and served its purpose – achievement of behaviour outcomes;
- obtaining guidance for programme decisions.

Outputs/coverage and outcomes are already presented in section 1 of this document. Impact would be aligned with the IMCP-3 goal. It is however, recognized that many other determinants beyond BCC contribute to the outcomes/impact.

- BCC output/coverage would be reported monthly/quarterly through Monthly Indicator Report and Progress Update & Disbursement Request (PUDR) templates.
- Data source of BCC activities: BCC Input Forms, CHV registers and surveys, as appropriate.
- BCC activities would be tracked relative to District Implementation Plans (DIP).
- CHVs, FSs would record BCC activities in BCC input form and submit it to DPMU on a monthly basis as per stipulated timeline. The same would be collated and checked, after which the data would be uploaded on project MIS.
- Review and planning meetings at state/district levels: BCC activities would be reviewed in monthly/quarterly/annual review as an integral component of overall project review.
- At state levels, the focal points of Caritas India would interact with the state VBDCP, take stock of BCC, capacity building aspects. At district levels, coordination and colaboration with the District VBDCP would be ensured.
- As the NVBDCP conducts survey, etc., the outcome indicators would be captured and appropriate actions would be taken.
- Regular supervision by staff would assess outputs and coverage, stakeholder involvement as detailed under:
  - villages, target audience covered; number, timing of activities;
  - noticeability, comprehension, recall;
  - constraints, if any; and way forward;
  - training/re-orientation needs.
- During field visits, carry out home/patient visits who participated in the events to check if they recall the key messages.
- Meet key stakeholders/community members to see if they know the CHV/FS and the conduct of activities by them.
- The supervisor would attempt to address issues identified during visits or as early as possible and provide feedback to the supervisee.

5. Maintenance of inventory of BCC tools/give away materials

Responsibility: SRs

- The DPMU would maintain inventory of all BCC tools/give away materials specifying quantity, type, date of receipt, date of issuance to CHV, Field Supervisors.
- The BCC tools/give away materials received would be stored at the project office premises and would be distributed within a stipulated timeframe.
- Receipt note would be taken by DPMU from CHV and Field Supervisors upon issuance of BCC tools/give away materials.