SOCIAL AND BEHAVIOUR CHANGE STRATEGY

DEPARTMENT OF WOMEN & CHILD DEVELOPMENT,
GOVERNMENT OF MADHYA PRADESH

VOLUME I:
Policy & Strategic Approach

Implemented by
giz Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

Published by:
Deutsche Gesellschaft für
Internationale Zusammenarbeit (GIZ) GmbH

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Bonn and Eschborn, Germany

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Design and layout: MASH

Photos: © GIZ India/SENU and DWCD Madhya Pradesh

GIZ is responsible for the content of this publication

On behalf of the German Federal Ministry for
Economic Cooperation and Development (BMZ)

New Delhi, October 2022

Message

Madhya Pradesh is a diverse state. It is divided into many zones based on language, culture and economy. The Department of Women and Child Development, Government of Madhya Pradesh is working on women and children's health and nutrition, their protection and gender equality. Almost 75% of the total population of Madhya Pradesh is addressed by the various programmes and interventions of the department.

The success of such programmes and interventions for women and children's issues often depends on individual and community's mindset and perceptions and social norms and beliefs. To address these challenges, the department, at its level, keeps implementing activities for social and behaviour change. We have wanted to build on such efforts and develop a holistic social and behaviour change strategy. The vision has been to create a policy that will guide how we will interact with our citizens and help them in their health and overall development.

Therefore, with the support of GIZ India, we have now developed a comprehensive social and behaviour change strategy, in two volumes. Volume-I details the Policy & Strategic Approach and Volume-II serves as a Guide for Implementation. I sincerely believe that the effective implementation of this strategy will benefit the community, our beneficiaries and also our department officials.

Dr. Ram Rao Bhonsle

LIST OF ACRONYMS

ANC	Ante -Natal Check -up
ASHA	Accredited Social Health Activist
ANM	Auxiliary Nurse Midwife
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BBBP	Beti Bachao Beti Padhao
BCG	Bacillus Calmette-Guerin
B/E	Barriers and Enablers
BLCPC	Block Level Child Protection Committee
CCL	Child in Conflict with Law
CHAI	Clinton Health Access Initiative
CNCP	Child in Need of Care and Protection
CNG	Community Nutrition Gardens
CWC	Child Welfare Committee
DCPU	District Child Protection Unit
DPT	Diphtheria, Tetanus and Pertussis
DWCD	Department of Women and Child Development
ECCE	Early Childhood Care and Education
EVAC	Ending Violence Against Children
EVAWG	Ending Violence Against Women and Girls
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GO	Government Organisation
ICDS	Integrated Child Development Services Scheme
ICPS	Integrated Child Protection Scheme
IEC	Information, Education and Communication
IFA	Iron Folic Acid
JD	Joint Director
JJ	Juvenile Justice
JSY	Janani Suraksha Yojana
LLY	Ladli Laxmi Yojana
MCP	Mother and Child Protection
MHHM	Menstrual Health & Hygiene Management
MNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MP	Madhya Pradesh
MSS	Matr Sahoygini Samiti
NCRB	National Crime Records Bureau
NGO	Non - Government Organisation
NFHS	National Family Health Survey
N -PLA	Nutrition - Participatory Learning and Action

NRC	Nutrition Rehabilitation Centre
ORS	Oral Rehydration Salt
OSC	One Stop Centre
RKSK	Rashtriya Kishore Swasthya Karyakram
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques Act
PLFS	Periodic Labour Force Survey
PMMVY	Pradhan Mantri Matr Vandana Yojana
POCSO	Protection of Children from Sexual Offences
PRI	Panchayati Raj Institution
SBC	Social and Behaviour Change
SBCC	Social and Behaviour Change Communication
SHG	Self Help Group
THR	Take Home Ration
TT	Tetanus Toxoid
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAWC	Violence against Women and Children
VAWG	Violence against Women and Girls
VHSND	Village Health, Sanitation and Nutrition Day
WASH	Water, Sanitation and Hygiene

TABLE OF CONTENTS

1. INTRODUCTION **2**

2. METHODOLOGY **3**

3. LIMITATIONS **5**

4. GOAL & OBJECTIVES OF THE SBC STRATEGY **7**

5. THEMATIC AREAS **7**

6. PRIORITY BEHAVIOURS & BARRIERS AND ENABLERS **8**

6.1 Cross-Cutting Barriers 8

6.2 Systemic Barriers 10

6.3 Barriers/Enablers Of Priority Behaviours 10

Nutrition, Health & Hygiene 11

Child Protection 23

Women Safety & Empowerment 30

7. STRATEGY **36**

7.1 Building Blocks: Strategic Approach For SBC 36

7.2 Key Messages 40

Nutrition, Health & Hygiene 40

Child Protection 51

Women Safety & Empowerment 57

7.3 Approach And Implementation 60

7.4 Other Recommendations 66

7.5 Tools 67

7.6 Monitoring 67

8. HOW TO USE THE DOCUMENT **70**

Annexure – I: About Madhya Pradesh 75
Annexure – II: District-wise statistics 77
Annexure – III: Current situation in thematic areas of DWCD 79
Annexure – IV: Media environment and exposure 90
Annexure – V: List of desired behaviours 92
Annexure – VI: Prioritised issues and behaviours 102
Annexure – VII: Division-wise mapping of barriers/enablers & tools 103
Annexure – VIII: List of GO and NGO stakeholder consultation at state level 115
Annexure – IX: Schedule and number of participants of divisional workshops 116
Annexure – X: Google Form for Behaviour/Barrier/Enabler Mapping 117
Annexure – XI: Screenshots of divisional virtual workshops 118
Annexure – XII: Schedule and number of participants of field visits 120
Annexure – XIII: Questionnaires for FGD with beneficiaries 121
Annexure – XIV: Photos of direct observations in the field 123
References 126
Image Source 127

INTRODUCTION & METHODOLOGY

1. INTRODUCTION

A vast, diverse state situated in central India, Madhya Pradesh is often called the 'heart' of the country. It is the second largest state in India and is bordered by Rajasthan (north-west), Gujarat (west), Maharashtra (south), Chhattisgarh (south-east) and Uttar Pradesh (north-east). Madhya Pradesh has 52 districts, divided into 10 administrative divisions, namely, Bhopal, Chambal, Gwalior, Indore, Jabalpur, Ujjain, Sagar, Rewa, Narmadapuram and Shahdol.

The Government of Madhya Pradesh is committed to ensure the overall development of all its residents, especially women and children. The Department of Women and Child Development (DWCD) works to sustainably improve health and nutrition outcomes for women of reproductive age and children below 6 years, enable holistic development and protection of children and ensure safety, equity and empowerment of women. The department implements the Integrated Child Development Services (ICDS) scheme for improving maternal and infant nutrition and health. It also implements the Integrated Child Protection Scheme (ICPS) and various other schemes and programmes for health, gender equality and women empowerment.

Over the years, a lot of progress has been made. However, there are still a few indicators that are not doing well as expected. Census 2011, National Family Health Survey – 4 (2015-16) and NFHS-5 (2019-21) have found that low sex ratio, lack of women empowerment, experiencing gender-based violence, substance abuse, low female literacy, child marriage and small landholdings are some of the determinants of poor health and empowerment of women and children. Individual and community behaviours, attitudes, social norms and practices are some of the reasons for such indicators.

To bring about an improvement in these indicators and positively transform the status of women and children in Madhya Pradesh, a comprehensive state-specific social and behaviour change (SBC) strategy has been developed for DWCD. This strategy is supported by the recommendations provided in the department's other policies. The state's Nutrition Policy (2020-30) emphasizes on the importance of designing SBCC plans in local dialects for its acceptability and greater involvement of the community. The centre's Poshan Abhiyan which DWCD follows stresses on community mobilisation and behaviour change, highlighting the need to take-up sustained efforts requiring multi-pronged approach and bring grass-root synergy and convergence. The state's Child Protection Policy (2020) also highlights the need to build awareness and stakeholder capacities to strengthen implementation and the enabling environment to ensure child well-being and protection.

This document details the SBC strategy which includes thematic area-wise priority and desired behaviours that should be practised by the target groups for improved indicators, barriers and enablers to its adoption, key messages to be communicated and strategic approach and interventions that will facilitate positive change.

The strategy will guide DWCD's activities and enable desired changes in those practices that will have the highest impact in improving it's thematic objectives. The strategy will also help bring progress in the Sustainable Development Goals, particularly SDG 2 (zero hunger), SDG 3 (good health & well-being), SDG 4 (quality education) and SDG 5 (gender equality).

The strategy has been developed in collaboration with Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ).

2. METHODOLOGY

The first discussion was held with the Director, DWCD which highlighted the vision of the department and the objectives that it is seeking to achieve through the SBC strategy. The goal and objectives of the strategy define the path and pillars on which sustainable social and behaviour change will stand, adoption of desired behaviours by respective target groups, enabling environment for change and trained functionaries and stakeholders.

1 **Identification of thematic areas**

The first step in this direction was identifying the thematic areas and sub-issues under the DWCD's objectives of maternal and child health, child protection and women's safety and empowerment. Following initial discussions with DWCD in April - early June 2021, the thematic areas were identified and categorised into sub-issues (See Section V). The areas were aligned with the mandates of the department.

2 **Understanding the state and districts context**

The second step involved the profiling of the Madhya Pradesh and it's 52 districts. The state's profile was understood in terms of geography, demography, economy, climate and culture (See Annexure I). This step highlighted the diversity as well as regional and cultural variations of the state which were instrumental in understanding the behavioural determinants and designing the strategy. The media, environment and consumption of different communication channels by men and women was also looked upon (See Annexure IV). Information and data were gathered from the various government websites, Census 2011 data and National Family Health Survey – 4 (NFHS-5 data was published later in November 2021).

3 **Situation analysis of the thematic areas**

The next step was understanding the current situation of the different thematic areas. This involved looking at the issue through current statistics, causes/reasons for the same, perceived consequences, actions/interventions undertaken by DWCD and stakeholders and any identified needs (See Annexure II, III). The current situation was looked at from a system's thinking approach, identifying inter-connecting factors and interactions between thematic areas. A desk review of available reports and documents was done. This included reports by DWCD, GIZ, UNICEF, UNWOMEN, Vikas Samvad, Oxfam, WHO, ZMQ, etc. and research papers. Analysis of data from publicly available credible sources such as NFHS-4, Census 2011, National Crime Records Bureau (NCRB), online versions of national and regional newspapers like Times of India was done. Online discussions were held with the Director of DWCD, various divisional officers, IEC team and representatives of development partners including UNICEF, Vikas Samvad, UNWOMEN, Mamta Health Institute and GIZ (See Annexure VIII for list of names). These discussions gave further information on the causes behind the current situation of the issues, current programmes, challenges of communication and the areas where change is required. Information was also collected from webinars organised by DWCD.

4 **Identification of list of theme-based desired behaviours**

Based on the situation analysis data, discussions with stakeholders, evidence supported from previous research and studies by the aforementioned partners, and mandates of the department, a list of 52 desired behaviours across the 3 thematic areas (and 17 sub-issues) was developed. Desired behaviours are those which when adopted by the target audience lead to positive outcomes in thematic areas. The behaviours were discussed with the various stakeholders on their feasibility to adopt (by target audiences) and promote (by DWCD) and the possibility to measure actual change from them. Desired behaviours have been identified keeping a systems' thinking approach in mind. Successful adoption of one behaviour will bring about positive change in another. There are, however, some behaviours that have been repeated under specific sub-issues to highlight their strong, direct impact to that issue. This is, in case of gender-related behaviours (See Annexure V - Behaviour Ref No. 33, 45, 51). Their barriers/ enablers are similar.

5 **Prioritisation of issues, desired behaviours, and identification of barriers/enablers**

The next step was to identify the factors limiting the target audiences from adopting the desired behaviours, i.e. barriers, and the factors that encourage adoption, i.e. enablers. The process followed also helped to prioritise the issues and desired behaviours which needed

immediate focus in the strategy. Barriers/Enablers were identified in 3 layers –

- Cross-cutting barriers/enablers which affect the enabling environment required for behaviour change and those responsible for decisions made by target audiences.
- Systemic barriers, including challenges faced by officials and Anganwadi workers (and identification of needs to improve the same – highlighted in Annexure VII).
- Barriers/Enablers for adoption of desired behaviours under thematic issues.

The process was as follows -

a. Discussions and online workshops with officials and AWW

Discussions were held with officials and stakeholders at the state level and virtual workshops were conducted with officials at the division and district level, supervisors and AWWs. The state is divided into 10 administrative divisions; further categorised into 7 divisional clusters – namely Rewa-Shahdol, Gwalior-Chambal, Jabalpur, Bhopal- Narmadapuram, Sagar, Ujjain and Indore. Each division also has district clusters, i.e. districts where similar trends and patterns can be found. The virtual workshops were conducted for each divisional cluster, in two parts – one workshop with respective divisional and district officials, including Joint Director (division), Deputy Director, District Programme Officers (DPO), Assistant Director (AD), Child Development Project Officer (CDPO), and one workshop with select supervisors and AWWs of the respective divisions. Local NGO representatives also participated in the workshops. A total of 8 workshops were conducted in October 2021 (7 for each divisional cluster and 1 repeat for Chambal division) with a total of 1189 participants. (See Annexure VII for detailed division-wise findings, Annexure IX for the workshop schedule and number of participants and Annexure XI for pictures of the workshops). A google form was developed and circulated for collecting detailed inputs from the participants (See Annexure X). These discussions led to prioritisation of thematic sub-issues and desired behaviours based on the need and current situation in the divisions. Barriers and enablers for adoption of the desired behaviours were identified and mapped, along with the tools for effective communication. The dialects spoken in the districts and sources of information were understood. The needs and requirements of the officials and AWW were also identified.

b. Direct observation and consultation with beneficiaries

After this, field visits were conducted to select villages and observations , discussions and interviews were conducted with the beneficiaries and target groups of the desired behaviours. This included adolescent girls and boys, pregnant women, lactating women, women between 18-49 years of age, women above 49 years of age, men/fathers, AWW. Direct observations and focus group discussions were conducted in 15 locations across 5 divisions of MP, namely, Indore, Bhopal, Sagar, Gwalior and Chambal. The divisions and districts were selected based on the inputs from the divisional workshops and in consultation with the state, respective divisional Joint Directors and DPOs. Villages were selected based on best representation, feasibility to travel and organise meetings (support from local NGO partners) and geographical importance. A total of 754 people were consulted with in-person which included 240 women, 18 men, 254 adolescent girls, 116 adolescent boys, 60 AWW and supervisors and 66 stakeholders (JD-division, AD, DPO, CDPO, Teachers, NGOs, staff of One Stop Centre, BMOH, ASHA, ANM). (See Annexure XII for the schedule and number and type of participants and Annexure XIV for pictures). Separate questionnaires were developed for focus group discussions with women, men and adolescents. In villages where discussions were held with a mixed group, the questions were modified accordingly. In most locations, the discussions were conducted at the Anganwadi Centre. Participative activities were played to set the tone of the discussions and create an ambience for healthy and two-way communication. (See Annexure XIII for the questionnaires). At one location, One Stop Centre was visited, and discussion was held with the staff. The observations and consultations helped in identifying the priority behaviours that need to be promoted first as part of the strategy. Detailed barriers and enablers for adoption of the behaviours by the target groups were also identified. Variations in answers were found based on and influenced by the type of community, location of the village and its access to nearby cities and other states and level of education of women. The beneficiaries were consulted on the communication tools/approaches they identify with most and use.

6 **Development of key messages and identification of approaches/tools**

Finally, the key messages for promoting the priority behaviours were developed and approaches/tools for bringing the behaviour change among the target groups were highlighted. The mechanism for implementing and monitoring the interventions/activities was proposed.

3. LIMITATIONS

It is to be noted that the information collected from the state and districts in the aforementioned steps includes experiences and perspectives of the state, division and district officials, AWW, stakeholders and beneficiaries. The information (especially barriers and enablers) is to be considered representative and cannot be (blankly) generalised as standard for the entire state. Given the size and diversity of the state, variations may still be found with further research and study. However, the sample size was sufficient representation of the diverse findings at the current stage and an adequate assessment could be drawn on the findings as reported. The strategy and recommendations are focused on the priority behaviours.

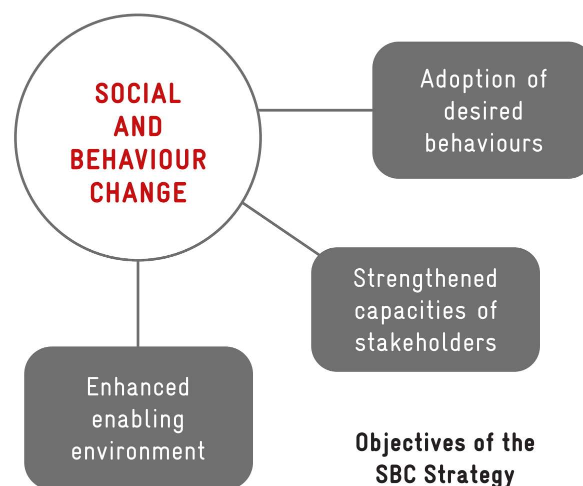
GOAL, OBJECTIVES, THEMATIC AREAS
DESIRED BEHAVIOURS, BARRIERS & ENABLERS

4. GOAL & OBJECTIVES OF THE SBC STRATEGY

The goal of the SBC strategy is to strengthen DWCD's state-wide efforts for holistic development of women and children by addressing the individual, families' and community behavioural aspects pertaining to different interventions and programmes.

The strategy seeks to achieve the following objectives –

- To enable adoption of (issue-based) desired behaviours by respective target groups.
- To enhance the enabling environment supporting social and behaviour change in the thematic areas.
- To strengthen capacities of stakeholders to implement and monitor thematic social and behaviour change-driven strategic action plans.



Objectives of the SBC Strategy

5. THEMATIC AREAS

DWCD works on the thematic objectives of maternal and child health, child protection, and women's safety & empowerment. The highlighted thematic sub-issues are the prioritised issues for the SBC strategy. See division-wise category in Annexure VI.

NUTRITION, HEALTH & HYGIENE	CHILD PROTECTION	WOMEN SAFETY & EMPOWERMENT
• First 1000 days – window of opportunity	• Ending abuse and violence against children	• Gender equity and equality
o Care during pregnancy	• Ensuring children in need of care and protection	• Prevention of violence against women and girls
o Care of lactating mother	• Rehabilitation of children in conflict with law	• Enabling women economic empowerment
o Breastfeeding	• Prevention of child marriage	
o Complementary feeding	• Prevention of substance abuse by children	
• Nutrition of children (2-6 years)		
• Immunisation & supplementation		
• Prevention of anaemia		
• Prevention and management of malnutrition		
• Water, sanitation & hygiene		
• Early childhood care & education		
• Back to school		
• Menstrual health & hygiene management		

6. PRIORITY BEHAVIOURS & BARRIERS AND ENABLERS

To bring about positive social and behaviour change for women and child development in Madhya Pradesh, a list of 52 desired behaviours across the 3 thematic areas (17 sub-issues) has been developed. These behaviours when adopted by the target groups will lead to positive outcomes in thematic areas. (See Annexure V for the complete list of desired behaviours).

Among these behaviours, **19 priority behaviours have been identified for the SBC strategy**. These priority behaviours are critical to be targeted by the strategy in the beginning stages and will set a strong foundational structure for positive change. They will also be instrumental in enabling adoption of other desired behaviours.

For each behaviour, factors have been identified and mapped that limit and enable beneficiaries/target groups from adopting the desired behaviours (i.e. the 'barriers' and 'enablers'). Challenges faced by the officials and AWWs that affect communication and behaviour change interventions have also been identified. The secondary research, consultation with stakeholders at various administrative levels, direct observations and consultations with beneficiaries have affirmed that nutrition-related behaviours are strongly driven by factors such as social practices and beliefs, values associated with family, social constructs and education, household income. Child protection as well as women's safety and empowerment behaviours are driven heavily by gender norms – status of girls and women in society, lack of education, gender-power dynamics and acceptance of social roles. With respect to children, the inter-generational gap and vulnerability due to their low bargaining power, dependence on guardian for protection and security are some of the factors.

This section is structured as follows –

6.1 Cross-cutting barriers affecting the enabling environment of adoption of the desired behaviours
6.2 Systemic barriers, including challenges faced by officials and AWW
6.3 Priority behaviours (as per thematic area) and their respective barriers and enablers for adoption. The priority behaviours are coded as per the reference number given in the detailed list of desired behaviours (See Annexure V).

For division-wise detailed findings, please see Annexure VII.

6.1 CROSS-CUTTING BARRIERS

Below given are the barriers that affect the enabling environment required for positive SBC and which are cross-cutting all thematic areas.

6.1.1 Poor attitude towards malnutrition & WCD issues

In many cases, men and women are reluctant to accept that their children are malnourished. They comment that children are still playing and running around, they look fine, so nothing is wrong with them. Comments like "children are like fruits on a tree, some ripen and can be used, some don't and fall" describe the attitude. There is limited understanding on the importance of women and child development issues, and they are mostly considered the job of AWWs. Further, parents and family's role and responsibility in preventing malnutrition is not clearly understood. Gender and livelihood issues also play a major role to it. Issues faced by women are often considered "women's problem" and childcare is considered as the primary responsibility of the mother. Higher priority is given to the work and earning money, thus, attention to the health and development and quality of care takes a backseat in many cases.

6.1.2 Lack of and disruption in education

In many villages, the present generation of the children are the first-generation learners in their families. Low value attributed to education, along with concerns of safety, distance, prevalence of child marriage, burden of domestic responsibilities, etc. results in dropping out from schools. Many children remain enrolled on the register, but do not attend school. They occasionally attend to avail midday meals. As per Unified District Information System for Education 2015-16, the annual school dropout rate of boys is 8.16% while among girls, it is 6.63%. At the upper primary level, the dropout rate

is higher for girls at 12%, compared to boys at 10%. As of 2015-16, the average annual dropout rate of boys at the higher secondary level is 7.85% while 5.49% girls quit from study at secondary level. School attendance is 90% at age 6-14 years, and then drops sharply to 65% at age 15-17 years. This disruption and lack of gainful education reduces children's and adult' ability to understand behaviours and make informed choices. It also perpetuates the vicious cycle of child marriage, child labour, abuse against children and girls, engagement in illegal activities, etc.

6.1.3 Lack of agency of women

Women, especially in the rural areas, have a limited understanding of their rights and lack decision making power in their families and society. They are heavily influenced by their husbands and mothers-in-law and are unable to participate in activities without their permission or consent. Further, a strong fear of social isolation exists when a woman chooses to raise her voice against the abuse. In many villages, girls are not welcomed to their maiden houses after marriage, especially, if she has been thrown out of her marital home. Women are the primary target audience in many of the desired behaviours, but lack of power prevents them from taking decisions for themselves and their children's health. Many women also lack financial agency. They have no control over how their earned money would be spent. In some families, they want educated daughters-in-law who would earn and contribute to the family income, but at the same time, they also expect her to behave 'like a typical daughter-in-law'. This indicates the attitude towards women.

6.1.4 Strong preference for male children and poor family planning

Even today, there is a strong desire for sons in Madhya Pradesh. The situation is reflected in the poor sex ratio (948 sex ratio and 918 child sex ratio). There is the felt need that many families desire atleast one son even if they have more than 3 (girl) children. This desire is what prevents them from even availing the beneficial Ladli Laxmi Yojana scheme and reflects the strong inherent patriarchal set up of the society. Although the total fertility rate is 2.3, there are some families that have more than 4 children. Madhya Pradesh also has an infant mortality rate of 51 and under-five mortality rate of 65. A minimum spacing of 2 years between children is not observed in many families. The situation as described by an AWW is such that "a mother has one child in the cot, one in the arms and one in her womb." However, it has been observed that many men and women do not respond well to direct messages on family planning. When AWW's try to explain them, they are told that its none of their business.

6.1.5 High rate of migration

Poverty, unemployment and access to the bordering states are the reasons behind high economic migration observed in Madhya Pradesh. (MP is bordered by Uttar Pradesh, Gujarat, Rajasthan, Maharashtra and Chhattisgarh). Communities usually migrate after harvest season and return during festival season (around Holi and Dussehra/Diwali). Usually, the whole family migrates, and they are away for an average of 4-8 months. This affects the health monitoring of women and children by the AWW and continuum of care. It is also found that when the families return, they are often malnourished, requiring urgent attention. Child marriages, malnourishment and child labour are high among migrant families. Many children who migrate with their parents are forced to leave school and due to the odd and uncertain duration of movement, they are not enrolled in school elsewhere either. This causes a disruption in their education and results in eventually dropping out of school.

6.1.6 High incidences of child marriage

One-third of girls and boys in MP are married as minors. Fear of elopement and ensuring a girl's safety is one of the main reasons girls are married off. When girls are not allowed to go to school and are at home, getting them married is considered the most feasible option. Marriage is also considered when children reach a certain age of maturity. Child marriages among boys is equally high, especially in tribal regions. When families need to migrate and want more earning members, they consider marriages of boys to get them to become responsible and start earning for the family. Child marriages also perpetuate the vicious cycle of disruption in education, teenage pregnancy, anaemia, malnourished mother and children, women becoming victim of violence and intergenerational transmission of violence (children of perpetrators of violence are more likely to commit acts of violence themselves).

6.1.7 High alcoholism and wife beating

Alcoholism, especially among men, is a common problem in most areas. After consuming alcohol, some men become violent and abuse women, especially their wives. Women victims of violence suffer from malnutrition and poor health and invariably it results in malnutrition in children. However, women are blamed for giving birth to low weight and malnourished babies.

6.1.8 Lack of male engagement in communication

There are multiple layers in this issue since women and child development issues are considered AWW's

responsibility and women's problem, participation from men is low. Most men consider it to be women's responsibility. Mothers-in-law are also the ones who make decisions on health of infants and women, especially during their pregnancy. There is therefore a strong communication focus on women. However, since women lack agency and these issues are not solely their responsibility, there is a strong need to ensure male engagement in behaviour change interventions. AWWs also feel that men have more exposure so will be able to connect to the messages if properly communicated with.

Lack of education, gender inequality and high economic migration are the principal barriers affecting the overall environment for behaviour change in all thematic areas.

6.2 SYSTEMIC BARRIERS

Below given are the barriers affecting capacities of officials and AWW to undertake SBC interventions along with challenges faced by them.

6.2.1 High work burden

At the district, village and AWW level, officials and AWW balance tasks and responsibilities of different departments. They participate in field work, election duties, emergency duties like vaccination campaigns which makes time management a major challenge to focus on DWCD duties. There are also connectivity and access issues in remote areas, especially tribal regions. In such cases, there is high dependency on AWW and their families to communicate information.

6.2.2 Varying skill levels

There are limited field level functionaries, and they are of varying qualification and skills. Officials feel that AWW cannot multi-task or undertake diverse tasks at the same time. Many times, many AWWs tell target groups what behaviours to practice, but are unable to convey the "how" and "why". Lack of time, communication skills and counselling are some of the reasons.

6.2.3 Lack of technical expertise

- Some AWWs are not comfortable with digital media and data entry via online apps.

- Many AWWs and supervisors (and some CDPOs and district level officials) lack technical knowledge and understanding on the objectives of ICPS and women empowerment issues, schemes, forms, etc. There is a strong focus on nutrition and knowledge and experience on child protection and women empowerment is limited. AWW are unable to fill the forms required in home study report for foster/sponsorship cases, etc.

- Most AWW have heard of and downloaded the Anganwadi radio app but not many have used it.

- All AWWs have completed the 22 ILA modules but, only in Chhatarpur, they were aware of Anganwadi Shiksha (based on consultations in the field). PLA trainings were highly praised by AWW in Chhatarpur (district where it was implemented).

6.2.4 Lack of positive motivation

Due to burden of work, challenges faced in the community and technical difficulties, many workers and officials lack positive motivation to attempt behaviour change interventions with vigour and enthusiasm. They also feel tremendous pressure to perform and deliver.

6.2.5 Focus is more on protection/curative behaviours

While the objective of most interventions and programmes is to prevent conditions of malnutrition, child marriages, cases of violence, etc., the activities are geared more towards curative behaviours in case of nutrition and mitigation, rehabilitation and protection in case of others. Base work on women empowerment is minimal.

6.3 BARRIERS/ENABLERS OF PRIORITY BEHAVIOURS

In this section, the priority behaviours that have been targeted in the SBC strategy are given. For each behaviour, the barriers and enablers for its adoption by target groups are also given. It is to be noted that specific barriers, when overcome, also become enablers for practising the desired behaviour.

The behaviours and barriers are written sequentially, separated by main thematic area. The priority behaviours are coded as per the reference number given in the detailed list of desired behaviours **(See Annexure V).**

NUTRITION, HEALTH & HYGIENE

BEHAVIOUR 1	CURRENT SITUATION
Pregnant women register their pregnancy in the first trimester at the nearest health facility	Among mothers who gave birth in the five years preceding the survey, four-fifths (81%) registered the pregnancy for the most recent live birth (NFHS-4).

BARRIERS AND ENABLERS

a. **Declaration of pregnancy -** Many women don't declare their pregnancies in the first trimester. One reason is that they discover their pregnancy late, almost in the second trimester and another reason is that they fear that if they reveal, it will attract the evil eye of others and cause miscarriage. There is also a lack of awareness on the importance of early registration of pregnancy.

b. **Connect with AWC -** Most women, until their pregnancy is registered, are disconnected from the AWC. Their access to and regularity with AWC is initiated and maintained only after they are either tracked by the AWW or learn of their pregnancy and visit to get it registered.

c. **Tracking of menstrual cycle -** Sometimes, there are errors in tracking the menstrual cycle and pregnancy - one of the ways to do so is to ask women their LMP (last menstrual period) by asking when they last washed their hair. Women often tell the date of the 5th or 6th day whereas the day it started needs to be specified. AWWs also sometimes miss out on enquiring further and cross-checking the same.

d. **'Migration' to maiden homes during pregnancy -** There is another kind of 'migration' observed. When women become pregnant, many are sent to their maiden homes which makes it difficult for AWW to track them and monitor their pregnancy and health.

e. **Desire for son -** Pregnant women with no sons are more likely to have an ultrasound test than those with at least one son. They are also more likely to register their pregnancies.

OTHER ENABLERS

f. **ANC visits -** Pregnancy monitoring is done by women who regularly attend ANC.

g. **Sensitising newly married couples –** Sensitising newly married couples on anaemia testing and pregnancy registration enables better health indicators thereafter.

BEHAVIOUR 3	CURRENT SITUATION
Pregnant women consume one additional meal every day which is nutritious, diverse & balanced diet including consumption of THR (take-home ration)	Pregnant women are lacking the adequate nutrition and dietary diversity as is recommended (data from workshop and field).

BARRIERS AND ENABLERS

a. **Responsibility of care -** While it was agreed by most women consulted (under 45 years) that childcare is the responsibility of the mother, father and family together, the primary responsibility of childcare is still

considered to be that of the mother. Most of the mother's decisions are heavily influenced by family pressures, especially that of the mother-in-law. Many women felt that nowadays men help, while many opined that the man's responsibility is to earn and provide for the family.

b. **Balancing household duties -** In most cases, pregnant women continue to do household chores for long hours, with little rest. Household duties are not shared by men. Most pregnant women often eat last and what is left after serving all male members of the family. When they get some free time, they prepare a meal for themselves. Therefore, optimal quantity and correct time of eating is not always ensured. Due to this irregularity, many women often feel nauseous and complain about lack of appetite as well. Many pregnant women are also stopped from going outside the house, especially, in the final trimester, which lead to anxiety in them.

c. **Misconceptions around foods -** Pregnant women are often not allowed to consume eggs, curd, lemon, banana, papaya, pomegranate, hot foods, jaggery, milk. There is a belief that pregnant women should not eat lemon during pregnancy, as the child will get a skin disease. Other beliefs include that eating cold, sour things will cause the baby to catch a cold, women should not eat much because it will put pressure on the womb (it will crush the child or baby will not grow properly) and eating as well as resting more will lead to painful delivery.

d. **Knowledge-action gap -** It was found that incorrect practices are prevalent despite beneficiaries knowing the correct information. Many mothers-in-law argue with daughters-in-law that they know better than the doctors. Beneficiaries are also motivated by their personal experiences. If they have seen one case of a child having been born stuck (chipka hua) and found that the mother had consumed a lot of curd before delivery, the assumption will stick, and they would refuse to feed curd to any other expectant mothers. If there is even one miscommunication, they stop practising the behaviour.

OTHER ENABLERS

e. **Regular ANC -** Women who regularly attend ANC and receive advice from a health professional are more likely to take better care of their nutrition and diet during pregnancy.

f. **Inter-state DWCD collaboration -** It has been found from experience in the bordering districts that inter-state DWCD collaboration has helped ensure continuum of care of migrant workers. This is working with workers migrating to Gujarat who are receiving services form DWCD Gujarat.

g. **Counselling -** Families should be counselled on health and marriage before they migrate.

BEHAVIOUR 6	CURRENT SITUATION
Lactating women consume one additional meal every day which is nutritious, diverse and balanced diet including consumption of THR (take-home ration)	Lactating women are lacking the adequate nutrition and dietary diversity as is recommended (data from workshop and field).

BARRIERS AND ENABLERS

a. **Awareness on types of foods and nutrients -** While most women consulted shared that they eat a nutritious diet while breastfeeding, it was found that many women had limited awareness on the types of foods they must eat during the period, how to prepare it, how much to eat, etc.

b. **Misconceptions around foods -** Many mothers are not given food after delivery because of the belief that it will have an adverse effect on baby. Sometimes, mothers are not given anything to eat for 3 days.

There are other myths that affect nutrition of lactating mothers such as –

- Should not eat green vegetables since it will impact quality of breastmilk
- Should not eat banana because child will get a cold
- Should not eat fruits and vegetables because the wound/stitches may get infected
- Having rice, lemon and sour foods in the 1-2 months after delivery will make baby catch a cold

c. **Knowledge-action gap -** It was found that incorrect practices are prevalent despite beneficiaries knowing the correct information. Many mothers-in-law argue with daughters-in-law that they know better than the doctors. Beneficiaries are also motivated by their personal experiences. If there is even one miscommunication, they stop practising the behaviour.

d. **Women's agency -** Many lactating women do not get to decide what food will be purchased and eaten. In many cases, women's agency to take independent decisions in the household is limited.

e. **Balancing household chores -** Like pregnant women, many lactating women also continue to do household chores for long hours, with little rest. They quickly prepare what they can when they have some free time and eat. Optimal quantity, correct time of eating are therefore, not always ensured. Household duties are not shared by men.

f. **Tradition of not eating food cooked by others -** There is Bhagat parampara in Alirajpur, (followed by over 30% of the population). People following this tradition do not eat what others have touched. This affects nutritional intake.

OTHER ENABLERS

g. **Counselling -** Families should be counselled on health and marriage before they migrate.

BEHAVIOUR 8	CURRENT SITUATION
Newborn children are put to the breast within one hour of birth	41% of newborns start breastfeeding in the first hour of life (NFHS-5)

BARRIERS AND ENABLERS

a. **Prevalent misconceptions -** There continues to be some misconceptions around colostrum which deters many families from practising early initiation of breastfeeding. Many still believe that the initial breast milk after delivery is not "fresh" because it was in the mother for 9 months. In some cases, they believe that till the colour of the breastmilk is yellow, the milk is not coming, so they throw the colostrum. When it turns white after 3 days, they think it is coming. In some traditions, mother's first milk is devoted to God while in others it is discarded because of being impure.

b. **Technical issues -** Many first-time mothers are unaware of the correct technical position for breastfeeding or face issues with the child not being able to latch well. In many such cases, the milk does not flow well initially. So, mothers are unable to feed colostrum.

c. **Connection with caesarean delivery -** There is also a misconception that women having caesarean deliveries (C-section) cannot breastfeed their child. Many are unaware that a mother can breastfeed her child at the operating table, right after delivery. Over 80% of women in MP undergo institutional deliveries, which is a positive factor in ensuring the practice of breastfeeding. However, with around half of these deliveries being

C-sections and the misconception prevailing, children lose out on colostrum feeding.

d. **Prevalence of home deliveries -** In remote villages, due to cultural beliefs, home deliveries via midwives (daai) are preferred. If ASHA is there during such births, early initiation is done otherwise, no.

OTHER ENABLERS

e. **Coordination between AWW and ASHA -** In areas where ASHA works together with AWW, there, an early initiation of breastfeeding is working. Women who are connected with and regular visit the AWC are more likely to practice colostrum feeding. Any delays observed are due to birth-related complications like caesarean delivery, low birth weight baby, etc.

f. **Availability of advice in health facility -** Delivering the child at a health facility also provides access to trained staff who can counsel women on the importance of colostrum and support them to start breastfeeding early.

g. **Supportive mother-in-law -** In families where mother-in-law understands the importance of breastfeeding and is in favour of it, the incidence of early initiation of breastfeeding is higher.

h. **Incentive to take pregnant woman to delivery point -** In Barwani, reimbursement for petrol/diesel is provided to any villager who brings a pregnant woman to any delivery point via his/her own private vehicle. This increased institutional delivery.

BEHAVIOUR 9	CURRENT SITUATION
Mother feeds baby only breastmilk for the first 6 months of the child's life	74% of children under 6 months are exclusively breastfed (NFHS-5)

BARRIERS AND ENABLERS

a. **Participation of family members and responsibility of care -** One of the core challenges to ensure the practice of early and exclusive breastfeeding is the low level of participation of all family members, especially the father, in encouraging the mother and ensuring support to practice breastfeeding. While pregnancy, childbirth and care of the child are considered vital in a woman's life, they are also considered to be the primary responsibility of the woman. Even then a woman's decision is heavily influenced by family pressures, especially that of the mother-in-law. Husbands/Fathers lack general awareness on care practices and don't consider it their responsibility. Therefore, they are not actively involved in supporting the woman in breastfeeding related practices. Alternatively, there are some fathers who know breastfeeding is important but are not aware about whether the mother fed the child or not. Due to patriarchal belief, generally, fathers are not allowed to take care or pay much attention to wife.

b. **Misconception around 'not enough milk' -** This is one of the most common misconceptions held by members of the community, especially mothers-in-law. There are two aspects to it – one, it is believed that 'women are not producing enough milk' to satiate the hunger of the child and the other, it is considered that 'only milk is not enough for the child'; the child will not be full. Due to this belief, families initiate semi-solid or solid foods before 6 months. More than 1 in 10 children (12%) are given something other than breastmilk during the first three days. One of the most common rituals is to get the baby to taste some honey. The other is to feed jaggery mixed with water (gud ka paani) or gutthi (mix of breastmilk,

almond paste, khari and nutmeg). Practices like feeding only from one breast, so the milk in the other doesn't flow well are observed and misconstrued as not having enough milk.

c. **Knowledge-action gap -** It was found that incorrect practices are prevalent despite beneficiaries knowing the correct information. Many mothers-in-law argue with daughters-in-law that they know better than the doctors. Beneficiaries are also motivated by their personal experiences. If there is even one miscommunication, they stop practising the behaviour.

d. **Awareness on technique of breastfeeding -** Many first-time mothers face difficulties in breastfeeding since they are unaware of the position, face issues with latching, etc. In some cases, the nipple is tied with a thread for better feeding. In others, mothers can't hold the child for feeding. This could also be as she got immunised so finds it difficult to sit or is unaware of the correct posture.

e. **Balancing work and household chores -** Child's breastfeeding is affected when mother goes to work in the fields or is occupied with household chores. In many cases, if mothers spend more time with children, they are accused of not working. Many employers, especially in daily wage work, do not allow mothers to take the necessary breaks to feed the child. Taking the child to work is also not possible for many. In these cases, when the mother does not have access to the child, the grandparents feed water or gud ka paani or gutthi or even biscuits sometimes to satiate the hunger of the child and calm him/her down.

f. **Maternal nutrition -** Lactating women who are suffering from poor nutrition or are not able to take care of their diet properly face difficulties in producing breast milk and feeding the child.

BEHAVIOUR 10	CURRENT SITUATION
Mother and family members initiate complementary feeding at the age of 6 months of the child, ensuring consistency (differentiate by age groups), quantity (optimal portion size), quality (home-based freshly cooked), diversity of diet (including THR) and frequency	At age 6-8 months only 40% children receive breastmilk and complementary foods (NFHS-5). Only 36% of children aged 6-23 months are fed the recommended minimum number of times per day and even fewer (16%) are fed from the appropriate number of food groups. Only 7% are fed according to all three recommended practices (NFHS-4).

BARRIERS AND ENABLERS

With complementary feeding, opposite trends are observed. In some cases, it is initiated early when children should only be exclusively breastfed and, in some cases, it is initiated late till the child learns to sit on his/her own.

a. **Misconception around 'not enough milk' -** Most women consulted said they breastfeed for 6 months and feed colostrum to the baby; however, they also agreed that families sometimes initiate feeding of biscuits, gutthi, tea to the baby before 6 months. One of the most common reasons is the perception that breastmilk is not enough to satiate the hunger of the child. In some cases, complementary feeding is initiated early due to annaprasana ritual (first time a child is fed solid food).

b. **Delayed introduction -** In the case of complementary feeding, the opposite scenario is also observed. In some communities, there is a belief that children should be fed after they learn to sit otherwise it will affect their legs. This happens almost at 11 months, which significantly delays the timing of initiating complementary foods.

c. **Access and agency of working mothers -** Complementary foods are often initiated in the absence of mother (when she goes to work or is busy with household chores), when families feel that the child is not getting enough milk or when the crying child needs to be pacified. Working mothers (rural areas) have limited control about when / what / how children eat.

d. **Self-efficacy -** Mothers with poor self-efficacy feared that their child would become ill, and they would be blamed, if family members' and elders' advice is not followed.

e. **Awareness on nutritional value of foods -** It was found that many women had limited awareness on the variety of nutritional benefits from different types of foods and what can be fed to the child for their cognitive and physical development.

f. **Lack of food in households -** Poor income households are often unable to purchase and stock good quality, nutritious food items required for good health.

g. **Meal pattern -** A two-times a day meal pattern is followed in areas like Narsinghpur. The same applies to children as well. In many villages, children eat once at AWC and then evening supper/dinner at home.

h. **Linkage between growth monitoring and feeding -** There is limited efforts by some AWWs to link growth monitoring with child feeding practices. The significance of measuring the child's height and weight is often not communicated along with the importance of nutrition.

OTHER ENABLERS

i. **Effective counselling by AWW/ASHA to family members (including men) on nutrition topic and low-cost nutritious recipes -** Many Anganwadi workers ensure frequent home visits to families of children aged 6-8 months old and provide repeated counselling to mothers about the importance of timely initiation of complementary feeding. This also boosts the mother's confidence in adopting correct feeding practices.

j. **Mangal Diwas -** Mangal Diwas, including Annaprasana ritual at AWC, is a platform for women to receive advice from AWWs about complementary feeding.

BEHAVIOUR 12	CURRENT SITUATION
Children aged 2-6 years consume body-building foods (protein), immunity-boosting foods (vitamins, minerals) and energy-giving foods, including THR (2-3 years) and hot-cooked meal (3-6 years)	The trend observed in complementary feeding extends to the nutrition of age group of 2-6 years as well. A baseline survey by GIZ in Sheopur and Chhatarpur districts found that children suffered low dietary diversity in children <2 (<4 food groups) (77.4%).

BARRIERS AND ENABLERS

a. **Meal pattern -** A two-times a day meal pattern is followed in areas like Narsinghpur. The same applies to children as well. In many villages, children eat once at AWC and then evening supper/dinner at home.

b. **Tradition of not eating food cooked by others -** There is Bhagat parampara in Alirajpur, (followed by over 30% of the population). People following this tradition do not eat what others have touched. This affects nutritional intake.

c. **Food preferences -** Local food is put in Poshan Matka, which is not preferred by many. Some women tell AWW that they are being given what is available in their homes, so they lose interest. Some mothers don't want to take or feed their child THR since they feel it is the same since the last 13-14 years.

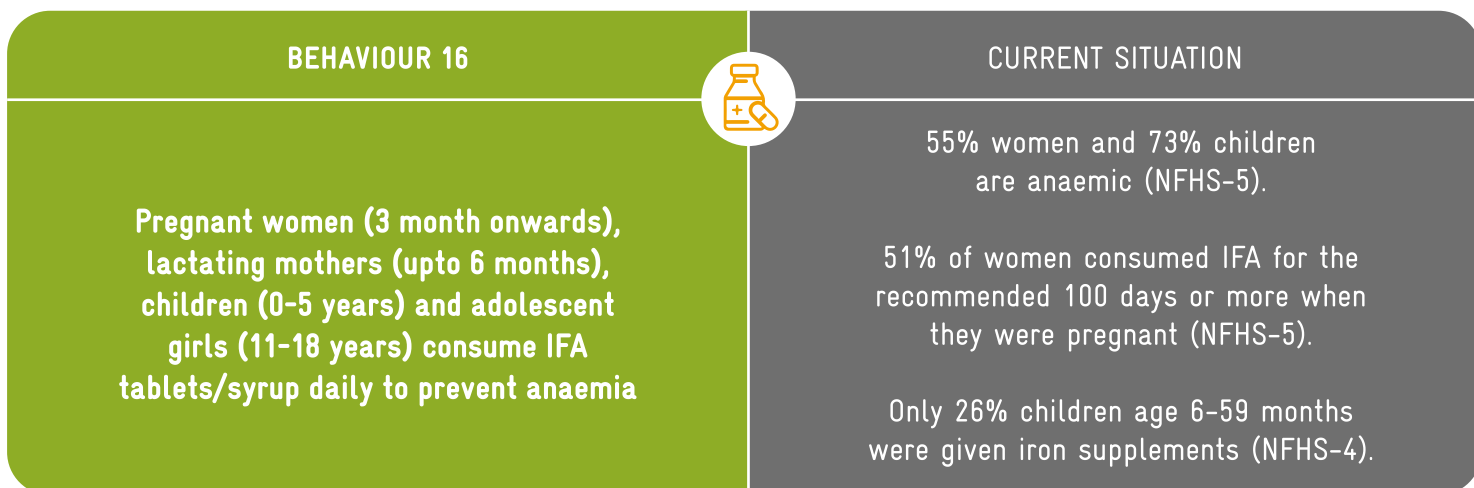
d. **Access and agency of working mothers -** Many mothers are not able to take care of their children when they go to work. In her absence, at home, the grandparents often feed the child what is there at home but pay limited attention to whether the child finishes the meal, how much he/she eats, etc. Many mothers lack the time to prepare nutritious meals as they have to go to work, sometimes travelling long distances.

e. **Awareness on nutritional value of foods -** Many parents lack the know-how on which foods are best for the cognitive and physical development of children. Men lack knowledge about adequate nutrition of children.

OTHER ENABLERS

f. **Effective counselling by AWW/ASHA to family members (including men) on nutrition topic and low-cost nutritious recipes.**

g. **Access to local, nutritious food -** This includes THR, community nutrition gardens (CNG), which have been regarded as a positive intervention which not only helps women earn money but also provides local, nutritious food and other initiatives improving families' access to food.



BARRIERS AND ENABLERS

a. **Awareness on first signs -** Many AWWs are not aware of the first signs that they can observe to recognize a person is suffering from anaemia. Many beneficiaries are also not aware of the signs and symptoms of anaemia. Anaemia is often detected when it becomes as severe as requiring a blood transfusion.

b. **Misconceptions -** There are beliefs that consuming iron tablets will make the child dark so pregnant women avoid consuming IFA. IFA tablets are considered 'heat inducing' and many elders restrict pregnant women from consuming it.

c. **Association with negative experience -** Many women and children stop consuming IFA tablets/syrup after suffering symptoms of loose motions, nausea (which is usually accompanied with consumption of IFA).

d. **Connect with pregnancy registration -** Many pregnant women do not receive IFA on time since they don't declare their pregnancy or receive ANC.

e. **Awareness on nutritional value of foods -** There is lack of awareness on what is iron and iron-rich foods and what can be consumed to reverse anaemia.

f. **Provision for Haemoglobin (Hb) testing -** This provision is lacking. Haemoglobin levels are found out only after 5 years when the NFHS surveys are done. In the interim, it becomes difficult to track anaemia status among women and children. Only families that have children with NRC get Hb tests, not others.

OTHER ENABLERS

g. **Sensitising newly married couples -** Newly married couples need to be sensitized on anaemia testing and pregnancy registration

h. **Focus on IFA consumption along with distribution -** There is a need to build awareness on what is iron and why it is important when distributing IFA pills.

i. **Awareness among other women -** Many non-pregnant and non-lactating women are unaware that they can consume IFA if suffering from anaemia. (This is not directly related to this desired behaviour but rather an extension of it because all women aged 15-49 years must consume IFA and iron-rich foods to prevent anaemia).

BEHAVIOUR 19	CURRENT SITUATION
Anganwadi workers (along with Accredited Social Health Activists and Auxiliary Nurse Midwives) conduct screening and referral of complicated severe acute malnourished (SAM) children to Nutritional Rehabilitation Centres (NRC) and follow-ups	36% of children under 5 years are stunted (low height as per age) and 19% are wasted (low weight as per height). 33% are underweight (NFHS-5). Among the children who are eligible to receive services at the AWC, 58% had received growth monitoring, 52% health check-ups and 60% supplementary food (NFHS-4). Families are still hesitant to take children to NRCs.

BARRIERS AND ENABLERS

a. **Reservations on keeping children overnight at NRC –** Many families are reluctant to keep children overnight at the NRC and do not also want to keep them there for 14 days.

   i. One of the main reasons is that mothers are concerned there will be no one to take care of the other children if they are away with one child at the NRC.

   ii. Other reasons include concerns by family members that if the mother is away, who will cook food, take care of the pets, etc. Many husbands tell AWW "tu aayegi kya mere ghar mein khana banane" (you will come to cook food in my house or what!)

   iii. Only when AWW take complete responsibility and take the child to NRC and bring them back home at night every day do families comply in some cases. But it's not always possible for AWW to do this every time, for every child.

b. **Women agency -** Many women refuse to take their child to the NRC without husband/mother-in-law's permission. Even if they are convinced, if the husband/mother-in-law are not home and they take the child, women fear that they will be reprimanded for it later. In Dhar, especially in Muslim families, AWW don't get access to women to explain about NRC. Elders don't allow AWW to talk to women on the issue.

c. **Monetary concerns -** Even though monetary support is provided to guardians accompanying the child to the NRC, many fathers opine that they earn more money in a day than what monetary support is given. They are reluctant to forgo their daily wage in lieu of accompanying the child to NRC.

d. **Preference to traditional medicine -** Many families also prefer traditional medicine rather than NRC. They opt to visit quack doctors or 'ojhas' rather than taking children to a hospital, especially in tribal areas. Many also feel that children will get better on their own.

e. **Association with experience -** In some cases, mothers feel that the food given at NRC is not good/ adequate. (At NRCs, the focus is on treating the SAM child and mothers are given special diets during their time there like milk, etc.). Such mothers spread the same in the community when they return which deters others from going to the NRC.

OTHER ENABLERS

f. **Education of women -** Women in areas with better access to cities and with education degree till Class 10-12 were aware that weight and height measurement of children are indicators of malnutrition.

BEHAVIOUR 20	CURRENT SITUATION
Angwanwadi worker enrols uncomplicated SAM children under CSAM programme	Followed in AWCs but not all children tracked due to family resistance

BARRIERS AND ENABLERS

a. **Acknowledging and understanding importance of malnourishment -** Many parents are reluctant to accept that mother and child are malnourished. They feel that the child is playing and running around, so he/she cannot be malnourished. In Adivasi belt of Sagar, often children are found playing without clothes, playing in dirty water and parents find that to be ordinary - "samanya vyavahar mante hai" (it's normal behaviour). When AWW try to explain the need to take care to prevent malnutrition, they are told sentences like "kya yeh aapki problem hai, aap chup karo" (is this your problem, keep quiet) (Indore), "it is my child, what is your problem?" (Rewa), etc. In Jabalpur, AWW feel that beneficiaries are unable to understand the gravity of the malnutrition issue - "They are afraid of cancer, but not malnutrition."

b. **Priority to work and livelihood -** Income poverty and financial concerns are a major reason why many families tend to give more priority to work and earning money and they are unable to think much about the children they leave home (when they migrate or go to work). In the absence of the parents, the elders and older siblings are at home who take care of the younger children. In some cases, the elders are not concerned about the care of young children and in other cases, they are overtly involved to the point that mothers fear to take decisions for their children's health if it upsets the mother-in-law. Malnutrition is high in children of migrant parents. This makes it difficult for AWW to monitor the growth of the child and health of the woman. In such cases, the children go back to SAM status. When the families return, it puts pressure on the AWW to improve nutrition levels. Such families

also get left out of vaccinations when they migrate.

AWWs shared that during the COVID pandemic, when families couldn't migrate and had to be at home, nutrition levels of children went up. This is because families could give time and took care of the children. However, due to economic concerns and lack of understanding on the importance of nutrition, they are unable to invest in quality care of their children on a regular basis.

c. **Support from villagers -** There is a lack of support from villagers in reducing malnutrition; it is considered to be AWW's work.

BEHAVIOUR 27	CURRENT SITUATION
Parents send their children to AWC for the entire duration to receive complete quality pre-school education	63% of children under 6 years receive services of some kind from AWC. However, the service that is least likely to be accessed is ECCE (42% of children age 3-6 years) (NFHS-4). As per Annual Status of Education Report (ASER) 2018, at age 3, 72.6% children are enrolled in AWC. This enrolment rate declines with age - age 4 (61.4%), age 5 (24.4%) and age 6 (5%).

BARRIERS AND ENABLERS

a. **Preference to private schools -** There is a strong preference by most parents to send their children to private school instead of AWC for ECCE. Some of the reasons given by parents are that it becomes easier to enrol children in higher classes if they are enrolled at pre-school level and children will learn more subjects and get certificates at schools.

b. **Skill level of AWW -** Some AWW feel they are not able to do ECCE activity well. Due to varying skill levels, many AWW have low level of competency as ECCE instructors. They are also unable to balance the quality of ECCE with their multiple tasks.

c. **Delay by children -** Children do not come to the AWC at the dedicated 9am time slot for ECCE. One of the reasons for this is that they wake up at 8-9am. They end up coming late at 10.30am with the older children. (This is seen in Mandsaur).

OTHER ENABLERS

d. **ECCE coordinator -** In previous years, AWW supported by designated, trained ECCE coordinators were able to deliver ECCE well.

BEHAVIOUR 28	CURRENT SITUATION
Parents ensure that their daughters (11-14 years) re-enrol in school	From 2016-17 to 2018-19, school dropout among girls has sharply increased. This was identified when the THR went up from 1,22,230 to 3,05,000 in the time period (Times of India, 2019). In Madhya Pradesh, the dropout rate at upper primary level (Class 6-8) is 12.06% in girls (Unified District Information System for Education Plus).

BARRIERS AND ENABLERS

a. **Safety concerns and distance between school and home –** Many parents discourage girls from pursuing higher education due to low value attributed to education as well as concerns over safety. Middle and high schools are often far from the villagers (7 km or more) and parents feel that girls will not be safe in the travel. Girls also refuse to travel that distance feeling the areas are desolate or forest areas and they will not be safe. Some girls say they want to study but won't go against family. There is also a lack of trust in children by many parents. Even in areas where schools are near, some parents are reluctant to send girls to school because they fear she might be eve-teased on the way or be pursued by older boys (leading to elopement).

b. **Experience with violence -** Girls who have faced violence are reluctant to go to school.

c. **Domestic responsibilities -** Many older siblings are dropping out in primary to middle school due to having to take care of younger siblings. Some girls are taken to work by the mother so that she learns the job.

d. **Disconnect with academics -** Once studies get difficult, or they fail one-two subjects, some girls get discouraged and do not want to continue school. In the event that they have to discontinue due to an illness or other reason, they are reluctant to go back fearing that they won't be able to cope up with academic pressure. Many men feel there is no point in forcing children who do not want to study; it is better to let them work.

e. **Marriage -** Many girls drop out early to prepare for their impending marriage (child marriage).

f. **Menstruation -** Many girls hesitate to go to school once started they start menstruating because of inadequate facilities in the school and stigma around menstruating girls.

g. **Discontinuation due to migration -** Child education gets affected due to migration. Many parents are unable to enrol their children anywhere since they keep moving. With low education, probability of child marriage increases.

h. **Discontinuation due to COVID pandemic -** Due to the pandemic, many children are not in school. Economic conditions have forced them to enter the workforce or do begging. There is also a digital divide leading to lack of access.

i. **Women agency -** Mothers want that their children go to school but only few are willing to go against husband/family to insist on education if husband/family refuses.

OTHER ENABLERS

j. **Children strongly refuse marriage -** Incidences of child marriage are lower in cases where the girl or boy strongly refuse to get married before completing their desired level of education.

k. **Encouragement by peers -** Girls are more likely to continue going to school if they peers are going. This is especially in the case of schools that are far off. When a group goes, parents are less afraid over safety of their daughter and allow her to go to school.

l. **Education of women –** Educated women are the most insistent when it comes to encouraging their daughters to study. They are willing to stand in opposition to their husbands on this matter. However, it's rare.

BARRIERS TO ADOPTION OF OTHER NUTRITION-RELATED DESIRED BEHAVIOURS

Other pregnancy related behaviours

1. There is lack of awareness about service package of ANC and current available facility like VHSND. Many pregnant women are unaware of the need for immunisation. Pregnancy monitoring is highly dependent on the women going for their ANC visits.

2. For some home births, JSY vahan doesn't reach because beneficiaries don't inform on time.

Menstrual Health and Hygiene Management

1. There is still a lack of knowledge on how to maintain hygiene during menstruation.

2. Many girls still hesitate to talk about menstruation. In some cases, the Panchayat representatives also feel uncomfortable talking about MHHM with girls.

3. Many girls still use cotton clothes in place of napkins. They are also concerned about the cost of napkins.

4. Many girls don't want to go to school when they are going through menstruation because of the lack of toilets and proper water, disposal and hygiene maintenance in the ones where toilets are there.

5. There are prevalent myths like girls can't touch pickles, can't go to temples or kitchen, can't handle food.

6. Girls' diet is affected by myths that they should not eat sour food or consume milk when menstruating.

Water, Sanitation and Hygiene (WASH)

1. In MP, there is still high unavailability of pure drinking water at home - it takes over 30 minutes to obtain drinking water and only 8% treat the water at home.

2. Awareness related to cleanliness and handwashing has come, especially after COVID, but there is still scope for progress. Sometimes beneficiaries simply forget to follow hygiene. In many of the tribal villages, children are observed in a very unkempt state – have not bathed, washed hair, do not wear underpants.

CHILD PROTECTION

BEHAVIOUR 31	CURRENT SITUATION
Men and women do not practice verbal, physical and sexual abuse against girl and boy children in the family, school, workplace and public places (including passing comments, eve-teasing, inappropriate touching, staring, beating, slapping, bullying, rape, etc.)	• 19028 children have faced violence against them. • In 2019, 31% children were victims of kidnapping and abduction. Of this 18% were cases of missing children which were deemed as kidnapping due to inability to track whereabouts. 5% kidnapping cases were to compel the minor girl to marry. • In the last 3-5 years, cases of sexual abuse and violence against girl children has increased. 21% children faced sexual abuse in 2019. 6123 child sexual abuse cases have been registered under POCSO Act. 15% girls were victims of sexual abuse under POCSO. Of this, 8% were victims of rape and 7% were victims of sexual assault. • 11022 children have been reported as missing. (NCRB 2019) • 7 lakh children aged 5-14 years are employed as labourers (Census 2011)

BARRIERS AND ENABLERS

a. **Awareness on rights of children -** Largely, school-going children in urban areas are aware that they have rights and know a little about the types of touch (safe, unsafe and confusing). Right to Survival and Development is commonly known. In comparison, Right to Protection and Participation is less known. Children who are not going to school lack awareness on rights. In general, many children do not understand or identify what acts of violence are. They lack awareness on laws protecting them like the POCSO Act.

b. **Unmonitored social media and internet usage -** Through social media and usage of mobile phones, girls and boys are getting connected, without understanding the pitfalls of such cyber interactions, etc. Many POCSO cases were found in such scenarios. Boys and girls are unaware that even with mutual consent, underage sexual relations are a criminal offence. Unmonitored access and use of the internet has perpetuated the problem.

c. **Children getting employed -** In many families, where the father is an alcoholic and abusive, the children start working. Working and earning money makes them feel independent and thus, they stop studying. This affects their education, development and eventually, some of the children get married as minors or engage in illegal activities. In other cases, as soon as children reach a certain age and maturity, they are put to work – "jaise hi bache thode samajhdar hote hai, unhe kaam mein laga dete hai".

d. **Violence as a means to discipline -** Violence is accepted as a means to discipline children, especially in rural areas. Neighbours do not interfere if a parent is beating his/her child.

e. **Victims of domestic violence -** Children are also sometimes the victims in domestic violence cases (often targeted after the mother).

f. **Victim blaming and treatment of girls -** In case of violence against girls, victim blaming is common. Many people believe that the girl is only bad and responsible for what happened to her. Many such girls are then not accepted by her own family thereby increasing her vulnerability to trafficking and abuse. In tribal communities, mentally disabled children are married off or 'given to someone'.

g. **Child marriage as guise for trafficking -** Child marriage is often used as a guise for trafficking. Girls considered 'bad' are sold off (slave marriage). In tribal areas, in particular, groom's family pays money to bride's family to buy girl for marriage. There is a 'bride price'.

h. **'Violent' traditions -** By tradition in some communities like Bediya (Morena), Banchda and Sansi (Rajgarh), minor girls (12-13 years+) are sent as prostitutes. Generation to generation sex workers are found in these communities. Children are sold by their parents.

i. **There is ignorance that boys face abuse.**

j. **Issues in jurisdiction -** For prevention of trafficking, there are issues in jurisdiction, lack of coordination between CWC, DCPU and Police of different jurisdictions.

OTHER ENABLERS

k. **Awareness programmes in schools -** In some districts, every week functionaries go to schools and interact with children, giving them information about trafficking and what schemes and provisions are required to support them (Class 6 to 12, go to every school and talk to children and for under 6, talk to guardians). RKSK coordinators come to teach children about gender, child rights, EVAC.

l. **ECCE admission -** Admission into ECCE is a way to track if a child has gone missing or not by taking note of his attendance/absence.

m. **Education of women -** Women in areas with better access to cities and with education degree till Class 10-12 were aware that weight and height measurement of children are indicators of malnutrition, and that women and children have rights.

BEHAVIOUR 33c	CURRENT SITUATION
Girls and boys pursue and complete higher education (atleast Class 12 and higher)	The dropout rate of boys is 8.16% while among girls, it is 6.63%. At the upper primary level, the dropout rate is higher for girls at 12%, compared to boys at 10%. As of 2015-16, the average annual dropout rate of boys at the higher secondary level is 7.85% while 5.49% girls quit from study at secondary level (Unified District Information System for Education 2015-16).

BARRIERS AND ENABLERS

a. **Denial over gender discrimination –** In general, there is still a basic denial by many men and women over the discrimination meted out against a child based on their gender. The standard answer people give is that they do not discriminate between girls and boys. What they mean is that they give them equal quantities of food in meals and send both to school. But often girls are the ones that are made to drop out early to prepare for marriage or over concerns of their safety. Boys are also made to drop out to earn and support the family.

Most men are uncomfortable to talk about incidences of VAWG and do not acknowledge gender discrimination. School-going adolescent girls have awareness on gender discrimination.

b. **Value of education and children getting employed -** Low-income households often give priority to work and livelihood. It has been observed that in many such families that education for them must translate to employment or it has minimal or no value. In many cases, as soon as children reach a certain age and maturity, they are put to work. When families migrate, children are put to work (and subsequently married off) instead of being put in school. In many families, where the father is an alcoholic and abusive, the children start working. Working and earning money makes them feel independent, and thus, they stop studying.

c. **Safety concerns and distance between school and home –** Many parents discourage girls from pursuing higher education due to low value attributed to education as well as concerns over safety. Middle and high schools are often far from the villagers (7 km or more) and parents feel that girls will not be safe in the travel. Girls also refuse to travel that distance feeling the areas are desolate or forest areas and they will not be safe. Some girls say they want to study but won't go against family. There is also a lack of trust in children by parents. Even in areas where schools are near, some parents are reluctant to send girls to school due to the fear that she might be eve-teased on the way or be pursued by older boys (leading to elopement).

d. **Experience with violence -** Girls who have faced violence (at home, school or public place) are reluctant to go to school. Boys who have been victims of bullying also tend to drop out of school.

e. **Domestic responsibilities -** Many older siblings are dropping out in primary to middle school due to having to take care of younger siblings.

f. **Disconnect with academics -** Once studies get difficult, or they fail one-two subjects, many children get discouraged and do not want to continue school. In the event that they have to discontinue due to an illness or other reason, they are reluctant to go back fearing that they won't be able to cope up with academic pressure. Many men feel that there is no point in forcing children who do not want to study; it is better to let them work.

g. **Marriage -** Many girls drop out early to prepare for their impending marriage (child marriage). Many boys leave school when they migrate and eventually get married.

h. **Menstruation -** Many girls hesitate to go to school once started they start menstruating because of inadequate facilities in the school and stigma around menstruating girls.

i. **Discontinuation due to migration -** Child education gets affected due to migration. Many parents are unable to enrol their children anywhere since they keep moving. With low education, probability of child marriage increases.

j. **Discontinuation due to COVID pandemic -** Due to the pandemic, many children are not in school. Economic conditions have forced them to enter the workforce or do begging. There is also a digital divide leading to lack of access.

OTHER ENABLERS

k. **Children strongly refuse marriage -** Incidences of child marriage are lower in cases where the girl or boy strongly refuse to get married before completing their desired level of education.

l. **Encouragement by peers -** Girls are more likely to continue going to school if they peers are going. This is especially in the case of schools that are far off. When a group goes, parents are less afraid over safety of their daughter and allow her to go to school.

m. **Education of women –** Educated women are the most insistent when it comes to encouraging their daughters to study. They are willing to stand in opposition to their husbands on this matter. However, it's rare.

BEHAVIOUR 39	CURRENT SITUATION
Parents do not marry their girls and boys before they reach the legal minimum age of marriage	23% of women aged 20-24 years were married before the age of 18 years 30% of men aged 25-29 years were married before the age of 21 years (NFHS-5). 5% kidnapping cases were to compel the minor girl to marry (NCRB 2019). Young women who had no schooling are much more likely to have started childbearing (27%) than those with 12 or more years of schooling (2%) (NFHS-4). Education levels therefore have a significant impact on child marriage and early child-bearing.

BARRIERS AND ENABLERS

a. **Fear of elopement -** Child marriage is more common in the rural areas. One of the main reasons for this is the fear that the girl will elope and bring dishonor to the family. When AWW try to explain, many men and women tell them "agar ladki bhaag gai, nak kat gai, toh aap aaogi kya?" (Will you come to save our face when the girl runs away from home and brings dishonour to our family?).

b. **Concerns over safety -** Safety of girls is one major reason why child marriages are high. Many families become concerned that once girls hit puberty, their risk of being sexually harassed, eloping with a boy, etc. becomes higher. This is why restrictions are posed on education and even employment. Once girls get older, their mobility is also restricted. They are not allowed to leave the house after evening time or go to places without a chaperone. Lack of social security deems marriages as the only safe option for daughters by families. In Ujjain, many parents are concerned that something will happen if children are left alone. They feel that if they send child to school, the child will leave after school gets over and what they will do then. They feel they can't leave children alone at home and can't send them to school unmonitored, least they get involved with children of the opposite sex. In some cases, girls were found lying to their parents and going elsewhere instead of school. Due to schools being far off, fear of safety, girls are made to drop out and subsequently married off – parents consider it to be "saving their lives".

c. **Value of education -** Low value is attributed to education which makes many parents discontinue their children's studies and marry them off instead. Some girls are not interested in bridge /vocational courses. They and their parents feel that they have studied till Class 9-10 which is enough. Then they get married. Child marriage is high in tribal blocks especially because they think what will the child do sitting at home, it is better to get them married.

d. **Awareness on pitfalls of child marriage -** In villages with better access to urban areas, people were aware of the pitfalls of child marriage. However, in rural areas, awareness is low. Largely, women say that they do not support child marriage, but they will not report against it. Some feel that girls are excited and want to marry (as a minor). Children, largely, were unaware of the pitfalls and how it perpetuates the cycle of malnourishment.

e. **Girls considered a social burden -** Due to high income poverty, many families prefer to get girls married off to reduce household expenses. They also regard boys higher because they believe the boy will work and bring income into the household which the girl will not. Loss of livelihoods during pandemic further pushed poor families to opt for early marriages.

f. **Importance attributed to marriage –** People in the rural areas in particular save money to get their children married; they don't save up for education as much. Many parents opine girls can continue their education after marriage, if her in-laws give her permission. But priority is to ensure that the girl gets married in time, to a good family. That is what such parents consider their primary responsibility.

g. **Unsafe cyber usage and POCSO cases -** Through social media and usage of mobile phones, girls and boys are getting connected, without understanding the pitfalls of such cyber interactions, etc. There is little awareness on safe cyber practices. Many POCSO cases were found in such scenarios. Boys and girls are unaware that even with mutual consent, underage sexual relations are a criminal offence. When girls are found in such scenarios, they are married off soon to cover up the incidence.

h. **Migration -** It was found that when people migrate with full families, adolescent girls and boys are often put to work. In such cases, the boys are then married off to become responsible men and earn for the family. In Dhar, at the age of 16-17, many girls migrate for work. When they return, they have a child in their arms. Such women if they stay in the marital home, also face violence. Many times, they file a case against the person they went with under family pressure. Sometimes they desert the child - this is rare, but it happens. When abandoned by family members, it also becomes difficult to keep these girls in CCI because of the fear of the impact they will have on the other children in care.

i. **Age of maturity/responsibility and need for earning members -** Another reason that child marriage is common is that many parents believe their wayward children will become better if they undertake responsibility - "zimmedari aaigi to sudhar jayega". One more reason is that low-income families want more earning members and feel that they will get the son married and get him employed.

- Dahej - Dowry practice is still widely prevalent. A young bride means lower dowry so child marriages are high.

- Nathra - In Bhopal-Narmadapuram, there is Nathra tradition. At an average of 12-15 years, girls are engaged to a boy. As it happens that the girl continues education and becomes more educated than the boy who discontinues and joins work. In such cases, then the girl doesn't want to marry the boy and the families get into a major fight with the groom's family expecting the bride's family to keep their word. In most cases, child marriages eventually happen.

- Dehaj Dhapa - There is a norm of Dehaj Dhapa prevalent in Indore division - when the girl and boy elope. In case, if they are caught and brought back to the village, and talks about their marriage comes up, the girl's family demands 8-10 lakh rupees in exchange for the girl's hand in marriage. If the boy's family refuses, POCSO case is registered against the boy. (Consent for sex is considered invalid in the case of minors, as per the law). In situations, where the girl refuses to file a case, admitting that she ran away from her own will, there is a tremendous pressure from the villagers to do so. This is because the money that will be given by the boy's family will be used in a wedding feast and that will be given to all villagers. There is also a fear of isolation by fellow villagers so the girl's family caves.

j. **Marriages during auspicious time -** Child marriage is common in February - March when it's the auspicious occasion of Akshya Trithiya and during festival season like Holi and Diwali. Migrants return home during this time, because of festivals and to rent out their farms, etc. This is also a time when they get their children married.

k. **Issues in enforcement –** In many cases, officials stop child marriages, but the families later stealthily get the children married. To negate that, proof is required which becomes a challenge. Many families also

threaten AWW when they go to stop child marriages.

OTHER ENABLERS

l. **Children strongly refuse marriage -** Incidences of child marriage are lower in cases where the girl or boy strongly refuse to get married before completing their education.

m. **Male engagement -** Engaging and interacting with fathers for child marriage is important. They are the main decision makers in the family.

BEHAVIOUR 42	CURRENT SITUATION
Men and women report cases of child marriage to 1098 or Police	Underreporting of child marriages is high (Data from workshops and field).

BARRIERS AND ENABLERS

a. **Stigma against reporting –** Reporting of child marriage cases is relatively low, because of the stigma and fear that the girl will not get married if police comes to the wedding (to stop the marriage).

b. **Awareness on helpline numbers -** It was found that children were more aware of the 100 (Police) and 181 (CM Helpline/Women Helpline) number but there was little awareness on 1098 (Childline) number.

OTHER ENABLERS

c. **Reporting by peers -** In many cases, child marriages were prevented when peers reported the marriages.

BARRIERS TO ADOPTION OF OTHER CHILD PROTECTION-RELATED DESIRED BEHAVIOURS

Proper care for CNCP in child care institutions

1. It has been reported that staff at the CCIs do not maintain individual assessment, care plan and regular review. There is a lack of sufficient resources for education, nutrition, vocational training.

2. There is a lack of homely environment for children in CCIs. Whole care home is looked after by 1-2 persons – number of workers are comparatively lower than required. Older children brainwash younger children disrupting appropriate care for both.

3. There is a lack of homes for children with special needs – they are asked to go to Social Justice. Most staff members do not know how to handle children with special needs.

4. There is overcrowding in institutions. Care homes for CNCP children in Rajgarh district is not there. Girls sent to Bhopal and boys sent to Ujjain.

Adoption

1. Families prefer to adopt infant children. People are reluctant to adopt children over 6 years of age. Some of the reasons for this is that they do not want children who have developed an understanding of the

world ("duniyadari ki samajh").

2. Older children brainwash younger children - younger children insist they want to stay at the home with the older children instead of with a family.

3. There is a stigma against adoption

4. The attitude of parents is that "I want a child", not that the "child needs a family" - therefore, when any issue crops up, they want to return the child/face struggles leading to child finding it difficult to adjust.

5. Families do not want to adopt children with special needs and hard to place children (children whose placement has seen disruption).

Foster Care

1. There is a lack of awareness on foster care and prevalent stigma.

2. If there is some friction with the child, the families seek to return the child which causes disruption for them.

3. Older children brainwash younger children causing disruption in foster care process especially with children insisting on returning to homes.

4. Foster care is often used as a back-door entry for adoption (for adopting preferred child). Currently the adoption process doesn't allow you to 'select/choose' the child you want to adopt.

5. Counselling prospective parents is important; however, quality of counselling is poor - it is being done just as a formality.

Rehabilitation and counselling of children in conflict with law

1. It has been observed that most CCLs come from a poor socio-economic background, dropped out of school, addicted to drugs/alcohol, suffer from depression and mental health issues, victim of violence and mostly they are on their own. Boys and girls involved in child marriages are also highly vulnerable. Child marriage is taken as seriously as marriage - children in the marriage then feel they need to take responsibility and do something. When they are unable to get gainful employment, they then take illegal means. They also get addicted to alcohol and commit acts of violence.

2. In Bhind-Morena, importance is given to things like gun license, etc. Exposure to such things at a young age has made children's attitude rough and they often slide "will hit you, will kill you" kind of words in conversation. A violent mentality develops at a young age.

3. Adults use children in criminal activities especially drug peddling by getting the children addicted to the substances first.

4. Children are reluctant to undergo counselling. The quality of counselling is also poor – it is done just as a formality.

5. Some boys face sexual abuse in observation homes, so they run away.

6. CCL process should get over in 6 months but in many cases, children don't get bail.

7. CCL children face stigma and labelling and are treated as criminals and not children which affects their rehabilitation.

Substance abuse by children

1. Substance abuse is most commonly done by children who follow what they observe from their parents – common substances they start with includes tobacco and gutka. Such children then don't go to school. They have their name enrolled in school but do not attend. As per RTE rules, they keep passing but no gainful education is received by them. Boys start having gutka and supari from Class 3, 4. Many children start gambling once they are a little older.

2. If exposed to substances in society or at home, children are more likely to take it up.

3. Adults use children in criminal activities especially drug peddling by getting the children addicted to the substances first.

4. Case of substance abuse is higher in children who are not associated with families.

5. Lack of parental care is also a causal factor behind addiction in some children.

6. Drug cases are often not registered – They have to go into detail investigation into the whole network of organised crime which is a deterrent.

WOMEN SAFETY & EMPOWERMENT

BEHAVIOUR 45,51	CURRENT SITUATION
Men and women treat girls and boys equally at home, school, workplace and society	The sex ratio of the total population in Madhya Pradesh is 970. There are however, huge differences in district statistics. In 2019-21, the highest sex ratio is recorded in Seoni at 1089 and lowest in Sehore at 894 (NFHS-5). 18-19% of women and men in the state want more sons than daughters. Only 2-3% women and men want more daughters than sons (NFHS-4). 23% of women have had 10 or more years of schooling (NFHS-4).

BARRIERS AND ENABLERS

a. **Denial over gender discrimination –** In general, there is still a basic denial by men and women over the discrimination meted out against a child based on their gender. The standard answer people give is that they do not discriminate between girls and boys. What they mean is that they give them equal quantities of food in meals and send both to school. But often girls are the ones that are made to drop out early to prepare for marriage or over concerns of their safety. Boys are also made to drop out to earn and support the family. Girls are taught how to behave, their movement is monitored but boys are given free access to travel and discussions on understanding self, respecting self and others, behaving well with others is not done with them. Most men are uncomfortable to talk about incidences of VAWG and do not acknowledge gender discrimination. School-going adolescent girls have awareness on gender discrimination.

b. **Patriarchy and desire for son -** A strong patriarchal set-up still exists in society. Many families have a strong desire for sons. Even in tribal areas, where women are relatively empowered, preference for boys is increasing, VAWG is rampant and attitude towards women is poor. Families with no sons will refrain from availing the LLY scheme because they still want to try for a son. Sex ratio is lower in urban areas than rural - it is suspected that sex detection is being done in urban areas resulting in illegal abortions. Although in the last 7-8 years, there have been improvements in gender situations, there is still a significant preference towards boys.

c. **Value of girl child -** Girls are considered a burden and financial responsibility by many families, with added challenges of ensuring her safety and security. Low value of a girl child combined with household poverty makes families think that they have to spend their limited resources on ensuring education, protection, marriage, dowry of girls, which does not reap benefits but increases household burden. Issues with ownership of land is also a reason why many families prefer boys over girls. In some communities, families with daughters have to always maintain a low profile, bow to others, touch the feet of daughter's in-laws, etc. Girls are thought to be ones who will leave home and become part of another family. Boys, on the other hand, belong to the family, will earn and support the household income. The patriarchal form of society further strengthens such views. Girls, therefore, face gender-based discrimination in all spheres. If any situation/event requires physical presence, then female participation is low. Girls still say that they have to seek permission of their fathers.

d. **Independent agency of women -** Many women don't have their own voice and say in decision making. There is high influence of husbands and family elders. If husband doesn't allow, women can't go out of the house or participate in activities. In Alirajpur, men are present in FGDs, but women are not. Many working women also have to give their earnings to the man or mother-in-law.

e. **Victim blaming -** Many girls hide their problems for fear of shaming and that no one will understand - they don't tell their mothers or AWW. Some girls feel that because of other girls they are receiving the punishment - they ask why they have to suffer because of what other girls did.

f. **Male engagement -** Communication is done often with adolescent girls and mostly on nutrition. AWC is not accessed by boys and men at all and often, they are left out of the conversation on gender issues and issues requiring their participation. Programmes that have addressed both boys and girls, especially in schools, have seen positive responses.

OTHER ENABLERS

g. **Participation of girls/women in community-based events -** When more girls and women participate in events which involve the larger community, they get an opportunity to share their thoughts and opinion which builds greater awareness and brings focus to gender issues. Girls who have stood against social norms and pursued their education, etc. prove to be an inspiration for other girls.

h. **Promotion of positive masculinity -** Women who are supported by husbands have shown higher education completion levels, participation in AWC (growth monitoring, ANC visit, immunisation, etc.). Some of these men do participate in meetings held at AWC when invited. Their example serves as positive deviance and encourages other families.

i. **Education of men -** NFHS-4 reported that as education among men increased, the desire to have sons decreased. Value of girl child is higher in families with educated men.

j. **Birth registration -** Birth registration helps to track service dissemination to girl children.

BEHAVIOUR 46,50	CURRENT SITUATION
Men and women do not practice verbal, physical and sexual abuse against girl and boy children and other men and women in the family, school, workplace and public places (including passing comments, eve-teasing, inappropriate touching, staring, beating, slapping, bullying, sexually inappropriate behaviour at work, rape, etc.)	• 28% women of ever-married women have experienced physical or sexual violence against them (NFHS-5). • 14% women faced domestic violence (cruelty by husband and relatives) • 14% women faced assault with intent to outrage modesty • 6% women were kidnapped to be forcefully married off • 6% women were raped • 8% women faced sexual harassment (per 1 lakh population) • 0.2% cases of cyber related violence • Other cases like dowry related abuse, acid attacks, witch hunting less than 2% • In 99% cases, the perpetrators were known to the victims (NCRB 2019) • 53% women find it acceptable for husband to beat his wife under some circumstances • 28% of ever-married women report having been slapped by their husband; between 9-14% have experienced other forms of physical violence. • 7% were victims of marital rape, having been physically forced by husband to have sex even when they did not want to. • 4% were forced with threats by husband to perform sexual acts they did not want to perform. • 12% women reported emotional violence by their spouse. (NFHS-4) • 96% women respondents in Bhopal rated sale of drugs/ alcohol in the vicinity as the most important reason for feeling unsafe, while being in a secluded or an isolated place was rated as the most important reason for feeling unsafe by 97% women in Gwalior. About 65% women feel unsafe owing to poor maintenance of public infrastructure such as streetlights and public toilets (Safety Pin, 2019).

BARRIERS AND ENABLERS

a. **Patriarchy and acceptance of violence -** The strong, current patriarchal set-up of the society enforces the idea among many that it is 'ok' to beat one's wife. Women are often treated as the weaker, second sex and violence against them, often at home, is deemed acceptable in several situations. An acceptance of violence was observed in half of the women population. These women find violence justifiable if she shows disrespect for her in-laws, if she argues with her husband and if he suspects her of being unfaithful. Other reasons include if she goes out without telling him, neglects the house or children, doesn't cook properly or refuses to have sex with him. 43% of men say that wife-beating is justified for the same reasons. The notion of acceptance of violence has another angle - groom's family pays the bride's family for the marriage. The girl is bought in marriage. That's why oftentimes she cannot complain if she is a victim of violence because she feels that she was bought with money and has no option.

b. **Intergenerational transmission of violence –** This phenomenon is stated as the high likelihood of children of violent offenders becoming violent themselves. Children often observe and follow what their abusive father does. Such children develop a violent mentality at a young age and commit crimes against women as well. On the other hand, it is also seen that women whose mothers were beaten by their fathers are twice as likely to be in abusive marriages themselves.

c. **Status in society and fear of isolation -** Women who are widowed, divorced, separated, or deserted are the most likely to have experienced violence during pregnancy. Not having a son is also one of the reasons mothers (and in many cases daughters) are subjected to emotional and physical violence. Majority of the cases such violence is inflicted by the mother-in-law. There is differential treatment between daughter and daughter-in-law. Abuse, especially verbal and mental abuse is meted out against the daughter-in-law. Young mothers in particular face a lot of abuse from their mother-in-law. There is also fear of being thrown out of the house or obligation to stay since a lot of money was paid to the family in exchange for the girl's hand in marriage. Fear of isolation, being kicked out of the house, not being welcome in maternal home are some of the reasons why women do not speak up against or report violence against them.

d. **Awareness on rights and protection mechanism -** Largely, rural women are unaware of their rights and do not understand what is happening with them is violence. Many people are unaware of the existence of Local Complaints Committee and Internal Complaints Committee and that they can report incidences of sexual harassment at the workplace.

e. **Feeling unsafe in public spaces -** Women in the urban areas (like Bhopal and Gwalior) consider using public spaces and public transport unsafe. Reasons for feeling unsafe include isolated/deserted public places, almost empty or overcrowded public transport, sale of drugs/alcohol in the vicinity, poor lighting, lack of public toilets/poor infrastructure, lack of police/security, lack of adequate signage/information and lack of vendors/stalls.

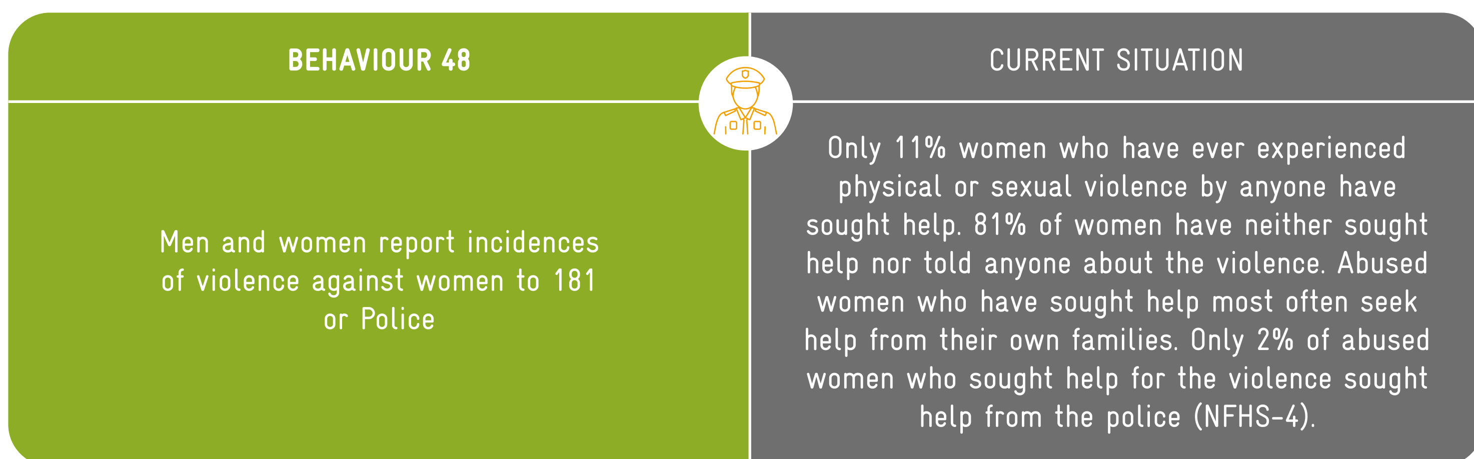
f. **Alcoholism -** Alcoholism is high in many rural places in MP which is a causal factor behind wife beating. In many cases, the husband comes home drunk, doesn't let the woman eat, creates havoc and beats his wife. If the wife is pregnant, she doesn't get to eat; malnourishment can cause premature delivery and malnourished child and then the woman is blamed for such a situation.

g. **Isolation during pandemic -** During pandemic and situations of emergency prohibiting movement, VAWG increases. Isolated at home, increasing friction within family members due to loss of livelihood, lack of access to services (due to issues of mobility, reduced services in the pandemic), limited access to phones, etc. are some reasons.

OTHER ENABLERS

h. **Education of women -** Women in areas with better access to cities and with education degree till Class 10-12 were aware that weight and height measurement of children are indicators of malnutrition, and that women

and children have rights. Uneducated women still unaware how sex of a child is determined and said that even today mothers of daughters have no honour or respect in the family.



BARRIERS AND ENABLERS

a. **Stigma against reporting -** There is still a stigma against reporting. If VAWG case goes to the police, the situation often worsens rather than getting better. If neighbours intervene, the wife is reproached for discussing personal matters with non-family members. There is also a lack of social support for victims of violence. That's why most women are strongly against reporting especially cases of domestic violence.

b. **Preference to Police over One Stop Centre -** In situations, where women do want to report cases of violence, they are more accustomed to going to the police than OSC. Distance of OSC from villages is also a reason why women don't go there. Currently OSC is at district levels.

c. **Awareness on provisions of OSC -** Most AWWs are not aware of the benefits of One Stop Centre, who can be admitted to OSC, etc. Disabled women are sometimes forcibly admitted to the OSC when that is against the rules. But the rules are not clear to the staff and CDPO can't handle, so the matter goes to district and division. They opine that Social Justice Department don't cooperate in such matters saying they have no guidelines on the same.

d. **Training, support and rehabilitation plan –** There is a lack of support and an individual rehabilitation plan for and after reporting. There is a lack of training on gender responsive and age sensitive response to women and girl survivors of violence, including SGBV. Procedural delays, inadequate gender sensitization/awareness in responding to survivors is also observed in OSC.

BARRIERS TO ADOPTION OF OTHER GENDER-RELATED DESIRED BEHAVIOURS

Women economic empowerment

1. Many women have low aspiration and limited ideas of career paths and a future outside of marriage and family. They also lack trainings and education.

2. Most rural women have low agency, especially financial agency. Many women are not permitted to leave the house, especially if it's for work/job.

3. Many women are not gainfully employed due to burden of housework and caregiving. They get involved in home-based agricultural work but receive no remuneration.

4. Most women's knowledge and use of microcredit programmes is very limited.

STRATEGY

7. STRATEGY

The strategy has been designed on the principles of the socio-ecological model of communication and has taken a holistic approach, looking at inter-connecting factors and interventions that will bring about ripple change, i.e. improvement in one area will create a positive, ripple effect of change on another. The core interventions at this stage focus on the priority behaviours and their barriers/enablers. The complete list of desired behaviours can be referred to when planning future interventions.

7.1 BUILDING BLOCKS: Strategic Approach for SBC

The strategy will work towards women and child health and development in the state with the primary goal of achieving a '**Healthy and Empowered Madhya Pradesh**'. For ensuring effective and sustainable social and behaviour change, the following strategic positioning will be undertaken for interventions –

- **#SahbhagitaSeVikas – Collective responsibility:** Re-enforcing that health, care and protection of women and children are the collective responsibility of all members of the family and community.

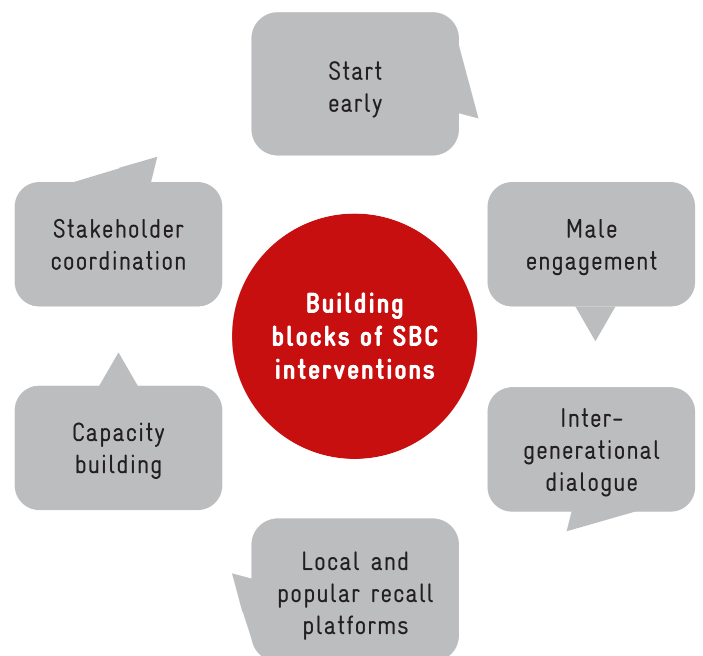
- **#AaiyeAnganwadi – AWC is a resource centre:** Re-branding and promoting Anganwadi Centres as their original function of being resource centres (where both tangible and intangible services are provided).

- **#SabEkHaqAnek – Nutrition, education, protection are rights of every girl and boy:** Promoting the rights of women and children to live and have good health, education and protection, and support of family and society for realisation of the rights.

This positioning will be the crux behind messages conveyed to the target audiences. The strategy puts **greater focus on prevention** and the mission is to ensure inclusivity, responsibility and equality such that members of the family and community can support one another, without bias or discrimination, and avail services and rights that will ensure their development.

The strategy will further have some '**building blocks**' – points that will serve as and strengthen the foundation of every intervention. The building blocks should be kept in mind when planning and implementing any intervention, which will help ensure better reach and effectiveness. Continuous efforts will bring about beneficiary ownership and sustainability. These blocks are not absolute in nature and can be customised by the implementer/facilitator based on the situation and needs.

Below given is what each building block entails:



7.1.1 Start early

The focus of the strategy is to strengthen prevention – that is what will create sustainable change, and limit recurrent problems. So, there is a need to start early.

AWCs are normally visited by pregnant women, lactating mothers, children under the age of 6 years and less frequently, adolescent girls. Women and children outside these groups do not frequently visit the centre. Men are almost completely detached from it and only accompany wives when they come to register their pregnancy. Migrant families also get disconnected once they move out of the village. The first mission is to ensure that all connect with the AWC and regard it as a resource centre where they will get services, advice/counselling and information.

› **Counsel newly married couples** - Newly married couples should be encouraged to attend atleast one counselling session at the AWC. This will help connect them with the AWC and provide information

on importance of pregnancy registration, regular ANC, nutrition during pregnancy, breastfeeding and role of family. It will also help the AWW to track pregnant women and better, help women come themselves to register and seek services.

- **Counsel migrant families** - March (around Holi) and October/November (around Navratri/Deepavali) are the months when migrant families are usually available in their hometowns/villages. They stay/return during this period to celebrate the festivals, complete auspicious ceremonies/rituals, manage landholdings and then migrate after. During these months, the families should be encouraged to visit the AWC and attend a counselling session, as well as get a check-up by the ASHA worker. They can receive information on the pitfalls of child marriage, importance of nutrition, breastfeeding so that they can ensure continuum of care in the new city. This will help prevent the occurrence of malnutrition, child marriage and lack of education usually observed in migrant families.

- **Engage adolescents on discussions on gender and rights** - From the age of 10 years (start of adolescence), children start to develop an understanding of sex and gender and where they stand on the spectrum. From the age of 10 to 14, these ideas are more fluid and children respond to what they receive from their surroundings (peers, family, school, society). By the time they enter the late adolescent age group (15-18 years), their notions and ideas about gender and themselves become solider and stricter and they begin to strongly identify with those perceptions (and stereotypes). Adolescence is the time period where children undergo hormonal changes, go through various emotions and develop an attraction to the opposite sex. Lack of understanding and proper guidance, coupled with notions on gender (can) trigger actions that (may) put them in jeopardy and force parents to take steps like child marriage, dropping out of school, etc. It is therefore imperative that conversations on gender start early when children are developing their understanding. This can happen at home, in school and at the AWC. Parents can be encouraged to discuss with children at home. Interactive workshops can be conducted at the school. AWW can conduct a session along with ASHA to address children's queries and concerns.

- **Encourage boys to participate in AWC sessions** - Discussions on anaemia, nutrition, child marriage, menstrual hygiene can be done with boys in participation, along with girls. It will help make them feel more included, ensure their good health as well and will break stigma around these topics. These issues (except MHHM) are not faced by girls alone.

7.1.2 Male engagement

Nutrition, education and protection issues are the collective responsibility of men and women. To bring about inclusion and instil this sense of responsibility, men must be included and engaged in programmes and discussions. They are also the key influencers and decision makers, so it is important that they have the right information and are positively motivated.

- At the beginning, independent workshops with men should be conducted, at a time most convenient to them (often, early morning, before they leave for work).

- At every counselling session at the AWC, husbands should be invited to participate.

- Women must be encouraged to ask their husbands to accompany them when they are visiting the doctor for ANC or delivery.

- Mid-media communication approaches like street theatre can be used to convey messages to men. Community mobilisation techniques are used to encourage participation and men don't feel forced to attend. Naturally many men come to see theatre and then participate in subsequent discussions. They can also be engaged in discussions in the Gram Sabha, in the presence of the sarpanch.

7.1.3 Inter-generational dialogue

Decisions on women and child health and care are not made by women alone. They are influenced by husbands/fathers, mothers-in-law, family, etc. Children in general have low bargaining power and many decisions are made for them. In such scenarios, it is important that there be inter-generational dialogue so that each group can understand the other and positive decisions are made. Creating avenues for such discussion will strengthen bonds and facilitate dialogue on issues that are often considered taboo or not discussed due to fear. In the case of children in particular, many often are unable to discuss their issues with parents and end up making misguided decisions.

- When talking about breastfeeding, nutrition, mothers -in-law and fathers-in-law should be invited to the sessions along with the pregnant and lactating women.

- When conducting discussions on gender, rights, child marriage, parents can be invited after 2-3 sessions.

7.1.4 Local and popular recall platforms

Communication interventions should be delivered via platforms that are local, popular and have the highest reach. A mix-media approach should be undertaken.

- Tools/approaches include IPC (discussions, home visits, counselling), street theatre, short videos, VHSND, community events, local media channels for tehsil areas, TV for areas closer to urban cities, social media for large urban areas, and posters/picture cards.

- Messages should be conveyed in the local language and dialect.

- A single communication tool, at a time, must convey a maximum of 3 messages only. This should include the why, call to action and resource number/helpline, if any.

7.1.5 Capacity building

Preparation is key. Organisers and facilitators must have the relevant information, understanding and skills to deliver the messages they are attempting to do using various communication tools/approaches. It is not sufficient to just convey the message – why it is important and why the target group must practice it should also be explained.

- Prior to any session/discussion, an orientation session must be conducted with the facilitators.

- Regular feedback sessions must be organised in the DPO-CDPO-Supervisor-AWW system. Challenges faced by the AWW and supervisors (the most ground level staff) must be conveyed to the district (and state, if required) for timely resolution and assistance.

- Refresher trainings must be conducted of the DWCD staff and AWW on communication, technical information on departmental programmes and schemes, digital media.

- Agency of women groups and adolescents must be developed for leading grassroot level activities and advocacy supporting the government functionaries.

7.1.6 Stakeholder coordination

Practice of behaviours and change doesn't happen in isolation – there are many inter-connecting factors and players involved. Therefore, when there is convergence of action between stakeholders, it strengthens SBC efforts and improves access and use of services. Stakeholder participation and dialogue also helps in ensuring two-way communication.

- Along with DWCD, support from Department of Health, Department of Education is important. This is because AWW (DWCD), ASHA and ANM (Health) and teachers and coordinators (Education) are the grassroot level functionaries of the respective departments and the ones with the closest access to families and community, especially in the rural areas. Their collective efforts will (and do) ensure better reach and cover all aspects of nutrition, health and education.

- There are other sub-entities within the aforementioned departments and other departments as well whose participation and coordination are important in programmes.

- Non-government entities can support DWCD in planning and implementing many programmes and campaigns. They can also offer supportive functions and services such as counselling, referral, etc.

- Key influencers and change-agents in the community should also be engaged in programmes.

The core thematic areas of DWCD include issues which overlap with each other (have integrated causes and consequences) and with operational areas of other departments and agencies. Therefore, a matrix has been developed below which provides a glimpse into the various stakeholders who are connected with the issues and who can be mobilised and/or integrated for implementation of the SBC strategy. The matrix looks at 4 core types – related departments under the Government of Madhya Pradesh, non-government entities like CSOs and multilaterals that are doing work in the state, change agents identified or formed by the government and NGOs, and the various target groups in the community.

MATRIX OF STAKEHOLDERS WORKING ON WOMEN AND CHILD DEVELOPMENT ISSUES

Government departments and functionaries	Non-government entities
• Department of Women and Child Development (State officials, divisional joint director, DPO, Assistant Director, CDPO, Sector Supervisor, AWW) • Department of Health (including ASHA and ANM) • Department of Rural Development • Department of Education • Police • Child Welfare Committee • Block and Village level Child Protection Committee • State Legal Services Authority and District Legal Services Authority • State Adoption Resource Authority	• GIZ • Welthungerhilfe • Clinton Health Access Initiative • Nutrition International • Piramal Foundation • UN agencies (UNICEF, UNFPA, UNWOMEN) • Action Against Hunger • Coalition on Food and Nutrition Security • Vikas Samvad • Action Aid • World Vision • 181 Women's Helpline • Childline (1098 Helpline) • Workers association • Atal Bihari Vajpayee Institute of Good Governance and Policy Analysis • Schools and colleges/universities • Pod Pitara • Others
Change agents in community (government or non-government formed)	**Target groups in the community**
• Shaurya Dal • Ladli Laxmi Champions • BBBP brand ambassadors • Nutrition ambassadors • Paralegal volunteers • SHG members and MSS members • Counsellors • Gender clubs in schools and colleges	• Women, including pregnant & lactating women • Mothers-in-law & Fathers-in-law, elders • Husbands/Fathers • Adolescent girls and boys • Youths • Doctors and Hospital staff • Teachers • Faith-based leaders

Along with the aforementioned building blocks, some other important approaches are –

- **Adoption of gender-responsive approach -** It is important to take into account that men and women (may) have different social, economic, emotional needs, experiences and access. Intervention and delivery of message (communication) must be done accordingly.

- **Message convergence and adaptability -** Facilitators must respond to the needs/questions of the target groups. Suppose the discussion is on breastfeeding and questions on gender or sex determination are raised, facilitator must adapt and respond. Similarly, if there is an opportunity to provide information/ message on another important topic, facilitator can avail it and discuss – for example, talking about child marriage and its effect on malnutrition.

7.1 KEY MESSAGES

Below given are the key messages that need to be conveyed and promoted to the target groups to facilitate their adoption of the 19 priority behaviours (and by ripple effect, the other behaviours as well). SBC interventions should be planned to deliver these messages. The table is an exhaustive list and messages are given against the relevant barriers/enablers. All messages do not need to be communicated together. Communicators/planners can refer to the table and use relevant messages to communicate to respective target groups as per need, barrier and situation. It is to be noted that not all barriers can be addressed via messages.

BEH. REF NO.	THEMATIC AREA & PRIORITY BEHAVIOUR	BARRIERS (-) ENABLERS (+)	MESSAGES	PRIMARY TARGET GROUP
NUTRITION, HEALTH & HYGIENE				
1.	**Pregnant women register their pregnancy in the first trimester at the nearest health facility**	(-) Delayed declaration of pregnancy	• Mothers, registering your pregnancy in the first trimester will help you get timely check-ups, THR, supplements and nutrition guidance for your and your child's health. Visit the nearest AWC or health facility and register your pregnancy in the first 3 months.	Pregnant women
			• Fathers and grandparents, support the mother to register her pregnancy at a health facility in the first trimester. She will get a timely check-up, THR and other support for her and the baby's health.	Husbands, mothers-in-law, fathers-in-law
		(-/+) Connect with AWC of non-pregnant women	• Any person can visit the AWC to seek information and counselling from AWW on nutrition, health, child protection or any women and child related issue. Visit the nearest AWC and consult the AWW to seek guidance.	Newly married couples, adolescents
		(-) Error in tracking menstrual cycle	• Ladies, tracking the LMP (last menstrual period) from the 1st day of the last cycle will help to find out the month of the pregnancy. Consult the AWW and get a check-up to find out if you are pregnant and in which month of your pregnancy.	Menstruating women
		(-) Migration to maiden homes during pregnancy	• Ladies, register your pregnancy in the first trimester and get timely check-ups, THR and supplements. If you are going to your maiden homes, carry your Mother and Child Protection (MCP) card and visit the AWC for continuing pregnancy care.	Pregnant women

		(-) Desire for son	N/A	
		(+) Regular ANC	N/A	
		(+) Sensitising newly married couples	N/A	
3.	**Pregnant women consume one additional meal every day which is nutritious, diverse and balanced diet including consumption of THR (take-home ration)**	(-) Burden of care during pregnancy on women – considered their prime responsibility	• Fathers and grandparents, do you want the baby to be born healthy and well? Support the mother and encourage her to consume everyday foods rich in proteins, vitamins and minerals, such as milk, eggs, rice, lentils, fruits and vegetables. • Fathers and grandparents, do you want the baby to be born healthy and well? Help the mother to have enough time to eat one extra small meal or snack each day.	Husbands, mothers-in-law, fathers-in-law
		(-) Balancing household duties [including feeling tired, anxious, nauseous]	• Husbands, help your wives take some time out from her household chores and eat one extra small meal or snack each day. • Does nausea or lacking appetite make it difficult for you to eat during pregnancy? The following tips could help like eat smaller portions but more frequently (every 2 hours); avoid foods that trigger nausea; do not drink 30 minutes before eating; and avoid highly spicy, fat and gaseous foods.	Husbands Pregnant women
		(-) Misconceptions around foods	• Grandmothers, growing babies need enough energy to develop well and be healthy. Encourage the mother to eat one extra small meal or snack each day. • Mothers, do you want a safe delivery and a healthy baby? It is important that you consume everyday foods rich in vitamins and minerals, such as fruits and vegetables.	Mothers-in-law Pregnant women
		(-) Knowledge action gap [esp. negative experience]	• Are you expecting a baby? Eat one extra small meal or snack each day to help your growing baby to be healthy.	Pregnant women

		(+) Regular ANC visits	• Are you expecting a baby? Attend antenatal care at least 4 times during pregnancy. These check-ups are important for you to learn about your health and how your baby is growing. • Is your wife expecting a baby? Help her and the baby to be safe - make sure that she attends antenatal care at least 4 times during pregnancy.	Husbands Pregnant women
		(+) Counselling families before they migrate	N/A	
		(+) Inter-state DWCD collaboration for continuum of care	N/A	
6.	**Lactating women consume one additional meal every day which is nutritious, diverse and balanced diet including consumption of THR (take-home ration)**	(-/+) Awareness on types of food and their nutrients	• Is your wife lactating? Her diet should include proteins, iron, vitamins and minerals. Support her to eat one extra small meal or snack each day. • Is your wife lactating? She and the child need enough protein to be healthy. Give her foods rich in protein, such as lentils, soya, beans, chickpeas, millets, nuts, milk and eggs. • Do you want a healthy baby? It is important that you consume everyday foods rich in vitamins and minerals, such as fruits and vegetables.	Husbands Lactating women
		(-) Misconceptions around foods		
		(-) Knowledge action gap, [esp. negative experience]		
		(-) Lack of women's agency	N/A	
		(-) Balancing household duties	• Husbands, help your wives take some time out from her household chores and eat one extra small meal or snack each day.	Husbands
		(-) Tradition of not eating food cooked by others	N/A	
		(+) Counselling families before they migrate	N/A	

		(+) Supportive mothers-in-law	• Grandmothers, proper nutrition is important for mother and baby. Support the mother to consume one extra meal or snack each day. • Grandmothers, proper nutrition is important for mother and baby. Encourage the mother to consume everyday foods rich in proteins, vitamins and minerals, such as milk, eggs, rice, lentils, fruits and vegetables.	Mothers-in-law
8.	**Newborn children are put to the breast within one hour of birth**	(-) Misconceptions around colostrum	• Grandmothers, the first yellow, thick mother's milk is breastmilk only, filled with nutrients for building the immunity of the child. Help mothers to feed it to the baby straight after delivery.	Mothers-in-law
		(-) Technical issues with breastfeeding	• Mothers, if you are facing difficulty in breastfeeding after delivery, seek help from your AWW or health worker. They are here to help you.	Mothers of newborn children
		(-) Caesarean deliveries miss out on feeding at the table	• Mothers, don't miss the golden hour! Breastmilk can be fed to the child at the operating table, right after delivery. Feed colostrum to your baby within one hour of birth. • Nearly all women can start breast-feeding soon after delivery. Ask the health facility members for help on how to initiate breastfeeding.	Mothers of newborn children
		(-) Prevalence of home deliveries	• Fathers and grandmothers, do you want a safe delivery of your baby? Ensure that it is delivered in a health facility. Do not take any risks.	Fathers, mothers-in-law
		(+) Coordination between AWW and ASHA	N/A	
		(+) Institutional delivery and availability of advice at health facility	• Health workers, many women face difficulty in timing and position of breastfeeding. Guide the mothers on initiating breastfeeding the right way immediately after delivery.	ASHA, ANM, hospital staff
		(+) Incentive to take pregnant woman to delivery point	N/A	

		(+) Supportive mothers-in-law	• Grandmothers, colostrum, the thick yellowish milk, is like the first natural medicine that protects the newborn baby's health. Help mothers to feed it straight after delivery.	Mothers-in-law
9.	**Mother feeds baby only breast milk for the first 6 months of the child's life**	(-) Low participation of family members	• Fathers and grandmothers, do you want your newborn baby to thrive? Help the mother to have enough time to breastfeed the child frequently. The baby needs it.	Fathers, mothers-in-law
		(-) Misconception around 'not enough' milk [enough milk is not being produced and milk is not enough to satiate hunger and thirst of child]	• Do you want your newborn baby to be healthy and to thrive? The single best way is to feed her/him only breastmilk in the first six months. It contains all the nutrients your child needs during this time. • From 0 to 6 months of age, a baby's stomach expands from the size of a marble to an egg. It doesn't need anything other than breastmilk for nutrition and energy. Feed your baby only breastmilk for 6 months. • Mothers, the more you breastfeed, the more milk your body makes. Breastfeed your baby frequently.	Mothers of children under 6 months of age
			• No water, no cow's milk, no gutthi, only mother's milk is enough for a newborn child till 6 months of age. Breastmilk has all the nutrients a child needs during this time.	Mothers, Mothers -in-law
		(-) Low participation of family members since primary responsibility considered to be that of the mother/woman's	• Fathers and grandmothers, do you want your newborn baby to thrive? Help the mother to have enough time to breastfeed the child frequently. The baby needs it.	Fathers, mothers -in-law
		(-) Knowledge action gap, especially negative experience	• Grandmothers, feeding only breastmilk in the first six months protects the baby from many illnesses, such as diarrhoea and respiratory infections. Encourage the mother to feed only breastmilk in first 6 months.	Mothers-in-law

		(-) Technical issues with breastfeeding	• Mothers, if you are facing difficulty in breastfeeding, seek help from your AWW or health worker. They are here to help you.	Mothers of children under 2 years
		(-) Balancing work and household duties	• Fathers and grandmothers, breast-feeding helps a newborn baby to thrive. But it also takes time. Help mothers to have enough time to breastfeed.	Fathers, mothers-in-law
		(-/+) Maternal nutrition	• Fathers and grandmothers, a woman who is breastfeeding is nourishing not only herself but also the child. She needs to eat more. Help her to eat two extra snacks each day.	Fathers, mothers-in-law
10.	**Mother and family members initiate complementary feeding at the age of 6 months of the child, ensuring consistency (differentiate by age groups), quantity (optimal portion size), quality (home-based freshly cooked), diversity of diet (including THR) and frequency**	(-) Misconception around 'not enough' milk [milk is not enough to satiate hunger and thirst of child]	• From the age of six months, breast-milk alone is not enough. Feed your child the recommended number of meals every day, so that s/he grows well! • Mothers, do you want your child to be healthy and nourished? Give them complementary foods along with breastmilk after 6 months of age (180 days). The nutrients they need for their growth and development are not met only with mother's milk after this age.	Mothers of children under 2 years
		(-) Delayed introduction [waiting till child can sit on its own]	• From the age of six months, breast-milk alone is not enough. Feed your child the recommended number of meals every day, so that s/he grows well! • Do you want your child's body and brain to grow well? If the child is breastfed, feed at least 2 meals at 6-8 months and 3 meals at 9-23 months. If the child is not breastfed, feed at least 4 meals, irrespective of age.	Mothers of children under 2 years Parents of children under 2 years
		(-) Access and agency of working mothers	• Grandparents, you can help! When the baby's mother is busy, feed the child the prepared meal and make sure that he/she finishes the food.	Mothers -in-law, fathers -in-law
		(-) Poor self-efficacy	N/A	

		(-/+) Awareness on types of food and their nutrients	• When the child turns 6 months, along with breastfeeding, start feeding fresh homemade food which includes - - Locally available foods - Grains like rice, wheat, millets, etc - Vegetables with starch like sweet potato, etc - Seasonal fruits like mango, banana, papaya, etc - Add one teaspoon ghee or oil - Cook, serve and feed while ensuring hygiene Timely complementary feeding will help your child grow well! • Meals that are rich in protein, such as lentils, soya, beans, chickpeas, millets, nuts, milk and eggs, develop children's brain. They help them to be smart. Feed them every day. • Meals that are rich in protein, such as lentils, soya, beans, chickpeas, millets, nuts, milk and eggs, help children to grow well and be strong. Feed them every day. • Roti, rice and other starchy foods can fill stomach. But they don't provide all the nutrients a child's body and brain need to develop well. Feed your children meals rich in protein, vitamins and minerals.	Parents of children under 2 years of age, mothers-in-law, fathers -in-law
		(-) Lack of food in households	• Fathers, do you want your children to be healthy? Buy or grow vegetables and fruits that give them the vitamins and minerals they need!	Fathers of children under 2 years
		(-) Two-time meal pattern	• Fathers and grandmothers, supervise and encourage young children during meals, so that their bodies and brains grow well! • Parents and grandparents, accompany your child when they are eating. Support them in eating, so that you make sure that they ate enough.	Fathers of children under 2 years, mothers -in-law, fathers -in-law, mothers
		(-/+) Linkage with growth monitoring	N/A	

		(+) Effective counselling by AWW/ASHA	• Mothers, visit the AWC and consult with the AWW to receive guidance on how to introduce timely complementary foods.	Mothers of children under 2 years
		(+) IPC during Mangal Diwas	N/A	
12.	**Children aged 2-6 years consume body-building foods (protein), immunity-boosting foods (vitamins, minerals) and energy-giving foods, including THR (2-3 years) and hot-cooked meal (3-6 years)**	(-) Two-time meal pattern	• Fathers and grandmothers, supervise and encourage young children during meals, so that their bodies and brains grow well! • Parents and grandparents, accompany your child when they are eating. Support them in eating, so that you make sure that they ate enough.	Fathers of children under 2 years, mothers -in-law, fathers -in-law, mothers
		(-) Tradition of not eating food cooked by others	N/A	
		(-/+) Awareness on types of food and their nutrients	• Meals that are rich in protein, such as lentils, soya, beans, chickpeas, millets, nuts, milk and eggs, develop children's brain. They help them to be smart. Feed them every day. • Meals that are rich in protein, such as lentils, soya, beans, chickpeas, millets, nuts, milk and eggs, help children to grow well and be strong. Feed them every day. • Roti, rice and other starchy foods can fill stomach. But they don't provide all the nutrients a child's body and brain need to develop well. Feed your children meals rich in protein, vitamins and minerals. • A simple step can add nutrition to food – add one teaspoon ghee or oil in any fresh homemade food and feed to your child. And they won't say no to food anymore!	Parents of children between 2-6 years of age, mothers -in-law, fathers -in-law
		(-/+) Food preferences [do not want to take THR since same available at home]	• AWC provides THR and supplements that provide nutrition to your child and help them grow healthy. Visit the AWC and collect your THR packets from AWW or Sahayika.	Mothers of children between 2-6 years of age

		(-) Access and agency of working mothers	• Grandparents, you can help! When the baby's mother is busy, feed the child the prepared meal and make sure that he/she finishes the food.	Mothers -in-law, fathers -in-law
		(+) Effective counselling by AWW/ASHA	• Proper nutrition is the right of every child. Ask AWW to learn how you can ensure nutritious and inexpensive diet for your child	Parents of young children
		(+) Access to local, nutritious food	• Fathers, do you want your children to be healthy? Buy or grow vegetables and fruits that give them the vitamins and minerals they need!	Fathers of children between 2 - 6 years
16.	**Pregnant women (3 month onwards), lactating mothers (upto 6 months), children (0-5 years) and adolescent girls (11-18 years) consume IFA tablets/syrup daily to prevent anaemia**	(-) Awareness on first signs of anaemia	• Do you experience fatigue, breathlessness, headaches or falling sick often? You might have anaemia. Visit the doctor or nearby AWC and get a check-up. • Do you experience fatigue, breathlessness, headaches or falling sick often? You might have anaemia. Taking IFA pills can help you feel better!	Pregnant women, lactating women, adolescent girls
		(-) Misconceptions about IFA tablets	• Are you feeling a warm sensation in the stomach after taking IFA pill? Don't worry, this is normal. Take IFA pill after dinner to prevent symptoms.	Pregnant women, lactating women, adolescent girls
		(-) Negative experience like suffering symptoms of vomitting	• Are you feeling nauseous or having a slight stomach-ache after taking IFA pill? Don't worry, this is normal. Take IFA pill after dinner to prevent symptoms.	Pregnant women, lactating women, adolescent girls
		(-/+) Connect with pregnancy registration	• Ladies, if you register your pregnancy, you can get IFA pills from the AWC on time. Register your pregnancy in the first trimester and collect IFA pills from AWW.	Pregnant women
		(-/+) Awareness on types of food and their nutrients	• Are you feeling nauseous or having a slight stomach-ache after eating certain foods? Consult AWW or your doctor to know the correct method of food intake. • Food rich in iron help give your body energy, immunity and help in body temperature regulation. Consume foods like spinach, lentils, broccoli, soya regularly.	Pregnant women, lactating women, adolescent girls

		(+) Provision for Hb testing	N/A	
		(+) Sensitising newly married couples	N/A	
		(+) Focus on IFA consumption along with distribution	N/A	
		(+) Awareness among non-pregnant and non-lactating women	• Do you experience fatigue, breathless-ness, headaches or falling sick often? You might have anaemia. Taking IFA pills can help you feel better!	Women between 15-45 years
19.	**Anganwadi workers (along with Accredited Social Health Activists and Auxiliary Nurse Midwives) conduct screening and referral of complicated severe acute malnourished (SAM) children to Nutritional Rehabilitation Centres (NRC) and follow-ups**	(-) Reservations on keeping children (and mothers) overnight at the NRC	• Fathers, NRC will provide the complete medication and care to ensure that your child's malnourishment is treated. Consult AWC and take your child to the NRC for treatment if he/she is mal-nourished. • Parents, is your child displaying rolling eyes, irritated behaviour, sickly thin? - he/she may be malnourished! Visit the AWC for a check-up and take child to NRC for complete treatment.	Fathers Fathers, mothers
		(-) Women's agency to take decisions	• Parents, don't forget to go to AWC to get your child weighed and height measured - you will learn how well is s/he growing!	Fathers, mothers
		(-) Monetary concerns	N/A	
		(-) Preference to traditional medicine	• Fathers, NRC will provide free and complete medication and care to ensure that your child's malnourishment is treated. Consult AWC and take your child to the NRC for treatment.	Fathers
		(-) Association with negative experience	N/A	
		(+) Education of women	N/A	

20.	**Anganwadi worker enrols uncomplicated SAM children under CSAM programme**	(-) Attitude towards malnourishment	• Parents, don't forget to go to AWC to get your child weighed and height measured – you will learn how well is s/he growing!	Fathers, mothers
		(-) Priority to work and livelihood	• Parents, is your child displaying rolling eyes, irritated behaviour, sickly thin? – he/she may be malnourished! Visit the AWC for a check-up.	Fathers, mothers
		(-/+) Support from villagers	• Neighbours, encourage parents to take their children to the AWC regularly for getting weight and height measured. They will know how well the child is growing.	Community members
27.	**Parents send their children to AWC for the entire duration to receive complete quality pre-school education**	(-) Preference to private schools	• AWCs provide education to all children between 3-6 years of age. Parents, send your child to AWC so he/she can eat, play and learn!	Parents of children under 6 years
		(-/+) Skill level of AWW	N/A	
		(-) Delay by children	N/A	
		(+) ECCE coordinator	N/A	
28.	**Parents ensure that their daughters (11-14 years) re-enrol in school**	(-) Safety concerns and distance between school and home	• Education sets the foundation for a good future! Parents, send your girls to school and support them to pursue higher education • If all go together, there is no need to fear! Send your children to school together with others. Don't let distance come in the way of a good future.	Parents of adolescent girls
		(-) Experience with violence	N/A	
		(-) Domestic responsibilities	• Adolescence is the period for children to learn, play and grow! Parents, support your children's good future by sending them to school. • Neighbours, if you see any girl discontinuing school, be a responsible citizen and encourage parents to send their daughter to school.	Parents of adolescent girls Community members

		(-) Disconnect with academics	• Girls, go to school and seek help from your peers and teachers in studies. Don't let one poor academic performance get in the way of a bright future.	Adolescent girls
		(-) Impending marriage	• Education sets the foundation for a good future! Girls, attend school every day and complete your higher education first.	Adolescent girls
		(-) Menstruation	• Girls, menstruation is a very natural bodily process and there is no need to feel embarrassed. Attend school normally and seek your teacher or AWW's help if you need any guidance.	Adolescent girls
		(-) Discontinuation due to migration	• Parents, don't let your child miss out on a good education. Enrol them in school in the place you migrate to.	Parents of adolescent girls
		(-) Discontinuation due to COVID pandemic	N/A	
		(-) Lack of women's agency	N/A	
		(+) Children strongly refuse marriage	N/A	
		(+) Encouragement by peers	• Girls and boys, encourage your friends to attend school with you every day. Don't let them miss out on a bright future!	Adolescent girls and boys
		(+) Education of women	N/A	

BEH. REF NO.	THEMATIC AREA & PRIORITY BEHAVIOUR	BARRIERS (-) ENABLERS (+)	MESSAGES	PRIMARY TARGET GROUP
CHILD PROTECTION				
31.	**Men & women do not practice verbal, physical and sexual abuse against girl and boy children in the family, school, workplace and public places**	(-/+) Awareness on rights of children	• Children, you also have legal rights! You have the right to eat good food and be healthy, to play and participate, to go to school and to be protected from abuse and violence against you. Report to 1098 or tell your teacher or parent if any right is being violated.	Adolescent girls and boys

31.	**Men and women do not practice verbal, physical and sexual abuse against girl and boy children in the family, school, workplace and public places**	(-) Unmonitored social media and internet usage	• Parents, teach your child the steps to ensure cyber safety - do not share personal information, password, address, location with anyone on social media.	Parents of adolescents
		(-) Unmonitored social media and internet usage	• Children, be safe online. Tell your parent immediately if you face any cyber bullying or threats online. • Children, be safe online. Do not share your personal information or location randomly with anyone on social media. Keep your photographs and videos private.	Adolescent girls and boys
		(-) Children getting employed	• Engaging children under 14 years in any form of labour is illegal. Children, there is a 24x7 helpline for you. Dial 1098 if you need help!	Adolescent girls and boys
		(-) Violence as a means to discipline	• Parents, talk to your child and discuss what problems they are facing. Hitting them is not the solution.	Parents of adolescents
		(-) Children also victims of domestic violence	• Children, if you face unsafe touch or any abuse, tell your parents, teachers or call 1098. You can also seek help from AWW. • Children who face violence are more likely to commit acts of violence themselves. Do not hit or abuse your child.	Adolescent girls and boys Parents
		(-) Victim blaming and treatment of girls	• Blaming victims for the abuse against them is part of the problem. Listen to victims, support them and guide them to call 100 or 1098.	Community members
		(-) Child marriage as a guise for trafficking	• Asking for young girls' hand in marriage (dowry free or otherwise) can be a guise for trafficking. Beware! Do not get your minor children married.	Parents of adolescents
		(-) 'Violent' traditions [minor girls sent as prostitutes]	• Adolescence is the period for children to learn, play and grow! Parents, support your children's good future by sending them to school.	Parents
		(-) Issues in jurisdiction	N/A	

		(-) Ignorance that boys face abuse	• Even boys can be victims of abuse. If any boy is facing any physical or sexual abuse, call 100 or 1098 and report.	Parents
		(+) Awareness programmes in schools	N/A	
		(+) ECCE admission	N/A	
		(+) Education of women	N/A	
33C	**Girls and boys pursue and complete higher education (atleast Class 12 and higher)**	(-) Denial over gender discrimination	• Girls, not domestic duty, not work, not early marriage, but education is your right! It will help you fulfil your dreams and build a good future. Go to school and complete your higher education.	Adolescent girls
		(-) Low value of education and children getting employed	• Education sets the foundation for a good future! Parents, send your girls and boys to school and support them to pursue higher education.	Parents
		(-) Domestic responsibilities	• Adolescence is the period for children to learn, play and grow! Parents, support your children's good future by sending them to school.	Parents
		(-) Safety concerns and distance between school and home	• Education sets the foundation for a good future! Parents, send your girls and boys to school and support them to pursue higher education • If all go together, there is no need to fear! Send your children to school together with others. Don't let distance come in the way of a good future.	Parents
		(-) Experience with violence	N/A	
		(-) Disconnect with academics	• Children, go to school and seek help from your peers and teachers in studies. Don't let one poor academic performance get in the way of a bright future.	Adolescent girls and boys

		(-) Impending marriage	• Education sets the foundation for a good future! Children, attend school every day and complete your higher education first.	Adolescent girls and boys
33C	**Girls and boys pursue and complete higher education (atleast Class 12 and higher)**	(-) Menstruation	• Girls, menstruation is a very natural bodily process and there is no need to feel embarrassed. Attend school normally and seek your teacher or AWW's help if you need any guidance.	Adolescent girls
		(-) Discontinuation due to migration	• Parents, don't let your child miss out on a good education. Enrol them in school in the place you migrate to.	Adolescent girls
		(-) Discontinuation due to COVID pandemic	N/A	
		(+) Children strongly refuse marriage	N/A	
		(+) Encouragement by peers	• Girls and boys, encourage your friends to attend school with you every day. Don't let them miss out on a bright future! • Convince your peer and say let's go to school together! Learning is fun with a friend. If you all go, distance won't matter.	Adolescent girls and boys
		(+) Education of women	N/A	
39	**Parents do not marry their girls and boys before they reach the legal minimum age of marriage**	(-) Fear of elopement	• Parents, be a good friend to your child. Listen to their troubles. Give a helping hand. Your girls and boys need you. • Parents, trust your children and discuss their concerns and problems. Talk to them about hormonal changes that are normal during adolescence.	Parents of adolescents
			• Adolescents, feeling attracted to the opposite sex during this period is natural. Hormonal changes occur during adolescence. Don't be worried, discuss your concerns with your parents.	Adolescent girls and boys

		(-) Concerns over safety	• It's education, not early marriage that will guarantee your child's bright future. Parents, please wait till your child is of legal age to get them married.	Parents
		(-) Low value of education		
		(-/+) Awareness on pitfalls of child marriage	• Did you know that child marriage disrupts education of a child and can cause malnourishment in mother and baby? Please wait till children are of legal age to get married. They will be physically and mentally ready to handle the responsibilities of marriage then. • Did you know that a minor married boy who has to discontinue studies and start work can get stressed and start showing violent tendencies? Please wait till children are of legal age to get married. They will be physically and mentally ready to handle the responsibilities of marriage then.	Parents
39	**Parents do not marry their girls and boys before they reach the legal minimum age of marriage**	(-) Girls considered a social burden	N/A	
		(-) Importance attributed to marriage	• It's education, not early marriage that will guarantee your child's bright future. Parents, please wait till your child is of legal age to get them married.	Parents
		(-) Age of maturity and need for earning members	• Did you know that a minor married boy who has to discontinue studies and start work can get stressed and start showing violent tendencies? Please wait till children are of legal age to get married. They will be physically and mentally ready to handle the responsibilities of marriage then.	Parents
		(-) Unsafe cyber usage and POCSO cases	• Parents, teach your child the steps to ensure cyber safety - do not share personal information, password, address, location with anyone on social media.	Parents of adolescents
			• Children, be safe online. Tell your parent immediately if you face any cyber bullying or threats online. • Children, be safe online. Do not share your personal information or location	Adolescent girls and boys

			randomly with anyone on social media. Keep your photographs and videos private.	
		(-) Migration	N/A	
		(-) Social norms around marriage [Dehaj, Nathra, Dehaj Dhapa]	• It's education, not early marriage that will guarantee your child's bright future. Parents, please wait till your child is of legal age to get them married. • Girls are a gift, not burden. Parents, don't get them married early because dowry will be low. Discourage practice of dowry.	Parents of adolescents
			• Adolescents, feeling attracted to the opposite sex during this period is natural. Hormonal changes occur during adolescence. Don't be worried, discuss your concerns with your parents.	Adolescent girls and boys
		(-) Marriages around auspicious time/occasions	N/A	
		(-) Issues in enforcement	N/A	
		(+) Children strongly refuse marriage	N/A	
		(+) Male engagement	N/A	
42	**Men and women report cases of child marriage to 1098 or Police**	(-) Stigma against reporting (-) Awareness on helpline numbers	• There is a 24x7 helpline for children for any of their needs – 1098. Dial if you need help or want to report child marriage.	Adolescent girls and boys
		(+) Reporting by peers	• Children, help your friend. If they are being forced into early marriage, report to Panchayat or teacher or call 1098. Your identity will be kept anonymous.	Adolescent girls and boys

BEH. REF NO.	THEMATIC AREA & PRIORITY BEHAVIOUR	BARRIERS (-) ENABLERS (+)	MESSAGES	PRIMARY TARGET GROUP
WOMEN SAFETY & EMPOWERMENT				
45, 51	**Men and women treat girls and boys equally at home, school, workplace and society**	(-) Denial over gender discrimination	• Parents, treat your girl and boy children equally. Teach life skills and good manners to both. Parents, allow both your girls and boys to participate in various educational and cultural events. Treat girls and boys equally.	Adolescent girls and boys
		(-) Patriarchy and desire for son	N/A	
		(-) Value of girl child	• There is only a biological difference – apart from that, girls and boys are equal in all ways and rights. Give them equal opportunities and watch them perform. Treat girls and boys equally.	Parents, family members, community members
		(-) Agency of women	N/A	
		(-) Victim blaming and treatment of girls	• Blaming victims for the abuse against them is part of the problem. Listen to victims, support them and guide them to call 100, 181 or 1098.	Family members, Community members
		(+) Male engagement	N/A	
		(+) Participation of women in community-based events	• Parents, allow both your girls and boys to participate in various educational and cultural events. Treat girls and boys equally.	Parents
		(+) Promotion of positive masculinity	• Work is not divided by gender. Parents, let both girls and boys lend you a helping hand in household chores.	Parents
		(+) Education of men	N/A	
		(+) Birth registration	N/A	

46, 50	**Men and women do not practice verbal, physical and sexual abuse against girl and boy children and other men and women in the family, school, workplace and public places**	(-/+) Patriarchy and acceptance of violence	• Domestic violence isn't a matter between husband and wife; it is a situation to be removed from a marriage. Call 100 or 181 to report cases of domestic violence. • It is NOT OK to tease, mistreat or abuse a woman anywhere, be it at home, school, work or public place. Call 100 or 181 to report cases of violence against women. • It is NOT OK to tease, mistreat, abuse or demand sexual favours from a woman at the workplace. Seek help from the Internal Complaints Committee under the Prevention of Women from Sexual Harassment at Workplace Act.	Women, men, community members
		(-) Intergenerational transmission of violence	• Children who face violence are more likely to commit acts of violence themselves. Do not hit or abuse your child.	Parents
		(-) Status in society and fear of isolation	• Domestic violence isn't a matter between husband and wife; it is a situation to be removed from a marriage. Call 100 or 181 to report cases of domestic violence.	Women, men, community members
		(-/+) Awareness on rights and protection mechanism	• Women, you also have rights! DO NOT ACCEPT VIOLENCE. Keeping quiet will not take your troubles away. Speak up and seek help at 100 or 181.	Women
		(-) Feeling unsafe in public spaces		
		(-) Alcoholism	N/A	
		(-) Isolation during pandemic	N/A	
		(+) Education of women	N/A	
48	**Men and women report cases of violence against women to 181 or Police**	(-) Stigma against reporting	• There is no shame in seeking help. There is a 24x7 helpline for women in need – 181. Dial if you need help or call the police at 100. • Neighbours, support women who are facing violence and need your help.	Women, community members

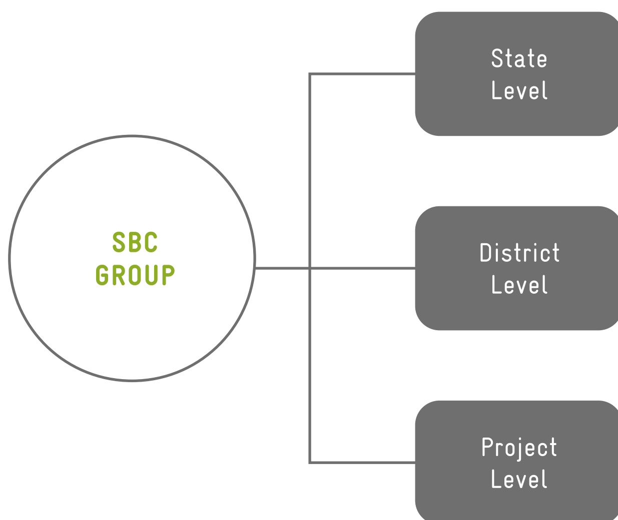
			Encourage them to call 100 or 181 and report. • Be Alert, intervene and help the victim! Come forward and report cases of violence against women at 100 or 181	
		(-) Preference to Police over One Stop Centre	• Women victims of violence can seek help and free legal aid at One Stop Centres.	Women, Community members
		(-) Awareness on provisions of OSC	N/A	
		(-) Lack of training, support, plan for rehabilitation	N/A	

7.3 APPROACH AND IMPLEMENTATION

- The strategy strongly suggests formation of district and project level SBC teams or key resource person group that can coordinate with the state SBC team and lead interventions and provide guidance at their respective levels. The following will be the benefits –

  - Regular coordination with state team – better understanding of objectives and expected outcomes
  - Ownership of interventions at the respective levels – customised plans as per need
  - Localisation of messages for better outreach
  - Creation of a smooth system of information transfer and issue redressal
  - Regular tracking and monitoring

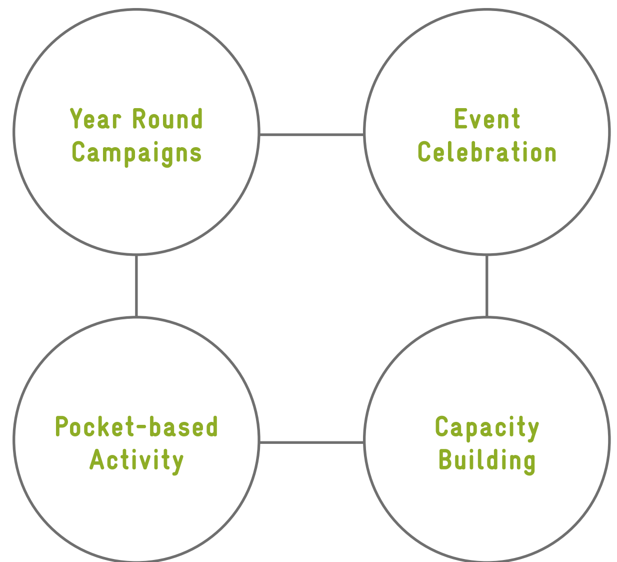
  The aforementioned system will help ensure a bottom-up systems-thinking approach that will ensure effectiveness and inform and improve future interventions.



- Building blocks are the **small doable actions** that will progressively bring change. For example, just using a local dialect or song to talk about a message, having one or two meetings with men will initiate the wheels of change.

- **Inter-personal communication** has been identified here as the most popular and strongest tool for communication on behaviour change. In many of the behaviours, it has been observed that rather than a lack of awareness, it is a matter of convincing that is required – target groups are aware of the pitfalls of many of the behaviours but their lack of agency and strong influence of family and society prevents them from practising it. In this case, regular and consistent IPC along with clear delivery of messages is key. To support this, **PLA tools, street theatre, communication via local influencers and workshops with children** are required. In urban areas, social media, posters and local YouTube/ Facebook channels can be used more. Regular dialogue on these issues must be facilitated for best results. And **technical and skill training** of system staff and AWW is most important.

- The strategy suggests **interventions under 4 approaches -**



Below given is what each approach entails and what to prioritise:

7.3.1 YEAR-ROUND CAMPAIGN

Among the priority behaviours, there are some that are urgent and require regular intervention, all year round. These issues include education, gender and strengthening foundation of immunity and nutrition, which serve as the strong base of other issues as well. Multi-media approach will be used for this campaign format.

The targeted issues for year-round campaign include the following –

1. Complementary Feeding – especially time, quantity and diversity
2. Send all to school and encourage to pursue higher education
3. Early and exclusive breastfeeding
4. Consumption of IFA tablets
5. No discrimination or violence against boys and girls – girls and boys are equal

Each month, messages on the aforementioned five issues should be promoted. IPC sessions at AWC, home visits, posters via social media, educational series, street theatre, outreach programmes with adolescents and other community events can be used.

- Development of posters and social media promotion can be undertaken at the state level. Page followers can like, share the posts and even upload their own posts and tag DWCD's social media handles. Every 6 months, the posts can be boosted for larger reach.

- AWW can follow the key message table and ensure that they communicate the same in their IPC sessions.

- Outreach programmes with children can be initiated at the project/school level, in coordination with the education department or with support from development partners.

Following are suggested activities –

- **Strategic positioning in IEC -** In every IEC material, there should be a hashtag #AaiyeAnganwadi to re-brand AWC as a resource centre and encourage people and children alike to visit and seek information, service and counselling. If there is scope, slogan on the same can be added in the IEC. There can also be the #SahbhagitaSeVikas to instil the message of collective responsibility. These hashtags will be written at the AWC.

- **Educational series -** An educational series can be developed to convey messages on the five topics. One or two episodes a month could be developed and broadcasted via YouTube and promoted on other social media handles. Each month, few specific messages should be targeted. For example, to promote breastfeeding and complementary feeding, episodes should progressively focus on issues like the size of a newborn's stomach to breastmilk being enough for first six months to when complementary feeding should be introduced and how quality and quantity of food can be ensured. Tips on how to prepare morning meals can be given. Myths and misconceptions could be addressed by providing alternatives to balance the nutritional intake rather than insisting on consuming the food they have a my of all family members should be talked about. AWW can view the episodes and circulate on WhatsApp or implement it in their next IPC session. [Many AWWs have created WhatsApp groups with beneficiaries. For those who haven't, it is advisable that they do so for more direct interaction and to create a platform for further dialogue]. They can also watch it together with the women at the AWC at the time of the episode broadcast. Based on the budget, it can be developed as an animated series with common set of characters or as a live video with same anchor each episode and different guests. The latter is highly encouraged because it will give an opportunity to showcase positive deviants from districts and excite viewers about coming on TV (media).

- **'Let's do something new today' series -** The tips on how to prepare morning meals can be broadcast in local languages on the AWW radio app. The key takeaways from the educational series can be included here.

- **Recipe books -** Recipe books can be circulated for improving quality and nutritional intake of food. THR will be connected to the recipes. The resources of GIZ and WHH nutritional recipes can be referred to for this purpose.

- **Compilation of existing IEC -** DWCD and partners have developed many useful IEC over the years with catchy slogans and key messages. The posters in particular can be compiled into an e-guide so that AWW can refer to them and use them in their IPC sessions.

- **Memes -** Memes on the myths around complementary feeding, breastfeeding can be developed and circulated via social media on the days preceding the broadcast of educational series. It will garner interest and debunk misconceptions. Subsequent to each post, there can be one in the form of a quiz, poll or ask a question so that communication could be made two-way.

- **Targeted IPC -** Specific IPC session should be conducted with mothers-in-law and fathers-in-law motivating them to support the mother in complementary feeding of the child (after 6 months of age) and exclusive breastfeeding. The Mangal Diwas days can be used for this purpose. On other days, they can conduct IPC with children and parents on the other issues. AWW can refer to the key message table and existing IEC with messages on the issues.

- **Using PLA -** Trained AWWs can adopt this technique in their IPC sessions. They can initiate the dietary recall technique to capture and convey what is missing in a meal, what to include, etc. They can provide demonstrations. In one of the series, simple

PLA tips will also be provided so that AWW who haven't received formal PLA training can also adopt the techniques. [A PLA training module should be developed and implemented for AWW]

- **AWW & adolescent groups work together -** Shaurya Dal and Ladli Laxmi champions can accompany AWW on their home visits and counsel the children at home to attend school and the podcast sessions. They can also talk to the children about cyber safety. (Shaurya Dals and Ladli Laxmi champions can be trained on the topics regularly.)

- **Chat with local influencers -** Local influencers can be invited to IPC sessions, one day every week (say, every Friday) to talk about the issues. Each week, a different message can be targeted. Influencers must be motivated to encourage the community to adopt the said behaviours. A balance of participation from different generations must be made so that inter-generational dialogue is facilitated. These influencers can then be encouraged to undertake mentoring/counselling sessions with adolescents.

- **Competitions -** Poster making, slogan writing, video making competitions can be organised at the AWW, school or online mode on different topics encouraging participation from children and adults (as applicable).

- **Podcast for children -** On one particular day during each month, a podcast session can be uploaded on DWCD social media handles. There should be a common anchor who will conduct the session (in a format similar to that of radio shows). Previously collected questions from adolescents (and adults later) can be incorporated in the show segment. The format can be such that each show is on a particular theme, a story could be narrated, there can be 2-3 songs/jingles and then audience questions can be answered. An expert's advice could be added into the segment. At the end, there should be a provision for audience to put forth their new questions. These questions should be addressed in subsequent podcasts. The format will help provide anonymity to children as well as provide them an avenue to express and learn. Topics will be on gender, rights, sexuality, feelings and other adolescent issues. In these podcasts, sheroes – those who have completed graduation, started a job, etc. will share their stories of inspiration. The podcast can be played at AWC for those who don't have access to individual smartphones. (Podcasts will have to be pre-recorded if the provision for live shows is not there.)

- **Conversations with children about gender -** Every month, a 1-2-hour session can be conducted at schools to talk to children about gender, touch, laws to protect them. Demonstrations should be used since children respond best to that. 2-3 children can be given scenarios to act out and then discussions can be held on that. (Disclaimers should also be given that these are representative scenarios, children must not tease each other based on their characters, etc.). Different interactive games can be played to debunk notions of gender. Parents can be invited after 2-3 sessions to have a participatory dialogue with children where questions can be asked to children like do you know what your mother's favourite dish is, etc. This way a stronger bond between parents and children can be built.

- **One meeting each month with men -** One meeting with men at the Gram Sabha or AWC to talk about women and child health and education should be conducted. AWW will need support to conduct the same. Supervisors can support AWW to conduct the meetings at AWC. Initially, husbands can be invited with wives so that a mixed group will be easier for AWW to handle. For independent meetings or workshops with men, it is suggested that coordinators from development partners support AWW in organising and implementing the same. (A men care model is implemented by World Vision in the districts they work in including Narsinghpur). The Sarpanch will have to be mobilised beforehand and consulted that a particular issue related to women and child development will be discussed at the Gram Sabha.

- **Circulation/Sharing of good videos/IEC produced -** On a regular basis, IEC, good practice stories, features, posters, videos, etc. can be circulated via social media handles of DWCD. Page followers can like, share the posts and even upload their own posts and tag DWCD's social media handles. For the first 6 months, aggressive social media marketing will have to be done to ensure that every urban population is connected with DWCD social media handles, users in rural areas have DWCD on their newsfeed, AWW is connected to the handles. Every 6 months, the posts can be boosted for larger reach. Social media events will have to be created consistently to maximise reach.

7.3.2 EVENT CELEBRATION

Each month, there are state, national or international events/days which are commemorated. These 'days' also provide a perfect platform to talk about issues related to the particular event.

The strategy suggests that based on the core events of the month, focus must be laid on the messages of those issues in activities. Extend the 'day' to not only talk about that particular event but also, how it is related to other issues. For example, in January, messages can focus on gender equality and power of youth to bring about change. Examples of Swami Vivekananda can be used to talk about these topics rather than only showcasing a poster celebrating his birthday and memory. Along with this, in a month focus on other issues when needed – for example, messages on child marriage needs to be extensively promoted in February-May and September-October. This is because March, April/May (around Akshay Tritiya) and October are the most prominent months when marriages happen.

Below given is the table of events (not exhaustive) and suggestions on the issues that can be talked about in related months. Highlighted events are accorded high priority status by DWCD.

Month	Date	Name of Day	State Activity	District Activity	Issue to focus on
January	12-Jan	National Youth Day			Girls and boys are equal Girl child education Importance of nutrition for girls
	24-Jan	**National Girl Child Day**	Y	Y	
February	10-Feb	National Deworming Day			Anaemia Malnutrition Careers for women Pitfalls of child marriage Education builds future
	11-Feb	**International Day of Women and Girls in Science**			
	13-Feb	World Radio Day			
March	**08-Mar**	**International Women's Day**	Y	Y	Why gender equality Ending VAWG Positive masculinity Women in different fields Importance of hygiene in nutrition Child marriage is illegal
	22-Mar	World Water Day			
April	06-Apr	International Day of Sport for Development and Peace			Hygiene and nutrition Benefits of NRC Why growth monitoring Status of people in society, especially girls Pitfalls of child marriage
	07-Apr	**World Health Day**	Y	Y	
	14-Apr	Ambedkar Jayanti			
	24-Apr	Panchayati Raj Day			
	25-Apr	World Malaria Day			
May	Second Sunday of May	**Mother's Day**	Y		Collective responsibility of mother and child care Anaemia and nutrition Role of all family members
	15-May	International Day of Families			
June	01-Jun	World Parents Day World Milk Day			Importance of dialogue between parents and children Exercise, food, healthy life
	21-Jun	International Day of Yoga			

Month	Date	Name of Day	State Activity	District Activity	Issue to focus on
July	15-Jul	World Youth Skills Day			Going to school Vocational education Career options Trafficking ramifications Cyber safety
	30-Jul	**World Day against Trafficking in Persons**	Y		
August	**1-7 Aug**	**World Breastfeeding Week**	Y	Y	Breastfeeding Nutrition Girls and boys are equal Opportunities for women
	12-Aug	International Youth Day			
	29-Aug	National Sports Day			
September	**1-30 Sep**	**Poshan Month**	Y	Y	Complementary feeding Nutrition Pitfalls of child marriage Importance of education
October	**11-Oct**	**International Day of the Girl Child**	Y	Y	How violence affects children and women Girls and boys are equal Child marriage destroys health and good future Nutrition
	15-Oct	International Rural Women's Day			
	16-Oct	**World Food Day**	Y		
November	**14-Nov**	**Children's Day**	Y	Y	Communicating with children No gender discrimination Hygiene and nutrition Need for infrastructure for women safety Rights of children
	19-Nov	World Toilet Day			
	20-Nov	Child Rights Day			
December	05-Dec	International Volunteer Day			Girls and boys are equal Health, education and protection are basic rights

7.3.3 POCKET-BASED ACTIVITY

The strategy considers that MP is a diverse state with different topography, connectivity issues and individual area-specific issues. Therefore, it encourages projects and districts to implement the following activities where applicable.

[Note: Respective authorities in the state/district/project levels can identify the vulnerable/target areas and devise specific implementation plans as per needs and budget. The functionaries have also mentioned in the workshops that they would like to be involved in developing messages and activities, which will be best because it will be contextual and involve local ownership. State/district/project level SBC group can support in this purpose.]

- **Life skill building of children -** In areas with greater coverage by development partners, life skill building of children should be done. This is one of the primary driving change interventions. It will guide children to understand themselves, their character and personality, identity, society as well as make informed choices based on the 10 core life skills. Tools like UNICEF's AdhaFull toolkit can be used. It is however time-intensive and requires consistent efforts with children. Doing 1-2 sessions only will be inadequate. Therefore, development partners can support in taking this up and scaling up as per suitability. [Mamta Health Institute already implements this in its project areas and UNFPA also has a life skill building module and implementation in place.]

- **Sessions on cyber safety and trafficking ramifications -** In areas closer to urban cities where children are more exposed to different forms of media, there can be sessions on cyber safety and ramifications of trafficking. (These children are already aware of the pitfalls of child marriage but do not know how

marriage can be a guise for trafficking – awareness on protection mechanism is required). These can be done in school or AWC, with the support of development partners.

- **Parent-teacher interaction -** Teachers and AWW together can conduct home visits and interact with the parents of children under 10 years of age on the importance of education, gender equality, etc. Parents of adolescents should be encouraged to visit the school and interact with the teacher to learn about the progress of their children. Teachers can visit the homes of children who have dropped out of school to encourage parents to re-enrol their children.

- **Counselling of migrant families -** In the districts bordering different states, counselling sessions with migrant families must be conducted. This is so that continuum of care can be done as well as incidences of child marriage can be prevented. The best months to do so are March and October. [MP doesn't have an existing system where migrants must inform the Panchayat of their migration. Therefore, AWW must identify the households with migrant families and with the support of development partners and rural development department, invite them for counselling sessions.]

- **PLA trainings -** PLA trainings of AWW could be initiated across all projects of Chhatarpur and Sheopur and can be expanded to other districts as well. It has proven highly beneficial for the recipients of older trainings. PLA trainings strengthen IPC skills of participants as well. The trainings should be expanded beyond topics of nutrition to include education and gender as well. A PLA state trainer pool can be developed.

- **Community nutrition gardens -** In areas where there is lower migration, community nutrition gardens can be created. (When migration happens, the gardens usually get neglected.) Support from development partner will be required in training.

- **ECCE using gender neutral activities -** In areas where AWW has an educational degree of Class 12 or higher or has been successfully conducting ECCE sessions, she should continue doing so using gender neutral activities. This means not limiting girls or boys to certain kinds of toys, instead encouraging them to play with all, doing role play inter-changing characters, narrating stories and examples of male and female personalities. [Department of Education must also promote ECCE for children upto 6 years of age. Teachers should advise parents to send children to AWC instead of private school when they seek admission].

- **Street theatre -** Second to IPC, street theatre is the most favoured communication tool. In selected villages, street theatre on child marriage which leads to malnutrition should be done. The skit should be in the local dialect and ideally, by a local theatre/youth group.

- **Posters in community events -** Bhajan sangeet, local melas are good avenues where people gather. Existing posters and drawings with key messages can be displayed at the events. They should have more images and just the key call to action text to attract attention and communicate the doable.

- **Women empowerment programmes -** To start with, in areas with better access to urban cities, women empowerment programmes could be initiated. It is important for a community-based network to develop that would support women in their times of need and allow for more agency in decision making. Conversations around equality must be done – what does it mean to you, what do you want to see in an equal world, what does safety mean to u – what would a safe world look like. This will also help facilitators understand what makes women afraid (affecting their decisions on marriage, education, employment, etc.). These programmes can then start doing safety audits of the areas and inform the findings to the authorities to take improved action for women safety and security. [Safety audit is a participatory tool used to identify factors affecting women's safety and what changes are required to improve the same. A guided training will be required for this. Under the Safe City programme, UN Women can support for safety audits. Alternatively, basic training can be given to Shaurya Dals and women's groups.] One of the core objectives of the women empowerment programmes will be to strengthen women's sense of self identity. (Currently, in most areas, it is seen that women's social identity is stronger – who she is as part of a social group, a mother, wife, daughter, daughter-in-law, etc. Women whose social identity is stronger than self-identity are more likely to stay in abusive relationships due to fear of isolation).

- **Self-defence training of girls -** Under the Beti Bachao Beti Padhao scheme, some districts are conducting self-defence training of adolescent girls. This programme can be scaled up in more areas within districts and can be taken up by more districts.

7.3.4 CAPACITY BUILDING

As mentioned in the core building block, capacity building is of key importance. Given the COVID pandemic situation (effects of which will sustain for expectedly another year) and time and labour-intensive nature of these capacity building trainings, a hybrid model – online and offline – will need to be adopted. The execution plan will have to be discussed in consultation with the department, based on their priorities and budget.

The objective of the capacity building trainings will be to -

i. Build understanding of DWCD officials and AWW on social and behaviour change and capacitate them to develop micro-plans for SBC interventions
ii. Build knowledge of AWW on thematic sub-issues and build their capacities on communication and PLA for effective community engagement
iii. Build capacities of local community groups who can support and partner with AWW in conducting activities
iv. Strengthen counselling

The following trainings need to be conducted:

1. Sensitisation of DWCD Staff on SBC and how to make micro-plans – state officers, divisional officers, DPO, CDPOs

2. Training AWW, supervisors, CDPOs on -
   - Improving IPC, how to effectively convey messages, facilitating divergent discussions
   - How to use existing IEC tools, local resources and publicise any programme, developing micro-plans
   - Using apps and digital media (especially for data entry)
   - Subject-based training in the following areas:
     a. Gender – sex and gender in society, what is abuse, types of violence against women, rights of women, legal provisions, sex determination
     b. ICPS – rights of children, functions of ICPS
     c. ICDS – knowledge building on complementary feeding alternatives, signs of anaemia

3. Positive motivational training for functionaries

4. Sensitisation of media on reporting news on women and children

5. Thematic training to Shaurya Dal and other groups to communicate on life skills and adolescent themes

6. Refresher trainings to existing counsellors in state homes to better address needs of CCL and CNCP children and provide quality case reports

7.4 OTHER RECOMMENDATIONS

Based on the 4 approaches, district/project level activity calendars can be developed. Each project/ district level will have to plan and implement interventions as per current priority, budget and feasibility. However, the approaches provide suggestions on what can be done, and ideas can be taken for implementation in respective areas.

The strategy also provides other recommendations as follows –

- Discussions on women and child health and protection issues can be conducted atleast once a month at the Gram Sabha, using it as a forum for service provider-recipient dialogue and community-based monitoring of practices.

- Tadvi-Patel communities should be mobilised in tribal areas for supporting SBC interventions.

- A team with college kids, educated villagers, etc. can be created for partnership in activities. Youths from NSS, NYK, Shaurya Dal should be mobilised to support in activities.

- Newly elected Panchayati Raj women representatives should be oriented and trained on women and child health and protection issues.

- BLCPC/VLCPC should be thoroughly oriented on their duties, and they should be connected with the AWC. Development partners can work with BLCPC/VLCPC to promote child friendly spaces in villages.

- Pamphlets on foster care can be distributed to people who offer services in other homes like those for destitute women. Such people are more likely to agree to foster children as well.

- Case workers should do individual care plans, individual assessments and regular reviews of CNCP.

- Positive recreational and engaging activities like sports, gardening should be planned in care homes and observation homes to channelise the energy of

children and direct them towards positive outcomes.

- Eligible women should be mapped and connected to training programmes/relevant schemes like for UPSC coaching, vocational training programmes.

- Local safety audits can be conducted by women groups, guided by development partners like UNWOMEN, to identify challenges to women's safety and identify locally owned solutions.

- Convergence should be done with different departments, along with clear identification of respective department's responsibilities - Panchayat Prathinidhi, Department of Public Health and Family Welfare, Department of Education, Department of Farmer Welfare and Agricultural Development, Department of Scheduled Caste and Schedule Tribe Welfare, Department of Social Welfare, Department of Panchayat and Rural Development, Khadi Department.

- Coordination should be done with local NGOs who are able to convey messages related to the issues in the local dialect. Local NGO involvement is beneficial because they are aware of the context and challenges.

- Partnerships with various media, academic institutions and corporates can be built for strengthening implementation and outreach, resources and skills.

7.5 TOOLS

The key message table and activities suggested under approach and implementation indicate the tools being suggested in the strategy – it's a mix-media approach. Those tools are used by the beneficiaries as their main sources of information and are most effective in conveying thematic messages to them. The modes of communication that are being strengthened are –

- Inter-personal communication using PLA, especially home visits, counselling early, dietary recall, PLA cards
- Locally contextualised IEC materials using pictorial representation in local language.
- Peer communication
- Social media and mass media like television, radio for wider reach in urban and semi urban areas and influencing opinions through bulletins, radio jingles, phone-ins
- Using street theatre and folk media to strengthen communication among communities with low access to print media or television owing to geographical isolation, lack of literacy and poverty
- Using school, AWC, VHNDs, Gram Sabhas as platforms for generating dialogue and stakeholder engagement
- Using community events and local fairs and festivals as platforms for awareness and mobilisation

New tools: The strategy does not strictly suggest developing new tools for activities. There are plenty developed by DWCD and development partners that can be used in different ways. However, the following may be required –

› IEC material needs to be translated in local dialects
› Training modules on skill building of DWCD staff and AWW
› PLA picture cards on education and gender –
(i) showcasing how domestic responsibilities, distance, fear of safety cause girls to leave school,
(ii) why education is important for good future,
(iii) what gender equality and equal treatment means – teaching girls and boys the same thing, etc.
› Short videos on cyber safety – how children can be cyber-bullied or victims of trafficking via internet, dos and don'ts for cyber safety
› Street theatre script on how child marriage affects education and malnutrition
› Scripts for educational series and podcasts
› 2-3 minute videos on schemes that the AWW needs to communicate to beneficiaries along with some videos with details for the officials (LLY, PMMVY, how to counsel malnourished children, how to maintain cleanliness)

7.6 MONITORING

As mentioned in the approach and implementation section, it is suggested that a core SBC group be formed with teams at the state, district, and project level. They will spearhead the interventions and provide guidance and inputs wherever required.

The state SBC team will be the nodal point for this strategy. At the district level, the DPO will be the nodal, supported by Assistant Director(s). At the project level, CDPO will be responsible, supported by selected supervisors and AWW. Even if there isn't a hierarchal SBC group, the DPO, with support from CDPO, will have to assign some supervisors and AWW who can lead SBC interventions and provide guidance to others when required. They will also lead monitoring and reporting efforts.

The state team will be responsible for leading the social media and mass media activities and developing the core IEC materials. Once a month meeting could be conducted to discuss the need for interventions and providing inputs on key messages and localisation of IEC materials in the presence of district and project level SBC teams. Development partners can also be the part of these meetings. Coordination with them for grassroot level initiatives is important.

The monitoring may be based on activity/input and outcome monitoring which collects data against outcomes such as attitudes, behaviour and services delivered. The tracking will be done by the authority at the level at which the activity is implemented, and further monitoring will be done by the hierarchal levels. Qualitative assessment should be done to record best practices and case studies. The stories highlighting the change can be shared via social media.

Apart from this, AWW regular update information on Sampark app. Review meetings should also be recorded and challenges discussed must be shared upwards for regular redressal and appraisal of the current situation. While the state needs to know the exact issues and problems faced during implementation and replanning for effective outputs, the district and block level needs to monitor field activities on a regular basis to achieve qualitative and quantitative results.

What to monitor:

For any event, basic indicators would be as follows -

1. Number of trainings or orientation sessions organised
    a. At which level
    b. Organiser
    c. Number of participants (male/female – age group)
2. Date, timing, venue of event,
3. Nature of event
4. Objective of event
5. Number and type of community-level participants (beneficiaries, PRI, stakeholders)
6. Questions asked and addressed
7. Coverage of event in newspaper/social media (if social media, then number of posts and audience reach)
8. Any success story/change story?

Behavioural monitoring comprises of two set of indicators - inputs and behaviours.

- What are the inputs: The inputs are the various approaches and tools being used for effective SBC interventions. The following can be monitored as part of inputs -
    - Number of persons involved in the monitoring committee/SBC team
    - Number of home visits made (stakeholders who accompanied)
    - Number of IEC materials developed and distributed (and broadcast)
    - Number of meetings, FGDs (and the venue – AWC/school/other place)
    - Number of AWW using mobile based applications
    - Number of theatre teams formed and trained
    - Number of street theatre shows conducted
    - Number of festivals where posters were put up
    - Number of programs conducted with children

- Behaviour change outputs would consider the following -
    - Number of persons who have attended meetings/-sessions/festivals
    - Number of women attended VHND and have taken ANC
    - Number of women who registered pregnancy in the first trimester
    - Number of children who were admitted to NRC and completed the entire course of treatment
    - Number of children enrolled in CSAM program
    - Number of children re-enrolled in school
    - Number of child marriages prevented
    - Number of persons and villages reached through theatre shows
    - Number of persons counselled at various institutions and mid media, etc.
    - Success stories
    - Social media outreach

More detail on input, coverage and impact indicators is given in Volume II.

Photographs and videos must be taken of the events for documentation. Record forms should ideally be filled and shared with the district and state.

HOW TO USE THE DOCUMENT

8. HOW TO USE THE DOCUMENT

The SBC strategy document can be used in multiple ways. It can guide current activities, help in developing micro-plans for new activities and provide inputs for future interventions as well.

8.1 Adapt by implementation type

Administrative level-wise implementation: While the strategy outlines SBC interventions to be implemented under 4 approaches, different administrative levels can use the document to develop respective micro-plans.

- **State:** Trainings, IEC development, mass media interventions, especially social media, trainings, and supportive guidance for events will be pivoted at the state level.

- **District:** Districts will provide inputs for the IEC material to be developed and share social media posts. They will pivot the pocket-based field activities and implement activities under specific events. They will also monitor and provide district reports (with outreach) to the state.

- **Project/AWC:** AWWs will conduct the IPC sessions and local activities with beneficiaries. They will be supported by supervisors. CDPOs, supervisors and AWW will provide support to external facilitators of select pocket-based activities.

The SBC group can work together to plan which activities will be conducted in the current year, what support will be required and what capacity building (such as orientations) will be done, etc. The responsibilities could be divided or taken up as suggested above.

Section-wise implementation: The strategy hopes that different sections of the department will factor in SBC when planning their interventions (specific to the section). Sections can also use and adapt the interventions as per the need and requirement. For example, if the women empowerment program is to be developed and the respective section takes charge, they can refer to the complete and priority list of desired behaviours and its barriers/enablers to better customise the program and target accordingly. They can also consult with the state SBC team and district SBC team (or appointed district officers in charge of SBC) to design the program.

Barrier-wise implementation: Knowledge and awareness related barriers can be controlled via mass media, mid media, and IPC. Attitude related barriers will require targeted IPC. Skill related barriers will require capacity building and redressal mechanism. Access related barriers will require system strengthening. Based on the priority and current need, SBC interventions can be implemented based on which barriers to address first. Plans can be made accordingly.

8.2 Strengthening an existing intervention

If an intervention/program is already underway, program implementers/facilitators can use the document to review or improve it.

- The first step would be to understand what desired behaviours are being targeted in the program/intervention and what are the challenges – is there any barrier/enabler that has not been factored in? Facilitators can refer to Section VI.
- The next step would be to map what key messages are being delivered. Facilitator can refer to the key message matrix to improve if required.
- The next step would be to review the building blocks suggested in the strategy and map which block is missing in the activity and then plan on how to incorporate it.

8.3 Planning a new intervention

The facilitator can ask themselves the following questions and refer to the document for information and guidance.

- At which level will you be operating? – state/district/project
- What specific issue or desired behaviour is being targeted?
- What are the barriers/enablers for adoption of that desired behaviour among the target groups?
- What is the most relevant barrier/enabler that can be addressed at the current time? What type of barrier is it? – knowledge/attitude/skill/access/others
- What key message needs to be promoted?

- What is the time frame? Can a year-long campaign be planned or activity in some pockets or one event – what is the requirement and time possible?
- How much is the budget?
- Given the time, requirement, resources and budget, which activity can be conducted?
- How can the building blocks be incorporated in the activity?
- What support will be required? – from team/other administrative levels/external
- Does any IEC need to be developed?
- How will the activity be monitored and reported? What indicators to use?

8.4 Creating a micro-plan

Social and behaviour change is a deliberate process and highly contextual. Interventions need to factor in the ever-changing environment and needs/circumstances of target groups. As such, districts or projects need to periodically review their objectives and resources and develop micro-plans for planning and implementing SBC interventions. Below given is an example (can be treated as a template) of a micro-plan that can be developed by supervisor and AWW to plan any event. In this case, Lalima Diwas has been used. This plan will help ensure that the facilitator is aware of the level of preparation and the basic requisites and building blocks are taken care of. It will also help them monitor participation and progress. Some tips are also given on planning the event.

The first step for the AWW will be to develop a small plan. The AWW can ask herself the following questions and note down the answers on a sheet of paper. The result will lead to a plan. (Below, also given are suggestive answers).

Question	Answer (representative for example)
What is the name of the day to be celebrated?	Lalima Diwas
Why am I celebrating this day?	To raise awareness on pitfalls of anaemia and how to prevent it
Who should I invite to participate in the event?	Adolescent girls, their mothers and fathers
Who can help me in preparation?	Sahayika, ASHA, children in nearby families
Who can help me in facilitation?	Sahayika, ASHA, Mannu tai (fictional name of a respected grandmother in the village)
What activities can I do?	• Designing a welcome banner • Storytelling session with participants • Short quiz • Feedback session • Showing a video • Taking pictures of the event

Question	Answer (representative for example)
Are my building blocks ensured? • Start early • Male engagement • Inter-generational dialogue • Local and popular recall platforms • Capacity building • Stakeholder coordination	• Yes • Yes • Yes • Yes • Yes. Oriented the adolescent groups • Yes.
What key messages will I deliver?	• Do you experience fatigue, breathlessness, headaches or falling sick often? You might have anaemia. Taking IFA pills can help you feel better! • Are you feeling nauseous or having a slight stomach-ache after taking IFA pill? Don't worry, this is normal. Take IFA pill after dinner to prevent symptoms. • Food rich in iron help give your body energy, immunity and help in body temperature regulation. Consume foods like spinach, lentils, broccoli, soya regularly.

Once the AWW writes down her answers, she will have a better idea on how she should progress in planning and conducting the event.

Below given is a suggestive way in which the AWW can successfully use communication to conduct the event. All of them may not have to be implemented in the same session. Before conducting one, she can plan what to do and if she has the resources for the same.

a) Before the event (planning, decoration and invitation)

i. AWW can approach some of the adolescent girls living in homes in the nearest vicinity of the AWC and seek their support in designing and creating a colourful banner for the centre where Lalima Diwas will be written. (If there are younger children or boys who want to participate, encourage them to do so. They can help in decorating the AWC).

ii. When making the banner, the AWW can talk to the girls. If the girls are very participative, work with them to create a small 2-line jingle.

iii. AWW can then request the girls to sing the jingle and help in inviting other girls and mothers to the Lalima Diwas on the upcoming Tuesday.

b) At the event (welcome, session facilitation and feedback)

i. On the day of Lalima Diwas, AWW should welcome the girls and mothers who have come to participate.

ii. The session can be initiated with a game or any activity. It does not have to be about anaemia. The idea of a game is just to welcome everyone and break the ice between them. They will feel energised and be more willing to listen to what you have to say.

iii. During the session, AWW or Mannu tai can share a real-life story. To narrate this story, participants can be asked to close their eyes and then the story can be shared so that they experience it, not only listen to it. Then, a discussion can be conducted.

iv. Activities like a short quiz or a agree/ disagree game can be played to bust myths.

v. A feedback session can be done after this (it will also help in reporting).

vi. Co-facilitators can take pictures to document the event celebration.

c) After the event (follow-up)

i. After the session, AWW can invite some girls and mothers to write the key messages on the walls of the AWC.

ii. With the permission of the participants, a WhatsApp group can be formed for follow-up and sharing of key messages and media.

After the event, the record form must be filled and shared with the supervisor. It must contain details of the event, number of participants, activities conducted, questions asked, photo, video and case studies. Any challenges faced while organising the event must also be listed so that supervisor is aware and further issues can be resolved.

ANNEXURE

Annexure – I: About Madhya Pradesh

A vast, diverse state situated in central India, Madhya Pradesh is often called the 'heart' of the country. It is the second largest state in India (after Rajasthan) with an area of 3,08,000 sq.km. Its neighbouring states are Rajasthan (north-west), Gujarat (west), Maharashtra (south), Chhattisgarh (south-east) and Uttar Pradesh (north-east). Madhya Pradesh is bordered by the plains of Ganga-Yamuna in the north, by the Aravali range in the west, Chhattisgarh plain in the east and by the Tapti valley and the plateau of Maharashtra in the south. It is a landlocked state but it falls within the region of five major river basins – Ganges basin in the north where the Betwa, Chambal and Son rivers flow, Narmada basin below that, and Mahi basin, Tapi basin and Godavari basin which cover smaller portions of Madhya Pradesh.

Madhya Pradesh has 52 districts, divided into 10 administrative divisions, namely, Bhopal, Chambal, Gwalior, Indore, Jabalpur, Ujjain, Sagar, Rewa, Narmadapuram and Shahdol. The city of Bhopal is the capital of the state.

Given its surface area (9.38% of the country's area) and unique topographical positioning, Madhya Pradesh is extremely diverse. Districts differ from each other in their demographic profile, weather, cultural practices, etc.

Demographic profile

As per Census 2011, the population of Madhya Pradesh stands at 7.27 crores (7,26,26,809), with 51.8% male population and 48.2% female population. 72.4% of the population resides in rural areas, while 27.6% live in urban areas. On an average, households in Madhya Pradesh are comprised of 5 members. 9% of households are headed by women.

The sex ratio in Madhya Pradesh is 931, which is below the national average of 940 as per Census 2011 (In 2011, there were only 50 districts). This figure improved to 948 as per NFHS-4 (2015-16) (sex ratio of children under 7 years of age is 918) and further to 970 as per NFHS-5 (2019-21). There are however, huge differences in district statistics. In 2011, Balaghat district recorded a sex ratio of 1021, the highest in the state. This was followed by Alirapur (1011), Mandla (1008) and Dindori (1002). The lowest recorded sex ratio statistics were observed in the Chambal region – the lowest being in Bhind at 838, followed by Morena at 840. In 2019-21, as per NFHS-5, the highest sex ratio is recorded in Seoni at 1089 and lowest in Sehore at 894.

The average literacy rate of men is 81.8% and of women is 59.4%. As per NFHS-5, hardly 29% of women have had 10 or more years of schooling. This is up only 6 percentage points from NFHS-4. As per Census 2011, Jabalpur has the highest overall literacy rate at 81.07% whereas Alirajpur has the lowest literacy rate at 36.1%. Entire list of district-wise total population, literacy rate and sex ratio in Annexure-II.

Community profile

The majority population is Hindu, with Muslims making up the largest minority community. The Scheduled Tribes of Madhya Pradesh constitute over 21% of the state's population (1.52 crores). The largest tribe is the Bhil tribe, constituting 38% of the total ST population. The second largest tribe is Gond, followed by Kol, Korku, Sahariya and Baiga. Tribal communities are concentrated in the southern, southwestern and eastern parts of the state. For earnings they depend upon agriculture, forest produce and local crafts like bamboo-related craft. This trend is however seeing a change with progressing times and growth in economy.

Languages

Hindi is the official language of Madhya Pradesh. It is the most widely spoken language across the state. There are however, many regional dialects. Malwi, Bundeli, Bagheli, Nimari, Bhili and Gondi are among the few. Both English and Hindi language texts are used in signages, milestones, shops and office signboards across the state.

Economy

Agriculture is the main occupation for the population residing in the rural areas. Wheat, soybean, sorghum, along with paddy, coarse millets, pulses, cereals and groundouts are the main crops. The five major river basins contribute to the irrigation in the state. 30% of the state's area is covered by forests. Teak, Sal, Bamboo and Tendu trees are found in abundance. Madhya Pradesh is also the second richest state in terms of mineral resources. Balaghat and Chhindwara districts in the south-eastern part are rich in Manganese, whereas Jabalpur, Mandla, Shahdol, Satna and Rewa produce

Bauxite. Iron ore deposits and coal reserves are also there. Industrial development is primarily concentrated in the more advanced districts like Indore, Bhopal, Gwalior and Jabalpur. Cement, sugar, paper, textile, steel, soya, vehicles and medicine are the major industries.

Climate

Being a landlocked state with many major rivers traversing across it, Madhya Pradesh has a dry to humid and temperate climate. The northern part, near to Rajasthan and Uttar Pradesh, experiences hot climate with temperatures crossing over 40°C in summer. The central to southern regions experience better rainfall in the monsoon months.

Connectivity and Tourism

Madhya Pradesh is well connected by road, rail and air. Telephone and cellular service provider BSNL and other private operators are operational; internet access is easy across the state. The state also has numerous monuments of historical, archaeological, architectural and pilgrimage importance. The forests are teeming with all kinds of wildlife.

Annexure – II: District-wise statistics

POPULATION, LITERACY RATE, SEX RATIO (AS PER CENSUS 2011)

Note: In 2011, there were only 50 districts in Madhya Pradesh. Agar Malwa became the 51st district in 2013 and Niwari became the 52nd district in 2018.

S.N	District	Administrative Division	Total population	District literacy rate (%)	Sex ratio (no. of females per 1000 males)
1	Agar Malwa	Ujjain	-	-	-
2	Alirajpur	Indore	728999	36.1	1011
3	Anuppur	Shahdol	749237	67.88	976
4	Ashoknagar	Gwalior	845071	66.42	904
5	Balaghat	Jabalpur	1701698	77.09	1021
6	Barwani	Indore	1385881	49.08	982
7	Betul	Narmadapuram	1575362	68.9	971
8	Bhind	Chambal	1703562	76.59	838
9	Bhopal	Bhopal	2368145	80.37	918
10	Burhanpur	Indore	757847	64.36	951
11	Chhatarpur	Sagar	1762375	63.74	883
12	Chhindwara	Jabalpur	2090922	71.16	964
13	Damoh	Sagar	1264219	69.73	910
14	Datia	Gwalior	786754	72.63	873
15	Dewas	Ujjain	1563715	69.35	942
16	Dhar	Indore	2185793	59	964
17	Dindori	Jabalpur	704524	63.9	1002
18	Guna	Gwalior	1241519	63.23	912
19	Gwalior	Gwalior	2032036	76.65	864
20	Harda	Narmadapuram	570465	72.5	935
21	Indore	Indore	3276697	80.87	928
22	Jabalpur	Jabalpur	2463289	81.07	929
23	Jhabua	Indore	1025048	43.3	990
24	Katni	Jabalpur	1292042	71.98	952
25	Khandwa	Indore	1310061	66.39	943
26	Khargone	Indore	1873046	62.7	965
27	Mandla	Jabalpur	1054905	66.87	1008
28	Mandsaur	Ujjain	1340411	71.78	963
29	Morena	Chambal	1965970	71.03	840
30	Narmadapuram	Narmadapuram	1241350	75.29	914

S.N	District	Administrative Division	Total population	District literacy rate (%)	Sex ratio (no. of females per 1000 males)
31	Narsinghpur	Jabalpur	1091854	75.69	920
32	Neemuch	Ujjain	826067	70.8	954
33	Niwari	Sagar	-	-	-
34	Panna	Sagar	1016520	64.79	905
35	Raisen	Bhopal	1331597	72.98	901
36	Rajgarh	Bhopal	1545814	61.21	956
37	Ratlam	Ujjain	1455069	66.78	971
38	Rewa	Rewa	2365106	71.62	931
39	Sagar	Sagar	2378458	76.46	893
40	Satna	Rewa	2228935	72.26	926
41	Sehore	Bhopal	1311332	70.06	918
42	Seoni	Jabalpur	1379131	72.12	982
43	Shahdol	Shahdol	1066063	66.67	974
44	Shajapur	Ujjain	1512681	69.09	938
45	Sheopur	Chambal	687861	57.43	901
46	Shivpuri	Gwalior	1726050	62.55	877
47	Sidhi	Rewa	1127033	64.43	957
48	Singrauli	Rewa	1178273	60.41	920
49	Tikamgarh	Sagar	1445166	61.43	901
50	Ujjain	Ujjain	1986864	72.34	955
51	Umaria	Shahdol	644758	65.89	950
52	Vidisha	Bhopal	1458875	70.53	896

Annexure – III: Current situation in thematic areas of DWCD

Below given is the detailed information on the current situation in the thematic areas addressed by the Directorate of Women and Child Development, Government of Madhya Pradesh. The information reflects data released by Census 2011, NFHS-4 (2015-16), the recently published NFHS-5 (2019-21) (published officially in November 2021) and other sources. The most current data is that of NFHS-5.

(A) NUTRITION, HEALTH & HYGIENE

Integrated Child Development Services (ICDS) is the most comprehensive scheme for maternal and infant nutrition and health run by the Government of India and implemented by Government of Madhya Pradesh as well, which covers a wide gamut of issues. It is implemented by DWCD in the state. For years, this scheme is in place working closely with pregnant women, lactating mothers, members of the family, infant children and society to improve indicators of maternal and child health.

A lot of progress has been made. However, there are still few indicators that are not doing as well as expected. They have been looked at below. The state's nutrition policy also highlighted challenges in the below mentioned thematic sub-issues. It also found low sex ratio, lack of women empowerment, experience of gender-based violence, substance abuse, low female literacy, child marriage and small landholdings as the structural determinants of low nutrition status of women and children.

Individual and community behaviours, attitudes, social norms and practices and infrastructure are some of the reasons for such indicators.

(A1) First 1000 days – windows of opportunity

A1.1 Care during pregnancy

Pregnancy and childbirth are considered vital in a woman's life. Families and communities consider it auspicious and attribute huge importance to it. It is therefore interwoven with many traditions and cultural practices which are deemed important by the members of the society. These norms and factors have been found to influence the behaviours that guide maternal and child nutrition and health.

Pregnancy care and child care are principally considered the responsibility of the woman, although her decisions are heavily influenced by family pressures, especially that of the mother-in-law. Husbands/Fathers lack general awareness on such care practices and don't consider it their primary responsibility (Chatterjee et al, 2020). Therefore, they are not actively involved in supporting the woman in practices such as registration of pregnancy, ante-natal check-up, exclusive breastfeeding, birth registration. Improper care during pregnancy is also responsible for maternal mortality. The maternal mortality ratio in the state is 227 in 2012-13.

- **Registration of pregnancy –** Pregnancy registration is important for women to avail the services of ante-natal care at public health facilities, receive take-home ration (THR) and other services of schemes run by the department, in particular the Pradhan Mantri Matru Vandana Yojana. At present, 97% of mothers who gave birth in the last 5 years registered their pregnancy and received a Mother and Child Protection Card (MCP Card). This went up from 81% in NFHS-4.

- **Ante-Natal Check-up (ANC) –** A minimum of four ANC visits are recommended for adequate and timely care during pregnancy. ANCs in the last trimester are also crucial for facilitating breastfeeding practices. The proportion of women who received four or more ANC visits substantially improved in the last decade. Over 75% of women received antenatal care during the first trimester of pregnancy and 58% had four or more antenatal care visits. In 2015-16, a little less than 60% of men accompanied their wives to at least one ANC visit. Health professionals try to convey the importance of maternal care to husbands of pregnant women but many still regard it as the primary responsibility of the woman and do not realise their role.

- **Pregnancy monitoring –** As per NFHS-4, more than 85% of women who received antenatal care for their last birth received each of the services needed to monitor their pregnancy: having their weight taken (94%), having their blood pressure measured (91%), having urine and blood samples taken (88-90%), and having their abdomen examined (86%). Such monitoring is therefore highly dependent on the women going for their ANC visits. Pregnant women with no sons are more likely to have an ultrasound test than those with at least one son. This is because

the desire for a son is very high in the communities. Ultrasounds, they believe will reveal the sex of the child (although such detection is illegal as per The Pre-Conception and Pre-natal Diagnostic Techniques Act, 1994).

- **Nutrition and rest during pregnancy -** Beliefs such "as pregnant woman should not have cold, sour things else the baby will catch a cold inside the womb" or "pregnant mother should not eat a lot because it will put pressure on the womb ('crush the child' or 'the baby will not grow in size')" are some myths that affect the food and nutritional intake of pregnant women. Eggs, curd, lemon, bananas, papaya and pomegranate are some of the foods that the women are asked not to consume. Other diet restrictions include hot/warm foods, jaggery and milk. Some even believe that eating a lot and resting a lot will lead to a painful delivery. Therefore, many continue to work till the day of delivery. Household chores and lack of rest and proper food led to fatigue among women. Many women are also stopped from going outside the house, especially, in the final trimester, which causes anxious feelings. Pregnant women are still subject to gender norms such as eating last (and what is left) after serving all the male members.

- **Consumption of iron and folic acid (IFA) supplement –** 51% of women consumed IFA for the recommended 100 days or more when they were pregnant. This went up from 23% as per NFHS-4. Symptoms of loose motions which usually accompany consumption of IFA are faced by the women, a major reason why they are reluctant to continue to consume it. Many believe that iron tablets can make their unborn child 'dark'. Many also do not receive the IFA pills on time because they don't declare their pregnancy until the 4th or 5th month nor get ANC done. IFA pills are also considered to be "heat inducing" by many and thus elders prohibit pregnant women from consuming them.

- **Recommended immunisation –** As per NFHS-4, only 18% of mothers took an intestinal parasite drug during pregnancy. Since the complete ANC cycle is poor for many women, the recommended immunisation of tetanus injection is often skipped by many. Only 11.4% women got the full antenatal care which includes at least four antenatal visits, at least one tetanus toxoid (TT) injection and IFA tablets or syrup taken for 100 or more days.

- **Delivering the child at a health facility –** 91% of births take place in a health facility (with 80% in a public health facility). Many women who delivered at a health facility were recipients of the Pradhan Mantri Matra Vandana Yojana and Janani Suraksha Yojana which strengthened the importance and practice of institutional delivery. The percentage of births in a health facility have more than tripled in the 10 years. Further on the positive side, even in home births, a majority percentage delivered with the help of a health professional or skilled provider and followed the recommended protocol such as using clean blade to cut cord, wiping baby dry immediately after birth and wrapping without bathing the newborn first. The district-wise statistics of institutional delivery also look very promising. Infant mortality rate in MP is 41. It is much lower than some other states of India where the rate statistic are in the hundreds.

- **Registration of birth –** 94% of children under 5 years of age had their birth registered with the civil authority. Birth registration is important since it helps the department track the newborns and connect them to services of immunisation, nutrition, supplementation and health. It also helps to track the sex ratio in the state and connect eligible families to the Ladli Laxmi Yojana scheme.

A1.2 Care of lactating mother

Post-natal care was common among those mothers who gave birth at a health facility. On an average, 84% women had received a post-natal check-up within 2 days of delivery.

Food and nutritional intake challenges for lactating others is similar to that of pregnant women. It is riddled with traditional beliefs. Where eating nutritious food, from 5 food groups each day is important for lactating mothers, many are not even given any food for few days after delivery (3-10 days) because of the belief that if a new mother eats nutritious food, it will have an adverse effect on the baby. It is believed that in the first months after delivery women should not eat green vegetables since it impacts breastmilk quality.

A1.3 Breastfeeding

Only 41% of newborns start breastfeeding in the first hour of life (colostrum feeding). There is a general lack of knowledge in new mothers to initiate breastfeeding. Influential family members like mothers-in-law hold misconceptions like the initial breast milk after delivery is not "fresh" because it was in the mother for 9 months and prohibit colostrum feeding. In some traditions, mother's first milk is devoted to God while in others it is discarded

because of being impure.

Many children are given something other than breastmilk during the first three days. One of the most common rituals is to get the baby to taste some honey (since honey is sweet and tasting it is auspicious; additionally, it implies that the child will have a well-mannered speech). The other is to feed jaggery mixed with water (gud ka paani) or gutthi (mix of breastmilk, almond paste, khari and nutmeg).

Delivering at a health facility is an enabler in ensuring that children are fed colostrum and exclusive breastfed for 6 months. Mothers who were aware that colostrum should be fed were informed by the nurse at the facility.

74% of children under 6 months are exclusively breastfed. Very few mothers know about the benefits of early initiation of breastfeeding and other care techniques. Fathers lack knowledge and perceive newborn care as the mother's responsibility. Therefore, they do not get involved in ensuring that the child is exclusively breastfed for the first 6 months of its life (Chatterjee et al, 2020). The mother does not have enough milk is another belief because of which early initiation and exclusive breastfeeding is not practiced. They believe that till the colour of the breastmilk is yellow, the milk is not coming, so they throw the colostrum. When it turns white after 3 days, they think it is coming. There are also traditions like annaprasana (the first time the child is fed solid food) which are celebrated early (5 months for girls and 6 months for boys), breaking the first 6-month exclusive breastfeeding requirement. Additionally, many families also believe that breast milk does not satiate the thirst of a child, so they give them water during the first 6 months. Some also believe that just breastfeeding does not fill a child's stomach or the mother is not producing enough milk to feed the child.

Child's breastfeeding is also affected when mother goes to work in the fields. Employers do not allow mothers to take the necessary breaks to feed the child. Taking the child to work is also not possible for many. However, this situation has seen improvement due to the state's efforts with the Pradhan Mantri Matra Vandana Yojana which provides conditional cash transfers to women as maternity benefits.

A1.4 Complementary feeding

After the first 6 months, complementary foods (semi-solids and solid food from different food groups) should be added to the diet of the child. However, at age 6-8 months only 40% children receive breastmilk and complementary foods. There is a belief that if the child is served complementary food after 6 months, it will have a big stomach, its knees and legs will be weak and he/she will be unable to walk. Many also believe that children should be fed after they learn to sit on their own. This is usually around 11-12 months of age, which already is a considerable delay from the required 6 months of age.

As per NFHS-4, only 36% of children aged 6-23 months are fed the recommended minimum number of times per day and even fewer (16%) are fed from the appropriate number of food groups. Only 7% are fed according to all three recommended practices. These figures haven't significantly improved in NFHS-5.

Alternatively, in some cases, complementary feeding is initiated earlier than recommended. Annaprasnna or first solid food feeding happens at 5 months for baby girls as opposed to at 6 months for baby boys. There is therefore a unique situation is observed. In some cases, complementary feeding is initiated early, and the exclusive breastfeeding recommendation is violated. Whereas, in other cases, it is delayed because of the aforementioned reasons. Myths around nutrition are some of the main reasons for this.

The Mangal Diwas celebration (event celebration on Tuesdays at the AWC) facilitates complementary feeding practice.

(A2) Nutrition of children (2-6 years)

As can be seen from the data above that between 6-23 months, children are not fed the recommended amount of food from the different food groups. This trend extends to the age group of 2-6 years as well. A baseline survey by GIZ in Sheopur and Chhatarpur districts found that children suffered low dietary diversity in children <2 (<4 food groups) (77.4%). This data provides an indication of the status prevailing in the state.

Mothers, fathers and family members often lack the know-how on which foods are best for the cognitive and physical development of their children. Family income also restricts the purchase of food items which are considered expensive such as fruits. In many cases, women lack the time for preparing nutritious meals and feeding the child as they go to work.

(A3) Immunisation & Vitamin-Mineral Supplementation

Although there is a list of government-recommended and administered routine immunisation shots, most children are partially vaccinated. Vaccination coverage was observed more among children with mothers who had more than 10 years of schooling and if they were the first child. A noticeable gender imbalance was not observed in this case.

- 83% have received basic vaccinations against tuberculosis, diphtheria, pertussis, tetanus, polio, and measles. 95% have received the BCG vaccine, 81% all doses of polio vaccine and 87% DPT vaccine.
- Of the children who suffered diarrhoea, about 66% were taken to a health facility or health provider for treatment. 9 out of 10 mothers had heard of oral rehydration salt (ORS) packets for the treatment of diarrhoea, but only 65% of children with diarrhoea were given ORS. 36% of children were given zinc supplements.
- Vitamin A supplement, an important micronutrient for children, was given to 78% of children age 9-35 months.

(A4) Prevention of anaemia

Anaemia is a common issue faced by women and children in Madhya Pradesh. 55% women and 73% children are anaemic. In comparison, barely 22% men are anaemic. This is largely connected with the nutritional intake of the child and lack of IFA intake. As was seen in pregnancy care, women often do not consume IFA due to uncomfortable symptoms or myths regarding its effect on their unborn children. Similarly, children are also not given IFA. As per NFHS-4, only 9% of children age 9-23 months ate iron-rich foods, and only 26% children age 6-59 months were given iron supplements. Not only are women overworked with chores and responsibilities, in many households a nutritious diet for them is also not a focus. The lack of a good diet and anaemia are concerns particularly faced by adolescent girls. Because of gender bias, even today, young girls do not receive as much nutrition/food as their male counterparts in the family.

(A5) Prevention and Management of Malnutrition

36% of children under 5 years are stunted (low height as per age) and 19% are wasted (low weight as per height). These are indications of malnourishment among children. 33% are underweight which means both chronic and acute undernutrition.

There are only small differences in the level of undernutrition by the sex of the child (Prevalence of malnutrition was found marginally more in males compared to females). Differences are more pronounced for other background characteristics. Undernutrition generally decreases with increasing levels of mother's schooling, better nutritional status of the mother, and decreasing birth order. The level of undernutrition is relatively high for children living in the rural areas.

The use of iodized salt which prevents iodine deficiency (which can lead to miscarriage, goitre, and mental retardation) was seen in more than 95% of households, up from 59% in NFHS-3.

One of the recommended ways to address malnourishment among children is to regularly monitor their grown at the AWC and refer severe cases to Nutrition Rehabilitation Centres (NRC). As per NFHS-4, among the children who are eligible to receive services at the AWC, 58% had received growth monitoring, 52% health check-ups and 60% supplementary food. In case of referral to NRC, in many villages, NRCs are far-off and conveyance becomes an issue. In many cases, even after visiting the NRC, when the child returns home, due to a lack of an adequate healthy diet, the child's condition worsens again (Pandey, K & Singh, J., 2013).

Consumption of nutritious and balance diet, literacy levels, access to and practice of consuming clean drinking water, sanitation, etc. are all connected to malnutrition and management of severe and acute malnourished children. The probability of a malnourished mother giving birth to a malnourished child is high. Malnourishment is also common among young mothers (ibid).

(A6) Water, Sanitation & Hygiene (WASH)

Infrastructural issues and lack of awareness on proper hygiene maintenance protocol are two of the major reasons why issues related to water, sanitation and hygiene are prevalent. 89% of the households have an improved drinking water source (86% in rural areas). As per NFHS-4, for 19.7% of the population, it still takes more than thirty minutes to obtain drinking water. Only 8% of households treat their drinking water appropriately to make it potable (which includes boiling, bleaching, filtering, and electronic purifying). 65% households use an improved sanitation

facility. This figure is low in the rural areas, standing at 59%. With COVID-19 pandemic hitting the world, including India, communication related to handwashing was strengthened. Therefore, awareness on the method and importance of handwashing was strengthened in the last 2 years.

(A7) Early Childhood Care Education (ECCE)

63% of children under 6 years receive services of some kind from AWC (NFHS-4). However, the service that is least likely to be accessed is early childhood care or preschool (42% of children age 3-6 years) as per NFHS-4. Children of 3-6 years attending AWCs are offered informal learning through games, storytelling, use of pictures, etc. AWWs are trained to conduct pre-school education sessions during their job training and refresher training courses (Annual Project Implementation Plan 2012-13).

As per Annual Status of Education Report (ASER) 2018, at age 3, 72.6% children are enrolled in AWC. This enrolment rate declines with age - age 4 (61.4%), age 5 (24.4%) and age 6 (5%). One of the reasons for this is that some children get enrolled at nursery schools.

The Annual Project Implementation Plan 2014-15 highlighted several challenges in ECCE as follows –

- Gaps in infrastructure
- AWCs not interfaced and linked with schools
- Low level of competency as ECCE instructors and motivation among AWWs
- Curriculum not defined separately for ECCE
- Undernutrition and poor health status
- Disparity between urban, rural and tribal areas
- Low community participation

A structured ECCE activity 'Bal Chaupal' is organised on every 25th of the month at AWC. It serves as a platform for dialogue between AWW and parents on pre-school education and its importance in developing learning abilities in children. It also encourages community participation as it is celebrated with Gram Swasthya Samiti. The state has developed a pre-school education policy 2020 to bring about an improvement in the same. The policy also looks at pre-school education by private education providers.

(A8) Back to School (girls 11-14 years)

From 2016-17 to 2018-19, school dropout among girls has sharply increased. This was identified when the THR went up from 1,22,230 to 3,05,000 in the time period[1]. In Madhya Pradesh, the dropout rate at upper primary level (Class 6-8) is 12.06% in girls (Unified District Information System for Education Plus).

Reasons for school dropout include distance of secondary schools from one village to another, low importance of girl child education (Times of India, 2019), hesitation by girls to attend school once they start menstruation, impending marriage (child marriage), domestic responsibilities and disassociation with academics. Girls who have faced violence suffer from trauma and become reluctant to leave home to go to school. In many cases, mothers take young girls to their job so that she will learn the work. The rate of dropout doesn't completely signify the number of girls out of school. Officially, many are enrolled but they stop attending due to the aforementioned reasons.

(A9) Menstrual Health & Hygiene Management (MHHM)

Overall, 61% women age 15-24 use a hygienic method of menstrual protection. Women with at least 12 years of schooling are almost seven times as likely to be using a hygienic method as women with no schooling. Use of hygienic methods of menstrual protection is much higher among urban women (82%) than rural (54%) women. There is still a lack of knowledge on how to maintain hygiene during menstruation like wrapping pads in newspaper, drying cloth in the sun, changing every 6 hours, taking a bath every day, etc.

One of the core challenges, however, is the discrimination faced by girls and women when they are on their period. Untouchability is still practiced when a girl gets period; her movement is restricted, and she is often not allowed to touch things in the house or enter the kitchen or prayer room. Her diet is affected by myths that girls should not eat sour food or consume milk.

The lack of knowledge, along with discrimination faced leads to many girls not going to school during menstruation.

To create awareness and promote MHHM, the department runs the Udita scheme which prepares activities for adolescent girls by creating a platform to discuss issues related to nutrition and health of adolescent girls.

[1] THR is given to adolescent girls who do not get the benefit of mid-day meals after they drop out of schools.

(B) CHILD PROTECTION

27% population of the state is under 15 years of age. Protection of children includes ensuring that they receive access to and quality food, shelter, clothing, safety from violence, education and protection. The Government of India has implemented the Integrated Child Protection Scheme (ICPS) which has guidelines and structures to ensure the same.

DWCD implements ICPS for child protection in the state. Under this, Child Welfare Committees (CWC) (as per Juvenile Justice Act) are operational, and Block and Village Level Child Protection Committees have been formed. CWCs identify children in need of state care as Child in Need of Care and Protection (CNCP) and ensure their protection, counselling, rehabilitation. They are also responsible for care given to juveniles in care homes (those who have committed crimes and are recognised as Child in Conflict with Law - CCL).

The Child Protection Policy 2020 of DWCD highlighted many challenges in child protection issues, as follows –

i. Authorities, officials, families, communities, agencies responsible for ensuring protection of children and ordinary people have limited awareness and understanding of the national and regional laws and mandates for the same.

ii. Lack of understanding on the forms of violence faced by children at home, school or places they are engaged in.

iii. Lack of monitoring and attention given to the forms of violence faced by children at home, school or places they are engaged in.

iv. Lack of importance given to the fact that need for and type of protection given to children differs based on context, their circumstances and has to be ensured by factoring that in. It also has to account for their age and growing autonomy.

v. Lack of and unavailability of experienced, patient and trained child protection stakeholders such as community leaders, teachers, medical staff, counsellors, police, etc.

vi. Lack of access to services to strengthen child protection

vii. Gap in implementation and monitoring of laws and programmes for child protection

In collaboration with the state of MP, organisations like UNICEF, CSOs like Mamta Health Institute and adolescents themselves are working towards adolescent empowerment which addresses nutritional and protection goals for children. The department has also recently launched the Mukhya Mantri Bal Sewa Yojana to support children who lost both parents due to COVID.

A lot of achievement has been made. There are, however, more areas where work is required to strengthen child protection.

(B1) Ending abuse and violence against children

In 2019, 31% children were victims of kidnapping and abduction. Of this 18% were cases of missing children which were deemed as kidnapping due to inability to track whereabouts. 5% kidnapping cases were to compel the minor girl to marry.

21% children were victims of sexual abuse and violence in 2019. In the last 3-5 years, cases of sexual abuse and violence against girl children has increased. In 2019, 15% girls were victims of cases registered under the Protection of Children from Sexual Offences Act (POCSO). Of this, 8% were victims of rape and 7% were victims of sexual assault (NRCB, 2019).

In many cases, the perpetrators have been identified as teenage boys. Pornography has also increased in the rural areas. At present, 94% of urban and 80% of rural households have a mobile phone. Access to the internet has become very easy and unmonitored.

During the pandemic, with no schools, increasing friction between family members at home, prevalence of remote, low traffic public places, safety of children, particularly girls, was threatened and became a major reason for increase in violence against children and child marriages.

Cases of violence against children are also under-reported. Many children do not understand or cannot identify that what is happening with them is violence. In many cases, social taboos supporting victim blaming, particularly in the case of girls, is a cause for not reporting. People believe that the girl is bad which led to the case of violence against her. However, there is ignorance of the fact that boys also face abuse.

(B2) Ensuring children in need of care & protection

Among children below 18 years of age, 5% have experienced the death of one or both parents. In all, 89% of children live with both parents; 7% live with one parent (mostly with their mother), and the remaining 4% live with neither parent.

The state believes that a child is restored when it is connected with a family, its own or foster/adoptive, which will ensure the complete requirements of a child (food, shelter, education, protection, etc.). Many children who do not have a guardian, have run away from home, were victims of violence at home, come under the custody of the Juvenile Justice Act and are provided rehabilitation at government run shelter homes. For those identified as Child in Need of Care and Protection under the JJ Act, the state seeks to connect them with adoptive families. There is, however, stigma related to adoption. In the cases where families are willing to adopt, the demand for newborns is very high. People are reluctant to adopt children over 6 years of age. Some of the reasons for this is that they do not want children who have developed an understanding of the world ("duniyadari ki samajh"). In many cases, a newborn is easier to integrate into the family without revealing to the world that the child was adopted.

Similar challenges are observed in ensuring foster care for children (those whose parents have passed away or are in prison or children are vulnerable but not yet categorised as CNCP). The understanding of the concept of foster care is very low in India.

(B3) Rehabilitation of children in conflict with law

Over 5000 criminal activities in 2019 were committed by children. This included 1586 cases of causing hurt and grievous hurt, 700 cases of theft, 348 cases of assault on women to outrage her modesty, 295 cases of rape and other crimes. 427 incidences were POCSO cases (NCRB, 2019). These statistics are one of the worst in the country.

Children in conflict with law (CCL) are reluctant to undergo counselling and often run away from shelter homes. There are 115 shelter homes for children and 106 counsellors working across the state in each district.

(B4) Prevention of child marriage

23% of women aged 20-24 years were married before the age of 18 years, while 30% of men aged 25-29 years were married before the age of 21 years (NFHS-5) in Madhya Pradesh. However, the incidences of child marriage are 25% lesser than that reported in the last decade.

There are many reasons for the prevailing trend of child marriage.

- There is lack of awareness among girls and boys, men and women on the pitfalls of child marriage and they are unable to understand why they need to wait.
- Dowry in marriage is a common social custom in MP (like most of India) and highly prevalent in rural areas. The amount of dowry (in monetary terms and kind) to be given becomes higher once the girl gets older. Therefore, families prefer to marry off their girls early for lesser dowry. This trend is driven by family poverty.
- Girls who lose interest in academics or are burdened with domestic responsibilities voluntarily agree to get married without understanding the repercussions of child marriage.
- Girls are considered a social burden. Due to high income poverty, families prefer to get girls married off to reduce household expenses. They also regard boys higher because they believe the boy will work and bring income into the household which the girl will not. Loss of livelihoods during pandemic further pushed poor families to opt for early marriages.
- The COVID pandemic saw high incidences of child marriage due to the low expenses of weddings and limited access of administration (to stop the wedding) during lockdown. 117 marriages were recorded in June 2020 (Dutta, 2020).
- Safety of girls is also one of the reasons why child marriages are high. Families become concerned that once girls hit puberty, their risk of being sexually harassed, eloping with a boy, etc. becomes higher. This is why restrictions are posed on education and even employment. Once girls get older, their mobility is also restricted. They are not allowed to leave the house after evening time or go to places without a chaperone. Lack of social security deems marriages as the only safe option for daughters by families.
- Low value of education and poverty, among other reasons, is responsible for children being

forced to discontinue studies and encouraged to marry or work instead.

- 82% of children age 6-17 years attend school (86% in urban areas and 80% in rural areas). School attendance is 90% at age 6-14 years, and then drops sharply to 65% at age 15-17 years. There is little gender disparity in school attendance in the 6-14 years age group; however, in the age group 15-17 years, 62% of girls compared with 67% of boys are attending school (NFHS-4).

- As per Unified District Information System for Education 2015-16, the annual school dropout rate is high in Madhya Pradesh. The dropout rate of boys is 8.16% while among girls, it is 6.63%. At the upper primary level, the dropout rate is higher for girls at 12%, compared to boys at 10%. As of 2015-16, the average annual dropout rate of boys at the higher secondary level is 7.85% while 5.49% girls quit from study at secondary level.

- Underreporting of child marriages is high. One of the reasons is stigma against those who report (their neighbours or community members). Some field GO and NGO functionaries (who are also locals) who have knowledge of all local happenings fear reporting child marriages due to possible community repercussions.

Child marriage is also a cause and consequence for the poor health of young women and infants in the state. Although fertility rates have gone down (2.0 children per woman in 2019-21, down from 3.1 in 2005-06), due to a significant rate of child marriage, women are having children before 20 years of age, making them weaker and leading to higher infant mortality rate (Infant mortality is 72 per 1,000 live births for teenage mothers compared with 47 per 1,000 live births for mothers age 20-29 and 30-39). The proportion who have started childbearing rises sharply from 0.2% at age 15 years to 11% among women who are 18 years old and to 23% women who are 19 years old. Young women who had no schooling are much more likely to have started childbearing (27%) than those with 12 or more years of schooling (2%) (NFHS-4). Education levels therefore have a significant impact on child marriage and early child-bearing. Anaemia is prevalent among this population (82.4%) (UNICEF, 2020).

The department has taken multiple initiatives focused directly on child marriage. Among those, the state has been the first to launch a dedicated Lado campaign in 2013 to prevent child marriage, focused on community participation and behaviour change. Workshops have been organised at the district, block, school and village level and multiple approaches like wall writing, awareness rallies, rath yatras, pledges not to perform child marriages in government/ religious programmes, jingles, documentary, street plays, hoardings and advertisements in daily newspapers have been implemented.

(B4) Prevention of substance abuse by children
Children are found to be addicted to substances like tobacco, gutka from an early age. Many observe and follow what members of their family do. Other substances children are addicted to are whitener, adhesive used in cycle tyres, etc.

(C) WOMEN SAFETY & EMPOWERMENT

Ensuring safety of women and girls and enabling women empowerment is another core area of DWCD's intervention. The department seeks to protect women from all forms of violence against them and ensuring access to protection and remedial services. It runs the one stop centre which is operational in all districts of the state. It also works with 181 women helpline.

Women economic empowerment is also a target of the department. It worked on the Tejaswini project on a pilot basis with the Department of Rural Development. Currently, it does not have a focused program or scheme like the ICDS or ICPS for the other two core thematic areas.

(C1) Gender equity and equality

There is a strong desire and preference for sons in the community. 18-19% of women and men in the state want more sons than daughters. Only 2-3% women and men want more daughters than sons. The most common preference is to have at least one son and one daughter. In families with 2 daughters, mothers haven't undergone family planning operation because they still hope to have a son. (This is one of the direct reasons affecting the availing of Ladli Laxmi Yojana scheme by eligible families). However, such operations are common in the society and more prevalent if the families have sons.

Role and status of women in the society is a key factor. Girls are considered a burden and financial responsibility, with added challenges of ensuring her safety and security. In some communities, families

with daughters have to always maintain a low profile, bow to others, touch the feet of daughter's in-laws, etc. Girls are thought to be ones who will leave home and become part of another family. Boys, on the other hand, belong to the family, will earn and support the household income. The patriarchal form of society further strengthens such views. This is the reason why gender-based discrimination prevails and there is gender inequality observed. This inequality is reflected in levels of education, higher child marriages observed in cases of girls, higher prevalence of violence faced by girls, lower workforce participation of women, low nutritional status, higher cases of anaemia, etc.

The aforementioned is also why sex ratio is still low in the state. The sex ratio of the total population in Madhya Pradesh is 970. There are however, huge differences in district statistics. In 2019-21, the highest sex ratio is recorded in Seoni at 1089 and lowest in Sehore at 894.

Ladli Laxmi Yojana is one of the main schemes of the department (and its structure and success has led to its adoption by other states as well) targeted towards improving sex ratio. Its primary goal was to ensure gender equality followed by reducing rate of child marriage and improving girl child education. The scheme has reached to over 40 lakh families in the state. However, the coverage is still not enough and the overall objectives of girl child promotion is not being fulfilled.

In a primary research study done by the department and Atal Bihari Vajpayee Institute of Good Governance and Policy Analysis, it was found that majority of the families that are eligible but not availing the scheme claimed to do so because they still desire to have a son. Literacy/education has no significant correlation to the behaviour of not availing the Ladli Laxmi scheme. There is little difference in the uneducated respondents who have taken the scheme or those who are eligible but haven't. However, it was also positively observed that as education among men increased, their desire to have a son decreased. It was also found that if people believe that girls will have a safe and secure life in society, the prevalence of availing the scheme will improve.

AWC is a key link to connecting people to the scheme. 66-78% are aware of the process of availing scheme; however, the relative percentage of men who have information is lesser.

It was observed that amongst the families that were eligible but not availing schemes, malnutrition among children was high. It was also found that many respondents had miscarriages in the second, third and fourth month of their pregnancies. These are the months when sex determination of the foetus is possible. Many respondents admitted to getting a sonography done prior to the miscarriage. (Sex determination is now illegal as per PCPNDT Act. However, families continue to use traditional methods or other options to try to determine the sex in order to decide whether to continue with the pregnancy or not. Such methods are illegal and never guarantee correct assessment. They in turn harm the mother.)

Not having a son is also one of the reasons mothers (and in many cases daughters) are subjected to emotional and physical violence. Majority of the cases such violence is inflicted by the mother-in-law.

On the positive side, the desire to educate the girl further (till 10-12th or higher) is one of the reasons families do avail scheme. There is positive improvement in awareness and attitude towards girls' birth, health, nutrition, education, treatment at home and marriage. This is because of the Ladli Laxmi scheme.
The Beti Bachao Beti Padhao scheme also works in towards the goals of LLY but a linkage between the two schemes is lacking.

(C2) Prevention of violence against women & girls

About one-third of ever-married women (28%) age 15-49 years in Madhya Pradesh have experienced physical or sexual violence (NFHS-5). From the time of her conception till her entire life cycle, a girl faces discrimination, abuse and violence, including societal apathy towards her health and educational needs and social evils like child marriage, dowry and domestic violence (UN Women, 2018).

Domestic violence is one of the most prevalent forms of violence against women in the state. In 2019, 14% women experienced cruelty by husband and relatives and the same percentage were assaulted with the intent to outrage a woman's modesty. 15% women were kidnapped and abducted, of which 4% was to compel her for marriage. 6% women were victims of rape. In 99% cases, the perpetrators were known to the victims. While cyber-crime targeting women were a lower percentage at 0.2%, they are still prevalent and growing by the day (NCRB, 2019). Sexual harassment cases per one lakh population is also high at 8.4%, second only to Uttar Pradesh (9.1%) in 2016. The forms like acid attacks, dowry related

abuse, witch hunting have prevalence in the state, but the figures are less than 2%.

Among those who experienced physical violence since age 15, the most common perpetrator for ever-married women was the husband and for never married women, it was a mother/stepmother, sister/brother, and father/stepfather. Forms of physical violence include pushing, shaking the woman, throwing something at her, twisting her arm, pulling her hair, slapping, punching, kicking, dragging, beating, choking, burning and threatening with knife or weapon. Slapping is the most common.

The patriarchal form of the society, prevalent gender norms and low status of women in society is a major factor for such a situation. Daughters are considered a financial liability and social burden. Low value of a girl child combined with household poverty makes families think that they have to spend their limited resources on ensuring education, protection, marriage, dowry of girls, which does not reap benefits but increases household burden. Issues with ownership of land is also a reason why families prefer boys over girls (UN Women, 2018). Overall, such a societal structure and low value of girls leads to increased susceptibility of violence against women and girls.

In the case of domestic violence, acceptance of violence by wives/daughters-in-law is a major issue. There is a culture of acceptance of violence against women, especially beating of a wife by her husband.

As per NFHS-4, over half of women (53%) believe it is justifiable for a husband to beat his wife under some circumstances such as if she shows disrespect for her in-laws, if she argues with her husband and if he suspects her of being unfaithful. Other reasons include if she goes out without telling him, neglects the house or children, doesn't cook properly or refuses to have sex with him. 43% of men say that wife-beating is justified for the same reasons.

Even among women and men who have completed at least 12 years of schooling, about one in three (30% of women and 34% of men) say that a husband is justified in beating his wife for one or more of the specified reasons.

- Violence during pregnancy - One in 30 women who have ever been pregnant have ever experienced physical violence during one or more of their pregnancies. Women who are widowed, divorced, separated, or deserted are the most likely to have experienced violence during pregnancy (9%).
- Spousal violence – 28% of ever-married women report having been slapped by their husband; between 9-14% have experienced other forms of physical violence. 7% were victims of marital rape, having been physically forced by husband to have sex even when they did not want to. 4% were forced with threats by husband to perform sexual acts they did not want to perform. 12% women reported emotional violence by their spouse. Although the prevalence of spousal violence is lower among more educated women, about 1 in 7 women (15%) who have at least 12 years of schooling have experienced physical or sexual spousal violence. Women whose mothers were beaten by their fathers are twice as likely to be in abusive marriages themselves. Women whose husbands consume alcohol are much more likely than women whose husbands do not consume alcohol to experience spousal violence, especially if the husband often gets drunk. Among men who drink alcohol, almost half (49%) drink alcohol at least once a week.

The COVID-19 pandemic aggravated the situation of violence against women and girls. Isolated at home, increasing friction within family members due to loss of livelihood, lack of access to services (due to issues of mobility, reduced services in the pandemic), limited access to phones, etc. are some of the reasons for this.

However, as Heise says in 2011 paper 'What Works to Prevent Partner Violence? An evidence overview', "no single factor alone causes VAWG. It is caused by a combination of drivers operating at different levels of the social ecology."

Seeking help and access to services - Only 11% women who have ever experienced physical or sexual violence by anyone have sought help. Over four-fifths (81%) of women have neither sought help nor told anyone about the violence. Abused women who have sought help most often seek help from their own families. Only 2% of abused women who sought help for the violence sought help from the police.

One Stop Centres are in place to provide temporary shelter, police desk, law aid, medical and counselling facility to women and girls suffering from all forms of violence. However, people are unaware of it and are also hesitant to register cases due to victim blaming, among other reasons. Maximum cases that are registered in OSC have been found to be cases of domestic violence.

There is also the Mukhyamantri Mahila Sashaktikaran Yojana which targets linking women to skill upgradation training programs or providing support so that they become self-reliant, in the absence of any family or societal support.

Shaurya Dal groups were also formed by the department comprising of women who worked to prevent violence against women in the society. This group has now been restructured and includes adolescent girls and youths who will work in this direction while also targeting overall women empowerment.

DWCD is also working on the Safe Cities programme by UN Women targeted at safe private, public and workplaces for ending violence against women and girls.

(C3) Enabling women economic empowerment

As per the National Sample Surveys' Periodic Labour Force Survey (PLFS), 2017-18, compared to 2011-12, women's participation in the workforce increased in 2017-18. For urban women, it increased from 11.5% to 14.7% and for rural women it increased from 23.9% to 25.6%. Overall, the increase was driven, largely by increase in self-employment in the rural areas and regular employment in the urban areas (IWWAGE, 2020). MP is one of the top ten performers in the Pradhan Mantri Mudra Yojana (PMMY), and has been for the last 3 years, and witnessed a 17% increase in its sanctioned loan amount under the scheme in 2018-19.

However, women's participation in economic activities is significantly lower than men. In agricultural occupations, their economic participation is even lower. Two-fifths (40%) of all women aged 15-49 were employed in the 12 months preceding the NFHS-4 survey. In the same period, 84% percent of all men aged 15-49 were employed. This is a more than double difference. Of the total number of employed women, 34% worked in non-agricultural occupations, compared with 54% of employed men.

Lack of education, lack of aspiration (and lack of knowledge of career opportunities), no permission to go outside the house, issues of access and participation in non-economic activities (household work, caregiving, supporting family agricultural work) are some reasons for this. The low level of MNREGA performance is a factor. In urban areas in regular employment, many quit working due to lack of paid leaves and social security benefits, burden of caregiving and experience of sexual harassment at the workplace.

In agricultural occupations, women are involved in tasks supporting home-based farm work, but they do not receive any remuneration for their work.

A challenge often considered in economic empowerment of women is their financial agency – the agency to determine how the money they earn will be spent. This affects other health and protection goals as well. Among currently married women who work and are paid in cash, 80% decide how their earnings will be used, either alone or jointly with their husbands.

As per NFHS-5, 86% women participate in decisions about their own health care, about making major households purchases, and about visits to her family or relatives.

35% of women have some money that they can decide how to use. The proportion of women with money which they control is higher among urban than rural women, increases sharply with age, and is highest among women with 12 or more years of schooling (49%), women aged 40-49 (45%), and women who are employed for cash (44%) than any other group of women. Education, therefore, is a factor for economic empowerment. However, where 59.4% women are literate, hardly 23.2% of women have had 10 or more years of schooling.

74% women have a bank or savings account that they themselves use (NFHS-5). Women's knowledge and use of microcredit programmes is very limited. 32% of women know of a microcredit programme in the area and only 4% have ever taken a loan from a microcredit programme.

As per NFHS-4, only 33% of women are allowed to go by themselves to all three of the following places: the market, a health facility, and places outside the village/community. The only groups of women in which more than two-fifths are allowed to go to all three places alone are women aged 40-49, urban women, women with 12 or more years of schooling, employed women who earn cash and women with 3-4 children.

Therefore, it can be seen that young women, unmarried women and those with lower levels of education face challenges of access (such as not being allowed to go out of the house) and economic empowerment.

Annexure – IV: Media environment and exposure

Community

Media exposure is moderate among women and men in Madhya Pradesh. It is the highest in the age-group of 15-24 years of age (almost 19% both in men and women). This trend decreases as per age with the lowest percentage seen in ages 40-49 years.

65% of women and 72% of men watch television at least once a week. However, men (44%) are much more likely than women (22%) to read a newspaper or magazine at least once a week. 21% of men and 31% of women are not regularly exposed to print media or other forms of media. Only 13% of women and 19% of men listen to the radio at least once a week. Therefore, it can be understood from these figures that mass media has more popularity than print media amongst the general masses, especially in rural areas. Inter-personal communication, is however, quite common due to regular visits by the AWW workers (and ASHA and ANM).

A study done under Poshan Abhiyan in July 2019 in 4 states (Andhra Pradesh, Bihar, Gujarat and Madhya Pradesh) to inform the Ministry of Women and Child Development on SBCC found that in Madhya Pradesh, the most favoured communication platforms with highest reach are home visits, TV, VHSND, community-based events and posters.

84% households in Madhya Pradesh have mobile phones, 55% have television and 16% have radios. 13% households have internet at home and only 6% have computers. Only 29% women have a mobile phone that they themselves use, and among women who have a mobile phone that they themselves use, 70% can read SMS messages. While literate women and not literate women have a close percentage of media exposure (59% and 40% respectively); this trend is drastically different in the case of men where 82 % literate men are exposed to media whereas only 18% of not literate men have media exposure.

Education, access to infrastructure and communication channel and interest are therefore influencing reasons for community's media exposure and consumption.

AWW and supervisors

AWW and supervisors have increased media exposure due to their constant interaction within the DWCD structure and trainings received. Owing to COVID, with trainings and interactions shifting to e-mode, AWW have learnt the usage of the Zoom platform and also access YouTube, Facebook and WhatsApp regularly. However, AWW struggle a bit with data entry in digital applications due to lack of frequent exposure and usage of the same.

A study by Vikas Samvad in 2014 found that AWW didn't have a platform to discuss their issues. For day-to-day operational challenges, they would turn to their peers or senior staff for advice. A systemic mechanism for feedback and access to new knowledge was missing. This lack of a platform became particularly challenging when they needed guidance on technical issues such as judging if a child needed to be sent to the NRC or not. To facilitate dialogue with AWW (and ASHA and ANM) on nutrition issues, in 2015, Vikas Samvad started Poshan Samvad[2]. In 2019-20, with the development of the e-learning platform Anganwadi Shiksha by DWCD, AWW were able to access new and updated information on thematic issues. The Zoom platform for trainings also provided a forum for sharing. However, a systemic forum of this sort is still required.

Communication Channels used by DWCD

DWCD uses multiple channels for communication. It has a dedicated wing for IEC and SBCC. DWCD has pages on Facebook, Twitter, YouTube and Instagram. It uses WhatsApp for communicating to its district level functionaries. Audio spots, street theatre shows, radio jingles, print ads, posters, video clips are commonly used. Trainings are facilitated for AWW to provide updated information and capacitate them to conduct inter-personal communication with target groups.

Every Tuesday, an event is organised at AWC, where key messages are communicated. Every week, the theme is different.

- 1st Tuesday – Mangal Diwas – godh bharai (baby shower ceremony) is done – messages of care during pregnancy are shared

[2] Poshan Samvad - Nutrition Dialogue - is a mechanism for establishing an ongoing consultation amongst the field functionaries of the departments of Women & Child Development and Public Health & Family Welfare.

- 2nd Tuesday – Annaprasana – first rice-eating ceremony of infant – messages of complementary feeding are given
- 3rd Tuesday – Lalima Diwas – communication with adolescent girls on anaemia
- 4th Tuesday – Bal Choupal – immunisation and message on early childhood care and education
- 5th Tueday – Suposhan Diwas – messages on nutrition

Main messages are promoted on these days. Those messages are also given as a chart in the AWC.

Communication channels & avenues being used

- **Mass media –** newspaper ad, hoardings, documentary, radio campaigns, jingles, IEC digital repository, Google digital ad
- **Mid media –** Street theatre, trainings on Zoom & StreamYard, awareness rallies, wall writing, day celebrations, Anganwadi radio app, e-learning platform, Sahbhagita Samvad, competitions for target groups
- **Print media –** posters, leaflets, booklets, guidebooks
- **Social media –** Facebook, Twitter, YouTube, Instagram, WhatsApp
- **IPC –** house visits, counselling, event celebration at AWC

Every year, key international and national days are celebrated such as World Breastfeeding Week (1-7 August) and Poshan Maah (September). In 2020, DWCD inaugurated the days online and launched a dedicated website https://www.amrutpaan.org/. Online technical sessions were conducted, competitions like selfie taking competition, slogan writing, recipe making were organised with different target groups, audio spots were broadcast, videos of PRI and MLAs were circulated, digital ad by Google was promoted, quizzes were organised and AWWs were trained to conduct house visits, counsel families, etc.

The department has developed its own radio channel called the Anganwadi Radio App. Audio spots are shared on the app for mass circulation. The platform is also being used to ensure that AWW can capture and upload stories from the ground. So far, 25000-30000 people have downloaded the app.

In the COVID-19 pandemic scenario, DWCD adopted a unique methodology to reach out to and communicate with multiple target groups across its thematic divisions. Keeping in mind the challenge of no physical outreach and work-from-home mode, in 2020, the department conceptualized and started live streaming of Sahbhagita Samvad – a series of programmes and events designed for trainings, meetings and information sharing with target groups and broadcasted via live streaming platforms. The series led to approximately Rs.7.18 lakh benefit being received by target groups till May 2021. Different programmes are planned in this series. Sometimes a webinar is organized, which is facilitated by a departmental officer or a subject expert who showcases a film or PPT and then conducts a discussion with the participants. Experts with vast experience in the field are invited to share their experiences. Successful models in the field like people who have benefitted from a programme or those who have implemented something unique in their lives are also invited to speak. Information on important topics like how to prevent anaemia, how to deal with issues faced by women, how to use participatory approach in community mobilization, roles and responsibilities of stakeholders, etc. are also communicated in the programmes. Special sessions are also organized to celebrate specific international and national days and events.

DWCD developed an e-learning platform called Anganwadi Shiksha with 7 modules covering information on nutrition, communication, etc. for AWW to access and learn remotely. As of July 2020, 25000 AWW started the course and 7000 completed it. The department also has an e-repository of its IEC at www.esanchayika.mp.gov.in. It collaborates with various non-government stakeholders to develop IEC and implement campaigns.

Annexure – V: List of desired behaviours

S.N	THEMATIC AREAS AND SUB-ISSUES	Ref No.	DESIRED BEHAVIOURS What behaviour should the target groups adopt for positive change?	TARGET GROUPS For whom are the desired behaviours intended?
A	**NUTRITION, HEALTH & HYGIENE**			
A1	**First 1000 days - window of opportunity**			
A1.1	**Care during pregnancy**	**1**	Pregnant women register their pregnancy in the first trimester at the nearest health facility	• Primary – Pregnant women, husband, mother-in-law • Secondary- Family members, other influential community members
		2	Pregnant women get atleast 4 ante-natal check-ups done	• Primary – Pregnant women, husband, mother-in-law • Secondary- Family members, other influential community members
		3	Pregnant women consume one additional meal every day which is nutritious, diverse and balanced diet including consumption of THR (take-home ration)	• Primary – Pregnant women, husband, mother-in-law • Secondary- Family members, other influential community members
		4	Pregnant women deliver their baby at a health facility	• Primary – Pregnant women, husband, mother-in-law • Secondary- Family members, other influential community members
		5	Husband or member of family registers the birth of the newborn child at the health facility (where the child was delivered)	• Primary – Pregnant women, husband, mother-in-law • Secondary- Family members, other influential community members
A1.2	**Care of lactating mother**	**6**	Lactating mother consumes nutritious and diverse diet (atleast 5 food groups) every day including consumption of THR (take-home ration)	• Primary – Lactating women, husband, mother-in-law • Secondary- SHG/MSS members, Family members, other influential community members
		7	Lactating mother consumes Ca++ supplementation	• Primary – Lactating women, husband, mother-in-law • Secondary- SHG/MSS members, Family members, other influential community members

<table>
<tr><td rowspan="2">A1.3</td><td rowspan="2">Breastfeeding</td><td>8</td><td>Newborn children are put to the breast within one hour of birth</td><td>• Primary - Lactating women, mother-in-law
• Secondary- Family members, other influential community members</td></tr>
<tr><td>9</td><td>Mother feeds baby only breastmilk for the first 6 months of the child's life</td><td>• Primary - Lactating women, mother-in-law
• Secondary- Family members, other influential community members</td></tr>
<tr><td rowspan="5">A1.4</td><td rowspan="5">Complementary feeding</td><td>10</td><td>Mother and family members initiate complementary feeding at the age of 6 months of the child, ensuring consistency (differentiate by age groups), quantity (optimal portion size), quality (home-based freshly cooked), diversity of diet (including THR) and frequency</td><td rowspan="4">• Primary - Lactating women and all mothers of children upto 2 years of age, husband, mother-in-law

• Secondary- Family members, other influential community members</td></tr>
<tr><td>10a</td><td>Caregivers of children aged 6 months start feeding solid, semi-solid or soft foods to the child</td></tr>
<tr><td>10b</td><td>Children aged 6-23 months consume foods and beverages from at least five out of eight defined food groups</td></tr>
<tr><td>10c</td><td>Children aged 6-23 months consume solid, semi-solid or soft foods at least the minimum number of times</td></tr>
<tr><td>11</td><td>Mother continues to breastfeed her child for upto 2 years</td><td>• Primary - Lactating women and all mothers of children upto 2 years of age, mother-in-law
• Secondary- Family members, other influential community members</td></tr>
<tr><td>A2</td><td>Nutrition of children (2-6 years)</td><td>12</td><td>Children aged 2-6 years consume body-building foods (protein), immunity-boosting foods (vitamins, minerals) and energy-giving foods, including THR (2-3 years) and hot-cooked meal (3-6 years)</td><td>• Primary - Children (2-6 years), mothers of children, fathers, mother-in-law
• Secondary- SHG/MSS members, Family members, other influential community members</td></tr>
</table>

A3	**Immunisation & Vitamin-Mineral Supplementa-tion**	**13**	Parents and family members take their children for timely and routine immunisation	• Primary - Mothers, fathers, family members • Secondary- SHG/MSS members, other family members, other influential community members
		14	Children consume vitamin A supplementation (9 months onwards) and deworming syrup/tablet (from one year of age) twice a year	• Primary - Mothers, fathers, family members • Secondary- SHG/MSS members, other family members, other influential community members
		15	Parents and family members of children with diarrhoea give them increased fluids, same amount of food (not reducing intake of nutrients), oral rehydration solution and zinc supplementation	• Primary - children (6 months to 5 years of age), mothers, fathers, family members • Secondary- SHG/MSS members, other family members, other influential community members
A4	**Prevention of anaemia**	**16**	Pregnant women (3 month onwards), lactating mothers (upto 6 months), children (0-5 years) and adolescent girls (11-18 years) consume IFA tablets/ syrup daily to prevent anaemia	• Primary - Pregnant and lactating women, children (6 months to 5 years of age), mothers of children, adolescents, husbands/ fathers, elder women of • family Secondary- SHG/MSS members, Family members, other influential community members
		17	Pregnant women, lactating mothers, children and adolescent girls consume a diverse and balanced diet containing variety of foods rich in iron and vitamin C	• Primary - Pregnant and lactating women, children (6 months to 5 years of age), mothers of children, adolescents, husbands/ fathers, elder women of • family Secondary- SHG/MSS members, Family members, other influential community members
A5	**Prevention and Management of Malnutrition**	**18**	Anganwadi worker conducts regular growth monitoring of children (6 months - 5 years) and parents are actively involved in the process	• Primary - children, Mothers/caretaker of children upto 5 years of age, Anganwadi workers • Secondary- Family members, other influential community members

A5	**Prevention and Management of Malnutrition**	**19**	Anganwadi workers (along with Accredited Social Health Activists and Auxiliary Nurse Midwives) conduct screening and referral of complicated severe acute malnourished (SAM) children to Nutritional Rehabilitation Centres (NRC) and follow-ups	• Primary - children, Mothers/caretaker of • children upto 5 years of age, Anganwadi workers Secondary- Family members, other influential community members
		20	Anganwadi worker enrols uncomplicated SAM children under CSAM program	• Primary - children, Mothers/caretaker of • children upto 5 years of age Secondary- Family members, other influential community members
		21	SAM children enrolled in CSAM program consume Antibiotics, deworming, Folic acid tablet, IFA syrup and Multivitamin	• Primary - SAM children, Mothers/caretaker of children upto 5 years of age • Secondary- Family members, other influential community members
A6	**Water, Sanitation & Hygiene (WASH)**	**22**	Men and women, girls and boys, consume clean and safe drinking water	• Primary – Pregnant women, lactating mothers, Mother/ caretaker of all children upto 5 years of age, older children, and Adolescents, families • Secondary- SHG/MSS members, Family members, other influential community members
		23	Men and women, girls and boys, wash hands using soap for atleast 20 seconds in the WHO-recommended way before and after cooking/ preparing meal (and handling meat), before eating, before feeding a child, after cleaning a child's bottom or changing nappies, after using toilet and after coming in contact with any dirt (such as coming home after work, touching something dirty)	• Primary - Pregnant and lactating women, Mother/ caretaker of all children upto 5 years of age, older children, Adolescents, families • Secondary- SHG/MSS members, Family members, other influential community members
		24	Men and women, girls and boys, use improved sanitation facilities	• Primary - Pregnant and lactating women, Mother/ caretaker of all children upto 5 years of age, older children, Adolescents, families • Secondary- SHG/MSS members, Family members, other influential community members

A7	Early Childhood Care Education (ECCE)	25	Trained Anganwadi worker monitors and ensures age-wise child development milestones along with active involvement of parents	• Primary – Mothers/caretaker of children upto 5 years of age, fathers • Secondary – family members
		26	Trained Anganwadi worker provides quality pre-school education at AWC	• Primary – Mothers/caretaker of children upto 5 years of age, fathers, Anganwadi worker • Secondary – family members
		27	Parents send their children to AWC for the entire duration to receive complete quality pre-school education	• Primary – Mothers/caretaker of children upto 5 years of age, fathers • Secondary – family members
A8	Back to School (girls 11-14 years)	28	Parents ensure that their daughters (11-14 years) re-enrol in school	• Primary – Adolescent girls, parents • Secondary – family members
A9	Menstrual Health & Hygiene Management	29	Girls follow proper menstrual hygiene management steps (use of napkins, proper disposal, hygiene maintenance)	• Primary – Adolescent girls, mothers • Secondary – Elder women of family
		30	Men and women do not treat girls differently because they are going through menstruation	• Primary – Adolescent girls, mothers, fathers • Secondary – Family members
B	**CHILD PROTECTION**			
B1	Ending abuse and violence against children	31	Men and women do not practice verbal, physical and sexual abuse against girl and boy children in the family, school and public places (including passing comments, eve-teasing, inappropriate touching, staring, beating, slapping, bullying, rape, etc.)	• Primary – Parents, family members, teachers/ educators, youths • Secondary – community elders, faith-based leaders, adolescent/youth groups, school administration, PRI, block administration
		32	Men, women and children report suspected/confirmed cases of child abuse to 1098 or police	• Primary – Children, parents • Secondary – Family members, teachers/educators, faith-based leaders, adolescent/ youth groups, school administration, PRI, block administration
		33	Men and women treat girls and boys equally at home, school and society	

B1	Ending abuse and violence against children	33a	Caregivers provide girls and boys with equally adequate nutrition in meals and supplementation	• Primary - Parents, family members, teachers, community elders • Secondary - Faith-based leaders, adolescent/youth groups, school administration, PRI, block administration
		33b	Parents of girls and boys between the ages of 5 and 18 years ensure that they all attend school	
		33c	Girls and boys pursue and complete higher education (atleast Class 12 and higher)	
		33d	Teachers/Educators/School administrators treat girl and boy students equally (equal participation/ opportunities in class and activities, mixed seating/preferred seating)	
		33e	Girls and boys equally participate in public forums and voice their opinion	
B2	Ensuring children in need of care and protection	34	Trained child care workers ensure that children identified as CNCP (children in need of care and protection) by Child Welfare Committees are provided protection, maintenance, education, training and counselling at shelter homes	• Primary - Children, child care workers • Secondary - CWC
		35	Men and women from eligible families adopt children in need of care and protection, of all ages	• Primary - Children, men and women • Secondary - Faith-based leaders, community influencers
		36	Men and women provide foster care to vulnerable children (not declared CNCP by CWC)	• Primary - Children, men and women • Secondary - Faith-based leaders, community influencers
		37	Designated members of block and village child protection committees monitor at-risk children and report cases to higher level CPC	• Primary - BLCPC/VLCPC • Secondary - Parents, Family members, DCPU
B3	Rehabilitation of children in conflict with law	38	Trained child care workers ensure that children involved in anti-legal activities below the age of 18 years are provided protection, maintenance, education, training and professional counselling at observation homes	• Primary - Children, child care workers, counsellors • Secondary - CWC

B4	Prevention of child marriage	39	Parents do not marry their girls and boys before they reach the legal minimum age of marriage	• Primary – Children, parents, family members • Secondary – Faith-based leaders, community influencers
		40	Parents of girls and boys between the ages of 5 and 18 years ensure that they all attend school	• Primary – Children, parents, family members • Secondary – Faith-based leaders, community influencers, teachers
		41	Girls and boys pursue and complete higher education (atleast Class 12 and higher)	• Primary – Children, parents, family members • Secondary – Faith-based leaders, community influencers, teachers
		42	Men and women report cases of child marriage to 1098 or Police	• Primary – Children, men and women • Secondary – Faith-based leaders, community influencers
		43	Men and women discourage parents from marrying their children below the legal minimum age of marriage.	• Primary – Elders in the family, neighbours, community influencers, faith-based leaders
B5	Preventing substance abuse by children	44	Children do not consume alcohol or addictive substances	• Primary – Children, parents, family members • Secondary – Faith-based leaders, community influencers, teachers, police, PRI, block administration, CPC
C	**WOMEN SAFETY & EMPOWERMENT**			
C1	Gender equity and equality	45	Men and women treat girls and boys equally at home, school and society	• Primary – Parents, family members, teachers/educators, youths, LLY champions • Secondary – community elders, faith-based leaders, adolescent/youth groups, school administration, PRI, block administration
		45a	Men and women are in favour of both girl and boy child births	
		45b	Caregivers provide girls and boys with equally adequate nutrition in meals and supplementation	
		45c	Parents of girls and boys between the ages of 5 and 18 years ensure that they all attend school	
		45d	Girls and boys pursue and complete higher education (atleast Class 12 and higher)	

C1	Gender equity and equality	45e	Teachers/Educators/School administrators treat girl and boy students equally (equal participation/opportunities in class and activities, mixed seating/preferred seating)	• Primary - Parents, family members, teachers/educators, youths, LLY champions • Secondary - community elders, faith-based leaders, adolescent/youth groups, school administration, PRI, block administration
		45f	Men and women provide equal opportunities to men and women employees at the workplace	
		45g	Parents do not marry their girls and boys before they reach the legal minimum age of marriage	
		45h	Men and women do not give or take dowry in marriage	
		45i	Girls and boys equally participate in public forums and voice their opinion	
		45j	Girls and boys equally participate in religious rituals, parent care-giving	
		45k	Parents allow girls and boys to go out of the house for education, training, work, recreation, other purposes	
		46	Men and women do not practice verbal, physical and sexual abuse against girl and boy children and other men and women in the family, school and public places (including passing comments, eve-teasing, inappropriate touching, staring, beating, slapping, bullying, sexually inappropriate behaviour at work, rape, etc.)	• Primary - Parents, family members, teachers/educators, youths, LLY champions • Secondary - community elders, faith-based leaders, adolescent/youth groups, school administration, PRI, block administration, police
		47	Girls from eligible families avail the Ladli Laxmi Yojana scheme	• Primary - Eligible families, girls, parents • Secondary - Faith-based leaders, community influencers, LLY champions
C2	Prevention of violence against women and girls	48	Men and women report incidences of violence against women to 181 or police	• Primary - women, AWW, Shaurya Dal, community resource person Secondary - frontline workers, • doctors, nurses, hospital assistant, Law enforcement agents including prosecutors, police, para-legal volunteers

<table>
<tr><td rowspan="13">C2</td><td rowspan="13">**Prevention of violence against women and girls**</td><td>**49**</td><td>Women victims of violence avail services of the one stop centre</td><td>• Primary - women, AWW, Shaurya Dal, community
• resource person
Secondary - frontline workers linked to the OSC, local authorities, local groups, SHG, elected representatives, Legal Facilitator, Police Facilitator, OSC administrator, Counsellors</td></tr>
<tr><td>**50**</td><td>Men and women do not practice verbal, physical and sexual abuse against girl and boy children and other men and women in the family, school, workplace and public places (including passing comments, eve-teasing, inappropriate touching, staring, beating, slapping, bullying, sexually inappropriate behaviour at work, rape, etc.)</td><td rowspan="5">• Primary - Parents, family members, teachers/educators, youths, employers

• Secondary - community elders, faith-based leaders, adolescent/youth groups, school administration, PRI, block administration, Local Complaints Committee, One Stop Centre, Police</td></tr>
<tr><td>**50a**</td><td>Violence doesn't occur at home</td></tr>
<tr><td>**50b**</td><td>Violence not faced in school</td></tr>
<tr><td>**50c**</td><td>Violence not faced in work place</td></tr>
<tr><td>**50d**</td><td>Violence not faced in public place</td></tr>
<tr><td>**51**</td><td>Men and women treat girls and boys equally at home, school, workplace and society</td><td rowspan="7">• Primary - Parents, family members, teachers/educators, youths, employers, community elders

• Secondary - faith-based leaders, adolescent/youth groups, school administration, PRI, block administration, LLY champions, Shaurya Dal, SHG/MSS members, workers association, trade union</td></tr>
<tr><td>**51a**</td><td>Men and women are in favour of both girl and boy child births</td></tr>
<tr><td>**51b**</td><td>Caregivers provide girls and boys with equally adequate nutrition in meals and supplementation</td></tr>
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<tr><td>**51d**</td><td>Girls and boys pursue and complete higher education (atleast Class 12 and higher)</td></tr>
<tr><td>**51e**</td><td>Teachers/Educators/School administrators treat girl and boy students equally (equal participation/ opportunities in class and activities, mixed seating/ preferred seating)</td></tr>
</table>

C2	**Prevention of violence against women and girls**	**51f**	Men and women provide equal opportunities to men and women employees at the workplace	• Primary - Parents, family members, teachers/educators, youths, employers, community elders • Secondary - faith-based leaders, adolescent/youth groups, school administration, PRI, block administration, LLY champions, Shaurya Dal, SHG/MSS members, workers association, trade union
		51g	Parents do not marry their girls and boys before they reach the legal minimum age of marriage	
		51h	Men and women do not give or take dowry in marriage	
		51i	Girls and boys equally participate in public forums and voice their opinion	
		51j	Girls and boys equally participate in religious rituals, parent care-giving	
		51k	Parents allow girls and boys to go out of the house for education, training, work, recreation, other purposes	
C3	**Enabling women economic empowerment**	**52**	Women participate in economic activities and directly receive the payment/remuneration for the work they do	• Primary - Women, husbands, fathers, mothers, employers, community elders • Secondary - faith-based leaders, youth groups, school and college administration, PRI, block administration, workers association

Annexure – VI: Prioritised issues and behaviours

The discussions with state, divisional workshops and field visits informed the issues and behaviours to be prioritised in the SBC strategy. Below given is a table showing the prioritised issues identified by divisional cluster.

Topics	Rewa-Shahdol	Gwalior-Chambal	Jabalpur	Bhopal-Narmadapuram	Ujjain	Sagar	Indore
Nutrition, Health & Hygiene							
First 1000 days		✓		✓			
a. Care during pregnancy							
b. Care of lactating mother							
c. Breastfeeding							
d. Complementary feeding					✓		
Nutrition of children							✓
Immunisation and supplementation							
Prevention of anaemia		✓	✓	✓		✓	✓
Prevention and management of malnutrition	✓	✓	✓	✓	✓	✓	✓
Water, sanitation and hygiene							
Early childhood care & education	✓				✓		✓
Back to school							
Menstrual health & hygiene management							✓
Child Protection							
Ending abuse and violence against children	✓					✓	✓
Ensuring children in need of care and protection				✓			
Rehabilitation of children in conflict with law							
Prevention of child marriage		✓		✓	✓	✓	✓
Prevention of substance abuse by children							
Women Safety & Empowerment							
Gender equity and equality		✓			✓		✓
Prevention of violence against women and girls		✓				✓	✓
Enabling women economic empowerment							

Annexure – VII: Division-wise mapping of barriers/enablers & tools

Below given are the findings of the workshops conducted at the divisional cluster level and field visits. It includes the direct feedback and perspectives of the participants.

DIVISIONAL CLUSTER: REWA-SHAHDOL

Main issues:

- ECCE
- Malnutrition
- EVAC

Challenges faced (barriers)

Nutrition

- It is difficult to take mothers and children to NRC. One of the main reasons is that mothers don't want to leave their other children behind. When AWW insist, families respond saying "it is my child, what is your problem?"
- SAM children (especially 6 months to 2 years) have been observed as not willing to eat
- Interest in education is going down, resulting in low awareness, high child marriage, malnourished mother and child and condition of anaemia.
- Parents don't want to send their children to the AWC for ECCE; instead, they want to send to private school.
- Some families want educated daughters-in-law who will earn and contribute income to the family but they want her to behave 'like a daughter-in-law'.
- Colostrum feeding is low inspite of high institutional delivery - the 20% who are not opting for institutional deliveries are the ones who often go into SAM status.

Child Protection

- POCSO cases are prevalent.
- With regards to education, parents don't want their children to travel far to go to school. There is also a lack of trust in children. Also, older siblings have burden of domestic work.
- Substance abuse is done by children who observe and follow what their parents do - common substances they start with are tobacco, gutka. Such children then don't go to school. They have their name enrolled in school but do not attend. As per RTE rules, they keep passing but no gainful education is received by them.

Gender Equality & Women Empowerment

- High illiteracy, patriarchal society, cultural importance in bordering districts, high alcoholism prevalent.
- Women don't have their own voice and say in decision making. High influence of husbands and family elders.
- In some cases, men don't allow women to participate in activities.
- EVAWG is there but it's also because reporting is high.

Challenges faced by staff

- AWW feel that beneficiaries want to practice the behaviours but their economic situation and financial condition comes in the way.
- In some cases, beneficiaries ask for incentive when organising FGD.

What will work/is working (enablers)

- Cooperation from society
- Counselling and discussion with family elders
- Communication must be done when people are available, not when it is convenient to the communicator
- Mother and family most important as far as child is concerned
- Not to think of the person you are communicating with as inferior to you, try to understand them and their circumstances, know about their community, interact and mix with them. Communicating in local language more impactful.
- Home management in case of SAM children unable to go to NRC - maybe a video tutorial guiding them on the process and therapy food.
- Relationship between beneficiary and influencer is important

Effective communication tools

- IPC
- A/V material better than print, and in local languages

Need/Requirements

- Training field functionaries on how to talk/communicate with beneficiaries and on which issues, what to inform supervisor and CDPO
- Officials and AWW training required on counselling, how to use AV tools
- Tips for IPC and tools

Local dialects

Bagheli, some of it touches with Bengali, Maithali

Main issues:
- Gender inequality
- Safe city - EVAWG
- Malnutrition
- First 1000 days - especially early registration
- Child marriage
- Anaemia

Challenges faced (barriers)

Nutrition

- Strong influence of mothers-in-law in decision making Many people don't understand their responsibility and don't want to give time to discuss or work on the issues, especially in Chambal area.
- In general, people are attracted to things that are free.
- Errors in tracking menstrual cycle and pregnancy - one of the ways is to ask LMP (last menstrual period) by asking when did you last wash your hair. Ideally, it should be counted from the day it started but women usually answer 5th or 6th day and AWW miss out on enquiring further.
- For a long time, women do not reveal that they are pregnant in a bid to ward off the evil eye. As a result, the main 3 months of pregnancy care gets missed out.
- Malnutrition is high in children of migrant parents. Every 3-4 months, people migrate (to Rajasthan, Gujarat) and take their children with them. This makes it difficult for AWW to monitor the growth of the child and health of the woman. At the new locations, the full focus of the family is on work, not child. In such cases, the children go back to SAM status.
- Some people don't have ration cards and therefore, don't get subsidised food supplies.
- Families are unwilling to admit children to the NRC.
- They are unwilling to leave other children at home.
- Some of them say that if they admit children to school who will take care of the pets/animals, who will cook food.
- Family planning is not done - some families have 3-4 to 8 children. Families with such high children count are often found malnourished.
- People are unaware of what is iron, calcium, vitamin
- Other causes for malnourishment are a lack of basic hygiene, cleanliness, not getting meals on time, etc.
- Common reason is that parents have to go to work so there is no time to prepare big portion, nutritious meals.
- There is a lack of awareness on what to eat, how to prepare meals, how much to eat, etc.
- Mothers don't want to take or feed their child THR since they feel that it is the same since the last 13-14 years.
- Mothers are not able to take care of the child since they go to the field. In her absence, at home, the mother-in-law, sister-in-law feed the child what is there at home but don't pay attention to whether the child eats or not, how much he/she eats, etc.
- Even if the child's mouth is dry, water/tea is fed to the child when they should only be breastfeeding.

Child Protection

- In cases of child marriages, the mother becomes pregnant soon after, leading to a malnourished mother and malnourished child.
- The cycle of child marriage - discontinuation of education - malnutrition - facing violence prevails
- Dowry practice prevails
- Child marriage is high due to the fear that the girl will elope. Parents feel that they are saving the girl's life.
- In many such marriages, the wedding happens when the girl is a minor but her gauna (the ceremony of bride's going to her husband's house after a post-marriage interval) is done after she becomes an adult.
- Often when AWW try to stop child marriages, they are threatened or attacked.
- Priority is given to marriage over education. Many families save money to get their children married; they don't save up for education.
- Girls are not taking an interest in education
- In Bhind-Morena, importance is given to things like gun license, etc. Exposure to such things at a young age has made children's attitude rough and they often slide will hit you, will kill you kind of words in conversation.
- A violent mentality develops at a young age.
- Children observe and follow what their abusive father does – they often don't listen to their mother. (Intergenerational transmission of violence)

Gender Equality & Women Empowerment

- Gender-sensitive area - sex ratio is low. Strong desire for sons.
- Illiteracy is high - parents often don't allow children to go to school, economic problem, low value of education
- Priority given to work and earning money - economic requirement is primary. People in rural areas go to work as daily wage labourers.
- Sheopur is more of a tribal belt (Sahariya) with poverty and poor hygiene. There is dependence on government schemes for economic support. Education is low, people don't go to AWC. AWC, PDS shops, schools are far off. Migration is high. There is a connectivity issue faced by atleast 20% of the population. It takes time to convey information. It is also an area where local

medicinal herbs are available.
- There are pucca homes now because of PM Awas Yojana.
- Communication with boys is very less. Communication is done often with adolescent girls and mostly on nutrition. However, it has been observed that adolescent girls are not motivated.
- Although in the last 7-8 years, there have been improvements in gender situations, there is still a significant preference towards boys. If any situation/ event requires physical presence then female participation is low. Girls still say that they have to seek permission of their fathers.
- Approximately 80% of the children admitted into observation homes (CCL) are from Bhind. CCL are accused of theft, eve-teasing, rape, murder, etc.
- Women lack support from the society. They also lack education.
- Women are not able to understand what is happening with them is violence. They are not aware of what their rights are and do not speak of the violence meted out against them due to fear of being thrown out of the house, not being accepted, etc.
- Girls especially are not sent to schools because they are far from the village.
- Girls hide their problems for fear of shaming and that no one will understand - they don't tell their mothers or AWW.

Challenges faced by staff
- AWW feel that people listen, understand but don't practice the behaviour. One of the main reasons for this is economic situation and time.
- Since AWW get allotted additional duties, they are unable to give time to do FGDs.
- AWW are unable to get and manage enough time to conduct quality IPC sessions and discuss topics in detail
- Nukkad natak (street theatre) have been done previously but hadn't been able to reach till the ground level
- Technical expertise of district level staff is lacking; district staff very busy with multiple tasks and budget is an issue (divisional funds very low). Human resource enthusiasm is low due to technical challenges.

What will work/is working (enablers)
- Building relationships with community members and seeking their support in interventions
- Coordination between different departments is required - women and child development is not only a DWCD issue.
- A stronger, dedicated team is required which will work on SBC.
- ANM, school teacher, sevak are key influencers
- There is a need to speak to and engage men because they have more exposure so would be willing to listen and understand (especially Morena)
- Vaccination day is an avenue to share information
- More street theatre like those done by Bandho Mutthi Behna group in previous years
- Continuous and regular interventions are required, along with personal connect.
- There are some pockets in Morena where there is no gender issue observed like Bagchini kasba of Johra block and surrounding areas
- Need to strengthen counselling of CCL
- Need to plan interventions for school-going children
- It was seen during COVID lockdown, when people could not migrate, they stayed at home and gave attention and care to the child, leading to an improvement in the child's health.
- Community nutrition gardens (CNG) have shown to be a positive intervention which not only helps women earn money but also provides local, nutritious food.
- Need to target 1000 days, especially when coming to register pregnancy - that will set the foundation for elimination of malnutrition.
- ECCE improved when a dedicated coordinator worked on it.

Effective communication tools
- IPC
- Mobile - sms/WhatsApp
- Rally
- Nukkad natak (street theatre) similar to the efforts made by Bandho Mutthi Behna group - it has a visual appeal that attracts people
- FGD
- Discussion with Panchayat
- Home visit
- Counselling
- TV (not so much because women don't watch much TV)

Need/Requirements
- Training on communication and counselling
- Ground level IEC is required
- Development and training of local theatre groups that will perform street theatre shows
- Orientation of CDPOs on ICPS issues and protection mechanism available for children
- Orientation of child care institutions, JJB, CWC on ICPS so that they can better plan what to do

Local media

Mangal geet

Local dialects

Bundeli (spoken most in Guna), Banjara dialect, Desi dialect

Main issues:
- Malnutrition
- Anaemia

Challenges faced (barriers)

Nutrition
- Beneficiaries are unable to understand the gravity of the malnutrition issue. "They are afraid of cancer, but not malnutrition," feel many AWW.
- A malnourished mother leads to a malnourished child
- A 2-times a day meal pattern is followed in areas like Narsinghpur. The same applies to children as well. So, they miss out on adequate nutrition.
- In Narsinghpur, there are good and adequate local, nutritious foods available but they are not consumed by the locals. Majority of it is sold for income.
- Families don't want to keep their children in NRC. One of the reasons is that they have too many children and don't want to keep the others alone behind at home.
- One of the common statements given by families is that children will get better on their own.
- Gond adivasi are still dependent on ojha (traditional doctors) for medical treatments.
- Counselling part is not included in NRC.
- Tribal areas like Balaghat are far off and earlier had severe issues of access. That has improved now.
- Balaghat also has a good sex ratio, literacy rate and women are doing well. However, there are issues like anaemia which is a major concern.
- In Balaghat, they don't take THR. Some take it during vaccination day. There is a myth that THR causes diarrhoea.
- Lack of resources due to poverty
- Migrant population – they leave immediately after delivering child. For almost upto 6 months, families migrate to other districts making it difficult to monitor and administer care to the mother and child
- Mothers have to go to field to work so they can't give time to children.
  Alcoholism is a common problem. Malnutrition
- observed in women who drink.
- Parents prefer to send children to private school instead of ECCE.

Child Protection
- The coordination process between Childline and DCPU needs to be worked upon.
- Boys start having gutka and supari from Class 3, 4.
- Many start gambling once they are a little older.

Gender Equality
- In communication, the focus is too much on mother.
- Counselling is also only done with the mother.
- New members of the family do not get involved.

Challenges faced by staff
- Officials feel that they are unable to convince the beneficiaries due to lack of time, motivation, proper IEC. The situation of malnutrition is recurring despite best efforts – a child treated and returned home is again becoming malnourished.
- Officials feel that AWWs cannot work with diversity – working with too many messages and too many issues is a challenge for them.
- AWW has her limitations of how much she can communicate with community because she belongs to the same village – she is the daughter of one of the families in the village and is often married into the same village.
- Officials and AWW not able to focus on core work due to multiple tasks

What will work/is working (enablers)
- Collective involvement of everyone will be required to address malnutrition and other issues. This includes other departments and the community (for cooperation, AWW take help of Sarpanch, MSS sometimes)
- One stop centre is working well
- Inter-departmental coordination is required
- ASHA and AWW coordination is required
- Engaging men in communication – need to focus on father along with the mother. Everything is not the mother's primary responsibility. (A men care model is implemented by World Vision in the districts they work in including Narsinghpur)
- Mothers-in-law and fathers should be included in communication
- In Seoni, to reduce IMR and MMR, a committee was made that targeted high risk mother first. Weekly follow ups were conducted by block functionaries including BMO and ANM
- Bal Arodhya Shivir – 10 departments were involved
- Bal Choupal works well
- Montessori training given to AWW and Sahayika who have passed Class 12 has worked well
- Shaurya Dal has done Nukkad natak (street theatre)
- Hospital staff, ANM should support AWW

Effective communication tools
- Counselling
- Short videos
- Door-to-door (Home Visit and IPC)
- TV

- Videos with dance, music component more attractive for children
- Nukkad natak (street theatre)
- Film demonstration
- Rally with drum beating

They receive information from mobile, fb

Need/Requirements
- Training on better counselling
- Montessori training to more eligible AWW and Sahayikas

Local dialects
There is Marathi dialect in language in areas bordering Maharashtra, similarly impact of Chhattisgarhi language in respective bordering area. Gondi language in tribal areas.

DIVISIONAL CLUSTER: BHOPAL-NARMADAPURAM

Main issues:
- First 1000 days
- Malnutrition, especially admission into NRC
- Anaemia
- Child marriage
- Care of CNCP children

Challenges faced (barriers)

Nutrition
- Beneficiaries are unable to understand the gravity of
- One of the biggest challenges of malnutrition is being unable to prevent the transition of the child from MAM to SAM. Parents are unwilling to keep the child in NRC citing that they will lose one day's wage. Another reason is having too many children and citing inability to leave the other children at home.
- Another reason children are malnourished is because there is less than 2 years gap between two pregnancies.
- Messages on family planning are not taken well by the community.
- There is a strong influence of the mother-in-law in decision making.
- JSY vahan doesn't reach on time because beneficiaries don't inform on time resulting in home deliveries.
- The general attitude is that families will take care of daughter but not daughter-in-law. When daughter-in-law becomes pregnant, she is sent to her maiden home. This also becomes a problem for monitoring by AWW because she moves to another area where AWW cannot keep track of her or her pregnancy care.
- Another attitudinal issue is that there are too many children in the family and parents are not willing to 'invest' in their children.
- Anaemia testing is very minimal
- Awareness related to cleanliness and handwashing has come, especially after COVID outbreak, but there is still scope for progress.
- ECCE to start again after COVID will be challenging.
- Even with ECCE, the parents want to send their children to private schools as soon as they turn 3. AWWs also share that they are not clear on what they should do.

Child Protection
- At an average of 12-15 years, girls are engaged to a boy. As it happens that the girl continues education and becomes more educated than the boy who discontinues and joins work. In such cases, then the girl doesn't want to marry the boy and the families get into a major fight with the groom's family expecting the bride's family to keep their word. This is Nathra tradition.
- Often children leave school after 14 years of age due to child marriage, school being far and responsibility of younger siblings
- Encouraging children to pursue higher education is low because high schools are far and moreover, there is a fear that the children will elope.
- In areas like Betul, violence against children is high.
- Children are sold by their parents. Children are also sometimes the victims in domestic violence cases (often targeted after the mother)
- Care homes for CNCP children in Rajgarh district is not there. Girls are sent to Bhopal and boys are sent to Ujjain.

Gender Equality & Women Empowerment
- The notion of acceptance of violence has another angle - groom's family pays the bride's family for the marriage. The girl is bought in marriage. This is why oftentimes she cannot complain if she is a victim of violence because she feels that she was bought with money and has no option.

Challenges faced by staff
- Core schemes are getting diluted and priorities also keep shifting based on what is decided needs to be promoted at a particular time – previously work was done on Aadarsh Anganwadi and now there is no update on that.
- Many AWW are not comfortable with using mobiles
- AWW of different education levels are given the same kind of recruiter training - however everyone has different capacities so training must be according to matching skills
- There are areas in Betul where there is no network,

lack of access due to bad roads, no electricity, high migration, illiteracy, etc. In such areas, communication is a challenge.
- In Harda, floods are a common problem limiting access due to bad roads.

What will work/is working (enablers)

- Support is required from health department to improve anaemia testing
- Tele-medicine from empanelled doctors
- Give picture card (Vriddhi chart) to every household
- There shouldn't be too many messages because beneficiaries cannot assimilate too many at a time
- The menu suggested for Poshan should be compact.
- First 1000 days is connected to malnutrition. To fix malnutrition, full focus must be on ensuring the first 1000 days.
- Men and families should be engaged in conversations
- Behaviour change depends on skill of communication and technique used for communication. There must be scope - budget, knowledge and technique.
- The women empowerment programs need to be revamped. Partnerships should be built with associated departments like Khadi etc, women should be encouraged to take courses connected to skill development
- A steady source of income and livelihood has to be ensured. Most of the issues especially malnutrition are triggered by poverty.
- Women can be given training in alternative livelihood like making chalks, sanitary napkins, etc.
- Admission into ECCE is a way to track if a child has gone missing or not by taking note of his attendance/ absence.

Effective communication tools

- Village level community participation camps
- Counselling
- Mobile/WhatsApp groups
- Pamphlet, posters (especially related to schemes)
- A/V tools and online pdfs if hard copies not feasible
- Communication via phone to AWW and her family in areas that are media dark and lack access due to bad roads, no electricity, poor to no network, etc. Also, word of mouth publicity via passers-by
- Effective avenues for reaching out to a large population are bhajan mandlis and local cultural programs like raam leela (Bhajan events effective in bringing upto 70% community participation)
- Social media - Facebook
- Communication via influencers - this could be anybody the person/family listens to
- Nukkad natak (street theatre)

Need/Requirements

- 2-3 minute videos on schemes that the AWW needs to
- communicate to beneficiaries along with some videos with details for the officials (LLY, PMMVY, how to counsel malnourished children, how to maintain cleanliness)
- Regular training required for all DWCD officials at all levels and AWW on
  - how to communicate on schemes
  - how to publicise any program
  - how to fill forms and records
  - how to counter negative news or misinformation
- Media needs to be sensitised on how to report news related to children and women
- AWW must show video to whole family when she is registering pregnancy
- Need a pre-school education curriculum which includes poems/dance/colors
- Just the way vaccination programs have a key message broadcast via national media that before everything, get your vaccine - similarly, a slogan is required for women and child development - "saare kaam chod do, pehle bacche ko dekho"

Local media

Rahi Bhajan event

Local dialects

Adivasi dialect

DIVISIONAL CLUSTER: UJJAIN

Main issues:

- ECCE
- Child marriage
- Malnutrition
- Gender inequality
- Discontinuation of education
- Complementary feeding

Challenges faced (barriers)

Nutrition

- Parents are eager to enrol their children in private schools instead of sending them to AWC for ECCE. One of the reasons for this is that parents feel that enrolling the child into LKG in the private school will help in securing admission for higher classes.
- In Mandsaur, in some villages, AWW have experienced that children do not come to the AWC at the dedicated 9am time slot for ECCE. One of the reasons for this is

that they wake up at 8-9am. They end up coming late at 10.30am with the older children.

- Children at AWC also don't take snacks separately. They eat with meal only.
- One of the reasons for malnutrition is that families give more priority to work and do not think much about the children they leave home. Unemployment is very high in areas like Shajapur so parents' priority is to secure work and livelihood. In the absence of the parents, the elders and older siblings are at home who take care of the younger children. In some cases, the elders are not concerned about the care of young children and in other cases, they are overtly involved to the point that mothers fear to take decisions for their children's health if it upsets the mother-in-law.
- Where there are 2-4 children at home, parents are not able to give individual attention. Malnourishment has been observed as high in such families.
- Due to economic reasons, parents go to work and sometimes, the older children join them as well. There is discontinuation of education in such cases.
- High migration especially in the border areas (Ratlam borders Rajasthan). This affects care of maternal and child health.
- In Ratlam, there are good crops and availability of food, however, beneficiaries are not clear on what to eat and how much to eat
- Complementary feeding is an issue - they are unwilling to start feeding alternative foods after 6 months and almost wait till a year. Strong influence of mother-in-law observed in such cases. Most MILs are unwilling to listen.

Child Protection

- Safety of girls is one major reason why child marriages are high. Parents are concerned that something will happen if they are left alone. They feel that if they send child to school, the child will leave after school gets over and what they will do then. They feel they can't leave children alone at home and can't send them to school unmonitored, lest they get involved with children of the opposite sex. They question the AWW that who will take responsibility if something happens to their children. In some cases, girls were found lying to their parents and going elsewhere instead of school.
- Through social media and usage of mobile phones, girls and boys are getting connected, without understanding the pitfalls of such cyber interactions, etc. Many POCSO cases were found in such scenarios. Boys and girls are unaware that even with mutual consent, underage sexual relations are a criminal offence. When girls are found in such scenarios, they are married off soon to cover up. One crime leading to another.

Gender Equality & Women Empowerment

- Gender is an issue in Ratlam and border areas in particular - awareness on girl child education is low, child marriage is high, girls aged 16-17 are getting pregnant with their second child already.

Challenges faced by staff

- AWW feel that they are getting occupied with multiple tasks related to other departments, which is giving them lesser time to focus on their DWCD duties.

What will work/is working (enablers)

- Engaging men and families in conversations
- Talking to boys and girls together - not only addresses their curiosity but facilitates effective communication
- Home visits are effective in the morning time when mothers are available
- To improve intake of nutritional snacks, some AWW have connected with Shaurya Dal, giving them the responsibility to take care and convince 2-3 children of the same.
- Working with Shaurya Dal together in outreach and communication
- In case of children, giving examples like foundation of a building connected to IFA building foundation of a child's health

Effective communication tools

- Counselling
- Mobile/WhatsApp groups
- Poem/short videos to be played on mobile phones
- Storytelling
- Nukkad natak (street theatre)

Need/Requirements

- Officials and AWW training required on counselling

Local dialects

Bhili, Malwi and mix of Neemari and Malwi

DIVISIONAL CLUSTER: INDORE

Main issues:

- Anaemia
- Nutrition of children
- Malnutrition
- Child marriage
- Violence against children (POCSO cases registered due to child elopement/marriage cases)
- Lack of education

- Menstrual health and hygiene management
- VAWG
- ECCE

Challenges faced (barriers)

Nutrition

- AWW are not aware of the first signs that they can observe to recognise a person is suffering from anaemia. Anaemia is often detected when it becomes as severe as requiring a blood transfusion.
- Provision for haemoglobin testing is not there - levels are found out only after 5 years when the surveys are done. For interim, difficult to track anaemia status.
- Supply of IFA in schools is not enough.
- Midday meal is not given to older children (so unlike younger children, they are unable to consume IFA which must be done after a meal).
- Once the minor boys are married, they have the burden of family responsibility which forces them to seek work. Many have to migrate in search of work. They take the whole family with them. This makes it difficult to track the mother and child, causes malnutrition. If woman is pregnant when migrating, vital care required during pregnancy gets lost. When they return, it puts pressure on the AWW to improve nutrition levels. Such families also get left out of vaccinations when they migrate.
- AWW are told by families "kya yeh aapki problem hai, aap chup karo" when they talk about malnutrition
- In Barwani, community is not willing to accept that they are malnourished or anaemic. They think that children are playing, eating, nothing is wrong – it's normal
- No support from villagers in reducing malnutrition - it is considered to be AWW's work. Educated people also don't help due to lack of time.
- Women leave children with elders who don't care much about proper child care.
- Women don't want their babies to be weighed in front of others - ""tok lag jayegi"" which means that they feel the child will get the evil eye from others
- Husbands don't support NRC admission. They don't want to stay overnight and for so long.
- In Dhar, especially in Muslim families, AWW don't get access to women to explain about NRC
- Communities still believe in traditional medicine - they would take kids to traditional doctors over hospitals
- Women feel they get less food in NRC. They are also not happy with the food at AWC.
- Proper amount of food is not given to child
- There is Bhagat parampara in Alirajpur, followed by over 30% of the population) - people following this tradition do not eat what others have touched. This affects nutritional intake.
- Local food is available which is put in Poshan Matka - then people say you are giving us what is available in our homes - so they lose interest
  Women don't register their pregnancies in the first 3 months - they don't reveal their pregnancy for fear of miscarriage. Some of them are also not aware that they are pregnant till the 2nd month.
- Girls still hesitate to talk about menstruation. In some cases, the Panchayat representatives only feel uncomfortable to talk about MHHM with girls.
- Many girls still use cotton clothes in place of napkins. They are also concerned about the cost of napkins.
- Girls don't want to go to schools when they are going through menstruation because of the lack of toilets and proper water, disposal and hygiene maintenance in the ones where toilets are there.
- Everyone is not able to do ECCE activity well. Parents want to send children to private schools to get certifications and because they feel the child learns more subjects. Some other parents feel that children who receive ECCE at AWC are not as good as those who get educated at private schools.

Child Protection

- Awareness and orientation of CDPOs and AWW on ICPS and women empowerment is low - they are unable to tell what are the rules, schemes, etc. AWW, in particular, are unable to fill the forms required in home study report, foster/sponsorship cases, etc.
- Child marriage is more common in rural areas. One of the main reasons for this is the fear that girl will elope and bring dishonour to the family. When AWW try to explain to women, they tell them ""agar ladki bhaag gai, nak kat gai, toh aap aaogi kya"" (will you come to save our face when the girl runs away from home and brings dishonour to our family).
- There is a norm of Dehaj Dhapa prevalent - when the girl and boy elope and are caught and brought back to the village, talks of their marriage comes up. The girl's family demands 8-10 lakh rupees in exchange for the girl's hand in marriage. If the boy's family refuses, POCSO case is registered against the boy. (Consent for sex is considered invalid in the case of minors, as per the law). In situations where the girl refuses to file a case, admitting that she ran away of her on free will, there is tremendous pressure from the villagers to do so. This is because the money that will be given by the boy's family will be used in a wedding feast that will be given to all villagers. There is fear of isolation by fellow villagers so girl's family caves.
- Positive norms like self-selection of grooms, has evolved negatively in modern society leading to elopement of boys and girls.

- In Dhar, at the age of 16-17, many girls migrate for work. When they return, they have a child in their arms. Such women if they stay in the marital home, also face violence. Many times, they file a case against the person they went with under family pressure. Sometimes they desert the child - this is rare, but it happens. When abandoned by family members, it also becomes difficult to keep these girls in child care institutions because of the fear of the impact they will have on the other children in care.
- Child marriage is higher in cases of boys especially in Dhar, Jhabua and Alirajpur. One reason is that families want more earning members and feel that they will get the son married and get him employed. Another trend observed is that people migrate with full families where adolescent girls and boys are often put to work. In such cases, the boys are then married off to become responsible men and earn for the family.
- People threaten AWW when they go to stop child marriages. Even if they manage to stop, then families get children stealthily married.
- In many families, where the father is an alcoholic and abusive, the children start working. Working and earning money makes them feel that they are independent and they stop studying. This affects their education, development and eventually, some of the children get married as minors or engage in illegal activities.
- A new fashion/trend is emerging in girls to drop out without reason.
- There is low value attributed to education. Girls are not interested in bridge course/vocational courses. They and their parents feel that they have studied till Class 9-10 which is enough. Then they get married.
- Parents don't want to send to school which is far. Some girls say they want to study but won't go against family.
- As soon as children reach a certain age and maturity, they are put to work – "jaise hi bache thode samajhdar hote hai, unhe kaam mein laga dete hai"
- Child marriage is taken as seriously as marriage - children in the marriage then feel they need to take responsibility and do something. When they are unable to get gainful employment, they then take illegal means.
- Reporting of child marriage is low since there is stigma against reporting

Gender Equality & Women Empowerment

- In tribal areas, it is assumed that women are empowered. However, even in those areas VAWG is rampant. Attitude towards women is poor.
- Sex ratio is lower in urban areas than rural - it is suspected that sex detection is being done in urban areas leading to consequent abortions.
- In tribal areas too now preference for boys is increasing
- If husband doesn't allow, women can't go or participate in activities. In Alirajpur, men are present in FGDs but women are not.
- Alcoholism is high resulting in wife beating. When the wife is in such condition, she is unable to take care of the child.
- Some girls feel that because of other girls they are receiving the punishment - they ask why they have to suffer because of what other girls did.
- No family planning
- AWW are not aware of the benefits of one stop centre, who can be admitted to OSC, etc. Disabled women are sometimes forcibly admitted to the OSC when that is against the rules. But the rules are not clear to the staff and CDPO can't handle, so the matter goes to district and division. Social Justice Department don't cooperate in such matters saying they have no guidelines on the same.

Challenges faced by staff

- AWW are not comfortable with apps/computer - they make mistakes in online data entry (AWW has to update in Sampark app). AWW have Class 8-12 qualifications and have limited to none computer knowledge.
- AWW and supervisors struggle to fill the forms required by ICPS such as foster care forms, home study reports
- Staff has to help other departments and faces challenges of time to do their own DWCD work.
- Data collected by health department, in particular, is referred to when requiring any information. AWW collect a lot of data when they do home visits regularly.
- The data they collect is not referred to often.
- There are limited field level functionaries and they don't have the same level of skill as the district level staff.
- AWW cannot multi-task
- Staff and AWW lack positive motivation
- There is a balance that staff has to keep between Department's expectations and District Collector's expectations.
- At the divisional level, attachment to tools is limited since they are not deemed as practical or applicable to the specific area contexts.

What will work/is working (enablers)

- IFA consumption needs to be ensured and monitored that it is being consumed. Focus is always on distribution but should be on ensuring consumption as well.
- Awareness needs to be built and misconceptions need to be addressed.
- Newly married couples need to be sensitised on testing

and registering pregnancy in the first month itself.
- Clear identification of respective departments' responsibilities is required on overlapping matters.
  Orientation of CDPO and AWW on ICPS and women empowerment
- Need to give importance to research done and data collected at the local level
- Tadvi-Patel very influential communities in the tribal areas such as Jhabua, Dhar, Alirajpur - motivating them
- Creating a team with college kids, educated villagers Strengthening positive behaviours (especially in tribal areas) such as khatla baithak, if death happens, Diwali date is postponed by villagers, self-selection of groom
- Incremental learning, in smaller portion
- Support by ECCE coordinator
- Children need to be connected to education
- Convergence with Department of Education - work with teachers
- Choupal discussion
- Panchayat discussion via Sarpanch
- Mobilising youth from NSS, NYK, Shaurya Dal
- Sensitising BLCPC
- In Barwani, reimbursement for petrol/diesel is provided to any villager who brings a pregnant woman to any delivery point via his/her own private vehicle. This increased institutional delivery. Dry fruit laddoos are also provided to children leaving NRC for sustaining MAM status

Effective communication tools

- Khatla baithak (arrange a group discussion around leading people seated on a khatiya)/choupal
- Incremental learning
- Short films
- Mobile - social media, videos, status updates, messages
- Stories of AWW - identifying champions
- Local songs
- Slogans and rally
- Multimedia van
- Nukkad natak (street theatre (although can't reach far off places)
- Miking during garbage collection

Need/Requirements

- Training of AWW on using apps and digital media (especially for data entry)
- Practical hands-on training with simulations
- Divisional level officer/contact point is required who can support and address queries, unlike the current structure of seeking support from a contact point at the state level
- AWW need training to recognise the first signs of anaemia
- Training of CDPOs and AWW on ICPS and women empowerment structures, schemes, provisions, formats
- Resources to AWW
- Positive motivational training for CDPO and AWW
- Tools like competitions, cultural competitions at the state level, health check-up of AWW should be done to motivate them
- Simplified MIS + CSAM tool

Local media

Songs, Puppetry

Local dialects

Bhili, Adivasi, Bareli, Kurku, Malvi, Nimari, Patiya

DIVISIONAL CLUSTER: SAGAR

Main issues:

- Child marriage
- Malnutrition
- Child trafficking
- Anaemia
- EVAC and EVAWG

Challenges faced (barriers)

Nutrition

- 2-3 blocks in Chhatarpur that are touching UP have different culture, different language - this is called Banda culture (similar to what is seen in Chitrakoot).
- In this area, women empowerment prevails but main challenge in the area is that it is remote area, there is language barrier and poverty. Malnutrition is prevalent.
- There are many superstitions prevalent in the communities which is a primary hindrance.
- Child marriage is high – early pregnancy – malnourished mother resulting in malnourished child
- The attitude towards malnutrition is that the children will get better on their own. "Apne aap thik ho jayenge". Families don't want to send children to NRC. For 14 days, they can't stay at NRC. They especially don't want to stay at night. They feel they will lose one day's wage. When told that they will get wage if they keep at NRC too, fathers say they will earn more doing what they do instead of NRC. Only when AWW take complete responsibility and take the child to NRC and bring them back home at night every day do they comply in some cases. But it's not always possible for AWW to do this every time.
- Having too many children and being unable to leave

the others at home is also a reason for not keeping at NRC. In some places, NRC is far off.
- Mother is burdened with household duties as well as manual labour in the fields. The attitude is that who will feed us if she goes to NRC.
- Beneficiaries do not practice family planning - (one child in cot, one in lap, and one in womb - that's the situation). "Bachhe bhagwan ki den hai," they say. They do not respond to messages on family planning, especially when there is a strong desire for sons.
- In adivasi belt, often children are found playing without clothes, playing in dirty water and parents find that to be ordinary – "samanya vyavahar mante hai".
- In some areas in Damoh, beneficiaries do not want to take THR because they feel they have what they need.
- Due to migration, child care is not done properly which results in malnutrition.
- Where there are no schools near, AWC is overcrowded for ECCE. Another reason is that they will get food at AWC.
- Girls follow MHHM

Child Protection

- Child marriage is high in tribal blocks especially because they think what will the child do sitting at home, better to get them married.
- Child marriage is common in Feb-March when its Akshya Trithiya and during festival season like Diwali.
- Another reason that child marriage is common is that parents believe their wayward children will become better if they undertake responsibility - ""zimmedari aaigi to sudhar jayega"
- 20-30% migration after May-June, post harvesting season. Usually they return during Dussehra-Deepavali time, because of festivals and to rent out their farms, etc. This is also a time when they get their children married.
- Officials stop child marriage but the families then stealthily get the children married. To negate that proof is required which again becomes a challenge.
- Child education gets affected due to migration.
- Parents are unable to enrol their children anywhere since they keep moving. With low education, probability of child marriage increases.
- People who have migrated to areas like Delhi, when they return, they develop a superiority complex and don't want to listen to locals
- People think preventing child marriage and malnutrition is AWW's work only.
- Children are strongly affected by violence at home.

Gender Equality & Women Empowerment

- Primary reason for discontinuation of education is that school is far. Parents, fearing for safety of their girls, are unwilling to let them go. Girls themselves are afraid that the roads are lonely, it's a forest area, will not go. Boys lose interest in education and start working.
- There is differential treatment between daughter and daughter-in-law. Abuse, especially verbal and mental abuse is meted out against the daughter-in-law. Strong influence of mother-in-law. Young mothers in particular face a lot of abuse from their mothers -in-law.
- Fear of isolation, being kicked out of the house, not being welcome in maternal home are some of the reasons why women do not speak up against or report violence against them. Lack of support and a rehabilitation plan for and after reporting.
- Issue with reporting is that if case goes to police, situation worsens rather than getting better.
- Husbands want women to bend/compromise a bit. Listen to him, etc.
- Alcoholism is high. Husband comes home drunk, doesn't let the woman eat, creates havoc, beats wife.
- Mother doesn't eat, premature delivery, malnourished child and then woman is blamed.

What will work/is working (enablers)

- Messages should be in local language and developed in consultation with AWW. (A workshop can be called or it can even be online. A competition can be held to get the best slogans)
- Hold a competition for Bundeli lok geet
- Booklet like Sakhi Samvad in Bundeli
- Spread messages on digital platforms and increase frequency
- Coordination with local NGOs who are able to convey messages related to the issues in local dialect. Local NGO involvement is beneficial because they are aware of the context and challenges.
- For improving health, education and status of women and children, the focus should be on adolescent age and school-going children. Rather than counselling pregnant women about health and other things, the communication should start from adolescent period before they develop notions and follow malpractices.
- Receiving correct information at this stage can break the vicious cycle.
- Every week go to school and give children information about trafficking and what schemes and provisions they have to support them
  - Class 6 to 12, go to every school and talk to children
  - Under 6, talk to guardians.
- Cooperation is required from school education department. DWCD can go and speak during parent-teacher meeting.
- Connect with people who speak in local languages
- Communication should factor in migration, and availability of people.

- Sarpanch and influencers can convince people
- Focus on areas where the issue is prevalent, not where it's not. Doing an overall campaign in all areas will not be effective.
- Campaign on preventing child marriage should be done in the months before the prime 'marriage season' like in January, when the marriages are being fixed. The chain of child marriage and pitfalls need to be explained.
- In Damoh, peers are reporting child marriage
- Migrants should be counselled on health and child marriage before they migrate.
- Ground level functionaries need to understand that preventing child marriage, improving health, etc. is everyone's work and all need to work together. Functionaries include Panchayat Prathinidhi, Health Dept, Education Dept, Agriculture Dept, Tribal Welfare Dept
- Use social media
- Engage and interact with fathers for child marriage.
- They are the main decision makers.
- Men engagement in programs
- For family planning, can connect is with child care benefits if there is 2-3 gap between children, also connect with income benefits
- RKSK person comes to teach children about gender, child rights, EVAC
- Adolescent girls and boys were included in vaccination prog
- For counselling, help is taken from Shaurya Dal, Panchayat Sacheev
- First focus of AWW is to ensure that the family of the woman doesn't break. So, in cases of violence, they intervene and counsel the husband. In extreme cases, police or OSC are called. AWW offer support to women to report.
- Cooperation from police in cases of VAWG
- Literacy/education is important

Effective communication tools

- Nukkad natak (street theatre) - can also be done in local programs
- Storytelling and designing activities using local folklore like hardual ki kahani, rahi lok geet, Rani Laxmi bai to talk on women empowerment
- Facebook/WhatsApp effective – Social media especially required in remote areas like Banda area
- One-to-one communication
- Using local media like YouTube channel of local media person/influencer who creates videos in Bundeli
- Community events - samuhik baithak - choupal
- Kirtan/Bhajan events
- Saas-Bahu Sammelan
- Puppet show

Need/Requirements

- Training on counselling for staff and AWW
- Translation of IEC into Bundeli dialect
- Media sensitisation especially on how they report news on women and children
- Capacitate Shaurya Dal to support AWW
- Increase zooms with officials and AWW - make it a monthly so that they share their progress and challenges
- IEC activity should have something new
  - give liberty to district/CDPO to give inputs in IEC
  - develop a timeframe - some topics should be given some time, not whole year - a calendar can be developed

Local media

Bundeli lok geet, Faag music, Miking, local songs like aalha, tiwari

Local dialects

Bundelkhandi/Bundeli dialect

Annexure – VIII:
List of GO and NGO stakeholder consultation at state level

Functionaries of the Directorate of Women and Child Development, Government of Madhya Pradesh

1. Ms. Swati Meena Naik, Director (9 June 2021)
2. Mr. Suresh Singh Tomar, Joint Director
3. Mr. Subodh Garg, Assistant Director, Pradhan Mantri Matra Vandana Yojana
4. Mr. Prabhat Thakur, Assistant Director, Women Empowerment
5. Mr. Vikas Gupta, Assistant Director, Ladli Laxmi Yojana
6. Mr. Vishal Srivastava, Assistant Director, ICPS
7. Mr. Shaktivishal Yadav, Poshan Abhiyan
8. Dr. Nisha Jain, Supervisor, IEC section

Non-government stakeholders

1. Ms. Indu Saraswat, Mamta Health Institute
2. Ms. Seema Jain, Mamta Health Institute
3. Ms. Pooja Singh, Consultant, UN Women
4. Mr. Sachin Kr. Jain, Vikas Samvad
5. Ms. Advaita Marathe, Child Protection Officer, UNICEF
6. Ms. Susanne Milcher, Project Director, GIZ India
7. Ms. Nadine Bader, Technical Advisor, GIZ India
8. Ms. Neha Khara, Nutrition Expert, GIZ India
9. Mr. Hanif Shaikh, Technical Expert, GIZ India
10. Mr. Petr Schmied, Independent Consultant, M&E and Behaviour Change
11. Ms. Scherazade Siganporia, Technical Expert – Gender & Cross Cutting Issues, GIZ India

Discussions were also held in webinars and meetings organised by DWCD which involved participation and inputs from the following NGO representatives –

1. Ms. Tuhina Verma, Nutrition International
2. Ms. Pushpa Awasthy, Nutrition Officer, UNICEF
3. Ms. Monica Maurya, C4D Officer, UNICEF
4. Mr. Tarkeshwar Mishra, State Consultant, UNICEF
5. Mr. Rakesh Kumar Malviya, Vikas Samvad
6. Ms. Reeta Mohan, Clinton Health Access Initiative (CHAI)
7. Mr. Mohsin Khan, Welthungerhilfe
8. Ms. Shringar Bedi, Action Against Hunger
9. Ms. Sandeep Dewal, Action Against Hunger
10. Ms. Lubna Abdullah, Coalition for Food and Nutrition Security
11. Ms. Seema Kurup, SBC Study Data Consultant, GIZ India
12. Dr. Sheela Bhambal, Senior Paediatrician
13. Mr. Manish Agarwal, 181 Women's Helpline

Annexure – IX:
Schedule and number of participants of divisional workshops

S.N	Divisional cluster	Districts	Date of workshop	Number of participants		
				Division level officials	AWW and supervisors	Total
1.	Rewa-Shahdol	Satna-Rewa Sidhi-Singrauli Shahdol-Umaria-Anuppur	11.10.21	90		90
2.	Gwalior-Chambal	Ashoknagar-Guna Bhind-Morena Shivpuri-Sheopur Gwalior-Datia	12.10.21	5	70	75
	Gwalior-Chambal	Bhind-Morena Sheopur	12.10.21	14	41	55
3.	Jabalpur	Jabalpur-Narsinghpur-Katni Chhindwara-Seoni Mandla-Dindori-Balaghat	13.10.21	40	103	143
4.	Bhopal-Narmadapuram	Bhopal-Raisen Sehore-Vidisha Rajgarh Harda-Betul Narmadapuram	18.10.21	30	103	133
5.	Ujjain	Neemuch-Mandsaur Ratlam Ujjain-Dewas-Agar Malwa Shajapur	21.10.21	60		60
6.	Sagar	Niwari, Tikamgarh, Chhatarpur, Sagar, Damoh, Panna	22.10.21	21	80	101
7.	Indore	Indore Dhar – Alirajpur – Jhabua Khargone – Khandwa – Barwani – Burhanpur	26.10.21	92	440	532
TOTAL						**1189**

Annexure – X:
Google Form for Behaviour/Barrier/Enabler Mapping

विभागीय प्रचार-प्रसार एवं

Social Behaviour Change and Communication Strategy Behaviour/Barrier/Enabler Mapping

विभाग महिलाओं और बच्चों के बेहतर स्वास्थ्य, पोषण, सशक्तिकरण आदि के लिए कई कार्यक्रम, योजनाएं चला रहा है। कई सेवाएं हितग्राहियों को दी जा रही हैं। परंतु स्वास्थ्य, पोषण, सशक्तिकरण सूचकांकों में बहुत परिवर्तन परिलक्षित नहीं हो रहा है। प्रभावी संचार, व्यक्तिगत, समुदाय और परिवारों के व्यवहारों में परिवर्तन ला सकता है। विभाग का प्रयास है कि इस मंशा के साथ पूरे प्रदेश के लिए स्थानीय मुद्दों पर आधारित एक रणनीति तैयार की जाए। यह रणनीति उपयोगी और प्रभावी बने ताकि आपके सेवा प्रदाय को गति मिले और अपेक्षित परिणाम प्राप्त हो सकें । यह रणनीति आपके सहयोग से तैयार की जानी है, इसमें सभी मुद्दे आपके द्वारा सुझाए हुए हों।

संचालनलय स्तर से योजनाओं और कार्यक्रमों को संचालित करने वाले प्रभारियों और स्वैच्छिक संगठनों से बातचीत कर कुछ विषयों और व्यवहारों को चिन्हांकित करने की कोशिश की गई है। आप इसके अलावा भी कोई विषय/ व्यवहार शामिल करना चाहते हैं, तो कर सकते हैं। आपको सभी विषय/ व्यवहारों पर स्थानीय कारणों से हमें अवगत कराना है -

आपका नाम –

गाँव का नाम -

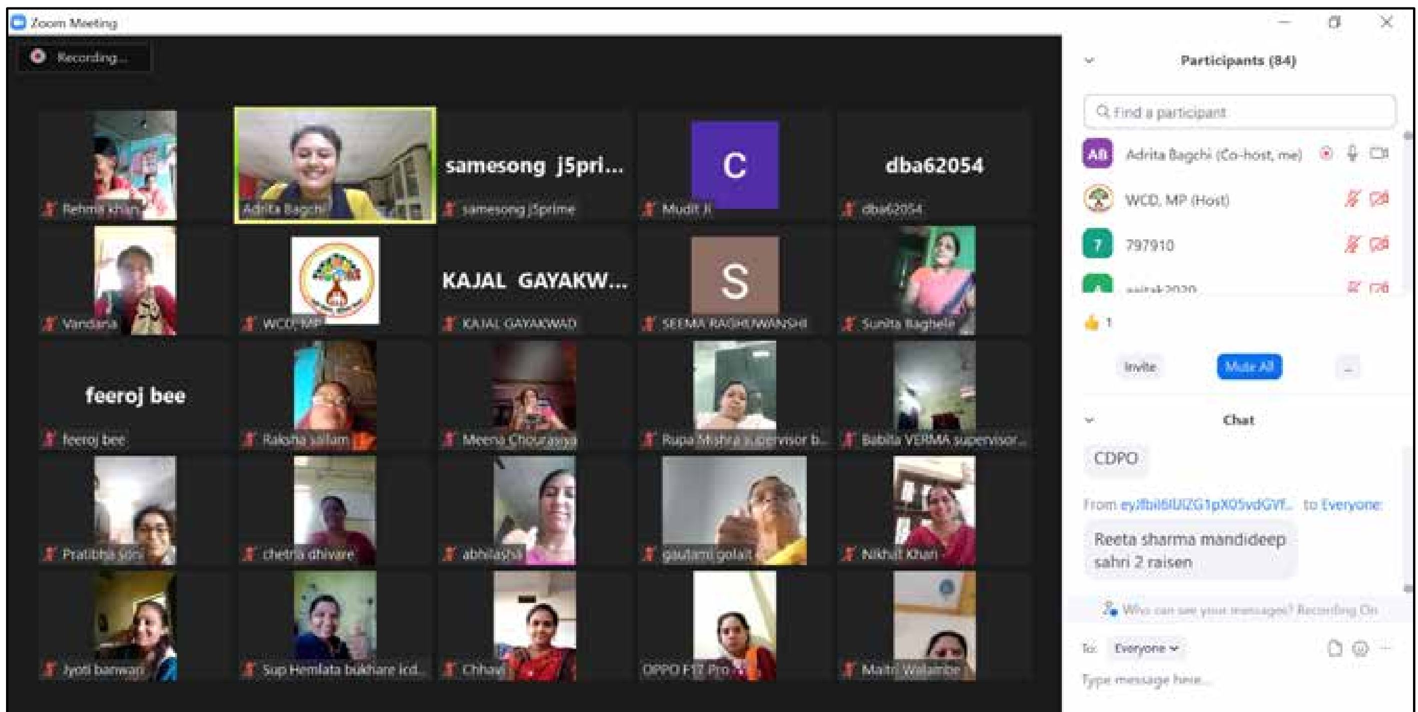
परियोजना -

जिला –

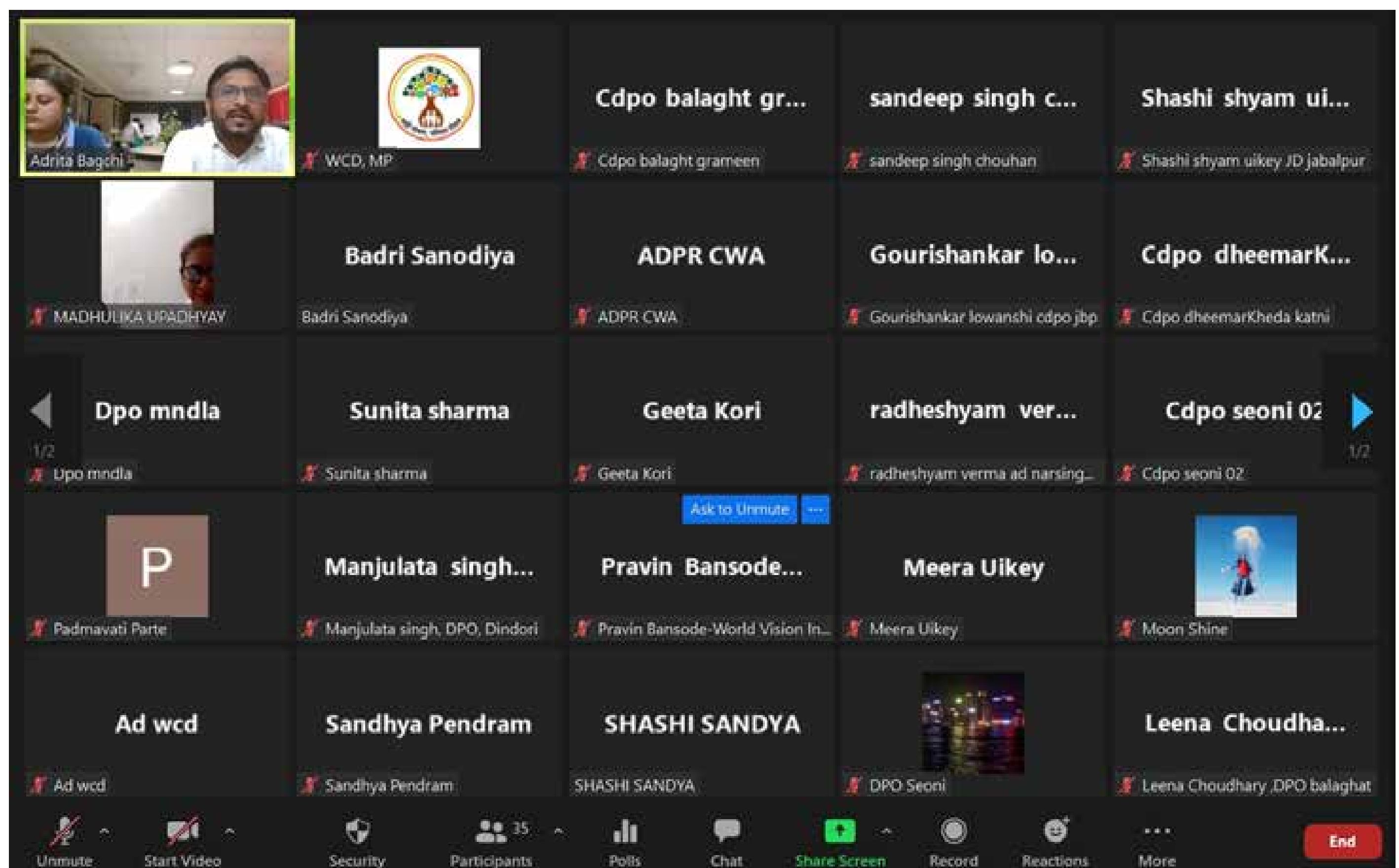
मोबाइल नंबर -

1. आपके क्षेत्र में विभागीय मुद्दों पोषण, बाल संरक्षण और महिला सशक्तिकरण से जुड़े समस्याएं कौन कौन सी ही ?
2. विभागीय मुद्दों पोषण, बाल संरक्षण और महिला सशक्तिकरण से सम्बंधित सामाजिक व्यवहारों में परिवर्तन लाने के लिए क्या बाधाएं आती है ?
3. आपके काम में आपको किस तरह की चुनौतियों का सामना करना पड़ता है ?
4. आपको और समुदाय को कोई भी सूचना / जानकारी कहाँ से, किस source से प्राप्त होती हैं? (मीडिया)
5. आपके क्षेत्र में संदेशों को समुदाय तक पहुँचाने के लिए कौन कौन से संचार के तरीके प्रभावी होंगे ?
6. क्या आप में कोई कौशल है जैसे गाना गाना, कविता लिखना, नृत्य, इत्यादि?
7. आप के क्षेत्र में कौनसी बोली बोली जाती है ?

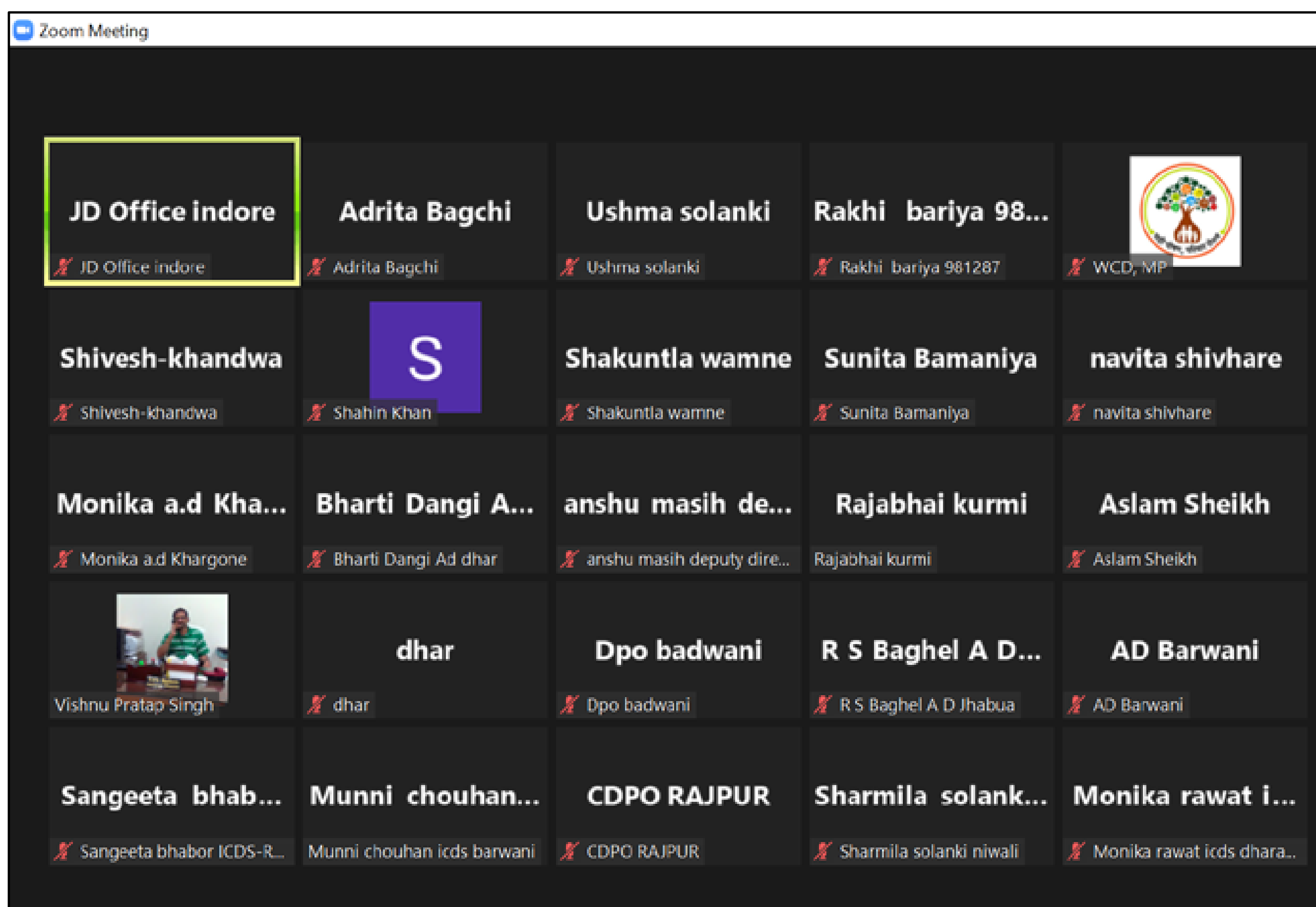
Annexure – XI: Screenshots of divisional virtual workshops



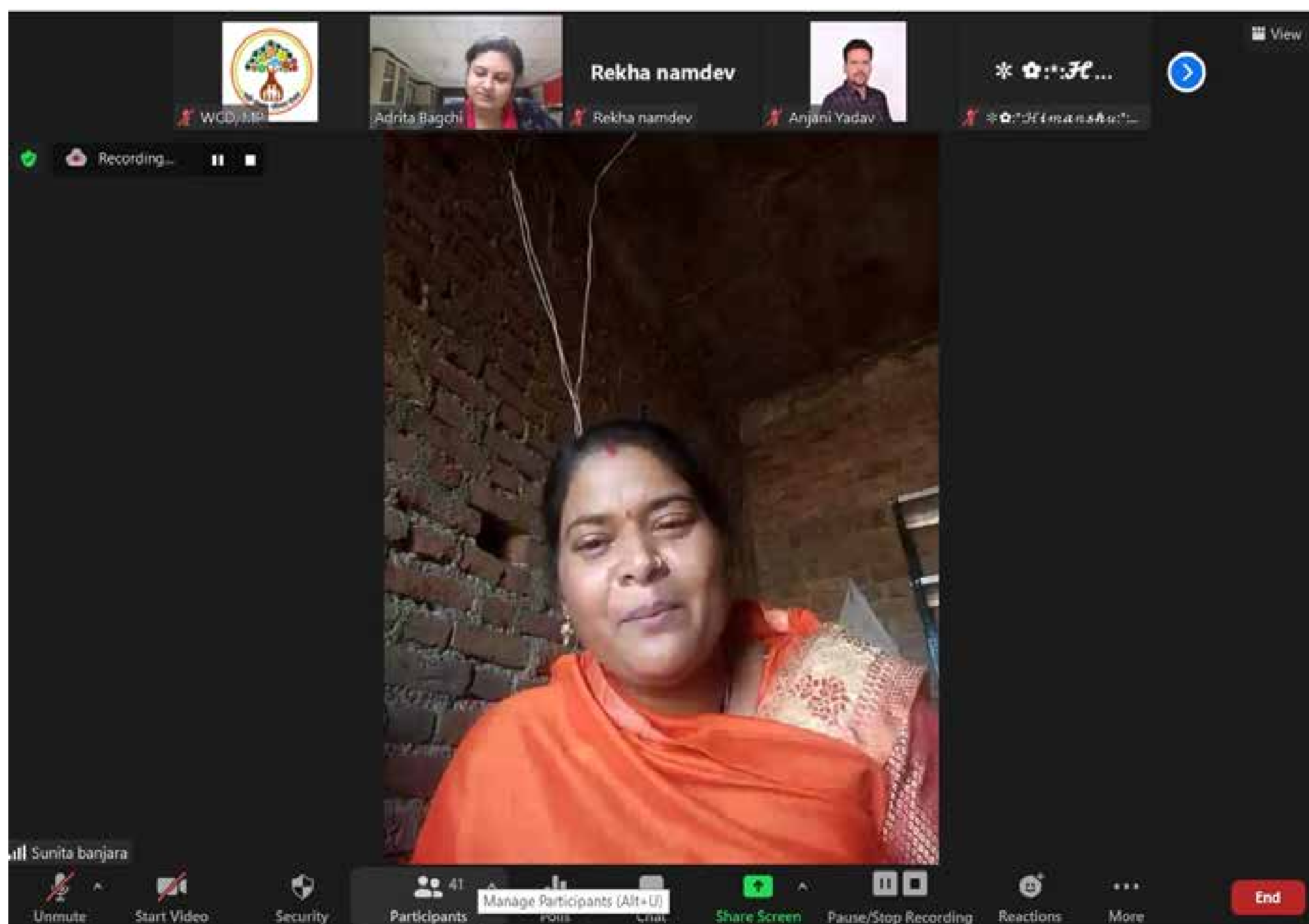
Workshop with AWW and supervisors of Bhopal-Narmadapuram division



Mr. Suresh Singh Tomar, Joint Director, DWCD sharing the context of the SBC Strategy with the participants of Jabalpur division workshop



Workshop with JD and officials of Indore division



AWW Sunita Banjara talking about challenges related to malnutrition in the Gwalior-Chambal division workshop

Annexure – XII: Schedule and number of participants of field visits

S.N.	Date	Division	District	Development Block	Village	Women	Men	Adolescent girls	Adolescent boys	AWW & Supervisors	Stakeholders	Type of stakeholder	Total participants
1	12.11.11	Indore	Indore	Indore	Indore	0	0	0	0	0	4	JD, AD	4
2	16.11.21	Indore	Dhar	Nisarpur	Narmadanagar Dangi Mohalla	9	0	2	0	2	0		13
3	16.11.21	Indore	Barwani	Pati	Nadi Phalia Pati-I	4	0	3	1	1	1	CDPO	10
4	17.11.21	Indore	Barwani	Barwani	Borlai	36	0	3	0	2	3	DPO, AD, NGO	44
5	18.11.21	Indore	Indore	Mhow	Mhowgaon	23	3	1	0	6	1	CDPO	34
6	22.11.21	Bhopal	Sehore	Pachama	Pachama	0	0	156	94	22	7	CDPO, Teachers	279
7	24.11.21	Sagar	Chhatarpur	Rajnagar	Kundarpura	21	0	2	0	2	1	CDPO	26
8	24.11.21	Sagar	Chhatarpur	Rajnagar	Khairi	0	3	0	0	0	0		3
9	25.11.21	Sagar	Chhatarpur	Bizawar	Gulganj	32	3	1	0	3	0		39
10	25.11.21	Sagar	Chhatarpur	Bizawar	Majhguva	5	0	34	16	4	1	CDPO	60
11	27.11.21	Chambal	Morena	Morena	Jigni	50	6	50	5	7	5	CDPO, NGO, OSC staff	123
12	29.11.21	Gwalior	Gwalior	Morar	Jamahar	22	0	0	0	2	0		24
13	29.11.21	Gwalior	Gwalior	Gwalior urban	Resham Mill	22	3	0	0	7	2	JD, CDPO	34
14	30.11.21	Gwalior	Shivpuri	Shivpuri	Kathmai	16	0	2	0	2	2	ASHA, ANM	22
15	30.11.21	Gwalior	Shivpuri	Shivpuri	Shivpuri	0	0	0	0	0	39	DPO, CDPO, BMOH	39
Total						**240**	**18**	**254**	**116**	**60**	**66**		**754**

Annexure – XIII: Questionnaires for FGD with beneficiaries

विभागीय प्रचार-प्रसार एवं Social Behaviour Change and Communication Strategy के लिए कुछ जिलों का दौरा

उद्देश्य:

1. महिलाओं, पुरुषों और बच्चों के साथ बातचीत करके यह पहचान करना कि सामाजिक व्यवहार में सुधार लाने के लिए परिवार क्या कर सकते है / कर पाएंगे
2. स्थानीय संचार के माध्यम की पहचान करना जिसे स्थानीय लोग इस्तेमाल करते है
3. यह पहचानना की सामाजिक व्यवहार में सुधार लाने के लिए मुख्य संदेश कौनसे होंगे

संदर्भ:

सामाजिक व्यवहार में सुधार लाने के लिए निचे दिए गए मुद्दों को प्राथमिकता दी गयी है –

- **पोषण, स्वास्थय और स्वच्छता** – कुपोषण, एनीमिया, पहले 1000 दिन, 2-6 वर्ष के बच्चो का पोषण, शालापूर्व शिक्षा और स्कूल वापसी
- **बाल संरक्षण** – बाल विवाह, बच्चों के विरुद्ध हिंसा
- **महिला सुरक्षा और सशक्तिकरण** – लैंगिक समानता, महिलाओं के विरुद्ध हिंसा

शिक्षा का अभाव (खास कर कि बच्चों का 6-8 के बाद स्कूल छोड़ देना), लैंगिक असमानता और पलायन महिला और बाल स्वास्थ्य और विकास के लिए सबसे बड़ी बाधाएं है ।

महिलाओं के साथ सहभागी चर्चा में पूछे जाने वाले मुख्य प्रश्न :

1. क्या आप जानते है कि आयु अनुसार बच्चों के वजन और ऊंचाई मापने से उनके पोषण की अवस्था समझ में आती है ?
2. बच्चों का पोषण और देखभाल सुनिश्चित करने के लिए आपको परिवार के सदस्यों, समाज और आंगनवाड़ी दीदी से कैसी सहयाता की ज़रुरत है ? (स्तनपान, पौष्टिक आहार)
3. आपमें से कितनों ने गर्भावस्था का पंजीकरण पहले तिमाही में कराया था? (आप क्यों नहीं कराना चाहते)?
4. क्या आप डिलीवरी के बाद आने वाले पहले गाढ़े दूध का महत्व जानते है ?
5. गर्भावस्था और स्तनपान कराते वक़्त क्या आप पौष्टिक आहार खा पाते है ? क्यूँ नहीं ? कैसे हो पाएगी ?
6. क्या आप जानते है कि कौनसे खाद्य पदार्थ में क्या गुण है और बच्चो को क्या और कब खिलाना चाहिए? क्या जानकारी मिलने से आप बच्चो को वो खाद्य पदार्थ खिला पाएंगे या किसी सहयाता की ज़रुरत है ?
7. क्या आप आयरन की गोली खाना नापसंद करते है ? क्यों ? क्या आप उसका महत्व जानते है ?
8. बच्चो को NRC में भर्ती करने में क्या दिक्कत आती है ? कैसी मदद मिलने पर आप उन्हें NRC ले जाने के लिए राज़ी होंगे ?
9. आप 3-5 साल के बच्चो को (शालापूर्व) शिक्षा के लिए आंगनवाड़ी भेजते है ? क्यों नहीं ?
10. क्या आप चाहते है कि आपके बच्चे उच्च शिक्षा प्राप्त करे ? अगर सब बच्चे स्कूल जाये तो क्या आप अपने बच्चे को स्कूल भेजेंगे?
11. क्या आप बाल विवाह का समर्थन करते है ? क्या आप उसके दुष्परिणाम जानते है ?
12. अगर कोई अपने बच्चे का बाल विवाह करते है या महिलाओं के खिलाफ हिंसा करते है तो क्या आप उसका रिपोर्ट करेंगे ? क्यों नहीं ?
13. क्या आपके इलाके में लड़का-लड़की के बीच भेदभाव होता है? किस तरह का भेदभाव होता है और क्यों? इसे कैसे रोका जा सकता है ?
14. क्या आपको पता है कि महिलाओं के भी कानूनी अधिकार होते है ?
15. आपको जानकारी कहाँ से मिलती है ?
16. TV, रेडियो, नुक्कड़ नाटक, पोस्टर, इत्यादि में से कौनसा आपको पसंद है?
17. Local dialect, local media

पुरुषों के साथ सहभागी चर्चा में पूछे जाने वाले मुख्य प्रश्न :

1. आपके अनुसार बच्चों का स्तनपान कराने, उनके स्वास्थ्य की देखभाल, पालन-पोषण की ज़िम्मेदारी किसकी है ?
2. क्या आप जानते है कि आयु अनुसार बच्चों के वजन और ऊंचाई मापने से उनके पोषण की अवस्था समझ में आती है ?
3. क्या आप अपनी पत्नी के गर्भावस्था का पंजीकरण कराने में सहायता करते है? क्यों नहीं ?
4. क्या आप डिलीवरी के बाद आने वाले पहले गाढ़े दूध का महत्व जानते है ?
5. क्या आप गर्भावस्था और स्तनपान कराते वक़्त अपने पत्नी को पौष्टिक आहार खिलाते है ? क्यूँ नहीं ?
6. क्या आप जानते है कि कौनसे खाद्य पदार्थ में क्या गुण है और बच्चो को क्या और कब खिलाना चाहिए? क्या जानकारी मिलने से आप बच्चो को वो खाद्य पदार्थ खिला पाएंगे या किसी सहयाता की ज़रुरत है ?
7. बच्चो को NRC में भर्ती करने में क्या दिक्कत आती है ? कैसी मदद मिलने पर आप उन्हें NRC ले जाने के लिए राज़ी होंगे?
8. आप 3-5 साल के बच्चो को (शालापूर्व) शिक्षा के लिए आंगनवाड़ी भेजते है ? क्यों नहीं ?
9. क्या आप चाहते है कि आपके बच्चे उच्च शिक्षा प्राप्त करे ? अगर सब बच्चे स्कूल जाये तो क्या आप अपने बच्चे को स्कूल भेजेंगे ?
10. क्या आप बाल विवाह का समर्थन करते है ? क्या आप उसके दुष्परिणाम जानते है ?
11. अगर कोई अपने बच्चे का बाल विवाह करते है या महिलाओं के खिलाफ हिंसा करते है तो क्या आप उसका रिपोर्ट करेंगे ? क्यों नहीं ?
12. क्या आपके इलाके में लड़का-लड़की के बीच भेदभाव होता है? किस तरह का भेदभाव होता है और क्यों? इसे कैसे रोका जा सकता है ?
13. क्या आप जानते है कि अगर बच्चे घर में हिंसा होते देखते है तो उनकी हिंसक मानसिकता पैदा हो सकती है ?
14. आपको जानकारी कहाँ से मिलती है ?
15. TV, रेडियो, नुक्कड़ नाटक, पोस्टर, इत्यादि में से कौनसा आपको पसंद है?
16. क्या आप भविष्य में बच्चों और महिलाओं से जुड़े मुद्दों पर चर्चा या कार्यक्रम में भाग लेना चाहेंगे?
17. Local dialect, local media

बच्चों के साथ सहभागी चर्चा में पूछे जाने वाले मुख्य प्रश्न :

1. क्या आपको पता है कि आपके कानूनी अधिकार है ?
2. क्या आप स्कूल जाना पसंद करते है? (क्यों नहीं ?)
3. क्या आप उच्च शिक्षा प्राप्त करना चाहते है ? अपने भविष्य के बारे में कुछ सोचा है - क्या बनना चाहते है या करना चाहते है ?
4. क्या आपके इलाके में लड़का-लड़की के बीच भेदभाव होता है? किस तरह का भेदभाव होता है और क्यों? इसे कैसे रोका जा सकता है ?
5. अगर आपको कोई तकलीफ़ होती है या दिक्कत आती है तो आप किससे बात करते हो ? (अगर माँ-बाप से नहीं, तो क्यों?) क्या आप जानते हो कि आप आंगनवाड़ी दीदी के साथ भी बात कर सकते हो ?
6. क्या आप बाल विवाह के दुष्परिणाम के बारे में जानते हो ? क्या आप अपने दोस्तों को बाल विवाह करने से रोकोगे ?
7. लास्ट आपने कौनसा पोस्टर/विडियो देखा ? वहाँ क्या संदेश दिया जा रहा था ?
8. क्या आंगनवाड़ी में लिखे और बनाये चित्रों को देखा है आपने ? क्या सीखा ?
9. अगर आपके लिए कोई ज़रूरी जानकारी पहुंचानी हो तो आप कहाँ देखना चाहोगे ?

AWW

1. संचार में आपको कैसी चुनौतियों का सामना करना पड़ता है / क्या दिक्कत आती है ?
2. क्या किसी संचार के माध्यम को इस्तेमाल करने में दिक्कत आती है / सहायता की ज़रुरत है ?
3. क्या आपने आंगनवाड़ी शिक्षा (इ-लर्निंग) कोर्स को पूरा किया है ?
4. आपको कैसी सहायता की ज़रुरत है ?
5. क्या आपने आंगनवाड़ी रेडियो एप्प का इस्तेमाल किया है ?

Annexure – XIV: Photos of direct observations in the field

Nisarpur, Dhar

Pati, Dhar

Borlai, Barwani

Mhow, Indore

Pachama, Sehore

Rajnagar, Chhatarpur

Bizawar, Chhatarpur

Morena, Morena

Morar, Gwalior rural

Resham Mill, Gwalior urban

Kathmai, Shivpuri

Meeting with DPO and CDPOs, Shivpuri

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