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An Initiative on Nutrition in the Title II based Safe Motherhood and Child Survival Program of Catholic Relief Services, Lucknow, UP, India

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ABSTRACT

The current article is about the health program of Catholic Relief Services (CRS), Lucknow during the period from 1996 to 2010. The program was food aid based through the Indo-US agreement where CRS implemented the program through its Non-Governmental Organization (NGO) partners in Lucknow. During the period 2003 to 2004, CRS, India implemented a project supported by Academy for Education & Development funded Linkages project which focused on integrating the nutrition component in the health program of CRS, India. The health program of CRS, Lucknow also implemented the nutrition intervention with one of its NGO partner in Shivgarh block of Raibareily district of Uttar Pradesh.

The article details out the outlines of the food aid programs between India & the United States & the role of CRS in the process. It also gives a glimpse of the health program of CRS, Lucknow that is known as the Safe Motherhood & Child Survival (SMCS) program & its components. Thereafter, it delves into the details of the nutrition component integration in the program, its plan to replicate with other NGO partners while focusing on the lay out plan to build the capacity of the program staff to integrate the component in their programmatic areas in various parts of the state of UP. The integration process is highlighted through a case study that depicts the benefit of the integration. An example is also given & illustrated lucidly for the simplification of the process of application. The article is an reflection of how far the state of UP has moved ahead in the field of Maternal Neonatal Child Health & Nutrition (MNCHN) that is reflected through the data of National Family Health Survey 4 of 2016. A clear path has been laid out since the last 16 years.

Keywords: *Title I, II, III & IV, SMCS, CRS, BCC, TIPS, 24-hour dietary recall, PL 480*

Introduction

The food situation in India was marked by severe shortages in early 1940s [1]. To overcome shortages, the Government of India felt the need for reserve of food grains as there was wide fluctuations in production of food grains. Secondly, the planned budgeting of activities in five- year plans was bound to put inflationary pressure in the food grain sector than elsewhere [2]. Thus, to create a buffer stock of out of imported food grains, the Indian Government entered into negotiations with the United States Government & signed an agreement in 1956 for import of agricultural commodities, mainly food grains under Public Law 480 [3].

The Food for Peace program of the Government of United States operated under the Agricultural Trade Development & Assistance Act of 1954 (as amended), better known as the Public Law (PL) 480. The law authorized four types of special programs such as Title I, Title II, Title III & Title IV [4]. Title I focused on sale of surplus food grains, II on donations to governments for disaster relief, economic & community development, III on donations to voluntary agencies for distribution & IV on foreign buying of US farm products [4]. From 1956, Catholic Relief Services was engaged in Title III program in India [4].

The concept changed from food aid to food assistance in the period from 1990-2014. Use of food aid was more forthrightly in programs aimed at community development. These programs are best examples of United States efforts to reach people directly. Three-fourths of the food donations were administered by American Voluntary Agencies one of which was CRS [5]. To increase the flexibility of food aid, the United States Government allows sale of food in recipient countries to generate cash resources for other programs addressing the causes of hunger, a practice known as monetization & CRS also used the monetized food to address hunger in India & from 1991 to 2001, levels of monetization of the non-emergency Title II food increased from 10% to 70% [6].

The Agency for International Development office in India operated the Title II program as USAID was given the responsibility to implement the Title II programs [7]. The Title II program in India was at the time the single largest humanitarian food donation program in the world providing food commodities through CARE, CRS, Lutheran World Relief, UNICEF & others [8].

CRS implemented projects from 1997 to 2010 in three sectors such as maternal & child health & nutrition, agriculture (watershed development) & education. CRS devoted its last project cycle called the Phase Out Plan (POP) to transitioning or phasing over their activities to Government of India programs [9].

SMCS program in public domain

The Safe Motherhood & Child Survival Program of Catholic Relief Services in India was operated in 13 states across the country serving 182, 121 pregnant & nursing mothers & children of 0-3 years of age from around 3169 villages. The program was operational through 600 social service wing of the dioceses as local partners thus reaching the inaccessible & the underserved. The goal of the program was to empower women to address their own health needs as well as those of their children & communities [10].

CRS India implemented baseline studies in the second project cycle in 2002 after the first Development Activity Project phase I (1997-2001) ended in 2001. The base line studies of SMCS program was done in 2002. The Development Activity Phase II was from 2002-2007. The baseline for the Phase out Plan (POP) was from 2007. End line evaluation for POP was done in 2010 for CRS, India. The end line evaluation was replicated in 2012 for CRS, India in a follow up quantitative survey implemented in a subset of the states in which the end line evaluations were conducted. Qualitative survey was also done. Uttar Pradesh was also one of the states in which the end line was done [9].

The end line evaluation of SMCS program reflected increase in institutional deliveries, immunization coverage, increase in prenatal & postnatal care. The underlying assumption was that improving maternal care practices would ultimately affect rates of malnutrition but the indicators on Early Initiation of Breast Feeding, Exclusive Breast Feeding, Complementary Feeding and continued breastfeeding & feeding during illness did not show any significant effect on the probability of a child being stunted [9]. This shows less effective implementation of these indicators as these are proved & effective interventions if done strategically [11]. However, the evaluation focused on identification of factors leading to the sustainability of those changes in activities, outcomes & impacts that were achieved by the project [9].

A peep into the article

One such effort to augment the SMCS program in Shivgarh block of Raebareily district was done in the second DAP period in the year 2004. Shivgarh block was then a non-ICDS block as ICDS was not universalized in the Nation by that time [12]. The ICDS program was universalized through a order of supreme court in December 2006 where by the Government of India was asked to cover all the blocks of the country through the ICDS by 2008 [12].

The approach was to implement the Behavior Change Communication (BCC) strategy project at partner Gramin Vikas Sansthan (GVS) based in Raebarely district of the state of Uttar Pradesh in a group of villages where the CRS supported Title II Safe Motherhood and Child Survival (SMCS) development program was already operational since 1997. CRS works with Non-Governmental Organizations (NGO) to implement the programs & one such NGO was GVS. The behavior change methodology involved a series of processes like baseline survey, two phases of Trial for Improved Practices (TIPS), adoption of 24-hour dietary recall approach, development of food frequency calendar, market survey, formative research, development of detailed implementation plan and monitoring and evaluation of the activities. The project ended with a process evaluation.

The current article has the simplified approach where the important contents of TIPS and 24-hour dietary recall methods so that the process is integrated into the SMCS program of other NGO partners of CRS Lucknow. The benefits and impact of this approach can be gauged by going through one attached case study of a program participant of partner GVS area. The integration envisages such outcomes in the program areas of other partners.

The article gives an overview of the process with explanation through an example, major contents of the training planned for the workers, implementation plan of the integration process and the expected benefits from the integration of BCC into the SMCS program.

Case Study on the initiative

She changed the custom

"Earlier we listened to what our mother-in-law told us, now we listen to the Village Health Worker (VHW)," said Kismatun of village Kumbhi. Kismatun has six children. Her eldest is 15 years old and the youngest six months. Earlier they believed the baby should not be given mother's milk till three days were over - because on the third day the midwife, a woman of a particular "untouchable" caste, came and gave her a massage for speedy healing. Following norms of untouchability, it was advised the newborn baby only be given a little honey or a few drops of cow or goat milk. Five of Kismatun's children were fed thus.

By the time she conceived the sixth child, she had come into contact with VHW Shailkumari, who began by asking her what she had eaten in the last 24 hours. After analyzing her diet pattern, the VHW recommended changes. For example, when Kismatun went to work on the farm she remained hungry for a long period. Shailkumari suggested she take some wheat flour *laddoos(balls made up of sweets)* with her so that she could have at least a couple of them now and then.

Then Shailkumari found that Kismatun was not having enough green leafy vegetables. Shailkumari suggested she pick some mustard leaves from her farm and have them regularly. It was also the season of radish, whose leaves Kismatun liked very much. Shailkumari encouraged her to have that also. She then took Kismatun for her three antenatal check-ups during the third, fifth and eighth month.

When the baby was born, Kismatun did not wait for three days. As soon as the midwife cut the umbilical cord, cleaned the child and gave it to the mother, she gave her newborn breast milk; it was difficult in the beginning, but only for a little while.

Kismatun's neighbor, Shehzadi, was also sitting there when Kismatun was recounting her learning process. She said: "I too gave my child breast milk soon after it was born. It makes a lot of difference if you start breastfeeding immediately; there is more milk and the child is satisfied." Both Shehzadi and Kismatun said, in their experience, the child also suffers much less from diarrhea, fever and boils.

To this Kismatun's mother-in-law nodded in assent. Earlier she had advised her daughter-in-law to wait for three days before breastfeeding, now she herself advocates immediate breastfeeding to everybody. As she said, "Shailkumari has changed the custom in our village."

About the SMCS program & the augmentation

The SMCS (Safe Motherhood and Child Survival) program has four basic health delivery components such as monthly growth monitoring, health education sessions for mothers in small groups once a month, maintenance of MIS records and finally home visits for giving need specific Information Education and Communication (IEC) to priority houses. Such priority houses are houses with newborn children, pregnant women, and growth faltered children in the 0-3 years age group and children nearing 6 months of age. The staff in the SMCS program provides these services. Among all these services, home visit is very critical as it involves personal contact with the program participants to counsel them for adopting healthy behaviors. Besides these services, the aspects of antenatal care and provision of IFA tablets for pregnant women, immunization of pregnant women and infants are provided through developing effective linkage with the government health system.

Program quality can be enhanced to a great extent if the health Behavior Change Communication (BCC) strategy is integrated into the program. CRS, Lucknow has had the prolific experience of this integration at partner Gramin Vikas Sansthan based in Raebareli district of Uttar Pradesh. Based upon the experience, the BCC methodology seems to be an effective tool to improve the health behaviors at the household level. The benefits of the BCC approach can be optimized to enrich the program if primary focus is laid on the feeding practices of pregnant women, lactating mothers and children.

A two-pronged strategy will be adopted for integration of the BCC strategy into the SMCS program at the household and community level. The strategies are-

1. Use the methodology of TIPS (Trial for Improved Practices) and 24-hour dietary recall to assess the dietary pattern of mothers and children so that appropriate messages are given at the household level.
2. Recipe demonstration during the monthly health education sessions where mothers learn to prepare the dishes as well as get to know the nutritive contents of the dishes.

Why to prioritize these feeding behaviors?

The behaviors related to feeding practices of women and children are entirely in the hands of the program staff and the household, as there is no dependency on the health system for the implementation of these behaviors. This is not the case with the antenatal service related behaviors as skilled personnel both from the public and private health system provide services. These are provision of IFA tablets, tetanus toxoid and routine checkups. These services are beyond the control of the program staff as various modalities and external factors are involved in the provision of these services.

Currently, the efforts to improve feeding practices of pregnant women and children are done through the health education sessions and home visits where the program participants are given need specific IEC. The message given in this regard is a generalized one as the mother and household members are told about the type of food (as mentioned in the nutrition books and related IEC materials) they are supposed to give to the mother and child.

This method does not take into account the ground realities like the financial capacity of the family to afford those food items or whether the family culturally accepts these food items. The techniques of BCC strategies like "Trials for Improved Practices" (TIPS) and "24-hour dietary recall" takes these aspects into account while trying to improve the feeding practices at the household level.

The TIPS methodology helps the health worker/supervisor to give appropriate messages at the household level after ascertaining the current practice through interview of the mother and the household members like the mother-in-law, husband. The interview will consist of dietary recall of the last 24 hours i.e. what the mother/child ate during the last 24 hours. This will give a clear picture about their regular dietary habits. The 24-hour dietary recall will reveal the particular food items with the frequency and amount as per the household measure. The health worker will see whether the diet incorporates major nutrients like protein, carbohydrates, fats, vitamins and minerals while reviewing the prepared diet chart. The next step is the application of the TIPS (Trial for Improved Practices) methodology to suggest the appropriate behavior at each household level.

The TIPS methodology only recommends those practices, which are mutually agreed upon with the family members and they agree to practice it in their daily lives. The next task of the health worker will be to find out all those practices or behaviors that the household members agree to do. Prioritization of the behaviors is the next step. The health worker then recommends one or two behaviors for the household and requests them to follow it. A follow-up visit is done within 10 days to the same household to see whether they have adopted the behavior. The next prioritized behaviors are recommended if the suggested behaviors are practiced and if not, the obstacles are identified and necessary modifications are suggested in the recommended behavior as per the circumstances. The phenomenon can be better understood with the help of the attached example.

The current status of community level intervention to improve the feeding practices can be enriched if "recipe demonstration" is done at the monthly health education sessions. During the health education sessions, the workers use IEC materials and interact with the mothers to apprise them of the relevant health issues particularly those pertaining to safe motherhood and child survival. The health workers know the community well as they are from the same community. With the help of this knowledge, a list of nutritious, low cost and culturally appropriate recipes will be finalized. The content of health education session would not only focus on the discussion of these recipes but also on demonstration of the method of preparation of these recipes. The mothers will be encouraged to bring the food items required for the preparation of these recipes in the health education sessions. The health worker will explain the nutritive aspects and the related health benefits of these recipes to the mothers. The community will consume these food items definitely as these are low cost and culturally appropriate. This activity will help the community to realize the importance of these recipes and the frequency of consumption of these items is likely to increase both for the pregnant mother and children.

Capacity building initiatives of SMCS program staff

The BCC manual developed for CRS India to orient the staff members would be used to train the staff. However, the content would focus on the methodology of TIPS and 24-hour dietary recall using the TIPS and formative research report of CRS Lucknow based upon the BCC program at partner GVS in Raebareli district. The nutrition aspect will focus on

the layperson's concept of the types of foods. As per this concept, all foods are classified into three categories- health building or 'badho' (proteins), health promotive or 'chalo' (carbohydrates and fats) and health protective or 'bacho' (vitamins and minerals). To simplify, the trainees would be made to understand that-

1. Milk, fish, meat, egg, all pulses and beans etc. are health-building foods.
2. All cereals, sugar, jaggery, oils, ghee etc. are health-promotive foods.
3. All green vegetables and fruits etc. are rich in vitamins and minerals.

This would be the basic concept on which the workers will analyze the nutritive contents of the foods of the diet charts at the household level and of the recipes at the community level.

Each of the workers will be oriented on the counseling guides to be used at the household level to promote the behavioral practices on feeding of mothers and children. The formats of the 24-hour dietary recall chart and behavior selection (attached) will be used in the training to orient the participants on the use of the formats. The counseling guide would primarily focus on the feeding behaviors of pregnant women and children as follows-

1. Pregnant and lactating women - Eat at least one more meal in addition to their current pattern.

2. Lactating women - Breastfeed the child 8 times a day in 24 hours. Empty one breast before switching to other one as only after 10 minutes of feeding from a breast, the nutritious hind milk starts to flow.

3. Mothers of children nearing 6 months - The quantitative aspect of complementary feeding emphasizes that the child should be fed in a separate bowl or small bowl (katori) while having the complementary feeding. The age wise schedule for children are in this manner- 6-9 months (1 small bowl (1 katori) per day), 9-12 months (2 small bowls (2 katoris per day), 12-24 months (3 to 4 small bowls (3 to 4 katoris) per day) along with breastfeeding besides two snacks. The other important aspects in complementary feeding are-

* *The quality aspect*--it ensures that the feeding should have all the three types of foods in semi- solid consistency and hygienic practices should be followed.

* *The child should be fed actively*--this means that the child should be encouraged to eat and not be left alone while eating.

The counseling guide will help the staff to know the obstacles while promoting these behaviors. It also suggests ways to tackle the obstacles or common myths in the minds of the people during the behavior promotions. The guide will act as a ready reckoner for the program staff both at the household and community level while promoting the behaviors.

At all stages, staff will see whether the consumed foods include all three types of foods or not. This will ensure that mothers and infants are consuming a balanced diet.

Implementation plan as envisaged by CRS, Lucknow in 2004

By March 2005, at least 5 partners (three health partners of NGO Counter Part (CP) PGVS and two health partners of CP SSA) will have integrated the BCC strategy into their existing SMCS program. By March 05, the plan may also include training of Operating Partners, Lokarpan and GVS if time permits. A Training of Trainers (TOT) would be held to train the coordinators at the CP as well as OP level, selected group of supervisors and health workers at each CP level. This group would then train all the staff at the OP level. It is hoped that the integration process will not require large additional funding.

Benefits of the integration

The SMCS program participants especially children in the age group of 6-24 months show a high incidence of low weight for age. These children silently suffer from under nutrition without any protest. This silent emergency needs to be tackled. The monthly growth-monitoring cards of these children as SMCS program participants stand testimony to this fact. The National Family Health Survey (NFHS) II data for the state of Uttar Pradesh shows that only 17.3% of children in the age group of 6-9 months are introduced to complementary feeding. The integration strategy not only talks of initiation of complementary feeding but also adhering to the practice till 24 months of age. Proper implementation of the activities will result in a substantial decrease in the growth-faltering rate at the sensitive period of 6-24 months. This trend can be clearly reflected in the monthly growth cards of these children and subsequently in the QPR (Quarterly Progress Reports) of the partners. The staff members can themselves notice the change during the monthly growth monitoring sessions of the SMCS program.

Like children, weight of pregnant women is also monitored every month. The gradual weight gain during pregnancy is a significant antenatal care, which ensures that a woman will deliver a baby weighing at least 2.5 kilograms (the standard birth weight which is considered to be normal in India). Birth weight is the single most important indicator, which reflects on the feeding practices of the community. Given proper implementation of the activities in promoting the feeding behavior of pregnant women, staff members can easily notice the weight gain among pregnant women.

Lactating mothers will also benefit from these practices, as the intakes of locally available nutritious foods will not only increase the quantity of milk but also the quality. Adherence to proper breastfeeding methods will benefit children in many ways like boosting their immunity.

Understand the example

The example is of an infant of 10 months of age. The first step is the 24-hour dietary recall where the intake is measured as per the household measure. The second step is the behavior selection for the infant. After selecting the suggested behavior, the roles of all the household members, who are directly responsible to practice the behavior, are clearly noted down. Usually the household members in the case of a child happen to be the mother, father and the grandmother.

Two important factors are considered during the interview, like sickness of the child and who feeds the child. These two factors exert a great influence on the dietary pattern of children. When dietary intake in terms of the basic complementary feed is analyzed, it is found that the child gets only health promotive (rice, biscuits) and health building (dal, rasam) foods only. The diet would be complete if health protective foods are added. Hence, the suggested behaviors will be-

1. To add green leafy vegetables to the diet of the child.

2. As the child is 10 months old, half katori (bowl) more of rice, dal and green vegetables could be added to the diet.

3. Give fruits (whatever is affordable or locally available and decided on after mutual agreement) once a day as a snack so that the child gets adequate health protective foods.

4. The child can be given breast milk two times more a day.

Once the behaviors are suggested, there is some initial resistance or objection. In this case, the mother says that she has no time to feed the child the extra half bowl suggested as a behavior. After discussions with her, she agrees that she will tell the child's grandmother to feed the child in her absence during the day. She was not feeding the child with green vegetables as she had the opinion that the child is adequately fed. On the issue of giving fruits, her response puts the onus on the husband to get fruits from the market and the child can be fed on weekly market days only. The suggested behavior on breast milk implies that the mother is unable to do so because of lack of time. However, she agrees to squeeze out the breast milk and keep it for the child to be fed by the grandmother during the daytime in her absence.

Adoption of behaviors needs a comprehensive approach on the part of any household where there should be role clarity for the members responsible to implement the behavior. The roles of the mother-in-law and the husband in this case are clarified. The challenge now is to follow-up on these agreements through subsequent home visits so that continuous reinforcement at the household level brings about change as per the suggested behavior.

The approach will be to prioritize behaviors and follow- up on one- to- one basis. For example, in this case, the prioritized behavior could be that the child should get green vegetables in the diet. The adults need to ensure that the child's food is cooked separately or the child's share can be removed from the family pot before adding spices. Once the family adopts this behavior, the next behavior could be suggested. In case the family shows a good degree of compliance, two behaviors can be suggested at one time with a follow- up period of 10 days to see whether the behavior is being practiced or not.

Similarly, the process will be applied to pregnant women and lactating mothers too. With basic inputs in the BCC training, the workers will be in a position to put the process in place at priority case households in the SMCS program areas. The good thing about the process is the degree of flexibility that it provides both to the worker and as well as to the family members. The counseling guide which will be made available to the workers will come in handy at this hour. The demonstration of locally available, culturally appropriate recipes and discussion on the nutrition content of these recipes along with the health benefits from these nutrients during the health education sessions will catalyze the creation of an enabling environment for the community to adopt the suggested feeding behaviors.

Current health program of CRS, Lucknow

After the Phase Out Plan of SMCS program in 2010, CRS, Lucknow continued to work in the field of Maternal & Child Health. Since April 2011, CRS, Lucknow is operating the project named Reducing Maternal & Newborn Deaths (ReMiND). The strategy of the project is entirely different from that of the SMCS program. The details of the project can be obtained from the site given in the reference [13]. The SMCS program can be called as the precursor of the current project.

Nostalgic Acknowledgement

The lead author was an employee of CRS from 1997 to 2012. The SMCS program taught the lead author the basics & intricacies of public health & community medicine. All the learning & activities were part of augmentation activities of SMCS program in which the lead author worked. The author duly acknowledges CRS, Lucknow for the contents of the article. The author thanks all the colleagues of CRS, Lucknow for their support. Special thanks are due for Late Ms. Shivakamy Iyer for her support as the State Representative of CRS, Lucknow. The lead author has retained her original note with signature as a supplemental file of the article. The author has also retained his language as such written by him 16 years ago.

It may be recalled that the Hindi language version of the document was printed for internal consumption within CRS, India. It was printed in March 2007. The note in Hindi by Mr. Kushal Neogy for the document is also attached as a supplemental file of the article. Kushal was the State Representative of CRS, Lucknow during that period. The lead author's note in Hindi in the document is also attached. The lead author also thanks Kushal for his support. Ms. Anjali Tripathy, the co-author of the article was a colleague at CRS, Lucknow who also worked in the SMCS program.

Funding

Nil

Conflict of interest

Nil

Declaration:

The authors declare that the contents are as of 16 years ago. There have been changes in the IYCF guidelines & nutrition strategy both at state & center level since then. The contents can be categorized as a small step towards development of future strategies in Maternal, Neonatal & Child Health Nutrition (MNCHN).

Supplemental Files

Here, the notes written by the lead author & the state representative of CRS, Lucknow in the internal document in English language for CRS, Lucknow are attached. Following that, two scans are also attached that shows the notes by the lead author & the state representative of CRS, Lucknow regarding the internal document in Hindi language are attached. It is to be noted that the English language was published internally in 2004 & the one in Hindi language in 2007. Ms. Shivakamy Iyer was the state representative in 2004 & Mr. Kushal Neogy in 2007.

INTRODUCTION TO THE INTEGRATED APPROACH

This is an approach to simplify the learning from the implementation of the Behavior Change Communication (BCC) strategy project at partner Gramin Vikas Sansthan (GVS) based in Raebarely district of the state of Uttar Pradesh in a group of villages where the CRS supported Title II Safe Motherhood and Child Survival (SMCS) development program was already operational. The behavior change methodology involved a series of processes like baseline survey, two phases of Trial for Improved Practices (TIPS), adoption of 24-hour dietary recall approach, development of food frequency calendar, market survey, formative research, development of detailed implementation plan and monitoring and evaluation of the activities. The project ended with a process evaluation.

This simplified approach has singled out the important contents of TIPS and 24-hour dietary recall methods so that the process is integrated into the SMCS program of other partners of CRS Lucknow. The benefits and impact of this approach can be gauged by going through one attached case study of a program participant of partner GVS area. The integration envisages such outcomes in the program areas of other partners.

The document gives an overview of the process with explanation through an example, major contents of the training planned for the workers, implementation plan of the integration process and the expected benefits from the integration.

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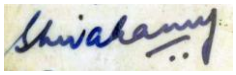
2.8.04

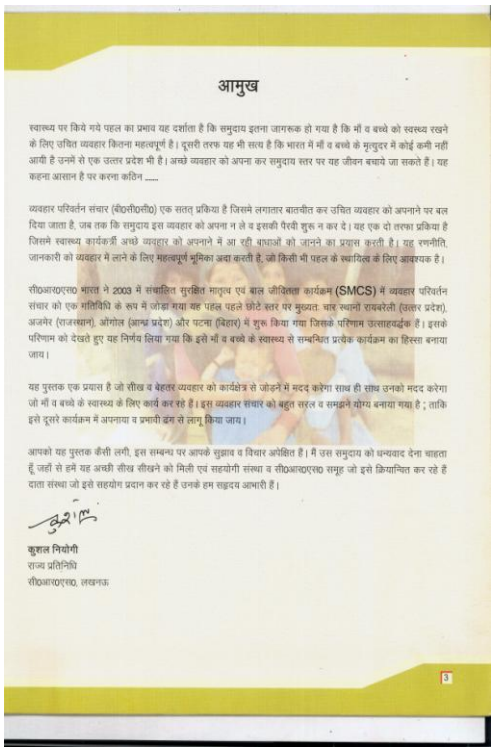
ABOUT THE DOCUMENT

CRS India implemented the Behavior Change Communication (BCC) project in Safe Motherhood and Child Survival (SMCS) program areas at four places namely Raebareli, Ajmer, Ongole and Patna in 2003 through partners operating in these areas. This document is an effort of CRS, Lucknow to adopt the learning of the BCC strategy at SMCS program areas of partners where the project was not operational.

The approach follows a simplified version of the BCC methodologies, which are doable and practically feasible. We hope this becomes an effective tool to enrich the existing SMCS program.



Shivakamy Iyer
State Representative
CRS, Lucknow
2.8.04



आमुख

स्वास्थ्य पर किये गये पहल का प्रभाव यह दर्शाता है कि समुदाय इतना जागरूक हो गया है कि माँ व बच्चे को स्वास्थ्य रखने के लिए उचित व्यवहार कितना महत्वपूर्ण है। दूसरी तरफ यह भी सत्य है कि भारत में माँ व बच्चे के मृत्युदर में कोई कमी नहीं आयी है उनमें से एक उत्तर प्रदेश भी है। अच्छे व्यवहार को अपना कर समुदाय स्तर पर यह जीवन बचाये जा सकते हैं। यह कहना आसान है पर करना कठिन .....

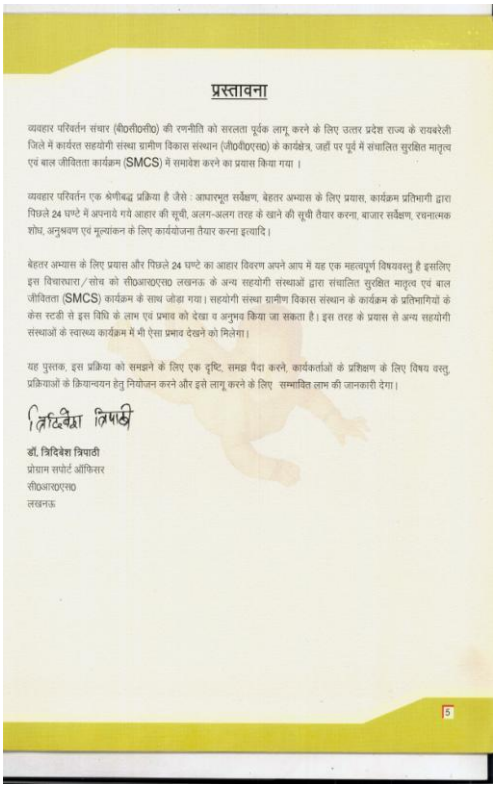
व्यवहार परिवर्तन संचार (बी0सी0सी0) एक सतत् प्रकिया है जिसमे लगातार बातचीत कर उचित व्यवहार को अपनाने पर बल दिया जाता है, जब तक कि समुदाय इस व्यवहार को अपना न ले व इसकी पैरवी शुरू न कर दे। यह एक दो तरफा प्रकिया है जिसमे स्वास्थ्य कार्यकर्ता अच्छे व्यवहार को अपनाने में आ रही बाधाओं को जानने का प्रयास करती है। यह रणनीति, जानकारी को व्यवहार में लाने के लिए महत्वपूर्ण भूमिका अदा करती है, जो किसी भी पहल के स्थायित्व के लिए आवश्यक है।

सी0आर0एस0 भारत ने 2003 में संचालित सुरक्षित मातृत्व एवं बाल जीवितता कार्यक्रम (SMCS) में व्यवहार परिवर्तन संचार को एक गतिविधि के रूप में जोड़ा गया यह पहल पहले छोटे स्तर पर मुख्यत: चार स्थानों रायबरेली (उत्तर प्रदेश), अजमेर (राजस्थान), ओंगोल (आन्ध्र प्रदेश) और पटना (बिहार) में शुरू किया गया जिसके परिणाम उत्साहवर्द्धक हैं। इसके परिणाम को देखते हुए यह निर्णय लिया गया कि इसे माँ व बच्चे के स्वास्थ्य से सम्बन्धित प्रत्येक कार्यक्रम का हिस्सा बनाया जाय।

यह पुस्तक एक प्रयास है जो सीख व बेहतर व्यवहार को कार्यक्षेत्र से जोड़ने में मदद करेगा साथ ही साथ उनको मदद करेगा जो माँ व बच्चे के स्वास्थ्य के लिए कार्य कर रहे हैं। इस व्यवहार संचार को बहुत सरल व समझने योग्य बनाया गया है ; ताकि इसे दूसरे कार्यक्रम में अपनाया व प्रभावी ढंग से लागू किया जाय।

आपको यह पुस्तक कैसी लगी, इस सम्बन्ध पर आपके सुझाव व विचार अपेक्षित हैं। मैं उस समुदाय को धन्यवाद देना चाहता हूँ जहाँ से हमें यह अच्छी सीख सीखने को मिली एवं सहयोगी संस्था व सी0आर0एस0 समूह जो इसे क्रियान्वित कर रहे हैं दाता संस्था जो इसे सहयोग प्रदान कर रहे हैं उनके हम सहृदय आभारी हैं।

कुशल नियोगी
राज्य प्रतिनिधि
सी0आर0एस0, लखनऊ



प्रस्तावना

व्यवहार परिवर्तन संचार (बी0सी0सी0) की रणनीति को सरलता पूर्वक लागू करने के लिए उत्तर प्रदेश राज्य के रायबरेली जिले में कार्यरत सहयोगी संस्था ग्रामीण विकास संस्थान (जी0वी0एस0) के कार्यक्षेत्र, जहाँ पर पूर्व में संचालित सुरक्षित मातृत्व एवं बाल जीवितता कार्यक्रम (SMCS) में समावेश करने का प्रयास किया गया ।

व्यवहार परिवर्तन एक श्रेणीबद्ध प्रक्रिया है जैसे : आधारभूत सर्वेक्षण, बेहतर अभ्यास के लिए प्रयास, कार्यक्रम प्रतिभागी द्वारा पिछले 24 घण्टे में अपनाये गये आहार की सूची, अलग-अलग तरह के खाने की सूची तैयार करना, बाजार सर्वेक्षण, रचनात्मक शोध, अनुश्रवण एवं मूल्यांकन के लिए कार्ययोजना तैयार करना इत्यादि।

बेहतर अभ्यास के लिए प्रयास और पिछले 24 घण्टे का आहार विवरण अपने आप में यह एक महत्वपूर्ण विषयवस्तु है इसलिए इस विचारधारा/सोच को सी0आर0एस0 लखनऊ के अन्य सहयोगी संस्थाओं द्वारा संचालित सुरक्षित मातृत्व एवं बाल जीवितता (SMCS) कार्यक्रम के साथ जोड़ा गया। सहयोगी संस्था ग्रामीण विकास संस्थान के कार्यक्रम के प्रतिभागियों के केस स्टडी से इस विधि के लाभ एवं प्रभाव को देखा व अनुभव किया जा सकता है। इस तरह के प्रयास से अन्य सहयोगी संस्थाओं के स्वास्थ्य कार्यक्रम में भी ऐसा प्रभाव देखने को मिलेगा।

यह पुस्तक, इस प्रक्रिया को समझने के लिए एक दृष्टि, समझ पैदा करने, कार्यकर्ताओं के प्रशिक्षण के लिए विषय वस्तु, प्रक्रियाओं के क्रियान्वयन हेतु नियोजन करने और इसे लागू करने के लिए सम्भावित लाभ की जानकारी देगा।

त्रिदिवेश त्रिपाठी

डॉ. त्रिदिवेश त्रिपाठी
प्रोग्राम सपोर्ट ऑफिसर
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