



Health Sector Case Study

Save a Mother Foundation

Effective Social Persuasion Platform and Program (SAM-ESP3)

Dr Shiban Ganju



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Published by:
Rajiv Gandhi Institute for Contemporary Studies, New Delhi

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Foreword

The Rajiv Gandhi Institute for Contemporary Studies (RGICS) is an independent national policy think tank promoted by the Rajiv Gandhi Foundation. RGICS carries out research and policy development on contemporary challenges facing India. RGICS currently undertakes research studies on the following five themes of general public utility including:

- i. Constitutional Values and Democratic Institutions
- ii. Growth with Employment
- iii. Governance and Development
- iv. Environment, Natural Resources and Sustainability
- v. India's Place in the World

Under the RGICS theme of Governance and Development, among other issues, we look at the contemporary status of public systems, particularly education and health care systems. Healthcare is an important determinant to realise any individual's potential and it is extremely important in infancy, as at that stage the body and the brain are both developing at a rapid pace. Thus immunization, safe drinking water and adequate nutrition for the infant is very important to minimise morbidity and mortality, And infant health is not possible unless pregnant and lactating mothers are also health and have good nutrition.

While RGICS Research Papers bring out policy and systemic issues, we also publish case studies of innovative good practices which have made an impact at scale on a sustainable basis and carry lessons for the wider system improvement. It is in that context that we requested Dr Shiban Ganju, a highly qualified research physician who graduated from the AIIMS, New Delhi and was certified by American Board of Internal Medicine and Gastroenterology. He practiced in the US and was also a consultant at The University of Chicago Ingalls Hospital and Advocate Healthcare, Illinois. For the last decade, Dr Shiban has been running the Save a Mother Foundation (SAM) working on Maternal and Child Health and this case study is based on the work of SAM.

We hope the paper is found useful by policy makers, health systems administrators, maternal and child health care professionals , as well as NGOs involved in the field.

Vijay Mahajan,

Director, Rajiv Gandhi Institute for Contemporary Studies (RGICS)



Introduction: Deficiencies of healthcare systems have attracted supply driven solutions. The traditional recourse is to plug the deficiency by increasing the supply of hospitals, clinics, labs, drugs, devices, X-Rays, ambulances, paramedics, doctors and nurses. This supply side model is expensive and unaffordable to resource poor communities. The answer may lie in reducing the disease burden by empowering the consumer with responsibility to change health seeking behavior.

Save a Mother (SAM), a healthcare NGO, works on the demand side by embedding health activists in the communities to carry healthcare to the doorstep. SAM has developed an Effective Social Persuasion Platform (SAM-ESP3), a model for social behavior change, which reduces disease burden, thus reducing demand on the health system. SAM has successfully replicated the model in different locations in India.

About Save a Mother (SAM): Established in 2008, SAM has worked with vulnerable communities of 6.2 million people living in 3200 villages and three urban slums, located in 11 districts of 4 states of India. SAM is currently active in over 2000 villages in four districts.

SAM-ESP3 Innovation: SAM has developed a cost-effective model of Effective Social Persuasion Platform and Program (SAM-ESP3) to ensure sustainable social behavior change of a community. In partnership with local public and private healthcare stakeholders, trained health activists enable a community to convert awareness to actionable knowledge. ESP3 relies on seven assumptions.

1. Behavior modification is the least expensive way to reduce disease burden.
2. Health is an individual and community responsibility; ownership of this responsibility empowers a community to demand healthcare rights.
3. A campaign to push health information may improve awareness but is not sufficient by itself. Awareness is just one of many steps to change behavior.
4. Other essential steps include: a sustained, intensive, repetitive campaign without a predefined end time-point, encouraging peer to peer nudge and a methodical transfer of ownership to the community leaders.
5. Messages scripted by the community encourages their ownership.
6. Trained volunteer activists can lead and sustain the ESP3 without external help.
7. An established SAM-ESP3 platform can be used to address multiple health problems.

SAM-ESP3 is not yet another awareness building program. Awareness is often assumed to be equal to behaviour change. In practice, it is not true. Communication programs and prevalent awareness programs merely touch the surface without translating into significant behaviour change. SAM-ESP3 is a multi-step process, where awareness is just one of many steps for a sustainable behaviour change. SAM promotes community ownership of both health and healthcare. SAM believes, that health is an individual and community responsibility. And demanding healthcare, as a right, has to be learned. SAM-ESP3 is a peoples' program, which ensures that the health system is responsive and accountable

The model of ESP3 has three components: Platform, Persuasion and Program.

Each of these components of ESP3 addresses its designated end beneficiaries and the combination P3 brings out the social behavior change.

P3 components	End Beneficiary
Persuasion for ecosystem	Community
Platform of health	Village health volunteers
Programs current	End beneficiaries
*Maternal health	Pregnant mothers
*Infant health	Newborn
*Child health	Children under 5 years
*TB control	TB Patients ,TB Contacts
*Population stabilization	Other surveillance
*Encephalitis control	Reproductive age population
	Children Under 10 years

Platform: This is a human platform, made of frontline paid workers and volunteers. We have trained 1 to 5 volunteers from each village. We have trained close to 37,000 community health volunteers in the past 12 years. On average knowledge score, before training they were able to answer 18 questions of 38 questions and after training they were able to answer 32 questions of 38 questions. We have approximately 25% attrition of volunteers annually. We replenish the field force by training new volunteers. They form the backbone of sustainability and take over the program at the end of 3 to 5 years. We are able to withdraw from 25% villages annually after third year.

Persuasion: Behavior of an individual changes when aided by an enabling community. SAM field force persuades a community through weekly and monthly meetings to develop a conducive ecosystem for behavior change. The meetings are intensive, repetitive and participatory. SAM conducts 8000 to 10000 meeting in each district annually. It is our estimate that it takes between 20 to 120 hours of social persuasion with an individual to change his / her behavior and it takes 6 to 18 months to see the changes in a community.

SAM trains volunteer health activists who lead the program and develops a cadre of social entrepreneurs, who sell contraceptives, sanitary pads and nutritional products. SAM field workers are from the community where they live and work. They are available 24/7, and take health to the doorstep of recipients. The program sets no predetermined end date; repetitive training continues till SAM meets the objectives. The following steps describe its execution

1. Organize, create structure and build leadership capacity: SAM has a well-trained field staff and managers; the voluntary directors of the organization are professionals from healthcare and management. Each district has a manager, trainers and supervisors who are selected from the

local population. They receive intensive training not only in health issues but also in motivational techniques, training methods and leadership.

2. Develop messages: SAM believes that a good message should be simple without technical jargon, short with less than five points, easy to understand without explanation and emotionally connected with a local need. For better retention, a message could be in the form of a story, song or a slogan. Some messages should be created by the community to feel ownership.
3. Train health activists: Master trainers train volunteer health activists to be responsible for village health issues. Training is repetitive and intense.

4. Teach people: SAM organizes the village into a health care community. Field supervisors motivate and mobilize villagers and discuss each topic of health care with a specific training module. SAM uses local community resources to create training material and health leaders script their own songs and slogans. Activists meet villagers repeatedly to discuss best practices. Repetitive training of health activists and villagers is essential.



5. Cooperation with public and private health systems. SAM establishes linkage with the local private and public health system. Utilizing all available public health resources is an essential component of the program. Public health workers are invited to all meetings. This linkage creates awareness, which improves demand of health care and encourages accountability.
6. Evaluation and improvement: Programs are monitored by community involvement and by participatory research action. Results lead to course correction.
7. Replicate: Solutions are validated and replicated in other locations.

Programs: These are targeted towards specific population groups with specific health needs. The program end beneficiaries are pregnant women, infants, children, reproductive age couples, TB patients

and their contacts. The end beneficiaries are motivated by the platform of trained health workers, nudged by peers and enabled by the ecosystem of the community.

SAM selects the target population on the following criteria:

1. Targeting vulnerability: SAM works with the poor and vulnerable communities who lack education, income, assets, status and access to healthcare.
2. Targeting maternal and child health including pregnant women, infants and children.
3. Targeting reproductive age: For population stabilization, SAM targets reproductive age group women and couples between ages 18 and 49 years and adolescent girls from 10 to 19 years.
4. Targeting disease: TB patients and their contacts, malnourished children and those susceptible to encephalitis

Impact measurement: Each program starts with a baseline and finishes with an end-line evaluation. SAM defines objectives, activities, outputs and outcomes before the start of the program. They measure monthly progress against all these parameters. Process of measuring impact is a four step process:

1. Data Collection at community level: The field workers collect data during house visits and community meetings. They upload it on a smartphone.
2. Data review at block level: Field officers collate and review data every month at a block level. They validate it by through client interaction.
3. Data validation at district level: SAM validates data through a monitor and evaluation protocol which includes field visits, focus groups and comparison with public health data. SAM compares outcomes and impact with similar programs run by the government and other private organizations.
4. External agency evaluation: Periodically, SAM engages external agencies to evaluate its work. The funding partners also send external evaluators to check the progress and impact

Direct impact : SAM has trained 37,000 volunteer health activists who live in the villages and are available to the community. SAM has directly impacted over 1,150,000 million people through maternal, child health, Population stabilisation and TB control programs.

Through maternal, child health and population stabilisation programs, SAM has directly impacted: 530,000 women and over approximately 100,000 infants. SAM follows all (100%) pregnant women in the villages and has reduced maternal mortality by 90% and infant mortality by 60%. In some places SAM have done even better. Example: In the past 6 years, in 167 villages of Gadag in Karnataka, maternal mortality rate has decreased to 15.8 from 364 and Infant mortality rate has decreased to 5 from 46.

Through population stabilisations program, marriage of girls under 18 years of age has decreased to almost zero. Contraceptive use has increased from 28% to 62% and supply chain management has reduced the unmet need of contraception from 10.8 % to 2% .

Since 2013, TB control program has been running in 700 villages. 287,042 people have participated in 14,552 community meetings. 13,973 people have had sputum tested. Sputum was positive for TB in 1329 people and 14 had multiple drug resistant TB. All received supervised treated. SAM has directly helped with education and surveillance of 130,000 contacts of TB patients and helped another 317,000 community members with awareness program. TB detection rate has improved 3.7 times.

Indirect impact: SAM estimates that approximately 0.9 to 1 million people, who did not actively participate in its programs, became aware of the benefits from those who attended our programs.

Women feel empowered, which has opened their minds to many choices in life. They express their opinions freely. Men and elderly women, who were suspicious and objected to their women attending public meetings, have mellowed their resistance and have even become enablers. Girls attend school more regularly and the number of girls attending college has increased. Adolescents participation has increased. Public health system and their workers are more responsive to public demand. Local elected politicians are responsive.

In Jan 2020, SAM expanded its population stabilisation program to Bahraich district in Uttar Pradesh. The district has 1400 villages. The following table gives the numbers of people SAM has impacted, directly or indirectly since the program started till Nov 2019, before SAM expanded to another 2.5 million people in Bahraich in 2020.

Total direct and indirect impact in all programs and locations from May 2008 to Dec 2019

Location	Start year	Till year	Number of villages	Population Covered	Direct Impact	Indirect impact	Program
Sultanpur	2008	2011	245	245000	30625	100000	MCH
Raibareli	2008	2011	450	450000	56250	200000	MCH
Hospet	2013	2015	20	18000	3250	12300	MCH
Dharwad	2014	2015	50	90000	6900	12500	MCH
Nizamabad	2015	2019	100	160000	39000	77400	MCH
Jaunpur	2014	2018	110	141000	29105	50000	MCH
Varanasi	2018	2019	2 slums	13000	5850	13000	CD&NCD
Bahraich	2019	2019	117	218000	76000	163500	MCH & PSP
Gadag	2012	2019	167	470000	185405	200000	MCH
Amethi	2008	2019	635	1500000	282500	375000	MCH
Amethi	2013	2019	635	As above	69865	287032	TB control
Amethi	2014	2019	635	As above	358000	400000	PSP
Muzaffarpur	2019	2019	152	340900	30000	125000	Encephalitis prevention
TOTAL			2048	3,645,900	1,172,750	2,015,732	

Validation of Impact in Gadag: We validate impact by internal analysis and external evaluation. We conduct studies to validate our data. As example, we conducted the total review of work done in 167 villages of Gadag, Karnataka since the beginning of the program and compared it with 162 villages of the same district Gadag, where we don't work and also compared it with an adjoining district Haveri.

Internal analysis of Gadag district: data from 2012 to 2019 about community meetings

Year	Pregnant women meeting	Participants	Lactating mothers meeting	Participants	SHG women meeting	Participants
2013	1560	20040	1535	18600	1490	18900
2014	3720	44400	3672	35400	3516	42600
2015	1740	17760	1596	19152	1524	15389
2016	1860	18500	1680	17400	1560	16550
2017	2040	19440	2080	19000	2100	22680
2018	2148	20280	2004	20650	2210	22800
TOTAL	13068	140,420	12567	130202	12400	138919

Impact analysis; Number of training sessions for staff health workers in Gadag

Year	Number of trainings	Participants
2012-13	4	108
2013-14	6	129
2014-15	5	128
2015-16	8	323
2016-17	8	339
2017-18	6	328
2018-19	3	145
TOTAL	40	1500

Impact on maternal mortality reduction in Gadag since 2013 till Dec 2019

Year	Number Of Deliveries	Maternal Deaths	Maternal Mortality Rate	Infant Deaths	Infant Mortality Rate
2013-14	4284	08	141	65	15.47
2014-15	6512	08	123	75	11.53
2015-16	7307	03	42	59	8
2016-17	6057	01	25	38	6.35
2017-18	6519	01	15.4	25	4
2018-19	6402	01	17.2	27	4.21

Comparison of SAM data on maternal mortality rate (MMR) with similar programs.

Gadag district, Karnataka	MMR
167 Villages of Gadag where SAM is working (2016- 2019)	15.7
162 Villages of Gadag where SAM is not working (2018)	38.42
Adjoining Haveri District (2018)	43
Karnataka State MMR (2014-16)	108
India (2014-16)	130

Validation by internal study of maternal and infant mortality in Amethi

We saw a steady fall in maternal mortality from 2011 till 2017 when it hit a plateau. It dropped from MMR 345 in 2011 to 64 in 2016. Then there was a spurt. In 2017, there were 16 maternal deaths among 14084 pregnancies.

We conducted the root cause analysis and found deaths happened in the institutions or at home, which had no provisions of blood transfusion or an obstetric surgeon. We changed our protocol. Since then, all pregnant women have been directed to deliver in public or private hospitals, which have obstetric surgeons and blood transfusion available. The result is dramatic. In 2019 maternal mortality was 62 among 6502 child births.

Impact on maternal and Infant mortality in Amethi

	2016	2017	2018	2019	TOTAL 16-19
Total pregnancy	26585	21961	14084	10428	73,058
High risk pregnant	1089 (4.1%)	878 (4%)	543 (3.85)	433 (4.15%)	
Institutional delivery	16484 (98.5%)	16418 (99%)	8789 (96%)	6504 (100%)	48,195
Home delivery	247 (1.5%)	165 (1%)	366 (4%)	0	778
Maternal death	4 (MMR 64)	9 (68.3)	16 (MMR 176)	4 (MMR 62)	33 (MMR 68.47)

MMR Maternal Mortality Rate: deaths / 100,000 births

IMR Infant Mortality Rate: Deaths / 1000 births

Population Stabilization program Internal validation of impact in Amethi. Jan 18 to Dec 18

Total population	837,582
Eligible couples	82,014 (164,028 population)
Couples using contraception	34,128
Condom	20,624
Birth control pills	13669
IUCD	1253
Sterilization female	584

Details	Phased out villages	Percent	Not Phased Out	Percent
Total Population Covered	165537		672045	
Newly married Couples	4005		14529	
Newly married Couples Contacted	3607	90%	12501	86%
Using contraceptives	2226	62%	6161	50%
Condom	1208	54%	3544	58%
Oral Pills (Mala N)	533	24%	1370	22%
Saheli (weekly Oral Pills)	384	17%	992	16%
IUCD	101	4.5%	255	4%
Reproductive age couples excluding newly married	12063		52416	
Couples contacted	10658	88%	44206	84%
Using contraceptives	6661	62%	21082	48%
Condom	3617	54%	12255	58%
Daily birth control Pills	1703	26%	4900	23%
Weekly birth control Pills	940	14%	2847	14%
IUCD	236	4%	661	3%
Sterilization female	165	2.5%	419	2%

Phased out villages: Where local community volunteers have taken over the program

Not phased out: where Save a Mother is still working

T B Control Program: March 2012 to December 2018; Amethi

Year	Villages	Meeting held	Participants	Suspected people		Sputum Test done			X-Ray Test			Positive Patients		
				M	F	M	F	T	M	F	T	M	F	T
2012	24	246	8610	1107	2258	839	1082	1921	0	0	0	93	63	156
2013	24	569	19915	1886	3261	636	1195	1831	0	0	0	58	49	107
2014	44	881	22025	1204	2181	876	1106	1982	0	0	0	63	32	95
2015	700	513	9621	1976	2772	1203	1709	2912	0	0	0	56	26	82
2016	700	4530	83921	1148	2491	601	1229	1830	96	135	231	194	136	330
2017	700	4084	76703	1292	1545	793	827	1620	100	90	190	162	110	272
2018	700	3729	66237	1128	1499	848	1029	1877	88	82	170	157	130	287
Total		14,552	287,032	9741	16007	5796	8177	13973	284	307	591	783	546	1329

Validation by external agencies: We have had two external evaluation done by IIHMR Delhi and Sigma. They concurred with our internal assessment. (Note: The external evaluations are expensive. One evaluation costs as much as the annual budget of a district. It creates a dilemma about the proper use of funders money: to use the money for the program or for external evaluation.)

Validation by funder mandated evaluation, monitor and reporting: Our funders monitored our operations regularly. They have conducted audits on our programs. The funding partners have renewed grants repeatedly based on past performance

Cost: Most of the expenses go towards salary of the workers and training of the community.

There are multiple ways of calculating the cost. Annual expenditure per capita of the population varies between INR 4 and INR 15. If looked as cost for end beneficiary population, average expenditure for each pregnant woman will be INR 300. SAM has found an efficient platform of volunteer and paid activists can absorb and lead many programs without significant increase in the cost.

Sustainability: Preventive healthcare, unlike curative care, has no market. It has to be subsidized, promoted and organized from outside. To keep it sustainable, SAM uses two tools: volunteer drivers and low cost. In Amethi and Gadag, we were able to hand over 25% of the villages to volunteer community leaders after 3 years and 25% each year thereafter. We have observed the villages for the past two years and they seem to be self-sufficient. Whether they will be able to carry on the activity for longer time is not known.

Opportunities: SAM faced same challenges which all rural NGOs face: funding and good field workers. This model offers opportunities to explore the application of ESP3 to other social problems like



domestic violence, gender discrimination and drug abuse. Could we apply ESP3 to urban middle class or richer communities? Another opportunity could be the frame public policy informed with field evidence. We also believe that suitable technology needs to be developed to accelerate the scaling up of this program.

Discussion: While multiple theories have attempted to explain the influencing factors of health behaviour, models and protocols for application in a resource poor communities are rare.

Health Belief Model (HBM) postulates that people make healthcare decisions based on perceived susceptibility to disease and consequences. The response is tempered by perceived benefits of action and with a belief that benefits outweigh risks. While this theory, like other theories, builds a plausible reference point to explain behaviour, it gives no guidance for modification of individual behaviour.

Theory of Planned Behaviour suggests that a person should be empowered with ability (Self efficacy) to change behaviour. The person should believe that the behaviour will improve his health and is socially approved. It has also been recommended that principles of marketing could be applied to a social cause, where the product to be sold is behaviour change.

Social Cognitive Theory explains the complex interaction of the individual with the environment. It encompasses the influence of the community on individual behaviour and suggests that change in the social norms is essential to health promotion.

Social marketing theory for application suggests that the principles used for selling products can be used for selling concepts of behaviour change.

SAM model is a hybrid of HBM and building self-efficacy. SAM develops social efficacy through the agency of health activists by using techniques similar to social marketing. SAM ESP3 is a simple, sustainable and a scalable model to reduce disease burden and a poor community and reduce demand on the healthcare system.

Epilogue: Can Covid19 be controlled by SAM ESP3 model?

Our answer is : yes. The current measures to control Covid 19 are social distancing, identification of patients and their quarantine. When a vaccine becomes available, mass vaccination will be the next big public health project. We believe that the SAM ESP3 model, with the help of suitable technology, is eminently suitable to prevent, contain and mitigate Covid 19.



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