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FICCI – ADITYA BIRLA
CSR Centre For Excellence

Sharing of Best Practices

IMPROVING MATERNAL, NEW BORN AND CHILD HEALTH IN INDIA








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This publication is intended strictly as a learning document. The handbook compiling team has used their best efforts in collecting and preparing the material. The information put forth is original script of what has been shared by organization on the projects.

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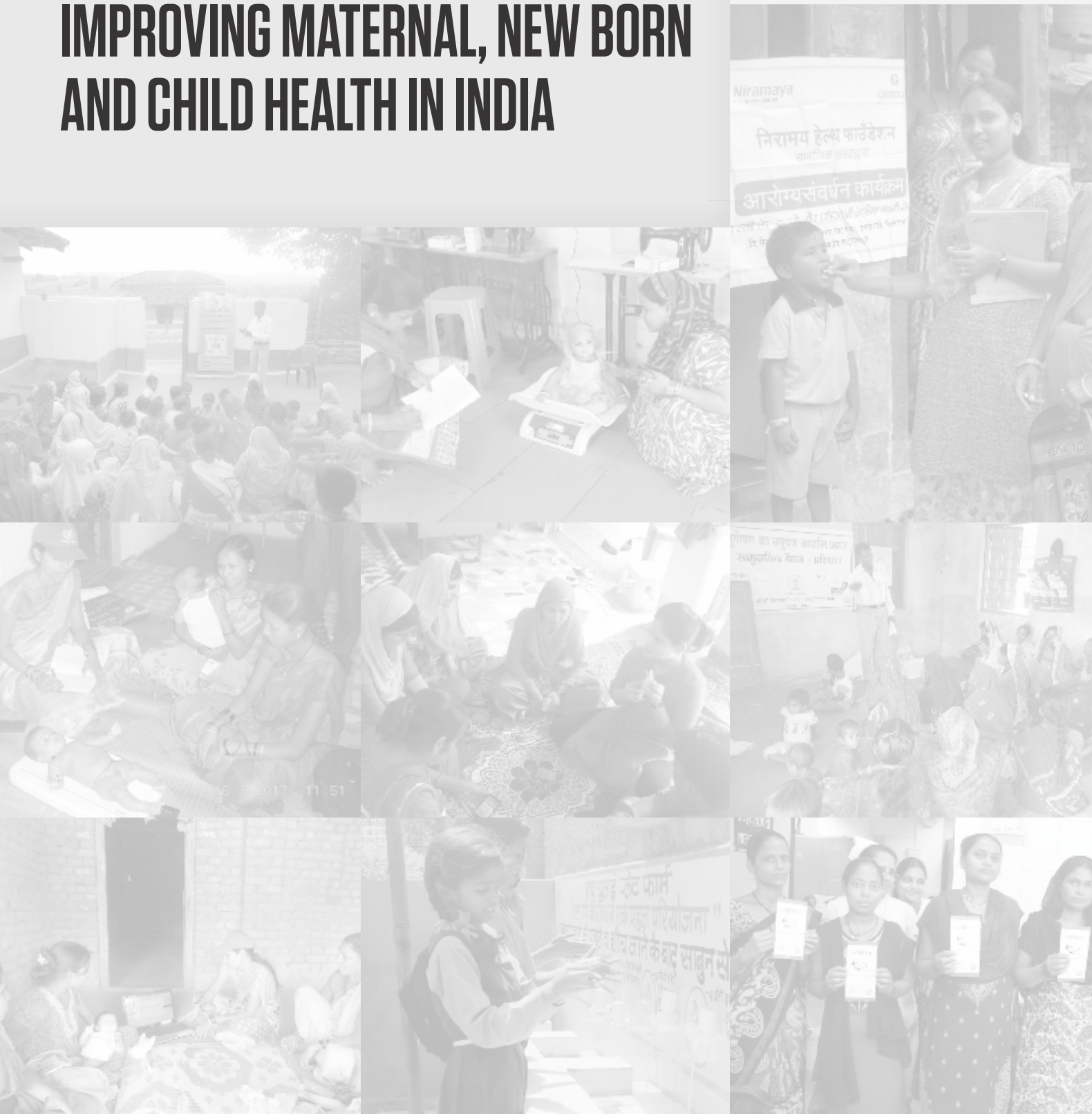

Photo Credit- Hamara Swasthya Hamari Awaz

FICCI ADITYA BIRLA CSR CENTRE FOR EXCELLENCE

FICCI, the oldest and the largest business chamber has been advocating CSR since 1995. FICCI, through its two arms: FICCI Aditya Birla CSR Centre for Excellence and FICCI Socio Economic Development Foundation (FICCI-SEDF), has a long standing practice in designing and implementing CSR Programmes, in partnership with corporate houses and development organisations, as well as directly with the communities. Since then, FICCI has played an advisory role to various organisations in developing relevant CSR strategies. FICCI ADITYA BIRLA CSR CENTRE FOR EXCELLENCE is a joint endeavour of Federation of Indian Chambers of Commerce & Industry (FICCI), a rallying point for free enterprise in India since 1927 and the Aditya Birla Group - a prominent business group with a mission to deliver superior value to customers, shareholders, employees and society at large. It works towards advocacy and capacity building for both Corporates and NGOs and awards Companies for exemplary CSR practices through annual FICCI CSR Awards.

GLENMARK FOUNDATION

Themed around 'Healthier Children, Healthier World', Glenmark Foundation, the CSR arm of Glenmark Pharmaceuticals, is actively working towards improving maternal and child health. Glenmark Foundation aims to encourage a positive health seeking behaviour among pregnant women and mothers with infants, and caregivers towards right nutrition including – good hygiene practices and ensuring complete immunization for children. Along with its NGO partners, the foundation has undertaken several community programs focused towards reducing infant and child mortality among the vulnerable population groups. The various interventions in child health are spread across Madhya Pradesh, Rajasthan, Maharashtra, Himachal Pradesh, Sikkim and Gujarat in India and Nairobi in Kenya.

GLENMARK PHARMACEUTICALS:

Glenmark Pharmaceuticals Ltd. (GPL) is a research-driven, global, integrated pharmaceutical organization. It is ranked among the top 75 Pharma & Biotech companies of the world in terms of revenue (SCRIP 100 Rankings published in the year 2017). Glenmark is a leading player in the discovery of new molecules both NCEs (new chemical entity) and NBEs (new biological entity). Glenmark has several molecules in various stages of clinical development and is focused in the areas of oncology, dermatology and respiratory.

The company has a significant presence in the branded generics markets across emerging economies including India. Glenmark has 16 manufacturing facilities across five countries and has six R&D centers. The Generics business of Glenmark services the requirements of the US and Western European markets. The API business sells its products in over 80 countries, including the US, various countries in the EU, South America and India.

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Photo Credit- Association for Sustainable Community Development (ASSCOD)

Acknowledgement

We appreciate all the leaders and team members of all the organisations that feature in this compendium, for supporting us in our efforts to develop a compendium of successful projects in the field of Maternal Newborn and Child Health (MNCH).

Each of these projects has contributed significantly towards developing ground-breaking service delivery models and best practices in the area of Maternal and Child Health in India.

Foreword

Though India has achieved a significant reduction in below five neonatal infant and maternal mortality ratio, the rates are still very high in many parts of the country. Strengthening neonatal health care is crucial as maximum mortality and morbidity occurs in below age five. Even today, efficient Indian health care systems are still lacking. In addition to early sepsis, communicable infections, malnutrition forms the main bulk for high mortality. On the other hand, survival of low birth weight (LBW) is on the rise due to superior expertise in neonatal intensive care units.

Under the National Health Mission (NHM) of Government of India, evidence-based interventions to improve maternal and child survival are being promoted. Many challenges are being faced by programme managers while implementing these programmes.

FICCI, the oldest and largest business chamber has always been in the forefront to advance and advocate the social development goals of the nation. We have been mobilising India Inc's efforts to address various developmental gaps and support the initiatives of the Government through CSR.

Being an important stakeholder of India's inclusive and sustainable development journey, FICCI understands the need of the hour is integration of thoughts and ideas and processes in order to meet the humongous challenge put forth by the health scenario of the country.

It is with this view that FICCI has taken the lead with initiatives such as 'Swasth Bharat', an initiative on public health. This high level Task Force set up in 2016, includes members from the government, industry and multilateral and bilateral organisations. The focus areas are Non-communicable diseases (NCD) & Mental Health, Road Safety and Emergency care and IISH (Indian Industry in Solidarity for Health) Kosh.

IISH Kosh was launched by FICCI to work collaboratively with the Government to meet health challenges of the country. The aim of the IISH Kosh is to bring under one umbrella, Health experts, Academics, Industry, Civil Society groups, Financial Institutions, media, donors/ bilaterals/ multilaterals and others to create a knowledge pool, identify priority areas in the health sector in alignment with Government goals for appropriate channelization of CSR funds. The IISH KOSH shall work as an aggregator of fund, knowledge and networks with nationwide outreach. IISH Kosh has been endorsed by Ministry of Health and Family Welfare, Government of India.

I take this opportunity to extend my appreciation to Glenmark Pharmaceuticals Limited for highlighting and addressing this important issue of our country and also our NGOs for sharing their initiatives from the field. I look forward to this initiative touching the lives of our children and women.

Jyoti Vij
Deputy Secretary General
FICCI

Foreword

It is a truism entailing no further emphasis that India accounts for a significant percentage of the child deaths under the age of five, notwithstanding the fact that a healthy life lays the template for the firm foundations of a healthy nation. Today's children are the foundations of tomorrow's future and so it is incumbent upon us to ensure a healthy atmosphere for the nurturing and development of our children. Over the last decade the percentage of child deaths have dwindled owing to various interventions including better nutrition and medical facilities. To this end, not only the government but also the non-governmental sectors have joined hands. However India still has an uphill task for remedying this problem of maternal and child health.

Glenmark Foundation has been relentlessly working to make a difference in the lives of children and women given its fervent belief that every individual has the right to live a healthy life. This book will certainly be a reference for those wishing to know and understand the role of NGOs and civil society organizations all over India (with a focus on 33 case studies) along with the best practices to support maternal and child health as well as to promote the Sustainable Development Goals. It will be a beginning with regard to this ambitious effort that is been undertaken and of which Glenmark Foundation and FICCI happen to be major stakeholders.

Best Regards,

Cheryl Pinto
Director, Corporate Affairs
Glenmark Pharmaceuticals Limited

Introduction

A healthy start to life is vital in establishing the foundation of a healthy nation. India contributes to 17.5% of the world's population and nearly one-fifth of the total live births.

Even though child deaths in India have been halved in the last 15 years owing to better nutrition, healthcare, and standards of living, even today, India contributes significantly to the annual global tally of deaths of children under five years of age.

In India, every 20 seconds a child under the age of 5 dies due to causes which could have been prevented, like pneumonia, preterm complications, new-born infections, diarrhoea, birth complications and malaria. India also observes over 30 million pregnancies every year and of this, 27 million women reach the stage of delivery and over 56,000 mothers die during or within 48 hours of delivery. As per the Medical Council of India, there is one government allopathic doctor for every 1,668 people. Strengthening primary healthcare hasn't got the priority it needs and the sick reach hospitals after faith-healers, quacks and other unqualified practitioners fail to cure them.

The Government of India (GoI) recognizes healthy mothers and decreasing child survival is essential for the overall development of the society and has progressively strived for the dramatic reduction in maternal and child mortality rates over the past two decades.

Two important milestones in this direction have been the National Rural Health Mission (NRHM) which focused on public investment in strengthening health systems. Schemes under it such as Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakram (JSSK), Facility Based New Born Care (FBNC) and Home Based New Born Care (HBNC) are steps towards ensuring zero out of pocket expenditure and improving access to healthcare for the vulnerable sections of society and the Reproductive, Maternal, Newborn, Child and Adolescent Strategy (RMNCH+A Strategy) was developed by the Government of India to accelerate progress toward these goals and focus more attention on key high impact interventions in India's 184 High Priority Districts (HPDs) which span 29 states and Union Territories.

Standing firm on India's commitment in the 67th World Health Assembly, India Newborn Action Plan (INAP) is another step that has been taken towards India's commitment to the global agenda and affirming its priorities for new born. The policy outlines a targeted strategy for accelerating the reduction of preventable newborn deaths and stillbirths in the country. Complementing this, the Government of India also launched Clean India (Swacch Bharat Abhiyan) and Beti Bachao, Beti Padao (Save Girls, Educate Girls) to strengthen the health of mothers, newborn and children.

While there has been remarkable growth and innovation in national policies over the last few decades. There has been significant decrease in neonatal mortality rate even though a large proportion of new-born deaths are preventable. India does not have enough hospitals, doctors, nurses and health workers, and since health is a state subject, disparities and inequities in the quality of care and access to health varies widely not just between states but also between urban and rural areas.

Similarly, a majority of Indian women, especially in the rural areas, still lack access to basic health amenities. Many women are bereft of care during pregnancy and childbirth due to poverty, distance, lack of information, inadequate services and cultural practices.

In the last decade, significant investments have been made to improve health care that are likely to have additional impact on the status of maternal, newborn and child health in India. Understanding the need for equitable, affordable, accountable and effective primary healthcare facilities, many non-government organizations, social development organisations, CSR wings of corporates are experimenting and innovating to ensure high quality, sustainable, low-cost maternal and child healthcare services.

In the book, we have identified and documented 33 case studies on maternal and child healthcare initiative in India and their different approaches by non-profit organisations. This compendium documents interventions by civil society organisations to strengthen maternal, newborn and child health in various parts of India. The case studies also aim to aid non-profit organisations, teachers to educate students in medical, public health and CSR professionals on ways to strengthen maternal, newborn and child health.

Aahar

2012-2015

SNEHA (Society for Nutrition, Education and Health)

Website	:	www.snehamumbai.org
Founder of the Organization	:	Dr. Armida Fernandez
Project Budget	:	₹ 9.8 crores
Coverage/ Geographical reach	:	10 beats in Dharavi (over 31,000 children and 6000 pregnant women

Project Brief

The *AAHAR* program was implemented in Dharavi, covering 300 Anganwadis (crèches) with the goal of reducing wasting (low weight for height) by 25% among children under three years of age, in partnership with the ICDS and the Municipal Corporation of Greater Mumbai. In total, the program has directly served 37,480 children and pregnant women across 110,468 households. AAHAR follows the Community-based Management of Acute Malnutrition (CMAM) principles and adopts a two-pronged approach to impact and reduce the prevalence of child malnutrition: (a) working with communities to improve care-seeking behavior and increasing access to health services; (b) working with local Government stakeholders to ensure high quality of service delivery. The program pivoted from a daycare centre that was dependent on physical infrastructure to a light-weight, scalable, community-based model of intervention.

The program was delivered at the community level by SNEHA field staff, known as Community Organisers, and focused on early screening and treatment of children and behaviour change communication for pregnant women and mothers. As per SNEHA's baseline study, over 30% of children under three in Dharavi were stunted and nearly 30% of them were underweight. Unhealthy living conditions in Dharavi, including lack of access to safe water, visible open sewers, limited pathways, uncontrolled dumping of waste and inadequate sanitation, can pose serious health risks, especially for young children. SNEHA's experience in Dharavi has shown that environmental and infrastructural problems affect the health and nutrition of infants and young children.

SNEHA's first intervention on Child Health and Nutrition commenced in 2009 in Dharavi, one of the largest slums in Asia, with two Day Care Centers catering to approximately 20 children in each center. After gaining some experience in managing this program, SNEHA upscaled its intervention in Dharavi through the Aahar program in November 2011. From two centres we expanded to five centres to cater to children in the catchment area of 150 Anganwadi in two four phases over a period of two years. We realized the lack of perceived need of such centres and gaps in the understanding of malnutrition in the community. We decided to adopt a model that devolved greater responsibility on the community and adopted the WHO CMAM model. The iterative development of the program saw a change in focus from addressing undernutrition to treating wasting with a RUTF as recommended by WHO; from community volunteers to full time paid staff and protocolized intervention in all 300 ICDS Anganwadis in Dharavi to intensify the home-based care to ensure changes in the care practices of children in the 0-3 years, pregnant and lactating mothers. We have learnt to balance the work in communities and with ICDS; to motivate both mothers and families as also ICDS staff; we have stretched ourselves to run the largest urban malnutrition project in Asia to deliver a reduction in child malnutrition using an electronic supervision and monitoring system. The project has covered till date, an estimated population of 300,000 in Dharavi, 300 ICDS Anganwadis, 31,000 children in the 0 to 3 years age group, 6000 pregnant and lactating mothers.

Implementation Model

A team of three program coordinators, ten officers, 75-100 community organizers ran the intervention supported by a pediatrician, monitoring a team of six staff and admin team of two staff and led by the Associate Program Director and Program Director. The intervention:

- Screening of children was done at the Anganwadi jointly with the ICDS on a monthly basis, using WHO guidelines and the metric, weight-for-height (wasting) to determine nutritional status. The program targets the most vulnerable children who are suffering from Severe Acute Malnutrition (SAM) or Moderate Acute Malnutrition (MAM). Referrals are made to a pediatrician, the local government municipal hospital or the Nutrition Rehabilitation and Research Centre at Urban Health Centre, Dharavi

- Medical screening in community pediatric health camps or in the Nutrition Research, Rehabilitation and Training Centre, Urban Health Centre, Dharavi and at Sion hospital,
- Appropriate outpatient treatment and referral for inpatient care and follow up,
- Referral for complete immunization to MCGM health posts and outreach camps,
- Enrolment in the Community based Management of Acute Malnutrition (CMAM) Program, observed feeding and support for improved home feeding and hygiene practices through home visits and weight gain monitoring,
- Support to pregnant and lactating mothers for appropriate antenatal and postnatal care,
- Group sessions of mothers for peer learning, community events for sensitization to child malnutrition,
- Training of ICDS Anganwadi workers and supervisors for improvement in the quality of their services,
- Convergence workshops and monthly meetings of ICDS and MCGM to build rapport, improve collaboration and reduce duplication of effort.

All processes were standardized in protocols, rigorous program staff training, on the field supervision, electronic documentation, real-time data collation and feedback of performance to the field team on a monthly basis and quarterly program reviews.

Community Outreach

AAHAR has been recognized as India's first urban model project, implemented on the principles of Community-based Management of Acute Malnutrition (CMAM). Designed and implemented to bring about a 20% decline in malnutrition among children under three years of age in Dharavi, the program reinforces sustainable behavior changes among primary caregivers. Community Organisers (COs) serve as nutrition link workers within the intervention area to facilitate access and treatment through available Government services and schemes. COs screen children and pregnant women to identify early signs of malnutrition, conduct regular growth monitoring at Anganwadi centres in conjunction with ICDS and conduct home-based counseling sessions on feeding and care practices. Medical assessments are conducted in community-based pediatric health camps. Other community processes include group activities for caregivers and community events for sensitization to child malnutrition. Monthly events such as Khana Khazana, Ustavan, Godbharai and campaigns held during Breastfeeding and Nutrition weeks aim to bring about behavioural and attitudinal changes within the community.

Uniqueness of the Project

A key facet of the program was that it collaborates with and closely mirrors the structure of existing government programs, namely the ICDS and its key components, Anganwadi (crèche) and the Anganwadi frontline worker, the sevika. SNEHA not only involves the government field staff in its activities but also conducts on-going trainings for sevikas to equip them with the required growth monitoring and critical response skills required to tackle malnutrition This alignment allowed Aahar to

provide the government with a replicable intervention model with valuable insights into the resources and activities required to improve nutrition levels in the community.

Role of Information and Communication Technologies (ICTs)

Technology-based data collection in development programs poses interesting challenges: they are often used by Frontline Workers (FLW) with minimal technical expertise and in densely populated slums where data connectivity might be unreliable. Electronic data collection has multiple benefits including real-time data collection, a potential for analysis and processing and more targeted programming, such as behavioural change communications to beneficiaries who actually need it. In addition, it also improves the overall quality of data and maximizes efficiency, accuracy while also saving significant resources and time.

For the AAHAR project, data was collected on smartphones and stored on the CommCare database, replacing manual registers and data entry. The CommCare software has the ability to automatically calculate the nutritional status, Estimated Date of Delivery and the age, this minimizes errors in data collection and processing to a great extent. The interface also has checks to prevent entering of invalid data and does the first level cleaning of data automatically. The data is stored in the CommCare Cloud-based repository to enable case management and to monitor activities to improve the intervention. Apart from greater efficiency and transparency, the FLWs mentioned the unexpected benefits of using electronic data collection methods- having their families and communities view them as tech-savvy and productive members of society.

Challenges Faced

AAHAR has been recognized as India's first urban model project, implemented on the principles of Community-based Management of Acute Malnutrition (CMAM). Designed and implemented to bring about a 20% decline in malnutrition among children under three years in Dharavi, the program reinforces sustainable behavior changes among primary caregivers. Community Organisers (COs) serve as nutrition link workers within the intervention area to facilitate access and treatment through available Government services and schemes. COs screen children and pregnant women to identify early signs of malnutrition, conduct regular growth monitoring at aanganwadi centres in conjunction with ICDS and conduct home-based counseling sessions on feeding and care practices. Medical assessments are conducted in community-based pediatric health camps. Other community processes include group

activities for caregivers and community events for sensitization to child malnutrition. Monthly events such as Khana Khazana, Ustavan, Godbharai and campaigns held during Breastfeeding and Nutrition weeks aim to bring about behavioural and attitudinal changes within the community.

The following are the strategies that the AAHAR program used with a high degree of success:

1. At the core of SNEHA's beliefs is that public health workers want to do their best for the community and given enough support and by working with them to upskill their competencies and motivating them, they will provide optimal care and support to the community's health needs. Rather than working in a silo, AAHAR worked with the ICDS machinery to help them carry out critical growth monitoring and follow-up activities.
2. SNEHA facilitated ongoing interaction and engagement between ICDS and the community, through joint events, meetings and workshops. This helped motivate the ICDS staff, who were able to receive real-time feedback from the community. It also helped to improve care-seeking behavior among stakeholders in the community and creating a need for sound health and nutrition as well as a friendly disposition towards the Aahar program.
3. Convergence workshops were held and attended by SNEHA staff members as well as members from ICDS and MCGM. These workshops included activities like joint capacity building, sharing of positive experiences and trading feedback.
4. Implementation protocols went through multiple iterations based on real-time feedback, need and analysis. This added a layer of complexity to program implementation and the Senior Staff had to ensure clarity and explain changing responsibilities and protocols to the field staff.
5. Intra and inter-slum migration, as well as migration from Mumbai, was a recurring challenge. It is estimated that the project period saw a 25 to 30% migration and movement. This would invariably affect the health and nutritional status of women and children. Sustaining behavioural changes, such as optimal infant feeding, too, was a challenge due to the above factors. To ensure that no child from the intervention area is left out, field teams were given monthly targets for enrolling

Outcomes

- By July 2014, the program was successfully scaled up to all 10 beats covering over 1,10,468 Households
- 31,075 children and 6,405 pregnant women were screened over the four years. Of its core beneficiary group (children), 83% were children below the age of 3.
- SNEHA trained over 300 Child Development Project Officers, Anganwadi sevikas and supervisors through the program.
- In the year 2015 alone, over 500 community mobilization events, 200 health camps and over 3000 group meetings were held, reaching over 16000 participants

Outreach & Scalability

The new Phase of AAHAR is being implemented in Dharavi, since 2016, with a more indirect implementation approach and focusing more on hand-holding and capacity building role, where SNEHA is working with ICDS and MCGM to develop the effective implementation skills that affect the health and nutrition of children in the community. SNEHA is also working towards building the community's ownership towards Government services and empowering them to seek services from the Public Health System.

SNEHA's Aahar program intervention has worked in partnership with the systems and communities. In the new phase, we have gradually increased the responsibility of ICDS services to enable them to undertake critical activities relevant to child health and nutrition, with progressively reduced support from SNEHA Community Organizers and other levels of staff. This has involved considerable investment in the capacity building of all cadres of ICDS staff by SNEHA staff.

While we address issues on the supply side, we accept that we need to address the awareness and uptake of ICDS services by the community. To increase knowledge and bring about behavior change in the community, we have worked on educating mothers and caregivers on different aspects of child health and nutrition, sanitation, hygiene and the services they are entitled to from ICDS and MCGM. We now build the capacity of the community to expect, demand and negotiate availability and improved quality services from ICDS and on the other hand, to demonstrate their responsibility for the community mothers and young children. We act as facilitators for the community to act as the catalyst for sustained change.

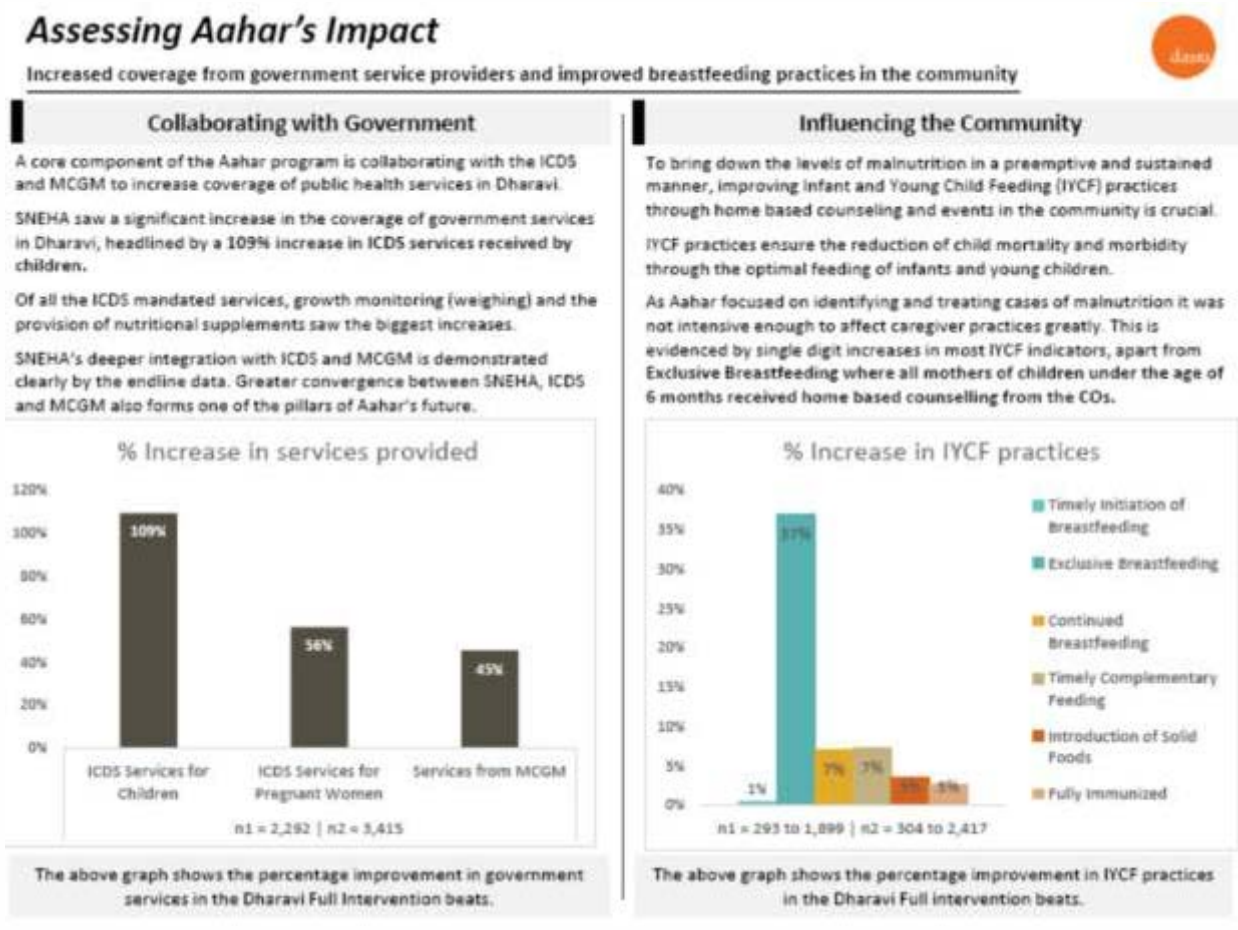
SNEHA has focused its efforts in the Aahar program on reduction of malnutrition i.e on moderate and severely malnourished children through well supervised protocolized intervention. In the new phase, we have increased the scope of our work to the prevention of malnutrition by also focusing on normal children to prevent growth faltering and reduce children slipping into moderate and severe malnutrition.

Replicability

Aahar has proved to be a high-impact, cost-effective, community-based model to tackle child malnutrition while working in partnership with public health systems.

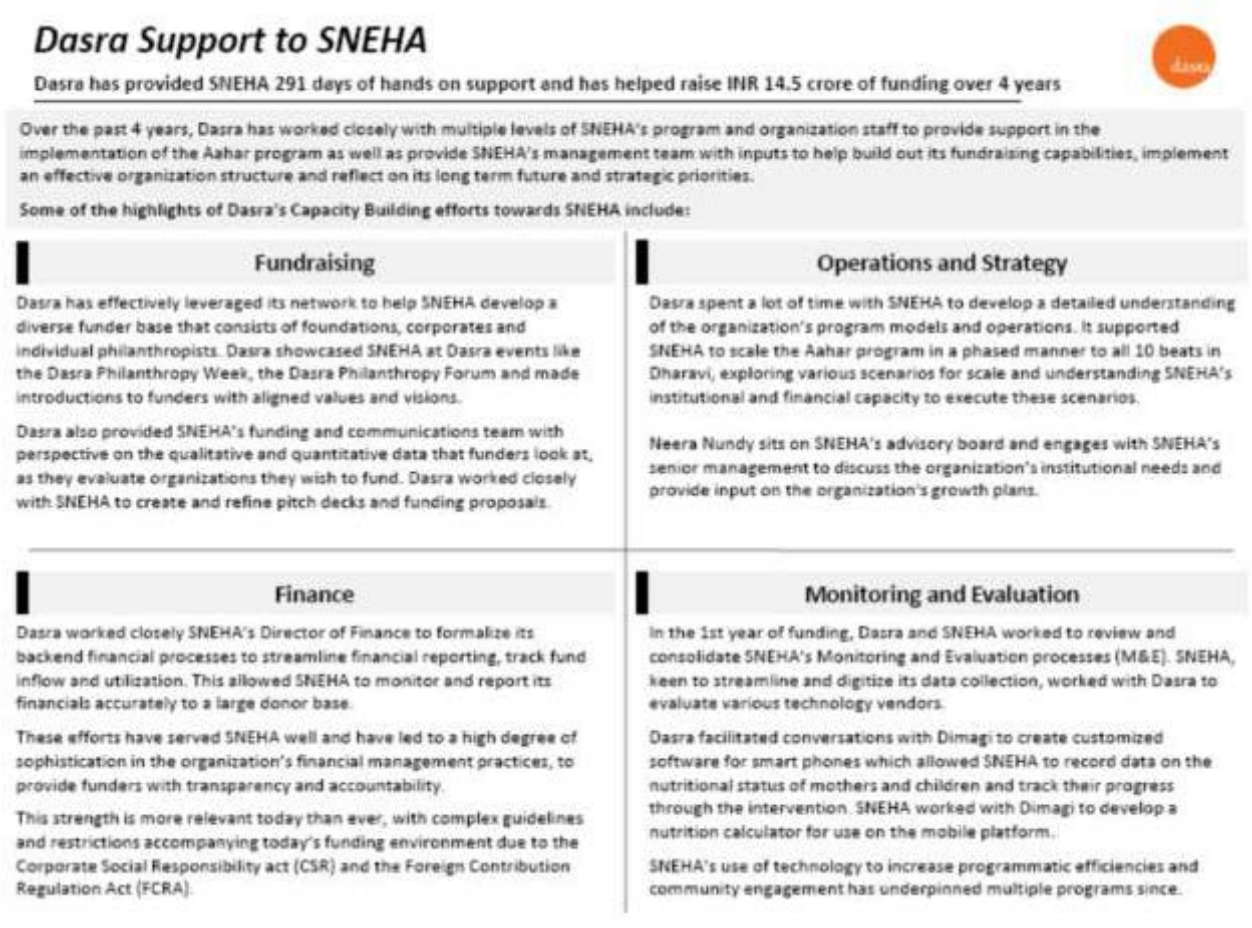
Impact Achieved

SNEHA conducted quantitative assessments of its program in all 10 beats of Dharavi. A control area of Wadala was evaluated to determine whether outcomes were possibly affected by secular trends. The project was able to reduce levels of wasting from 18% to 13% achieving an overall 29% reduction in the Full Intervention (FI) beats. The control area of Wadala recorded a reduction of 5% in levels of wasting. Adjusting the % reduction in wasting in Dharavi with the reduction seen in Wadala, SNEHA's Aahar program achieved a 23% net reduction in wasting levels. The program also saw a significant increase in the coverage of government services in Dharavi, headlined by a 109% increase in ICDS services received by children. Of all the ICDS mandated services, growth monitoring (weighing) and the provision of nutritional supplements saw the biggest increases.



Through its impact assessment studies, SNEHA's AAHAR program has been able to prove that a well implemented CMAM model can reduce malnutrition prevalence rates in an urban slum setting in a time-bound and cost-effective manner. By mirroring the organization and field staff structure of the ICDS and collaborating with existing public health institutions, SNEHA has implicitly demonstrated that the AAHAR model can be potentially replicated and scaled across the country. In terms of cost-effectiveness, SNEHA's CMAM program recorded an estimated cost of USD 23 per DALY averted. The cost of a DALY averted through the CMAM program compares favorably against in-patient care cost (treatment in a medical facility). SNEHA also found that the cost borne by the parents (of a malnourished child) were lower through the CMAM approach.

Capacity Building



Dasra Support to SNEHA

Dasra has provided SNEHA 291 days of hands on support and has helped raise INR 14.5 crore of funding over 4 years

Over the past 4 years, Dasra has worked closely with multiple levels of SNEHA's program and organization staff to provide support in the implementation of the Aahar program as well as provide SNEHA's management team with inputs to help build out its fundraising capabilities, implement an effective organization structure and reflect on its long term future and strategic priorities.

Some of the highlights of Dasra's Capacity Building efforts towards SNEHA include:

Fundraising

Dasra has effectively leveraged its network to help SNEHA develop a diverse funder base that consists of foundations, corporates and individual philanthropists. Dasra showcased SNEHA at Dasra events like the Dasra Philanthropy Week, the Dasra Philanthropy Forum and made introductions to funders with aligned values and visions.

Dasra also provided SNEHA's funding and communications team with perspective on the qualitative and quantitative data that funders look at, as they evaluate organizations they wish to fund. Dasra worked closely with SNEHA to create and refine pitch decks and funding proposals.

Operations and Strategy

Dasra spent a lot of time with SNEHA to develop a detailed understanding of the organization's program models and operations. It supported SNEHA to scale the Aahar program in a phased manner to all 10 beats in Dharavi, exploring various scenarios for scale and understanding SNEHA's institutional and financial capacity to execute these scenarios.

Neera Nundy sits on SNEHA's advisory board and engages with SNEHA's senior management to discuss the organization's institutional needs and provide input on the organization's growth plans.

Finance

Dasra worked closely SNEHA's Director of Finance to formalize its backend financial processes to streamline financial reporting, track fund inflow and utilization. This allowed SNEHA to monitor and report its financials accurately to a large donor base.

These efforts have served SNEHA well and have led to a high degree of sophistication in the organization's financial management practices, to provide funders with transparency and accountability.

This strength is more relevant today than ever, with complex guidelines and restrictions accompanying today's funding environment due to the Corporate Social Responsibility act (CSR) and the Foreign Contribution Regulation Act (FCRA).

Monitoring and Evaluation

In the 1st year of funding, Dasra and SNEHA worked to review and consolidate SNEHA's Monitoring and Evaluation processes (M&E). SNEHA, keen to streamline and digitize its data collection, worked with Dasra to evaluate various technology vendors.

Dasra facilitated conversations with Dimagi to create customized software for smart phones which allowed SNEHA to record data on the nutritional status of mothers and children and track their progress through the intervention. SNEHA worked with Dimagi to develop a nutrition calculator for use on the mobile platform.

SNEHA's use of technology to increase programmatic efficiencies and community engagement has underpinned multiple programs since.

Partners of the Project

Dasra- Funders (through a group of inidividuals, known as the Dasra Giving Circle) as well as capacity building partners.

MCGM and ICDS- public health system implementers and delivery of services to target communities.

Measurement of weight Aarogyasanvardhan Project

Aarogyasanvardhan Program

2017 - 2018

Niramaya Health Foundation

Website	:	www.niramaya.org
Founder of the Organization	:	Dr Janaki Desai, Founder and Hon. Medical Director
Project Budget	:	₹ 32 Lakh
Coverage/ Geographical reach	:	Marol Pipeline, Andheri

Project Brief

It was seen that there are many children who are underweight as per our baseline survey. Then Niramaya Health Foundation tried to look after the causes of the malnutrition in children. It was observed that there were many issues in the community from the nutritious diet, hygiene, sanitation, congested houses, water problem and so on. which were leading these children to malnutrition. It was also seen that not only the children but their mothers are also anemic, malnourished. So Niramaya Health Foundation laid down some strategies to fight against this malnutrition in children and mother. To perform this task Niramaya Health Foundation deployed a team of health workers, a social worker at the field level and a program officer for management part.

Intervention camp-Aarogyasanvardhan Project

1) Home visits – identification of key population
2) The intervention of key population
3) Rigorous follow up of the intervention cases
4) Daily filling of Health card, ANC card, PNC card and updating the Care Mother App with the data.
5) Analyzing the data is done on monthly basis.
6) Monthly meeting with PEER Educator, stakeholders, govt. officials for strengthening referral system, activities and event in the community.
7) Monthly parents meeting of the malnourished children.

Implementation Model

1. Home visits:-

From the day one of the project Niramaya Health Foundation believes that home visit is the backbone of the project, it not only helps in building the rapport with the community people but also helps to identify the accurate cause behind the problem or issue.

Home visits are done regularly to identify key population and health needs and for rapport building with adolescents and women.

2. Intervention with children (0-2 years):-

The children identified during home visits are then addressed through intervention. The health worker carries a weighing scale and a health card of the family along with the growth chart. The

weighing of the baby is done on monthly basis and if growth is not seen, the health worker then refer those children to a nearby health facility. The health worker also notes down the immunization status of the child in the health card.

During the home visit, along with the weighing the health worker also creates awareness about the importance of

1) Exclusive breastfeeding practices,
2) Infant, child and young feeding practices (side effects of bottle feed)
3) Immunization
4) Complimentary feeding
5) Demo of Paushtik powder (made from regular pulses at an affordable cost)

In the group session with the help of flip charts, documentary, songs, rallies, events like Anna Prashan.

Lactating mother intervention- Aarogyasanvardhan Project

3. Intervention with children (2-10years):-

This group is identified during the home visit; the health worker takes the weight and height of the child and plots it on the growth chart.

The growth chart is then explained to their parents and then tablet are given accordingly. In most of the cases, first Albendazole stat dose of 400 mg is given, then iron supplement is given for 10 days and later follow up is done to rule out any allergies or side effect of the supplements. The iron supplements are given for 100 days. And Tab. Albendazole is given half yearly.

The intervention is carried out thrice in a year i.e. quarterly basis. After the first intervention is done, the Paushtik powder is distributed to the children who come in the malnutrition grades.

4. Intervention with pregnant women:-

The pregnant women are identified during home visits, their Antenatal card is filled along with the family health card. ANC card contains detailed history of the pregnant women and the Antenatal checkup visits. The pregnant women are counseled about the trimester wise messages on importance diet, rest, ANC visit, investigation to be done during pregnancy. And referral is done for early registration, investigation, immunization and supplements. The focus is also given on the importance of institutional delivery.

Powder Distribution-Aarogyasanvardhan Project

Some of the pregnant women do not get supplements from the facility, then Niramaya Health Foundation provides them with IFA and Calcium tablets.

5. **Intervention with lactating mother:-**

The identified lactating mothers are counseled on importance of exclusive breastfeeding for first six months, timely immunization and weaning practices to start after 6 months. The women are advised by the health workers to follow a family planning method through a session.

Community Outreach

The communities are reached through door to door- home visits, intervention, health awareness session- in the group and one to one interpersonal session, activities like Annaprashan, Godbharai (baby shower), parents meeting of malnourished children, Paustik powder demonstration, nutrition recipe demo, Sanitation meeting and through events like breastfeeding week, nutrition week, children's day, youth day, Cleanliness drive and international women's day.

To reach out to the masses the health worker, identify the stakeholders and volunteers from the community through stakeholder meeting.

To address the health needs of the community, Niramaya health Foundation also looks to the get the support from the facility side i.e. MCGM health post and dispensary as well as the ICDS who looks after the nutrition of children from 3-6 years age group. This is done through the networking meeting with authorities of MCGM and ICDS by the program officer and project coordinator, while the health worker does the field level meeting.

FGDs--Aarogyasanvardhan Project

Uniqueness of the Project

- **Annaprashan-** This is a half-yearly birthday, the mothers of the 6-month-old baby are counselled to start with soft, semisolid food along with breastfeeding.
- **Godhbharai**- The baby shower is celebrated with ICDS in the community for pregnant women. In this activity the focus on newborn care, birth preparedness, and importance on institutional delivery.
- **Nutritional recipe demo**- Initially it was seen that the children were in malnourishment due to malpractices of cooking practices, so address this Niramaya Health Foundation started with the demonstration of nutritious recipe at low cost. Later we had organised nutritious recipe competition for the community women.
- **Paustik powder demo**- This is a high protein rich powdered demonstrated by our health worker in the community for malnourished children, pregnant women and anaemic adolescent and community women.
- **Health Libraries**- These are the libraries kept in the community which has booklets on health topics such as environmental and personal hygiene, addiction, tuberculosis, ANC care, Anemia, Nutrition etc.
- **Peer Educator**- These are the community women, identified by the health workers of Niramaya Health Foundation who participates in the activities of Niramaya Health Foundation on a voluntary basis. There is a health education training for the Peers, later these Peers themselves address the queries of the community women in groups through health awareness session.

Role of Information and Communication Technologies (ICTs)

To track high risk pregnancy in the community, Niramaya Health Foundation use a technology which has the sphygmomanometer, foetal Doppler, Hb testing kit, Accu check to rule out diabetes, urine testing, weighing scale, stethoscope and all the reading or the data is filled in the mobile app name CareMother which show the result by highlighting the high-risk pregnancy according to the various categories, such Pregnancy-induced hypertension, pregnancy-induced diabetes or anemia etc.

Challenges Faced

Home Visits-Aarogyasanvardhan Project

The project has completed its sixth year in the community. Over these 06 years, the activities have been replicated in new communities of Marol pipeline. The Main constraint of the project are

1. Due to lack of space in communities conducting health sessions becomes an issue, yet effort is made to conduct the session with the women in their houses or in common areas of the community if available.
2. Most of the women working as domestic workers are not available in morning time for any activities. Timings were adjusted for health sessions and other activities in accordance with the time available to community women.
3. The major challenge was to reduce the malnutrition level to the lowest and carry malnourished children into normal status. This has significantly shown the impact of 50% change. Effort has been made to provide nutrition education and cooking demonstrations to mothers for dietary modification to increase protein intake by children; also address the issue with providing Food Grain Supplements from different donors to the malnourished children.
4. Timely immunization of every child is a major challenge; Team has developed a good rapport with community women and children. This has helped us a lot in covering children to complete immunization with the help of Community Health Volunteer.
5. The misconception with respect to breastfeedings and weaning practices.

Outcomes

The project has developed a good ground level rapport with the community. Women in the community help in mobilization for behaviour change communication activities, like health education sessions, event participation. This project has the strength of 51 Peer Volunteers identified from the community. These Peers are vigorously trained on health curriculum and every year through capacity building workshop. This is conducted as a part of sustainability efforts and to be future community leaders.

As per the proposal and annual action plan,

- Through the 4342 home visits, reached around 6,564 families covering around 20,300 beneficiaries for conducting intervention camps for below 06 years children with regular followed up, Pregnant and Lactating mother & Women, Identifications of Peer, provided Health awareness session for community women.
- Reach out to 89400 Pregnant women and lactating mothers over a period of 6 years

- Timely Immunization for143 children and 95% children are completely immunized
- 100% Hospital registrations and institutional deliveries
- Provision of IFA and multivitamins and calcium to identified lactating mothers
- 25 active Health libraries in the community
- Adolescents trained for Family Life Education- 754
- Personal Hygiene kit to 100 kids- Maintained by kids
- Acceptance Family Planning Methods- 44 women
- Peer Volunteers Identified- 52 Peers
- Capacity Building workshop- to strengthen skills
- Peers support to promote health – Mobilization
- Job Placements- 8 peers
  - 03 work as Community Health Volunteer (conduct health trainings-WVI)
  - 01 works as Health Supervisor in an NGO (fulltime in the clinic- Swasth India)
  - 02 work as Balwadi Teachers in an NGO (Mumbai Smile)
  - 01 work as Health Trainer in an NGO (Mumbai Smile)
  - 01 work as Health Coordinator in an NGO (mMitra)

Outreach & Scalability

Total 51 peers identified from the community; voluntarily participate in community mobilization. They also have some added responsibilities:

- Organizing Health sessions- min 5 sessions by each pair of peer every month
- Help in Organizing Checkup camp- mobilizing communities
- Help in planning Marker days- Promoting community participation

Getting registered for PARA-Professional Course - peers to enrol on a pilot basis- still open

Health libraries at household level will be continued through peer volunteers.

Use of First AID box- after completing the course, first Aid boxes will be made available for emergency care in the community. This would also give them additional recognition and appreciation in the community for their work.

Hygiene kit, food grain supplementation program will be continued by Peers in the community for children or malnourished children

Replicability

The program can be easily integrated into other location with all the activities of the program.

Impact Achieved

- Community participation in an increase and demand for health sessions
- Couples being convinced for the usage of family planning methods
- Records of weight and height of malnourished kids
- Increased levels of awareness about the importance of ANC and PNC
- Increase in the registration of nearby hospitals for deliveries.
- Community population convinced of the benefits of immunization
- Increased number of children immunized, and increased referrals for immunization, immunization during pregnancy
- Behaviour change towards women health during pregnancy and post-pregnancy care

Capacity Building

- Annual Capacity Building Program is organized for the staff in the month of June, firstly to brush up, enhance and strengthen their knowledge and skills and secondly to evaluate their capacity for ongoing project activities.
- Conducting exams after the training the sessions to evaluate the knowledge gain through the sessions.
- Calling of renowned resource persons for various talks on health from renowned organizations, institutes and firms.
- Workshops are conducted using multimedia content, such as videos, informational and demonstrative graphics, and multiple-choice quizzes, to remind HWs of important maternal health concepts and to educate the pregnant women they attend.
- This year staff has been asked to make presentations on various health topics and provide the training. This has changed them from listening mode to presenter.
- Fortnight meetings are conducted to get the update about the work and to decide the strategies that need to be adopted to overcome the hurdles or issues of the community.
- Monthly and weekly planning is carried out to make sure the efficient and smooth working of the team.
- Conducting of monthly meetings of the staff to share their community experience, challenges and update the management about the current status of their work. The probable solutions for those challenges are discussed.

- Conducting training sessions and lectures on several health issues for the team members, so that they are aware of the scientific development in the field of healthcare.
- Exposure visits along with peers are conducted to make them aware of development in various sectors.
- A group called Lakshvedhi has been created, where staff write a script on themes given to them and form street play. This training was specially organized in capacity building workshop.
- Workshops address prevention and education activities related to:
  - Physical activity and nutrition for women and children
  - Reproductive health of women by decreasing the rates of STD's and unintended pregnancies.
  - The importance of breastfeeding during the first six months of age.
  - HIV/AIDS
  - Healthy pregnancy and childbirth services, and other maternal health issues.

The capacity of health workers to provide safe motherhood and newborn care services in the target area is strengthened through these workshops. They also help to build the capacities of health workers, particularly in identifying high-risk pregnant women who need higher levels of care.

Partners of the Project

Glenmark Foundation has been the CSR partner for this project. The support from the Glenmark has been remarkable. They had constantly supported the ideas put forth by Niramaya for the betterment of the communities.

- Participate in the design of the programme
- Participate in the implementation of the programme
- Provide technical assistance to the team for implementation

Awards/Endorsements

Yes, the project has received following awards for the work it has carried out in the field of Maternal and Child Health

- **'Best NGO of the Year Award'** – the year 2014–15 by Glenmark Foundation amongst its partner NGO for excellent field activities and work for marginalized communities.
- **'Best NGO of the Year Award'** – the year 2012-13 by Glenmark Foundation amongst 11 partners NGO for excellent field activities and work for marginalized communities.

Addressing Malnutrition Issues among the Women and Children

1 July, 2012 - 30 June, 2013

Association for Sustainable Community Development (ASSCOD)

Website	:	www.asscod.org
Founder of the Organization	:	K.Loganathan
Project Budget	:	₹ 6, 45,000
Coverage/ Geographical reach	:	Kattakolathur, Block of Kancheepuram District, Tamil Nadu

Project Brief

As malnutrition is one of the serious health issues among the women (mainly among Pregnant women) and children, project was started to address malnutrition issues and anemia correction program through adopting Indian System of Medicine (ISM). mainly the pregnant women, newborn and children were targetted.The capacity of the health staff was built through enabling them to attend the special training programme organized to address malnutrition issues. The training programme was conducted by Tamilnadu Voluntary Health Association (TNVHA), Chennai.

Objectives:

1) To improve maternal health
2) To reduce Maternal mortality and infant mortality
3) To eradicate anemia among pregnant women and children
4) To address the malnutrition issues through facilitating the target groups to use locally available nutritional items
5) To raise awareness on Anemia among the target people.

As the organization's approach is implementing the development projects through women self-help groups (SHGs), awareness was created on Anemia in both prevention and curative aspects among the self-help groups in the target villages. As the target villages are located in remote, they had no access to healthcare facilities. Hence, solutions was needed for addressing malnutrition issues using the locally available nutritious items. So, keeping this in view, programme was started in 15 Villages of Kattankolathur Block, Kancheepuram District.

Plan was made to address malnutrition among the pregnant women, lactating mothers, and children through providing nutritious items women self-help groups. 238 pregnant women were identified and tested for their hemoglobin level before the intervention. Similarly, school children in the age group of 6-14 in 10 schools and about 300 lactating mothers were identified as programme beneficiaries.

If the hemoglobin levels were equal to 8 or less than 8, they were enrolled as their target groups.

Locally available nutritious items were distributed for 6 months and then post that hemoglobin test was conducted. Our intervention helped the beneficiaries to improve their hemoglobin levels from 8 to 12. Although this programme did not benefit the newborns directly, this programme highly benefitted the pregnant and lactating mothers.

Implementation Model

Awareness Component:

We raised awareness on Anemia among the School Children, Teaching Staff, Pregnant mothers and lactating mothers and the members of women Self-Help Groups (SHGs).

We conducted the programme orientation among the school teaching staff and built their capacity on addressing anemia through using locally available nutritional items such as sesame sweets, dates, drumstick, papaya. We also introduced energy foods made out of Raggy, millets, sesame and cereals.

Action Component

Before our intervention, we used to conduct pre hemoglobin test to measure hemoglobin levels and recorded the same for assessing the impacts. If the hemoglobin levels were 8 or less than 8, they were selected as our target groups for our intervention.

After the selection of beneficiaries, we distributed "Murukkan Seed" to deworm and clean the stomach of anemia patients so that our nutritional items intake will be effective in raising the hemoglobin levels. After deworming, we scheduled a programme of distributing energy food at the villages level both times in the morning and evening. We also recorded the weight of each beneficiary. So, we supplied the nutritional items for continuous 6 months. For the school going children, we integrated our nutritious food supply with the noon meal scheme centres run by the Government in schools.

We used to check the weight of each beneficiary every month and record the measurement. If the weight is getting reduced then we referred them to the local hospitals for health check up. After the distribution of nutritious food for 6 months, we conducted post hemoglobin test and recorded the same against each beneficiaries. Both pre hemoglobin and post hemoglobin tests results were compared and studied to decide the results of the programme. We also conducted external evaluation to assess the impacts of the programme using the expertise of dieticians.

Community Outreach

As our organization implements any development programme through the women Self Help Groups(SHGs), we gave programme orientation to the Self-Help Groups (SHGs) first and involved them fully in the project implantation. Women Self-Help Groups(SHGs) were our strategic tools to implement this programme through reaching out the communities for project intervention and support.

We formed a committee of 10 members from the Self-Help Groups(SHGs) and that committee facilitated the process of reaching the community to deliver the services planned in the programme. Our Health Programme Associate coordinated with the committee members and carried out project activities.

Uniqueness of the Project

Because of malnutrition and Anemia, rural women and children faced a lot health issues and spent both money and time in hospitals. It was unfortunate that anemic issues were not addressed though the

locally available nutrition items and Indian system of medicines were available locally say in their door steps. The innovative and ground –breaking features of the project that the women learnt addressing malnutrition issues using locally available nutrition items and changed their food pattern and prevented anemia rather than cure.

Each family developed their own kitchen garden so that they planted and cultivated nutrition food plants/trees in their home using the waste water and used the same to address malnutrition issues.

We integrated kitchen garden programme with our micro finance programme and that resulted in each and every family to concentrate on consuming nutritional food. Unique feature of this project is that communities owned and sustained the activities.

Challenges Faced

We had some problems in taking the lab technicians to the villages and schools for blood testing as they wanted to charge more amount and they would come only in their preferred days and time. So, we struggled hard in bridging the gap between the target groups and the lab technicians in scheduling for blood testing. Similarly, in schools, the teaching staff needed permission from their higher authorities to conduct mass blood testing and this caused some troubles in completing the activities as per the time frame.

While distributing nutritious food for the anemic patients, general public also wanted the food and they created some troubles that affected both quality and timely service to the patients.

Lessons learnt:

1) If the similar project is implemented in the future, we need to have our own lab technicians (Possibly lab also)/blood testing kits so that blood testing can be done on time and we can save the cost assuring the quality of testing without complaints

2) It is better to involve the Govt health officials so that we will be able to involve local Village health nurses those who have strong rapport among pregnant and lactating mothers.

3) The project activities with impacts should be disseminated among all the stakeholders so that we will be able to involve all of them and can implement the future projects efficiently.

4) Implementation of similar project in all areas through networking with like minded organizations will increase the outreach and benefit more people.

Outcomes

- 238 pregnant women delivered healthy babies with the normal weight of 3kg.
- No maternal mortality among the target groups
- Assured breast feeding for the new borns for 18 months-22 months.
- 300 Lactating mothers feeded the babies breast milk maintaining hemoglobin level of 12 that ensured the rich feeding among the children.
- No anemia among the target groups/no malnutrition issues in the target villages.
- Raised the hemoglobin levels from 8 to 12 among 800 school going children ensuring healthy growth both in physical and mental aspects

Outreach & Scalability

This programme was one of the highly result oriented programme of our NGO. We built the capacity of our staff team and some of the leaders of our SHGs in raising awareness about anemia in the schools, self help groups of other villages.

We have shown the impacts created by this programme and discussed the same with the Tamilnadu Nutrition Integration Project (TNIP) and improved the quality of supplementary food distributed by them to the pregnant mothers and the babies in the day care centres. We have shared the best practices of this project to other like minded NGOs in Kancheepuram and Thiruvannamalai Districts of Tamilnadu.

As awareness is the major component and cost effective, we implemented all our development projects and integrated anemia awareness raising activities among the target groups. During the time of disaster, our NGO priority was addressing the anemic issues among the victims and in that way we covered about 30 flood affected villages in Kancheepuram during the devastating flood in 2015.

We worked with organisations like Give India and ICharity and reached nearly 1200 children to address their anemic issues. We used to submit project proposals if they were solicited by funders, our priority was anemia correction proposal only.

We have shared the project concept note to other funding organizations and they implemented these projects with the support of their field partners in Villipuram and Cuddalore districts of Tamilnadu.

Replicability

We can identify health programme based NGOs and build the capacity of their staff members to implement this programme. CSR projects on Anemia correction can be implemented massively to achieve the desired results. Concerned State Voluntary Health Associations can be invited to be technical partners in implementing this project.

We can also involve the education department higher authorities in other locations and build the capacity of teaching and non teaching staff on addressing anemia among the school children.

Impact Achieved

This project was planned based on the training programme attended by our health staff members in Tamilnadu Voluntary health Association (TNVHA). As the programme was a need based and worthful one, we developed a project proposal titled "Anemia Correction Programme" and started approaching funding agencies. Bhoomika Trust, Chennai and Give India Mumbai funded this project.

This project had 2 major components such as Awareness Component and Action component.

Awareness Component:

In the awareness component, we trained our health staff as master trainers and they visited the schools and self help groups in villages and raised awareness on Anemia. We also printed handbills and distributed among the children, women and public. In this way, we were able to achieve the awareness raising among the target groups successfully

Action Component:

As part of action component, we conducted pre hemoglobin test and those who had the hemoglobin levels 8 and below 8, were identified for our intervention. As part of addressing malnutrition issues among the school children, we divided the target schools as Experiment group and Control group.

In the experiment group, we just tested the pre-hemoglobin test and recorded the blood test findings. Whereas in the control group, we conducted pre hemoglobin test and identified the anemic children and provided nutritious food for 6 months. In the control group, after the distribution of nutritious food, we again conducted post hemoglobin test to assess the health improvement of children and the result showed improved hemoglobin levels to 12.

We have used only locally available nutritious items such as dates, papaya, sesame seeds and specially prepared supplementary food and distributed the same for two times every day for the target groups (anemic school children, pregnant and lactating mothers in the target villages). Even for deworming, we used "Murukkan Seed" used in Indian System of Medicines (ISM)

The major highlight of the programme is that we convinced the noon meal scheme department of Tamilnadu government and integrated some locally available nutritious items in the noon meal served to the children which will address malnutrition similarly in the day care centres .

So, if this project is implemented systematically, it will definitely address the malnutrition issues and people will also easily learn how to address malnutrition using locally available nutritious items.

Capacity Building

Tamilnadu Voluntary Health Association (TNVHA) was our technical partner and they used to refresher training to the master trainers of Anemia awareness. Whenever we conducted the anemia awareness raising programme among the school children, teaching and non teaching staff and among the Self Help Groups members, TNVHA deputed their staff to build the capacity our staff through conducting practical training sessions.

Partners of the Project

We had two types of partners in this project. One was technical partner and another one was funding partner. The technical partner known as Tamilnadu Coluntary Health association (TNVHA) built the capacity of our organization in understanding the concept of correction programme. They supported us to prepare handbills, wall posters, pamphlets and booklets on Anemia. They also helped us evaluate the project with their staff team. Whenever we applied for funding with other agencies for implementing Anemia correction programme, TNVHA was the reference agency to recommend the project.

Apart from this, they used to depute their staff to clear the doubts while implementing this programme in the field. Funding partner helped us to implement the project through releasing the fund on time. They also recommended with other funding agencies to help us to scale up this project

A woman submitting proposals on maternal health issues during a Gram Sabha in Falasiya, Udaipur

Advocacy for Continuum of Quality of Care in Maternal, Newborn Child Health

2014-2017

Centre for Health, Education, Training and Nutrition Awareness (CHETNA)

Website	:	www.chetnaindia.org
Founder of the Organization	:	Ms. Indu Capoor, Ms. Pallavi Patel and Ms. Meenakshi Shukla
Coverage/ Geographical reach	:	The project was initiated in 2014 in eleven districts of Rajasthan-Dungarpur, Udaipur, Sirohi, Jodhpur, Rajsamand, Chittaurgarh, Jhunjhunu, Tonk, Jhalawar, Karauli and Baran. The efforts spanned over 83 villages, 28 Sub Health Centres, 11 Primary Health Centres (PHCs) and Eight Community Health Centres (CHCs)

Project Brief

Rajasthan, one of the largest states of India is among the high focus state of the National Health Mission (NHM) of Government of India. Under the National Health Mission, Government has made several efforts for improving maternal and child health and addressing the universal barriers to access health care such as transport, cost, medicines, supplies etc. The Government of Rajasthan has also initiated state specific efforts such as free medicines, nutrition schemes etc. However, the focus of government's efforts has been on increasing institutional deliveries. This has led to inadequate attention to pregnancy and post partum period. High demand for maternal health services at selected hospitals has resulted in massive overcrowding and an inevitable decline in the quality of care women and children receive. The coverage of care during pregnancy and postpartum is inadequate, fragmented and of poor quality. As a result there is a gap in continuum of quality care.

In this context, SuMa- White Ribbon Alliance for Safe Motherhood, Rajasthan, which is anchored by CHETNA since 2002, rolled out a project to advocate for continuum of quality care and promote social accountability for maternal health.

The main objectives of the project were:

- To enhance capacities of SuMa members to advocate for continuum of care.
- To build communities/women's voice to ensure service delivery and enhance accountability.
- To analyse gaps in health facilities; develop citizen's report card on the status of maternal health services in the intervention areas and share the findings at district and state levels
- To strengthen the functioning of accountability mechanisms- Village Health Sanitation and Nutrition Committees (VHSNCs), facility based planning and monitoring committees known as Rajasthan Medicare Relief Societies(RMRS) and Gram Sabhas (constitutionally mandated spaces for citizens' participation in local self governance).
- To increase access to and influence on local, national and international SRHR policy development and implementation

Implementation Model

The main components of implementation model were following

- Mobilising women/communities and listening to their voice
- Developing simple tools, forming teams of community members and visit to Health facilities and evidence collection
- Analysing gaps and strengths and development of Citizens' report card on Maternal Health Services.
- Engaging BDOs/Sarpanch to organise Gram Sabhas

- Mobilising women to make proposals at the gram sabha and followup
- Strengthening village health sanitation and nutrition committees; facility based planning and monitoring mechanism known as Rajasthan Medicare Relief Society (RMRS).
- Engaging Department of Medical Health and family welfare, Government of Rajasthan

Broadly, the methodology of the intervention was based on identification of accountability mechanisms, strengthening capacities of SuMa members, building women's voice, developing citizen's report card for evidence based advocacy, strengthening facility based planning and monitoring mechanism(RMRS), engaging with gram sabha and strengthening women's voice at the gram sabhas and dialogue with Department of Medical Health and family welfare, Government of Rajasthan, and engaging national level guardian institutions.

The Village Health Sanitation and Nutrition Committees (VHSNC), Rajasthan Medicare Relief Society (RMRS) and Gram Sabhas were identified as accountability mechanism. CHETNA held trainings for SuMa members to strengthen their capacities of evidence collection and conduct evidence based advocacy . SuMa members developed action plans to mobilise women, engage with VHSNCs, Gram Sabha and RMRS. They listened to experiences of around two thousand women of accessing maternal health services. Information/evidence regarding maternal health services provided at the Village Health and Nutrition Days (VHNDs), Sub centres, Primary Health Centres (PHCs) and Community Health Centres (CHCs) was collected from 83 villages, 28 Sub Health Centres, 11 PHCs and eight CHCs. This evidence was analysed and Citizens Report Card on maternal health services for each area was developed. The report cards were shared with women/ communities and issues were prioritised. These issues were then taken up by the women and SuMa members to the gram sabhas. SuMa partners shared the Citizens report card with duty bearers and demanded actions to fill the gaps in maternal health services of public health facilities. At the state level, CHETNA submitted Citizens Report Cards to the Mission Director, National Health Mission (NHM), Government of Rajasthan, and approval was received for strengthening of RMRS.

Community Outreach

In the beginning, SuMa members held discussions with around 1200 women from 83 villages from 11 districts and listened to their experiences of accessing maternal health services. Meetings were also held with the members of VHSNCs of the villages and RMRS of the health facilities- PHCs and CHCs. They included elected panchayat members, ASHA, Anganwadi Workers , ANM , senior citizens from the local communities. Information regarding functioning of the VHSNCs and RMRS were collected from them. VHSNC and RMRS members were mobilised for monitoring of maternal health services provided by public health facilities. Throughout the project period, regular meetings with communities, especially women were held in villages, maternal health issues were discussed with them and issues for advocacy with gram panchayats and health department were prioritised. Before the Gram Sabhas, SuMa members organised meetings with the communities, especially women, and the issues to be raised in Gram Sabha were identified. To increase community's participation in Gram Sabha, some SuMa partners

distributed leaflets among communities, affixed posters at prominent places in the villages and made announcement using loudspeaker. To increase women's participation in gram sabhas, SuMa members facilitated transport for the women living in far/ remote areas of the village panchayats.

Uniqueness of the Project

RMRS members conducting monitoring visit of PHC Gangdhar, Jhalawad

There were three unique features of this programme

1. **Strengthening and amplifying Women's Voice:** Meetings were held with rural women to listen to their experiences of accessing maternal and child health services. They were then enagaged in the process of articulation of their priorities and asks. Mobilisation was done to ensure their participation at the Gram Sabhas and dialogue with facility based committees. This facilitated action based on what women want rather than what the providers want leading to a better uptake of services.

2. **Engaging with the Gram Sabhas :** This initiative engaged with 49 gram sabhas which were held and saw participation of about 3000 women for the first time. The Gram Sabhas accepted proposals from women, took them up with the health and women and child officials. This resulted in opening up of public and democratic spaces for women which were once closed for women's participation and action to improve conditions of the health facilities and anganwadi centers.

3. **Strengthening and engaging with 17 facility based planning and monitoring committees: This intiative helped in strengthening of local facility based committees to listed to women's asks and take action to improve maternal and child health services at the PHCs and CHCs.**

A collective action plan was developed by alliance partners in 2014 to ensure that gram sabhas are held as per schedule, community, especially women participate in gram sabha, make proposals on maternal health issues and actions are taken by the gram sabha on the proposals made by women/community. In the first two years SuMa members advocated to selected Sarpanch/ Gram Panchayats for including maternal health in the Gram Sabha agenda and ensured submissions of women's demands/proposals in the selected Gram Sabhas. However it was realised that demand of RH services among women cannot be increased in isolation. Therefore, in 2016, SuMa members advocated to the block development officer (BDO)/Sub Divisional Officer (SDO), Chief Executive Officer (CEO) of district council for issuing orders for organizing Gram Sabhas of entire block/district and including maternal health in the Gram Sabha agenda. Orders to include maternal health in gram sabha agenda was obtained in eight blocks. It helped women and SuMa partners to articulate their views and interests for quality maternal health services in larger area. Women were mobilised to make submissions in Gram sabhas. Sarpanch and elected representatives were continuously engaged and followed up for action on women's submissions. During 2014-2017, SuMa engaged with a total of 49 Gram Sabhas in which over 3000 women participated. For most women, it was for the first time that they participated in Gram Sabha. A total of 188 submissions were made by them, of which 146 resolutions were passed by gram sabhas and 95 resolutions were addressed by gram panchayats. Most of the submissions were for improvement in basic infrastructure, human resource, medicines, equipment etc. and services provided at sub health centres, anganwadi centres and primary health centres.

Strengthening Capacities of facility based committees (RMRS)

During 2014-2017, eight SuMA members continuously engaged with RMRS of 17 facilities from ten districts. SuMa developed and implemented an action plan to strengthen these RMRS. SuMa Secretariat CHETNA held dialogue with Mission Director of National Health Mission for release of RMRS guidelines. A kit for orientation of RMRS members on their roles, responsibilities and functioning of RMRS comittees was developed by CHETNA. With support from block and district chief medical officers and CHETNA, SuMa members organised facility level orientation workshops for RMRS members in 2014 and 2015. Action plans were developed by RMRS which mainly focused on conducting regular meetings and taking action to improve the services of the facilities. However, it was realised that overall functionality of RMRS in the intervention area cannot be improved in isolation. Therefore SuMa made a strategy to cover all RMRSs of entire block in one orientation workshop. In 2016, SuMa members advocated with block/district level officials of health department, sub divisional officers/district collectors to organise block level orientation in each of the ten districts. Orders for orientation of RMRS of entire block were obtained in nine blocks and members of total 77 RMRS were oriented. During 2014-2016 total 42 orientation workshops were organised for total 618 members from the RMRS of 112 facilities. SuMa members made regular follow up visits to the facilities and participation in meetings of RMRS. Although SuMa members had no prior experience of working with RMRS, their rigorous efforts during 2014-2017 has resulted in significant influence on the 17 RMRS. The number of RMRS having SuMa as member increased from none in 2014 to nine in 2017. During this period 14/17 RMRS took at least one action for improving maternal health services. RMRS of 16/17 facilities became partially functional as 16/17 held meeting of members; 15/17 RMRS monitored the facility by using checklist; 14/17 RMRS visited labour room and 12/17 RMRS received women's feedback.

Challenges Faced

Some challenge that emerged during project implementations and steps taken to meet them are following:

- The project was implemented in selected facilities and due to limited resources it was a challenge to fully operationalise the Gram Sabhas and the facility based committees.
- Engaging with RMRS was challenging as the composition of the committee was complex with the administrators from state government as the chair who have several priorities. There was lack of clarity among the officials of the facility and administrators regarding functionality, roles and responsibilities of the committees and involvement of citizen /NGO members in the functioning of the committees.
- Gender stereotypes and social norms in the intervention area was a major challenge for building women's voice and ensuring their participation in spaces like gram sabhas. The challenge was overcame to a large extent by organizing regular meetings with communities, elected representatives and influential people in the villages and mobilizing women in large numbers for participation in gram sabhas.

Some key lessons learnt during the project implementation are following:

- Capacity building of implementation partners for developing collective action plan also fosters a spirit of collectiveness and solidarity. It facilitates active participation of partners in intervention area as well as in the state level efforts.
- Regular interaction and meetings facilitates cross learning from successes, challenges and successful strategies of other partners.
- Increasing access and presence of women in public spaces is an important step to bring about a change in their status. To increase access and presence of women in public spaces, mobilising them in large number is needed.
- Understanding the political context is important for advocacy. If the context is not enabling, one has to constantly track the environment, develop linkages and strategies and wait for the appropriate opportunity.
- The process of social change is slow and since the engagement with the facility based committees and gram sabha is new, it requires more time and energy, particularly capacity building of alliance and strengthening of committees.

Outcomes

SuMA alliance has been able to amplify women's voice and articulate interest on continuum of quality maternal health services at state and district level .

At local level, SuMa partners engaged 49 gram sabhas from 11 districts. A total of 188 proposals were given in the gram sabhas of which actions were taken on 95 proposals. Most of the actions were for improvement in basic infrastructure, human resource, medicines, equipment etc. and health and nutrition services provided at sub health centres, anganwadi centres and primary health centres.

SuMa partners strengthened seventeen facility based monitoring committee-RMRS and increased influence on their functioning. The number of RMRS having SuMa /NGO member increased from none to 9/17. The number of RMRS holding meetings increased from 4/17 in 2014 to 16/17 in 2017. The number of RMRS taking action to improve maternal health services increased from none to 14/17.

Outreach & Scalability

The initiative of Advocacy for Continuum of Quality of Care in Maternal, Newborn Child Health at gram sabha and strengthening of facility based monitoring Committees- RMRS for improvement in maternal health services can be scaled up in other districts of Rajasthan and it can be replicated in other states also. At present CHETNA is making efforts to integrate this initiative of strengthening Gram Sabhas to take action for maternal health in the capacity building trainings programmes of Panchayat members of Rajasthan.

The initiative of strengthening capacities of RMRS or facility based committees was initiated in partnership with the Department of Medical Health and Family welfare and State Institute of Health and Family Welfare, Government of Rajasthan and has been integrated by the department in regular monitoring activities.

However, given the short duration and limited resources, this intervention could make the RMRS partially functional and there is a need for greater investments to optimally strengthen the RMRS.

Replicability

The project has strengthened the mechanisms already existing within the public health system. The voices of women can be mobilised through women's groups linked with the national livelihood mission department of rural development; the facility based committees-Rogi Kalyan Samitis are already mandated within the National Health Mission and the health machinery can be involved in strengthening these committees at PHCs, CHCs and District Hospitals. Gram Sabhas are already constitutionally mandated, which can be focussed by the Department of Rural Development and Panchayati Raj as a nodal agency. A convergent action is required and partnership with Civil Society organisations and CSRS can enable their strengthening. CHETNA can play the role of a resource agency.

Impact Achieved

In the target area , this project has been able to strengthen accountability mechanisms- RMRS and Gram Sabha to perform their role, build women voice and facilitate dialogues between the women/community to press their demands and engage duty bearers to take action and comply to the

guidelines and standards. The project has also led to strengthening of maternal and newborn health services in the intervention areas.

Increasing women's participation in Gram Sabha and using this platform for solving the issues of maternal health at village level has helped in empowerment of women, especially from marginalised social groups. The spaces like gram sabha and RMRS, in which women hardly participated before this intervention, have opened up their doors for women. Women have started sharing public spaces like Gram Sabha and dialogues with elected representatives and government officials. In the baseline there was hardly any example of women's participation in Gram Sabha. Now a significant number of women not only participate in Gram Sabha but also raise and discuss their issues of maternal health services and make submissions in Gram Sabha. For most women, it was the first time they participated in gram sabha, discussed maternal health issues and submitted written proposals.

The orientation workshops for RMRS members have been helpful in increasing their knowledge and awareness about their roles and responsibilities. Overall the functionality of the RMRS of 17 facilities, which were working on papers only at the time of baseline in 2014, have improved significantly. The RMRS of 16/17 facilities have started organising members' meetings; 15/17 monitored the facility by using checklist; 14/17 also visited labour room and 12/17 RMRS received women's feedback. RMRS of nine facilities have included SuMa representative in the committee. RMRS of health facilities have also initiated dialogue with women. 14/17 RMRS took at least one action for improving maternal health services The actions included improvement in infrastructure and cleanliness of facilities, ensuring privacy and respectful service to women, appointment of human resource, etc.

State level advocacy dialogue with health department resulted in issue of government's guidelines for RMRS which contributed in improving functionality of the RMRS in the state. CHETNA's engagement with guardian institutions at national level contributed to increased access to and influence on national and international SRHR policy development and implementation.

Capacity Building

During 2014-2015, CHETNA organised four trainings for SuMa alliance members. Their capacities of evidence collection and evidence based advocacy for continuum of quality care (CQC) was strengthened through participatory training methods. Their skills for engaging with VHSNCs, gram sabhas and facility based RMRS, making action plans and implementing them, submission of proposals at the gram sabha and engaging with facility based committees was enhanced . CHETNA provided regular guidance and handholding support to facilitate implementation of action plans developed by partners.

Several other efforts were made by CHETNA to enhance partners' capacity so that they are sustained and amplify women's voice and articulate interest on CQC and RH. The writing skills of partners were also increased during 2015. CHETNA organised a Writeshop in Hindi language for all the partners during December 2015. It enhanced partners' capacity to articulate the changes expected at the community and health system level and how to write stories of change in context of maternal health.

Partners of the Project

This project was implemented by CHETNA and SuMA- White Ribbon Alliance for Safe Motherhood, Rajasthan. with Danish Family Planning Association as the global partners and Asia- Pacific Resource and Research Centre for Women (ARROW), Malaysia as a regional partner. SuMa partner organizations' role was local level implementation of project activities like collection of evidence, mobilising community/ women, strengthening of RMRS, engaging with gram sabha and follow-up for action on women's proposals in gram sabha . They also participated in state level joint advocacy actions.

A well-equipped labour room built by RMRS in PHC Islampur, Jhunjhunu .

CHETNA's role was to increase capacities of SuMa partner organisation for local level advocacy; developing advocacy tools and materials, kit for strengthening RMRS; provide mentoring support to partners in conducting activities, documentation and reporting and monitoring overall progress of the project and expand engagement with Guardian Institutions at state , national and international levels on CQC and SRHR policies.

Training

Community Based Management of Malnutrition

April 2013 - September 2015

Community Development Centre

Website	:	www.cdcmp.org.in
Founder of the Organization	:	Ameen Charles
Project Budget	:	₹ 7,77,600
Coverage/ Geographical reach	:	19 Anganwadi centres of 12 villages, Block Baihar, Balaghat MO

Project Brief

The project area is dominated by tribals, poor transportation, communication and basic health facilities. This area falls in high malnutrition in the district. Only one PHC is situated in between 54 villages and more than 50 thousand of the population, there are no doctors available since last many years. NRC is also 35 km. from connecting point. Child and maternal deaths are high compared to state and national rate. Despite government programs, the health status of the locals is poor.

To understand the issue, CDC conducted several surveys to know about communities health-seeking behaviours, like breastfeeding, cord care, immunization and most important food patterns. After survey reports and discussion at the community, it was observed that there is a problem on both sides, service providers and who are taking services, related to behaviour and understanding the seriousness of the problem.

Another issue that was identified was, change in food pattern, availability of local food and impact of market forces on food items. Due to many restrictions and laws related to forest protection and conservation, the tribal/ local community is not even able to to harvest their traditional foods i.e. tuber, leaf, fruits etc. There is a drastic change in food pattern in the rural community. A few years back, popcorn was traditionally prepared by community at home, now packed popcorn is available in the weekly market and local shops.

Implementation Model

As the project title, under model and methodology, community-based two-tier approach of the project was used, which was one was to work directly with community and other to work with service providers. The project activities were;

- Home visits
- Training programmes
- Change Agents
- Coordination at the village level
- Promotion of local/traditional foods.
- Community Meetings/ community growth monitoring
- Knowledge & Capacity building and share with PRI representatives, ASHA, AWW, ANM

Through the project, focus was on the coverage area of an Anganwadi centre and to work closely with AWW, tried to improve her quality of interaction in home visit, with proper planning and with the suitable knowledge to her beneficiary. One to one conversation has been developed with pregnant and lactating women. Involve all family members, for caring for a child or pregnant women. Use different

modules during home visits. Quality monitoring of growth of a child and pregnant women. A plan was prepared to track and support case to case and not in general.

Change agents have been identified and trained on three modules. Their role has been to supervise and provide feedback to mother, pregnant, lactating etc.

Community Outreach

- Planning with service providers
- Planning with Panchayat representatives

Various community level activities like Awareness drive, rallies, program at School has been organized and tried to spread the messages to all members of the community.

Uniqueness of the Project

Promote the use of local foods to treat the malnutrition in the community. Under the project, some innovative approach/method has been developed. i.e.

- Feeding Demonstration
- POUSHTIK LADDU, (Gram, Gud, Peanut)

- PARATHA, (Use of green vegetables)
- Powder of ASLI - GUD

Role of Information and Communication Technologies (ICTs)

- Technology used for tracking to growth monitoring of a child. Electronic weight machine for children. This machine keeps data and present in excel form.

Challenges Faced

- The challenge faced by the community during organizing community meetings or training, mainly during the crop season. During crop season, we focused on home visits and meeting the community at the field.

Outcomes

- Have worked around 754 children's (0-5) age group
- When the project was started there were 44 children in SAM category, by the end of the project there were only 2 SAM children in the project area.
- MAM children's reduced 176 to 88
- 381 change agents were trained on health and nutrition issues.
- 19 AWW skilled on growth monitoring, knowledge has been increased.

Outreach & Scalability

There is need to reach out to more tribal areas, the project could easily scale up because the organization has good and experienced staffs, learning material, work experiences and knowledge about local areas. Organization is trying to find resources for this project.

Currently the project has been integrated with ongoing project, but this kind of intervention needs separate intervention with proper human resources.

Replicability

Definitely! The project could be replicated in other areas.

Feeding demonstration

Poshan Baraat

Training at Community2

Impact Achieved

- Overall the project changes lots of behaviour at the community, myths and confusions have been resolved, Most important, that is knowledge of the service providers, this has been increased, which needs to be promoted in other areas also. We have worked with service providers and try to understand their problems. The problems have been shared with their department's higher level officers.
- Panchayat could work well on proper monitoring and support to nutrition and health services, which need to integrate with block officials and inter-department coordination.

Capacity Building

- Staff training on all 7 modules in regular interval
- Monthly staff meetings
- Documentation and collection of data and review of data

Partners of the Project

- The Vikas Samvad Samiti was the key partner for the project, they have developed and printed materials for distribution,
- Few capacity building training was organized by Vikas Samvad.
- Coordination at state level done by VSS.

Community Participation in Delivery of Family Planning services and Capacity Building of Service providers on Respectful Care

13 January 2017 - 30 September 2018

Centre for Catalyzing Change (C3)

Website	:	www.C3india.org
Founder of the Organization	:	CEDPA, USA
Project Budget	:	₹ 64,954,588
Coverage/ Geographical reach	:	i. Chhattisgarh: Raipur, Durg, Janjgirchamp, Bilaspur,Rajnandgaon, Dhamtari ii. Odisha: Balasore, Bolangir, Cuttack, Kalahandi, Khurda,Mayurbhanj

Project Brief

The project 'Community Participation in Delivery of Family Planning services and Capacity Building of Service providers on Respectful Care' seeks to ensure that quality, respectful and gender-equitable family planning services are available and accessible within the public health system by:

- Increased client provider interaction where contraceptive needs of men and women are met in the most respectful and culturally acceptable manner within a gender-equitable framework
- Increased engagement and participation of communities in promoting access to and usage of family planning services
- Increased accountability of the system towards client through client feedback on quality and availability of services

The project aimed at implementing a strategy that addresses the barriers towards community participation and integration of gender concerns in the quality of FP service delivery by combining capacity building of service providers with capacity building of and activation of community based platforms such as Rogi Kalyan Samitis at the level of Community Heal Centers (CHCs) and District Hospitals (DHs).The theory of change adopts a twin approach of improving interaction between providers and clients during women's visits to clinics and devising mechanisms for greater involvement of Community Members in ensuring accountability and transparency in the delivery of care. Taking into consideration the limitations and limited resources at hand, it aims to equip providers with tools to gauge client satisfaction from the gender and respectful care framework, after building their understanding of the nuances of gender and unequal power relations. At the same time, in order to secure community participation in improving services, Centre for Catalyzing Change (C3) is empowering community members to engage with service providers on an equal platform. Existing Rogi Kalyan

Samitis attached to the DH and CHCs will be leveraged to facilitate this interaction. Additionally, direct feedback will be sought from community members/women on their experience through new technologies like IVRS. All the feedback will segue into the reviews of DQAC and Quality Circles for action, thereby assuring the accountability of health services towards women and communities.

Implementation Model

Build the capacity of service providers of various cadres like CMO, ASHA's, ANMs, Staff Nurses etc. at the CHC level on FP counselling, informed choice, gender and exclusion and its links with reproductive Health, understanding Respectful Care and Women's Access to Family Planning Services, and Role of Health Care/ Medical Professionals and establish/strengthen existing health systems for better interaction.

Leverage existing platforms to facilitate processes that build linkages between the health system and community. Another strategy is to devise mechanisms for greater involvement of the community like creating platforms for more interaction and providing clients with a provision of feedback on their experiences. For this, effort is to strengthen the RKS platform and increase interface of these groups with providers to close the loop and address issues identified by clients.

Set-up a low cost IVR based feedback platform for clients to call-in to receive information of FP, and provide rating of FP services. This feedback generated from clients and communities will be collated to produce dashboards which will be shared with facility managers and other relevant stakeholders to strengthen the FP program's responsiveness to community perceptions. This client feedback will also be shared with community forums such as District Quality Assurance Committee (DQAC) and committees which are mandated to utilize feedback for quality improvement. E-dashboards will be provided to facilities, DQACs, and Quality Circles for review and action

Community Outreach

- Designed training packages: Developed three training packages on respectful care and counseling for FP services keeping in view respect, consent and choice for health providers and frontline workers (ASHAs/ANMs) and Rogi Kalyan Samity (RKS).
- Capacity Building: Conducted trainings and orientation workshops for administrators and decision/policy-makers, and the training for health providers and frontline workers, using the designed training packages. Also oriented ASHAs and ANMs attached to the facilities with higher client load, on the content related to respectful care and counseling for FP services keeping in view respect, consent and choice.
- Capture successes and ways to improve trainings: Developed brief reports on the observed successes and ways to improve the provider trainings. The key challenges and aspirations of providers in attending such trainings to provide respectful care are also documented.
- Active community engagement: Leveraged existing platforms to facilitate processes that build linkages between the health system and the community like the Rogi Kalyan Samitis in the districts each of Chhattisgarh and Odisha. Capacitated members of RKS and DQAC with community leaders

like PRI members and facilitated plan and monitor quality FP services. Reached out to the community with information around the benefit and uptake of FP.

- Activated NHM Community based Planning and Monitoring Processes: C3 worked with CSOs in each state to activate NHM's community action for health mandate which are not currently functioning to their full potential. This would entail conducting a quick assessment of the status of RKSs, and the effectiveness of the various RKS in ensuring proper functioning and management of the hospital and maintaining the quality of services. C3 and the NGO partners is working with the RKSs to ensure compliance to minimal standard for facility and hospital care and protocols of treatment as issued by the Government and ensure accountability of the public health providers to the community. C3 and the NGO partners also supported the RKSs to implement other activities as per NHM's Community Action for Health (CAH), for example, display a Citizens Charter in the health facilities, operationalization of a Grievance Redressal Mechanisms, facilitating, and establishing linkages with Quality Assurance Cells for Action.
- Activate and build capacity of RKS : Effort will be to capacitate the Rogi Kalyan Samiti, by giving Orientation and training workshops in the 12 districts to use of tools like Community Score Cards which provide forums for direct interaction with clients and systematic usable evidence for comprehensive community feedback. C3 will work with local NGO partners selected in consultation with MCSP and SHRC, in the districts to work to activate the RKS and push the agenda of respectful care during FP services at facilities in their meetings
- Present community feedback on quality of services to DQACs for review and action:. The activated RKSs will also be encouraged to meet with the DQAC and Quality Circle at frequent intervals so that feedback and findings can be discussed and solutions arrived at.

Role of Information and Communication Technologies (ICTs)

IVRS: An Interactive Voice Response System

In order to improve informed choice, respectful care, gender-sensitivity through greater community participation and to address social factors which affect the uptake of family planning methods, C3 has been focussing community engagement through Interactive Voice Response System (IVRS) in 6 districts of Odisha namely Balasore, Bolangir, Cuttack, Khordha, Kalahandi and Mayurbhanj. This digital platform provides clients information on the various family planning services available, share their feedback on quality of services and take appointment for sterilization services.

The data reported by women receiving family planning services is a powerful feedback loop that turns both women and providers into active contributors towards high quality family planning services delivery.

Challenges Faced

There are challenges in ensuring optimum access and utilization of health services by all, especially to marginalized communities. To achieve this, there is a need overcome barriers related to geographical remoteness, prevailing gender norms, social exclusion and behavior during health care delivery by providers. In this context, health workers especially ANMs and community level health volunteers-

ASHAs- can play an important role in reducing these barriers and inequities as they as the 'first point of contact' between health system and the community.

- Family planning related information were not available in gender sensitive and equitable manner.
- Barriers related to geographical accessibility and timely availability of both family planning clients and front line health worker for counselling services.

  Real time data on client feedback on quality of FP services.
- Rogi Kalyan Samiti members- a community platform actively engaged to take actions on identified gaps.

Outcomes

The outcome envisioned in the project called 'Community Participation in Delivery of Family Planning services and Capacity Building of Service providers on Respectful Care' was to ensure that quality, respectful and gender-equitable family planning services are available and accessible within the public health system by:

- Increased client-provider interaction where contraceptive needs of men and women are met in the most respectful and culturally acceptable manner within a gender-equitable framework
- Increased engagement and participation of communities in promoting access to and usage of family planning services
- Increased accountability of service delivery through client feedback on quality and availability of services

Knowledge on various contraceptive methods available within the health system in the state has improved among health workers. Reach and access of family planning information and services has significantly improved. The universal right of child bearing women to quality, equitable and respectful family planning service has been ensured.

Men are actively involved as partner, client and positive change agent in accessing family planning services. RKS members are more involved in ensuring quality and respectful care and availability of equipment and infrastructure which makes the service conducive.

Outreach & Scalability

Adopted for extension/ integration of program intervention

Sl. No	District	Population	Population growth Rate	Total Eligible Couple
1	Khordha	2251673	19.94%	247311
2	Balasore	2320529	14.62%	409232
3	Bolangir	1648997	23.32%	292137
4	Kalahandi	1576869	18.7%	281424
5	Mayurbhanj	2519738	13.33%	348268
6	Cuttack	2624470	12.10%	387087

Source: State Family Planning Plan 2015-2016

The project is being implemented in 6 districts of the state Odisha namely Balasore Bolangir Cuttack, Khordha, Kalahandi and Mayurbhanj with 1965459 eligible couples from urban, rural and tribal areas. A total of 13,429 frontline health worker both ASHA and ANMs, 1080 Service Providers including Staff Nurses and Medical Officers and 1080 RKS members are covered in the project. Review forums like Sector level meetings, Block Quality Circles, District Quality Assurance Committee strengthened under the interventions.

Replicability

The project has demonstrated how working with public health system and communities can deliver quality of family planning services in the most respectful and culturally acceptable manner within a gender-equitable framework.

Impact Achieved

There has been increased client-provider interaction in which contraceptive needs of men and women are met in the most respectful and culturally acceptable manner within a gender-equitable framework. Up take of family planning methods has increased with uninterrupted access to family planning information through IVRS. The human factors in access to information been overcome.

Further, increased dialogue between health care planner and communities promoted quality of family planning services. The mechanism for increased accountability of service delivery through client feedback on quality and availability of services has been revitalized.

Knowledge on various contraceptive methods available within the health system in the state has improved among health workers. Reach and access of family planning information and services has significantly improved. The universal right of child bearing women to quality, equitable and respectful family planning service has been ensured.

Capacity Building

Capacity Building Programs-Coverage in numbers					
State	**District**	**ASHAs**	**ANMs**	**Service Providers**	**RKS Members**
Chhattisgarh	Janjgir Champa	2306	153	115	60
	Bilaspur	4326	329	175	110
	Raipur	3060	245	125	50
	Dhamtari	1504	314	150	40
	Durg	2542	282	135	80
	Rajnandgaon	2397	292	115	50
Odisha	Bolangir	1481	23	235	80
	Balasore	1931	35	245	152
	Cuttack	2154	12	265	168
	Khurda	940	15	155	56
	Kalahandi	1730	23	215	128
	Mayurbhanj	3156	68	430	256
Total		**27,527**	**1,791**	**2,360**	**1,230**

The separate training manuals for Frontline Workers (ASHAs and ANMs), facility based Service Providers and RKS members on Gender, Social Inclusion and Respectful Care in family planning services were developed by Center for Catalyzing Change (C3). The contents of the training manual were developed based on the gaps in knowledge and understanding of key stakeholders of the project.

A Technical Committee under the Chairmanship of Director of Family Welfare, Govt. of Odisha and members involving senior state level health officials from Health and Family Welfare Department and National Health Mission (NHM) Odisha has approved these 3 training manuals.

The cascading approach adopted for successful implementation of the training programs. The pool of resource persons involving state level health officials trained at state level were involved in training Master Trainers from district level. The trained Master Trainers involved in facilitating block frontline health workers and facility level Service Providers training programs.

Partners of the Project

The Centre for Catalyzing Change (C3) under the umbrella of the Maternal Child Survival Programme(MCSP)/USAID is supporting Government's efforts, in collaboration with Directorate of Health and Family Welfare, Govt. of Odisha, and National Health Mission (NHM) Odisha to implement the project "Community Participation in Delivery of Family Planning services and Capacity Building of Service providers on Gender, Social Inclusion and Respectful Care in Family Planning Services".

The Health and Family Welfare Department, Government of Odisha and National Health Mission, Odisha are the important partners in this project. The work plan has been approved by the Government of Odisha and necessary directives have been issued from the state level to district level for smooth implementation of planed activities. All the training programs including system strengthening interventions carried out in close coordination with district and block level health functionaries.

Training of FLW in M. Rampur CHC of Kalahandi district

Training of FLW in Subarnpur CHC of Cuttack district

A Health Worker- Female from Tigiria CHC, Cuttack district accessing IVRS

An ASHA from Tigiria CHC, Cuttack district accessing IVRS

Ensuring Better Maternal Health Care Outcomes Through Community Action And Social Accountability Mechanisms (Phase 2)

March 2016 - July 2018

SAHAJ (Society for Health Alternatives)

Website	:	www.sahaj.org.in
Founder of the Organization	:	Renu Khanna
Project Budget	:	₹ 50,07,750.00
Coverage/ Geographical reach	:	Dahod, Panchmahal and Anand districts

Project Brief

Maternal health has remained a woman's issue and a private issue, within the realms of the family. We believe that women fulfil an important social function through reproduction and it is therefore the responsibility of society to look after them during this period of vulnerability. Thus, the community must be made aware of the implications of maternal health and their own responsibilities. By 'community action' we mean any action that the various groups/individuals take which will promote attention to maternal health, like, awareness raising campaigns amongst families of pregnant women, monitoring of services provided either at the community level or the facilities, dialoguing with the health care providers and Block and District Health Officers, raising these issues in Panchayat meetings and Gram Sabhas, being part of efforts to report maternal deaths and conducting their enquiries as well.

In order to achieve these goals, a collaborative project between three NGOs with a goal to visibilise a social determinants approach to maternal health and promote community action and social accountability in three rural and tribal districts of Gujarat, India was initiated in 2012-15 and Phase II from 2016-18.

The collaborative project is between SAHAJ, Area Networking and Development Initiatives (ANANDI) in Dahod and Panchmahal districts (amongst the 250 poorest districts of India) and Kaira Society for Social Service (KSSS) in Anand district.

The area covered were 23 villages under Baria and Goghamba blocks in Dahod and Panchmahal districts and 20 villages under Umreth and Anand blocks in Anand district.

The objectives include:

a) Enable communities to monitor access to and quality of maternal health care with involvement of pregnant and lactating women, women's collectives, Village Development Committee members and Panchayat/Gram Sabha members in prioritizing maternal health in their community.

b) Develop and disseminate tool kits, training manuals and other visual materials to the stake holders, networks and coalitions.

c) Advocate with stakeholders in the health system to facilitate community monitoring of maternal health care and community participation in Maternal Death Reviews (MDRs).

Implementation Model

The following strategies were applied to maternal health issues:

A. Conducting surveys on maternal health issues

- A survey tool was developed based on changes in knowledge, attitudes and perceptions we hoped to see in the community
- The tool was also the basis of forming IEC materials

B. Strengthening community action through-

- Various IEC tools such as Warli Madi (Healthy Mother) tool, posters, wall paintings, games, pamphlets
- Preparing women and Panchayat members to take up issues of maternal health in Gram Sabha and Jan Sunwais (public hearings)
- Community mobilization for monitoring of maternal health facilities/services and involvement in MDRs

C. Strengthening social accountability by-

- Training community women as volunteers to fill tools, monitor services, spread awareness, participate in campaigns, being part of MDRs
- Improving relations with local field level health worker (ASHA, Female Health Worker-FSW, Anganwadi Worker-AWW) and monitoring their service delivery
- Generating report cards of the services
- Monitoring the Village Health and Nutrition Days (VHND)[1] or Mamta Diwas
- Increase involvement of community leaders to enhance sense of responsibility towards maternal health issues
- Guiding and supporting the Panchayat members to be sensitive to and improve quality of maternal health services, facilities and infrastructures in their villages and to make blood donors and vehicle owners lists in case of emergency
- Involving community to meet health officials for increased political will

D. To disseminate widely the tools and methodologies and lessons learnt at community, state and national level.

- Making coalitions with other NGOs and campaigning groups working on this issue
- Presenting and promoting our experiences in workshops, conferences, meetings, websites, coalitions and campaigns

[1] *Once a month on a designated day, pregnant and lactating women are provided ante natal and post natal services by the government healthcare providers. It is also known as Mamta Diwas.*

Community Outreach

A baseline assessment was done to meet various community leaders. The NGOs were already working with the various women's collectives in the area. Faliya meetings were conducted for greater reach in the community. Along with this, the ground level health care providers (ASHA, FHW, AWW, Auxiliary Nurse Midwife-ANM) were befriended and trust building was done with them that the monitoring work was not to point fingers at them but to develop a good relation between them and the community for the greater common goal of improved maternal health.

Uniqueness of the Project

- Through the mamta toran (that described various ante natal services) that was eventually made into a poster, women started demanding the services and facilities they were supposed to get on Mamta Diwas.
- The poster on birth preparedness (it included information on basic ante natal and post natal care, high risk symptoms and a space for emergency numbers) was the most appreciated material of the project, with demands from even the health care providers to upscale it. It was useful for the family members and the space for emergency numbers helped in several instances along with recognizing high risk symptoms.
- Involving the Panchayat and Gram Sabha members helped increase visibility of maternal health as an issue in the community and led to improvements in the services, facilities and infrastructure related to maternal health.
- Involving the various women's collectives helped in sustainability and the rippling effect of transfer of knowledge to other areas as well.
- Rather than monitoring the health system by blaming them for the lack of services/ facilities or negligence on their part, a supportive encouraging and trusting bridge was created wherein they were also motivated to work towards this goal with enthusiasm. Our field staff members reported the changes in attitudes in the ASHA's or ANM's and even lab technicians. One such story was of a lab technician who always used to be busy with his mobile after collecting blood. Within a short span, as he was hearing our members discussing maternal health issues with the pregnant and

lactating women coming on Mamta Diwas, he started getting involved and would in fact conduct the sessions himself. This and several other experiences show that even healthcare providers when motivated and encouraged, can enjoy their work and take things forward.

- Board games on maternal health issues, entitlements and responsibility of self, community and Panchayat towards maternal health was well appreciated with women actually trying to answer questions even if they were wrong, thereby giving a good chance for discussions and information passing in a friendly and interesting way.
- Wall paintings, turned out to be a simple, cheap and innovative way of spreading awareness of services and announcing when and where the services were available.
- A comprehensive pamphlet with practical information related to different government schemes, the identity documents required, who could avail it and what benefits one gets, was useful and much demanded pamphlet in the community. In fact we are getting requests from other NGOs to replicate this simple but practical pamphlet.
- Meetings with Panchayat and Gram Sabha members as a group were useful in motivating many of them especially the stronger women leaders amongst them (and male members as well) to push the maternal health agenda forward. However, this needs to be a regular feature and inputs and some funding to continue this would go a long way. Getting them together as a group and giving them necessary kits (like posters) and making them aware of how they can help by simply monitoring the services and discussing maternal health issues in their meetings would make a big difference.

Thus, by strengthening Panchayat and Gram Sabha vis a vis our maternal health agenda, some actions that took place:

1. In Anand district money was granted for street lights, water and roads to reduce stress on women during pregnancy; dismal condition of health facility was pointed out in a Gram Sabha meeting resulting in the government sanctioning a new facility for delivery and checkups.
2. High risk symptoms are taken seriously by the field level health workers and Medical Officers (Mos). Because of awareness, at least 1500 women were identified with high risk and treated.
3. ASHA, AWW, MOs and Panchayat members showed interest in the birth preparedness posters.
4. MOs, Nurses, Chief District Health Officer (CDHOs) and other health department officials and providers have started showing more interest and care in their efforts for improved maternal health care.
5. Earlier Primary Health Center/Community Health Center staff used to hide information related to maternal death, but now they share during MDRs. ANANDI has become a part of the official government MDR committee.
6. Referral services have improved with Nurses and ASHA accompanying the women. Government vehicles are used to bring pregnant women to the centers for hemoglobin testing.

7. Mamta cards are filled regularly; VHND has improved and continues to have all stock and required facilities. New clinics have been initiated for women living in 'seem vistaar' – the fields in the remote outskirts of the village where the agricultural families live during the farming season (this is an equity effect). Also due to community monitoring the duration of the VHND has increased from 2.30 to 5pm.

8. Most MOs now more open and ready to attend Gram Sabha meets and regularly supervise the VHND.
9. Cases of negative blood group during pregnancy taken seriously and injections now available for it.

Role of Information and Communication Technologies (ICTs)

Only simple culturally appropriate monitoring tools and visual aids (developed with community participation) were used throughout the project.

The only technology truly used was the mobile to send SMS directly to the CDHO in case of any maternal death occurred so that it could not be hidden and would have to be investigated.

Another way the mobile was used was to note down emergency numbers and mobile numbers of health workers (ASHA/ANM) in the birth preparedness poster to contact at the time of delivery. This was a highly appreciated part of the poster.

Finally, in some villages, emergency blood donors and transport list with mobile numbers was kept in the Panchayat office to use.

So there was indirect use of technologies in that sense.

Challenges Faced

The main challenge was to bring forth the issue of maternal health from a 'private family affair' and making it a 'community issue in the public domain'. This was achieved over the years by involving the community at every step of the process with the NGOs working as facilitators and encouraging community leaders to take issues forward.

One important lesson was that participatory processes of developing consensus around problems, framing entitlements, and developing tools take time, but they reap deep dividends. However, investments in these processes (time, money, human resources) have to go beyond short project cycles.

Another learning was that monitoring tools have to be simple-yet effective-and suitable at the community level. The tools can become progressively more complex as the community groups mature and health system becomes more responsive- for example, initially just service availability maybe monitored. Once services are made available, their quality becomes the issue and can be monitored.

The most important challenge or lesson learnt was that capacity and relationship building is required at all levels – from the village level with the local health providers to the Primary Health Centre, to the block and district level health centers. Winning government healthcare system support especially at the local level was by letting them know that monitoring is not 'finger pointing' but that a supportive mechanism between community and health workers having a common goal of improving quality of maternal health care.

However, meeting health officials at state and district level was a major challenge. Advocacy with them and interdepartmental convergence has been the greatest challenge in the project and not achieved during this period.

Finally, some level of facilitation and organization is required to enable communities to monitor the situation. In contexts where suitable NGOs are not present, how can this be done?

Outcomes

Some important outcomes at community level:

- Increased knowledge and understanding of maternal health entitlements, services, high risk symptoms and In several villages, blood donors' and vehicle owners' lists are now kept in the Panchayat office for use in emergencies.
- Increased discussions in Gram Sabha meetings with demands for improved services, facilities and infrastructure
- During Gram Sabha meetings, due to inputs from the community, in some places health facilities were improved or they got government sanction for building a new facility for deliveries

- Increased institutional deliveries in government facilities
- Increased community participation in MDRs and its discussions in Gram Sabha meetings
- Better understanding of the role of ASHA, Nurse and what should be available/working at various health facilities
- Panchayat members too began accompanying women in cases of emergencies
- Major improvements in quality of services on Mamta Diwas (time period was increased so that more women could attend it, machines working, hemoglobin testing done etc)
- Mamta cards were now being filled (not filled earlier by the Nurse)
- Most Medical Officers are now more open and ready to attend meetings related to maternal health including Gram Sabha meetings
- Nurse and ASHA and Nurse more responsive and supportive to emergencies and deliveries
- Cases of negative blood groups in pregnant women taken more seriously now and necessary injection provided (not done earlier)
- Improved water, street lights and road facilities to reduce stress on pregnant women
- There was increased visibility of the maternal health issues in and around the project villages
- The listing of emergency numbers and messages in the birth preparedness poster was of great help at the time of delivery as the entire family was better prepared even in case of emergencies

Some important outcomes at organization level:

- Understanding, analyzing and documenting maternal deaths from a social determinants perspective increased amongst the team members.
- Team members were made part of the official MDR committee; they directly report maternal deaths to the CDHO via SMS and hence add pressure on health officials to do MDRs in a transparent manner.
- When the team members presented their reviews, gaps in MDR conducted by the government officials became apparent. Earlier PHC/CHC staff used to hide information related to maternal death but now they share the information during MDRs.
- MDRs helped in improvement in facilities, services, and added pressures on Nurse/ASHA to do their work well (now they accompany women at the time of delivery/emergencies).
- Big improvement in the relationships of organization staff and the Nurse / ASHA worker (strained earlier in many villages). Now they share information, coordinate and support each other.
- Taluka Health Officer (THO) appreciates efforts of the NGO in bringing about improvements in maternal health

Outreach & Scalability

SAHAJ: We continue to promote maternal health issue by training other NGOs (eg. ATAPI, state level workshop in 2016) in Gujarat and other states (eg. Assam) on these issues; also through Jan Swasthya Abhiyan (JSA) which is a network of 70 organizations in Gujarat, maternal health issues are promoted (one eg. recently the issue of blood availability during delivery was taken up in their consultancy meet in September 2017 and has become a JSA issue; The issue is a part of SAHAJ's urban health program in slums- also its adolescent program. SAHAJ is collaborating with Equal Measures 2030 wherein SDG 3 and 5 are focussed and maternal health is included as in integral part. Maternal health as an issue will be promoted where ever possible in SAHAJ's work and networks.

KSSS: They continue the maternal health work through their 400 SHGs; 40 Village Development Committees and connecting with Panchayat members of 40 villages using posters and games developed by us. Also staff from other projects, regularly discusses maternal health issues in their areas through posters developed by us.

ANANDI: Maternal health is now an integral part of their organizational vision. The Sangathans (women's collectives) from 150 villages consisting of over 7000 women members have health as an important aspect of their meetings and maternal health is integrated into this. Another project starting from January 2018 will involve 86 Gram Panchayats and they will discuss maternal health through the posters to ensure that it is seen as a community issue. The Village Health and Nutrition and Sanitation Committee (VHNSC) will be strengthened in this project as well and MH will be discussed and promoted. In future, they plan to strengthen Village Development Committee wherein again maternal health issues will be propagated. A health and nutrition program will also begin to deal with malnutrition infants and children and they will include mothers and hence maternal health issues will be part of it as well.

Overall, in all the three organizations, staff members even if given other project work keep an open eye for issues related to maternal health and spread awareness and continue to guide the community. Those who have left the organization, also continue to promote and spread the importance of maternal and women's health. One staff member who joined a local school as a teacher promotes maternal and reproductive health issue amongst the school going children. Another member joined a trust based hospital and works towards promoting women and maternal health issues by encouraging the hospital team to conduct health camps for women.

Replicability

The project design is easily replicable and the tools and materials are easy to use. With basic training and periodic reviews, it can be easily replicated and integrated to other locations and is being promoted as mentioned above.

- The practical and doable lessons learnt during the project period need to be published and the knowledge needs to be shared through various platforms especially in the marginalized communities.

- People require basic awareness and the Panchayat and Gram Sabha meetings are a good platform for the same.
- The partner NGOs have ingrained the messages so much that even members working on other projects push the maternal health agenda in their work as well and spread awareness as well. Also through our other coalitions and health groups, the agenda gets further outreach and sharing of ideas and learnings take place.
- In one such group, the CommonHealth group, meeting was organized in Assam in August end 2016, wherein the women's Self Help Groups wanted to use the tools and methodologies emerging from this project. Although not a direct sustainable issue, but it is a case of diffusion of learnings and outcomes of our project in other areas as well. Similarly, some state level NGOs have shown increased interest in conducting MDRs in their regions after having attended our training workshop on it.
- Most of our community volunteers and staff in the partner NGOs come from that region and they continue to spread these messages and impart knowledge even after the project period.
- The system of social accountability makes the health system and its staff (specially ground level) accountable and answerable to the society and not just their superiors, and hence they become more responsive to the citizens as has been the experience of our project. A simple example is how the Nurse/ANM/ASHA worker now makes better coordinated efforts to help the pregnant women of their areas. They accompany them in case of emergencies, make arrangements for vehicle to get them to the clinics for check up especially hemoglobin monitoring, to name a few of the changes.

Impact Achieved

The above objectives/activities were achieved by involving a) pregnant women and their families; b) women from local self help groups; c) Panchayat and Gram Sabha members (especially women members); and d) healthcare providers especially at field level (AWW, ASHA, ANM, MOs) for increased political will on this issue at village level.

Based on the rights and policies issued by the government regarding maternal health services, facilities, infrastructural facilities and entitlements, the community especially the Panchayat members and women's collectives were made aware of these and guided for the same.

Strengthening of community action

The knowledge, awareness and attitudes of the target groups on issues of maternal health in the project areas have shown significant improvement as per quantitative and qualitative data analysed. The most important message, that maternal health is a community and Panchayat issue was achieved to a great extent in the project villages, with transfer of knowledge in surrounding control villages as well. Initially, the Panchayat and community members did not feel responsible towards maternal health issues as they felt it was a family matter. However, with innovative means of reaching out to them brought marked changes in this attitude. In many villages blood donors' lists were created, use of 108 ambulances increased, ANMs/ASHA workers started accompanying the women to hospitals for

deliveries or haemoglobin testing, and community leaders became more supportive by providing private vehicles, money or even accompanying the women.

ANC services improved the most. The VHND or Mamta Diwas monitoring checklist used by the community leaders (especially women leaders) was very useful in bringing about improved attendance and services. There is now a regular supply of medicines, attendance by health workers including lab technicians is regular, facilities are improved and equipments are in working conditions.

Strengthening social accountability

Through trust building strategies, there is now a better and positive connection between the community, NGO members, local health system personnel and health officials at the block and district levels. Such measures have resulted in a more open, responsive and trusting environment with the community participating in monitoring and supporting the health system (and vice versa) than before. Involvement of community members and government heath care providers in reporting and investigating maternal deaths has improved.

Use of report cards and board games on maternal health issues and entitlements has become a part of the NGO advocacy efforts with community volunteers using it regularly in the field to spread awareness. Thus, the community is taking more responsibility in improving maternal health services and facilities by discussing it in Gram Sabha meetings and planning actions accordingly.

Dissemination

Efforts are on to scale the posters and other successful IEC materials. Posters on this issue have been distributed to other non project villages amongst Panchayat offices and women's self help groups there. The abstracts for publications and presentations will further the issue at various national and international platforms. Ongoing work will be taken forward by being part of the project on Sustainable Development Goals 2030.

Capacity Building

- Involving and training volunteers from the community to fill monitoring tools like the Healthy Mother (Warli madi) tool on ante natal care, delivery and post natal care services.
- This tool also helps in creating awareness amongst the pregnant and lactating women.
- Awareness building and motivating the women from various women's collectives to understand their rights.
- Awareness building of Panchayat members and other community leaders.
- Dialogues with health care providers and taluka and state level officers.
- Regular review and planning meetings amongst the partner organizations

Partners of the Project

The partners in our project were Area Networking and Development Initiatives (ANANDI) who had been working in Dahod and Panchmahal districts and Kaira Society for Social Service (KSSS) in Anand district. They were grassroots organizations who were well established in these districts with access to many villages that were part of the project.

It was through their staff members and community volunteers that we could reach out to the stake holders in these areas. While SAHAJ provided the technical inputs and monitored and guided the project, it was implemented, monitored and guided at the community level by these organizations.

During the project period, capacity building and experience of working on maternal health related issues from a social determinants and user perspective was developed and internalized by the teams of these organizations. They were well organized, focussed and motivated in terms of its activities and outputs. Coordinated team work and regular review meets between the organizations helped in achieving the goals set out. Staff from all the three organizations have understood and internalized the importance of improved maternal health and are sustaining the work even post-project period by continuing their alliances with women leaders and groups and the Panchayat members.

Awards/Endorsements

We have not consciously or deliberately sought any endorsements as such. However, the project strategies, achievements and lessons learnt have been presented in several national and international conferences where they have been recognised as a model of social accountability and community action in maternal health.

Ensuring Children Health and Nutrition Rights in Kaushambi district of Uttar Pradesh

Partnership since 1999 with CRY-Child Rights and You; this project was initiated in 2015

CRY-Child Rights and You (with on ground partner Doaba Vikas Evam Utthan Samiti (DVEUS)

Website	:	www.cry.org
Founder of the Organization	:	Mr. Rippan Kapoor (CRY); Mr. Parvez Rizvi (DVEUS)
Project Budget	:	₹ 3342170 (Period, January-December 2018)
Coverage/ Geographical reach	:	35 villages under 03 development blocks of Kaushambi District of Uttar Pradesh

Project Brief

Kaushambi district is one of the most backward districts of Uttar Pradesh and development indicators are very poor. Maternal and Child health status in abysmally poor due to lack of awareness as well as dysfunctional health care system. Keeping in view of such bleak scenario, the organisation has been working consistently among the rural communities to improve maternal and child health scenario.

As key strategies for intervention, we keep a track of all pregnant and lactating mothers and children under 6 years to ensure regular contact, follow up and linkage to services as per Government norms. The aim of the program is to provide targeted messages to identified families of pregnant and lactating mothers as well as new born children for timely registration in Aanganwadi centres, regular ANC check ups, identify high risk pregnancies, counselling for adequate diet and rest, advice for institutional and safe delivery, proper Post Natal check ups including care of new born with periodic weight monitoring and immunization. Apart from this the program gives lot of focus on initiation of early Breast Feeding mandating Colostrum feed for new born, complimentary feeding and proper IYCF practices.

The program also draws its linkages to the issues like Malnutrition and Referral services whenever needed. The issue of Malnutrition is very rampant in the intervention areas and it needs early and proper intervention to prevent the child from its long term ill effects.

The entire program plan demands strong support of local care givers like ANM, ASHA and Aanganwadi workers along with Government Health officials Medical Officers, BMO and CMO. The program also takes support from District health officials to organise health camps and also, strengthen monitoring of Govt. programmes. The organisation also follow up at local level to ensure meeting of village health sanitation and nutrition committee (VHSNC) to create community level awareness as well as ensure accountabilities of duty bearers.

Follow up done regularly at district and state level to address the identified gaps. Death audit based on 3D model (Delay in decision making, delay in transportation and delay in care and service) done in case of neo-natal/infant/child and maternal deaths to analyse the reason of deaths and sharing held with health department to undertake intervention accordingly.

Implementation Model

The implementation Model stand on three main pillars:

- Self
- System
- Society

The implementation of the project model is being done through undertaking initiatives as under:

I. Community level – Involving households as key unit and local community. At community level, methodology is largely participatory covering direct community meetings, one-to-one meeting as well as focused group discussion (FGD) on maternal and child health issues.

ii. Intervention at local duty bearer level – Involving ANM/ASHA and Anganwadi workers and local officials

iii. Stakeholders' engagement with key departments/ministries/N/SCPCR and other rights bodies. Direct engagement with stakeholders as well as sharing of evidence based report/fact sheet to address the identified gaps is also undertaken.

Community Outreach

The organisation organise regular community level meeting as part of mobilization process to discuss range of local issue along with maternal and child health related issues. Awareness generation meeting being organised on various governments schemes and programmes and also, facilitate processes for the same through laisioning with government department.

Since the reference communities are largely poor and daily wage earners, effort have been made to organise cluster level meeting/small group meeting as per their availability to make them aware about maternal and child health related issues as well as other issues including safe drinking water, hygiene and sanitation, national food security schemes, Maternal entitlements like PM Matri Vandana Yojana, and NGREGA. Door to door meetings organised as follow up with pregnant/lactating mothers, parents of newborn babies for immunization and care. Also, coordination health workers, Aanganwadi workers, ANM and AHSA at local level and motivation of community to participate in meeting in VHND organised at Anganwadi centre level.

Adolescent girls groups and children groups have been formed in each village to orient them on the health, hygiene, sanitation and nutrition issues. Special emphasis is being given at imparting life skills training to the adolescent groups for making them understand their self, increasing their negotiation, decision making and interpersonal skills so that they can influence the community and peers for their own rights as well as for adopting good practices with respect to health and nutrition. The program also works towards maintaining equitable gender relations so as to give the girls and women a dignified space as well as decision making power in communities to take up what is best for them and their children.

Uniqueness of the Project

Some good practices which have seemed to give a push to the entire program can be mentioned as below

- Working on Gender relationships – Working with Men's groups and Adolescent boys groups for making them a part of the discussion on Health and Nutrition of Women and Children.
- Behavior Change Communication – Understanding the current practices of the community and formation of messages which can tell them some 'Possible Practices' rather than 'Ideal Practices'. This has helped in acceptance of the messages and starting of change in Behavioral patterns.
- Community Nutrition Needs Assessment – this is a very focused child centric community nutrition needs assessment. In this assessment all the sections and stakeholders of the community are met

with and their views taken on the nutrition and health component which effect the Maternal and Child Health.

- Undertaking Death Audits – This practice has helped in understanding the root causes of rampant Maternal and Infant deaths and has also helped in presenting the facts with Government officials to help them to make required changes.
- Documenting Stories of Change – these stories have helped in cross learning and helping community learn and practice new things from the experiential learning's of others.
- Focus on Preventive Strategies – This is mainly towards identification of High Risk Pregnancies, ensuring timely referrals and focused messaging and regular home visits to identified families.

Role of Information and Communication Technologies (ICTs)

- IEC through Digital medium: Sharing of Information, Education and Communication through digital means.

Challenges Faced

There are multiple challenges faced by the organization with regards to implementation of the progamme.

One of the major challenges in the areas is seasonal migration of people which is seriously impacting ANC/PNC as well as immunization of children. Similarly, most of the reference communities are economically vulnerable; they are dependent on daily wage earning. Due to severe poverty, both parents need to earn and women are forced to step out for work within 7-15 days of delivering their baby. This keeps the child away from mother and in turn from exclusive breast feeding.

Apart from these, there are prevailing myths and superstition with regards to maternal and child care like disposal of the colostrum, keeping the mother in cowshed after delivery, restriction on certain food items during pregnancy etc. Efforts have been made by the organization to break such myths/superstition through awareness program and BCC session.

At the system level, there are inadequate health care professional and most of the ANM are also overburdened. The services at the PHC, CHC and District Hospitals are not up to the mark and people are many times forced to go to Private Hospitals and local quacks. Transportation is also a major challenge as some of the villages are very far off and not well connected with the mainstream transport and services.

Outcomes

Some of the major project outcomes are as outline below:

- Decline of infant deaths -from 41 infant deaths (with 868 live births) in 2015 to 20 infant deaths (with 669 live births) in 2017
- Improvement in institutional delivery in the intervention areas and from 81% in 2016 to 89 % in 2017
- Improvement in 3rd Ante-natal care (ANC) of pregnant women from 27% in 2016 to 37% in 2017
- Immunization of pregnant women improved from 73% 2015 to 80% in 2017.
- Immunization of children under 0-1 year marginally improved from 78% in 2016 to 80 % in 2017
- Regular vigilance from community worker has increased activity of ASHA/ ANM and anganwadi workers
- Physical development in the intervention area have been improved including 10 bedded Delivery point at NEW PHC Karari, NewBorn care corner (NBCC) has been set up at New PHC Karari,
- Sanctioning of CHC in Karari of Kaushambi and Hospital building is under construction

Outreach & Scalability

- Documentation of key challenges, best practice and these learning's' are being done.
- Community change makers and local stakeholders have been created to convince the beneficiaries of the new operational area.
- Capacity building of stakeholders being done with incorporation of current experiences so as to save time and energy.

Replicability

The learning and experience of this project can be integrated to other location including the effectiveness of the undertaking BCC as well as uniform messaging and also, follow up at household and community level. Collaborative effort of the organization with local duty bearer has set examples to bring positive changes in lives of children and above all improved the maternal and child health scenario.

Impact Achieved

Ante-Natal Care (ANC) and Post Natal Care (PNC) : The status of ante-natal care improved in the current year as compared to the previous years due to engagement of field mobilize with the target group as well as with the duty bearer including Anganwadi workers and ANM for ante-natal care. As compared to previous year 2016 data, there has been improvement in Ante-natal care (ANC) of pregnant women from 27% to 37% in 3rd ANC (in Jan-Dec-2016- ANC of 213 pregnant women achieved out of targeted 793 and in Jan-Dec 2017- ANC of 289 achieved out of 748 targeted pregnant women) and from 13% to 19% in 4th ANC (2016- 4th ANC-103 pregnant women out of 793 and in Jan-Dec 2017- 145 out of targeted 748 targeted pregnant women). The status of PNC is has little improved from last year to current year as 1st ANC is below 10%.

Institutional Delivery: There has been improvement in institutional delivery as compared to previous years. The status of institutional delivery in 2015 was 727 out of 868 pregnant women (84%), in the year 2016 -636 out of 769 pregnant women (81%) and in Jan-Dec 2017- 592 institutional delivery out of 666 pregnant women (89%). The increase in institutional delivery can be attributed to increase understanding of communities on importance of institutional delivery through regular field level mobilization as well as provision of better ambulance service in the areas.

Immunization of Pregnant women and children under 0-1 yr: Immunization of pregnant women improved from 73% to 80% (599 out of targeted 748). Immunization of children under 0-1 year marginally improved from 78% to 80 % (592 out of 740 children).

Infant and child Mortality: There is decline in numbers of infant and child deaths in the project villages, though the figure stills is very alarming. There were 41 infant deaths in 2015 with 868 live births, in 2016- 48 infant deaths reported with 769 live births and in this year 20 infant deaths reported with 669 live births. It was found in this year that 09 deaths were neo-natal deaths (deaths within 28 days of birth). Death audits have been done and sharing held with health department and District administration. With regards to child mortality, there were 7 deaths in 2015, 13 infant deaths in 2016 and 11 infant deaths in Jan-Dec 2017. In case of one infant death in Asada village, interns of Allahabad high court have filed PIL which resulted pressure on administration to active health care services. However, overall services in the areas needs further improvement through ensuring required equipments in hospital, resuming 24x7 services due to lack of require staffs in both CHC/District Hospitals.

Capacity Building

To strengthen the programming on child health and nutrition, capacities building initiatives of project implementation team have been done on to develop understanding on issues related to child health, newborn care, and maternal reproductive health issues, maternal care including fooding practices, ANC and PNC and related issues.

Apart from this, capacity building of team members done on developing understanding on functioning of health system including National Health Mission (NHM), Indian Public Health Standards.

Team members were also capacitated to track each and every pregnant women, lactating mothers and children for regular follow up. Training has been provided on maintaining a robust data base at the field level.

Beside this, project team also developed capacity to undertaken deaths audit based on 3D model (Delay in decision making at house hold level, Delay in transportation and delay in Facility based care) to analyse the reasons of neo-natal, infant/child and maternal deaths and strategise further intervention at community and health system level.

To assess the status of child health and nutrition, "Child Centric Community Health and Nutrition Need Assessment" was also carried out in project areas.

At the community level, capacity building initiatives taken up with reference community on maternal and child health issues as well as related government schemes and programme so that they could access the benefits.

Partners of the Project

The organization is supported by CRY-Child Right and You, New Delhi. To strengthen the intervention of the project regular capacity building inputs provided to the project team along with facilitation of external resource person having thematic expert of maternal and child health. CRY also organize quarterly visit to the organization for undertaking review against the targeted plan, community level processes and its outcome. Strategic inputs and guidance provided to the project based on the review process. Field level processes are assessed through interaction with reference communities and further discussion held with the partner to strengthen the programmes. Support to the partners done through providing resource materials as well as facilitating stakeholders engagements.

Mother's Health in Mother's Hand

Using Self-Monitoring Tool (Gamla/ Suraj Sitara Model) for empowering marginalized mothers to monitor their own health outcomes

August 2013 - January 2016, Still continuing

Plan International (India Chapter)

Address	:	E-12, Kailash Colony, New Delhi, 110048, India
Phone	:	+91-11-4655 8484
Website	:	www.planindia.org
Founder of the Organization	:	Ms. Bhagyashri Dengle, Executive Director
Project Budget	:	2013-14 - ₹ 500,000 2014-15 - ₹ 500,000 2015-16 - ₹ 500,000
Coverage/ Geographical reach	:	10 villages in Muzaffar Nagar district in Bihar .

Project Brief

Every seven minutes a woman dies in India during child birth. A majority of the maternal deaths are due to lack of proper ante-natal and intranatal as well as immediate post-natal care. Still today half of the pregnant women dionot avail complete antenatal services. Only one-quarter of women received a health check-up in the first four hours after birth and only 37% received a health check-up within the critical first two days after delivery. 80% of maternal deaths could be prevented if women had access to essential maternity and basic health care services and timely ANC services

Many causes of maternal deaths like APH (30%), anaemia (17%) hypertension/ eclampsia (19%), sepsis (7%) and obstructed labour (10%) can be averted by timely identification of danger signs during pregnancy. Birth preparedness and complication readiness (BP/CR) is considered as important strategic intervention for curtailing maternal deaths .

The 1000 days of life from conception till 2 years of age of the child is most critical for the survival of both mother and child. Multitude of health services needs to be received by the mother to have a health mother and healthy child. As in India a large proportion of the families are illiterate hence the complete uptake of the health services as package is still lacking as the complete ANC is hovering around 30% and other services like immunization, iron and folic acid uptake, Exclusive breast feeding and institutional delivery, skilled birth attendants and child complete immunization are all not up to the mark.

The simplest reason for not availing of the services is that women and their families cannot remember so many services as they are illiterate and cannot read through the ANC/immunization cards to monitor themselves regularly and further they don't understand on the importance of these services and hence the onus lies on the service providers and not the beneficiary.

Further as the cards provided by the health workers are mostly misplaced as data shows that in nearly more than 60% cases no cards where available , hence monitoring by the health worker through home visits are also not fruitful. . The standard approach to address this issue is the printing and distribution of ANC/immunization cards for self-monitoring, but the illiterate population cannot read these cards, and they are frequently misplaced.

Looking into the constraints of hard to reach areas with low reach of modern technological and AV mode of IEC, a new innovative locally available, understandable mode with no cost, which has been a part of the human development from the ancient prehistoric and pre-language human development era was developed.

This method is the depiction through pictorial diagram to be drawn in the wall/chart paper by the beneficiary/support or by the community health worker with either chalk, pencil/coloured pen and was named as Self-Monitoring Tool to monitor her and her child uptake of health services thus creating the demand for the services.

There are different types of self-monitoring tools used as per the convenience of the community to draw and how they relate. The Gamla model(Pot with flowers) is being depicted and understood by the farmers community , the model in the name of the Suraj Sitara(Sun & Star) is better visualized by the tribal communities as they worship Sun as God and dream of their children to be glowing and vibrant and full of energy like Sun .

This is being drawn in the wall of the pregnant mother by herself in the wall/ chart from the day she is registered with Nurse mid-wife for availing of the services. For each availed services she draws a line and with completion of all the services the Pot gets complete and if any of the services are not availed the pot (Gamla) will be incomplete and the flowers cannot be depicted. Hence the illiterate ladies are by themselves understanding and assessing their own and their child's health status and seeking health services accordingly

Thus depicting the services through these picture helps to bring the behavior change in the community on importance of each of these health services as the picture gets complete only when all the services are availed and it helps them to monitor their services as they are aware that if it's not taken their child will not be like a flower or like Sun & stars.

The utility of this simple tools are many folds :

1. Its cost effective as it's a social monitoring system, easy to depict.
2. It works as a behaviour change concept as the mother can monitor all the services which they are supposed to take. They are now aware the importance of each of the services as if they do not take then the Pot with all the flowers will not be developed which means the child which is a flower will not blossom.
3. This also improve the engagement of father in the overall development of the foetus and the family involvement as a whole during the pregnancy.
4. The home visits of the community health volunteers for monitoring also increases.
5. This has also enhanced the child led monitoring of the services in the community

Key Objective

- To ensure safe motherhood
- To ensure complete immunization of children

Result: A total of 1300 pregnant mothers were enrolled for this small scale low cost intervention in 10 villages in a 3 yrs period.

Implementation Model

Key Interventional strategies:

To improve maternal and child health service uptake in the most disadvantaged and marginalized communities of India, the solution is not to apply expensive and modern technological IEC, but rather to

use no-cost, locally available, locally relevant, non-literate means of IEC, which have been a part of human development from the ancient prehistoric and pre-language human times. In this case, the locally appropriate technology is a self-monitoring pictorial diagram, drawn either on the wall of the residence with chalk or on chart paper by the beneficiary with support from the community health worker.

The diagram helps the mother to understand and monitor her and her child's health services, thus creating the demand for the services and facilitating comprehensive service delivery in disadvantaged rural communities.

The Self-monitoring tool impacts both the behavior change, enhances knowledge, promotes increase in home visits by the community health volunteers and monitoring the health services by the families and also create demand for the services. The tool was introduced in 10 panchayat villages across Muzaffarnagar districts of Bihar including both tribal and non-tribal communities with the different versions of models of self-monitoring tools as relevant and acceptable and modified to the indigenous needs. This was compared in a period of 3 years with the non-intervention areas with similar demographic profile and other health parameters including available service delivery facilities available.

The self-monitoring tools was launched in discussion with the community on their preferences and their acceptability of the tools through a qualitative situational analysis and group discussions with the community. The various activities were interwebbed for introducing this concept into the system and the community and interlinking it with service provisions and monitoring which are as follows :

Capacity Building: Community health volunteers and government functionaries like the ASHA (Accredited Social Health Activist), Preschool teacher (AWW), ANM (Auxiliary Nurse Midwife),MPW (multipurpose health workers), Lady health supervisors(LHVs), Community leaders like PRI members, religious leaders and other secondary stakeholders were sensitized on the tools and usage of the tolls for the monitoring and BCC and information on the quality of the health service provision to be meted for the community.

Community sensitization by filling gender gaps: The community especially the pregnant women were sensitized through mothers meetings at the Anganwadi Centers, Women self-help groups coordination meetings, Saas-Bahu-Pati sammellan(Mother in-law- Daughter in Law – Husband) meetings which were held to increase the gender transformation increasing men involvement in child rearing practices.

Home visit: Regular home visits by the partner staff, community health workers & community leaders were promoted to see the progression of the model and gaps in the services. The continuity of the practice has helped in making it a tradition/ ritual for all the pregnant mother to undertake this activity as a good omen since it's a tradition to make such designs in the rural households. Use of this tradition for the health service monitoring has enhanced the uptake and become part existing traditional practice.

Community Outreach

This model was introduced with an objective of developing community based monitoring system and for involvement of community for ensuring safe motherhood and child protection. Pregnant mother along with their family members has become aware about the safe pregnancy and care about their children.

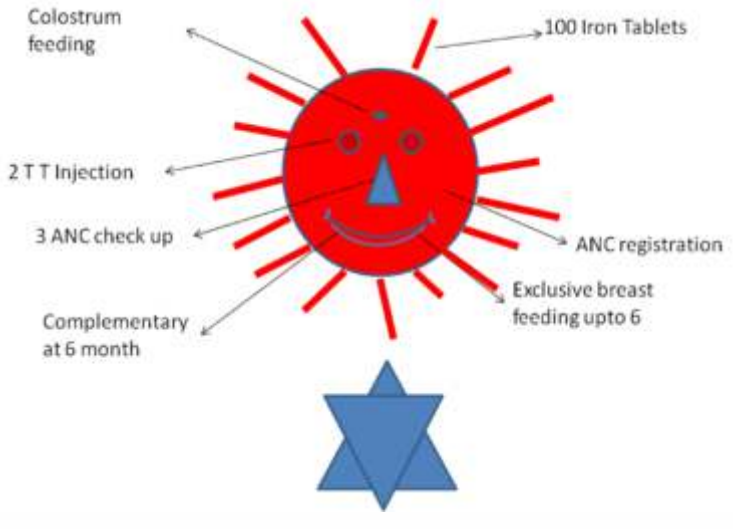
ADITHI-Plan staffs were oriented towards the importance of safe motherhood and childcare and at the same time they were also briefed about the importance of community based monitoring system and involvement of community especially beneficiary for ensuring safe delivery and complete immunization. Workers were oriented towards the step wise step development of GAMLA Model at pregnant and lactating women doorsteps. At first there was a lukewarm response from the community as most of the houses were thatched houses and there few people were having calendars. Chart paper was used as a substitute for the calendar and to promote this model pregnant woman along with their adolescent girls and boys and other caretakers were briefed about the importance of this model. Gamla model was initiated and our workers helped women to draw the GAMLA and slowly and slowly community have realized the importance and they are themselves drawing the GAMLA for ensuring safe motherhood and complete immunization of their children.

For the Gamla model, appropriate in illiterate agricultural communities, the drawing is done on the walls of the residence or on the back of a calendar or chart paper that hangs on the wall on the day the mother is registered with Nurse mid-wife, and goes as follows:

- The pot is the mother.
- The pregnancy is a dot inside the pot.
- Three ANC visits are 3 walls of the pot.
- Five preparedness steps for safe delivery are five leaves at the bottom of the stem.

Leaves from top to bottom repr.esent the routine immunization (BCG, DPT, Measles, Polio)

Suraj Sitara: In this model completion of the model will create a smiling Sun and thus uptake of the services will lead to a baby like a smiling sun full of energy and vitality Through this model we also explain the importance of each services. Community is advised that missing one TT injection makes the eye in the eye gone and thus distorting the picture. This makes them understand the importance of the services and increases their compliance.



Uniqueness of the Project

The self-Monitoring tool is the perfect example amalgamation of scientific knowledge with in the age old culture and tradition. This Gamla model and the Sun and star are being drawn in the walls or the paper and such drawings are part of the community culture. This has made the tool acceptable, adaptable and replicable to the community as a sign of Good omen in the society. Further it has increased the recall of the services strongly and enhanced the uptake of the services and demand for services. During the drawing of such models the mother and the family members are very eager to get

the picture complete and are constantly asking for the next date of services. Further if any services are missed they can now know it's implication as the model will not be complete and may look weird which increases their chance of compliance.

Challenges Faced

1. Male involvement was a challenge.
2. The festivals in India especially during Diwali the walls are repainted thus the self-monitoring tool which is depicted on the wall gets white washed, hence the entire efforts were challenged all the times.
3. Community meeting were organized and orientation through VHNDs as well as home visits and regular interface with ANMS and ASHA was organized.
4. Saas Bahu Pati Sammelans were organized and male involvement was ensured. Further separate orientation of the male members were also organized.

Outcomes

Community after little hesitant have accepted this model and today they are practicing the Gamla model on their own with little help from our workers and their family members. Community has realized the importance of this model and most importantly they have become aware about the precautions and necessities for safe motherhood and immunization.

Community has realized the importance of practicing self-monitoring tool. One of the most important aspect is that with the introduction of Gamla model family involvement in ensuring safe pregnancy has been observed as mother in laws, elder children and husbands of the pregnant are also helping in drawing the Gamla.

When Project started the attendance of pregnant and lactating mothers during VHND was very poor and was only 23% which has now increased by double.

Similarly celebration of Village health and nutrition day(VHND)was only 24 % which has improved to nearly 80%.

Outreach & Scalability

At first the self-monitoring tool like Gamla Model was initiated in Kaparpura and Sarmaspur village of Kanti Block, Muzaffarpur, but later it was replicated all over the project area, due in large part to the acceptance of people about the importance of this model. As the model is easily understood by the community and matches with the existing practice of Rangoli made by women as a good omen has enhanced the chance of this same age old practice into health programming.

Community action group has been formed to monitor the traditional flower and Sun diagrams and to see its get completed in their respective community. These committees comprises of elected representatives, teachers, and health volunteers. The committees has been strengthened by the Plan intervention to .monitor activities in the Preschools (Anganwadi center) This Village health committee monitors the Health and Nutrition interventions implemented at the Anganwadi Centre (AWC). This picture helps identifying the number of left-outs/drop-outs are monitored and counselling done to reduce them. This group works as a 'pressure group' on the community for adopting healthy behaviour practices.

Replicability

This observation from Plan India's experience over the last few years is what we propose to test using any future grants as well as our routine programs, to refine the model and support its replication at scale to reach other marginalized, illiterate populations. The model holds very strong potential for adaptation and/or application in other settings or for other health care needs, but at the very least it can bring much-needed maternal, neonatal and child health services and health-seeking behavior beyond the reach of current practice and modern technologies, to the villages and communities with persistent high levels of maternal and child mortality .

Plan India work with many external partners (National and International) to pilot, innovate and scale up its interventions. Building on its strong presence in the country, Plan India has established and nurtured partnerships with local NGOs in the 16 states. We have a cumulative experience of working with over 100 NGO partners on specific issue-based programs and grants-supported program. Plan India is part of various national as well as state level alliances to carry the advocacy agenda.

As it is cost effective model at the community level improvisation of the tool based on the type of community needs.

Impact Achieved

This self-monitoring tool besides being simple and cost-effective, the tool has proven to have value in engagement of father and family in the development of the fetus. One of the most important findings of previous implementation of the approach is family involvement in ensuring safe pregnancy, this has been observed as mother –in- laws, elder children and husbands of the pregnant are also helping in drawing the Gamla. The approach also facilitates home visit monitoring by community health volunteers. By building the awareness and demand for services by the most disadvantaged mothers, service delivery can also be improved through comprehensive programming that channels these newly engaged mothers into the appropriate avenues of pre-natal, safe delivery, and post-natal health care. Plan India has promoted preschools (Anganwadi Centers) as ideal settings to monitor maternal and child health seeking and health services, and in communities where the Gamla model was applied, saw the service provision at these centers double.

Capacity Building

1. Training of the pregnant mothers .
2. Training of the ANMs and AWWs as well as ASHAS on the self-monitoring tools
3. Orientation of male members of the families on the use of this tool
4. Training of SHG and PRIs for peer to peer monitoring and spread of messages.

Partners of the Project

- Local governance like Panchayati Raj Institution, Village Health Sanitation & Nutrition Committees
- Department of Health at the state, district, block and village level including Accredited Social Health Activist (ASHA), Accredited Nurse Midwives (ANM)
- ICDS functionaries at state, district, block and village level including Anganwadi Workers.
- Project staff at state, district, block and village level .

Women presenting their asks to Health Minister

Hamara Swasthya Hamari Awaz

December 2016 - April 2017

Centre for Catalyzing Change as the secretariat of White Ribbon Alliance India

Website	:	www.c3india.org
Founder of the Organization	:	CEDPA, USA
Project Budget	:	Most of the part of the campaign was voluntary, the sharing and analysis was supported by WRA for 20,000 USD
Coverage/ Geographical reach	:	PAN India

Project Brief

Despite a rapid decline of Maternal Mortality Rate (MMR) in the last 10 years, 15 % of maternal deaths around the world occur in 1 India. India's MMR is an estimated 167 deaths per 100,000 live births (SRS 2013). With around 45,000 women dying each year from pregnancy related causes, India has among the highest number of maternal deaths anywhere in the world.

Given that a woman's perception of the quality of care she is likely to receive during labour and delivery influences her decision on whether to seek facility-based health care, it is important to look at what quality of care means from the woman's perspective. Most accreditation agencies tend to focus on measuring facility infrastructure, human resources, and safety measures. Some more advanced schemes look at clinical measures, but few assess the quality of care through lenses most relevant to the woman and her family. Few examine aspects of care such as how the woman was treated by facility staff, whether care was given in a timely fashion, or whether the facility was clean.

WRAI understands that women, especially the ones living in rural areas of the country, face multiple challenges with maternal healthcare services. Hence, it is important to engage women directly and understand the change they would wish for in terms of a better maternal healthcare service, routing towards equity and dignity for all women. The key objectives of the campaign were to

- Focus on women's needs for the best possible health outcomes
- Focus on women's voices to understand what they want for quality reproductive and maternal care
- Present these voices to the highest possible political leadership with the expected outcome that there would be a better understanding of what women value and ask for in terms of quality of care

With the objective of amplifying women's voices, their needs and priorities, the WRAI initiated a Campaign 'Hamara Swasthya, Hamari Awaz' which means 'Our Health, Our Voices'. This campaign reached out to women directly to understand what they would need for quality maternal healthcare in India and engaged with women directly to put forward their one Ask to improve reproductive and maternal health in the country.

Implementation Model

Over the past 4 months from December 2016 to March 2017, WRAI members have spoken to 1,43,556 women across 24 states and UTs directly about their expectations on quality. Women from all over the country have spoken and submitted their one asks. All these asks collected were collated under larger MNCH umbrella and top five asks were identified. The respective call to actions were developed in response to the top identified asks. While collecting the data, women from all sectors of society belonging to different class, caste, religion were included. The WRAI members gave opportunity to all women in their geographical area of work reaching out to maximum number of women who were willing to submit their asks.

Community Outreach

WRAI is a vast network of NGOs and individuals committed to improve maternal health. The campaign engaged voluntarily WRAI members to sensitize women and collect data on their ask directly. These data were sent to the WRAI secretariat at C3 India. Around 184 member organizations and partners covering 24 states and 143,556 women were engaged. WRAI secretariat led the process of data collection and collation. The 184+ members and partners collected asks from women while they were working in their respective field areas on their on-going maternal health care programs.

Uniqueness of the Project

WRAI along with TFTS is staged a theatrical play, God Ki Delivery that incorporated experiences many women undergo in the process of child birth. Play was presented in form of a satire comedy depicting issues brought up by women in the Hamara Swasthya, Hamari Awaz campaign. This 90 minute play was introduced by the renowned theatre actor Ms. Sushma Seth. Over 200 people were reached through the play on National Safe Motherhood Day. The play was a tool to reach out to general masses on safe motherhood issues and inform them about the key challenges faced by women during pregnancy and childbirth

Role of Information and Communication Technologies (ICTs)

Not Applicable. All forms collected were in hard copy to maintain the authenticity and credibility ofwomen's ask

Challenges Faced

Challenges faced by agency during program interventions are listed below

- Women were not willing to speak initially. WRAI members played a very important role in sensitizing the women about the campaign and the objectives of collecting their asks.
- The collection of data was a voluntary effort of WRAI members. A long term relationship and regular engagement of the members eventually led to collecting a large number of ask
- Data were coming till the last few days of the sharing gala meeting, hence a lot of effort was put in to include all data and create collaterals based on findings

Outcomes

Social media buzz was created and regular updates were posted on social media pages like Facebook, twitter, Instagram. The social media campaign included posts on voices of women, about the campaign, vox-pop on women's ask, national safe motherhood day, case studies etc. The social media reached out to over 4000 people during the campaign. Press release were sent out to media for coverage on the campaign

- http://health.economictimes.indiatimes.com/news/policy/govt-committed-to-ensuring-maternal-child-health-nadda/58118950
- http://indiatoday.intoday.in/story/govt-committed-to-ensuring-maternal-child-health-nadda/1/925784.html
- http://www.business-standard.com/article/pti-stories/govt-committed-to-ensuring-maternal-child-health-nadda-117041001469_1.html
- http://health.economictimes.indiatimes.com/news/industry/23-of-indian-women-seek-dignity-and-respect-in-maternal-healthcare/59806920

Women from West Bengal participating in the HSHA campaign

The findings indicate that a sizeable 36% of the women have asked for access to maternal health entitlements, services and supplies, followed by 23% women who seek services provided with dignity and respectful care. 20% of the women seek availability of health providers while 16% seek clean and hygienic health facilities. Analysis also highlights that women desire respectful behaviour by health providers; no caste or religion-based discrimination; one bed per woman in a ward; a birth companion during delivery; privacy and confidentiality during check-ups and treatment; fixed visiting hours and a visiting room to ensure privacy; complete information and counselling; clean toilets and labour rooms; availability of skilled doctors, specialists and frontline health workers among others.

The asks collected from these women were shared with the Members of Parliament and other key influential including the national highest level maternal health leader. Key asks included (i) invest in generating awareness to ensure that all entitlements are known and accessed by women, (ii) Improve time bound payments to ensure that women fully access the entitlements, (iii) strengthen monitoring mechanism to track dispersal of all entitlements, (iii) create a cadre of professional midwives and ensure 24x7 availability of skilled doctors and specialists, (iv) commit to zero tolerance for abuse, to ensure that women receive respectful care without discrimination and abuse, (v) incorporate respectful care in Quality Assurance Guidelines and adopt the Respectful Maternal Care (RMC) charter, (vii) form Swachh Bharat Abhiyan flying squads to conduct surprise visits to check cleanliness and hygiene in toilets, wards

and labour rooms, and (viii) make display of free services and supplies mandatory at facilities to ensure easy access to information Responding to the asks the National Health Minister Hon'ble JP Nadda committed for a stronger feedback mechanism to address maternal health issues and concerns faced by women on quality of care.

Outreach & Scalability

The campaign directly engaged 143556 women across India to put forward their one key ask/aspiration to improve reproductive and maternal health in the country. Hamara Swasthya, Hamari Awaz campaign's main objective is to amplify women's voices, their needs and priorities and bring these voices to key high level influencers.

WRAI members and partners, covering 24 states, reached out to about 1.43 lakh women in India. All participation was voluntary. WRAI members have spoken to 1,43,556 women across 24 states and UTs directly about their expectations on quality. Women from all over the country have spoken and submitted their asks. WRAI, currently, has about 1800 member organizations from across the country.

States from where women participated :

1. Andhra Pradesh
2. Assam
3. Bihar
4. Chhattisgarh
5. Delhi
6. Haryana
7. Himachal Pradesh
8. Jammu & Kashmir
9. Jharkhand
10. Karnataka
11. Kerala
12. Madhya Pradesh
13. Maharashtra
14. Manipur
15. Meghalaya
16. Nagaland
17. Odisha

18. Punjab

19. Rajasthan

20. Tamil Nadu

21. Telangana

22. Uttarakhand

23. Uttar Pradesh

24. West Bengal

Replicability

Hamara Swasthya Hamari Awaz, an initiative by WRA India, is being scaled up globally as What Women Want – A Global Campaign

Building on White Ribbon Alliance India's powerful campaign—Hamara Swasthya, Hamari Awaz (Our Health, Our Voices)—What Women Want will support women to demand change, bring their demands to decision-makers and generate political support, investment and accountability for quality, equity and dignity in healthcare. What Women Want aims to hear directly from at least 1 million women worldwide about how they define quality maternal and reproductive health care. The findings will be aggregated for a global picture of what women want and disaggregated by country, ultimately distilled to reflect the top 10 asks along with specific recommendations about how to drive tangible improvements for women's health. The global campaign will be formally launched on International Day for Maternal Health and Rights i.e. April 11th, 2018.

Impact Achieved

These asks collected from women across the country were shared with Hon'ble Health Minister Shri JP Nadda on the eve of National Safe Motherhood Day on April 10th 2017. These were as follows :

Key asks put forward by the women were

- Invest in generating awareness of entitlements to ensure that all entitlements are known and accessed by women
- Improve time bound payments to ensure that women fully access the entitlements
- Strengthen monitoring mechanism to track dispersal of all entitlements

- Create a cadre of professional midwives and ensure 24X7 availability of skilled doctors and specialists
- Commit to Zero Tolerance for abuse, to ensure that women receive respectful care without discrimination and abuse,
- Incorporate respectful care in Quality Assurance Guidelines and adopt the Respectful Maternal Care (RMC) charter.
- Form Swachh Bharat Abhiyan flying squads to conduct surprise visits to check cleanliness and hygiene in toilets, wards, and labour rooms.
- Make display of free services and supplies mandatory at facilities to ensure easy access to information.

Mr. JP Nadda, Hon'ble Health Minister highlighted need of strengthened feedback mechanism to understand women's experiences, and spoke about the need for greater community participation to ensure safe motherhood. At state and district levels, women and partner agencies shared the key asks with decision makers.

Capacity Building

The efforts of the members were voluntary. Members were reached out through emails with guidance note, HSHA forms and data collection sheet. Regular reminder emails were also sent. In the note it was mentioned that the members who will be collecting large number of asks will get invitation for the gala event. Interested members got in touch with the secretariat and detail telephonic orientation were provided to many members. Challenges and learnings were discussed. Different strategies were adopted with various states. In few states, the partners were trained on data collection through training sessions and in remaining states the step-by-step guidance note were given to partners to build their capacity for implementation of the campaign.

Partners of the Project

In state of Bihar the campaign was supported through C3's ongoing grant and partners were engaged to do a more intensive data collection. In the state where WRAI has state level secretariats (like West Bengal, Rajasthan and Jharkhand) , the state WRA coordinated mobilizing women and collecting data. Many other member organizations collected data during their regular visits to community and voluntarily supported the campaign. Regular guidance and support were provided by the secretariat.

Awards/Endorsements

The project has received acknowledgement at forums like National Safe Motherhood Day by the Health Minister on his social media sites like Facebook and twitter. In addition to this, there were around 20 coverage on the campaign and its findings.

Flag Off by the CMO, East District

Health on Wheels for Children in East Sikkim

1st April 2016 - 31st March 2019

Inclusive India Foundation and Voluntary Health Association of Sikkim

Website	:	(www.inclusiveindiafoundation.org) & Voluntary Health Association of Sikkim (vhasikkimind.ngo)
Founder of the Organization	:	Voluntary Health Association of Sikkim
Project Budget	:	A. ₹ 34,69,300 for 2016-17 B. ₹ 32,45,070 for 2017-18 C. ₹ 35,49,245 for 2018-19
Coverage/ Geographical reach	:	Rumtek-Samlik, Tumlabong, Radong, Namin, Namli, Chuba, Tshalamthang and Chuja with 18772 population in East Sikkim District, Sikkim.

Project Brief

The project is being run in East Sikkim district in villages which are in remote locations and due to topography are not easily accessible. There is a shortage of doctors and medical staff, especially for Mother & Childcare. The focus of the project is to strengthen the existing government infrastructure and work in collaboration with the centres of the Integrated Child Development Services Program of the District, District Hospital, PHCs and the PHSCs of the operational area. Inclusive India Foundation & Voluntary Health Association of Sikkim is providing Quality Primary Health facilities and awareness among the communities through mobile health clinic at 30 ICDS areas under 8 villages in East District of Sikkim State. The main target population is the Pregnant & Lactating Women and Children below 6 years.

The Objectives of the Project "Health on Wheels for Children"

- To reduce and control diseases through mobile clinics covering the target population/proposed beneficiaries
- To provide health care to the poor and needy at their door step
- To undertake awareness and IEC activities informing the target audience regarding the programme and its operation
- To provide health education to the target population, especially women and adolescent girls
- To provide reproductive health care including immunization to the expectant and lactating women
- To provide complete immunization service for the children below 6 years of age
- To educate the target population on health and sanitation and the use of safe drinking water and protection of the environment
- To transport serious pediatric patients and emergency cases to nearby PHCs, District Hospital, Singtam or STNM Hospital, Gangtok or private clinics by Ambulance
- To strengthen the Village Health & Nutrition Day scheme of the Government through its activities in each ICDS Centre (AWC)
- To strengthen the hands of the Government as a collaborative partner in healthcare service delivery in order to progress towards its objectives of a completely healthy state

Implementation Model

Areas have been identified through a Need Assessment conducted prior to the starting of the project activities. Meetings have been conducted with the Panchayat Presidents, Ward Members, Angan Wadi Workers (AWW), ASHAs, PHC Doctors, PHSC Functionaries like the ANMs and MPHWs, and community opinion leaders from the operational area in which project objectives and how the activities will strengthen their work have been explained and their confidence gained. Meetings have also been conducted with the State Level

Health and Social Security authorities explaining them the need for our intervention and how it is a collaborative effort that is complementary to the objective of the State Government to bring down the IMR to a single digit and other social development objectives. An inaugural function was also held with almost all concerned being in attendance where the concerned Government authorities lauded the project interventions and expressed their support to the project thereby ensuring the support from the grassroots.

The Team conducts Health Camps at the Angan Wadi Centres/PHSCs/Gram Panchayat Offices/Schools as per the convenience of the beneficiaries at least once a month in each location in which apart from health check-up, medicines are given free of cost and awareness talks/presentations are made on various related topics. The Team also makes Home Visits to ensure reaching the last beneficiary. Monthly plans are made and executed. The mobile health van is also used as an Ambulance as per the need.

The project Team comprises of 7 efficient staff members as follows:

- 1 Program Coordinator (Part-time) having Master's Degree in Sociology and experience of 10 years of working in Community Health Program.
- 1 Medical Officer (Female) with MBBS & MPH Degree and experience in working with the Communities.
- 2 Nurses - Qualified GNMs with experience of working in hospitals.
- 1 Health Worker with BA and B. Ed. Degree having work experience of 3 years in the field.
- 1 Driver - One full-time driver is in place
- 1 Accountant (part-time) with B.Com. degree and pursuing M.Com. through distance mode and having work experience of 2 years.

One new Maruti Omni Ambulance has been procured and being used in the project.

Health Check Up in progress in a camp

Community Outreach

The process undertaken to reach out to the communities is preparing Monthly Action Plan and executing the plans accordingly. The Plans consist of every detail like date, time and venue of Health Camps, Home Visits, Health Awareness Programs, Meeting with Community People, stakeholders, PRI Members, School Heads/ Teachers and Government Officials etc. 26 Health Camps with 5 Health Awareness Programs in total per month at various project locations and Home Visits are scheduled every month and shared with the supporting agency. Looking upon the turnover of Target People, at some locations, the Health Camps are on weekly basis and at other locations, the Health Camps are on a monthly basis. The Project Team goes to the field for 5 days a week.

Uniqueness of the Project

'Health on Wheels for Children' is one of the first mobile health delivery service in Sikkim covering maternal and child health. Initially, the project was targeted for Mothers and Children and the free medicine facility was there for the target group only but the people from non-target population also attend the Health Camps regularly. Since the PHSCs do not have Medical Officer, people come to the Health Camps to meet the doctor with health problems and to have their BP and Blood Sugar checked. So, the project now provides free medicine for minor ailments like cold, cough, fever, skin diseases, gas problems etc. to the non-target population as well. Besides, the project Health on Wheels has a unique feature i.e. community people can utilize the Ambulance for free if they need to go the nearby higher institutions for further treatment and in case of emergencies.

Challenges Faced

Considering the difficult terrain, where the project is being implemented, there are multiple challenges which emerge from time to time. Over a period, a lot of those challenges have been taken care of, but some still remain:

The Ambulance for Health On Wheels for Children

A. Initially, the challenge was to find a suitable place for organizing Health Camps according to project requirements. We seek cooperation from Gram Panchayat Office, PHSCs and Anganwadi Centres for organizing Health Camps.

B. Then, the footfall in Health Camps was not that good as expected. So, we initiated the Home Visits to inform the people about the project and its activities and requested them to take advantage of the project.

C. Difficult terrain and weather conditions (Excessive Rain) and bad roads are also some of the challenges, but it is beyond our control.

D. Retaining Project personnel or finding a suitable replacement is one of the internal challenges considering the geography and limited availability of manpower.

Outcomes

A. 78 Health Camps per quarter

B. 15 Health Awareness Program per quarter

C. On average, 60 people do Blood Glucose Testing per quarter

D. No Maternal and Infant Deaths

E. 100% Immunization coverage

As of this day, the project has made an impact in the lives of the people it is serving by way of creating awareness on healthy living. People in general have become health conscious as they have been made aware that their poor health is directly affecting their productivity and is affecting the whole family adversely. Peoples eating habits have also changed for the better. The adolescent girls and women have become more aware about reproductive health and hygiene practices.

Awareness among women about the benefits about breast feeding in the first six months has increased leading to healthier infants.

Outreach & Scalability

Health on Wheels (HoW) Team have extended their support to all the 4 PHSCs under project villages during monthly Immunization programs and encouraged the Anganwadi Centres (ICDS Centre) to observe the Village Health & Nutrition Day (VHND) to make their presence felt in the project locations. The Team also visits Schools and convince them for organizing Health Camps. Sometimes, Gram Panchayats also invites the team for generating Awareness Program to the public on specific Health Topics. Social Justice, Empowerment and Welfare department officials also asked for help from HoW Team to organize Health Camps and Awareness Program at some area. Overall, it can be concluded that HoW team have reached where they need to be present. Initially also the project started with 6 villages which has been extended to 8 villages. There are also plans to work on training and empowering community workers to increase the outreach of the project.

Replicability

People are very happy with the services provided under HoW Project. In areas like Lower Chiba and Lower Martam, people from adjoining area (not included in project) also come to the Health Camp and awareness program. Looking into this, Self Help Group members and Panchayats have started requesting such programs in their villages as well. Within the approved budget, so far, we have organized 1 health camp each at 2 areas i.e. at Mangthang ICDS Centre and Sangkhola ICDS Centre. So, there is scope for integration of project to adjoining project villages as well.

Impact Achieved

In project villages, people are now aware that there is a project funded by Glenmark Foundations, where they can avail free Health Services and Medicines. They can also check their BP and Blood Glucose. They

The MO, HOW giving a talk and demostration on nutrition

use to call Doctor to their home in case of emergency when the patient is unable to come to the Health Camp venues. They have started using Project Ambulance when the need is there. Whenever the patients are shifted to nearby health facilities for higher level of treatment, project nurse used to accompany them to the Hospital.

The project has had a significant impact on the lives of the nearly 19000 population it serves as people have no access to the services of a Medical Practitioner at regular intervals which was lacking earlier. They also used to travel long distances in difficult terrains to get the service of a laboratory for the tests like Blood Pressure, Blood Glucose which are now available at their doorstep. The project has made great impact in terms of making people conscious about healthy living rather than to be unhealthy and go for medical treatment.

Immunization coverage has improved significantly to nearly 98% in which the project has contributed to a certain extent through its Home Visits apart from the health camps.

Pulse Polio coverage has been nearly 100% through the collaborative efforts of the HOW project thereby ensuring protected children below 5 years against recurrence of the dreaded disease.

Capacity Building

A. Weekly update and review meetings are held every weekend at VHAS Office in presence of Executive Director. He gave his inputs on how to make project effective.

B. Quarterly Monitoring Visits is done by Social Development Consultant from IIF and give his inputs and suggestions, field visits with team members also is a part of Capacity Building initiatives. The IIF Consultant had also conducted training of the team in Nutrition, Breast Feeding and Prevention Against Certain Cancers.

C. Project Staff are also given in house training on reporting and importance of document and how to keep the evidence of the program.

Partners of the Project

Glenmark Foundation in partnership with Inclusive India Foundation & Voluntary Health Association of Sikkim introduced Health on Wheels - HoW Project to create the access to health care services.

Indigenous Medicine Use for Sex Selection during Pregnancy and Risk of Birth defects and stillbirths

January 2014 - December 2014

Indian Institute of Public Health-Delhi (IIPH-D), Public Health Foundation of India (PHFI), India

Website	:	www.phfi.org
Founder of the Organization	:	The Public Health Foundation of India (PHFI) is a public private initiative that has collaboratively evolved through consultations with multiple constituencies including Indian and international academia, state and central governments, multi & bi-lateral agencies and civil society groups. PHFI is a response to redress the limited institutional capacity in India for strengthening training, research and policy development in the area of Public Health
Project Budget	:	₹ 17 lakhs
Coverage/ Geographical reach	:	All districts of Haryana

Project Brief

Declining sex ratio is a public health concern in this part of the globe. Besides sex selective abortions, people use different sex selection techniques to choose the child of the preferred gender use. Intake of indigenous medicines for having a son is a common practice in north India as reported by previous studies. Since these are consumed during the first trimester which is a critical time for fetal growth and development, this study was required.

Dissemination of messages in local dailies

On the request of the policy makers from the Government of Haryana, a study was conceptualized and undertaken by Public Health Foundation of India (PHFI) with support from National Health Mission, Haryana to explore the association of intake of sex selection drugs (SSDs) with two outcomes of pregnancy- structural birth defects and stillbirths.

Implementation Model

Two large scale population based research studies (case control studies) were conducted across Haryana with an objective to highlight the adverse effects of intake of indigenous medicines (sex selection drugs or SSDs) during pregnancy for a male child. This was done by:

- Studying the association of SSDs with birth defects
- Studying the association of SSDs with stillbirths
- Performing biochemical analysis to identify the ingredients or active principles present in such samples

Cases (birth defects and stillbirths) were selected from the state of Haryana. Controls were live births from the same area (village/ ward) as the case. To study the association with CMF, 175 infants with apparent structural deformities and for stillbirth study, 325 stillborns (beyond 24 weeks gestation) were selected as cases from the registry. Controls (175 for CMF and 325 for stillbirth) were normal live babies born consecutively at the same location as the case. Consenting mothers of every case/control were interviewed using a validated tool at their households. Bivariate analysis and logistic regression models were used to study the association.

Community Outreach

The work was facilitated by Government of Haryana. They only facilitated the process of data collection. Secondly, the findings of the study have been utilized by the state to improve the implementation of its program.

Uniqueness of the Project

Many indigenous practices exist in the community which never catches the attention of policy makers. Sex selection is a very sensitive topic and not many policy makers or researchers get involved in doing such areas since they presume that anything that is indigenous practices is safe. The unique feature of this project is that policy makers got directly involved in supporting this study and they are utilizing the study findings for their programs.

Challenges Faced

None in particular. In fact the study has opened up new areas for doing research that we are currently perusing with support from Department of Science and Technology, Government of India and Science and Technology Council, Haryana. The findings from these study reiterates harms of the use of SSDs.

Outcomes

The prevalence of intake of SSDs varied from 7.3% to 10% among live born babies without apparent birth defects. However, among babies born with defects, the use rate was as high as 25% while among stillbirths, it was around 16%.

These studies have shown that a pregnant woman consuming such drugs was at 3 times more risk of giving birth to a baby with visible birth defects like cleft lip/ palate, spina bifida, and club foot as compared to those who reportedly did not consume such drugs. The risk was found to be higher


Folk Remedies for Sex Selection are Risky, Study Finds

Traditional medicines taken by some Indian women to help them give birth to a boy are linked to an increased rate of stillbirths

Suryatapa Bhattacharya
July 4, 2016 11:22 a.m. ET
New Delhi

(around 3.5 times) among couples who already had a daughter. The findings were similar to another study conducted in a tertiary hospital in north India on more serious congenital malformations.

Another study to ascertain the association of the use of SSDs with stillbirths showed that the risk of stillbirths increased by more than 2.5 times with an exposure to SSDs during pregnancy. The study also revealed that out of every 5 women who get exposed to SSD, one would have stillbirth.

An analysis of the drugs was carried out to detect the presence of phytoestrogens and testosterone. As part of the study a total of 30 samples of SSDs were analysed. Nineteen samples (63%) were strongly positive for all phytoestrogens (genistein, daidzein, formononetin). Testosterone was detected in three out of the 15 samples analysed for testosterone. An average dose of each phytoestrogen was calculated thereafter based on this data and were as follows: daidzein: 14.10 mg/g sample, genistein: 8.52 mg/g sample, formononetin: 5.09 mg/g sample. The total quantity to be consumed represents a ten-fold increase over that recommended for dietary intake.

Outreach & Scalability

The issue dealt with here is a pertinent social problem that has implications on health. There is a lot of scope and opportunity to generate awareness among the community. We have 1 minute short ad on SSD developed that conveys the message very clearly. We are exploring the possibility of showing it in movie halls, railways and disseminate through radio channels, especially in north India. This seems to be the most effective way to reach out to masses.

We are seeking support from organizations who can take part in the dissemination of the messages through these various channels. There are requests from Punjab and Haryana to repeat the light and sound play in different villages and districts. There is a lot of opportunity under the flagship program of "Beti Bachao Beti Padhao".

Replicability

Parallel studies can be undertaken in others states to explore this practice since we were informed informally that many people in other states, mostly developed states also follow such practices

Impact Achieved

Impact can be assessed in terms of change in policy, development of new guidelines, media coverage or any other reasonable outcome independent of research.

The evidences from our studies have been and continue to be utilized by the Government of Haryana to address the menace of sex selection. Under the ambit of PCPNDT Act, First Information Reports (FIRs) are being lodged and raids are being conducted on those who are found to sell these spurious medicines or sell gender selection kits with the promise of facilitating the birth of a male child. A total of 65 raids have been conducted on people selling SSDs and 7 have been convicted. Strict enforcement of the Act has resulted in a slow but steady reversal of sex ratios in several districts. For the first time in history, the sex ratio in Haryana has crossed 900. The visible commitment of the leadership of the country starting from the Prime Minister at the top to the Chief Minister at the state and District magistrates at the districts have geared up the momentum to the grassroot level.

Partners of the Project

National Health Mission, Haryana

Awards/Endorsements

The study was captured in a front page news story in Hindustan Times on Aug 2, 2015 and March 7, 2016. The Government of Haryana took the initiative to inform the community about the harms of SSD through publication in local dailies in vernacular language in Aug-Sep 2015 and in social media through promos launched on Aug 13, 2016. The study findings were highlighted by Research gate, Wall street journal, Guardian and India post.

Based on study reports, sting operation was conducted by Aaj Tak and this was telecasted in an episode on Oct 13 and 14, 2015.

Journalists from India Spend, British Medical Journal, National Geographic, Vice news and New York Times have approached us for a possible coverage in digital media.

Integrated Nutrition Project for Under 5 children

February 1, 2015 - January 31, 2018

Plan International (India Chapter)
E-12, Kailash Colony, New Delhi, 110048, India
+91 -11-4655 8484

Website	:	www.planindia.org
Founder of the Organization	:	Ms. Bhagyashri Dengle
Project Budget	:	2015-16 - ₹ 2,88,43,531 2016-17 - ₹ 2,32,51,222 2017-18 - ₹ 175,25730
Coverage/ Geographical reach	:	70 villages in two Districts of Bikaner and Udaipur in Rajasthan, India

Project Brief

India has the largest population of under-5 children in the world and contributes nearly 2million under-5 deaths. High prevalence of malnutrition contributes to over 50% of child deaths. Malnutrition especially stunting, severe wasting and Low Birth weight are linked to 2.2 million deaths and 21% of disability-adjusted life years worldwide for children under five years. Malnutrition is India's silent emergency and one of the most significant human development challenges.

Sub-optimum breast feeding, and complimentary feeding is a leading factor in childhood morbidity and mortality. Improved maternal nutrition and ANC care positively impact malnutrition leading to reduction in low birth weight. Further early initiation of breastfeeding and exclusive breastfeeding during the first six months are vital in assuring the growth of the infant.

Rajasthan has one of the highest SAM prevalence rates in the country with 8.6 % children in Rajasthan being SAM (NFHS 4, 2015-2016). Although this prevalence has increased from 7.3 % (NFHS 3, 2005-2006). However, increase of 3 % has been noticed in wasted children from 20 % (NFHS 3, 2005-2006) to 23 % (NFHS 4, 2015-2016). Children with SAM have a nine times higher risk of mortality compared to well-nourished children. Even those who survive have compromised mental and physical growth.

The grave situation of the state's children warranted immediate and effective action to improve the condition. Plan International (India Chapter) responded to this nutritional crisis through its financial as well as technical support for three year (2015 till 2017) running an Integrated Nutrition project for under 5 children in 70 villages across one block of Bikaner and 2 blocks of Udaipur district of Rajasthan. T**his project covered 14974 households, 12582 children under 5 yrs., 2784 pregnant mothers.** In this project, an integrated approach of health, WASH as well as Nutrition intervention was provided as a composite package to bring the change in the nutritional status.

The social change communication model were used to bring the change in the nutritional status. This project is comprehensive approach of community management of malnutrition (CMM) as well as facility strengthening at the Anganwadi level; as well as Malnutrition treatment centers (MTCs). The project introduced an additional human resource in a name of Community Nutrition Worker (CNWs). These CNWs were provided mobile device to capture the behavior pattern of each house hold during home visits and provide appropriate counselling.

Further facility management was also incorporated with strengthening of the Malnutrition centers at the government level through infrastructure support as well as the software support on training and recurring cost. Through this project two MTCs were established and was made sustainable through our advocacy efforts with the government. 200 SAM children have been treated in these centers and brought out of the cycle of malnutrition.

Project Objective were as follows:

1. Improve maternal, new born, child health and nutrition by enabling community to access knowledge, change attitudes / practices regarding Water, Sanitation and Hygiene and Infant Young Child Feeding practices.

2. Enhance quality of services especially supplementary nutrition and health services in government run early childhood development centers or Anganwadis through influencing government.

3. Increase referral, treatment seeking behavior and management of Severe Acute Malnourished children at Malnutrition Treatment Centre.

Implementation Model

Key Interventional strategies:

1. Introduction of community Nutrition workers (**Poshan Prahri**)

2. Home visits by Community Nutrition workers (CNWs) to improve the home based nutritional practices and regular tracking of nutritional status as well as behavior change aspects with in the family.

3. Use of Mobile App and Digital platform for monitoring and counselling of each child in the village and entire project.

4. Capacity building for community as well as Government stakeholders

5. Nutritional Recipe demonstration and training for mothers

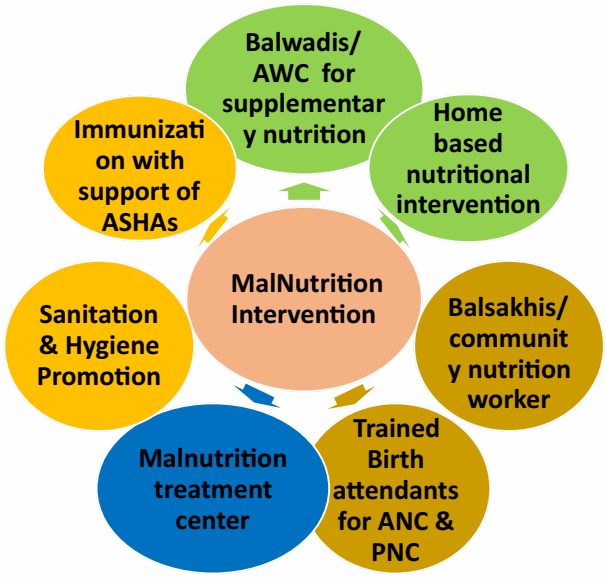
6. Health support through Malnutrition treatment centers , VHNDs and health camps and provision of Deworming tablets as well as micronutrients .

7. Water sanitation and Hygiene especially food hygiene , safe drinking water, using distribution of chlorine tablets as well as water ladle and appropriated hand hygiene .

To address the root causes of malnutrition the project adopted the following methodologies in an integrated fashion : (I) **Home based care** -Improved knowledge, attitudes and practices amongst families on food availability & consumptions , quality nutritional recipes based on the nutritional needs of the children , hygiene through community nutrition volunteers (ii) **Institution based:-** Improved provision of quality supplementary nutrition services through either partner run crèches (Balwadis) or govt run early childhood development centers (Anganwadis). (iii) **Health services : -** Improved health services like immunization, ANC, delivery and PNC services and Malnutrition treatment centers for severe malnourished children. (iv) **WASH :** addressing the wash aspects in the community through the hygiene and clean water management

Community Outreach

To role out the project in the communities many community participatory activities were undertaken to mobilize the community and enhance there knowledge and bring social behavior change.



Capacity Building : Module on IYCF, Local recipes and Gender manual were developed with local context and training imparted to all the stakeholders from ASHA, ANM, AWW, and CNWs along with SHG , PRIs and community groups . During the project period **970 IYCF training and 270 WASH trainings** with different stakeholders were organized.

Formation of Mothers Groups : Different category of mothers like pregnant and lactating and those under complementary feeding were created and sensitized regularly through community nutrition worker on various issues related on Integrated Infant and young child feeding practices and WASH . **A total of 126 mothers groups** were formed in 70 villages who were regularly called for meetings and imparted knowledge.

Home Visits: Focused home visits by CNWs were conducted on a regular basis to all the households with under 5 children and special extra home visits to children who are under nourished. **Total number of home visits made to pregnant mother were 13,180 on an average 4.7 visits /pregnant, 1,05,894 visits of children on an average 7 visits/children.**

Recipe demonstration: Mothers of under -5 children were trained on local low cost high calorific value age appropriate food recipes. They were also provided skills on responsive feeding and on the frequency and consistency as well as hygiene of the food. 160 recipe demonstration were organized in the community for the mothers and community members during the project period.

WASH & Health campaign: Various mass media activities were undertaken to mobilize community on the Health hygiene. Awareness vehicle was flagged off (WASH Caravan) was organized in all the project locations/ villages. Puppet shows, wall paintings wall writings as well as folk theater was organized as part of the campaign.

Health camps: Children identified through the home visits and at the AWCs were further investigated through medical doctor at the health camps to identify various diseases/ deficiencies and provided treatment as well as specific counselling and referral. **Under this project 12,000** children were provided

with micro nutrients including, iron, vit A as well as deworming tablets. **129 health camps** were organized during the project period.

Village health and Nutrition Days: Community based monitoring system has been established through PRIs to regularize and streamline the monthly health and nutrition services at the community level. **7308 VHNDs** were organized during the project.

Malnutrition Treatment centers: Project has strengthened 02 MTCs at CHC of project blocks with support of National Health Mission. Above **200** children were treated and recovered at MTCs.

Uniqueness of the Project

Community Nutrition Worker (CNWs) of 'Poshan Worker' - The project has created a cadre of 93 local rural women who have been intensively trained on issues related to maternal and child health, nutrition and WASH. These CNWs are and will continue to be responsible for creating awareness on these issues, bringing about a social change and improvement in the status of children under five years.

The CNWs cover households of pregnant women and that of children under five years in their own village. In some villages people live in much dispersed hamlets in that case two or more CNWs have been

deployed. Their responsibilities include conducting home visits to counsel mothers, caregivers, identify undernourished children and monitor the growth of these children, organize monthly mothers meetings at Anganwadi Centres on MCHN Days, do referrals and provide support in conducting regular health camps etc. For this purpose the CNWs are equipped with communication aids such as flip books, brochures etc. and will be provided with new material.

Digital Interface and real time monitoring (Plan MCH App): The intervention used Mother and Child Health App developed by Plan India, which supported the CNWs in identifying the condition of the child, related factors for his/her condition, advisory for combating the problem and also provided real time monitoring to the whole implementation.

Water handling Ladle to families of malnourished children: The project also introduced ladle as a prescription for combating the malnutrition, due to which hygiene got its expected importance which helped in behavior change.

Converting waste to nutrition: An innovative model for use of waste water (grey) and household organic waste (composting) in growing kitchen garden at the households level was adopted to grow fresh vegetables and fruits at low cost and provide added daily nutrition to children.

Hygienic Cooking Demonstration- during demonstration community was trained on hygiene and cleanliness. Videos on hygienic cooking habits were shown to the target group to help them to learn, relate and reflect.

Use of Tradition Grains- nutritious recipes were introduces using local grains and produces, which are low cost and easily available. This helped in revving the indigenous/traditional food grains, which were almost forgotten.

Kitchen Gardens - Project has established kitchen garden at **575 households** and **25 AWCs** of severely and moderately malnourished children. Through this ensured availability of micro-nutrient vegetables in the house. This intervention in the longer run improve nutritional security. Parents/care givers were provided with seeds and training on cultivating the vegetables with less use of water (using household waste water), and fencing.

Role of Information and Communication Technologies (ICTs)

Plan India has developed an android tablet based "Maternal and Child Health Application" known as **'Plan MCH app'** and web based portal as **'Plan MCH portal'**, under the Integrated Nutrition Project (INP). This application is developed under the project to be managed by village level 93 Community Nutrition Workers (CNWs). This application provides support to CNWs to counsel mothers. This app also provides communication tools and AVs which facilitates the counseling sessions by CNWs. This APP also helps the CNWs track the most vulnerable children (Severe Acute Malnourished, Moderate Acute Malnourished, Severely underweight including Low Birth Weight babies) and High risk pregnancies as the app provides timely notifications to CNWs and informs them about the need for visits to the most vulnerable.

KEY FEATURES OF THE APP

- Easy to operate by a field level worker having basic reading skills
- All household information is available in one unique bar code
- User friendly for every one as it does not need typing or writing.
- All health and nutrition related behaviors and practices of maternal as well as children up to 5 years are tracked.
- Instant analysis of growth indicator like weight-for-age, Height-for-age and weight-for-height and mid upper arm circumference-MUAC (as per WHO recommended standards).
- Tracking and nutritional gap analysis of food intake including frequency, quantity and type of food consumed
- Questions change automatically in relation with pregnancy trimester and child's age
- Pop-ups for high risk group
- Automated notification on important indicators
- Automated counselling support to field staff
- Automated analysis for key preforming indicators
- GPS profiling of each and every household

Challenges Faced

1 **Poor understanding of the Interrelationship between WASH, Health and Malnutrition:** Importance of WASH and health are neither understood nor integrated in most of the nutrition programmes. Hence, it was a challenge to convince all the stakeholders of the project towards increasing their emphasis on sanitation, hygiene, and maternal and child health as a composite program to achieve nutritional goals. The project tried to link WASH intervention directly to the nutritional outcomes. Each undernourished child was clinically assessed under

three aspects named Health, Nutrition and WASH. Of which WASH was an added parameter to understand WASH related reasons for the undernourishment which was duly addressed. To emphasize the important of nutrition all the households having undernourished children were provided with regular home visits and micronutrients as well as water ladle. With this small, innovative intervention added on, the community was sensitized to prevent undernutrition.

2 **Zero Access to MTC (Malnutrition Treatment Center) Facilities:-** before the project was started MTCs in both the project locations were dysfunctional and no admissions were being made in these centers. During the project the refurbishment was made of these government centers with HR, infrastructure and logistical support. Gradually these centers became active through addition of trained staff and severely malnourished children started staying in these centers through our referrals. A total of 216 SAM children were treated and recovered in these two centers.

3 **No model Anganwadi Centers:** Most of the AWCs are operating from private building and they also shift location depending upon their need. Hence, they lack, space for children to eat, utensils were not available for both cooking as well as serving. Anthropometric measurement was not available and also no toilet and hand washing stations. This deprivation restrains children to come to the center to avail of services. Considering which the project installed portable toilets with running water and hand washing station, water filters were provided in all the project AWCs and also provided utensils, growth charts , weighing machines as well as stadiometers and mattresses. This intervention enabled children/preschoolers to learn and work as agents of change. They conveyed the project messages to their households.

Outcomes

Community Knowledge: 93 village level community nutrition workers or poshan didi are skilled to address medico-social behaviors and practices. Who are from the community and is well recognized by the community.

Reduction in Undernutrition: 31.6% decrease in undernutrition (severe and moderate cases of weight by age) has been reported as a result of messages given systematically during home visit, mothers meeting and recipe demonstrations with emphasis on age appropriate feeding behaviors.

Reduction in Low Birth Weight: 4 % decline in low birth weight cases has been noticed due to sustained counselling on Infant and Young Child Feeding practices during mothers meeting and home visits. (15.1 % in baseline 2015 to 11.1 % in December 2018)

Breastfeeding: Improvement of 45.5 % has been found in initiation of breastfeeding practices within one hour of delivery. (44.5 % in baseline 2015 increased up to 90 % in December 2018)

Complementary feeding: Increase from 10.7% to 68.5% (57.8 % improvement) in initiation of semi-solid food with breastfeeding on completion of 180 days.

Reduction in Diarrhoea: Prevalence of diarrheal episode decreased from 18.4 % to 5.0% due to use of water ladder and improved hygienic practices. Increase in hand washing with soap after defecation and before eating meals or handling raw and cooked food was found to be gone up to 94.3% respectively.

Treating SAM children: 200 children treated in two MTCs Rishabdev and Lunkaransar, where project supported Human Resource, logistics and capacity building of MTC staff.

Hygiene interventions: Food handling and upkeep has shown significant improvement within the families. Families that cook in hygienic way and keep food in proper way has increased from 23% to 94% in last 3 yrs. Further the use of proper water storage and water handling techniques has also increased from 26% to 96%.

Outreach & Scalability

- **Government as the key stakeholder:** All the district level officials as well as the state level functionaries from both the department of health and ICDS were roped in from the start of the project.
- State level start up workshop as well as dissemination workshop were conducted and knowledge disseminated with government , as well as UN and other local partners
- As per the new Integrated Child Development Services (ICDS) restructuring model an additional community worker has been proposed at the Anganwadi Centre to support the behavior change activities at the community level. This project has demonstrated the need and important of additional community worker to bring in behavior change. This project has also demonstrated the roles and responsibility of this community nutrition worker in an integrated manner.
- Using Nutrition worker the project implemented innovative model which bridged two Government flagship programmes like ICDS and Swatch Bharat Mission with regular Health interventions. It also created comprehensive real time data management and monitoring system incorporating the components of health, Nutrition and WASH and interpreting on the nutritional status of children.
- This is a an important community based intervention model which utilized WASH and health interventions adequately at the community level to change the behavioral practices without a provision of any external financial or material support/subsidy to the family and still achieved considerable sustainable change in the growth and development of children **{significant reduction underweight childbirth (6.5%), overall malnourished children (18%), and severely malnourished children (5.8 %), moderately malnourished children (15%)}.** Plan India has own sponsorship financial model, an unrestricted fund with the flexibility to be allocated as per prioritized issues. Further, most of the activities are dovetailed with Government's routine activities at the community level like VHNDs, AWCs activities, Immunization programs, Swatchata Missions, Community Managed Malnutrition Programme, and Rastriya Bal Swasth Karyakram (RBSK) etc. Most of these programmes have already being strengthened under this project. Plan India is also trying to disseminate this project to various donors including Corporates to garner support. To cover the management cost and over all support Plan India already has ongoing programmes, state office,

regular internal staff and partner's staff to carry on the good work which has extended under the project.

Replicability

Plan India work with many external partners (National and International) to pilot, innovate and scale up its interventions. Building on its strong presence in the country, Plan India has established and nurtured partnerships with local NGOs in the 16 states. We have a cumulative experience of working with over 100 NGO partners on specific issue-based programs and grants-supported program. Plan India is part of various national as well as state level alliances to carry the advocacy agenda.

Plan India is also working with State and National Governments, providing technical support especially National Health Mission as well as ICD to role our best practices and the learnings of the project including technical materials developed during the project.

Plan is already member of the technical task force to review the IEC materials of ICDS .The sustainability component of the project is inbuilt and very strong:

- This project is able to develop and nurture Community based institutions and structures like local Civil Society Organization, Gram Sabha, Mothers Groups, Children's Group and Community Volunteer. CSOs will be able to sustain the interventions mobilizing crowd funding.
- The project has upgraded WASH facilities at the Anganwadis and hence, generated demand for services.
- Also created a cadre of trained CNWs in each of the villages it has worked, they are still continuing under ICDS restructuring model after the project has phased out.

Impact Achieved

The project has been able to mobilize 1.5 lakh population (of which 12000 were children below 6 years and pregnant women) spread across 70 villages in two districts of Rajasthan and supported in reducing malnutrition's by introducing safe water, sanitation and hygiene. Project villages achieved open defecation status and also disposed waste safely by introducing the concept of kitchen garden (25 AWCs and 575 households), which used grey water from bathrooms and kitchen. In addition, 3536 mothers meeting were conducted with pregnant women and mothers of children below 6 years.

Stakeholders trained- 93 CNWs, 75 Aganwadi workers, 26 Sanchailkas and 56 ASHAs on safe WASH and Nutrition practices. 93 CNWs were also trained on handling and use of Plan MCH app. In all, 168 Community Male members trained as Master Trainers to sensitize parents on gender issues. 1,029 SHG/PRIs and 5,712 Pregnant and lactating mothers trained on preparation of nutritionally rich recipes using local and seasonal ingredient. Further, 5,281 community members were triggered and oriented on the importance of hygiene and sanitation aspects.

Health camps & VHNDs: Project facilitated 1909 VHNDs/MCHNDs to ensure its effective and enhanced reach and organized 129 health camp for management of critical illness and referrals. Also ensured

regular micronutrient to children under 6 and supported vitamin A and deworming rounds. Also provided ORS and zinc supplementation to the children with diarrheal episode.

Potable Toilets "In addition, 56 portable toilets were constructed at the Anganwadi level and 3400 ladles were distributed to the households having malnourished children below 6 years.

Health outcome of the project is assessed in terms of reduction of malnutrition.This impacted in significant reduction underweight childbirth (6.5%), overall malnourished children (18%), and severely malnourished children (5.8 %), moderately malnourished children (15%).

Capacity Building

Module Development: Development of culturally appropriate behavior change and communication material for e.g. IYCF manual in English and Hindi, Recipe Manual, Gender in Nutrition manual Flipbooks, Posters, Pamphlets.

Training of community Nutrition Workers: Selection and capacity building of 93 local women as Community Nutrition Worker as a change agents.

Training of SHG and PRI members: 247 members were provided orientation on IYCF, WASH, and Gender.

Training of mothers and fathers: Mothers and fathers were capacitated on various issues and skills on breastfeeding, complementary feedings and on various recipes. They were also imparted training on identifying high risk children, complications related to malnutrition and proper referral.

Training of Government stakeholders: AWW, ASHA and ANMs were provided training. 126 persons were imparted training.

District as well as state level Workshops: 4 district level workshops was organized and one state level dissemination workshop was organized during the project .

Partners of the Project

- Local governance like Panchayati Raj Institution, Village Health Sanitation & Nutrition Committees
- Department of Health at the state, district, block and village level including Accredited Social Health Activist (ASHA), Accredited Nurse Midwives (ANM)
- ICDS functionaries at state, district, block and village level including Anganwadi Worker/Balwadi sanchalika
- Project staff at state, district, block and village level including Community Nutrition Worker.
- Two implementing partners namely Sewa Mandir and URMUL for daily activities under the supervision of Plan staff at the district as well as state level.

Konku-Puchiku Project

Spandan Samaj Seva Samiti

Website	:	www.spandan4change.in
Founder of the Organization	:	Ms. Seema Prakash
Coverage/ Geographical reach	:	200 Korku tribe dominated villages of three adjoining districtsnamely Khandwa, Burhanpur and Betul of Madhya Pradesh.

Project Brief

Konku –Puchiku (means cute little children in Korku dialect) Project was launched in 2011 with a shared vision among Glenmark Foundation and Spandan Samaj Seva Samiti to address the alarming malnutrition prevailing among the U5 Korku children. The Project was geared to implement a community-based intervention that would help scores of malnourished children recover at homes without having to resort to prolonged facility-based treatment like Nutrition Rehab Centers often an urban Hospital annex. Most of the tribals still are hesitant to leave home and stay longer at the hospital, having to leave her home, farm and other children behind. The project intervened with early nutritional tracking of children and following it up with adequate follow-up care like home visits, nutritional counseling, diet diversification advice and promptings for immunization. Health Camps at remote locations have been useful at bridging service delivery gaps.

Considering the fact that major determinant of malnutrition has been the growing household food & nutrition security. The Project has promoted Backyard Nutrition gardens and Backyard free range indigenous poultry. To further strengthen the food security, a sustained campaign was run to motivate Korku tribe farmers to revert back to growing traditional crops and Millet that once was the mainstay of community nutrition and coping mechanism in times of food crisis. When the project began the situation of peak hunger times prevailed and most of the poorest families had to undergo food shortages forcing them to seasonal distress migrate or be indebted. The campaign began with motivating and collecting indigenous Millet seeds and setting up Seed banks at strategic locations to outreach more number of farmers. It is now a community managed service and the number of Millet growing farmers has been increasing.

A corollary initiative was undertaken to evoke the now nearly forgotten tribal tradition of mutual help. The neighborhood land and water resources were developed through voluntary labor contribution and women taking lead. Hundreds of acres of land were amended by picking idle stones and stacking farm fences to check soil erosion, existing wells and ponds were deepened and some new wells were dug by women and water structures like stop dams were repaired or new sandbag check dams were installed

to increase water retention capacities. All this helped in increasing the per acre yield in this hunger prone region.

Anganwadis being the sole institution for child nutrition in a rural area were taken up for revamping. They were given a facelift and equipped with toys and recreational materials and clothing. The centers turned into genuine child-friendly spaces where children could be retained for a longer time and so could access most of the available services like supplementary nutrition, immunization and health checkups. A distinct intervention was the introduction of a range of Teaching –Learning Materials in indigenous Korku dialect. The regular events at the centers have motivated mothers and children to engage in center's activities.

Another anecdotal intervention was to run community crèches for children below three years and ones belonging to wage-earning tribal mothers. The wage-earning mothers can leave their children and crèche provides feeding and caring services for the whole day. A regular health check is extended.

The Project focuses on the Behavior Change Communication. Korku tribe community has been comparatively backward and held to many myths and superstitious beliefs and practices. Their quacks and priests promoted appeasing of deities. They correlated different symptoms of malnutrition as the curse of some or other tribal deity and its treatment ranged from offering oblations to tying talismans with lizard's tail. The Project in its proactive process to demystify malnutrition have been deploying a range of information, education and communication (IEC) methods to reinforce learning, generate widespread awareness and engage the community in a discussion on the issue in question. Use of local dialect has been very effective. The community opinion shapers comprise of their informal leaders (Patel), tribal priest (Bhumka) and tribal healer (Padiyar) and the elders. The Project has strived all through to transform them into Social Behavior Change Agents (SBCA). They have been proactively oriented and trained to know the observable symptoms of malnutrition use MUAC tapes and motivate the victim families to prefer scientific treatment over chants and rituals. An innovative method of Wall Comic Posters is used.

The efforts also include interactions with grassroots government service providers like Anganwadi Workers, ASHA, and ANM. Regular meetings, training, and joint visits have helped in forging collaborative actions at tracking, immunization, follow-ups, and referrals of mothers and children. A distinct collaboration has been to increase the outreach of most eligible children with Vitamin A and Deworming. District and Block level meetings with the concerned Departments have been organized.

Implementation Model

The Project has adopted a layered approach wherein it tries to relieve the sufferings of currently malnourished children on one hand while on the other hand, it tries to facilitate a food secure environment that can be accessed by most of the poor and needy families. It is community-based malnutrition management model that aims at helping most of the malnourished children recover from homes in a non –facility-based care and in the process capacitate the community to sustain the initiated process.

Community Outreach

The Project has an underlying component of community participation. It provided ample opportunity for the stakeholders to engage, share, learn from each other and plan and review the progress and resolve intervening problems. The key beneficiaries are identified families with malnourished children and ones that are prone to hunger like landless, frequently migrating, widows and single women-headed families.

Uniqueness of the Project

The innovation of the project has been its ability to see malnutrition beyond mere clinical issue and address the major underlying causes that have been triggering household hunger. The consequent activities in the form of revival of Millet & Traditional crops, aligning Backyard Nutrition Gardens and Free Range indigenous Poultry as a major source of direct absorption of protein and essential micronutrients, developing neighborhood land and water resources by and building a scientific temper among the community opinion leaders collectively could address the causative factors effectively. The community crèches have been trying to prove a point that adequate attention to children below 03 years who are most prone to damages of malnutrition can greatly reduce the physical and cognitive losses it can cause.

Role of Information and Communication Technologies (ICTs)

We have introduced Millet processing machines in the community to help ease the burden of women having to do it on manual mud grinders. With this they will be able to process the Millet easily can in future also consider surplus marketing.

Challenges Faced

The initial challenge was to demystify the malnutrition among the community. Secondly, it was needed to prove that low-cost non-facility based care was the need of the hour to help scores of children who were either victim or exposed to becoming one. The major effort was directed to establish a viable relationship with the community. They were engaged in various personal and group interactions. A concerted effort was directed to gauge vital information on their own perception of malnutrition and various practices that developed and lay embedded in their oral tradition. This gave us a deeper understanding that went into developing a range of communication tools and methods. The use of local dialect helped in increased participation. The focus on building a scientific temper among their community opinion shapers showed a good response. Now they can observe the obvious signs of malnutrition, use MUAC tapes and provide right counseling to victim families. Most of the mothers have been heeding their advice on preferring scientific treatment of malnutrition over rituals and chants they practiced earlier. Many mothers now know the current nutritional status of their children and have been trying to diversify diets with Millet and vegetables and poultry.

Outcomes

The Project over time has been able to engage the community in the process. They have contributed their knowledge and traditional wisdom to help the revival of Millet. The Millet has been forging its way back in the farms and plates of the family.

The direct absorption of protein and essential micronutrients through increased accessibility to vegetables and poultry and eggs has been crucial in reducing extensive protein-energy –malnutrition (PEM).

The increased awareness on causes and consequences of malnutrition among the community at large has helped families to access food and national entitlements, opt for proper treatment and have been consciously trying to diversify diets with most of the available food items they can collect from the neighborhood or grow themselves. There has been a gradual increase in a number of families reverting back to growing Millet and other traditional crops. This is rebuilding the nutrition base of the community.

There has been a significant decline in the rates of malnutrition. Especially the rate of underweight children has decreased and so the IMR. The latest NFHS IV data records 49% children underweight, 23% wasted and 43% stunted.

The community crèche has been appreciated with daily wage earner mothers not because they are being taken care of rather they have been showing sustained growth and are less prone to illness.

Outreach & Scalability

The project outreaches on an average 2000 U5 malnourished children every month and nearly 2500 Pregnant and Lactating mothers and 5000 families. The coverage is 200 villages across 03 adjoining blocks and districts namely: Khalwa (Khandwa district), Khaknar (Burhanpur district) and Bhimpur (Betul) district.

Replicability

The Project has established its efficacy by being able to reach 3000 children every month physically and engage mothers and the community elders in the process. It's a low cost and does not employ anything that is not culturally sensitive or will require import or high costs. The project design allows the capacity building of knowledge sharing among all the stakeholders. It has potential to be sustained. It can be best suited for tribal communities that face the highest burden of malnutrition in the state.

Impact Achieved

The overall impact of the project can be assigned firstly to the relation that could be established with the target community. It helped in not having them depend too much on external support or dole outs.

The Project had a dual focus – immediate and far-reaching. The former has been to alleviate the suffering of the children already malnourished and latter to create a food secure environment. This mix has been able to make it more effective.

Capacity Building

The Project lays great emphasis on capacity building of stakeholders. It involves training and workshops, planning & reviews, group meetings and awareness campaigns. The Thematic training is done both in-house and through external training. The community level training includes training of mothers on breastfeeding and care, diet diversification, technical inputs on nutrition gardens and poultry, various public entitlements related to food & employment. A specific focus is on orientation and training of Community opinion leaders to develop the right understanding of causes and consequences of malnutrition and equipping them with skills to become Social Behavior Change Agent (SBCA). The interactions with grassroots service providers an especially Anganwadi worker, ASHA and ANM have been to reinforce collaboration and updating their perspectives and skills in managing malnutrition cases. Various joint programs like home visits and follow-ups and referrals an event at Anganwadis and administration of Vitamin A and Deworming has been effective. The campaigns like Millet Campaigns have been very effective at facilitating discussions, generating new knowledge and information and motivation that have gone long way in reviving the Millet. The dialogues and deliberations have been done at Block and State levels to share knowledge and influence policymakers.

Partners of the Project

Partners of the Project include Glenmark Foundation Mumbai that has provided resources and guidance while Spandan Samaj Seva Samiti has been responsible to implement it on the ground with a shared vision – Healthy Children- Healthier world. GOONJ New Delhi had been an active partner and has been providing toys, clothing and other materials support that has been useful at mobilizing the community. The occasional help from Glenmark Employees too has been useful in meeting material needs.

Awards/Endorsements

The Project received following Awards :

- Best NGO partner Award by Glenmark Foundation Mumbai
- CSR Impact award for Healthcare
- Stree Shakti Samman –Rani Laxmibai Puruskar by W&CD Ministry GOI

Maternal Nutrition Supplementation project for antenatal and post-natal women in Palghar District, Maharashtra

May 2016 - June 2017

Impact India Foundation (IIF)

Website	:	www.impactindia.org
Founder of the Organization	:	Mrs. Zelma Lazarus, Founder Director & CEO
Project Budget	:	Approximately ₹ 50 lakhs.
Coverage/ Geographical reach	:	Malvada Primary Health Centre (PHC) Area, Vikramgad Block, Palghar District, Maharashtra.

Project Brief

In India, under nourishment poses a key challenge that remains to be tackled. The dietary intake of energy, micronutrient and protein in mothers is generally found to be low. Low purchasing power, large family sizes, gender bias etc. are some of the determinants of a compromised nutritional status. To improve this situation, various strategies were put forth:

Objectives: -

- To provide access to a nutritious diet for mothers in antenatal and post-natal stages to support their health during pregnancy and lactation.
- To promote the regular consumption of the foods by the mothers and help them overcome the dietary gap by nutrition education and counselling.

Implementation Model

The model was implemented as a part of Impact India Foundation's preventive health programme: The Community Health Initiative (CHI) in Palghar District, Maharashtra. A total of 110 beneficiary mothers were identified from different sub-centres in the area under Malvada PHC.

This short-term cohort intended for the proposed supplementation and education, was targeted for follow-up till the birth of their infants and six-months of post-natal period. The outputs and outcomes were to be assessed in relevance to the following variables:

- Gestational weight gain of mothers for the period of supplementation – Mean weight gain of the mothers in relation to the supplements intake.
- Maternal Haemoglobin status – Maternal haemoglobin levels noted over the gestational period.
- Birth outcomes- Mean birth weight, along with the reduction in the incidence of Low Birth Weight and other unfavourable results of pregnancy.
- Weight gain in infants – Mean weight gain of infants in relation to the consumption of supplements.

Registration of mothers: Confirmation and registration of pregnancy in general, often occurs as late as the second trimester in the Malvada Block (Tehsil). This is due to ignorance and lack of pro-activeness amongst females, due to which ante-natal care in turn, is delayed. Therefore the maximum no. of mothers (n=110) were included in their fourth month of pregnancy (second trimester), which is the limitation of the project. A total of 95 beneficiary mothers were the project beneficiaries after taking into account drop-outs and migration.

Provision of supplementary food: To proffer a maximum intake of nutrients, mothers were supplemented with daily hot cooked meals along with fortified Laddoos. The Laddoos were high in calories (550 Kcal) and with an inclusion of vegetables increased dietary diversity, otherwise unaffordable to mothers daily. Mothers were guided to the nearest ZilhaParishad (Z.P.) schools in their respective areas to receive the day –time meals by the CHI field team. The other nutrient dense foods like eggs, peanuts, etc. with a relative larger shelf- life were distributed by means of home visits. An assured amount of 1570 kcal was thus provided daily in the antenatal stage, with different combinations

of the foods. This was increased to 1724 kcal for the postnatal period to augment lactation. In addition Iron & Folic Acid & Calcium tablets were given.

Compliance of supplementation: The CHI field team ensured that the foods reached beneficiary mothers and were consumed regularly by means of home visits. Laddoos were distributed by IIF's CHI team.

Nutrient and Health Education: The importance of the consumption of these food items were stressed at each home visit and mothers were thus motivated to adhere to routine intake of the provided supplementary foods. The significance of diet diversification, improving levels of nutrient intake and other relevant ante and post-natal care practices were emphasized.

Community Outreach

Regular monitoring of weight gain and Haemoglobin (Hb) tests were done in the ante-natal period till birth. Weight gain in infants was checked monthly, for a period of six months post birth. However, mothers were unavailable for weight checks at certain days due to which there were discrepancies in recording. The birth data of all the infants is also not available for reasons like mothers moving to their maternal homes for delivery, etc.

Uniqueness of the Project

To proffer a maximum intake of nutrients, mothers were supplemented with a Laddoos high in calories (550 Kcal) and counseled on the intake of vegetables to increase dietary diversity, otherwise unaffordable to mothers on a daily basis. The other nutrient dense foods like eggs, etc. were distributed by means of home visits. An assured amount of 1570 kcal was thus provided on a daily basis in the antenatal stage, with different combinations of the foods in form of Laddoos. This was increased to 1724 kcal for the postnatal period.

Role of Information and Communication Technologies (ICTs)

Information Technology was used to maintain a database of the beneficiaries.

Challenges Faced

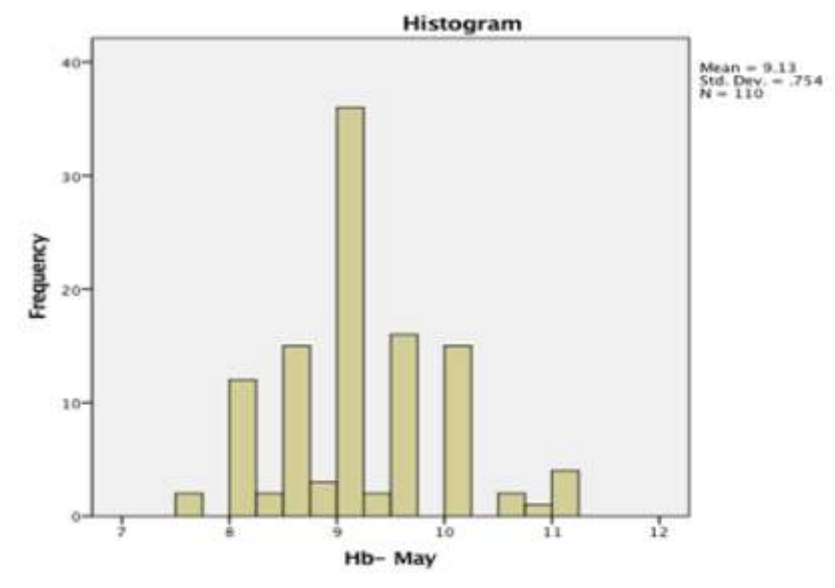
Migration of the antenatal and post-natal women is common in Tribal belt of Palghar District for work in factories, brick kilns and to cities. Learning from this experience IIF adopted the criteria of selecting women, in future Maternal Nutrition Supplementation projects, who would not migrate.

Outcomes

Percentage of women reported Hb less than or equal to 11gm/dcl when registering for Ante Natal Care (ANC) at PHC in the month of May 2016 (N= 110)

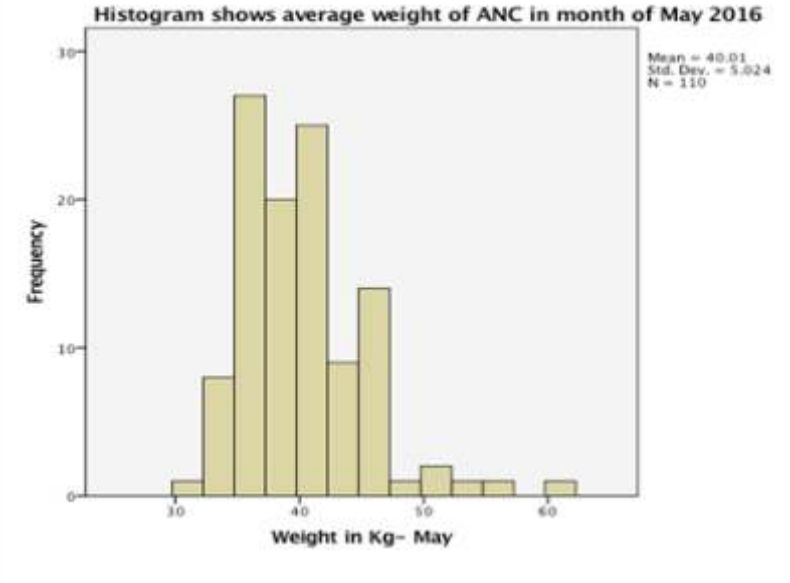
Parameter	Value
HB Mean	9.13gm/dl
SD	0.754
Range- Minimum	8.0 gm/dl
Maximum	11gm/dl

- Diagram No.1 depicts a Histogram showing the percentage of ANC women reporting Hb less than or equal to 11gms/dcl at PHC in the month of May 2016. (N=110)



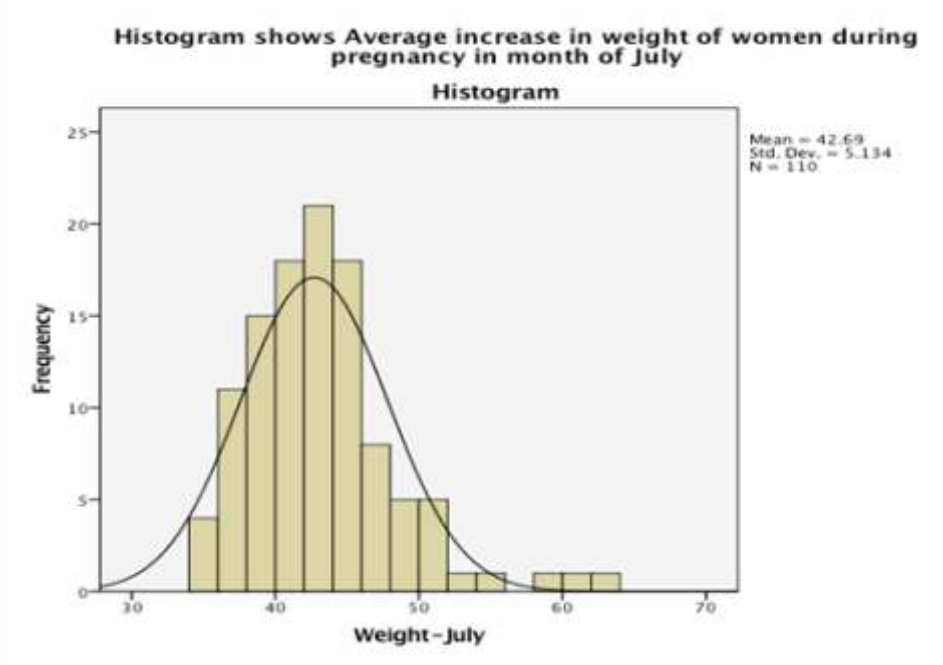
Average weight of women when registered for ANC at PHC in the month of May 2016 (N=110)

Parameter	Value
ANC mean weight (in Kgs)	40.01kg
SD	5.024
Range- Minimum	31.0kg
Maximum	60.0kg

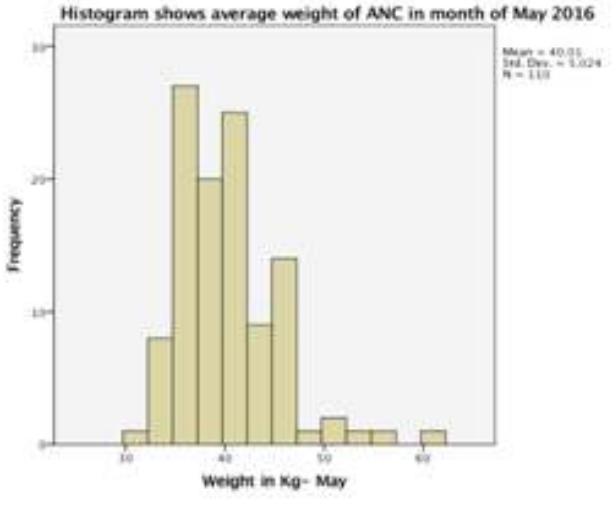


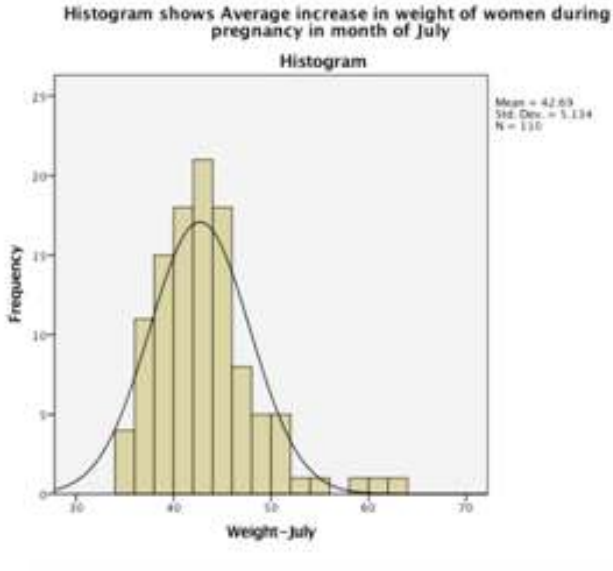
Average increase in weight of women during pregnancy in month of July 2016 (N=110)

Parameter	Value
ANC mean weight (in Kgs)	42.69kg
Standard Deviation (SD)	5.134
Range- Minimum	34.0kg
Maximum	62.0kg



Comparison of May and July 2016 graphs





Percentage of infants reporting weight greater than or equal to 1.6 kgs to 3 kgs and above at birth in different months (N=95)

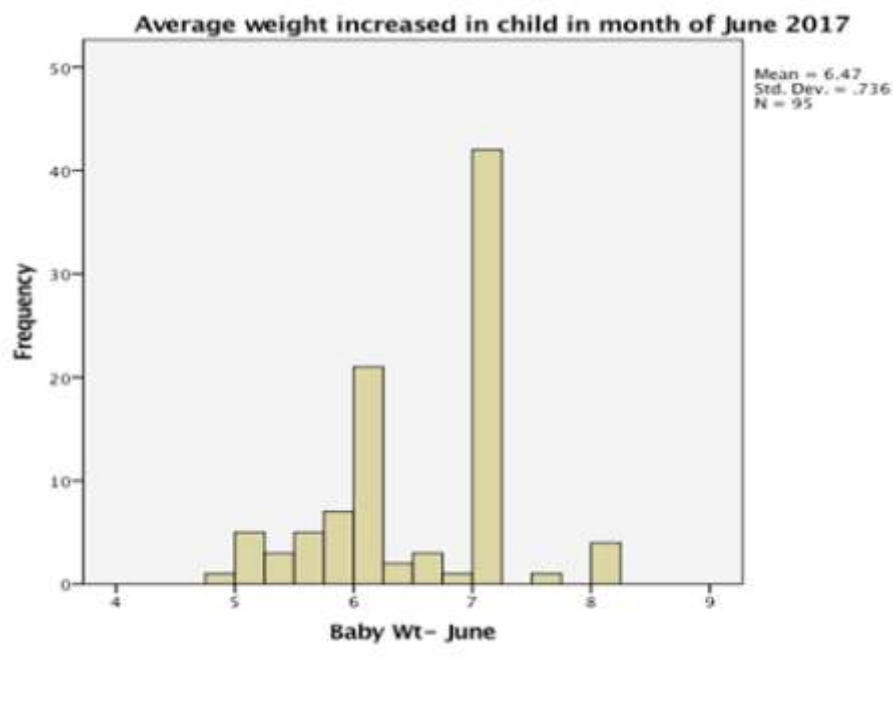
Variable	Value	Frequency %
September 2016	1.6kg to 2kg	0
	2.1kg to 2.4kg	1
	2.5kg to 3kg above	5
Total		**6 (5.7%)**
October 2016	1.6kg to 2kg	2
	2.1kg to 2.4kg	2
	2.5kg to 3kg above	17
Total		**21 (19.95%)**
November 2016	1.6kg to 2kg	4
	2.1kg to2.4kg	3
	2.5kg to 3kg above	24
Total		**31 (29.45%)**
December 2016	1.6kg to 2kg	4
	2.1kg to 2.4kg	5
	2.5kg to 3kg above	14
Total		**22 (20.9%)**
January 2017	1.6kg to 2kg	2
	2.1kg to 2.4kg	1
	2.5kg to 3kg above	6
Total		**9 (8.55%)**
February 2017	1.6kg to 2kg	2
	2.1 to 2.4kg	1
	2.5 to 3kg above	2
Total		**5 (4.75%)**
March 2017	1.6kg to 2kg	0
	2.1kg to 2.4kg	0
	2.5kg to 3kg above	1
Total		**1 (0.95%)**

- No. of babies with weight minimum 2kg:-14
- No. of babies with weight in range of 2.1kg to 2.4kg-13
- No. of babies with weight in range of 2.5kg to 3kg and above-68

Average increase in weight of infant in six months (N=95)

Variable	Frequency
• Minimum 5kg increased	**9**
• Minimum 6kg	**35**
• Minimum 7kg	**46**
• Maximum 8kg	**05**
• Mean	**6.47**
• SD	**0.736**
• Range- Minimum Maximum	**5kg** **8kg**

Histogram shows the average weight gain in children after 6 months



- Number of Miscarriages or wastage pregnancy- 11
- Child death- 2
- Still birth- 2

Outreach & Scalability

IIF has signed a ten-year MoU with the Palghar District administration to scale up Reproductive, Maternal, Newborn& Child Health + Adolescent projects in the remaining 43 PHC areas of the Tribal District (population: 30,00,000).

Replicability

The learning obtained from the outcome and impact of this project has informed the strategies of a similar Maternal Nutrition Supplementation project being implemented in another location in Palghar District.

Impact Achieved

- Gestational weight gain of mothers for the period of supplementation - Mean weight gain of the mothers in relation to the supplements given effective to weight gain during the antenatal and post-natal periods.
- Maternal Haemoglobin status - Maternal haemoglobin levels noted over the gestational period.

- Birth outcomes- Mean birth weight, along with reduction in the incidence of Low Birth Weight and other unfavorable results of pregnancy.
- Weight gain in infants - Mean weight gain of infants in relation to consumption of supplements by their mothers.

Capacity Building

Before the initiation of the project, the capacity building of the of the CHI Team was conducted on various thematic areas, which included the conduct of Body Mass Index surveys, Hb estimation, identifying signs and symptoms of high-risk cases for timely referrals to Doctors, Personal counselling to rest between work, breast feeding practices, training for family members on the creation of a supportive environment for the pregnant mother at home.

Partners of the Project

Johnson and Johnson Pvt. Ltd.

Awards/Endorsements

- The Breach Candy Hospital Trust has supported a similar project on Maternal Nutrition Supplementation in Palghar District for 15 months. The extra month was added to include best weaning (complementary feeding) practices after the completion of six months of breast feeding.
- Johnson & Johnson has expressed interest in the support of a similar project which includes the capacity building of Government Health Staff (Anganwadi Workers, Accredited Health Activists - ASHAS and Auxiliary Nurse Midwives) to support Mother and Child Health. This will promote sustainability of the gains achieved.

CHI staff (in blue cap) hands over a package of supplementary nutrition to a pregnant woman beneficiary.

CHI staff uses educational videos on laptops to sensitise new mothers and their families and augment personal and family counselling on Mother & Child Health.

Dr.Nitesh Sharma, Project Director,
Impact India Foundation's Community Health Initiative, March 5, 2018

Mentor field training_TN_Madurai District

Capacity Building and Training of Mentor Nurses- An initiative to create a resource of 192 master nurse trainers in the state of TN supported by United Way of Chennai (UWC) & Motivation for Excellence (MFE)

March 2015 to present

Ekam Foundation

Founder of the Organization	:	Dr. Sailakshmi Belijepalli
Project Budget	:	₹ 3,75,31,049
Coverage/ Geographical reach	:	Tamil Nadu – across all districts

Project Brief

In 2012, a Government Order to designate Mentor Nurse at the state level and district for training 4000 nurses was passed by the Government of TN. This set a platform to provide a mandate for significant intervention in healthcare, particularly maternal and infant care at the village level. Selected from the districts it, the mentor nurses were identified to train, work with the nurses in PHCs across TN as an interface between the District and the Block Level Hospital authorities, thereby leading to improved nursing delivery.

In late February 2015, United Way signed an MOU with Ekam Foundation, a healthcare based NGO working within the Maternal and Child Health spectrum. The project, which is run under the auspices of Directorate of Public Health, Tamil Nadu aims to build the capacity, empower and mentor 200 nurses from the Government health centers and enable them to take the knowledge and skills forward to the existing framework of nurses stationed within all the Government Hospitals in the state.

These nurses are being trained and mentored by specialists and experts in the field of Obstetrics, Pediatrics and Neonatology from premier healthcare institutes in the country. The project , planned over a two year period has been conceptualized keeping in mind that training these Master Trainers will essentially strengthen their skills and competencies and thereby make way for provision of quality care services for maternal and child health care.

The program is committed for excellence and was conceptualized with the sole intention of bringing down IMR and MMR in government healthcare settings and ultimately, that of TN. It is expected that the program will help build a resource pool of the best, the most qualified, skilled, knowledgeable trainers who will be masters in the field.

Implementation Model

The project aimed to create a cascading effect of the spread of knowledge and improving the standards of delivery of nurturing care from the 184 Master trainers to the 3808 staff Nurses and 2000 ANMS and finally, for this knowledge to trickle down to the community. This was done in phase 1 of the program.

TRAINING METHODOLOGY

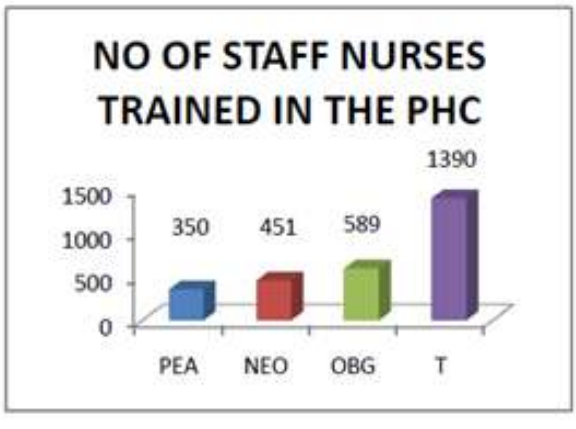
The training was given to the Staff Nurses in the form of interactive lectures and hands-on training by the specialists (doctors) in Obstetrics & Gynaecology, Neonatology and Paediatrics. As per schedule, all the activities were successfully executed without any interruption. Enthusiasm of the staff nurses was seen throughout the training program. Pre and post training tests were conducted. Pre test was conducted to understand the level of knowledge with regard to technical skills during the start of the program. Post training test was conducted to evaluate the impact by finding the difference in their knowledge. In addition to the technical sessions, change management workshop was also conducted. Subsequently, separate session for obtaining their feedback was also conducted to understand the pros and cons of the training programme.

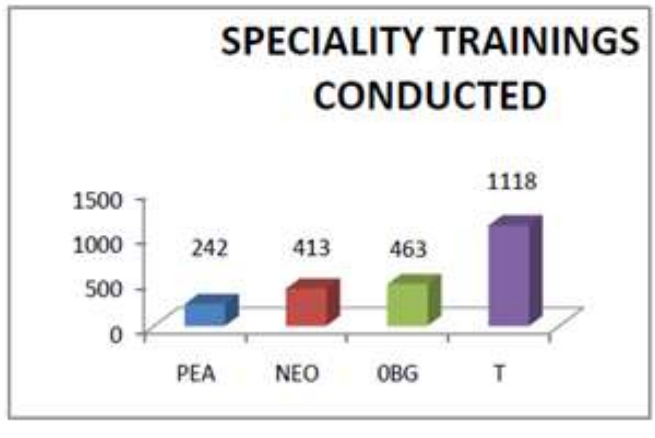
Community Outreach

- Total Number of Nurses Trained – 184
- No Of Days of Training given in all – 90
- No of training sessions conducted – 5
- No of days of training /session – 18
- No of PHCs visited - 1362
- Gap Assessment forms filled – 746
- Data entry and analysis completed – 220
- Data entry completed – 700 in all

Uniqueness of the Project

Out of the 184 nurses trained, around 90 percent of the nurses were regular mentor staff nurses who went about their duties. 1390 staff nurses were trained in all. 1118 trainings were conducted across Neonatal, Obstetric and Pediatric specialities.





Role of Information and Communication Technologies (ICTs)

Motivation Motivation is a fundamental part of focus as the Mentors are clearly disillusioned by the everyday banality of their job. External factors which can drive motivation and change behaviour, for example, the provision of incentives or penalties can perhaps be recommended. But internal factors, such as the nurses' self motivation, drive and desire to improve are very important too. Intentions and goals can impact on how much these nurses actually want to change. Nurses priorities and commitments may also interfere with their ability to change.

Acceptance and beliefs The nurses' individual attitude and belief will significantly affect their behaviour. Perceptions of the views of others [World View] may also have an impact. Some nurses may find it difficult to accept new inputs if it is in conflict with their inbuilt belief or learnings [unlearning]. A person's belief in their own ability to adopt a new behaviour also has an impact on whether a change can be implemented.

Skills Nurses will need to know not only about what change is required, but also how best to competently carry out the change. The nurses will need further training to ensure they have the skills to deliver best practice, time to learn new skills and practice them. Individual abilities, interpersonal skills and coping strategies will also affect how easy or difficult it will be for individuals to learn new skills. Practical barriers like situations in Government Hospitals can involve a lack of resources or personnel, or difficulties in establishing service delivery Another practical difficulty is maintaining change in the long term. If key members of staff leave or priorities shift it may be difficult to maintain any changes that have been introduced.

Challenges Faced

- Identification of Trainers on a regular basis despite having the necessary permissions from regulatory bodies

- Some of the nurses sent by the Govt to the central trainings were not Mentor nurses but regular staff nurses
- Nurses unhappy with long schedule of trainings
- Trainers not at all satisfied with honorarium paid.
- Skill lab in IPH not completely equipped. Trainers feel the training centres not upto the mark and hence, they have to rely on didactic training approaches.
- Teething problems regarding food supply during Trainings 1 and 2. Sorted

Mentor field training_TN_Madurai District

Challenges Post Training

- Decision making at the Government level was slow. Permissions not reaching the concerned authorities on time.
- Doctors in PHCs not briefed about project by the Govt.
- As some of the nurses are not mentor nurses, they are still doing clinical duty.
- Govt not providing nurses with the recommended TA/DA regularly . Nurses unwilling to travel. Ekam needs to consistently push the nurses to travel
- Gap assessments are not being encouraged by doctors in PHCS. Unresponsive and unreceptive to change.

Learnings

- Roles of supportive staff, supervisory and mentoring staff should be reviewed and discussed in the training.
- Supervisory guidelines and checklists also need to be developed.
- In concurrence with earlier evidence based reviews, capacity-building of Mentor Nurses should largely focus on important elements of change management should include the relevance of PHC visits, the established schedule regarding PHC visits, skills needed to conduct the visits, cultural, equity and gender norms, and record keeping on PHC visits
- It has been noted that in addition to technical or specialty trainings, adequate focus on change management is priority.

Outcomes

Some of the observed outcomes include

- Lowered number of infant, child, maternal deaths.
- Improved standards of nursing care within the PHCs in TN.

- Lower rates of infection related deaths.
- Fewer rate of morbidities in RMNCHA spectrum.
- Timely referrals of cases without compromising on quality of care.

Partners of The Project

1. United Way of Chennai (UWC) - Supported for training (central/in house) of Mentornurses
2. RGMFE - RG Manudhane Foundation for Excellence - Motivation for Excellence - Supported for Monitoring of Mentor Nurses & on field training, community institution building

On field training_TN_Kancheepuramdistrict

Regional officer, Ekam giving his feedback on mentor's training_TN_Tiruvallur District

PHC nurses getting trained by Mentor_Theni District

Mentor field training_TN_Madurai District

India_MIRA

MIRA Channel: Mobile Phone based Channel for Rural Women on Maternal & Child Health using RMNCH+A Approach

April 2012 – On-going (March 2020)

ZMQ Development

Website	:	www.ZMQ.in, www.MIRAChannel.org
Founder of the Organization	:	Mr. Hilmi Quraishi
Project Budget	:	₹ 5 Crores
Coverage/ Geographical reach	:	India – Haryana, Rajasthan, Orissa; LIC (Low Income Countries): Afghanistan, Uganda and Rwanda

Project Brief

Uganda_MIRA

MIRA Channel is an integrated mobile phone channel which provides health communication and information to rural women; and timely connects them with public health system for critical health service delivery. MIRA has multiple channels like Pre-natal, Child Immunization, Newborn Care, Family Planning and Adolescent Girl Health to improve MCH using RMNCH+A approach.

MIRA uses icon based interactive health bots with timely advisory tools based on Artificial-Intelligence using health-calculators-trackers like pregnancy-week-by-week-tracker, menstrual-cycle-calculator, ANC-calculators, immunization-calculators, and high-risk-forecasters; providing customized-localized audio-visual tools as **'Talking Toolkit'** for millions of semi-literate women. It establishes connect with service provisioning and delivery-system. MIRA has two level interfaces-one for individuals and ASHA workers-**'MIRA-Toolkit Model'** for self-management of health. It is used by ASHAs/MIRAs to deliver weekly messages on diet, medication, dons and dons and captures weekly-high-risk-pregnancies.

Another mode **'MIRA-PHCConnect Model'** is used by ANMs to track Live-progress of pregnancies, High-Risk-Pregnancy-status, ANC-check-ups and immunization-follow-ups, weekly-activity-(live) of beneficiaries and MIRAs. ANMs are provisioned with monitoring-toolkit which provides timely action based on High Risk Pregnancy status, ANC check-ups, Immunization etc. Here, beneficiaries get connected with public health service-system for basic health services needs of pregnant-women, ensuring institutional-deliveries and the newborn-care. MIRA platform provides multi-tier 'Live-Activity' dashboard for all hierarchical levels of public-health-system.

The system produces instantaneous 'Live-Data' for the state to take timely decisions and action. This dashboard is viewed by the state office on a minute-to-minute basis to review the status of women, ASHA activities, ANC check-ups, High Risk Pregnancies and ANM working. The state can then immediately take action based on the status of the women and/or performance of ASHA and ANM.

Apart from core tools, platform provides numerous **Value Added Services (VAS)** toolsfor capacity building of rural women using story-telling and decision-making tools on critical health issues, building sustainable behaviour change.

Implementation Model

We used both MIRA Toolkit Model and MIRA-PHC Connect Model for implementation. In the beginning of the project, we recruited 100 MIRA workers in Mewat. MIRA Workers are Community Health Workers

just like the ASHA workers. They were trained to use the MIRA toolkit which carried iconic information with localized audio support. Each MIRA was assigned a village and they registered each and every household in the village, and also identified pregnant women, children in the age group of 0-5 years for immunization and adolescent girls. MIRAs do a weekly visit and deliver iconic messages to pregnant women for that particular week. It delivers 5 critical messages for that week of pregnancy - status of the women in that week, medication/tests required; dietary information of the week, dos and dons. Every week women is also asked 5 questions related to high-risk pregnancy. The information is then stored and sent over the cloud which goes to the Midwife (ANM) through the ANM Toolkit under the MIRA-PHC Connect Model. ANM needs to take an immediate action based on the information received which is conveyed back to the MIRA to do necessary action as instructed by the ANM. MIRA model recommends 40 visits during the whole period of pregnancy.

One of the latest studies done based on the 'Gateway Behaviour Theory', pregnant women who have been visited at least 12times during the total period of her pregnancy (in MIRA program, one visit per week is mandatory and a MIRA is expected to be follow it), the women will 98.7% will deliver baby at the hospital and neither the mother nor the will die at the time of the birth.

MIRA also operationalize through in individual MIRA Toolkit Mode. It is being used under the Haryana Rural Health mission with over 2,500 SHG groups. It has also been implemented in schools with adolescent girls on related topics of Menstrual Hygiene, Adolescent Reproductive and Sexual Health, Life-skills and WASH. Through Community Radio Stations (CRS) MIRA has been implemented in the interiors of Mewat.

Community Outreach

Dedicated Community Health Workers like ASHAs and MIRAs work with the communities, do the household registration, identifies beneficiaries and make weekly visits to deliver information related to pre-natal care, immunization, post-natal care, family planning and adolescent girl's health. So the technology of MIRA and its workers are in direct connects with the communities on a day to day basis. Apart from the mobile toolkit, MIRAs also carry physical registers to register every activity being done. Apart from delivery of information, MIRAs also motivate women go for ANC check-ups and opt for institutional deliveries. MIRAs also assist women at the time of ANC check-ups.

Uniqueness of the Project

a. MIRA is a holistic channel which has moved away from away from the traditional concept of an App. An App is a single stand-alone application for a very specific need. MIRA Channel is based on a channel approach with multiple sub-channels like Pre-natal care, Child immunization, Newborn care, Family planning and Adolescent health issues with an objective to improve maternal and child health through ***RMNCH+A*** approach. The content system is dynamic where the new content gets downloaded on the mobile phones. It is one stop-channel for all the health needs of women in rural areas.

b. The distinguishing innovation of MIRA Channel is its highly graphical icon-based interactive toolkits, health calculators and trackers such as pregnancy week-by-week tracker, immunization tracker, menstrual cycle calculator, family planning tracker and infection prevention toolkit. Use of iconic messaging system throughout the channel enables women with low or no literacy levels understand issues easily and quickly. It also has local language audio support messages. The system works as a 'Talking Machine' but in low-resource settings. No content of type has ever been made available on low-resource phones with such interactivity, icons and audio.

c. This toolkit enables the health workers to provide consistent messaging and information to beneficiaries. Provisioning of messages through the mobile phones creates a level of trust among the communities. The system also brings in adequate amount of transparency in operations at various levels.

d. The channel is developed in 3 modes to reach to as many people as possible. First mode, 'MIRA Individual App' is made available on mobile phones of the communities for their individual self-management of health. This mode also has a facility for multiple registrations on a single device, seeing the fact that not every woman in a rural area has a mobile phone. This concept comes from our experience of working with SHG groups where group leader had a mobile phone and acts as peer leader to supports other women. Second mode is a 'MIRA Worker' toolkit content, communication and service provisioning. We have set up a chain of health workers called MIRA workers who go from house-to-house to do household registrations and identify pregnant women and 0-5 year children for RI (routine immunization) using mobile phones. Third mode 'MIRA-PHC Connect' of works as a total communication, information, management and service delivery system for National Rural Health Mission of the state. This toolkit has two applications - one for ASHA workers and another for ANM. The pairing of ANM and ASHA helps in monitoring and timely delivery of services.

e. The system produces instantaneous 'Live-Data' for the state to take timely decisions and action. This dashboard is viewed by the state office on a minute-to-minute basis to review the status of women, ASHA activities, ANC check-ups, High Risk Pregnancies and ANM working. The state can then immediately take action based on the status of the women and/or performance of ASHA and ANM.

f. MIRA channel also has numerous value-added services (VAS tools) like the stimulating social mobile games, story-telling tools and decision-making stories which provide edutainment to women on social health issues. The story telling engine creates decision-making stories where the stories are presented as interactive decision-tree with different situations (decisions) to choose from. Each situation (decision) has its alternate course of action and sequence of story with its own possible consequence. This enables the user to see the consequence of their decision, thus inculcating sustainable behaviour change by observing correct and incorrect decisions. This is based on 'Sabido' methodology of entertainment-education which has shown a unique capacity for raising awareness among large numbers of people on critical health issues and motivating audiences to adopt new behaviours.

g. MIRA Channel is also provisioned in different skins for different community members like customized skins for various beneficiaries like pregnant mother, adolescent girls and women seeking family planning services based on their needs.

h. MIRA Channel provides holistic one-stop channel to meet all the needs of rural women in India. The channel also has non-health content like skills development, vocational training, and entrepreneurial development programs for rural women. Such programs ensure that when a woman doesn't need any services or information related to healthcare, she shouldn't leave the channel, and opt for other non-health channels like edutainment, skills etc.

i. The larger social objective of MIRA Channel is to also make mobile phones women friendly, which is being achieved by provisioning serious and useful content for women to manage their health and lives. The biggest innovation is to create a mobile channel for rural women in low resource settings. The global objective of the channel is to improve the standard of living of rural women across the globe. Mobile content and technology has always been 'gender-biased', which is developed by men for men. By creating a women's specific channel and provisioning useful lifeline tools increases the uptake of mobile phones by women. There is a huge digital divide when it comes to women and mobile phones. In India alone out of 850 million mobile, almost 520 million mobile phones are owned by women and only 330 million mobile phones are owned by women, that is almost 37% less women use mobile phones as compared to men. This divide is much larger in the rural areas. Launch of this channel create a movement for making gender-neutralizing phones. The impact is huge as it is changing the lives of rural women by improving their health, increasing literacy levels, providing livelihood opportunities and overall increasing the standard of living.

Role of Information and Communication Technologies (ICTs)

Yes it has a universal backend system which interacts with DHIS-II. It has multiple mobile toolkits which support Java, Windows and Android. MIR also has a robust dashboard which gives instantaneous 'Live-Data' for the state to take timely decisions and action.

Challenges Faced

Some of the challenges and its mitigation strategies are as follow:

a. Being a male dominated society, majority of the phones in the community are owned by men. One of the challenges was to ensure that there is acceptance of this solution in the community and more

women use this. This was mitigated by engaging with the so called "Influencers" of the community and bringing in male in the solution design.

b. Development and validation of contextualized content for the communities was a challenge. This was mitigated by conducting workshops and trainings with the communities to get appropriate content and relevant messages in local languages.

c. Finding a right implementation partner is always a challenge. It is essential to have ethically correct partners to work with. This was mitigated by meeting as many partners as possible, doing due diligence and also meeting the network of Ashoka (Innovators for Public) finding ethically correct organizations.

d. Tying with the government and their buy-in is very important. We did pilot programs and shared with the government success of the program to bring them on board/.

e. Training large number of CHWs is always a challenge. We trained initial set of CHWs as peer trainers (Training of the Trainers - ToTs) who in turn further trained more CHWs and community mobilizers for the program.

f. There was a need to have a "change-in-the-process" related to the implementation of the MIRA Channel. The number of visits made by the CHWs is 3-4 visits in 9 months of pregnancy. MIRA Channel provisions a weekly visit for all of the 40 weeks of pregnancy. One of the latest studies done based on the 'Gateway Behaviour Theory', pregnant women who have been visited at least 12times during the total period of her pregnancy, the women will deliver baby at the hospital and in in 98.7% cases neither the mother nor the will die at the time of the birth. For additional visits by CHWs, we have created an incentive model to compensate the CHWs through sponsorships and by offering interactive content as Value Added Services (VAS) to the communities.

g. MIRA is a holistic channel based on RMNCH+A approach. As it is a growing channel which addresses critical needs, we don't want our valuable beneficiaries to be leaving the channel after their needs like pregnancy or child immunization are over. For this, we use have created a digital VAS channel which provides decision-making stories, social mobile games and capacity building interactive tools for other members of the community to keep hooked to MIRA Channel. This approach has a potential to convert MIRA Channel into sustainable revenue generation model.

h. One of the challenges is to bring the government on board. We generate lot of data and reports from the MIRA Channel. The sharing of the data with the government and their acceptance is always a challenge. We have successfully achieved this by providing access of 'Live-Dashboard' to the department

so that they can see live data on a regular basis which helps them in decision making and taking timely action.

Outcomes

MIRA is operational in Mewat district of Haryana. IN last 4 years MIRA has impacted 850,000 women, children and girls. It has been rolled out through SHG Federations with 511,000 women. MIRA is also distributed through telcos, re-charge kiosks, OEMs and CR stations to 106,000 women and girls. Through 67 schools, we have reached to almost 20,000 girls. A set of dedicated 100 MIRA worked in 128 villages covering almost 144,000 people. In the intervention area, there is an increase in ANC visits by 55%, institutional deliveries by 49% and immunization rates by 41%. MIRA PHC connect model has been piloted in the Haryana state with 47 ASHAs and 10 ANMs reaching to 69,000 women and children. Prompt action has been taken by ANMs in 84% of the High Risk Pregnancy (HRPs) queries raised by ASHAs. Live data produced by the platform enables the state to take timely action.

Outreach & Scalability

MIRA Channel has scaled to Uganda and Afghanistan. Uganda MIRA project has been implemented in the district of Jinja in local languages - Lusoga and Luganda (Eastern Uganda). After the successful pilot, the government has request ZMQ to scale the program in 3 more districts of Uganda - namely Mbrara, Mbale and Kabarole in the Western Uganda. There is a talk with the Ministry that successful program in the 3 new districts may trigger its national adoption by Ministry of Health Uganda. The Afghanistan MIRA project has been implemented in the Heart province in the western zone of Afghanistan (near the Iran border) in Dari language. There is a demand by the partner to replicate the model in the Pashto speaking areas especially Kabul and Ghazni. We are trying to reach out to partners to scale the program in Pashto region.

The MIRA project bridges the gap in information, decision making and timely service delivery. The project proposes to adapt and test its India model in Uganda and Afghanistan to improve MCH indicators there. With its operations in Uganda and Afghanistan, MIRA has reached to almost 66,000 populations in Uganda and almost 43,000 population in Afghanistan indirectly. The number of women who have successfully completed their pregnancies through MIRA has been 2900 in Uganda and 1700 in Afghanistan respectively. Almost 4200 children for immunization and 6000 girls in Uganda; and 2700 children for immunization and 3500 adolescent girls have been reached in Afghanistan. In last 18 months, in the area of project implementation, there has not been a single maternal death reported in Uganda and only one maternal death has been reported in Afghanistan.

With CSRs, we are also taking MIRA Channel intervention in other states of India like Karnataka and Odisha. We have created different models and strategies for scaling MIRA in different areas and locations. Some of them could be:

Afghanistan_MIRA

a. Technology Transfer;

b. Technology Adaptation and Tweaking;

c. Implementing MIRA on behalf of the donor, funder or support partners in their project region and in specific languages;

d. Building capacities of local NGOs and grass-root organizations to implement MIRA in their specific region

e. Collaborating with the government to implement with them

f. Supporting the program externally as O&M partner (Operation and Maintenance), and assisting as technology partner.

Replicability

We have the following strategies used in phases to integrate projects in other locations. Projects can have different points and may vary, not all the points below are required for one project.

a. Conducting Need Analysis

b. Contextualizing content as per local needs (language etc.)

c. Technology adaptation

d. Setting up Hierarchical model for the program

e. Initial bulk data entry

f. Recruiting teams

g. Training and capacity building

h. Ground implementation

i. Setting up Dashboard and Reports

j. Training the program team to look into data

k. Monitoring & Evaluation

Impact Achieved

Overall the project has helped in improving the following indicators

- Increase in ANC visits by the pregnant mothers
- Increase in uptake of IFA tablets and TT vaccine
- Increase in institutional deliveries
- Increase in institutional deliveries
- Increase in identifying danger signs early (just after the birth)
- Inculcate healthy habits in communities leading to adopt healthy behaviours
- Consistent delivery of messages by MIRA leads to correct delivery of messages
- Delivery of information through technology tools more acceptable to communities to adopt healthy behaviours
- Monitor the performance of Community Health Workers
- Live-data generated through Dashboard helps state to take timely action, leading to policy level change in health systems
- Overall resulting in reduction of MMRs and IMRs in the project

Capacity Building

The capacity building of the project can be categorized in 3 stages:

a. Content Design and Analysis:

The content of MIRA has been created after doing a thorough research. Once the research was completed, the messages were to be converted into iconic-graphical messages. Then we conducted several Focus Group Discussions (FGDs) with the communities to create localized graphics and icons which can easily be understood by the communities especially who are illiterate or semi-literate. We trained the communities to develop their localized icons which can be easily understood by the people. The same exercise we did in Afghanistan and Uganda where we trained communities to develop localized contextual graphics and icons for easy understanding.

b. Training and Capacity Building for Dissemination:

Once the toolkit is ready for deployment, ZMQ trains Community Health Workers (CHWs) and build their capacities to use the MIRA toolkit. They are trained for multiple activities - using the toolkit for content dissemination, registration of beneficiaries on the toolkit, submitting the data, monitoring & report generation etc. The same process was adopted for teams in Uganda and Afghanistan.

c. Transfer of Technology:

If the program continues in any region or community, the local teams which comprises of managers and coordinators are trained to become self-sufficient to manage the MIRA and it different components. In

order to transfer the technology and build the capacities of local partners, we provide them lot of technical manuals and guides so that they can manage the system on their own.

Partners of the Project

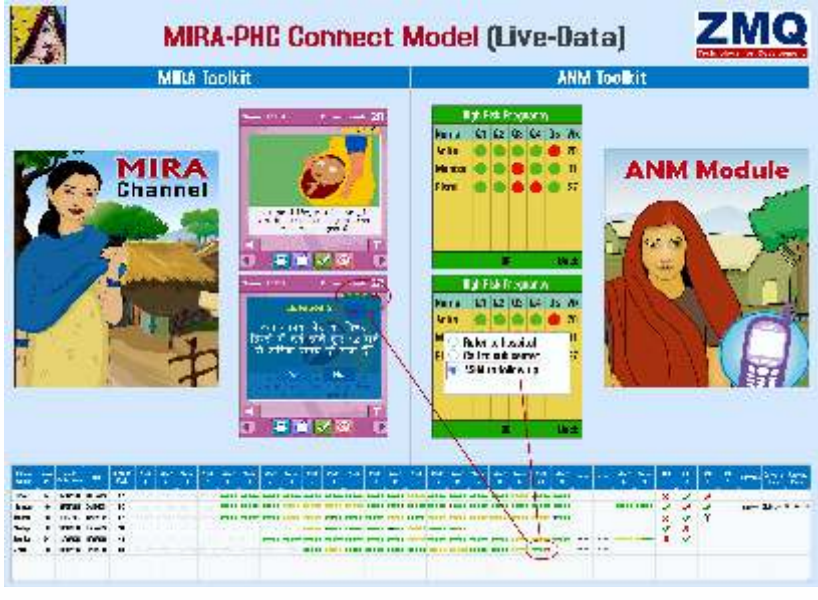
There have been several partners in the project. For government connection, we have Haryana Health Mission; and Haryana Livelihood Mission. From technology support end, we have Vodafone Foundation, Airtel (Uganda), Roshan Telecom (Afghanistan), Microsoft and Nokia. From donor's perspective, we have Millennium Alliance, USAID, UKAID& FICCI. From foreign implementation perspective, we have Health Child (Uganda), Afghan Institute of Learning (Afghanistan), RMS (Rwanda), Ministry of Health Uganda and Department of Health Herat. From dissemination perspective, we have SHG Federations Mewat and Community Radio Station Alfaz-e-Mewat.

Awards/Endorsements

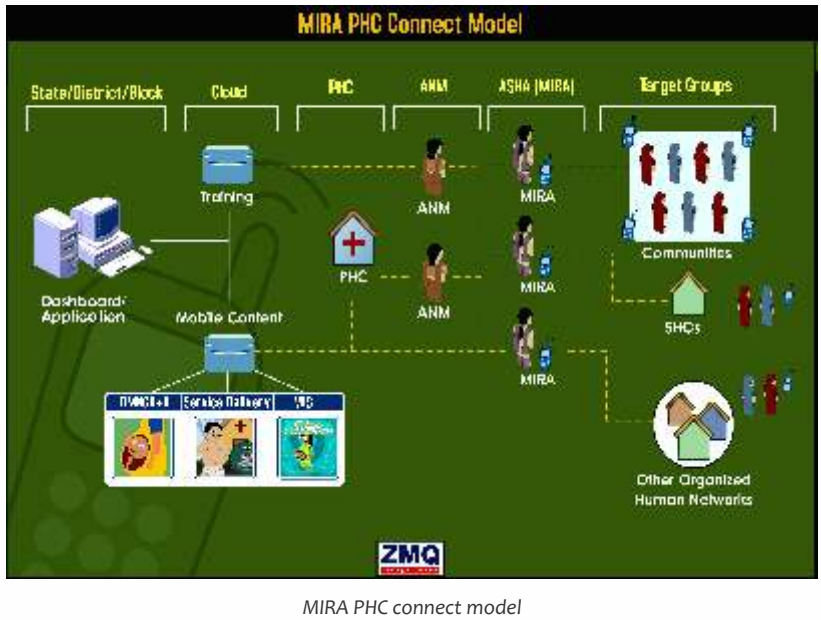
The project has received several awards. Some of them are as follows:

- **Ashoka Globalizer Fellowship 2018:** *"MIRA as one of the most impactful strategy for Maternal & Child Health and World's most exciting Social Innovation".*
- **Winner of "UNESCO-Pearson Initiative for Digital Literacy 2017":** *"MIRA Channel as one of the most impactful digital strategy to tackle Maternal and Child Health globally.*
- **Winner of "India Rwanda Innovation Growth Programme" in 2017 instituted by FICCI and Department of Science & Technology, Government of India:** *MIRA as a Global Strategy to tackle Maternal and Child Health in Rwanda.*
- **Winner of "Global South eHealth Observatory (ODESS) Award 2017" instituted by Fondation Pierre Fabre, France:** *"MIRA as a Global Strategy to tackle Maternal and Child Health in the developing countries.*
- **Finalist of "India Innovation Growth Programme 2.0" in 2017 instituted by Dept. of Science & Technology, Government of India, Lockheed Martin, Tata Trust and IIM, Ahmedabad:** *"ZMQ's MIRA Channel".*
- **Finalist Social Entrepreneur of the Year India 2016 instituted by Schwab Foundation and World Economic Forum, Geneva, Switzerland:** *"ZMQ's MIRA Channel".*
- **Winner of Business Action on Health Award 2015 for "Innovation /Technology to Improve Health" instituted by Global Health Council and GBC Health New York:** *"ZMQ's MIRA Channel".*
- **Winner of "Millennium Alliance" Round 2 Award 2014 instituted by USAID, FICCI and Technology Development Board (Ministry of Science & Technology, Government of India) for scale-up in Uganda and Afghanistan in 2015:** *"Women Mobile Lifeline Channel" as No.1 mHealth Solution in India.*

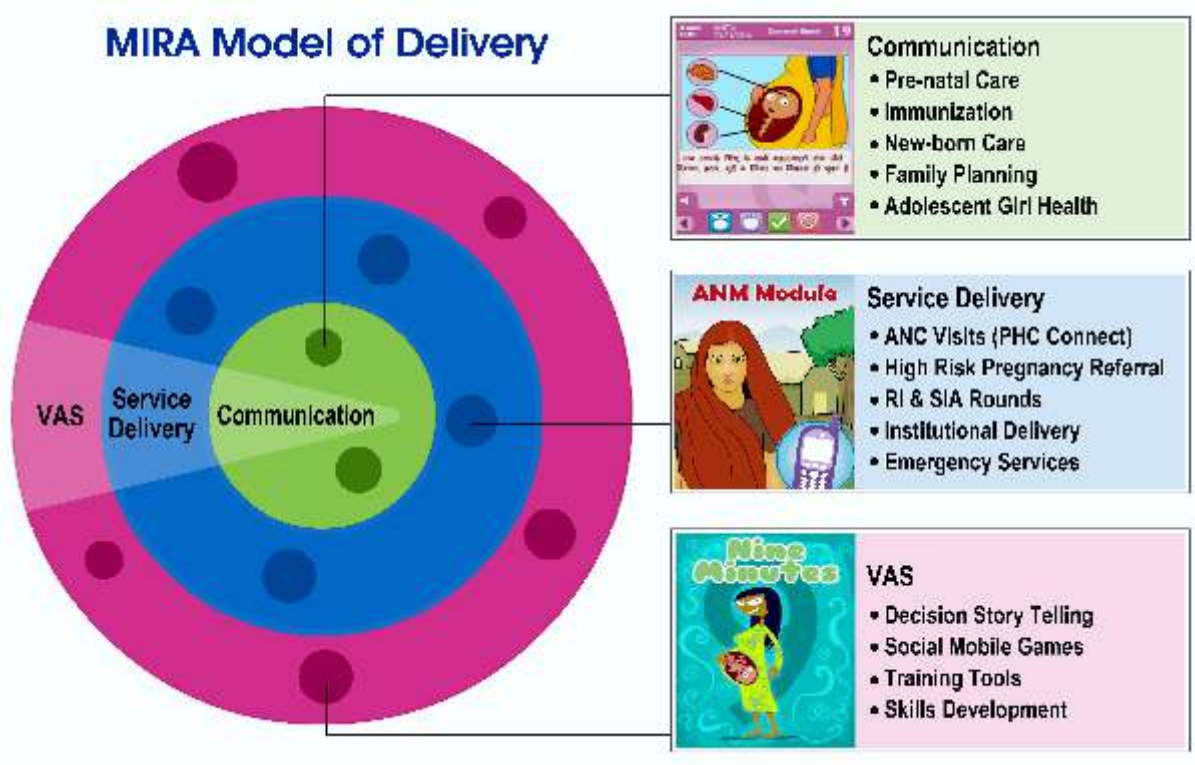
- **Yale School of Management's Global Social Entrepreneurship Fellow 2013-14, New Haven, USA:** *Best 5 Social Enterprises*
- **Winner of "Mobile for Good" Award 2013 by Vodafone Foundation and DEF:** *"Women Mobile Lifeline Channel" as No.1 mHealth Solution in India.*
- **Winner of "Millennium Alliance" Award 2013 instituted by USAID, FICCI and Technology Development Board (Ministry of Science & Technology, Government of India):** *"MIRA Channel then Women Mobile Lifeline Channel" as No.1 mHealth Solution in India.*



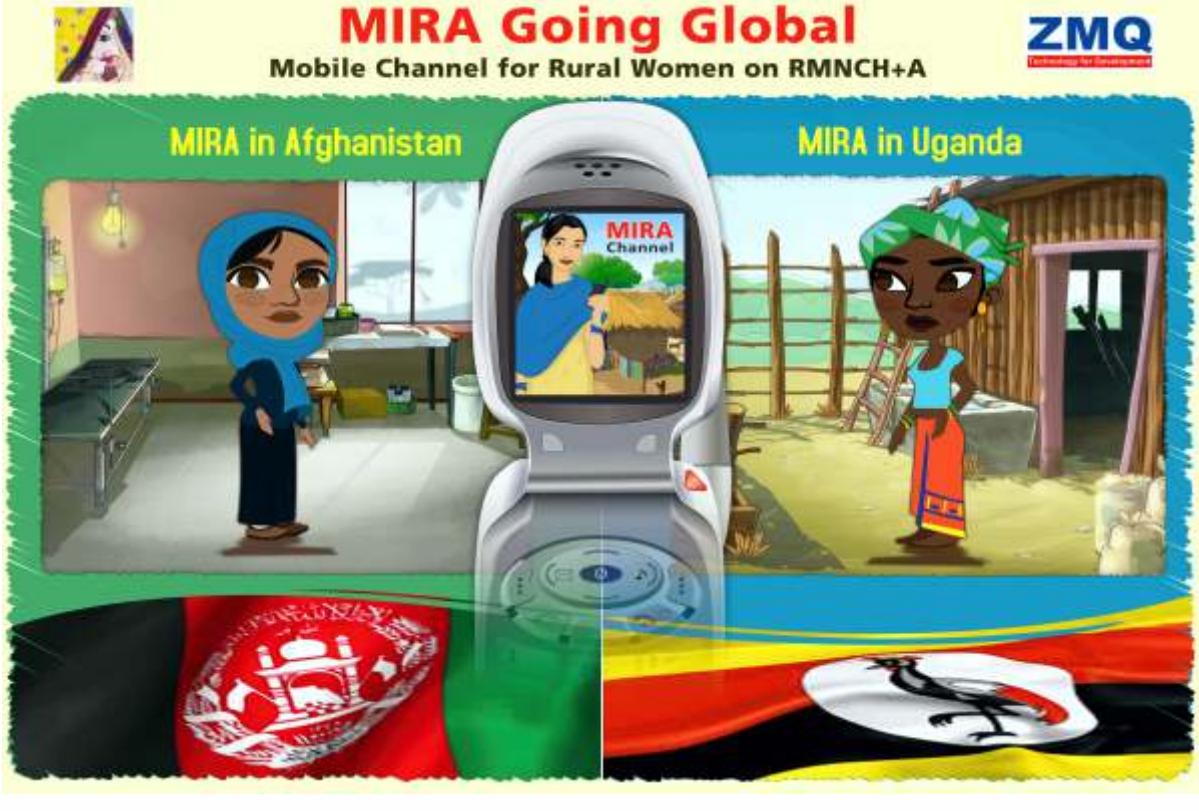
MIRALiveDataPoster



MIRA PHC connect model



MIRA Live Data Poster



mMitra Project

2014 onwards

ARMMAN

Website	:	www.armman.org
Founder of the Organization	:	Dr. Aparna Hegde
Project Budget	:	Average Budget over the last three years: ₹ 9,33,00,000
Coverage/ Geographical reach	:	1.6 million women reached across nine states.

Project Brief

In India, the maternal mortality ratio (MMR) and infant mortality ratio (IMR) is unacceptably high at 167 and 40 respectively. A woman dies in childbirth every ten minutes in India. More than 300,000 infants do not live beyond the first 24 hours after birth in India. A significant proportion of maternal deaths and 50-70% of child deaths are however preventable. In addition, 38.4% and 46% children in India under the age of three are stunted and underweight respectively (NFHS-3). About 6% of the children suffer from severe acute malnutrition (SAM) and over half a million children die before their fifth birthday due to SAM.

One contributing factor responsible for these woeful numbers is the lack of access to basic preventive care information during pregnancy and childhood. In order for behaviour change communication (BCC) to be effective, it must be **timed and targeted** to reach the right people at the right time. Counselling can lead to behaviour change only when the information is specific to the month of pregnancy or childhood as well as culturally specific and reinforced by repetition over a period of time in order to enable the beneficiary to fully accept the message.

However, due to the overcrowding in hospitals and lack of training, motivation and incentivisation of health workers to offer counseling, access to information is scarce. The high mobile phone penetration in India (over 1.034 billion in 2016, ranked 2nd in the world) accords a strategic opportunity to provide timed and targeted crucial lifesaving information directly to women through their mobile phones in a gender-sensitive manner when they need it. A voice call service is an easy to use technology even for illiterate end users as opposed to text messages. The service provides this information to women through easily understood voice messages in a warm sisterly voice, in a language that they understand, at a time when it is convenient. Thus these voice calls build awareness, educate and empower women to achieve healthy outcomes for themselves and their infants. Also, the enrolment into the program through trained women leaders in the villages and hospitals ensures that the program follows a 'tech plus touch' model. Whereby the program is introduced to the women through a friendly intermediary. The three tries for every message, missed call system and call center ensure deep engagement with the women.

The customized malnutrition add-on to the main mMitra program provides additional focus on nutrition and is tailored to not just the age of the child but also the dietary preferences of the region. Also the direct weekly/biweekly calls to the mothers of SAM children from trained call center counselors ensures not just adherence to the treatment but also proper rehabilitation in the next six months so that the child again does not relapse.

The mMitra calls target underserved pregnant women and mothers of children under age five, who reside in urban slums or rural India, are not highly educated and do not have ready access to health care information.

Implementation Model

The mMitra program began from a single government hospital in Mumbai in 2013 and is now present across nine states.

This rapid scale up of services throughout Mumbai and other cities has been possible through a successful partnership with 16 Municipalities, 50+ hospitals, 32+ community based NGOs and 3000+ Sakhis (health friends) enrolling women directly in the communities.

The enrollment of women in urban areas takes place through two verticals: Hospital vertical - health workers posted in the ANC/PNC clinics of government hospitals and maternity homes register women on to the program when they come for their first checkup visit and Community Vertical - ARMMAN has formed partnerships with community NGOs working in slum communities and have selected and trained women leaders in the slums as Sakhis (health friends) who enroll women directly from the slums in the early stages of pregnancy for a small incentive. In rural areas, women are enrolled into the service by the government health workers (ASHAs) in the villages.

Uniqueness of the Project

Features of the service:

1. **Frequency of voice calls:** Pretested, individualized voice calls of 60 - 90 seconds duration (145 voice messages in all) are sent through pregnancy and infancy with the following frequency: twice a week from the first month of pregnancy until birth, once a day in the first seven days after birth, twice a week until the infant is three months of age and once a week until the infant is one year of age.

2. **Three attempts are made for every message:** once daily for three days in the enrolled woman's chosen timeslot. If she misses all three attempts by the system, she can give a missed call to our missed-call system and the service will call her back immediately with the message she has missed.

3. **Timed & Targeted:** Voice Calls are delivered to the mobile phone of the woman and specific to the gestational age in a language of their choice.

4. **Call center:** mMitra also has a call center that monitors the calls sent and also enables the enrolled woman to inform the service regarding a change in her phone number, change in the preferred time slot, when she has delivered or if she has had an abortion/stillbirth. The woman can give a missed call to the call center and the call center personnel will call her back within 24 hours to take the necessary details.

5. **Voice message creation:** The messages were developed following a rigorous process. A preliminary study was first performed, followed by message creation by ARMMAN and Baby Center along with a group of experts drawn from national medical bodies. These were then focus-group tested amongst pregnant women and women with infants to determine their ease of understanding and whether the language and diction used was appropriate and if the content addressed their perceived needs.

The voice messages were then validated by experts FOGSI (The Federation of Obstetric and Gynecological Societies of India) and NNF (National Neonatology Forum).

Role of Information and Communication Technologies (ICTs)

mMitra voice calls are stored on an in-house voice platform and sent to women using an algorithm that assigns the correct message for the right week through a third party aggregator, IMI Mobile. Information on the preferred time to make the call and the pregnant woman's phone number gathered during registration and is accessed from the database for sending calls as per the algorithm. In case of missed calls, the algorithm is designed to make repeat call three times in the next consecutive days. To send automated calls, our platform is connected to the API of a third party aggregator who sends simultaneous calls to the registered women. The calling system uses Primary Rate Interface (PRI), the most robust system that allows for the simultaneous transmission of voice and data over public telephone networks.

The central system has been built using an open source software bundle known as LAMP (Linux, Apache, MySQL, and PHP). Our system thus consists of the Linux operating system, an Apache HTTP server, a MySQL database, and the PHP scripting language necessary for web development.

Tableau software enables real-time monitoring of the number of calls sent, missed, dropped or cut short, length of calls heard and number of missed calls to the system. The QA/QC division on the other hand is responsible for the overall monitoring of the entire Technical Platform which includes the Call Centre monitoring as well as ensuring that the service is robust.

Challenges Faced

Setup of a technology platform for real-time monitoring: When ARMMAN was implemented, there was no availability of a software that will enable real-time monitoring and updates. Since the call volume was extremely high due to a rapid scale-up, the lack of a technology platform was proving to be a hurdle. ARMMAN engaged a technology partner to design a customized platform for effective monitoring. This helped us monitor details like the percentage of calls being received, the average duration for a women listens to a call and so on.

Calls getting missed due to DND (Do Not Disturb) activation: The software put in place highlighted the fact that any calls were not going through because the number had DND activated. To resolve this issue, a separate helpline number has been instituted. Women who wish to avail mMitra voice call service give a missed call on this number and this is taken as an lectronic consent to receive mMitra calls. In parallel, a dialogue has been initiated with the Telecom Regulatory Authority of India (TRAI) to exempt mMitra from DND.

Outreach & Scalability

ARMMAN's five-year expansion plan for mMitra includes enrolling 2.2 million women in ten major tier I and tier II cities and spreading across rural areas in five states. These rural locations and tier I and tier II cities have been selected on the basis of proportion of underserved population and poor maternal and child health indicators. Tier 1 cities have been selected owing to their large migrant and slum populations. Tier II cities and rural locations are chosen from a list of 100 cities/districts with the worst MMR and IMR statistics.

We have managed to achieve economies of scale through efficient management of the program and the distribution strategy: per beneficiary cost for sending voice calls through pregnancy and infancy (145 voice calls) in the general mMitra program is only Rs 350 (approximately $5). Addition of the customized malnutrition program (additional voice calls till the child is five years of age and handholding of mothers with SAM children for 8 months of the malnutrition treatment and rehabilitation process) increases the cost per woman by only Rs 100 ($ 1.5/-) as most of the costs of enrolment and maintenance of the tech program are absorbed within the primary mMitra program. Economics of scale will itself ensure sustainability as cost per beneficiary reduces as the call volumes rise. Further, we intend to leverage telecom service providers' CSR programs to lower call costs. We hope to deepen our engagement with the state governments so that enrolments can be done through government health workers (ASHA and Anganwadi workers) leading to cost reductions. We also plan to diversify the donor base and become a model example of private-public partnership so that different corporate donors can be responsible for particular cities, reducing per-donor costs. Our decentralized hub and spoke model with four regional hubs (north, south, east and west with the head office in Mumbai) will also help to keep costs per hub low. Individual hubs will be responsible for program management and fundraising.

We are also running a pilot project in Hubli (Karnataka) where the women are charged partly for the service. We have been able to enroll 650 women for the paid service so far. Going forward we will be looking at retail sponsorships, a middle class service (cross-subsidy model) and 'Sponsor a Mother for mMitra' as ways to make the program self- sufficient.

Replicability

mMitra leverages technology for delivery of voice calls and to measure the success rate. It can be easily offered as an integrated part of other MCH services.

Impact Achieved

ARMMAN conducted a three-year Randomized Cluster trial, funded by UKAID, in 250 villages in Osmanabad, Solapur and Washim districts of rural Maharashtra, from January 2013 until December 2015, in which one of the tested interventions was mMitra. In addition to voice calls, the intervention included eight animation videos coded onto the phones of health workers to involve the family in the care of the woman and child.

End-of-pregnancy impact:

a. 36% increase in the proportion of women who knew the importance of taking 100 days of IFA (iron folic acid) tablets during pregnancy ($p < 0.05$)

b. 21.66% increase in the number of pregnant women who took IFA (iron folic acid) tablets for 100 days ($p < 0.05$)

c. 46.95% increase in the proportion of women who knew at least three methods of family planning ($p < 0.05$)

d. 29.95% increase in the proportion of women who knew that consistent condom use can reduce chances of contracting HIV/AIDS ($p < 0.05$)

e. 89.32% of the enrolled women received 70% of the voice messages and were satisfied with the content

End-line survey (conducted at the end of infancy) impact:

a. 33.79% increase in the proportion of infants who received ORS for an episode of diarrhoea ($p < 0.05$)

b. 48.46% increase in the proportion of infants who were exclusively breastfed ($p < 0.05$)

c. 43.4% increase in the proportion of infants who had their weight checked at least thrice in infancy ($p < 0.05$)

d. 13.5% increase in the proportion of infants who tripled their birth weight at the end of one year ($p < 0.05$)

Some findings published in the Indian Journal and Maternal and Child Health can be accessed here:

https://docs.google.com/a/ijmch.org/viewer?a=v&pid=sites&srcid=aW ptY2gub3JnfHd3d3xneDoxYWI xZmU3OTAyMTBmNzcw

Results of an end-of-pregnancy midline survey conducted among mMitra beneficiaries at an urban tertiary care center (Sion Hospital) in Mumbai indicate that mMitra voice calls (without animations) have impact:

a. 96% of women sought treatment for complications during pregnancy as opposed to only 72% of women in the baseline study ($p < 0.05$).

b. Only 9% of women suffered from pregnancy-related complications in the midline survey as opposed to 38% in the baseline study ($p < 0.05$)

c. 27% of women in the midline survey knew that IFA supplementation needs to be taken for 100 days as opposed to only 0.5% women in the baseline ($p < 0.01$).

d. 83% of women were aware of the period of exclusive breastfeeding as compared to 66% during the baseline study ($p < 0.01$)

e. 91% of women were aware of the importance of giving colostrum to the baby in the midline survey as opposed to 72% in the baseline ($p < 0.01$)

f. 88% of women in the midline survey were aware of the harmful effects of pre-lacteal feeds as opposed to only 41.35% in the baseline study.

g. Almost 97% of women were aware about the importance of immunization during pregnancy upon follow-up compared to the 61% at baseline ($p < 0.01$).

h. About 93% of respondents were aware about immunization schedules during infancy during the follow-up compared to 71% at baseline ($p < 0.01$).

¡. Almost all the respondents were satisfied with the voice messages (99%), information received in voice messages (99%), quality of the voice calls (99%) message length (98%), language (99%), frequency (97%), timeliness (95%) and relevance of the information (95%) provided.

Focus group discussions conducted through the 'Impact of mMitra Voice Call Service on Women's Involvement in Health Care Decision Making' study in Mumbai indicate high levels of satisfaction with voice calls.

Capacity building

Regular training of health workers at NGOs and other project staff are conducted for a successful implementation.

Partners of the Project

The mMitra calls were created by ARMMAN and Baby Center and validated by FOGSI and NNF. Other partners include, but are not limited to, Dasra, Johnson & Johnson, JSW, Aditya Birla Financial Services; Glenmark; Tata Trusts; **MCGM - Municipal Corporation of Greater Mumbai and Inscripts Technology Private Limited, SBI**. ARMMAN has partnered with more than 40 NGO partners to implement its programs across the country.

Awards/Endorsements

- ARMMAN won the WHO 'Public Health Champion' 2017 award in the Innovation Category.
- ARMMAN received Zee Media's Transform India 2017 award.
- mMitra won the GSK-Save the Children Health Innovation Award 2017. mMitra was one of the four awardees in the world and the first Indian NGO to receive this award out of 170 applicants from 40 countries.
- mMitra won the Silver award for the "Best Use of Mobile for Social & Economic Development" at the Indian Digital Awards 2017 by IAMAI forum.
- mMitra was a finalist at Vodafone Foundation's 'Mobile for Good Awards 2015'.
- mMitra won the "People's Choice Award" at "Saving Lives At Birth" event in 2011 organised by USAID, Bill and Melinda Gates Foundation, World Bank, Government of Norway and Grand Challenges, Canada.
- ARMMAN received the Best NGO of the year Award for the year 2016 by Glenmark Foundation

Supportive Community monitoring

MNCH- Sukshema

Technical assistance to improve maternal, neonatal and child health outcomes through the National Rural Health Mission in Karnataka, India
2009-2016

Karnataka Health Promotion Trust (KHPT)

Website	:	www.khpt.org
Founder of the Organization	:	Mr. Mohan H L, Managing Trustee
Project Budget	:	₹ 34,34,26,384.00
Coverage/ Geographical reach	:	8 high priority districts of northern Karnataka- Koppal, Bagalkote, Kalaburgi, Ballari, Bidar, Raichur, Yadgir & Vijayapura

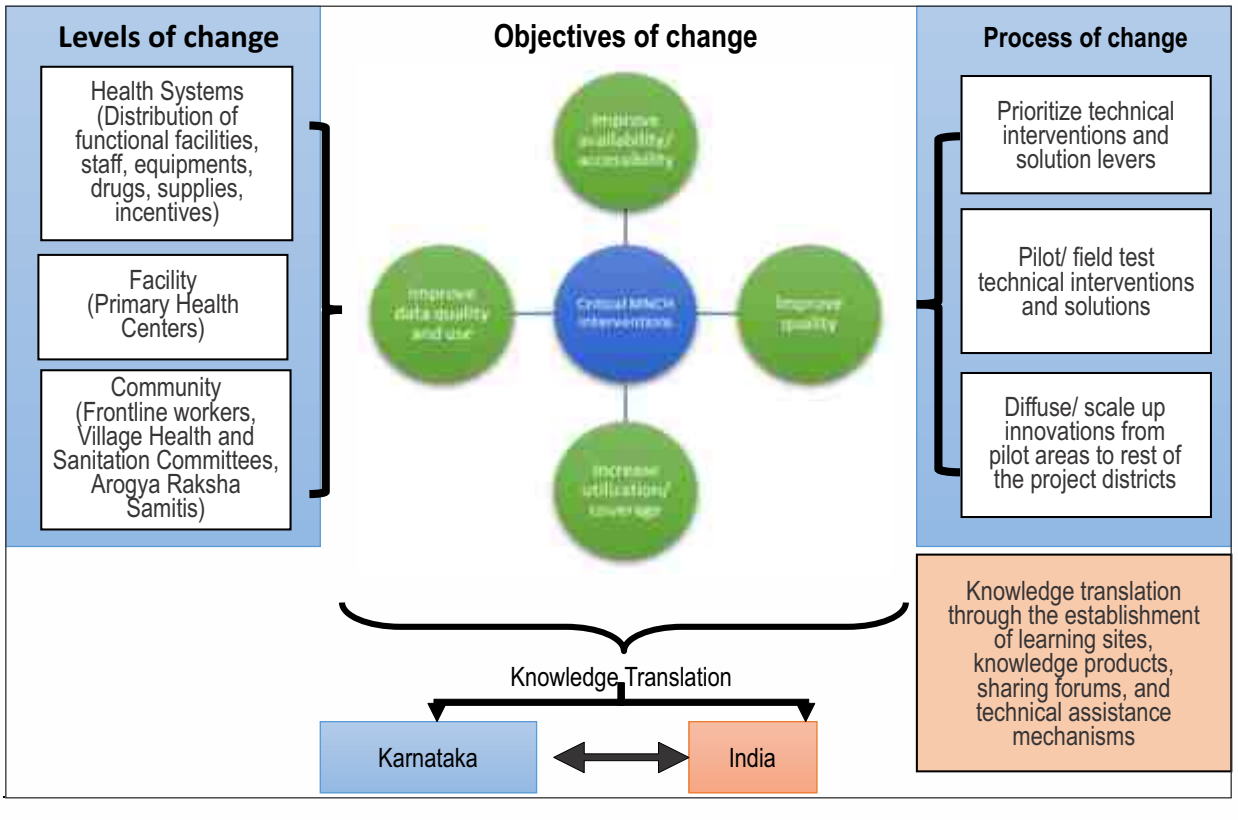
Project Brief

The disparities between northern and southern Karnataka districts with respect to accessibility, quality and coverage of critical maternal, neonatal and child health (MNCH) services affected state level progress. Particularly, the frontline workers lacked skills, tools and support systems to reach out, communicate effectively and link target groups to care across maternal and child care continuum. The focus on most vulnerable population groups was missing on the ground. The facilities failed to establish credibility due to the poor quality of care and referral linkages with higher systems. Heavily dependent on trainings alone for quality improvement, there was a need to do much more to accelerate provider preparedness and facility readiness to render client centric care and quality. Lack of ownership and community level accountability on MNCH issues affected utilization and coverage. The health systems faced challenges to collect, collate population level data and use it effectively for program planning on a real time basis. KHPT through a Bill and Melinda Gates Foundation/ University of Manitoba funded technical assistance grant principally worked with two stakeholders i.e. Government of Karnataka on the systems delivery side and communities/ families on the demand side to bridge the inequities that existed during 2009-10.

The project upon scaling up across the region, covered about 212,000 pregnant women annually through 22500 frontline workers, 385 24/7 PHCs and 16 FRUs during the years 2013-16.

Implementation Model

Project implementation model:



The project model included interventions at the following levels-

- Facility level to enable improvement in the quality of MNCH services for rural populations through onsite mentoring.
- Community level to enable expanded utilization and population coverage of critical MNCH services for rural populations through strengthening Frontline workers (FLWs) and Community structures
- Health system level to enable expanded availability and accessibility of critical MNCH interventions for rural populations.

The guiding approach of the project model focussed on continuum of care i.e. antenatal, intrapartum, and postpartum period and till the infant attained an age of 12 months. Since most of the deaths occur during delivery and the 48 hours to 1 week after birth, priority was given to have interventions during this period.

At the facility level, the key objective was to improve the quality of care during delivery and immediate postpartum period. ***Onsite mentoring*** was implemented using a dedicated cadre of nurse mentors helped to improve provider preparedness and facility readiness around critical MNCH services. Self assessment tools helped staff identify gaps in facility systems and develop action plans. Clinical mentoring was provided with the help of simplified case sheets as job aids, skill stations, case vignettes, audio-videos, etc. Bed side coaching, hands on support and telephonic mentoring helped to improve confidence of staff in managing complications. In addition, the emergency drills, quality improvement committees, additional support by specialist mentors from local medical colleges helped to improve care in the first referral units.

At the community level, the focus was to strengthen the frontline health workers and community structures to improve management and delivery of outreach services. The project did this through providing simple job aids and processes that helped the ASAH workers enhance their outreach planning for providing services, quality of interaction with the beneficiaries and cross departmental coordination with other FLWs like the Anganwadi worker and Junior Health Assistant (JHA). At the community level, efforts were made to enhance community accountability, participation and ownership. The provision of simple tools and processes to support the community structures like Village health Sanitation and Nutrition Committee (VHSNCs) improved their engagement in health delivery and monitoring of health services.

At the health system level, the project worked closely with the state's health department to capacitate government staff to influence policy and program planning. It worked towards strengthening data management and use, particularly the Health Management Information System (HMIS) and the Mother and Child Tracking System (MCTS).

Community Outreach

Through formal agreement with the state's NHM and support of the leadership within the health department, the project was able to closely engage with all the front line health workers. A series of consultations were held with frontline health workers like the ASHAs, Anganwadi workers, Junior Health Assistants (JHAs), community representatives and facility staff to understand their challenges in

the field and evolve joint solutions with them to effectively address the gaps. The tools and processes developed for the project is a result of consultative discussions with the front line workers.

The project reached out to the communities (pregnant women and lactating mothers and their family members) only through the existing front line health workers within the system. The community level activities focused on building perspective, skills and capacities of the FLWs, increase coordination and collaboration on the ground, improving the effectiveness of outreach through easy to use planning and tracking tools. Our processes for community engagement was based on the belief that confident, motivated and skilled FLWs would be able to reach the unreached and deliver the full package of MNCH services across the care continuum to the communities.

Uniqueness of the Project

A unique aspect of the project was that our intervention package were both piloted and demonstrated at scale. The pilot itself involved two districts of North Karnataka and the scale up covered 8 districts of north Karnataka.

Some innovative tools developed at the community level include:

- The ASHA DIARY tools developed for frontline workers were:
  - fully ASHA centric and simple to use
  - able to replace 13 registers used by ASHAs significantly simplifying her work
  - not only reporting but planning and reflection tools. ASHA has never been exposed to a planning and a reflection process before.
- **Pictorial ASHA reminder cards** and Home visit checklist
- **Birth Preparedness calendar** for Beneficiary
- The community level interventions worked on setting a strong foundation by addressing attitudes and perspectives around gender, caste and other structural aspects of MNCH.
- The **Three sisters concept** and the **AROGYA MANTAP** for the first time brought functionaries from three Departments together (from the President/ member of Panchayat, Anganwadi worker from the department of Women and Child Development and JHA and ASHA from the Health Departments) The **Supportive community monitoring** processes (SCM) was activated through VHSNCs using simple visual tool called the Supportive Community Monitoring Tool (SCMT) which could be used by illiterates and helped create engagement. This enhanced community accountability.

Innovation at the facility level:

- **Nurse Mentoring Intervention:** For the first time, Quality was looked at very holistically and comprehensively involving the provider, the client and the systems.

- The quality Assurance systems were limiting and instructive in nature but the nurse mentoring intervention brought in elements of self-assessment, joint review and joint problem solving
- This intervention too was demonstrated and piloted at scale
- Clinical mentoring, generally is implemented only at large facilities but we were able to implement this quality assurance model right from the most basic facility set up like the PHC and also at larger facilities like the district hospitals.

- **Case sheet:** A simplified case sheet that integrates safe birth checklist and bed head ticket which has been tested in the facilities and found to be effective in screening and management of complications was used to help the PHC staff.

Role of Information and Communication Technologies (ICTs)

Concurrent monitoring of the program was undertaken through regular observational surveys, where mobile technology for data collection was used. This helped the program to receive quick feedback to modify the field strategies.

Challenges Faced

Building confidence among the officials and staff of the department of Health and Family Welfare both at the state & district level was challenge. We offered our expertise in data use and management which

Family focussed communication by ASHA at home

the officials needed for program planning. The project staff started giving regular feedback to all the health facilities on HMIS & MCTS. This in turn helped in building rapport and confidence with all levels of officials and field level staff.

- Series of consultations were held with the department staff and community representatives to discuss upon the field challenges and evolve with solutions.
- The staff of the department were getting frustrated and discouraged due to issues like overburden of work, lack of appreciation and recognition of their work. Hence project staff started giving recognition and appreciation of efforts of the department staff to prevent them from getting frustrated, discouraged and tired of their work. This helped them to deliver quality services both at the facility and community level.
- Project had adopted peer led approach took time to establish itself in a strongly hierarchical set-up which has been, until now, used to a supervisory approach rather than a supportive one.
- Eliciting support for implementation from the department and the panchayat needed continuous effort and engagement.
- There was lack of trust, cooperation, coordination among the health department staff and Panchayath Raj. There was monitoring approach than the supportive monitoring of the health by the community structures (VHSNC, Arogya Raksha Samithi) .Project had focussed on convergence of Health and Family Welfare, Department of Women and Child Development and Panchayath Raj through strengthening community structures. This helped them to address many system and community level challenges locally.

Outcomes

Outputs:

- Basic case sheet uptake increased from 36.4 % to 86.9% of total arrivals and complications sheet uptake increased from 15.4% to 71% of total complications. Documentation of critical maternal and neonatal care significantly improved as seen by better hemoglobin testing (39.5% vs. 33.3%), AMTSL (99.2% vs. 96.2%), Vitamin K administration (80.2% vs. 66.6%), diagnosis of prolonged and obstructed labour using Partograph (65.7% vs. 40.0%), recording BP and administration of antihypertensive in severe PIH/ preeclampsia/ eclampsia (53.8% vs. 36.5%).
- The women who were listed in ASHA diary shown the chance of having received continuum of care (i.e. 3 or more times Antenatal check- up, institutional delivery , 48 hours stay post -delivery, and PNC visits by ASHA) was more by 4.6 times by the women who were not listed in ASHA diary.

Outcomes:

An external evaluation through baseline (2013) and end-line surveys (2016) indicated one of the fastest decline in mortality rates: Neonatal mortality rate reduced from 40.8 to 30.4; Infant mortality rate from

53.5 to 43.5; Institutional delivery rates moved up from 69% to 78%; FHR monitoring (on arrival), 39 to 67%; Maternal BP monitoring (post-delivery), 34 to 64%; Weighing of the newborn, 33 to 70%; Clean cord care, 30 to 63%.

Reach:

The project reached 212,000 pregnant women annually through 22500 frontline workers, 385 24 x 7 PHCs and 16 FRUs, 1150 Staff Nurses, during the years 2013-16

Outreach & Scalability

Right from the inception of the project, sustainability was configured. KHPT entered into an MoU with the NRHM at the inception stage of the project clearly articulating the areas of focus, approaches, specific gap areas and the testing component of the project. At every critical stage of the project, high level consultations were held involving the Mission Director and key officials from the Department at state and district levels to ensure joint decisions and continuous buy in from the State. District level staff of the project were co-located within the Department office embedded within the Government teams. All program tools and processes were jointly conceptualized with the end users like the ASHA workers, staff nurses as well as the beneficiaries.

Nurse mentoring concept has been incorporated in the state NHM quality care guidelines. ASHA Dairy and Village Health Sanitation and Nutrition Committee (VHSNC) tools has been adopted by the state government for all districts.

The program was able to make sustainable contribution to the existing program by forming a strong District Resource Persons (DRP) team. This was done by identifying and training the best performing ASHAs, ASHA Facilitators and Female Junior Health Assistants (JHA-F) to implement the programs through intensive perspective building and handholding

We supported the NHM to conduct a National level Dissemination and Learning workshop to share the findings and the innovation of the project for a wide spectrum of audience involving the representatives from different state governments.

Replicability

In the first year the project was piloted in two districts and then scaled up to other six high priority districts.

The tools and interventions were adopted by the state. NGOs were involved to sustain the community level interventions. The quality improvement processes were integrated into the state quality assurance systems.

Beyond the state, the interventions were replicated in Uttar Pradesh; they also informed MNCH programs in Bihar, Rajasthan, Telangana and outside of India (Kenya).

Onsite mentoring

Impact Achieved

An external evaluation through baseline (2013) and end-line surveys (2016) indicated one of the fastest decline in mortality rates: Neonatal mortality rate reduced from 40.8 to 30.4; Infant mortality rate from 53.5 to 43.5; Institutional delivery rates moved up from 69% to 78%; FHR monitoring (on arrival), 39 to 67%; Maternal BP monitoring (post-delivery), 34 to 64%; Weighing of the newborn, 33 to 70%; Clean cord care, 30 to 63%.

The impact can be attributed to a comprehensive program scientifically designed addressing gaps at all levels and implemented through the leadership of the skilled and motivated front line health workers from within the existing health system structures.

Capacity Building

To implement the community interventions project formed the District Resource Person (DRP) team by identifying and training the best performing ASHAs, ASHA Facilitators and Female Junior Health Assistants (JHA-F). These DRPs underwent an in depth perspective building training and were provided

with close handholding support in the field by project staff. The DRPs led the trainings of FLWs and community structures and provided handholding support to them to use the tools and processes.

To implement the facility level interventions, the project recruitednurse mentors. These nurse mentors underwent 5 weeks of comprehensive training at St. Johns Medical college and hospital, Bangalore on clinical, mentoring, communication and problem solving skills. These nurse mentors visited the facility and worked with facility staff to identify gaps and solutions using self -assessment checklist. They taught staff nurses about clinical topics through demonstrations and hands on experience to manage maternal and newborn complications, partograph to diagnose prolonged and obstructed labour etc.

Project had recruited District Monitoring & Evaluation Specialist to work with the district and block level officers of the department to help them to do data analysis and use of data in program planning. Eventually Government recruited district and block level M & E managers. These M& E managers were trained by the project on doing quality checks, data analysis and use of data in program planning at all levels of facilities.

Partners of the Project

The project worked in close collaboration with the following partners:

- St. John's Medical College was involved to train the project's nurse mentors on clinical aspects, mentoring skills and health system problem solving.
- Karuna Trust supported the advocacy initiatives of the project with the government departments at the district level.
- University of Manitoba was the lead technical partner
- IntraHealth supported the documentation initiatives of the project.
- National Health Mission, Government of Karnataka provided overall guidance to implement the project in northern Karnataka.

Awards/Endorsements

The project received the National level Impact award in August 2017 by Sambodi for deeply impacting the lives of communities through excellence in program implementation and innovations under the Public health category .

Multi-Sectoral Initiative for strengthening Convergent Actions for Nutrition, Education, and Child Protection in Malda district, West Bengal.

January, 2016 - December, 2018

Child in Need Institute

Website	:	www.cini-india.org
Founder of the Organization	:	Dr. S.N. Chaudhuri
Project Budget	:	₹ 1, 40, 00000
Coverage/ Geographical reach	:	65 Gram panchats (GPs) and 2577 Anganwadi Centres spread across six blocks (Kalichak III, Gazole, Ratua I, Harishchandrapur I, Chanchal I and Habibpur) of Malda district, West Bengal

Project Brief

The project titled **Multisectoral Initiatives for Strengthening Convergent Actions for Nutrition, Education and Child Protection** was undertaken in six high priority blocks of Malda district in West Bengal (India) during 2016-2017. It was steered by a partnership between the District Administration (Malda), UNICEF West Bengal Office and Child in Need Institute (CINI). The project aimed to enhance implementation of flagship programmes and missions (particularly ICDS, RMNCH+A, SSM and ICPS) with an emphasis on convergent actions for empowering communities regarding their rights and entitlements to demand and access government services and promote service delivery, improved coordination, decentralized joint planning, monitoring and feedback mechanisms.

Intervention specific to combating the intergenerational cycle of Malnutrition: The RMNCH+ strategy positions nutrition as a critical underlying and intersectoral element essential for realising the continuum of care across the life cycle. The interventions included working with pregnant and lactating women, promoting Infant and Young Child Feeding and hygiene practices and supporting responsive actions for community based management of malnourished children. Biannual VAS and de-worming rounds as well as IFA supplementation (NIPI) for children were supported. Adolescent girls constituted another key target group. Efforts focused on enhancing their awareness of nutrition related issues and services. This was situated within a broader emphasis on promoting adolescent participation and empowerment. The objectives of the project for management of child malnutrition with active engagement of communities and community based institutions are as follows:

- Increase availability and accessibility of key maternal, child and adolescent nutrition services through convergent actions at different levels

- Enhance capacities and capabilities of service providers and community based institutions for empowering families about their rights and entitlements on government services
- Advocate with government and development partners to scale up multisectoral evidence-based practices of nutrition programmes

Implementation Model

The project design was built on the principles of facilitation, systemic strengthening, improving governance and ensuring transparency and accountability to the local communities. It was conceptualised in keeping with the district plan of action priorities. It essentially sought to enhance implementation of flagship programmes and missions (particularly ICDS and RMNCH+A) with an emphasis on convergent actions. It prioritised identifying and bridging of gaps in awareness and resources; decentralised planning, action and review and demonstrating evidence based good practices/models that could be replicated.

CINI facilitated at multiple levels with the intention of enhancing access to services, promoting community ownership and strengthening convergent platforms from the village to the district level. It also undertook evidence based periodic reviews and feedback processes.

Community Outreach

The following processes were undertaken to achieve the project objectives.

Periodic understanding of quality service delivery and coverage- *A nutrition monitoring toolkit* was developed to enhance understanding and action on critical issues and barriers that impacted nutritional service delivery and coverage. The checklists were filled by project team members based on observation; inputs from the AWWs, ANMs, ASHAs and existing records. The data from these checklists helped identify gaps and barriers which were shared for discussion and action at multiple platforms - Fourth Saturday Meetings (GP level), Third Saturday Meetings (sub centre level) and Block Convergence Meetings (block level).

Behavior change communication drive: BCC aids were used in community meetings, feeding demonstrations and other awareness activities. Feeding Demonstration and Counseling Sessions constituted a key component for enhancing IYCF and hygiene practices and community based management of malnourished children.

Enhancing Capacities of ICDS and health personnel: Capacity building activities spanned the spectrum of structured trainings, handholding support and providing other specific inputs as needed to ICDS and health functionaries in the six project blocks. The ICDS Supervisors, supported by project team members, facilitated joint orientations for AWWs and ASHAs to equip them for conducting the AWC based sessions and follow up activities. These orientations also helped situate the proposed sessions within the broader purpose of promoting IYCF and hygiene practices for combating childhood malnutrition. Block level trainings of AWWs and ASHAs on a gamut of issues regarding intergenerational cycle of malnutrition were also undertaken. Further, a district level Refresher TOT was designed based on a Training Needs Assessment exercise. The Refresher ToT enabled the participants to discuss field level concerns, seek clarifications and also explore means of enhancing collective actions further.

Overall, 1246 AWWs, and 667 ASHAs were covered through the trainings. The training inputs were backed with handholding support. This included an emphasis on collectively strengthening the monthly VHNDs to maximise coverage of services. Aspects identified from the periodic gap analysis were utilised to provide supportive inputs to enhance service delivery.

Promoting Community Awareness and Access: Existing platforms, particularly meetings with pregnant and lactating women at the AWCs during NHED, were used to deepen the dialogue on maternal and child nutrition related issues and services. Registration of pregnant women within the first trimester of pregnancy, importance of antenatal care and accessing related services were consistently stressed. The importance of consuming IFA and Calcium tablets was outlined. The need for adequate weight gain during pregnancy was highlighted using the MCP cards. The fourth ANC, in particular, was promoted including its link in encouraging institutional delivery. Overall, 10320 pregnant and lactating women were reached through the community level meetings. Nutrition Week, Breastfeeding Week, and social events were commemorated as well.

Strengthening Micronutrient Supplementation for Children: The project supported micro-planning process for the bi-annual VAS and de-worming rounds and IFA under the National Iron Plus (NIPI) initiative. The status on indenting, supply and coverage was collated through the checklists. The data was used to understand the gaps and bottlenecks and drive dialogue and related actions. The gaps were discussed at the block convergence meeting and monitoring and follow up was stepped up.

Stepping up for severely malnourished children: The project team members supported discussions on status of SM and MM children among ICDS and health functionaries. They encouraged the personnel to review the data on SM children shared by the DIO-NIC and ensure that there were no discrepancies with

their internal records. They shared the procedural aspects related to admission, stay and follow up for children at the two NRCs operational in Malda with AWWs and ASHAs. The team members also disseminated information about the NRCs at the convergent meeting at different levels These discussions and combined efforts of the frontline workers helped in sending severely malnourished children from the project blocks to the NRCs.

Working with Adolescents: Trainings of adolescent girls (particularly Sakhis and Sahelis under the SABLA scheme) were organised. ICDS Supervisors, AWWs and project team members facilitated the trainings that covered 2015 girls across six blocks in the district. Nutrition related issues and services were stressed. A toolkit was also provided. It included a notebook (*Ami Kishori*) with key messages on nutrition and child protection and a Frequently Asked Questions (FAQ) booklet on these topics. These aids facilitated recall and articulation of the key messages.

Uniqueness of the Project

Community led process for care of malnourished children: AWC based 12 day feeding demonstration and counseling sessions constituted a key activity to promote infant and young child feeding practices and encourage community based care of moderately and severely malnourished children without medical complications. The current practices of complementary feeding were identified through participatory learning action. The existing recipes given to young children were modified adding the locally available nutritious foods (oil, seasonal green leafy vegetables, red/yellow vegetables, pulses, seasonal fruits, dairy, eggs and iodized salt) to make it more calorie dense with micro-nutrients rich. Each day, low cost age appropriate recipes prepared from family food baskets by the mothers and served to underweight children. The AWWs and ASHAs jointly discussed a range of key topics related to infant and young child feeding practices and personal hygiene with the mothers and other caregivers using message cards. By October 2017, 1225 sessions had been held covering 7657 children across the six blocks of Malda district. Of this number, 5700 children were tracked up to 90 days with reassuring results with their graduation to supplementary feeding and regular growth monitoring at AWCs. Weight loss was noted for 6% of the children after 30 days and 6.7% at 90 days. The reasons for the weight loss included frequent episodes of illness, lack of hygiene and the growing practice of giving children fast food. In some cases, the mothers had conceived again and were hence unable to take care due care of the children

Role of Information and Communication Technologies (ICTs)

A robust monitoring system was developed for this project based on the existing district monitoring system to measure the effectiveness of convergent actions at all levels for improved maternal, child and adolescent nutrition. Data on progress against the indicators was reported from bottom to top initiating from community level to district level. At each level, data was reported by bottom line was analyzed and collated for feedback at upper level.

To make the monitoring system user friendly, a web based MIS was developed in new technology environment having good performance to gather data of 1020 AWCs, 4080 Household, 408 Sub-Centers, and 204 VHNDs for the project period with facility of master entry and reporting module. The Reports was generated in such a manner so that multidimensional data could be obtained and fitted in different sections of the MIS.

Challenges Faced

At the community level:

1. The block wise variations for *full antenatal care and IFA consumption by pregnant women* represent aspects that needed more attention. *Awareness and uptake of calcium tablets among pregnant and lactating women* was also found to be extremely uneven. While systemic issues possibly contributed to the scenario, more awareness activities highlighting the need and benefits of these services were possibly required. Moreover, the continuing hold of deep seated patriarchal and gendered norms wherein women do not prioritise their own health and nutrition needs and access to services could also be at play.

2. *Complementary feeding among children* represented another key area for improvement. The growing and indiscriminate tendency, within families, to feed children biscuits and fast food items were pointed out by several frontline workers as one of the key reasons endangering the nutritional status of infants. Messages on quantity, quality and frequency of food items were yet to percolate to all families equally. Use of locally available nutritious snack items, to promote diversity and as alternatives to fast food, remained uneven. Lack of personal hygiene, for mothers/caregivers and other family members as well as children, also continued to impair nutritional status of children. The related messages needed to be emphasised more.

At the systemic level:

1. Lack of consistent supply of IFA and Calcium impacted uptake by pregnant women. This also created situations where the available supply was prioritised to meet the needs of pregnant women and the lactating women then had to be left out (this happened in case of Calcium tablets) or where the supply was distributed among them in a manner that none got the requisite amount. Supply issues also plagued availability of IFA and supplementary food for adolescent girls at the AWCs and contributed to a scenario where outcome indicators for adolescent nutrition were compromised.

2. AWCs which operated from rented areas did not always have sufficient space to undertake all the mandated services effectively. There were shortfalls in human resources as well.

Outcomes

The inputs and processes narrated below led to change at the outcome and impact level comparison with first quarter and end quarter project monitoring data as well as comparison with NFHS4/DLHS 4 data of Malda depicted in the table.

Impact level Indicators for Maternal and Child Nutrition			
Impact level Indicators	**First quarter**	**Last quarter**	**NFHS-4 Maldah/DLHS-4**
Percentage of under five children who are underweight (weight for age)	35	31.7	37.2

Outcome Level Indicators for Maternal Nutrition			
Outcome Indicators	**First quarter**	**Last quarter**	**NFHS-4 Maldah/DLHS-4**
Mothers who had antenatal check-up in the first trimester (%)	79	81.1	42.5
Mothers who had at least 4 antenatal care visits (%)	68	73.8	52.6
Mothers who had full antenatal care (%)	46.4	48.1	12.2
Mothers who consumed iron folic acid tablets for 100 days or more when they were pregnant (%)	41.9	49.8	19.3
Pregnant women whose weight gain during entire pregnancy is tracked. (%)	78.6	93.6	66.7 (AWC register)
Children whose birth weight is less than 2.5 kg (%)	8.5	7.9	9.2
Outcome Level Indicators for Child Nutrition			
Outcome indicators	**First quarter**	**Last quarter**	**NFHS-4 Maldah/DLHS-4**
Children under age 3 years breastfed within 1 hour of birth	83	84	43.3
Children under age 6 months exclusively breast fed.	81	82.4	63.7
Children age 6-8 months receiving solid or semi solid food and breast milk.	66.5	79.1	51.5
Micro plan and supplies (along with IEC) for bi-annual VAS and De-worming round available in all 6 intervention blocks	72.3	77.7	39.8 (RCH-register)
Children age 9-59 months received a vitamin A dose in last 6 months) %	64.4	83.3	55.1
Children age 6-59 months received child IFA syrup	49.8	74.4	71 (RCH-register)
Outcome Indicators for Adolescent health and Nutrition			
Outcome indicators	**First quarter**	**Last quarter**	**NFHS-4 Maldah/DLHS-4**
Ags eligible for supplementary food (%)	85.5	87.1	69.4 (SABLA MPR)
Ags received supplementary food (%)	29.3	32.3	17.7 (SABLA MPR)
Ags (out of school) consume IFA for 4 weeks in a month	4.3	5.4	20.2 (SABLA MPR)
Ags consumed de-worming tablet during bi-annual round.	0.01	0.2	1.3 (SABLA MPR)
Ags attended NHE counselling session	9.1	10	13.8 (SABLA MPR)

Note: The decision was taken that NFHS4, DLHS4, and Independent survey data of the district would be considered for setting the baseline of this project. No separate end line survey would be done at the end of project. The project impact as mentioned here would be comparing referring to NFHS-5 report, which will be available every two years. Since NFHS 5 data was not available at the end of the project, the first and last quarter monitoring data were compared referring to NFHS 4 data as baseline

Results from community led process for care of malnourished children: According to WHO growth chart, children's nutritional status was measured. Under weight based on child's weight for-age is a composite measure of stunting and wasting and was hence the chosen indicator to assess changes in the magnitude of malnutrition over time. On starting day of nutrition demonstration and counseling, 1977 severe and 3723 moderate under-weight children were identified based on data from ICDS. At the end of the nutrition counseling and demonstration session the children were followed up to 90 days. 386 children graduated from severe to moderate (295) and moderate to normal weight (91) after follow-up of 30 days and further 409 children graduated from severe to moderate (240) and moderate to normal weight (169) after follow-up of 90 days thus validating the possibility of improved nutritional status of children through effective interventions right in their homes. Follow up mechanism established in 1246 AWCs linked to monthly NHED session.

Outreach & Scalability:

The frameworks can now be considered for scaling up within Malda as well as other districts in West Bengal. Significantly, the emphasis on multisectoral convergence and linkages between communities and systemic service providers proved to be one of the significant supportive factors here. Replication and scaling up efforts, particularly within other districts, must account for and facilitate this. This community lead intervention for care of malnourished children has been adopted by GoI for its scale-up in the country with the name given as "Sneha Shivir"

Impact Achieved

Growth of multisectoral platforms as sites for data based reviews: The project supported VHNDs, Fourth Saturday Meetings, Third Saturday Meetings and VLCPCs and BLCPCs to function more effectively. Besides these mandated platforms, it also worked with and through Block Convergence Meetings. Findings from the gap analysis were utilised for channelising discussions. The performance on key indicators, particularly related to nutrition, was shared and helped prioritise efforts where needed. Further, district level reviews (including DPAC and ICDS reviews) reaffirmed this emphasis on institutionalising data based, multisectoral reviews for maximising coverage and impact.

Collaborative planning and implementation boosted: The enhanced collective review processes facilitated collaborative planning and implementation across sectors. This was particularly noticeable in the improved levels of micro-planning and coverage for micronutrient supplementation for children (especially Vitamin A Supplementation) and the growing effectiveness of VHNDs. The sub centre level planning also received a boost.

Improved service delivery including coverage of most vulnerable groups: Multisectoral convergent efforts bore fruit as the coverage of key services improved. This was borne by the data on the maternal and child nutrition outcomes and impact. These improvements signify increased linkages with the local communities and offer greater promise of breaking the intergenerational cycle of malnutrition, deprivation and poverty among communities that are, typically, affected the most. There is still a lot to be done though particularly in terms of impacting adolescent nutrition and empowerment - a crucial

investment that must be made for a range of immediate and intergenerational gains.

Evidence based models demonstrated that can now be replicated/scaled up: The feeding demonstration and counseling model linking to monthly NHED at AWC emerged as replicable frameworks. The project learning indicated need for certain additional elements that can be incorporated for enhancing their effectiveness.

Capacity Building

Building on the foundation of the Malda DPAC and project's efforts, the following pointers can be considered. These may accelerate progress to the stage of integration wherein development actors work collaboratively to ensure that sectoral interventions have some shared indicators that are planned and implemented in a concerted manner. Some of the actions are to

1. Ensure prioritization, tracking and ownership of themes and actions from the district level
2. Collectively outline and agree on process, output, outcome and impact indicators
3. Ensure monitoring and documentation of multi-sectoral convergent progress:

ASHA facilitating a mother group meeting

Newborn Survival (NBS) Project

1st October 2015 - 31 March 2018

CARE India Solutions for Sustainable Development

Website	:	www.careindia.org
Founder of the Organization	:	Mr. Wallace Justin Campbell, Mr. Arthur C. Ringland
Project Budget	:	₹ 1.95 CRORE
Coverage/ Geographical reach	:	The NBS project is intended to benefit the targeted beneficiaries of pregnant women and mother of newborns of all villages of Ajaygarh Block of Panna District of Madhya Pradesh.

Standard HBNC Record Register Roll out

Project Brief

Context and background: A key indicator of development is Infant Mortality figures. India has shown progressive improvement in IMR since 1990. It has registered a decline of 34.3% from 58.8 to 38.7 during 2003-05 to 2013-15. Similarly, the status of Under 5 Mortality Rate (U5MR) of India has also shown improvement but still very high. U5MR has reduced from 52 in 2012 to 43 in 2015 (SRS). *Neonatal deaths contribute to more than two-third of all Infant deaths in India.* Panna district has one of the poorest health and nutrition indicators in Madhya Pradesh which again scores poorest in India. The Neonatal Mortality Rate is 61 (AHS 2012-13) in Panna; IMR is 85 (AHS 2012-13); U5MR is 127 (AHS 2012-13); and Maternal Mortality is also very high at 322(AHS 2012-13).

Poor health seeking behavior: There is 'Delay in taking decisions for seeking health care'; there is 'Delay in reaching appropriate health care facility' and also there is 'Delay in initiating appropriate treatment'. The above theory of 3D holds true in the context of early detection and management of pregnancy & new-born complications in the district of Panna which is contributing to high mortalities among mother and child. High mortality rates is a direct manifestation of poor health seeking behavior, difficulty in access, poor quality of services at health facilities and high cost of care in private health facilities, coupled with all the 3Ds affecting health outcome of a pregnant women and newborn.

Gender Discrimination: The above context gets further compounded by gender discrimination with respect to girl child which impacts their survival. Only around 41 % girl children are admitted against approx. 60 % of male child, in the first few days of life. The report also suggests that mortality among female newborn is higher than that of male newborns. The report from UNICEF's Integrated Management of Childhood & Neonatal Illness (IMNCI) shows that girls with birth defect (for eg: Cleft Lip Cleft Palate) are denied breast milk, and this denial leads to their early death. Girl children have low birth weight, and the discriminatory practices further reduce their chances of survival. Social and policy interventions have improved awareness but the gaps are persistent.

High Risk Newborn: While looking at the admission pattern in the SNCUs of Madhya Pradesh, it is clear that out of total admissions during 2016, 60 percent of them were Low Birth Weight (LBW) babies. This though is good in terms of those getting admissions but if we look at the total number of LBWs taking birth in the state, we need to further strengthen the referral particularly community referral of LBWs and Preterms to Sick Newborn Care Units (SNCU).

Project objectives:

With the above context, CARE India with corporate funding from GlaxoSmithKline (GSK) is implementing the Newborn Survival (NBS) Project in the Ajaygarh block of Panna district with an overall goal to reduce newborn mortality among poor and marginalized communities with the following objectives:

1. Improve birth preparedness and newborn care in communities
2. Improve quality of health services delivered by frontline workers (ASHAs and ANMs) through training and mentoring
3. Strengthening delivery practices and NavjaatSishu Suraksha Karyakram (NSSK) also known as essential newborn care and resuscitation package through Mentoring of Birth Attendants, primarily the ANMs
4. Strengthening ASHA & ANM networks for institutional delivery and Home Based Newborn Care (HBNC)
5. Improving access of women from marginalized communities to health facilities, and improved tracking of babies with LBW, Birth Asphyxia and Infection

Implementation Model

NBS project is designed and planned with gender integrated intervention strategies in **continuum of care** approach aiming to bring about improvements in public health facilities for providing delivery and newborn care services; as well as to generate awareness and demand for safe pregnancy and newborn care in communities of Ajaygarh block. Following are some of the important project interventions through which we try to address the MCH care problems in the region:

1. **Facility based interventions** are aimed at improving capacity of nursing staff at all the sixbirthing facilities in the Ajaygarhblock, led by a skilled & qualified Nurse Mentor through an Incremental Learning Approach (ILA) and mentoring of nursing staff in improving safe institutional delivery and newborn care based on *NavjaatShishu Suraksha Karyakram* (NSSK) program of Government of India.

2. **Community based interventions** led by 10 field staff is supporting and mentoring Accredited Social Health Activist (ASHAs) / Frontline Workers (FLWs) in improving Home Based Newborn care (HBNC) services and also undertake activities to generate awareness and demand for safe and institutional delivery and newborn care in the villages.

   The project also focuses on creating positive attitude and support among family members for survival of newborn, with emphasis on female newborn.

3. **Trainings:** Onsight trainings of nurses on safe delivery practices and essential newborn care, Training of nurses on Essential newborn care and resuscitation (NSSK); Training of ASHA Supervisors and ASHA workers on Homebased Newborn care (HBNC) to build capacity of service providers.

Improvement in the following four broad areas positively influences newborn health outcome:

- Increased community awareness and changes in pregnancy care and newborn care including
- Enhanced skills, knowledge and capacities of Nurses in pregnancy care, safe delivery practices and essential newborn care & resuscitation
- Enhanced skills, knowledge and capacities of ASHAs in pregnancy care, birth preparedness and essential newborn care. Strengthened HBNC services.
- System strengthening and improved pregnancy and newborn care service delivery

Community Outreach

- **Community interventions:**
  - Community Awareness events - to increase awareness on pregnancy care, birth preparedness, institutional delivery, newborn care and generate demand.
  - Formation of Mothers Group in villages - as an interactive platform in villages for building leadership and capacity of women to advocate for appropriate care of newborn & pregnant women; to ensure that they receive desired services from public health system and also to ensure sustainability of project interventions.
  - Interactive meetings with the mother groups to build leadership and capacity of pregnant, lactating & women members

- **Strengthening existing public health platform:**
  - Monitoring and supportive supervision visits of Village Health & Nutrition Days (VHND) to strengthen capacity of ANMs and ASHAs/AWWs to deliver antenatal care and newborn care & counselling
  - Advocating and ensuring monthly Sub centre level meeting: This was to improve coordination among the AAA team (ANM, ASHA & AWW) in the forefront of health care delivery at gram panchayat level. This also helped identifying gaps at individual level and taking steps to improve.
  - Sensitization and capacity building of Village Health Sanitation Committee (VHSC) members who are important stakeholders and responsible to ensure better health at village level.
- **Tracking of newborn and pregnant women** through supportive supervision household visits to strengthen HBNC services:
  - Innovative mechanism to ensure daily delivery data recording and priority tracking of high risk newborns - The project developed an innovative daily delivery reporting and tracking mechanism wherein vital information of newborns delivering at 6 birthing facilities of intervention block of Ajaygarh are being collected on daily basis which automatically **highlights all high-risk newborns like low birth weight (LBW) babies, pre-term or who had birth asphyxia etc. requiring prioritized home visits and follow up.** This information is passed on to project field staffs who then ensures the needed screening, counselling and referral through ASHA workers. This process improved delivery of essential care to newborn and special care like **Kangaroo Mother Care (KMC)** for LBW or weak newborn baby.
  - Developed and rolled out a standard HBNC record register to further strengthen recording of HBNC services and linkage with referral.
- **Integrating gender in all project interventions:** To address widespread gender discriminatory practices, norms adversely impacting child and maternal survival, all project interventions highlight on gender issues and advocate for equitable breast feeding, seeking health care in case of complications among male and female newborn; ensuring Kangaroo mother care (KMC) by healthy family members including father of the LBW baby; ensuring household level support to pregnant women for adequate nutrition and rest etc. All trainings have integrated gender issues

"When I heard that awareness event will be held again in the village, I along with my wife came to participate in the awareness program from another purwa because we got to know so many things on care of pregnant women and how to take care of baby"
-**Lala Bhaiya Lodh**, husband of a pregnant women of Prakwapurwa, Nikain

"Mothers and family members in my village have become more aware and is ensuring cleanliness, hygiene, handwashing while holding baby and breast feeding; They have also started to come out of social customs and norms and practices which are bad for newborn health"
-**Alpana Ahirwar**, ASHA worker of Chandranagar Village

Mentoring on newborn resuscitation to nurse

Uniqueness of the Project

- **Onsight nurse mentoring and training:** capacity building of nurses working at labour rooms through nurse mentoring and training in their skills, knowledge, and practices to ensure safe delivery practices critical to saving pregnant women with post-partum haemorrhage, severe life threatening complication due to pregnancy induced high pretension etc ; and providing essential newborn care & resuscitation programmatically called NavjaatShishuSuraksha Karyakram (NSSK) critical to saving babies with birth asphyxia (difficulty in breathing), infection, special care of weak pre-term new-borns and Low birth weight (LBW) babies like ensuring kangaroo mother care (KMC)

- **Daily Delivery Reporting and Tracking of births:** Innovative mechanism to ensure daily delivery data recording and priority tracking of high risk newborns - The project developed an innovative daily delivery reporting and tracking mechanism wherein vital information of newborns delivering at six birthing facilities of intervention block of Ajaygarh are being collected on daily basis which automatically **highlights all high-risk newborns like low birth weight (LBW) babies, pre-term or who had birth asphyxia etc. requiring prioritized home visits and follow up.** This information is passed on to project field staffs who then ensures the needed screening, counselling and referral through ASHA workers. These had improved delivery of essential care to newborn and special care like **Kangaroo Mother Care (KMC)** for LBW or weak newborn baby.

- Developed and **rolled out a standard HBNC record register** to further strengthen recording of HBNC services and linkage with referral. There was no standard uniform register for recording HBNC visiting information resulting in loss of critical information of health status of newborns, screening and referrals during HBNC visits which are very important for self-tracking of visits by ASHAs and monitoring by Supervisors.

Role of Information and Communication Technologies (ICTs)

During the mentoring sessions of the nursing staff on safe delivery practices and newborn care; Mamanatalie and Neonatalie simulators were used to demonstrate proper management of labor & deliveries, and ENBC (essential newborn care) & resuscitation.

Challenges Faced

- **Govt priority programs delaying implementation of trainings:** The project faced challenge in completing trainings for nurses and ASHAs due to their engagement in priority programs like Mission Indradhanush, Dastak programme etc. and thus could not be released by block officials. However, the project was successful in undertaking most of the planned trainings with continued follow up and coordination with district and block officials.
- **Staff Recruitment and Attrition:** It was difficult to get suitable candidates to work in a remote location and additionally there were few attritions. **Mitigation:** It took time to select project staffs and but with repeat efforts, project could complete staff on boarding. Similarly, with dissemination and branding of NBS project and CARE India, replacements were not so difficult eventually.
- **Delay in decision making at sub district level:** Block officials from Health department take a lot of time in reaching to a decision or releasing the letters for organizing trainings.

Outcomes

- Increase in percentage of Institutional deliveries from current levels
- Increase in percentage of home deliveries attended by SBAs
- Increase in front line worker's knowledge related to new- born complications, early identification of problems and timely referral in appropriate health care centers
- Increase in detection of high risk pregnant women & their management at health facility
- Increase in follow up coverage of SNCU & LBW Babies graduates to improve newborn survival

The above stated interventions have helped to address the MCH care problems in the region; following evidences justify the same:

- 45 newborn lives with birth asphyxia saved by nurses through resuscitation in 2017. There was no record of any newborns saved through resuscitation at health facilities of intervention block.
- Newborn Stabilization Unit (NBSU) at CHC Ajaygarh is now functional from December 2017
- Early initiation of breastfeeding within 1 hour after birth has improved from 65.0 % in Jan - March quarter to 89.2 % in Oct - Dec 2017 (N=796 newborn tracked)
- Exclusive breast feeding has improved to 80.9% in Oct-Dec 2017 from 74.2 in April-June 2017 (N=796 newborn tracked)

Supportive Supervision HBNC visit

- Gender gap in exclusive breast feeding (EBF) of newborns has significantly narrowed to almost equitable level with follow up visits. EBF has improved to 50.4% in female and 49.6% in male in 3rd follow visit compared to 45.8% in female and 54.2% in male in the 1st visit.
- Awareness of Danger Signs in Newborns and among mothers has improved from 26.0% in the first visit to 65.8% in the third visit (N=796 newborn tracked).
- Institutional deliveries at the six public health facilities improved from 2021 in 2016 to 2346 in 2017 for the period April-December.
- Knowledge on Skin to Skin Care among nurses has improved from 14.3% during Jan - Mar 2017 to 83.3% during Oct - Dec 2017. Similar improvement can be observed in case of Newborn Examination. Their knowledge on Newborn Wrapping has gone up to a whopping 82.5% during Oct - Dec 2017 from a low of 0.0% during Jan - Mar 2017 (N=10 nurses)
- There is marked Improvement in essential skill sets and practices of nursing staff on Pre-Delivery & Birth Preparedness, during delivery care and essential newborn care and resuscitation (for which there are data based evidences).
- 33 ASHAs out of 35 could score in the range of 75 - 100% in counselling mothers on breastfeeding practices and danger signs among Newborns during HBNC visits in the current round of assessment.

Outreach & Scalability

The project focused on the following strategies to address the issues related to Newborn survival -

- Generate community awareness and demand for safe and institutional delivery, and newborn care.
- Create positive attitude and support among family members for institutional delivery and newborn care.

- Training and skills development of ASHAs on HBNC services; and Nurses on NSSK (Essential newborn care and resuscitation).
- Mentoring of ANMs and ASHAs on ante-natal and post-natal care, with key focus on newborn care as per Government of India's India Newborn Action Plan (INAP) guidelines.
- Maternal Health Referral linkages and transportation services - strengthening existing public system for safe delivery.
- Networking for institutional delivery - focus on strengthening public health system, based on our experience from Bihar in creation of Family Friendly Hospitals, to improve quality of maternal and newborn health services.

While dedicated efforts from NBS project is beginning to yield positive results/ improvement in delivery of pregnancy and newborn care services; awareness and demand in communities; and mother and families ensuring care of newborn and pregnant women; there is continued need of efforts/investment in the geography due to the persisting barriers and gaps in addition to poorest health and nutrition indicators impacting maternal and child mortality as evident from secondary data. **It is important to note that all the 5 districts under Sagar Division of MP falls under current high priority list.**

In addition to widespread socio -cultural barriers negatively impacting newborn and pregnancy care, there are compelling **Statistics of health indicators critical to newborn survival and maternal health in Madhya Pradesh and Panna District which calls for urgent wider investment and scale up of project of this nature in the geography.** With the above strategies in a continuum of care approach, project interventions primarily focused to strengthen capacity and skills of nurses, ANMs and ASHAs in delivering better pregnancy care, safe deliveries and essential newborn care; also focused to improve monitoring and supportive supervision. With the adopted strategies and interventions mix, the project is best suited to scale up in all the 5 high burden districts of Sagar division.

Major Project activities till December 2017

1. Training of 181 ASHAs on HBNC for 2 days
2. Training of 8 ASHA Supervisors and 10 project staffs on HBNC for 8 days
3. Training of 8 nursing staffs on NSSK and safe delivery practices; and 8 ANMs on pregnancy care, safe delivery and newborn care.
4. 210 mentoring sessions for nursing staffs
5. 249 community awareness events
6. 223 Mother Group formed and 270 meetings facilitated
7. 479 supportive supervision VHND visits
8. 26 VHSC and 18 SHC meetings facilitated
9. 44 ASHA Cluster meetings facilitated
10. 3057 household visits including 1578 for newborn and 1468 for pregnant women

NBS Project reach at a glance

- 24606 females in 15-49 age groups and 2213 males were reached directly through project interventions
- Indirectly project has been able to touch the lives of 60728 females
- Working in 195 villages

Mother Group meeting

Replicability

The project's system strengthening approach, strategies and interventions by complementing the existing public health system efforts to improve pregnancy and newborn care; coupled with similar poor health and nutritional status in other geographies particularly in all 5 blocks of Panna District of Madhya Pradesh gives the advantage, opportunity and suitability to integrate the project interventions in other locations as well.

Impact Achieved

- For 2783 live births in six delivery points during 2017, we could manage 45 cases of birth asphyxia. With reference to AHS (2012-'13) data, the neonatal mortality rate of Panna is 61 per 1000 live births. Considering the AHS data, about 170 out of 2783 newborns would have died before reaching the 28th day of their age. Managing 45 birth asphyxia cases out of 170 potential neonatal death cases (attributed to birth asphyxia) accounts for a reduction of about 26.5% in the neonatal mortality rate for the area.
- Early initiation of breastfeeding within 1 hour after birth has improved from 65.0 % in Jan – March quarter to 89.2 % in Oct – Dec 2017 (N=796 newborn tracked)

- Exclusive breast feeding has improved to 80.9% in Oct-Dec 2017 from 74.2 in April-June 2017 (N=796 newborn tracked)
- Gender gap in exclusive breast feeding (EBF) of newborns has significantly narrowed to almost equitable level with follow up visits. EBF has improved to 50.4% in female and 49.6% in male in 3rd follow visit compared to 45.8% in female and 54.2% in male in the 1st visit.
- There is significant improvement in skill, knowledge and practice areas among nurses in ensuring safe delivery and essential newborn care & resuscitation practices; and ASHA workers in HBNC services.
- There is improvement in awareness levels among mothers on newborn care.

The above with improvement in system level in HBNC services, essential newborn care and resuscitation coupled with enhanced community awareness indicates sustainable changes towards improving newborn care and pregnancy care.

Capacity Building

The project has a great focus on capacity building of ASHAs, ANMs and the nursing staffs. Provision for better quality training and skill development sessions would enable them to cleverly identify and manage complex cases of pregnancies and provide appropriate care to high risk newborns. Skill enhancement of FLWs also provides them the confidence to manage complexities on their own than immediately referring cases to higher facilities. This also reduce the time taken to seek immediate care during emergencies. In addition to innovative solutions to build skill capacity the project followed the training programmes institutionalized by GOI:

- Training of 181 ASHAs on HBNC for 2 days
- Training of 8 ASHA Supervisors and 10 project staffs on HBNC for 8 days
- Training of 8 nursing staffs on NSSK and safe delivery practices; and 8 ANMs on pregnancy care, safe delivery and newborn care.
- 210 mentoring sessions for nursing staffs

Awards/Endorsements

कार्यालय मुख्य चिकित्सा अधिकारी सामु: स्वा० केंद्र अजयगढ़ जिला पन्ना (म.प्र.)

क्रमांक: _____ सा/चि.स्वा/CSSD – NBS /Endurement Letter, 2018 दिनांक: 05/03/2018

TO WHOM IT MAY CONCERN

This is to acknowledge that CARE India is implementing a Newborn Survival Project at Ajaygarh block of Panna district with focussed strategy in **a continuum of care approach** to reduce neonatal mortality and bring about an improvement in the health status of newborn and pregnant women in Ajaygarh block of the Panna district of Madhya Pradesh.

The project interventions have shown positive impact in enhancing clinical skills of nursing staff at birthing facilities and has improved management of newborn complications, like birth asphyxia. The project has improved the home based newborn care (HBNC) services delivered by ASHA workers through training, strengthening household supportive supervision visits using an innovative tracking mechanism for high risk newborn. CARE India has also developed and rolled out a standard HBNC record register which will help in improving the quality of HBNC recording. It is engaging in substantial number of community awareness events, formed Mother's Groups in villages and is working to improve the Village Health Nutrition Days (VHNDs) services, Sub Health Centre and Village Health and Sanitation Committee platforms to generate awareness & demand in communities.

In view of the good efforts being put in on ground, I would strongly recommend for continuation of support and expansion of focussed interventions like that of Newborn Survival Project of CARE India to help the Government in its stride to reduce high neonatal and maternal mortality in the district.

मुख्य चिकित्सा अधिकारी
मुख्य चिकित्सा केंद्र अजयगढ़ जिला पन्ना

Mentoring to ANM of PHC Khora in essential newborn care and resuscitation

Dr. L.K. Tiwari, CMHO Panna and Dr. Sribash Saha, Project Manager, CARE India rolling out the standard HBNC register

Interactive facilitation meetings with mothers group members at Naikain supported by NBS project team

Supportive supervision of HBNC visits by project staff at Nabastha

Pahel – towards empowering women

2007 till date

Centre for Catalyzing Change (Formerly CEDPA India)

Website	:	www.c3india.org
Founder of the Organization	:	CEDPA, USA
Project Budget	:	Period September 2010 – August, 2015 - ₹ 5.1 Crores
Coverage/ Geographical reach	:	Initiated in two Blocks of Patna District (Punpun and Musaurhi) in 2007 and the project was scaled up to six blocks in three districts. Currently the geographic coverage is in districts of Aurangabad, Muzaffarpur, Nawada and Sitamarhi reaching approximately 2000EWRs from all three tiers of Panchayati Raj Institutions.

Project Brief

Context - The state of Bihar poses a significant challenge in the implementation of interventions targeting reproductive health outcomes and services. Of critical concern in terms of health service delivery in Bihar are the high MMR (208 per 100,000 live births – SRS 2013) as compared to the national average of 167 and a continued high Total Fertility Rate (3.4) that further impacts on the MMR in the state. Bihar continues to be one of the poorest states in the country, despite, high political leading to several inclusive, pro-people and effective governance policies, schemes, and reforms that have led to improvement in the several development indicators..Bihar is also the first state to formally reserve 50 percent of seats for women in local governance. There are currently more than 120,000 EWRs in the state at the three levels of local governance (district – *Zilla Parishad*[1]*, block- Panchayat Samiti*[2] *and village – GramPanchayat*[3]). Currently Bihar is in its third cohort of EWRs and the State Government has structured training programmes for all elected representatives of Panchayati Raj Institutions.

Aims and Objectives - The current *Pahel*model, combines the twin objectives of improving reproductive and maternal health (RH/MH) services by empowering elected women representatives from Panchayati Raj Institutions (PRI) as health advocates and in the process builds their voice, participation and leadership in local governance.

Long Term Outcome is to strengthen the voice, participation, leadership and influence of Elected Representatives (ERs) in decision making in Panchayats to enable them to improve Reproductive and Maternal Health (RH/MH) services at village, block and district levels, assisted with a mobile phone based IVR platform that collects and disseminates data entered by EWRs to inform improvement efforts on RH/MH.

Implementation Model

- **Centre for Catalyzing Change,** has been working with women and young people for over a decade in Bihar. For Pahel, strategic partnerships were formed with community based NGOs and advocacy with government departments at district and state level. Capacity development of EWRs (three day trainings on PRI structures/processes, gender inequality and public health delivery system in the context of FP/RH) to support better participation in Panchayat meetings and more pro-active role around issues of health, education, etc. A three day, 18 hour training module was created for transaction with EWRs through a cadre of female master trainers.
- Support to take planned, concrete actions on improving FP/RH/MH services and uptake, based on evidence generated through administration of checklists
- Mentoring through collective forums, quarterly MahilaSabhas and support to interface with government officials and strategise collectively to raise health and other development issues in Panchayat Meetings

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[1] *Zilla Parishad: Local government body at the district level in India*
[2] *Panchayat Samiti: Local government body at the tehsil (taluka)/block level in India*
[3] *Gram Panchayat: Local self-governments at the village or small town level in India*

Ward members attend a mahila sabha to share their experiences and draft their action plans

- Working with Departments of PRI and Health at district level to help fill the gaps and implement solutions
- EWRs use pictorial checklists to monitor health services in their areas and raise findings at Panchayat meetings
- Convergence meetings at district and block level where place their findings and demands before officials
- Exposure visits for EWRs inside and outside the state
- Pilot IVRS mShakti for monitoring services to test the feasibility of EWRs using their mobile phones to give feedback over phone that translates into a realtime dashboard which can be accessed by government officials at multiple levels
- Monitoring by C3 team and systematic third party evaluation to track impact.

Community Outreach

As a first step, C3 developed a training manual in Hindi for use by Trainers consisting of a three day module. A pool of 24 female master trainers was trained who in turn conducted residential trainings for 1200 EWRs. The module covered a range of topics - information on PRI structure, meetings, and committees; roles and responsibilities of elected representatives; gender inequality and low status of

women; components of Reproductive Health (RH) and options for Family Planning (FP); information about different levels of public health service delivery system, benchmarks and entitlements.

Four checklists were developed - Village Health Sanitation and Nutrition Day (VHSND), Health Sub-Centre (HSC), Primary Health Centre (PHC) and District Hospital (DH). EWRs were trained in using the checklists and these were administered with support from the three NGOs. These checklists served as a tool to support EWRs to monitor and act as health advocates in their respective constituencies and to bring an understanding/ insight in to the progress made so far in the usage, accessibility and quality of FP and RH services.

Tracking and mentoring of EWRs was an integral part of the intervention design. Tracking sheets were developed to enable regular feedback on participation of EWRs in different activities - participation in VHSNDs, monitoring of health services, participation in PRI meetings, vocalization of issues on FP/RH and Girls' Education during these meetings, sharing of health service data during PRI meetings as well as convergence meetings with department of health and Public Health and Engineering Department (PHED) and Integrated Child Development Services (ICDS), and meeting with health providers.

To facilitate monitoring of services by EWRs, C3 later developed pictorial checklists to enable illiterate and neo-literate EWRs to use them effectively. An Interactive Voice Response System (IVRS) was introduced as a pilot in January 2015. The EWRs used pictorial checklists to monitor the health facilities and used the IVRS to provide their observations using their mobile phones.

Uniqueness of the Project

Four checklists - were developed as tools to gauge the quality of services at the Village Health Sanitation and Nutrition Day (VHSND), Health Sub-Centre (HSC), Primary Health Centre (PHC) and District Hospital (DH). EWRs were trained in using these checklists that they administered with support from the three local NGOs. These checklists served as a tool to support EWRs to monitor and act as health advocates in their respective constituencies by looking at the usage, accessibility and quality of FP and RH services.

The checklists were administered in three rounds and pictorial checklists were later developed to enable illiterate and neo-literate EWRs to use them effectively. An Interactive Voice Response System (IVRS), mShakti was introduced as a pilot in January 2015. The pilot was implemented with 805 EWRs.

Evidence sharing at Panchayat meetings

The EWRs raised issues on FP/RH services and conducted regular follow-ups during the Gram Sabha and Panchayat meetings and urged the *Mukhiya (Gram Sabha* Chairperson) to place the gaps identified at the level of the local HSC during the *Panchayat Samiti*[4] bi-monthly meeting to ensure action by the Medical Officer In-Charge.

Evidence sharing with Health Department authorities

Annual district and block level convergence meetings of EWRs from all three levels were organised under the project as platforms for district level advocacy, where EWRs' shared their findings supported

[4] *Panchayat Samiti: Local government body at the tehsil (taluka)/block level in India. A block is a sub unit of District level administration that operates at the level of 100 villages with a population of a 1000 each*

with the data collected via the checklists with officials from different departments (Health, Social Welfare and Public Health Engineering Department/PHED). Many of these meetings resulted in positive collaborations between the EWRs and the health workers on use of untied funds, sanction of referral transport and regular services at HSCs.

Interface with health workers

The mentoring support provided under the project use of the checklist instilled new confidence in the EWRs. Over time, as the interface between the EWRs and health workers became more frequent, their relationship improved and a level of mutual trust has evolved. They have together found solutions - such as installing curtains for privacy during ANC, and using untied funds for purchase of basic equipment. The health workers in turn have requested for the EWRs assistance for mobilization and awareness generationon FP/RH issues.

Role of Information and Communication Technologies (ICTs)

mShakti: IVRS pilot : to test efficiency of a low cost tech solution as a supplemental add on was piloted :

- A tool to collect and exchange information--takes information in, and pushes information out
- A method for rating service availability and quality of care and getting that feedback into the ecosystem
- Incoming and outgoing possible, toll free
- Audio learning pack
- Real time data analysis

Process of Training EWRs on using mShakti

Preparatory: listing GP members with phone number and generating MIS with village name

Training: first level of training NGO field animators and coordinators by Gram Vaani, door to door training of EWRs by field animators and handhold support to respond to survey

Challenges Faced

Low literacy and gender were the biggest barriers. Women lacked confidence; they were dependent on their husbands to take decisions about them. Their mobility was restricted. It was a challenge to organize residential training programs; women faced criticism from their family members. These challenges were overcome by building trust with family members. To counter literacy the training content used was more graphic and pictorial and similarly pictorial checklists were developed for monitoring of FP/RH services. The other approaches which helped in achieving results were using non-confrontational and collaborative approach with multiple stakeholders. The government functionaries such as ASHA and ANM who initially saw them adversaries later became supportive as they saw EWRs were meant to complement their work and to improve quality of health services.

Outcomes

EWRs taking action on FP/RH issues - One of the key areas of intervention aimed at empowering EWRs to ensure availability of and access to health care services, particularly FP/RH related services. 62 percentage points increase is reported among EWRs reporting attending a VHSND in the last 3 months in the intervention group (Ib[5] [6] : 11%, IE[7] : 73%) as compared to an increase of 19 percentage points (CB[8] : 5%, CE[9] : 24%) in the control group indicating a 43 percentage points higher increase in EWRs attending VHSNDs in the intervention area.

EWRs reported **meeting with Auxilliary Nurse Midwife (ANM)/ Accredited Social Health Activist (ASHA) and Anganwadi Workers (AWWs)** more frequently than they did prior to *Pahel*program. 59 percentage points increase is reported in EWRs who reported meeting with ANM in last 3 months prior to the endline in the intervention group (IB: 27%, IE: 86%), while a 35 percentage points increase is reported on the same among EWRs in the control group (CB: 26%, CE: 61%). %). EWRs in the intervention group have shown an increase in meetings with ANM in last 3 months which is 24 percentage points higher than EWRs in the control group. 53 percentage points increase is reported in EWRs who reported meeting with ASHAs/AWWs in last 3 months prior to the endline in the intervention group (IB: 36%, IE: 89%), while a 39 percentage points increase is reported on the same among EWRs in the control group (CB: 32%, CE: 71%).

*Pahel*aimed to specifically increase **EWRs participation in access to healthcare services** through regular interactions and meetings with ANM/ASHA/AWW. Impact of the intervention is evident as many more (84%) EWRs who participated in Pahel reported that they provided support to ANM/ASHA/AWW in some form or the other as compared to slightly more than half (55%) EWRs in control area, which is a difference of 29 percentage points at the time of endline survey.

Higher number of EWRs in intervention group reported **providing support to frontline health workers in specific services**. For example, a higher number of EWRs (Comparative Difference, CD: 134) provided support in registration of pregnant women; on RH related services (CI: 135); 100 points in ensuring distribution of money to *Janani Suraksha Yojana* (JSY) beneficiaries (CI: 100) and in conducting activities related to VHSND (CI: 114). These changes can be attributed to *Pahel*program as the training and regular monitoring and tracking of EWRs aimed to strengthen their ability to perform their role as PRI effectively.

Pahel built **capacities of EWRs to engage with Medical Officers (MOs)** in-charge and raise local issues and concerns. A positive change was observed among the intervention group. Among the EWRs who had a meeting with the MO a higher number of EWRs in intervention group reported raising issues - supervision of HSC (CD[10] : 26), supplies of IFA tablets (CD: 46), visits by ANMs (CD: 38), regularity of

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[6] *Intervention Baseline*
[7] *Intervention Endline*
[8] *Control Baseline*
[9] *Control Endline*
[10] CD: Control District

Ward members of a panchayat in Muzaffarpur express their solidarity

VHSNDs[11] (CD: 37) and supplies of contraceptives (CD: 40). In addition, EWRs in the intervention group were found to be more active on issues like availability and use of untied funds (CD: 26) and counselling during VHSND (CD: 28) as compared to the control group.

Pahel also created an opportunity for **EWRs to interact with Civil Surgeon (CS)** through annual convergence meetings. 41% EWRs had met with the district Civil Surgeon in the intervention group as compared to 18% in the control group. An overall 23 percentage point higher engagement is reported in the intervention group.

EWRs who met with the CS in the intervention group focused on availability and use of untied funds, meetings of Patient Welfare Committee, supply of contraceptives, regularity of VHSND, supplies of Iron Follic Acid - IFA.

Impact of IVR platform - The mShakti package included an audio learning pack on FP, RH and maternal health care along with a survey to report back on corresponding services available at the HSC, PHC and VHSNDs. A pictorial checklist was developed to match with the IVR survey questions so that it can be used independently by EWRs. Centre for Catalyzing Change covered 6 PHC, 94 HSC and 415 VHSNDs through 800 EWRs at *Panchayat* level. 85% EWRs that were interviewed during endline were a part of mShakti. 98% of these EWRs had listened to information and entertainment programs on IVRS, 95% had provided information on facilities assessment and 100% had received support from the field animators to navigate through IVR and 81% shared that they can navigate through IVR independently.

Results from piloting low cost IVRS platform for monitoring of FP/RH services with select cohort of EWRs has shown that it is possible to scale the intervention at state level. The aim was to use mShakti as

[11] VHSND: Village Health Sanitation and Nutrition Day

a reporting tool on health services, wherein data could be analysed and distilled into an information dashboard. The IVRS activities were complemented with the EWRs engaging with health officials and *Panchayats* at ground level to initiate actions. There was a unanimous support from EWRs who engaged in this platform and a majority of them reported listening to information packs (98%) and provided information on facilities assessment (95%). While all the EWRs reported having received support from the field animators to navigate through IVR a majority of them (81%) felt confident in navigating the IVR independently. With support on negotiating IVRS, this program can be scaled up to become an effective instrument for receiving direct and real time feedback on community based monitoring processes that can be integrated within existing MIS of the Health Department.

Outreach & Scalability

Pahel was initiated in 2007, with only 2 blocks and 300 EWRs and based on encouraging evaluation results currently Pahel has scaled up operations in 10 blocks of four districts (Aurangabad Muzaffarpur, Sitamarhi and Nawada) reaching nearly 2000 EWRs and about 300 elected male members who are members of the Village Health Sanitation and Nutrition Committee. Creating a cadre of master trainers and monitoring the quality of training. Linking EWRs to the State Grievance Redressal Systems so that people's representatives can use the facility to solve problems related to the health system service delivery.

For the three project cycles, Centre for Catalyzing Change has widely shared results of the project at several national and international forums including the Gender and Evaluation Community India, American Evaulation Association and European Evaluation Conferences in 2014. Both qualitative and quantitative methodologies have been used to measure results. The good practices have been shared not only with government but also with civil society organisations.

The Pahel model has been used to mobilise EWRs across the state and mentor them as health advocates for a state level campaign on quality of care, *HamaraSwasthyaHamariAwaz.*

The Pahel model has been presented and shared over the NHSRC Innovation Portal (National Health Systems Resource Centre) and selected as best practice. Learnings from Pahel have been published by the Planning Commission Evaluations for Sustainable Learning: Experiences and Learning, 2017 and Second Edition of the Annual UN Women Publication on Gender and Evaluation 2014.

Replicability

The project evaluations have demonstrated far reaching impact and a new district has been added on from 2016. As a demonstration model, it achieved results and has scope of replication into other locations. The government can integrate the training modules into its training programs for EWRs in other states. The program learning indicates that for scale up of the model integrating community based monitoring led by elected representatives of the PRI as part of the curriculum for training elected representatives, can be an effective strategy.

The tools especially developed for low literate/illiterate women leaders can be adapted to the context of other states and other issues beyond health and education. In fact under Pahel a pictorial school monitoring checklist has also been created.

Impact Achieved

The changes brought about by the project are significant considering the fact that a majority of the EWRs had limited exposure and had not received any training/orientation from concerned department on their roles and responsibilities as PRI members. Despite the intention to serve the people they represented, the EWRs lacked the information on their role and confidence to vocalize their opinion.

Opportunity to bridge this gap between intention and lack of knowledge, skills, information source and guidance came through *Pahel* in the intervention group and through the Department of PRI in the control group. Most of the EWRs (in intervention area as well as control area) reported receiving information on their rights and role, and information on health, education and development programs with the exception of follow-up support which was provided by the project staff in the intervention area. EWRs in both the groups had similar levels of awareness and knowledge but a stark difference is visible in the following areas:

- Many more EWRs in intervention group advised community members on FP/RH issues, attended VHSNDs and reported provision of services during VHSNDs
- Many more EWRs in intervention group interfaced with ANM/ASHA/AWWs, MOs and CS as compared to control group.
- *Pahel* activities empowered EWRs to participate actively in *Gram Sabha (GS) /Panchayat* meetings and were motivated to raise issues on key areas of concern. EWRs in the intervention group have shown an increase in ability to raise issues during the GS/*Panchayat* meetings which is 38 percentage points higher than EWRs in the control group.
- Key to effective administration and fulfilling responsibilities is ability to take independent decisions. EWRs who participated in *Pahel*showed that they were able to take decisions independently on FP/RH related issues with a difference of 38 percentage points at endline between intervention and control groups of EWRs.

Pahel has shown that it is possible to effectively empower EWRs to perform their role as elected representatives of their constituencies, especially in the domain of health services. Although training has been given a lot of emphasis in capacity building including awareness about specific roles and responsibilities as well as knowledge about health and education services, related government schemes, but monitoring and support are equally essential to build their capacities to take decisions independently and vocalise themselves.

Findings of evaluation of *Pahel* are encouraging and indicate that *Pahel* can be an effective model for leveraging the role of elected representatives in

Women leaders in Pahel using mobile technology to improve health services

community based monitoring of health services within the framework of National Health Mission. Another innovation in *Pahel* is an emerging model where EWRs can collaborate with health service providers to find quick solutions to local problems by using untied funds, raising access, supply and procurement issues at meetings of Gram Panchayat and PanchyatSamiti and during their meetings with the officials of the concerned departments.

Capacity Building

Trainings - The training module developed by C3 focused on information on FP/RH with the view that if PRI members are aware of different methods of FP and components of RH, they will be better equipped to ensure health service delivery.

Pahel built capacities of EWRs to engage with Medical Officers (MOs) in-charge and raise local issues and concerns. A positive change was observed among the intervention group. Among the EWRs who had a meeting with the MO a higher number of EWRs in intervention group reported raising issues - supervision of HSC (CD: 26), supplies of IFA tablets (CD: 46), visits by ANMs (CD: 38), regularity of VHSNDs (CD: 37) and supplies of contraceptives (CD: 40). In addition, EWRs in the intervention group were found to be more active on issues like availability and use of untied funds (CD: 26) and counselling during VHSND (CD: 28) as compared to the control group.

Pahel also created an opportunity for EWRs to interact with Civil Surgeon (CS) through annual convergence meetings. 41% EWRs had met with the CS in the intervention group as compared to 18% in the control group. An overall 23 percentage point higher engagement is reported in the intervention group.

EWRs who met with the CS raised similar issues although EWRs in the intervention group focused more on availability and use of untied funds (IE: 30%, CE: 7%), meetings of Patient Welfare Committee (IE: 35%, CE: 28%), supply of contraceptives (IE: 78%, CE: 69%), regularity of VHSND (IE: 70%, CE: 66%), supplies of Iron Follic Acid - IFA (IE:74%, CE: 72%), whereas EWRs in the control group reported higher emphasis on ANMs visits (IE: 73%, CE: 78%), supervision of HSC by officials (IE: 51%, CE: 62%), non-availability of gynecologist (IE: 51%, CE: 62%), etc.

Partners of the Project

Role of partners - this intervention was in partnership with local partners based in coverage area of the project. Their role was to mobilize EWRs and building rapport with them. They facilitated capacity building initiatives like training programs and handholding support. They organized exposure visits, facilitated ward Sabha and cluster level meetings. They explained checklists and held hands while filling them. They provided support in linking with government functionaries.

Awards/Endorsements

The Pahel model has been presented and shared over the NHSRC Innovation Portal (National Health Systems Resource Centre). Learnings from Pahel have been published by the Planning Commission Evaluations for Sustainable Learning: Experiences and Learning, 2017 and Second Edition of the Annual UN Women Publication on Gender and Evaluation 2014.Pahel was selected by Ministry of Health and Family Welfare a best practice showcased at the 3rd National Summit on "Good and Replicable Practices and Innovations in Public Healthcare System".

In a health camp - members checking health status of their children

Pilot Project to Address Malnutrition Challenges in Kathikund Block, District Dumka, Jharkhand

November 2014 onwards

Website	:	www.pradan,net
Founder of the Organization	:	Mr. Deep Joshi and Mr. Vijay Mahajan
Project Budget	:	₹ 50 lakh from Nov 2014 till date
Coverage/ Geographical reach	:	11,300 Women 190 Villages 12 Panchayats Kathikund Block Dumka District, Jharkhand

Project Brief

The causes of malnutrition among women and children are multi-factorial and multi-dimensional. Issues of poverty, gender, socio-economic discrimination, livelihood opportunities, and poor state of services regularly contribute to the condition of malnutrition. The interlinked issues of poverty, food and nutrition security, health, and gender equality need to be addressed simultaneously and comprehensively. It is also well understood that the issues of women's health and nutrition and that of children are closely intertwined since women give birth to children and remain their main takers.

The project area lies in the Santhal Pargana region of Jharkhand where 90% of rural women are in anemic condition. The project aims to improve the health and nutrition status of women and children through a multi strategy approach, (i) working with women's group, (ii) systems strengthening, and (iii) leveraging the agricultural and livelihood practices towards improving human nutrition.

The intervention follows the belief that community involvement can make health services more accessible and sustainable, and that enabling communities to explore the consequences of health behaviour can yield lasting improvement in health outcomes. Thus, there can be a significant reduction in malnutrition levels among women and children through community mobilization, systems strengthening and community based management of malnutrition.

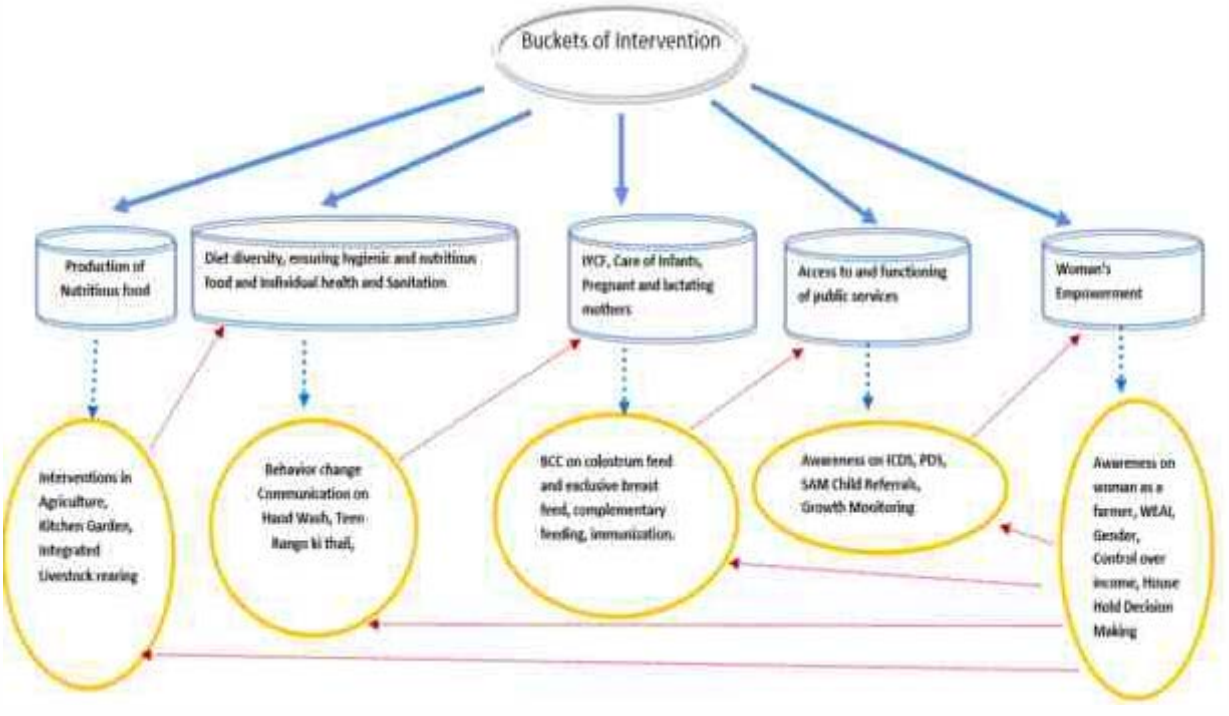
The interventions engage with individual households and women to help understand the underlying causes and practices related to malnutrition and ill health. Additionally it is needed to work with the community and public systems/institutions to ensure that services of public health and nutrition programmes are available and accessible in the project area. Additionally, working with PRADAN's existing livelihood platform as a strategy is to build linkages between livelihoods and nutrition.

The overall change in the existing condition of malnutrition will be indicated with the change in Body Mass Index (BMI) of women and decrease in the number of Severely Acute Malnutrition (SAM) children. The increase in awareness level of women around good practices of mother and child care, the entitlements and rights, control over income and household decision making will lead towards better condition of health and nutrition. This can be achieved by including the agenda of nutrition in discussion of self help groups (SHGs) and the village organizations (VOs) promoted by PRADAN.

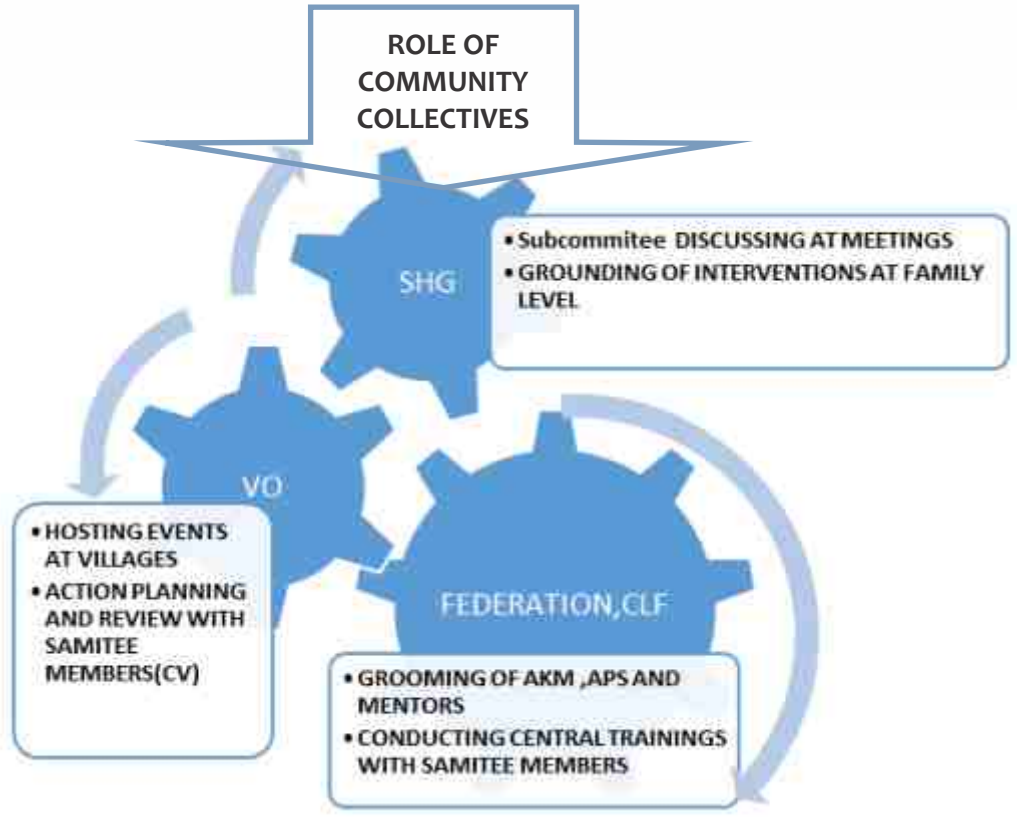
The initial perspective building around the subject was carried out for PRADAN professionals and the community members, which is done with the help of our partner organization, Public Health Resource Network (PHRN).

Implementation Model

Implementation Model: The intervention includes two major dimensions Nutrition Sensitive and Nutrition specific. To achieve the goal a pathway is designed as per the buckets of intervention which is as follows.



The investments are around Master trainers (in Nutrition), Ajivika Krishi Mitra (cadres in agriculture) and community collectives.



Support System	Function	Methods
Nutrition Master Trainers	Provide training around step by step modular trainings to VO subcommittee members and in follow-up discussions in SHG	Stories, Picture Cards, BMI camps, Plays and Videos, Exposure visits to Malnutrition Treatment Centre (MTC) centers and hospitals, Games on 'Diet Diversity', Sharing of success stories.
VO subcommittee members	Conduct focused discussion in VOs and SHGs around Nutrition and making action points. Take action against Liquor consumption, violence against women and corrupt practices around services like PDS. Participate in convergence program of government to provide ration to primitive tribe groups (PTGs)	-Use of visual tools like picture cards and stories and sharings, wall paintings -Rallies -PDS shop
SHG members	Conduct discussion on issues and awareness around Nutrition	Use of visual tools like picture cards and stories and sharing, wall paintings

Support System	Function	Methods
AKM(Ajivika Krishi Mitra)	Conduct training on Package of Practices (POP) of crops with Ajivika subcommittee members and SHG members. Ensure practice of Kitchen Garden with seasonal crops. Ensure production of Nutrition sensitive crops with promotion of Agriculture Productive Clusters (APCs) Promote practice of Organic Farming and Non Pesticide Management(NPM)	Exposure visits to farm and market. Picture cards, stories and Videos. POP trainings, handholding and support in input management -village level demonstration

Community Outreach

Because of PRADAN's continuous effort there is presence of community institution in the area. The theme of nutrition was integrated with each tiers of the community organization. For a community led initiative the theme of nutrition was mandated in the Aam Sabha or the Annual General Body meeting of the federation which is an apex body of the SHGs. This created an informed choice to work in nutrition. The selection of local community leaders increased the acceptability of the intervention. The use of local language, pictorial depictions and terms helped to connect with the community. The different processes undertaken are:

a) Community Need Analysis

b) Perspective Building

c) Transaction of Training Modules

d) Community Level Awareness Programs

e) BMI Camps

f) Monthly Evaluation and Review of Master Trainers

g) Village and Hamlet Level Trainings

h) Capacity Building of Trainers and Volunteers With Regular Refresher Trainings.

i) Regular Home Visits.

j) Handholding Support in Field.

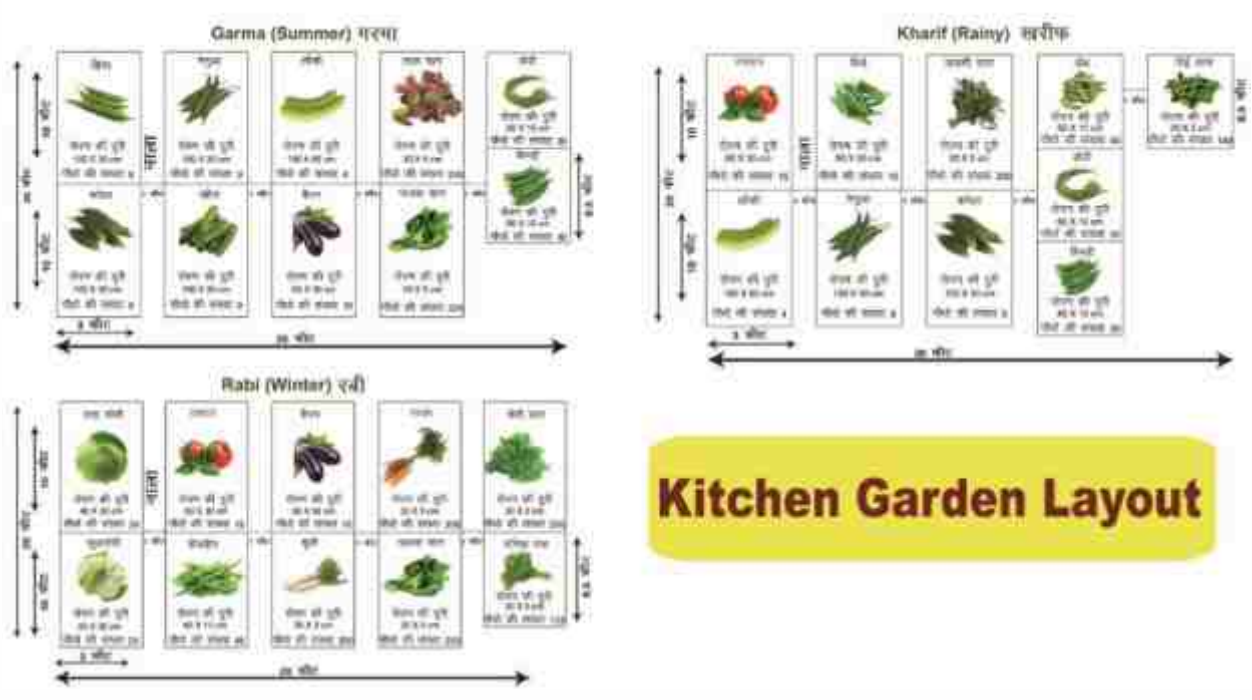
k) SHG wise planning for different cropping season. Emphasis on crop diversity with focus on nutritional requirement of the family

Uniqueness of the Project

- Introduction of Red and Green bands in BMI camps
- Use of more symbolic and visual methods; less lectures and more sharings.
- Inclusion of adolescent girls and children in training programs
- Developing local songs around nutrition
- Exposure visits to Malnutrition Treatment Centre in Government Hospitals
- Orientations of trainers by physicians.
- Connecting the trainings with local stories and live issues
- Converting complex messages into local and simplified versions like explaining the benefit of food and their nutrients in simple language and tools.
- Village level video show with pico projectors
- Wall paintings
- Input support for nutrition sensitive agriculture and kitchen gardening
- Use of organic fertilizers
- Regular sharing of success stories and cases of change

Nutrient	Benefit	Simplified terms used
Carbohydrate and fats	Energy giving	शारीर को ताकत और उर्जा देने वाला खाना
Protein	Body Building food	शारीर की वृद्धि करने वाला खना
Minerals and Vitamins	Food to protect from disease and increase blood	बिमारी से बचाने वाला और खून बनाने वाला खाना

***TRI-Colour (Saffron for proteins, White for carbohydrates and Green for minerals and vitamins)**



Role of Information and Communication Technologies (ICTs)

Use of mobiles and tablets by community cadres for BMI calculation.

Challenges Faced

The concept of nutrition is complex. There was no such tool to measure it or make visible identification to show increase or decrease in nutrition. The effect of nutrition or malnutrition was also not immediate due to which one could explain the importance. It was only explained in terms of good or bad health which was not enough as a person may look healthy but she may be affected by one or other kind of malnutrition.

There were initial hiccups among professionals (as many of us are men) to start a discussion on breast feeding and as soon we used start the discussion the women in the meeting would leave the meeting one by one, as they also used to feel hesitation. It was very difficult to start the discussing the issues of colostrum feeding and exclusive breast feeding.

Major challenges faced were:

a) Starting the discussion around nutrition. As the importance of nutrition was difficult to explain without any short term benefit or parameter to measure

b) Breaking the myths, taboos and intergenerational practices around Mother and Child care

c) Change of food habit and consumption pattern

Working On Solution:

We conducted sensitization camps around BMI as an entry point activity. We started discussion and sharings on real life situations and on 'Consequences of Bad Practices'. We encouraged sharing of good practices, used tools of picture cards and storytelling. These stories helped to relate them with daily life. We connected the issues of myths and taboos with discrimination of women. We also talked more about habit that have ill effect on child health. We did exposure visits to areas having good practices and to MTCs. Regular practice and brain storming was also done at the team level.

Learnings

Key messages are difficult to retain in mind and in practice. There is need for regular discussion on the issues and key messages in the community forums. Discussions with interactive and symbolic tools and stories are more effective. People relate more when there is quality training by skilled workers who talk with local and simple examples. A complex explanation and use of difficult terms do not retain messages in mind.

Outcomes

The outcomes are around five buckets of intervention (already described in the model above):

BUCKETS	OUTCOMES
1. Production of Nutritious food	1. Increase in production of nutrition sensitive **Traditional Crops** like spinach, okra, tomatoes, pulses including horse gram, Bengal gram, and pigeon pea. 2. Kitchen garden: Papaya, Moringa, Lemon, tomato, spinach, chili, okra and seasonal vegetables. 3. Increase in cultivation of oilseeds such as Mustard. 4. Intensive use of organic farming and women drudgery reduction equipments 5. Integrated livestock rearing for intake of protein. 6. identification of local fruits and vegetables including forest products
2. Diet diversity, ensuring hygienic and nutritious food and Individual health and Sanitation	1. Increase in daily diet diversity 2. Increased awareness around nutrient value of food groups. 3. Behavior change around: - Consumption of Four food groups of Cereals, Pulses, oils, Green Leafy vegetable - and translating production into consumption - Healthy practices of hand wash, use of iron utensils, Discouraging junk foods, cleanliness, Washing before cutting vegetables. -Use of toilets

BUCKETS	OUTCOMES
3. IYCF, Care of Infants, Pregnant	Behavior change around:-Increased adaptation of practices and lactating mothersaround IYCF including Early Initiation of Breast feeding including colostrum feeding, Exclusive Breast feeding, and Complementary feeding. Awareness around immunization. -Increased awareness around early marriage, anemia.
4. Access to and functioning of public services	Identification of Severe Acute Malnutrition in children below 5years and referrals. Strengthening of services -around THR(Take home ration) and hot cooked meal at anaganwadi, -Proper functioning of PDS (Public Distribution system) Provision of PDS card and Ration. -Proper Growth monitoring of children(Prevention before falling into SAM/MAM category)
5. Women's empowerment	Participation of woman in household decision making, control over income, challenging patriarchy. Increased role of women in Agriculture

Outreach & Scalability

Kathikund is situated in the foothills of Rajmahal, an extreme poverty stricken and tribal dominated pocket of Jharkhand state. In Kathikund block, Santhal (ST) community is one of the largest prevailing communities. It comprises the 60% of the total population of Kathikund.

The program is community led initiative. The women collectives in the area are the torch bearers of the program. The program extends and is implemented through the platform of community institutions like SHGs, VOs (Village Organization), CLFs (Cluster level Federation) and BLF (Block Level federation). There is presence of PRADAN promoted CBO and large scale social mobilization in Kathikund.

Institution at a Glance

Institution	Level	Member	Frequency of meeting
SHG(Self Help Group)	Hamlet	10 to 15 Primary Member	Weekly
Village Organization	Village	Representative of 8 to 12 SHG	Twice a month
Cluster Level Federation	Multi-panchayat	Representatives of VO	Twice a month
Block Level Federation	Block	Representatives from Panchayats	Twice a month

The institutions of women collectives with primary members have 10 to 15 women at hamlets is known as SHG. The next tier is the village level institution is Village Organization and constitutes representative members from SHG. A village organization (VO) constitutes members from 8 to 12 SHG. After VOs Panchayat or multi-panchayat level Cluster Level Federation. This tier constitutes 20 to 25 VOs. The representatives of Clusters level Federations constitute the Block level Federation. The tier at Block level is Block Level Federation or BLF. The members follow the principal of subsidiary. There is no hierarchy among the members and tiers. The flow of discussion, issue and decisions are taken at each level and shared at all levels.

Each Village organization constitutes four sub-committees. Each SHG in a village sends one member for each subcommittee at the meeting of VO. Thus from each SHG four members go for VO meeting. The members of Subcommittee have voluntary function .One of the subcommittee, Nyay Evam Adhikaar Samitee (Subcommittee for rights and Justice) discusses around the theme of nutrition. They initiate discussion around Women and Child nutrition in the primary members in SHG and take up issues and agendas of their SHG in VO meeting. These members also make action points around the issues, visit village level public institutions like anaganwadi and schools to monitor and strengthen their functions. These members also initiate the discussion around women and child nutrition in their SHG meetings.

They also help in organizing, handholding trainings and orientation events around nutrition with primary group by master trainers in the Village. There are Master trainers for Nutrition in each VO. These subcommittee members also receive oriented by Master trainers and Professionals. Thus there is a team consisting of PRADAN Professionals, PHRN BPO, Master trainers and Subcommittee members to reach out to the remotest area in the block.

There are currently at 190 villages in Kathikund with 874 SHGs, 80 VOs, three Cluster Level Federations and 1 Block Level Federation. We will reach up to 11,300 rural women and their household.

PRADAN Professional in conversation with SHG member in the leafy vegetable field

Current outreach and presence of PRADAN

Block Name	Total Villages	Total Panchayats	Total Household (as per census 2011)	Total SHGs	Total Vos	Cluster Level Federations	Block Level Federations	Total Rural House Hold Reached
Kathi-kund	190	12	14300	874	80	3	1	11,300

We have already done training on nutrition sensitive agriculture with 6,600 household and another 3,500 women have received initial orientation on Nutrition. In 2016-17 there were 4,800 household to whom we have supported with preparing their kitchen gardens.

Similar pilots are also being undertaken in others parts of PRADAN's operational areas. Once the prototype is developed and we see positive impact on a sustainable basis on maternal and child health we will adopt and take it to all our operational areas which is today more than 6 lakh women and 3 million people.

Replicability

a) Perspective building exercises and orientation of professionals and community leaders around nutrition and malnutrition with support from partner PHRN

b) Adding to it the training materials, modules and visual tools are shared to other locations.

c) Exposure visits from other location to Kathikund help to build prospective.

Impact Achieved

a) The large scale social mobilization and presence of community institution at different level helped to create awareness. It gave potential strength to the program. The mandate to work on nutrition was taken up in Annual General Meeting of the federation. This helped to create an informed choice to work around nutrition.

b) The focus on issues of women and children helped the program to gain momentum. The institution of women collectives helped and acted as a rich platform to generate regular discussion and awareness on the subject. The large scale and collective effort helped to raise several issues.

c) The theme of nutrition found its place in stalls and BMI camps of large gathering event of federation. These gatherings are Melas (congregations) and Adhiveshans (Assembly) of Federation. Here large number of women witnessed skits and songs around nutrition.

d) The presence of children and adolescent girls in the training events in VOs and SHGs gave wings to the program as they are fast learners. The hand wash events and stories with pictures were major attraction. In one of the case the children have forced the teachers to provide soaps for hand wash before mid-day meals in school.

A Nutrition Workshop

e) Contextual stories around women life cycle, nutrition garden were shared with actors having local names .These names like SONI, MADHAV, SILVANTI, ROPNI and MADHU are now famous in the villages.

f) Key messages of ill effects of early marriage, education till 12th and care during pregnancy receiving wide attention. Early marriage is a stigma to the society and a silent killer. The discussion on women life cycle gave voice to the issues. There have been 10 to 15 cases where the mothers took decision not to for early age marriage of their child. It contributed in saving the girls from early marriages. In some cases women collectives took action against the houses of Gram Pradhan who is the head of tribal community.

g) BMI camps helped to initiate the discussions around nutrition. After taking weight and height we calculated BMI and then tied hands with RED ribbon to the women with low or high BMI and a green ribbon on one in correct range of BMI. The the red and green colors caught visual attention and created disturbance.

h) Plays related to food diversity and nutritive importance of different food groups were conducted with demonstration of live foods from fields and forest.

I) The movement and actions of SHG and Federation around PDS and Liquor ban created large scale awareness in public and in line departments.

j) The referrals of SAM child and quick recovery of children generated interest to work around nutrition. This action also helped to create pressure in Anaganwadi to refer the SAM children and strengthen the growth monitoring process.

k) The effects of malnutrition are multidimensional. Thus integration with various themes is needed to address the issue. The intervention of integrated livestock rearing helped to reach out to landless non-agricultural families. The economic gains from the livestock are translated to consumption of nutritious food.

l) There were focused discussion around social determinants of malnutrition .The interventions have helped to break taboos around breast feeding in which several things like honey, goat milk were given to baby and sometimes babies were treated with heated iron rods to keep away stomach disease. Myths around keeping the women in fasting for few days to clean her impurities are now being challenge. There were myths related to consumption of moringa, papaya that it will create anemia etc. The awareness around benefit of foods has helped to clear such myths. The local shrubs and forest plants were also identified in such exercises.

m) The capacity building around skill gap and delivery method of trainers. Emphasis were given methods to make training and orientations catchy and attractive.

n) The pathways of intervention have led to change in the current situation.

   i. The increase in production of food and nutrition sensitive crops -have complemented in the behavior change around consumption of tri color food-This change in behavior is leading towards better health condition of mother and children.

   ii. The awareness around IYCF, regular discussion in community forums has increased demand towards services in Anaganwadi and Mid-Day -Meal. The movement around PDS and Liquor Ban has also helped in changing the condition of food security and mother and child care. The empowerment of women in taking household decision has given her choice of food for consumption and production. Their identity as a member of SHG, VO, Cluster and BLF has influenced the parameters in Production, Child and Mother Care, services delivery of public institution.

Capacity Building

I. Capacity Building of Community Leaders and master Trainer:

- The PHRN BPO and PRADAN professionals conduct these capacity building program
- Phase wise orientation program- The whole program is bifurcated into phases called Perspective Building 1,2 and 3
- In each phase there are three days residential Prospective Building and orientations.
- There are modules for each PB exercise .These modules are rolled out in form of stories with rural context.

- The modules are complemented with pictures cards of story and plays.
- The Classroom session of three days is followed by field exercise to check the skill gap of the trainers and provide them feedback.
- The field exercise consists of 2 to 3 days stay of trainers in selected villages to conduct the training.

ii. The Capacity Building of VO subcommittee members

- The members of VO subcommittee also undergo orientation for three days
- These members also go through the orientation and training of modules with stories and pictures.
- These subcommittee members are provided with training materials of Picture cards of stories and text.

iii. The training and discussions in forums of SHGs and Vos.

- The master trainers with support from subcommittee members roll out VO level and SHG level trainings.
- After the trainings the subcommittee members generate the discussion at SHG and VO level to keep the agenda alive. They use the interactive picture cards and refer to the stories to relate to their real life situations.

Partners of the Project

Broad activities of PHRN (PUBLIC HEALTH RESOURCE NETWORK) our partner organization which collaborates with us as a Technical Resource Agency include:

- A baseline study to understand the extent and nature of malnourishment in the area.
- Develop micro level implementation strategies of interventions for community mobilization and systems strengthening.
- Design and develop training modules on various health and nutrition issues for master trainers and develop training toolkits for Community Resource Persons.
- Training and capacity building on health and nutrition issues for (i) PRADAN staff of all levels; and (ii) implementation of training for BPO, executives and members of the Nutrition Monitoring committee, who will be the master trainers and mentors to Community Resource Person.
- Conduct refresher trainings, as required.
- Handholding PRADANs staffl; executives and members of the Nutrition Monitoring Committee/Community Resource Person to take these issues forward to the community and to engage with the service providers. Ensure regular monitoring and handholding for project implementation.

- Periodical review and reporting of project activities.
- Use learning from the small pilots that successfully link nutrition with livelihoods to engage with the community and facilitate their action towards new practices.

PHRN and PRADAN teams are working closely to incorporate nutritional objectives into agricultural and livelihood practices and interventions. This would involve the field teams of PRADAN and PHRN exploring ways to synergize the contribution of PRADAN's current projects and initiatives to nutritional outcomes. This could involve small pilots that will feed in to the larger intervention.

Awards/Endorsements

Not yet, however we consider FICCI considering us to present our work in this conference is an endorsement.

Story of Change

PHULOWATI DEVI LEADING THE PATH

-to a better health for all the mothers and children of Joraam Village

"Haraa haraa khayenge, haraa haraa lehrayenge (we will eat green and our fields will sway with greenery)", a loud voice of Phulowati devi now reaches every household in Joraam village.

Phulowati devi is a member of Gayatri Mahila Mandal, a self help group in Joraam Village in Bartalla Panchayat of Kathikund Block in Dumka. She stays with her husband and two children, both boys. The elder one studies fifth standard and the younger in second slandered in a local government school in the village.

Women taking care of their Poshak Batikas

The meaning of her slogan you can see in her backyard and in her farm. She grows a variety of green leafy vegetables like spinach, amaranth, coriander leaves, papaya, moringa and lemon round the year for household consumption and the essence of greenery to her house. She is a master trainer in our Nutrition programme.

The picture was not the same two years ago when her food plate only consisted of one or two items. She shares, *"I can recall those days when the color of our plate was white, we used to eat only rice and potatoes in almost every meal.. The only benefit that we could get from such food is to fill our stomach and feed our hunger. We hardly used to consume from the nutrition rich plants surrounding us and in fact neglected their presence".*

Ignorance, illiteracy and myths played evil in these remote and unreachable hilly villages of Kathikund block. While local food items were ignored due to superstitious beliefs attached to it. For instance moringa and most of the green leafy vegetables (like several varieties of spinach) was not eaten as it is believed that it will increase problem of cough and cold. Moringa was also attached with belief that it will weaken the body. Pulses like *masoor dal*(red lentils), *kulthi daal*(horse gram) were not consumed with belief that it will increase skin problem, wounds would not heal if it is consumed. Papaya is not eaten with belief that it will increase cold problems. Lemon was not allowed during periods as it will increase it. A healthy food was always regarded as a matter of expense (meat, fish, egg, fruits, etc). Health was a matter of fate and a business of doctors.

Few years ago Phulowati attended a BMI checkup camp conducted by PRADAN. After the camp she received a **red band** in her hand. She had already gone through an orientation programme, so she shares her state of mind after the camp, *"I was nervous to find out that I am not in a range of good health and the red band provided by PRADAN dada increased my curiosity to know what I should do to get a **green band**".*

To develop consciousness towards health and nutrition PRADAN conducts sensitization camps around BMI check and provides red band to women with low BMI and green band to women with optimal BMI. The visual input through color symbols has a deep impact among these women. Attending the orientation and an interactive session after the BMI camp Phulowati shares, "my concerns found solution when I attended interactive session with experts to understand the benefits of different foods, their groups and the importance of locally available nutrient rich foods. We understood their importance as body building foods, energy giving foods and foods to protect from disease and increase blood in our body. I also understood the concept of tricolor food plate and I could relate my food plate with the colours of our national flag. Now I recite the slogan in every group meeting with other women, ACHHEY KHANEY KI THALI TEEN RANGO WALI (A good plate has three colors), with major emphasis on eating green leafy vegetables." Thus slogans, colors and simplification of complex messages into local terms played an important role in delivering key messages that PRADAN wanted to give these women.

The consumption pattern slowly began to change in her family as she shares that, "The interactive sessions around nutrition by PRADAN helped us to understand the concept in a step by step manner . With increased curiosity after every meeting, I could now find time to think about my health and also started discussing on this theme in SHG meetings." She further shares that, "Even after gaining insight

from the meetings our souls were disturbed to find that there was very little scope for cultivation of round the year vegetable. Due suboptimal level of agriculture it was hardly possible for cultivation of round the year crops. The area is rain fed and the lands were undulating. We could hardly aspire for cultivating food crops in seasons other than *kharif(rainy)*. Thus the only option was to buy vegetable which was hard for our pockets".

Both Phulowati and her husband sell vegetables in local market in Kharif season but for them also the idea of round the year consumption of green vegetables was beyond imagination. The major portion of their plate was thus filled with rice and potato..

But she was determined as she understood the necessity to eat healthy food. Her family was often stricken by diseases. Jaundice and Malaria are invited diseases in her house every year. Her husband also regularly complained of weakness after a day's hard labour in field. So she attended further orientations around nutrition and nutrition sensitive crop organized by PRADAN. A low cost model of **kitchen garden** was introduced to her where several vegetables and few varieties of local pulses could be grown. She learnt that she could use the waste water in her house and local organic fertilizers to sow few seeds of 8 to 10 crops in her backyard. These crops needed very little irrigation and the use of organic fertilizers helped to retain moisture and productivity of the land.

Now it's no more a dream, it's a reality.

Phulowati shares, "Every morning I rise with fresh mind to see greenery in my backyard. I now include green vegetables in my family's everyday meal. My children have shining faces and they enjoy the variety in food. We have also started consuming forest shrubs, one of them famously known as Bindi Araa (Santhal Name of a vegetable).This vegetable has helped to retain my blood pressure level. I also serve lemon water to my husband after he comes from work and it is the best use of lemon plant in my backyard".

Phulowati understood that a wealthy life is not a precondition to consume healthy food, fighting ignorance could also lead the road to healthy living.Phulowati Devi in her kitchen garden with a basket of Brinjal

Within a span of two year her life became a song in which she added few more lines and sings it as , "Haraa haraa khayenge, haraa haraa Lahrayenga, sabkuchh ghar mein ugayenge, karidkar kuchh nahi khayenge (We will eat green and sway in greenery, we will cultivate everything at home and will not buy anything from market)."

Today like Phulowati, 40 women from the 6 self help groups of Joraam* village have influenced their family to have kitchen gardens in their backyard and eat healthy.

***Joraam is a village with 46 households and 218 population.**

Phulowati Devi in her kitchen garden with a basket of Brinjal

Professional Assistance for Development Action (PRADAN) was founded in 1983 by young professionals inspired by the **belief that well-educated people, with empathy** towards the poor, must work **directly** with them at the grassroots to alleviate mass poverty in rural India. They realised that the critical gap in creating change was the absence of capable people, *not material resources.*

PRADAN seeks to realize its **vision of creating a just and equitable society** where everyone lives and work with dignity by building robust collectives of women that will strive for large-scale change in human condition. PRADAN works with 588,289 families in 7,434 villages spread across 37 districts in 7 States, ~70% of who belong to most vulnerable groups such as dalits and tribals (indigenous community). Promotion of sustainable livelihoods is integrated with work on issues of gender, governance and access to rights and entitlements. Starting with a pilot project to improve the field

implementation of the Government of India's (GoI) rural development programs in 1987, PRADAN has played a **design improvement role** in all major programs like the IRDP, NREP, SGSY, NRY, and National Rural Livelihood Mission (NRLM). Today PRADAN is the National Support Organisation to NRLM, the flagship rural development programme of the GoI. Besides creating social capital, our livelihoods improvement work with our communities produces incomes of Rs 1,250 million annually and our sectoral programmes on small-holder poultry and tasar silk rearing are the largest organised efforts in the country.

PRADAN also has made seminal contribution to **professionalising the development sector** through its structured programme to induct, groom and deploy the best and the brightest for the poorest **(Leadership for change programme)**. Till date 2000+ professionals have gone through this programme and 80% of them are still in this sector. PRADAN has been an organisation of social entrepreneurs; 18 of our alumni are leading their own organisations. Today PRADAN has 400 plus trained development professionals working in far flung remote villages in most challenging conditions dedicated to the task of nation building.

With more than 34 years of engagement on issues of rural poverty, *PRADAN visualizes a just and equitable society to sustain the transformation of the human condition that it catalyzes*. PRADAN's aim, therefore, is to stimulate and enhance the 'sense of agency' of collectives of poor people, especially women, leading to occupying their rightful space as equals in society and taking on responsibilities of citizenship.

To fructify the vision our plan is to expand five-fold to be with **1.5 million rural poor families** (~10 million people) by 2022, this is 15% of poor families in the poorest 52 districts of India. Change at this scale will substantially impact the conception and delivery of public programmes and create multiple *'impact nuclei'* that will trigger economic vibrancy locally, allowing many more to emerge out of poverty as a consequence.

PRADAN is supported by prominent actors in the development ecosystem, including the GoI and state governments, UN Agencies, TATA Trusts, Bill and Melinda Gates Foundation, IKEA Foundation and corporate foundations like Axis Bank, HUF, Inter Globe Aviation Ltd (Indigo) etc. Much of the success of our work is attributable to our partners who have enriched our work. Integral to PRADAN's resource utilisation approach are leverage and efficiency. Every rupee that PRADAN spends on its own costs results in Rs 4 of Programme Investment in creating assets and capabilities for the poor. This is combined with a highly efficient operating model, in which only 4% of the overall investments are non-direct costs. Our work is currently being supported by over 80 donors.

Poshan-Community Based 1,000 days Initiative

January 2017 - December 2019

Foundation for Mother and Child Health

Website	:	http://www.fmch-india.org/
Founder of the Organization	:	Ms. Piyasree Mukherjee
Project Budget	:	₹ 57,00,00
Coverage/ Geographical reach	:	Kurla West, Mumbai; Population covered: 55,000

Project Brief

FMCH addresses the issue of maternal and child health and nutrition among vulnerable communities through a holistic approach of preventive care, treatment, community education, and partnership training programs. The organization's vision is "Healthy mothers and thriving children for a world of unlimited possibilities". This is being achieved by

- Promoting preventive health, nutrition and hygiene practices
- Influencing change in behaviours around health, nutrition and hygiene by presenting updated, accurate, actionable knowledge to the community
- Developing strategic partnerships with community, other organizations and government to scale the reach of our nutrition and health modules and practices

In India's current healthcare scenario, institutions tend to focus more on treatment delivery, and the importance of nutrition and preventive care tends to take a back-seat. The health seeking behaviour of the population also contributes to this. FMCH focuses on these components with a special emphasis on nutrition, which is critical in the health and economic development as well to achieve a number of Sustainable Development Goals. FMCH's model is to promote maternal and child health and nutrition through knowledge-based interventions and devising strong strategic partnerships with government and non-government agencies. Based on FMCH's experience on the ground with existing systems in an urban setting, Project Poshan was designed to ensure timely intervention for mothers and children in socio-economically vulnerable communities through the First 1,000 Days approach.

First 1000 days is a period of child's life from their conception until their second birthday. Proper nutrition during first 1000 days of a child's life is the key factor in ensuring that they survive and reach their complete potential. Right nutrition and health inputs during pregnancy and in the first years of a child's life provides the essential building blocks for brain development, healthy growth and a strong immune system. It also impacts maternal mortality since the focus is on ensuring the mother receives timely ante and post-natal care, which includes vaccinations, vitamin supplements and proper nutrition.

Through this approach FMCH is implementing aninnovative intervention by engaging with families of pregnant women and lactating mothers and their children. Poshan project is being implemented in partnership with the ICDS team and developing linkages with governmental healthcare agencies. The primary purpose is to optimise existing resources and building a strong and sustainable structure. FMCH believes in building capacities of families, communities and existing systems and helping bridge the gaps and not building parallel systems.

Here are the specific objectives of the project:

- Reaching out to600 pregnant women/lactating mothers and 800 children (0-2 years) by March 2019
- Preventing malnutrition during the first 6-months after childbirth by ensuring 85% of mothers with new-borns receive first breast-feeding assessment and counselling service within first 45 days after birth
- Successfully implement the First 1000 Days program by ensuring 85% of children who graduate the program are in 'Well Child status' as per the WHO guidelines

(meaning their weight for height will be above -2 percentiles on Z Score chart)

- Disseminating actionable knowledge to the community through special education modules to 75% mothers through pregnancy club, nutrition course and Achha Bacchasessions designed to disseminate accurate, actionable knowledge on ante & post-natal care, IYCF and Child Development

The aim is to focus on promoting preventive health and nutrition, thereby, building a sustainable structure by bridging the gap between demand and supply aspects of health ecosystem.

Implementation Model

The emphasis is on implementing a sustainable model that addresses challenges of ensuring proper input during first 1000 days of a child's life. This model is community based, and accesses the existing systems and services provided by the Government, linking them to pregnant/lactating woman and their children under age two by filling the knowledge gap as well as delivery of certain services which are not presently available.

- Anthropometric monitoring- Growth monitoring through regular anthropometric measurements like height, weight and mid-upper arm circumference for mother and children undertaken at the ICDS center.
- Home visits- Breastfeeding assessment and support, complementary feeding and weaning support, nutrition counselling, immunization counselling and referral, counselling of family members on importance of both ante and post-natal care, advocacy for the mother and the child with family take place through regular home-visits.
- Critical care clinic- For children who fall within the first 1000 days with critical issues (stunting/underweight/ acute malnutrition) or any high-risk pregnancy, providing appropriate treatment and referral. High risk pregnancies are identified using the Care Mother Kit, a potable medical kit and mobile application used by the frontline workers to identify high risk cases and linking them to appropriate referral points. Children with acute or chronic malnutrition are (what do we do with them?)
- Knowledge dissemination- Conducting small and large scale community engagement activities, as well as the education modules designed by FMCH based out of the ICDS centres.
- Training and capacity building of ICDS team- To ensure long-term sustainability of the program.

  Forming community-based health and nutrition committees- To support in mobilizing and influencing families and building capacities within the community.

Community Outreach

- Linkages with governmental and non-governmental agencies - Building strong relationship with existing governmental and non-governmental agencies is the first step towards getting to know a community.
- Baseline and Endline survey - Before initiating any intervention in a new project area, there are few

steps followed by FMCH. It starts with conducting a baseline survey to give an in-depth understanding of the current scenario. These indicators are also helpful in analysing impact of the intervention when compared with end-line result. It helps gather information of not just the quantitative indicators but also qualitative information like, socio-economic profile of the population, challenges faced etc.

- Community Mapping and Focus Group Discussions- This is conducted along with various community stakeholders like the local community and government representatives. Community mapping helps in a better understanding of layout of the area, identifying new and old resources, identifying partners for collaboration, and most of acknowledging individuals and local institutions who have the capacity to create real change. FGDs helps gather information on strengthens and challenges in the community and devise an appropriate plan of action for intervention.
- Household screening- A door to door survey aids in identifying families under the target groups. This is also used as an opportunity to introduce FMCH to the families. During this process a rapid nutritional assessment method helps in screening children suffering from acute malnutrition and appropriate action is taken.
- Community awareness and education- Small and larger scale events are conducted to mobilise the community by fostering communication and information exchange. This is used as an opportunity in spreading knowledge about need for good nutrition, health and hygiene practices.
- Community support systems- Creating support groups and identification of community change agents and influencers to help create a sustainable community system.

Uniqueness of the Project

- Simplifying nutrition into actionable information to educate families and communities through knowledge dissemination activities. The aim is to bring back local knowledge related to nutrition and health into the mainstream. This is being done through implementing various education modules developed by FMCH
- Influencing key decision makers in the families like fathers and grandparents, especially mother-in-law, by engaging with them through various innovative initiatives. This helps in building a strong support system for the mother and child.
- Integrating preventive and promotive strategies into existing systems. This will not only reduce the financial burden on families and state, but also have a positive impact on individuals being able to reach their full potential.
- Introducing technology like Salesforce and Care Mother kit for successful implementation and monitoring of intervention project.

Role of Information and Communication Technologies (ICTs)

a. Salesforce- Salesforce is a web-based customer management system that has been customized specifically for the organization. This software not only helps FMCH for monitoring of activities and progress of children, but also in donor reporting. The system provides real-time, individual and aggregated data for all FMCH programs, and is used to capture data for all FMCH projects.

b. Care Mother- Care Mother is a portable kit and mobile application developed for the frontline health

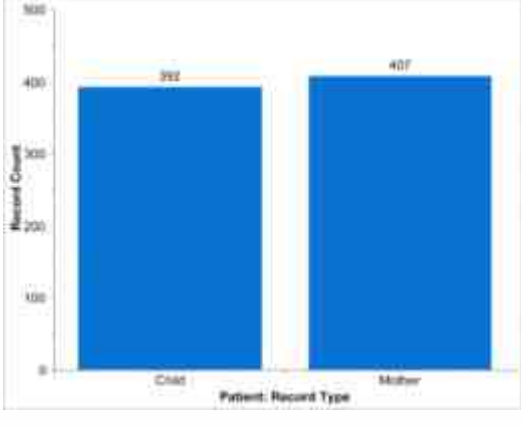
workers. This kit enables them to provide critical antenatal care at door the doorstep, thus encouraging health seeking behaviour and creating a strong referral system with the healthcare provider.

Challenges Faced

There is an urgent need for promoting the need of preventive healthcare and improving health seeking behaviour among the population. This is observed to be not just a challenge in marginalised communities but also among the affluent population. One of the specific challenges faced in the project area was delay in approaching healthcare provider to receive antenatal care. Most of the pregnant women register pregnancies at a health facility and avail services only by 6th or 7th month of pregnancy. This means that they have already missed out on receiving crucial support like nutritional supplements and assessment of current health condition. This also includes their resistance towards receiving tetanus immunizations during pregnancy which they believe causes infertility. Women tend to not consume essential pre-natal supplements like iron, folic acid and calcium which further leads to putting the woman at heath risk. This is also contributing to high incidence of anaemia among pregnant women being reported. To address this issue, FMCH focuses on identification of pregnant women early on in their pregnancy, refer them to the primary healthcare centre and closely monitor their well-being by providing nutrition education and support. The next key focus area is to engage with the entire family, to educate them and advocate for the mother so that family members, especially the decision makers provide all the support they need. We also build a trusting connecting with individual women to supportthem in making decisions regarding their own health.

Outcomes

- **Direct Reach**



In the first phase of the project, through screenings and assessment, FMCH has identified and registered 800 women and children in the program. These include pregnant women, lactating mothers, children under the age of two years, and children under the age of five identified with acute malnutrition.

- **Improved Nutritional Status**

The term malnutrition is multifaceted. It encompasses both over-nutrition, associated with overweight and obesity, and undernutrition, referring to multiple conditions including acute and chronic malnutrition and micronutrient deficiencies.WHO defines Wasting or Acute malnutrition as low weight for height/length. This condition is associated with increased morbidity and mortality in children thus making it a serious concern of malnutrition in children. Children with severe acute malnutrition are at 9 timeshigher risk of dying due to increased susceptibility to suffer from infections because of extremely low immunity.

Figure1. Baseline Wasting StatusFigure . Current Wasting Status

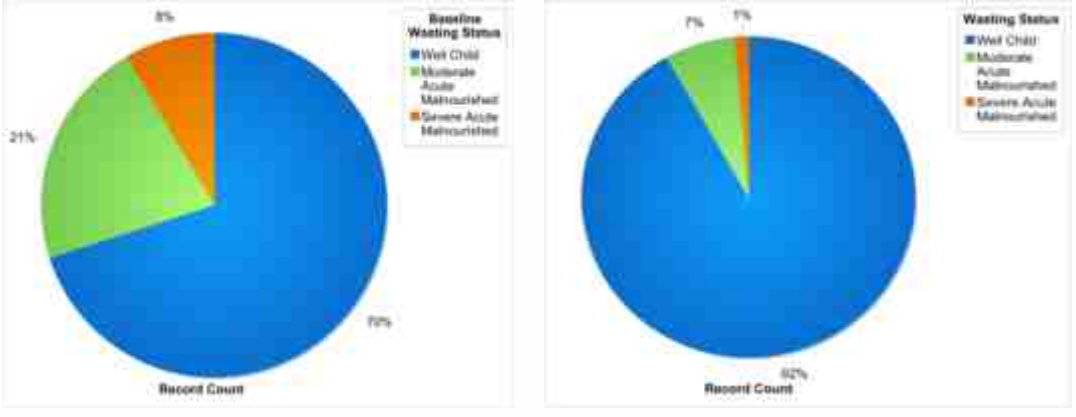
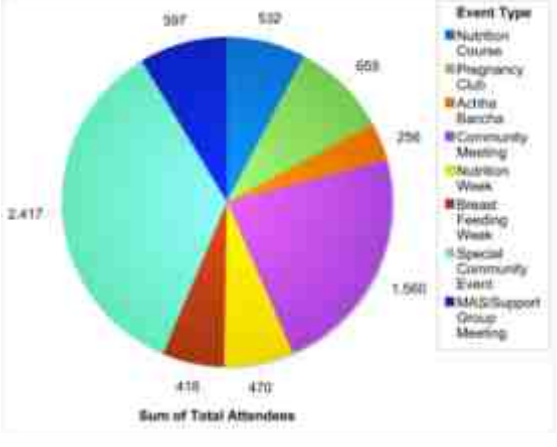


Figure 1 shows the wasting status of children when they were first registered at FMCH and Figure 2 presents their last measured status. The graph very clearly shows significant decrease in the number of children suffering from severe and moderate acute malnutrition and increase in children under 'Well Child' or healthy category. Regular growth monitoring, appropriate nutrition counselling and support is crucial in promoting behaviour change and thus improving the nutritional status of children.

- **Reach through Educational Activities**



Educating communities is key in influencing communities and behaviours. Since the beginning of intervention, the primary focus was to create awareness among all families in the community regarding various nutrition, health and hygiene related aspects impacting lives of mothers and children. This supports in mobilising communities and engaging with a much larger group of population. In the first phase of intervention close to 7,000 individuals have attended 430 small and large activities and events conducted in the community.

- **Adequate nutritional intake**

The First 1,00 Day's in child's life is a time of critical growth in which proper nutrition is absolutely necessary. Children who have poor diets, whether because of a lack of food or because of patterns of eating that lead to inadequate intake of nutrients, are prone to significant short-term and long-term health impacts. And the period of transition from exclusive breastfeeding to solid food is a crucial phase in this period. As per NFHS 4, only 8.7 children in India between the age of 6 to 23 months have adequate diets. Since the initiation of Poshan project, 20% children have been reported to have adequate diet. Though this number is not as desirable, there has been a significant improvement and it demonstrates success of the strategies.

- **Improved average birth weight**

Birth weight is a key indicator in assessing birth outcomes and used as a foundation for planning the goal

for achieving required growth of a child as per the standards. Low birth weight is defined by World Health organization as weight less than 2.5 kgs. A steady improvement in the birth weights has been observed in mothers who have had regular interactions and reported an average birth weight of 2.6kgs.

Outreach & Scalability

FMCH engages and educates the families and community through various activities. The emphasis is on creating a healthy ecosystem within the community. Along with this it focuses on strengthening the existing healthcare service system instead of duplication.

The intervention can be scaled through building strong partnerships and linkages with various stakeholders. The project design is unique in nature as it is devised to integrate first 1,000 Days approach into one of India's biggest government systems. As per a report released by Niti Ayog, ICDS today covers 8.4 crore children under the age of 6 in the country, 1.91crore pregnant women and lactating mother through 7,066 projects and 13.42 lakh Anganwadi centres. Hence, it gives an opportunity to scale-up through a strong and sustainable system.

One of the components of the project is to provide similar capacity building support to frontline workers of health department and other NGOs who cater to the same population in different capacities. E.g. an organization working on pre-school education also becomes a channel in educating families on the need for good nutrition and health choices. As this directly impact physical and intellectual potential of the child.

Replicability

This project can be easily integrated to other location as the FMCH modules are designed in a such a manner that it gives scope for customising it based onthe population profile. At the same time emphasises on principle of essential nutrition actions accepted internationally. Eg. Practical sessions on preparation of nutritious complementary food by incorporating local, inexpensive ingredients in recipes making it more acceptable.

Impact Achieved

The result framework of Poshan project is defined to achieve the following impact

- Positive Social Behaviour Change in the health ecosystem
- Bridged gap between demand and service aspects in health ecosystem
- Reduced malnutrition in malnutrition
- Improved health and nutrition indicators for reproductive, maternal, child and adolescent health towards achieving Sustainable Developmental Goals.

- Built capacities of stakeholders like families, communities, government and non-government agencies.

As impact evaluation is a long-term deliverable, it will be analysed after completion of the project.

Capacity Building

- FMCH Frontline - FMCHfrontline workers are identified and recruited from the community. The aim is to provide employment opportunities, encourage ownership and building stronger relationship within the community. These frontline workers receive intensive training on regular intervals to make them health and nutrition ambassador for the community. They are also trained on using technology and making them independent in executing their responsibilities.
- Capacity building of the ICDS team is an integral component ofintervention design. The approach is to engage with them on a regularly basis and train them on various topics related to the project. It covered topics like basics of nutrition, Infant and Young Child Feeding practices, Breastfeeding, Antenatal care, Science of malnutrition and using anthropometric measurements and WHO growth charts. The AWWs shared that they gained new information on nutrition and health which would be beneficial for implementation of their programs.
- Educating stakeholders - This includes educating key change agents and influencers from the community and partner organization who are instrumental in mobilising the community. The community support group members are also trained

Partners of the Project

- ICDS - ICDS team is the primary implementing partners of Poshan project. FMCH team members will be works with the ICDS centres in order to identify eligible women and children.

  These beneficiaries are registered both at the ICDS centre as well as FMCH for accurate follow-up work.

- Government Primary Healthcare Centres and Maternity Home- FMCH has partnered with these agencies of department of health under Municipal Corporation for building strong referral system. The high-risk pregnancy cases are closely monitored bysupporting their team. Children identified with illnesses and serious nutritional deficiencies are referred to their centres for further investigation and treatment.
- Nutrition Rehabilitation Center - Children identified with severe acute malnutrition(SAM) who need urgent medical care are referred Nutrition Rehabilitation Centre run at the tertiary care government hospital in Mumbai. These are children who cannot be treated for SAM at community level due to underlying medical conditions which need urgent attention.

Awards/Endorsements

Not yet

Project Kavach- Click Initiative

April 2017 - March 2019

Institute for Global Development

Website	:	www.igdinida.org
Founder of the Organization	:	Dr. Sunil Mehra
Coverage/ Geographical reach	:	Baddi, Nalagarh Block, Himachal Pradesh

Project Brief

IGD in association with Glenmark Foundation is working towards improved nutrition, health and well-being of infants, children & women by optimal Infant & young child feeding practices and provision of basic/ primary health care services and health awareness through provision of sustainable integrated services to socio-economically marginalized community in the Solan District of Himachal Pradesh.

Primary Healthcare services including basic diagnostic and referral services are provided at the target geography through Mobile Medicare Unit & Behaviour Change Communication for the pregnant mothers, caregivers, adolescent girls on issues related to nutrition, immunization and personal health and hygiene as well as sensitizing the other stakeholders in the health system and local governance, for reducing child mortality in the block.

Implementation Model

The methodology of Behavioural Change Communication is the basic component by way of regular visits to the field, active engagement with the pregnant women and lactating mothers. There are regular home visits that are done after identifying the women going through any complication during or after the delivery or towards the immunization and proper care of the new born children. The follow ups are done by linking the beneficiary to the public health system through Anganwadis, ASHA workers and the community health care centre.

The structure is made such that a health worker of IGD is working with the Community Health Care Centre to assist them and the community to seek health facilities especially towards the heath of mother and children. Technology and mobile App namely CareMother is also being used as an intervention mechanism through which the health indicators are tracked and accordingly follow ups are done.

Other than this, the primary health care services are provided to the targeted villages with the assistance of ICDS system and through the help of our Health Workers.

Community Outreach

There is recognition of important days where celebration is conducted within community especially women and children and the government healthcare facility. There is regular follow up by way of field visits, primary healthcare services through which the women come to seek healthcare not only in terms of their physical wellbeing but also their reproductive health which and the heath of the children between 0-6 years.

With the field intervention, the tracking of pregnant women and the pregnant women with complicated pregnancy are targeted and regular counselling and information sharing is done with them. The linkage is built between the public health services and women as beneficiaries.

Further, regular home visits are done towards the care and wellbeing of pregnant women with complicated pregnancy, children between 0-6 years with medical conditions or lactating mothers with medical issues and in need of assistance. IGD works with the family members to give and comfortable space to the children and the woman for healthy living.

Uniqueness of the Project

One of the ground breaking feature of the project is its ability to provide services at the interior of the villages and to bridge the gap between public health system and the beneficiary. The service delivery system is intended to be accessible for women especially pregnant women and lactating mothers can avail services through Medical Mobile Unit along with a doctor, assistant and lab technician as well facilitating immunization process and building linkages with the public health delivery system, and making the last mile delivery at difficult to reach locations.

The approach which is adopted is to increase the shared decision making at the household level to improve MNCH practices. The intention is to increase women's voice in household decision making about MNCH and encouraging involvement of their partners in the care and attention.

Role of Information and Communication Technologies (ICTs)

The targeted region of Himachal Pradesh is constant in having migratory workers and their families. It is then when it becomes difficult for them to follow up with their pregnancy or to give full information to the present health worker. With the Caremother application, IGD has been able to reach such women, track the risk they have towards their pregnancy and assist In follow up with these pregnancy either by way of connecting them to the public health system and health functionaries and provide required counselling and support system. This online platform has been developed with a vision to provide

holistic solution to pregnancy related complications and is being used in many states across the country. If a beneficiary gets migrated to another state where our platform is being used, she could still be able to get the services and care she needs.

Challenges Faced

The team still come across cases where the child birth is happening in the house without the support and assistance of trained midwife even after constant counselling and regular meetings. To overcome this situation, we are trying to increase our accessibility in the field to ensure that more attention goes to the field and to strengthen the trust building mechanism.

With increasing number of persons seeking medical help there remains shortage of medicines and staff to attend them. Though this is a positive sign that the response from Mobile Medical Unit is immense in its approach but the shortage of medicine remains a constraint. To overcome this, we are reaching out to the organisations to provide medicinal assistance to ensure it.

Outcomes

If looking at the recent outcome, we have a strong reach in six villages of Baddi. The number of patients provided with primary health care were 4000approx in the previous quarter. The trainings and capacity building programmes are conducted for the field level health workers and separately for pregnant and lactating mother and other care caregivers. The indirect beneficiaries became the children between 0-23 months.

During the quarter 3748 pregnant and lactating mothers were benefitted from Maternal health programme, 559 pregnant women have been registered through the CareMother App out of which 294 are high risk pregnancy. Proper monitoring and case is continued to be provided to women with high risk pregnancy. Regular intervention is done by way of Village Health Committees to encourage behaviour change among the underserved persons addressing issues of pregnancy, new born and child care and facilitating access to obstetric and new born care at public and private facilities.

Outreach & Scalability

At the beginning of the program the location and objectives of the project were the Block area of Nalagarh. With continuous work and intervention based on the Rapid Assessment of Maternal and Child Health Situation and Public Health Service Utilization in Nalagar block of Solan district, Himachal Pradesh, the objectives and activities of the intervention were set out and marked for implementation process. With time, the results were showing and with the end line survey, tremendous change was seen. With this, the reach was increased to the interiors of Nalagarh Block. Baddi, which has an extensive migration from the states of Uttar Pradesh and Bihar the families especially the young couples with limited knowledge and information on maternal and child health.

Along with the public health functionaries in Baddi, the interventions are planned along the line of need and resources required to strengthen health system in Baddi. With regular visits to the field and home visits along with fulfilling the need for primary health care.

Replicability

IGD is actively working in 10 villages of Baddi and the slum locations around the office building. Further, with active relationship with other organisation working in the area, the interventions on short term basis in the form of events are conducted.

Further, the similar project can also be replicated to the other districts of Himachal Pradesh for better performance.

Impact Achieved

The project has helped in improving the health indicators of the location and able to serve the migratory population in the targeted geographical locations.

Capacity Building

The trainings for the IGD staff is conducted on a regular basis with the assistance of the technical team. Further, the trained staff under the supervision of Doctor further disseminate the information on the important issues.

Partners of the Project

Glenmark Foundation is the supporting partner in terms of funds to keep the work going in the field.

CNA Participated In National Dissemination Workshop

Rajasthan Nutrition Project

January 2015 - December 2016

Freedom from Hunger India Trust

Website	:	http://www.freedomfromhunger-india.org/
Project Budget	:	500000$
Coverage/ Geographical reach	:	3 Blocks of 2 Districts, Sirohi(1 Block) and Banswara (2 Blocks) in Rajasthan, covering 68 Panchayats with 316 villages, 670 SHGs and impacting more than 8000 women members of SHGs, through a volunteer namely, `Community Nutrition Advocates' (CNAs).

Project Brief

Rajasthan is India's largest state by area and is in the north-west of the country, bordering Pakistan. Rajasthan's economy relies primarily on agriculture, with cotton and tobacco as its key cash crops; it is one of India's poorest states, with its poverty concentrated in its western and southern districts.

In the 2011 census, Scheduled Tribes constituted approximately 13 percent of the total population in Rajasthan, making Rajasthan one of the top four states in terms of the concentration of the Scheduled Tribe population in India. Scheduled Tribe populations are often defined by their historic geographic isolation from the general population in India, which has manifested in relative as well as absolute deprivation. Scheduled Tribe households generally face the greatest poverty and hunger, lowest levels of education attainment, and the poorest health outcomes. Seventy-six percent of the population in Banswara district in Rajasthan is Scheduled Tribe, making Banswara the district with the highest concentration of Scheduled Tribes in the state.

Within the Indian state of Rajasthan, women face poor health outcomes and gender constraints, often at levels greater than the national average. Approximately 60 percent of children and 46 percent of women suffer from anaemia, 39 percent of children under the age of five are stunted. Stunting is highest among tribal children in the region compared to non-tribal children (54 percent compared to 45 percent, respectively); severe stunting was greatest among tribal girls compared to tribal boys (31 percent vs. 27 percent, respectively), clearly indicating gender discrimination in intra-household feeding patterns.

The child sex ratio is one of the lowest in India: there are 888 girls to every 1000 boys. Moreover, women's empowerment status falls below the national average in Rajasthan as measured by a Gender Empowerment Index. Rajasthan scores 0.4, compared to the national average of 0.5, on a scale of 0-1 where 1 represents greater empowerment. Only 25 percent of married women make decisions about their own healthcare; only 35 percent of women participate in the workforce.

The Rajasthan Nutrition Project led by Freedom from Hunger India Trust (FFHIT) implemented its flagship project with a multi-sectoral and integrated approach: Linking Nutrition, Health, Agriculture and Financial services, focusing nutrition and household food security.

FFHIT implemented the project, along with two implementing partners, Vaagdhara in district Banswara and Pradan in district Sirohi. The objectives of the project were:

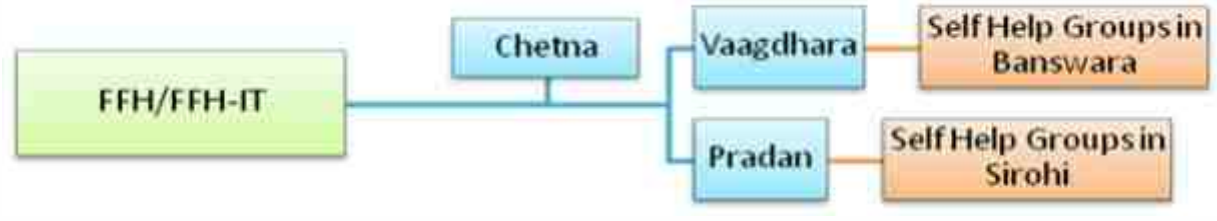
- To improve knowledge, behavior and access to local services related to nutrition for women, adolescent girls and young children.
- To facilitate dialogue that will lead to increased women's empowerment and more gender equitable resource management and food distribution within the household.
- To improve women's financial literacy, resource management ability and skills related to planning for better household nutrition

Four impact areas and targets were chosen to guide the RNP and measure its success at achieving improved food security and health-seeking behaviours among the rural Rajasthan population during its two-year implementation period:

1. Infants breastfed within first hour after birth and exclusively for six months: Target was to reach Rajasthan's breastfeeding rate for breastfeeding in the first hour
2. Use of ORS and increased fluids in treating diarrhoea: Target was to reach Rajasthan's ORS use-rate
3. Improved household food security: Target was to improve upon the baseline rate by the end line
4. Improved linkages and use of local health and nutrition services, such as the Integrated Child Development Services (ICDS) program, an Indian government welfare program which provides food, preschool education, and primary healthcare to children under 6 years of age and their mothers: Target was to improve upon the baseline rate by the end line.

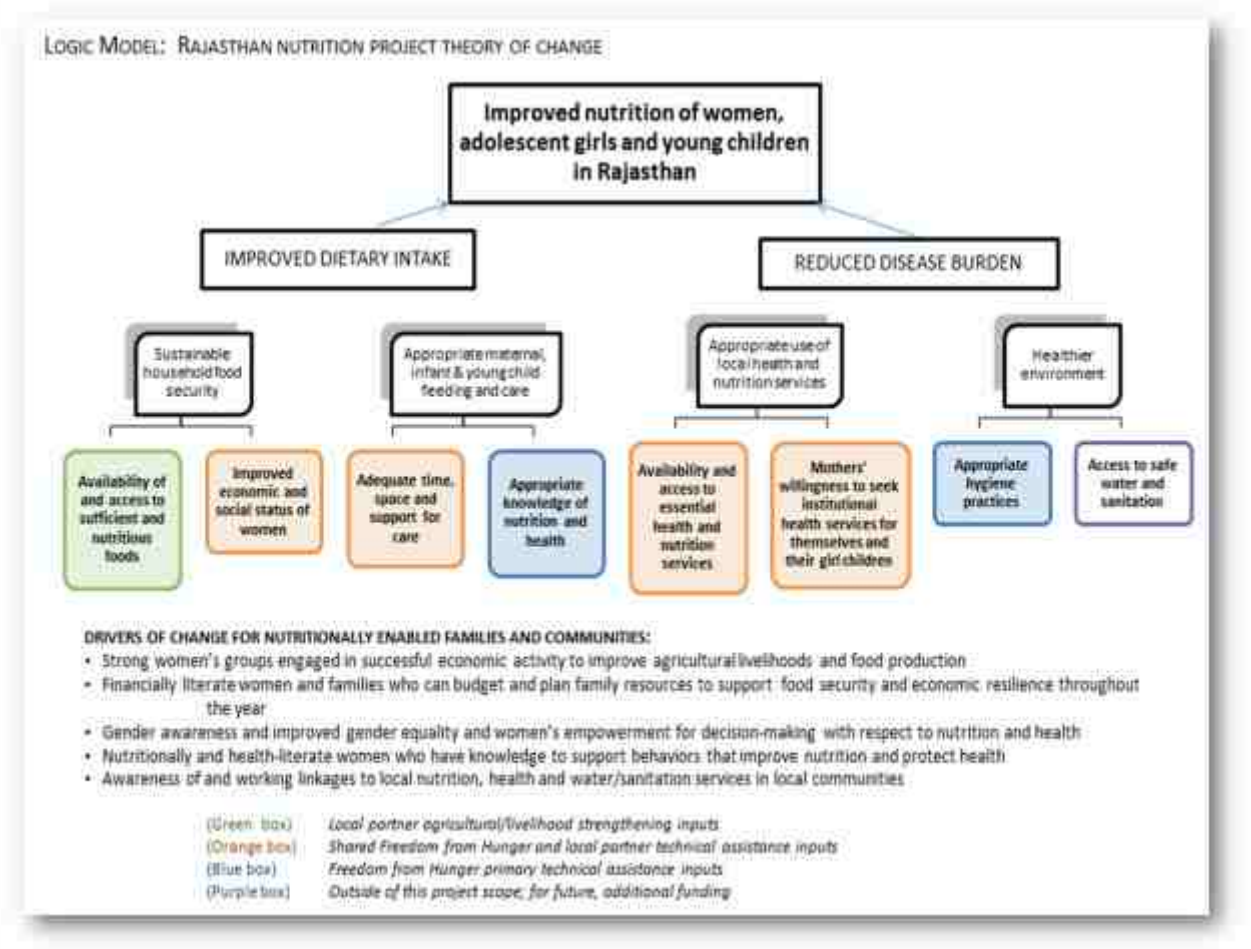
Implementation Model

Implementation Model:



Project Methodology:

- **Formative Research:** To understand food consumption, crop patterns, services availability and such.
- **Baseline:** To understand current status for comparison with end line.
- **Mapping facilities:** for building linkages
- **Designed PLC material:** based on learning from the above (simple doable messages were developed)
- **Building capacity:** of partner organizations and CNAs on Nutrition
- **Regular Monitoring:** With handholding support to partners and CNAs
- **End line:** for comparison



Community Outreach

To reach out to communities we focussed on SHG as a platform to have discussions and dissemination of information. The carriers of messages were the selected community nutrition volunteers selected through a community process by the implementing partners. So, it followed the basic three steps:

- Capacity building of implementing partners i.e PradanandVaagdhara.
- Capacity building of CNAs through implementing Partners
- Capacity building of SHGs and other community institutes for by CNAs.

Supporting processes:

- Monitoring and review of trainings at community level.
- Addressing public services gaps through community analysis

Uniqueness of the Project

As women being largely the care takers of food cooked and consumed at home, **multi-dimensional approach through women's SHG platform was considered to be of value**, through building capacity of a volunteer cadre from the SHG group itself, namely CNAs, These CNAs, facilitated conversations and hand-holding with the local self-help groups members on nutrition, and on related areas of maternal and child health, hygiene, and gender-equitable resource management. The key strategies features under the RNP were:

- **Multi-sectoral:** Linking Agriculture, Nutrition, Health & Financial Services on a **Women's SHG Platform.** (focusing Household Food Security)
- Building on **Partner's existing programming** and capacities
- Leveraging **SHG groups as a platform** for multiplier effect for reaching out to women on nutrition and health messages.
- **CNAs** as Volunteers were selected from SHG groups whose capacities were built to spread newly learnt messages, within SHG members. It helped to retain the Messages at SHG level in local access.
- **Gender being cross cutting** in all key messages and interventions for addressing gender equity on intra-household food distribution. It was the key thought that gender is not in isolation, the issues are percolated in every sector. So, keeping gender equality messages in every module in example the key strategy to address the issue.
- Building **Linkages with Government** facilities for improved coverage and sustainability.
- Community Score Card introduced to asses' public services and to bring necessary changes for the betterment of services.

Role of Information and Communication Technologies (ICTs)

Not in both the districts but in Sirohi, Pradan used mobile based community data collection system around retention of messages in SHGs.

Challenges Faced

Some challenges faced in the Project, such as an inadequate involvement of men, understanding and 'compensating' volunteers, and limited time, the RNP presents a model easily replicable, scalable, and sustainable since (i) it is about an issue which has direct relevance to people's lives (ii) presents them with doable and effective ways to address their situation (iii) builds on available community platforms and is hence (iv) cost effective.

The initial strategy of the project was to involve men to bring house hold level changes but after doing formative research and seeing gender gaps, it seems impossible to bring men on this platform to engage with. So, we developed another strategy to reach men. We promoted CNA's to have dialogues at common spaces like Panchayats, Schools and even trainings in such places attracted to men to sit for

a while an listen messages. The community institutes organised mass campaigns at village and Panchayat level and through songs and act they gave messages about required behavioural changes.

We understood that to expand and bring results we need a good pool of CNA's but seeing the literacy levels in women we accepted it as challenge and designed our training modules in TLC and PlC approaches so that it can be well understood by all. We simplified the key messages to retain by CNA's.

Both the partners were different approach wise. One wanted to train SHG's Directly and other wanted direct training at VO's (Village organisations). We accepted both the strategies and developed separate training kits for both partners as no. of participants at both platforms i.e (SHG and VO) were different.

Time was a challenging factor. The project time was only 2 years and said objectives and results requires time to bring action. But through accommodating innovations, different strategies by different partners and through strong community based monitoring all results became possible to bring.

Outcomes

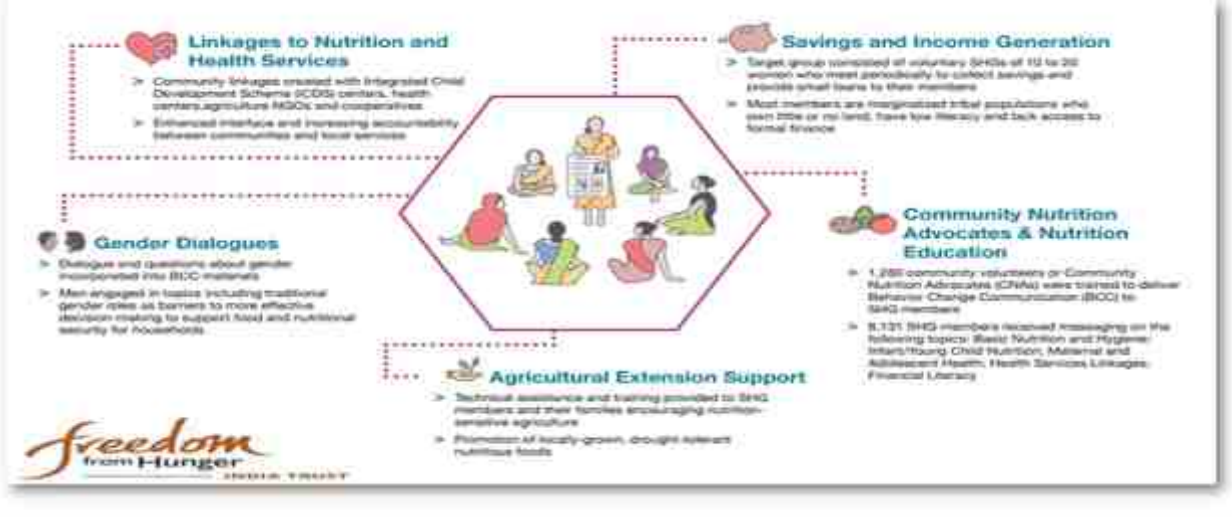
- Food security improved from 23% to 53%.
- Skip entire day without eating from 22% to 12%

- 53% of families taking meals together at least once a day
- Increase in green leafy vegetables from 13% to 58%.
- Increase in intake of other vegetables from 33% to 84.6%
- ORS used to treat diarrhoea 34% to 84%.
- Delayed medical treatment for children in past year due to cost from 55% to 15.9%
- Delayed medical treatment for herself (respondent) in past year due to cost from 62% to 28.4%
- Source of nutrition information from CNAs: 95%

Positive changes brought about by the Rajasthan Nutrition Project (RNP) The RNP has ensured that nutrition is on the agenda of the implementing partners and of the women involved. The women have made definite efforts towards

- diversifying what they sow in their fields,
- to use the 'adjacent unused lands' to grow green vegetables & medicinal plants for their own consumption,
- to send their children to ICDS centers to 'sit and eat' and not to 'go and bring',
- to fight out their rights at the PDS even if it means to go to the district level to resolve the matter,
- to ensure that a new mother is breastfeeding the child within the first hour of the childbirth,
- to cook a separate meal for their small children, and not give them a piece of a chapatti and let them be on their own,
- to go buy an iron cooking pot in groups of women from the same vendor at a cheaper price to count a few of them.

Outreach & Scalability



Even the best outcomes of a project, if not replicable have a limited value. Also, no best practices can be up scaled as a Xerox-copy, the larger things have to be possible with relevant contextual needs of the area. As a project, RNP has as an evidence based demonstrated that it has a great potential to be replicated for the following reasons:

1. **The SHG Credibility Advantage:** SHGs already exists as a platform in thousands in villages across the states in India, under both Government and non-Governmental programs, which can be easily leveraged for a multiplier effect to spread key nutrition, health and related messages of contextual importance to them.
2. **Environment building for community level changes:** Sending messages across to large numbers creates an environment for change, as the other members in the community is also adopting the same, therefore it adopts an inclusive approach rather than a secluding approach and expedites behavioural change.
3. **Community lead change (CNAs):** As the CNAs are part of the community, once they gain trust, the behavioural changes among communities become possible and the change is alleged to be more sustainable, as it is led by the community members itself.
4. **Monitoring by SHGs:** As SHG members become aware and involved there is demand generation, creating also community monitoring mechanisms.

Replicability

RNP has demonstrated that it is possible to move the poor families towards nutrition security using SHG platform for education and linkage, using CNAs to sustain the processes. There are SHG federations in Rajasthan which can be further strengthened with technical and handholding support to focus on the multi-sectoral approach engaging Panchayat, Local NGOs and frontline providers of ICDS, Health and Agriculture. Several small pilots relevant to the needs of ICDS programming can be undertaken, to provide enough evidence based impact to ultimately replicate and scale up across the state

Freedom from Hunger India Trust has both the **expertise and the experience** in providing necessary technical support to the system, based on the learning and challenges from RNP. Based on experiences of RNP, a **Policy brief** and a **Technical guide** was developed to introduce this multi-sectoral approach with other stake holders for wider replication. **Freedom from Hunger India Trust** through Community of Practice on Health & Microfinance (mostly SHGs), along with other national and international organisations, is committed to expanding the understanding of the SHG movement, and demonstrate its impact beyond financial inclusion and sustenance for poor communities and individuals.

Impact Achieved

Capacity Building: Strategy for bringing behavioural Change

Knowledge building is the first step towards bringing behavioural changes and this can happen only when a person understands and is conscious regarding the need for change. For this building

knowledge of the partners and CNAs was focused upon, by developing relevant educational material related to their needs, based on the formative research findings. As CNAs were illiterate, hence pictorial learning communication was developed with **simple doable messages that can bring behavioural changes.** Handholding support was provided throughout the project period, to ensure things moved in desired direction and make mid-course corrections. Technical expertise was provided by **Freedom from Hunger India Trust** in designing relevant training material and messages, for capacity building of the implementing partners in the areas of the following:

- Formative research to identify real time specific gaps on nutrition security
- Design of context specific user-friendly picture based education materials on mother on a series of related aspects on Nutrition, Health, Nutri-sensitive agriculture and financial services.
- Systematic monitoring and supervision using simple tools and key indicators to measure progress and challenges.

The Rajasthan Nutrition Project: Empowering Poor, Marginalized Women in Rajasthan for Improved, Gender-Equitable Household Nutrition" had a huge impact on women and their household to pick up basic practices for better nutrition and health. FFHIT with the help of its partners created a pool of community cadres called as CNAs (Community Nutrition Advocates) in the blocks, identified from SHGs by the Village organisations to facilitate the information and to engage with community institution as agents of change. These CNAs created an enabling environment in villages and facilitated behaviour change through their intense engagement with the fellow women members of the SHGs and the other villagers. This led to improved changes in health practices and nutrition status. CNAs are successful in establishing basic behaviour changes and practices in majority of households. Few practices are listed below:

- Women having **4 different colours of food** in their plate.
- Women growing at least **one nutritious herb** in their farm/courtyard.
- Men and women eating at least **one meal sitting together**.
- SHG leaders in **dialogue with the service providers. Every member linked with PDS** getting food as per entitlement

RNP Key Messages

The following 12 messages are those that were reflected in the sessions provided by the CNAs but were also used with the SHGs to create songs and other mechanisms to remember the messages:

1. Initiate breastfeeding within 1 hour of birth.
2. Exclusively breastfeed an infant for 6 months. Infants do not need any water.
3. The benefit of giving birth in the government health centers is to prevent complications and avail of JSY and JSSK8 benefits

4. Eating seasonal fruits and vegetables is beneficial for better health and nutrition of every family.
5. Every family should start a "poshanwadi" (kitchen garden) in their backyard to ensure food security and better nutrition of the family.
6. Use ORS to treat diarrhea at the household level.
7. Wash hands with soap and water before eating and after defecation to prevent diarrhea and other illnesses.
8. Every pregnant woman, lactating woman and adolescent girls must consume IFA tablet to prevent anaemia.
9. Every family is encouraged to cook their meals in an iron pot to ensure intake of iron for prevention of anaemia.
10. Adopt the practice of eating together for better nutrition of women and girls and promote family bonding.

11. Visit Anganwadi, Mamata Diwas9 (MCHND) Sub-centre and PDS to develop strong rapport with service providers such as ASHA, ANM, AWW.
12. Adopt the habit of health savings among SHG members to address emergency health care expenses.

These simple messages and intervention were retained by CNA's, which were chosen from community itself. These CNA's are SHG members and monitored the progress in Village level organisations and random house hold visits. This enabling monitoring helped the program to retain its foundation and accepted by all. The messages involved were actionable and very clear to understand. It helped community to adhere them to make simple changes in their practices and house hold chorus.

These are key factors that helped to take interventions to homes, which generally left my members at the discussion spaces.

Capacity Building

A Social and behavior change centered (SBCC) approach enables change in behaviors, including service utilization, by positively influencing knowledge, attitude and social norms. SBCC is a strategic, systematic and targeted approach that uses science and data to reach multiple level sof society- individual, community and institutional. It is systematic, evidence-based, participatory, and strengthens the stakeholders' capacities.

The SBCC approach focuses on:

- Changing or positively influencing social norms, in support of long-term, sustainable behavior change at the population level
- Fostering long-term, normative shifts in behavior, in support of increasing the practice of healthy behaviors,
- Improving the services of provider-client interactions,
- Strengthening community responses to issues,
- Influencing decision-makers, and family and peer networks,
- Increasing the demand for services and products,
- Increasing the correct use of services and products,
- Influencing policy, and
- Encouraging an increased capacity for local planning and implementation of health improvement efforts.

SBCC Approaches	Access to Food & better nutrition	Linkages to other sectors/services	Financial services
Interpersonal/ individual/ household approach	• Encourage homestead /backyard cultivation of vegetables & fruits • Communicate on how to increase the shelf life of food by processing and increasing bio-availability through germination and fermentation	• Provide information and women to access the health and nutrition services that are available, especially for maternal health and children	• Promote gender sensitivity encourage among men to ensure that women manage the household finances, especially food procurement
Community approaches	• Develop a model farm or nutrition gardens to showcase dietary diversity at low costs using locally grown crops/vegetables • Identify community advocates to promote good feeding and nutritional care practices	• Encourage the community to monitor government services to get their entitlements. • Monitor school meal program, if any, to ensure that children access nutritive food	• Encourage the community to form SHGs or microfinance groups for increasing access to finance • Encourage the creation of common/ social fund that could be used for meeting out of pocket expenditure to access health services

Partners of the Project

PROFESSIONAL ASSISTANCE FOR DEVELOPMENT ACTION (PRADAN)

PRADAN was established in 1983 and is a widely-recognized national-level organization that specializes in promoting livelihood opportunities among SHGs of women. PRADAN follows a four-pronged approach to achieve its goals: 1) Promoting and nurturing SHGs of poor women and strengthening them as organizations to leverage institutional finances for members' livelihoods; 2) Developing and introducing locally suitable economic activities to increase productivity and income among SHG members and building synergic collaboration with a wide variety of stakeholders; 3) Mobilizing finances for livelihood assets and infrastructure from government bodies, donors, banks and other financial institutions; and 4) Setting up mechanisms to sustain the livelihood gains made by the poor communities. In Sirohi, Rajasthan, PRADAN currently is reaching over 450 women's SHGs and implementing a variety of agriculture, livestock improvement, and nutrition and health projects.

Role: Implementing Agency for the project. Pradan implemented the project in 1 block of Sirohi distrct with the community based platforms like SHG's and VO, through their human resource whose capacities were built by FFHIT in Nutrition & Health topics.

VOLUNTARY ASSOCIATION OF AGRICULTURAL GENERAL DEVELOPMENT HEALTH (VAAGDHARA)

VAAGDHARA was formed in the 1980s to augment livelihood sources and options through improving traditional agricultural practices among the tribal population and other marginalized groups in Rajasthan. VAAGDHARA has broad expertise in developing and implementing programs that link interventions across multiple sectors to address poverty, women's empowerment, child protection, agricultural development and livelihood development and poverty alleviation. VAAGDHARA is currently reaching thousands of families in Banswara with livelihood, agriculture and food security initiatives and will use this as the foundation for increased focus on health, nutrition and gender.

Role: Implementing Agency for the project. Vaagdhara implemented the project in Banswara district with 2 blocks with their community based platform like SHGs through their human resource whose capacities were built by FFHIT in Nutrition & Health topics.

FREEDOM FROM HUNGER INDIA TRUST

Established in 2012, Freedom from Hunger India Trust (FFHIT) is an independent Indian nonprofit organization based in New Delhi with offices in West Bengal and Madhya Pradesh. The technical staff of FFHIT oversee health, nutrition, financial inclusion, vulnerable youth and savings group methodologies, and provide expert advice on leamer-centered curriculum design. FFHIT's goal is to achieve nutrition and food security, reduce poverty and improve economic and social status of poor and marginalized women and their families through increased integration of financial services with other essential services such as health, nutrition and livelihood opportunities. FFHIT is also an active member of National Coalition of Food and Nutrition Security.

Role: Overall project design, developing training content and design, building capacities of partners, defining process, designing monitoring indicators and project review and plan.

CENTRE FOR HEALTH, EDUCATION, TRAINING AND NUTRITION AWARENESS (CHETNA)

CHETNA, which means “awareness” in several Indian languages, addresses issues of women's health and development in different stages of their lives from a rights-based perspective. CHETNA supports government and non-governmental organizations through building the management capacities of educationists, health practitioners, supervisors, and managers enabling them to implement their programs related to children, young people and women from a holistic and gender perspective and advocates for people-cantered policies. CHETNA also does advocacy, development and dissemination of materials. CHETNA is based in Ahmedabad, Gujarat and primarily works in Gujarat and Rajasthan States.

Role: Partnered as resource agency and helped the project in training CNA's, Developing training modules and project design.

Awards/Endorsements

The project has not received any award but recognized by global and national media like BBC, The Hindu. Times of India etc and success stories are published by them.

Rajiv Gandhi Nagarf

Reduce Malnutrition and Childhood Illness

October 2015 - September 2020

World Vision India

Website	:	http://www.freedomfromhunger-india.org/
Founder of the Organization	:	World Vision was founded in 1950 by Mr. Robert Pierce. World Vision started operations in India and subsequently set up its office in Kolkata in 1958. Currently World Vision India works in 185 districts impacting 26 lakh children and their families in over 6200 communities spread across 25 states and the National Capital Region of India.
Project Budget	:	Being a five-year project we have observed a spending of more than ₹ 10.16 crore.
Coverage/ Geographical reach	:	Spread across 60 locations among 17 states. With a direct reach of about 27, 77,314 people (consisting 567,709 Boys, 618, 400 Girls, 784,018 Men and 807,187 Women).

Project Brief

India has been emerging as one of the countries among the G20 group of countries with Economic growth of around 7.5 per cent[1] ;however, we also notice that its huge population does not participate in this economic growth owing to their poor health and nutrition indices.

The state of maternal health reflects the current state of the country while that of child and adolescent health reflects the future state of the country. About 0.75 million neonates die every year in India, the highest for any country in the world. The neonatal mortality rate (NMR) declined from 52 per 1000 live births in 1990 to 28 per 1000 live births in 2013, but the rate of decline has been slow and lags behind that of infant and under-five child mortality rates[2] .

Under the Indian Constitution, Public health being a state subject as per the Indian constitution, each state has its own healthcare delivery system in which both public and private players operate and most often, there is sub optimal availability and utilisation of services across most of the states.

Given this background, World Vision India focusses on a multi-sectoral approach to tackle child mortality and morbidity by reducing undernutrition and childhood illness. This technical programme is implemented with four objectives. The first objective focusses on improving the maternal child health and nutrition (MCHN) practices by providing better access to ante and post-natal care services, improved feeding practices including promotion of exclusive breastfeeding and complementary feeding. The second objective emphasises on increasing the coverage, access and utilisation for sustainable water sanitation and hygiene (WASH) practices by providing better access to clean drinking water, sanitation facilities and creation of open defecation free communities. Since food insecurity is one of the contributing factors for malnutrition, this is the third objective that aims at increasing nutrition resiliency at the household level through targeted food security programmes. The fourth objective of this programme is the strengthening of systems and structures especially the functional elements of Anganwadicenters, Primary Health Care centers, Nutrition Rehabilitation centers and the local governance systems by strengthening the Village Health Sanitation and Hygiene committees.

Kala vidhya Mandirf

Implementation Model

World Vision India drafted the theory of change through a consultation workshop with internal and external

[1] *OECD Economic surveys India (2017) Overview. Available at https://www.oecd.org/eco/surveys/INDIA-2017-OECD-economic-survey-overview.pdf, retrieved on 13th March, 2018.*
[2] *M J Sankar, S B Neogi, J Sharma, M Chauhan, R Srivastava, P K Prabhakar, A Khera, R Kumar, S Zodpey, V K Paul 2016, State of new born health in India, J Perinatol. 2016 Dec; 36(Suppl 3): S3-S8. Published online 2016 Dec 7. doi: 10.1038/jp.2016.183*

Maruti Chawl3

stakeholders and experts. This enabled us to develop the pathway of change through improved food security, improved maternal neonatal child health and nutrition practices, water sanitation and hygiene practices and systems strengthening that will contribute to the reduction of undernutrition and childhood illness.

Based on this theory of change, a logical framework was drafted at the country level suitable for customisation as per the demands and needs of the community. A baseline assessment was conducted across these 60 locations during March 2016 which enabled in the customisation and adaptation of the logical framework in each of the operational sites.

To achieve programme outcomes, World Vision India, chose project models few of which are, timed and targeted counselling (ttC), Positive Deviance Hearth (PD Hearth), Community Led Total Sanitation (CLTS) and Citizens Voice and Action (CVA). In addition, we implement activities that emphasises and reiterates promotion of Infant Young Child Feeding (IYCF) practices, provision of clean and safe drinking water, promotion of food diversity through food security programmes and system strengthening through community mobilisation process.

Community Outreach

Maternal Child Health and Nutrition:

World Vision India has been implementing the Timed and Targeted Counselling model (ttc) over the past one year in forty-two locations across the country. The ttCmodel uses a Community health worker (CHW) approach, extending primary health care counseling at the household level to reach pregnant women and mothers with children aged less than two years (first 1,000 days) with messages pertaining to health, nutrition and water, sanitation and hygiene, at the right time, (just before they need to practice them) through ten scheduled household visits. Not only is ttC targeted in time (when each message is delivered), but it is also targeted in location. All messages are delivered by visiting a woman's home so that key decision makers in the family, such as male partners, mothers-in-law and grandmothers, also receive the information. The information itself is targeted and individualised, with messages focusing on the circumstances of each specific family. The counselling aspect of ttC uses positive and problem stories and probing questions to identify barriers to recommended health practices. A household handbook helps the CHW follow-up with the family and track their behaviour change in subsequent visits. The ttC model also helps obtain data on key nutrition and health outcomes on a quarterly basis.

om sai chawlf

In addition, the community health workers are also engaged in quarterly growth monitoring of children, both in terms of weight and acute malnutrition. Those children with severe acute malnutrition are referred to Nutrition Rehabilitation Centers (NRC) and a monthly food basket (a combination of cereals, pulses, oils and a health mix) is given to these families for a period of six months and followed up with health, nutrition, hygiene messages and counseling.

Ratna bhoomi school

These community health workers are trainedin partnership with the respective State Food and Nutrition board and provide them with the recipes, which have a combination of low cost nutritious foods. Apart from these, the Community Health Workers identify the mothers with positive deviant behaviours in terms of appropriate health care and feeding practices and organise twelve-day sessions to replicate those positive behaviours across the community. Creating access to food materials would address one off causal pathways of undernutrition and this technical programme has been providing food security programmes based on the context. We also promote nutrition garden, poultry (in meat and egg consuming communities) and other food-based programmes that would enhance food availability at the household level.

In order to achieve scale up the intervention in the operational area and sustain our efforts, World Vision India has been incentivising these community health workers based on the services provided. The incentives range within ₹ 2000 to 3200 on a monthly basis, who are monitored by the project staff to ensure the quality and the rigour of the program implementation.

Care group model is yet another global model implemented in its full essence for the first time in India in line with global program design. It is being rolled out in nine locations across the country to bring in the desired behaviour change among the women during the first 1000 days of importance and strives to achieve cent percent coverage of pregnant women and mothers of children under two years.

Care group creates a multiplying effect, by reaching every beneficiary household through neighbour-to-neighbour peer support using behaviour change activities. Care group volunteers provide peer support to one another, develop stronger commitments to implement health activities. During the course of implementation, the care group volunteers find more solutions to challenges as a group compared to individual volunteers expected to work independently. The unique structure of care group helps in efficiently and effectively cascading health promotion messages from the promoter, to the care group volunteer, and finally to the neighbour women through peer education.

[1] *ASHA:Accredited Social Health Activist is one of the key components of the National Rural Health mission is to provide every village in the country with a trained female community health activist ASHA. Selected from the village itself and accountable to it, the ASHA works as an interface between the community and the public health system.*

Care group session on quality and quantity of feeding

Addressing chronic undernutrition among communities:

Since water, sanitation and hygiene has been identified as a pathway to change the nutritional status of children, World Vision India is implementing Community Led Total Sanitation (CLTS) across the country to promote the use of latrines for defecation, hygiene and handwashing to address chronic undernutrition (stunting) among the communities we serve. Supporting the national campaign on 'Clean India Movement' and through leveraging of resources, 16009 households have been helped to tap the Government resources to construct the toilets covering 2,485 villages/ slums. As a result,592 communities is declared as Open Defecation Free (ODF).

Uniqueness of the Project

We would claim ttC and care group model as innovative models due to the uniqueness of these programs in line with social behaviour change communication, barrier analysis at the household level, provision of continuous and long-term follow up to ensure behaviour change, purposive inclusion of influencers (mothers in law, grandmothers) and decision makers (men) in the programme.

Over the past one year, ttC is implemented in 42 locations across the country, reaching over 9,500 pregnant women and 9,240 infants. We do observe that some of the indicators related to maternal and child health has been increasing due to the implementation of ttC. Especially at Khariar Area Development Programme, Odisha, our initiatives have been contributing to a major shift in the number of institutional deliveries from 553 to 781 and home deliveries have reduced from 347 to 255 during the year 2017. This reduction could be due to the household visits made by the community health workers and good rapport created by them with the ASHA (Accredited Social Health Activist)[1] in this community. Similarly use of Intra-Uterine Devices for birth spacing has increased from 603 to 795 and there has been a considerable increase in the use of condom, use for birth spacing among men as shared by the hospital authorities.

Care group is another innovative model being implemented in nine locations across the country. A compilation of monitoring data from the care group program implemented at Bardhaman Area Development Project, West Bengal is presented. In this site seven community health workers were chosen to work as Supervisor (1 person) and Promoters (6 persons) as a part of the staffing structure required for this project model. Through this model the ADP has 91 care group leaders and 1165 mothers. Every promoter has about 15 to 16 care group leaders. Under every care group leader, there are 12 to 15 neighbourhood mothers. At the start of the programme implementation, there were some concerns related to care during pregnancy, negligence for immunisation of infants, maintaining cleanliness and proper feeding for children, which led to malnutrition among children. After the initiation of the care group, the mothers started interacting in their small groups and shared their experience from pregnancy to feeding their children. The care group volunteers bring about behaviour change through skit, songs and games. Due to this approach the community is able to see visible changes in terms of

immunisation, antenatal care, exclusive breast feeding, complementary feeding and consumption of IFA tablets.

Another model that we believe has worked well is the Community based Management of Acute Malnutrition (CMAM) implemented at Chas and Chandenkiyari blocks of Bokaro District, Jharkhand, for children with Severe Acute Malnutrition (SAM). The current programme at Bokaro District commenced from January 2017, has screened 20,525 children within six months to five years.

World Vision India, worked along with the ICDS system and re-designated 51 Anganwadi Centers as Out-Patient Therapeutic centers and built on the Anganwadi workers potential to implement CMAM. This programme involved early detection of children with severe acute malnutrition (SAM) and referral of SAM children with medical complications to the NRCs. As on September 2017, about 61 per cent of the SAM were cured with 11.5 cm MUAC (Mid Upper Arm Circumference) with no cases of child deaths being reported during this period.

Role of Information and Communication Technologies (ICTs)

The programme did use mobile technology for an exhaustive baseline assessment across the country, we expect the same technology and tool to be followed during the midterm assessment and end term assessment.

Challenges Faced

System strengthening and working along with the Government system is key to deliver lasting solutions. In some cases, this has not been possible as the priority and the willingness of the officials limited the scope for partnerships and in some instances, we face challenges from new officials who are unaware of the work already done, and this affects achieving our deliverables. At times, building the skill set of the frontline workers, improving the infrastructure facilities and joint implementation of programmes becomes a challenge. In those cases, additional efforts have been taken to meet with the heads of the departments to convince them and clear the barriers that obstruct in joint implementation of the program.

In some of the drought prone communities, dry and arid regions many of the residents migrate. In cases where the men of the family migrate there are chances for the entire family to migrate with their children or leave back their children with elderly parents which disrupts the food security, feeding and caring practices that have been built on among those families.

During such instances, the wellbeing of the children in the families become critical. Despite having focussed behaviour change programmes we are unable to reach the families, which have migrated during the drought seasons. This has been a trend in

Sainath School

MP Addressing and encouraging Dharavi Community

some of the operational sites in Maharashtra, Odisha and Rajasthan. The registration and follow up of pregnant and lactating women becomes difficult as they migrate to other villages to earn and therefore lose out on follow up. When these families eventually return back to their communities the children and women are often undernourished. Counselling sessions are resumed and the follow up is brought back on track.

Outcomes

Based on the theory of change and the interventions rolled out we envisage improved maternal child health and nutrition (MCHN) practices, increased coverage, access, utilisation for sustainable WASH practices, increased nutritionally resilient households, strengthened systems and structures towards reduction of childhood malnutrition and morbidity that would result in reduction of mortality and morbidity among children under 5 years. Based on the timelines for implementation of this program, we would be having our end term assessment during September, 2020 which help is assessing the impact of this country wide program.

Outreach & Scalability

Partnership with the different government departments such as the Ministry of health and family welfare, Department of women and child development is critical and this engagement has been scaled up to the state level in the states namely Madhya Pradesh, Andhra Pradesh, Chattisgarh, Jharkhand and Uttar Pradesh. We work with the respective state, district and block Government Departments to implement and scale up their programmes, like the Swatch Bharat Abhiyan, Weekly Iron and Folic Acid supplementation (WIFS) programme,ICDS, Mission Indradhanush, at the state level.

World Vision India has memorandum of understanding (MoU) in 14 Blocks and 19 districts with the Department of Women and Child Welfare. Similarly, with the Ministry of Health, World Vision India has nineMoUs at the Block and sixMoUs at the district level. These MoUs has built in the elements of partnership, system strengthening and scale up wherever possible.

Community ownership in all our programmes are critical and we enhance their participation through strengthening of Village Health Sanitation and Nutrition Committee. In addition, we build on the local resources by hiring the community health workers from the same community and equip them through the technical training programmes. Even after the withdrawal of our programme, they continue to stay as an asset to these communities.

Replicability

ttCmodel is one of the programme models which has a greater chance of replication across the country

through the ASHA as there are areas of overlap in terms of ante natal care, post-natal care. Since ttC has robust monitoring it can be considered appropriate for the ASHA mentors and supervisors to follow up on the most vulnerable and excluded population who are often missed out in the mainstream.

Similarly, we also recommend care group as one of the scalable model and in fact, we are scaling it up in four blocks of our operational area in Odisha. Being a low investment programme with opportunities for scale and coverage it can be scaled up by the Government, like minded organisations, similar to women self-help groups with a primary intent of ensuring care during the first 1000-day period.

As detailed above, our CMAM intervention has been creating an evidence base for implementation in blocks with high burden of severe acute malnutrition. With the scale of Anganwadi centers across the country, the operational model experimented by World Vision India proves that it is feasible to implement CMAM with limited resources in co-ordination with the Department of Women and Child welfare and Ministry of health and family welfare with the guidance of the District Officials.

Impact Achieved

With the baseline assessment conducted during the month of March 2016, the programme did the Lot Quality Assurance Survey (LQAS) during September 2017. Over these 17 months, we found that institutional deliveries increased from 81.3 per cent to 87.3 per cent, antenatal visits increased from 56.7 per cent to 83.4 per cent and exclusive breast feeding increased from 58.4 per cent to 63.9 per cent. The progress in indicators related to institutional delivery, antenatal visits and exclusive breast feeding can be due to the intense efforts taken in the roll out of ttC and care group in addition to the capacity building investments for the frontline workers working with the health system.

We also observed that the use of latrines for defecation increased from 23.3 per cent to 39.5 per cent and access to safe drinking water has increased from 61.6 per cent to 64.5 per cent during these time points. Under the banner of the national campaign on Swatch Bharat Abhiyan programme our programmes has contributed to the improvement of these indicators.

Capacity Building

Intense capacity building efforts have been done in this technical programme, some of them are development of the technical material for roll out of ttC, care group, CMAM, strengthening of village health sanitation and nutrition committee. Simultaneously efforts are taken to build the knowledge of the programstaff across the country on each of these interventions. Series of training programs that emphasised on program models, monitoring and supervision which are critical for program quality are rolled out. Cascading training approachwas adopted, by training the technical team consisting of 18 staff later engaged in training the program staff there by training more than 380 programme staff.

In addition, we have a 'Facilitators manual for maternal new born and child health' as a training curriculum for building the skill sets of the Anganwadi Workers, ASHA and ANMs. Based on the memorandum of understanding with the Ministry of health and family welfare and Department of women and child welfare, the programstaff co-ordinate and jointly train the community health workers with the technical team. In addition, the technical team also constantly monitors the knowledge level of CHWs and provides on-going refresher trainings.

Partners of the Project

As a part of the technical implementation, we have been collaborating with various stakeholders through Memoranda of Understanding (MoU), coordination committees, networks and coalitions, with the shared goal of addressing child malnutrition and its contributing factors. This list includes stakeholders both government andnon-governmental organisations at various levels.

At the country level, we represent the Coalition for Sustainable Nutrition Security in India, (CSNSI)-Ministries and we are part of the two working groups namely Essential Nutrition Interventions and WASH. In addition, we are active members of the India Sanitation Coalition and White Ribbon Alliance, which is a national level coalition.

At the state level, we have MoUs with Andhra Pradesh Department of ICDS, State Nutrition Mission of Jharkhand. We also have partnerships with the district and block departments, especially the Department of women and child welfare, Ministry of health and family welfare, state food and nutrition board which enables us to co-ordinate and strengthen the existing government interventions.

In addition, we have established partnerships in all the operational districts with like-minded organisations at the block and district level to scale up our interventions.

Awards/Endorsements

At the project level, World Vision India has been receiving appreciation letters from the Department of health and welfare, women, and Child Development for promotion of health, reduction of malnutrition, support in the formation of open defecation free communities.

"A miracle child"

Living a happy and peaceful life is a dream for every person. In the Sundarbans region, a place where people live in great need, that dream is remote.

MP Varsha Gaikwad appreciating Sunita - MCI Mumbai Dharavi Team member

In the southernmost part of the Basanti Block, lies a small village. This is one of the government's unreserved area. There is no health facility and health workers cannot reach the interior parts of the village. Here lives Sarala Sarkar along with her daughters. Her husband left them, when he came to know that the second child was also a girl. Sarala did not have proper food to eat, neither did she have any ante natal check-ups. Hence, she was so weak that was unable to breastfeed her child. She struggled hard to raise her children. The family survived on labour work. She borrowed money from the community during emergencies.

The Community Development Facilitator from World Vision India visited Sarala's family and found that her baby, Sandhya, looked swollen and weak. He referred the child immediately to the Nutrition Rehabilitation Centre (NRC). She was malnourished and had serious health complications. Her body was swollen and she had stopped defecating. With the help from World Vision India, she was immediately taken to a hospital in Kolkata as the NRC was not equipped to treat her.

When they arrived at the hospital, the doctors refused to admit the child as her condition was critical. They referred her to the Calcutta National Medical College. Sandhya was admitted there at midnight. She was discharged from the hospital after several days of treatment. The hospital staff and doctors were amazed and happy to have saved Sandhya. Dr.PK Das, who treated the child said, "She is a miracle child because when she was brought to the hospital, there seemed to be no hope."

Baby Sandhya Sarkar with her mother

World Vision India further built a toilet for Sarala's family and also provided livelihood assistance to ensure food and livelihood security.

Today Sarala lives happily with both her daughters. "If it wasn't for World Vision, my child would not be in my arms now. The INR 10 in my hands was never sufficient to save her life," she says thankfully.

Baby Sandhya Sarkar with her mother

School Children Learning Hand washing

Stop Diarrhoea Initiative (SDI)

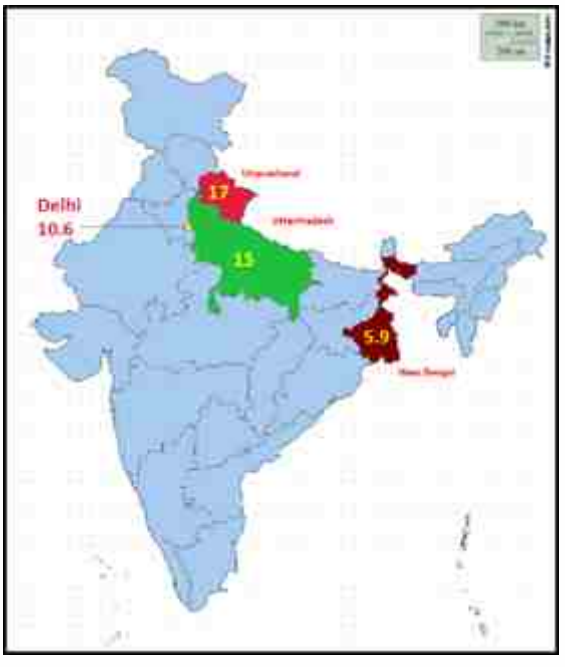
April 2015 - March 2019

Save the Children India

Website	:	www.stopdiarrhoea.in, www.savethechildren.in
Founder of the Organization	:	Eglantyne Jebb Save the Children India on 1st April 2008, started functioning as an independent Indian member of the Save the Children International Alliance under the name Bal Raksha Bharat. About a hundred years ago (1919), as the World War 1 drew to a close, a woman named Eglantyne Jebb launched a movement which became the leading voice of the most marginalised and disadvantaged children across the world - Save the Children Fund.
Project Budget	:	₹ 47 Crores for 4 years

Coverage - Geographical Reach

States	Delhi, Uttar Pradesh Uttarakhand, West Bengal
Number of Districts	9 districts
Number of Blocks / Villages	9 Blocks / Wards / 595 Gram Panchayat / Slums
Number of Partners	7 Implementing Partners
Target	Under 5 children - 2,08,269, Population - 20,59,828



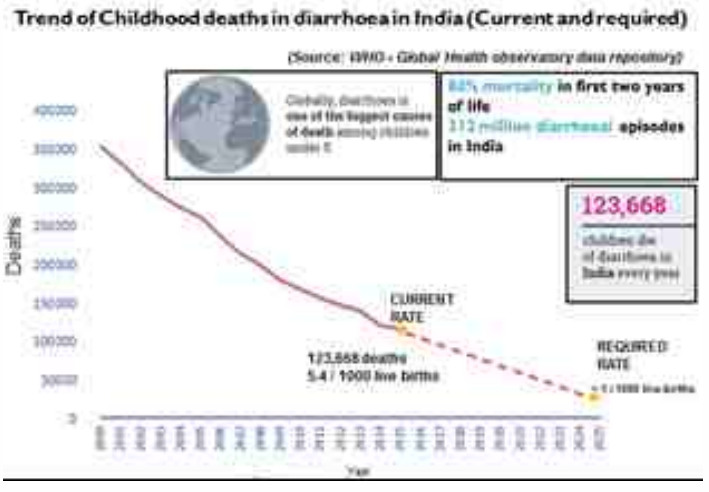
Project Brief

Diarrhoea and Pneumonia in general account for almost one quarter of total under five child deaths globally and particularly in countries with limited access to health services, basic sanitation and hygiene and nutrition. In India, diarrhoeal deaths among under five children contribute to around 22 per cent of total global diarrhoeal deaths. More than 320 children aged under five die every day due to diarrhoeal diseases accounting to almost 10 per cent of total under-five deaths in India. Approximately, 70 per cent of these under five child deaths occur in the first two years of a child's life. The World Health Organization (WHO) estimates that 88% of deaths from diarrhoea are attributable to four issues: consumption of unsafe water; inadequate sanitation; poor personal hygiene and the lack of access to childhood immunisation as a preventative measure.

To sustainably tackle these issues and eliminate diarrhoea as a public health burden, the WHO and UNICEF have proposed a 7 point plan for diarrhoea prevention and control. The plan is focused upon providing adequate coverage of interventions necessary to eradicate diarrhoea as a public health problem that results in the unnecessary deaths of children under-five.

The plan comprises:

1. Treatment package:
   - Fluid replacement to prevent rehydration;
   - Zinc supplementation.
2. Prevention Package
   - Rotavirus and measles vaccinations;
   - Promotion of early and exclusive breastfeeding;



- Vitamin A supplementation;
- Promotion of hand washing with soap;
- Improved water supply quantity and quality and community wide sanitation promotion.

To assist the Government of India to tackle diarrhoea as a public health challenge and reduce the number of children who die from this preventable disease, Save the Children with the funding support of Rickett Benckiser (RB), in partnership with the Government of India (GoI) implements the WHO/UNICEF 7 point plan as a Signature Programme.

The programme will contribute to Save the Children's global ambition of removing diarrhoea as a top five leading cause of death amongst children by 2020. This programme tests the effectiveness and efficacy of the WHO/UNICEF 7 point plan; collate evidence to demonstrate proof of concept and value for money, and advocate for the state and national government and its partners to replicate and scale up the approach nationally. In order to test the effectiveness the WHO/UNICEF 7 point plan, Save the Children is demonstrating proof of concept from several states which represent the socio-economic diversity of the Indian context. Save the Children designed an intervention for the WHO/UNICEF 7 point plan to be implemented and tested across four states: Delhi, Uttarakhand, Uttar Pradesh and Kolkata in West Bengal.

Stop Diarrhoea Initiative's Contribution to the Sustainable Development Goals (SDGs)

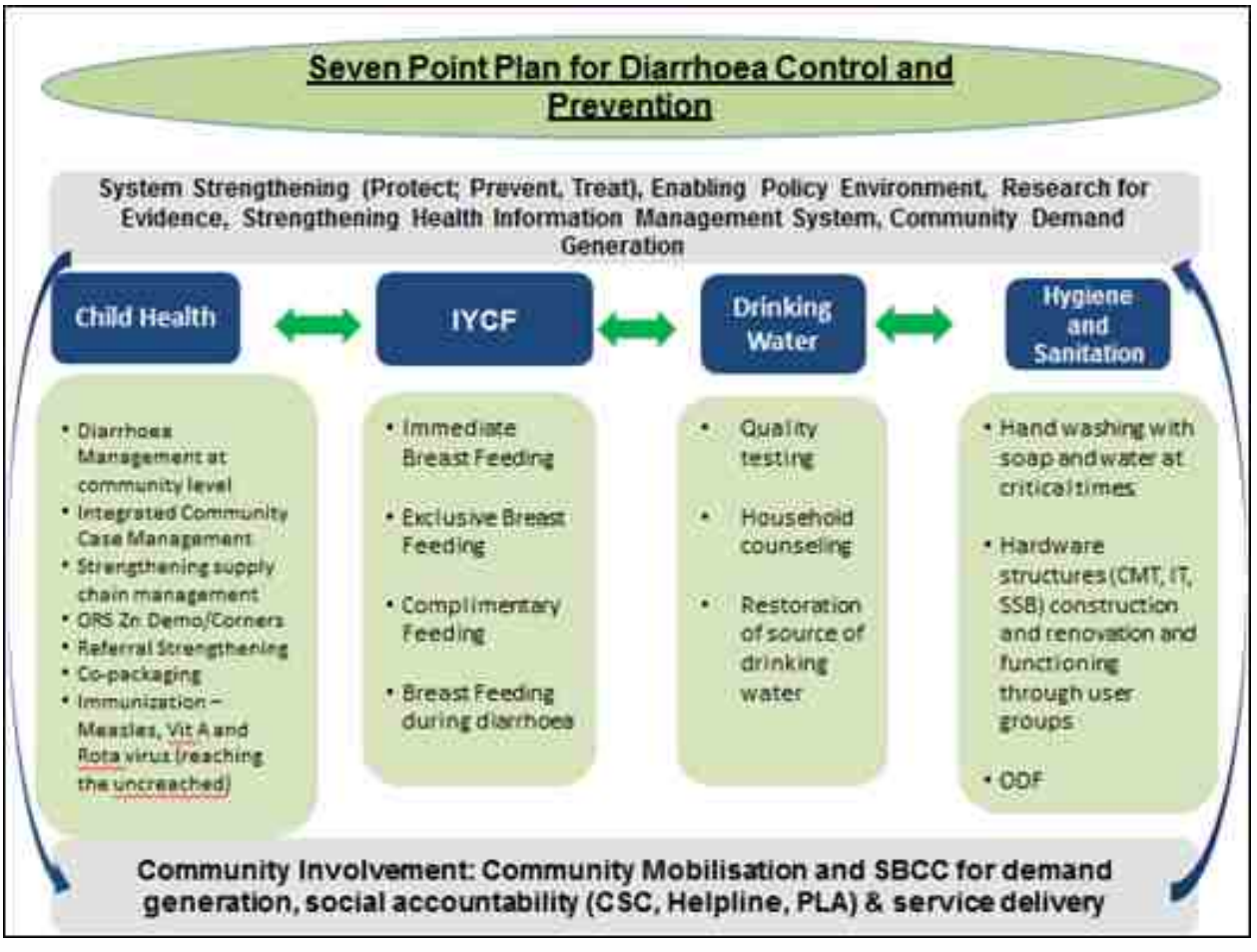
SDI project cumulatively contributes to SDG 3, 6 and 17 by ways to improving delivery to community based services primarily related to childhood vaccination, improving supply chain and logistics of commodities such as Oral Rehydration Solution (ORS) and zinc and also promoting positive behaviour changes related to infants and young child feeding practices; improving access to water and sanitation service along with personal hygiene, and collaborating effective partnerships for meeting the goal.

Implementation Model

The implementation model is focused upon providing adequate coverage of interventions necessary to prevent and control diarrhoea as a public health problem that results in the unnecessary deaths of children under-five. It has been designed to achieve a 100% coverage at ward level in urban areas and block level in rural areas, which is more than the 80% coverage recommended by WHO for a targeted location. Save the Children has demonstrated the effectiveness of the block level operational model in India, where it has been used to bring visible and measureable changes in relation to health and nutrition. This is well recognised by the Government of India and is now being adopted by other International Non-Governmental Organisations. Thus operating at ward and block level was an acceptable operational platform for producing evidence to leverage the WHO/UNICEF 7 point plan to the Government of India.

These four states are a fair representation of the socio-economic status of India, as two (Uttarakhand and Uttar Pradesh) are part of the Empowered Action Group (EAG) States. As EAG states are government priority states having highest infant mortality rates. Coverage of these seven interventions (both Treatment and Prevention package) in the target locations is below the WHO/UNICEF recommended standard of 80%. Through this Programme, Save the Children works with the Union and State Governments, RB and other partners such as World Health Organisation, UNICEF, iNGOs like Aga Khan Foundation (India), Clinton Health Access Initiative (CHAI), Family Health Initiative (FHI) 360, Micronutrient Initiative, PATH, Water Aid, WASH United etc. to increase coverage from the baseline to 80%. Successful implementation offers the unique opportunity for this to be the generation that contributes to stopping children dying from diarrhoea, by demonstrating how it can be eliminated as a public health problem and influencing the Government and other major stakeholders to take the approach to scale.

Children Learning WASH Behaviors though TSBAK



Community Outreach

Save the Children engagement in reaching out directly to the communities can be understood from the below given framework:

Save the Children has been involved in the followings:

- Contextualized Social and Behavior Change Communication (SBCC) strategies roll out for intended sustainable behavior change in the community. Conducted formative research to assess prevalent behavior in the different States, and used the evidence to design, create, implement, monitor and evaluate impact of these bespoke evidence-based interventions, focusing on social norms, cultural beliefs and attitudes in managing diarrhoea at the community level.
- Counselling, demonstration and education sessions at household and community level on hand washing, safe handling and storage of drinking water, child feces management.
- Established a community accountability and monitoring system to improve the responsiveness and quality of health service provision for the prevention and treatment of diarrhoea using Community Score Card tool. Save the Children has also adapted other accountability

mechanisms such as Complaints and Redress system facilitated by a non-emergency helpline and verbal autopsy of child mortality and diarrhoea incidents.

- Demonstration of innovative, sustainable models like Community Managed Toilet (CMT), Individual Toilets and School Sanitation Blocks (SSBs) complexes in order to generate demand at community level for replication.
- System strengthening for streamlining supply chain to ensure adequate and timely supply of low osmolality ORS and Zinc whilst creating demand at community level. Skill and capacity building of frontline workers and service providers.
- Strengthening WASH services and behaviors in schools through use of innovative infrastructures like age appropriate hand washing platforms, renovation of school sanitary blocks, inculcating child participatory learning tools in the learning curriculum of children.
- Community mobilization through Community Health Volunteers (CHVs) for raising community awareness about the prevention and control of diarrhoea and in influencing improved individual, family and community practices across the 7 point plan through a raft of interventions. These include: interpersonal communication (house to house visits and facilitation of community groups); two-way dialogue for collective action using the participatory learning & action cycle and Mother's Groups, User Groups, Youth's Groups, Children's Health and Hygiene Clubs (CHHCs) created in schools and Village Health and Nutrition Days (VHNDs) as a platform helping local group members to mobilize wider community members in solidarity and confidence to take action in the prevention and control of diarrhoea.
- Creating Child Champions - Children are key stakeholders in the programme and are seen as effective agents for behavior change. Meaningful and effective children's participation has been ensured through CHHCs to bring their learning from school and take positive action as peer educators and agents for change in their respective communities.

Uniqueness of the Project

Stop Diarrhoea Initiative project has many unique features built in it. The major ones are as follows:

Integrated model for diarrhoea control and prevention

As mentioned earlier, Stop Diarrhoea Initiative is based on the WHO-UNICEF 7 point plan which is a model of integrated approaches for diarrhoea control and prevention. Approaches under prevention package are implemented in a concerted way, since single interventions alone are likely to result in lesser overall impact. For example, diarrhoea caused by rotavirus cannot be prevented solely by improvements in water and sanitation. And rotavirus vaccine does not prevent other pathogens (such as E. coli and Shigella) from causing diarrhoea. The package is accompanied with clear, targeted and integrated behavior and social change communication strategies to improve uptake by families and communities.

Accountability mechanism for improving child health related services

Under the project, Save the Children has rolled out accountability mechanisms like community score card which is an on-going participatory tool for assessment, planning, monitoring and evaluation of services. It brings together the demand side ("service user") and the supply side ("service provider") of a particular service or program to jointly analyse issues underlying service delivery problems and find a common and shared way of addressing those issues. It is an exciting way to increase participation, accountability and transparency between service users, providers and decision makers. Further, project also introduced non-emergency helpline with an aim to use information communication and technology for enhancing the quality of care, bridge the gaps in healthcare services and improve access to reliable and actionable healthcare information related to child health illness specially diarrhoea.

Child Participating Learning Approach

The activity is related to participatory work with children for health promotion. It is more than using activity based learning and thinking as it involves children in decision-making in the design of specific, relevant actions that can be taken at family and community level. It is also related to using their natural creativity, ability and enthusiasm to communicate effectively with other children and it recognises and supports vital responsibility children often have at family level in the care of younger siblings.

Hardware structures as a demonstration model

Save the Children constructed Individual Toilet, Community Managed Toilet, school sanitation blocks and community toilet complex in order to generate demand at community level and demonstrate inclusive and innovate designs of toilets for replication. Project has constructed an 80 seated community toilet complex at Bhanwar Singh Camp, Vasant Vihar, New Delhi. This structure will cater the need of around 3000 slum residents. The toilet complex comprises technical features of bio-digester for treating the sewage, recycling the water received from washing, bathing and cleaning using Decentralised Waste Water Treatment System (DEWAT) and Water ATM by which residents can have RO water at a very nominal rates.

ORS Zinc Counselling at ORS Zinc Corners

Role of Information and Communication Technologies (ICTs)

Stop Diarrhoea Initiative project relies on successful use and adaption of technology for delivery of targeted interventions. Some of Key technologies and innovations under implementation are:

- **Mobile tablet based internal monitoring system (BRISK) which is** innovative Monitoring, Evaluation, Accountability and Learning (MEAL) tool used by Save the Children to strengthen project implementation though a robust case tracking mechanism and supports evidence based reporting of impact. BRISK synchronizes offline data entry system with online mode of operation, and has a strong project management component. The application is secure and scalable in both space and time.

- **Web based online and offline module on 7 point plan:** It promotes continuous learning of the health and development workers, encourages self-learning ensures simplification of complex topics and easy presentation of the content using animation, graphics and voice over and provides opportunity of engagement of the participants on the topics by way of virtual interaction.

- **Solar based Water purifier:** A Fully automated, compact, low cost, solar energy based community water treatment system is installed in Haridwar, Uttarakhand. This low cost and very low maintenance green energy based water treatment system designed specially to cater the needs of rural India where there is no/irregular electricity and availability of trained manpower is negligible. Unlike Reverse Osmosis (RO) plant, there is no water wastage here and is a very effective for water scarce areas too. It is an automated system including dosing of chemical with automatic switch off button, does not require operator. The system is based on a continuous water treatment process, using innovative coagulation/flocculation and disinfection technologies. The Project has also used Information and Communication Technology to bring capacity building self-learning health and development modules to improve quality of continuous learning of health workers at community and facility learning. The initiative brings the learning resources to masses at free of cost.

- **Child led advocacy through Photo Voice:** Every child has the capacity to bring in new insights, new learning. In partnership with Photo Voice, UK a premiere organization in the world that helps children weave their own stories, using a camera and not only limiting to use but teaching them to interpret the voices of their photos.

- **Non Return Valve technology in hand pump:** In the rural areas to ensure running water in the Community Managed Toilets (CMT) built under the SDI, Non Return Valve (NRV) technology is used to lift the water from hand pump to overhead tanks.

- **Happy box/ Team Swachh Bharat Action Kit:** In Partnering with WASH United, Save the children rolled out Happy box, an interactive game based methodology to deliver WASH related messages in Children. This was rolled out in 73 schools, training 338 teachers and 1,376 students in our project areas. This has proved to be great success in promoting hygiene and sanitation behaviours among school children and disseminating key WASH messages through them to their families and communities.

- **Community Accountability Tool:** Community Score Card, an on-going participatory accountability tool for assessment, planning, monitoring and evaluation of services provided to the community, is rolled out in the project implementation areas in the SDI. The objective to roll out the activity is to positively influence the quality, efficiency and accountability of the services which are provided to the community at different levels. It helps in bringing together the service user (community) and the service provider to jointly analyse the issues underlying service delivery problems and helps in finding a common and shared way of addressing those issues.

- **Age appropriate hand washing platforms:** The hand washing platforms constructed under SDI are child friendly hand washing platforms. Generally in a primary school there are children from 5-10 age groups and of different height. The idea behind this hand washing platform was that every child in school can access this platform for hand washing. Keeping this in mind we constructed hand washing platform with child accessible height. Each platform has 3-4 hand wash basins of different heights so that smallest child in the school can also wash his hands thoroughly.

Challenges Faced

The major challenges faced by the programme were:

- **Ensuring inter-sectoral collaboration and convergence between related departments on issues related to health and WASH and the 7 point plan.** The project works around the key determinants to prevent, control and treat diarrhoea at the community levels, Health Department, ICDS, Rural Development, Education Department, Public Works/Public Health Engineering/ Jal Nigam and NGOs. In order to halt the spread of diarrhoea, an integrated response to the disease, is required for lasting impact on child health. This therefore requires joint planning, execution, monitoring, reporting and reviews for efficient resource utilization and programme effectiveness. This has been a great challenge to bring all the stakeholders on one platform and to work together on integrated planning, implementation and monitoring as various departments are involved. The SDI project has envisaged a block/village level convergence model to deliver on this project. The proposed model involves forming a block/village level committee headed by Block /village administrative head. The committee is proposed to have representation from all the key departments concerning the health, education and water and sanitation and ICDS and other departments such as rural development and public works. The committee also propose to have representation from other NGOs working on the health and community development issues. The model promotes joint planning, execution, monitoring and review on a quarterly basis and cooperating in field operations on matters concerning child health. It relies on creating and sustaining a platform for sharing, learning, cooperating and joint problem solving for improved child health planning.

- Increasing coverage of Zinc utilization : The utilization of zinc for 14 days during diarrhoeal episodes of children has always been challenging and hardly 20% of children suffering from diarrhoea received Zinc. On other hand ORS utilization has been more than 65%. To address the issue of Zinc utilization, SDI project has taken up several innovations like introduction of co-package of Zinc and ORS in field, establishing Zinc ORS corners and depots in community, skill

building of frontline health workers on counselling follow up of beneficiaries, improving supply chain management of Zinc, feasibility of prescribing Zinc syrup, SBCC campaigns highlighting importance of Zinc.

Outcomes

By the end of the project we aim to contribute to at least a 50% reduction in the prevalence and incidence of diarrhoea in the project locations. The intermediate key outcomes of the project are:

Outcome 1: Access to quality diarrhoea prevention and control services for at least 80% of households in target areas of nine districts by the end of the programme.

Outcome 2: Community awareness and practices for prevention and control of diarrhoea in target areas improved by the end of the programme

Outcome 3: District, Block and community accountability and ownership for increased access to diarrhoea prevention and control and scale up at all levels enhanced by the end of the programme.

Outreach & Scalability

The approach Save the children has undertaken for outreach and scalability of SDI is based on Save the Children's Theory of Change, which comprises of the following elements:

1. Building strong **partnerships** with government authorities and stakeholders;
2. Leveraging global and local expertise to implement **innovative** solutions to strengthening local health systems;
3. **Being the voice** by advocating and campaigning for better practices and policies to fulfil children's rights and ensure children's voices are heard, particularly those most marginalised;
4. **Achieving results at scale** by improving access to proven and essential child health interventions.

Save the Children has demonstrated the effectiveness of the block level operational model in India, where it has been used to bring visible and measureable changes in relation to health and nutrition. Thus operating at ward and block level as an acceptable operational platform that will produce evidence to leverage the WHO/UNICEF 7 point plan.

SDI is designed to work in continuum with existing programs of various Ministries of GOI and Departments of State. The program adapts and innovates processes and tools for fostering the program implementation for better results, reaching the unreached and scalability of program. Innovative infrastructure modifications like age appropriate hand washing platforms in schools is contributing towards improving hand washing behaviours of children in school and community and the same is highly appreciated by school management and officials for its replication across all the schools and this contributing impactful towards Swachh Bharat Mission. Similarly the community managed toilets constructed / renovated and managed by project though community user groups in urban areas are models highly appreciated by municipal cooperation's and looking ahead for guidelines for adaption

across the urban areas. Co-package of Zinc and ORS, innovative way of supply chain management and diarrhoea management, has provided district health officials a way to increase the coverage of Zinc in their areas. Accountability tools like community score card and non-emergency helpline are providing evidences to government for its integration in their existing programs. Social behaviour change communication materials developed under the project are now being adapted by government for their larger campaigns like IDCF for larger outreach and impactful scalability.

Advocacy for Stop Diarrhoea Initiative aims to ensure the government's existing and new commitments towards diarrhoea prevention and control are influenced with the integrated approach of WHO/UNICEF 7 point plan. Broadly, this means to advocate for the alignment of government policies with this agenda and Save the Children's broader priorities.

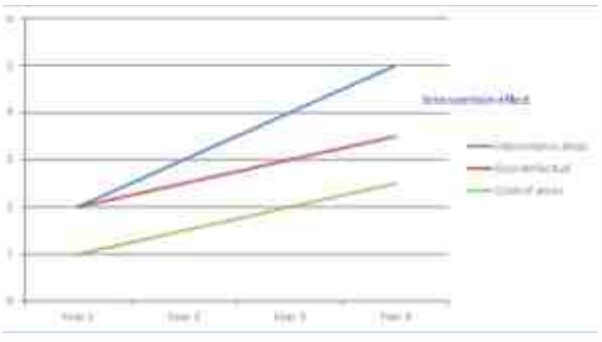
Replicability

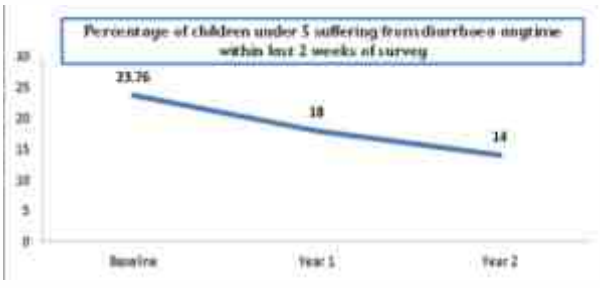
Sustainability to ensure a lasting impact for children has been integrated into our programme design at every level. The implementation design brings together all key stakeholders, including communities, CSOs and local institutions and Government Department to form a partnership network to ensure the lasting impact of our interventions. Sensitizing service providers and changing the behaviour of families and communities in a way that can be sustained in the long term is central to this project. We have undertaken a formative research with the intended beneficiaries to investigate their responses to a number of basic questions around the seven points before designing the project. The project design is capable of sustainably modifying hygiene, treatment and protection seeking behaviour. We monitor such progress with independent household surveys of our key process indicators. As part of our Social behaviour change communication (SBCC) strategy we use interpersonal, mid media and mass media tools to ensure a lasting change within targeted communities.

The project is designed to produce working model at gram panchayat and block level for its replication in other locations. The project will produce series of process documents, guidelines and standard operating procedures contextualized for government departments and development agencies for integrating the project and its interventions. Further, SDI project is working towards influencing the key policy level changes like introduction of co-package, minimum wash facilities in schools, and child friendly WASH infrastructures for its smoother integration in other locations.

Impact Achieved

The project is currently on its third year of implementation of its four year life cycle. We have progressed significantly on almost all of our key performance indicators and targeted outcomes from our baseline. The KPIs and outcome indicators are measured based on independent surveys in partnership with technical agencies to ascertain the effectiveness of the 7 point plan in the target areas. The Baseline has provided with the outcome and output indicators in treatment and control areas at the time of initiation of project and will provide a base from which impact can be measured on annual Key Performance Indicators (KPI) and the end-line evaluation. The end line evaluation shall use a **quasi-experimental approach** to evaluate the impact of the programme. To do this we shall measure the impact of the components on the target populations and a control group. Tracking the performance of both the





intervention and control groups will allow us to measure the programme's impact. The End line will have the same treatment and control group selected by matching key social indicators as in baseline. The measurement of the impact will use a Difference-in-Difference (DD) approach. We will calculate the mean difference between the Baseline and End line values of outcome and impact indicators for both intervention and control areas. Then, we will calculate the difference between these two mean differences. The second difference (the difference-in-differences) is the estimate of the impact of the programme.

Till date, we have been able to capture the reduction in the prevalence of diarrhoea in the past years.

Capacity Building

Save the Children through its Stop Diarrhoea Initiative has built capacity of facility and community level health and development workers on several topics related to Diarrhoea control and prevention using Information, Communication and Technology (ICT) based modules on diarrhoea prevention and control. Modules have been developed based on a comprehensive training and capacity needs assessment and analysis across four intervention states. These modules have been developed in Hindi, Bangla and English and are compatible with a range of devices.

Also SCI supports in capacity building of Government functionaries, local bodies and community. Save the Children builds capacity of Integrated Child Development Scheme (ICDS) supervisors on participatory approaches used in group activities, monthly meetings of Mothers' Groups led by Anganwadi Workers. Save the Children through local partners also builds the capacity to:

- Support public health service providers organising VHNDs to incorporate the 7 point plan for diarrhoea management and control (e.g. hand washing, breastfeeding, treatment with ORS and Zinc, Vitamin A supplementation, uptake of rotavirus);
- Ensure the capacity and functionality of Village Health Sanitation and Nutrition Committees (VHSNCs) by conducting functionality assessments;

- Build capacity and sensitize VHSNCs on roles and responsibility in Diarrhoea Prevention and Control including importance of ODF villages (as per government guidelines)
- Support and supervise WASH cadre to facilitate understanding and provide counselling to the community on safe water handling practices, water quality issues, sanitation related issues and hygiene behaviour such as promoting hand washing;
- Conduct refresher training to orient User Groups and Youth's Clubs on participatory learning and action approaches to identify, prioritise, implement and evaluate actions in diarrhoea prevention and control;
- Support exchange of experiences meeting between Women's Groups, User Groups, Youth's Clubs, and CHHCs on VHNDs to review successes, challenges and lessons and ways forward in community efforts for diarrhoea prevention and control;
- Develop community-based networks to help support appropriate infant and young child feeding at the community level.

Save the Children, through supporting active participation of CHHC members ensures better interface with School Management Committees and teachers for functional and hygienic WASH facilities in schools and better hygiene education.

Through capacity building, we have reached:

- 3375 facility and community health workers;
- 800 Mother to Mother Support Groups trained on Infant and Young Child Feeding Practices (IYCF);
- 347 community workers through training on community WASH;
- 800 WASH Paraprofessionals;
- 800 Laboratory technical and community workers;
- 720 local engineers;
- 72 local masons and hand-pump mechanics;
- 200 district and block level government authorities;
- 400 CHHC;

Partners of the Project

Building robust partnership is a crucial feature for the implementation of this programme. In the last programme implemented on WASH, Save the Children has developed important partnerships with relevant government departments for replication and scale-up of our WASH initiative. Save the Children is implementing the programme with support of 7 NGO partners having good experience in implementing maternal and child health projects.

Furthermore, key ministries, development agencies, international organisations, academic institutions are key stakeholders of this programme.

Government

In addition to state and district governments, the Ministry of Health and Family Welfare (MoHFW), Ministry of Drinking Water and Sanitation (MDWS), Ministry of Urban Development (MoUD), Ministry of Women and Child Development (MWCD) are the key stakeholders for supporting in implementation of the programme. Our government stakeholders roll-out their existing programmes providing access to necessary health services, safe drinking water and sanitation facilities to complement Save the Children work in diarrhoea prevention and treatment. Save the Children supports MoHFW in increasing the coverage of routine vaccination, supplies and uptake of ORS and Zinc, and raising awareness about the importance of hand washing and exclusive breastfeeding during regular VHNDs. The MoHFW supports Save the Children to deliver quality training to facility and frontline health workers whilst providing support and supervision to ensure appropriate diarrhoea case management.

Development Agencies

Both WHO and UNICEF have been engaged in the programme since the beginning of the inception phase and play a key role in providing technical support to the programme. They are also our advocacy partners for promoting the 7 point plan. Additionally, Save the Children has been collaborating with the Aga Khan Foundation (India), Clinton Health Access Initiative (CHAI), Micronutrient Initiative, FHI 360, PATH, Defeat Diarrhoeal Diseases (Defeat DD), WASH United and Water Aid. Save the Children partnered with PATH and its Defeat DD team for showcasing SDI key interventions by shooting videos intending to highlight the momentum around diarrhoeal disease and disseminating through consultation.

Non-Government Organisations

Save the Children also works with the Indian Medical Association, Indian Academy of Paediatrics, National Neonatology Forum and Breast Feeding Promotion Network of India to influence policy making and implementation at national and state level.

Academic Institutions

Save the Children established strong working relationships with the All Indian Institute of Hygiene and Public Health, the National Institute of Cholera and Enteric Diseases (NICED) Kolkata, the Indian Council for Medical Research (ICMR), Jawaharlal Nehru University Delhi, Indian Institute of Technology Delhi etc. Save the Children works with these institutions for seeking technical insights on programme and research component.

At the grass roots level

Save the Children partners with Accredited Social Health Activists (ASHAs), Anganwadi Workers, Panchayat Raj Institutions, Youth Clubs and Mothers' Groups for delivering our community based activities.

Awards/Endorsements

- For its contribution in making Uttarakhand 4th Open Defecation Free (ODF) state, Save the Children work on diarrhoea prevention and control was acknowledged by Uttarakhand government in June 2017. Over the last two years, Save the Children has been recognized for its efforts on Sanitation in Uttarakhand. Save the Children along with its partner organizations initiated the work by conducting a village based survey of the most marginalized communities. Series of meetings were then held with the community members motivating them to make their villages open defecation free. Awareness on benefits of sanitation and impact of open defecation on child health was disseminated through IEC activities and various campaigns like World Toilet Day and Global Hand washing Day.
- One of our Intervention School in Balrampur district of Uttar Pradesh has been awarded with Swachh Vidyalaya award by Ministry of Human Resource and Development under Swacch Bharat-Swacch Vidyalaya campaign. The school has been awarded 5 star rating at district level after field survey and physical verification by Government.
- SDI Community Health Volunteers have received special recognition by Swachh Bharat Mission and have represented their villages for better WASH facilities.
- SDI is key member of technical task force and committees at district, state and national level. SDI is recognized for contribution towards Integrated Diarrhoea Control Fortnight, campaign run by Ministry of Health and Family Welfare, Government of India.
- The key endorsements by international public health journals are as follows:
  - Paper titled **"Assessing critical gaps in implementation of WHO and UNICEF'S 7-point diarrhoea control and prevention strategy in Uttar Pradesh, India"** published in Annals of Tropical Medicine and Public Health in August 2017.
  - Research paper entitled **"Do community level interventions work in the same way on incidence and longitudinal prevalence of diarrhoea among under-five children in rural and urban slum settings? - Insights from Stop Diarrhoea Initiative in India"** accepted for publication in the journal of global health reports.
  - ICT enabled E-learning course using 15 modules on comprehensive diarrhoea control, developed by SDI project, accepted by Humanitarian Leadership Academy, London, a global non-profit e learning provider, for launching this launching this course globally to larger public health fraternity. The online course would be helpful in building the knowledge of the health professionals not only in India but also in other developing countries' with similar setting and challenges pertaining to child health and nutrition, water and sanitation.
  - Paper titled **"ICT Enabled Blended Learning for Frontline Health Workers – A Case of Capacity Building in Stop Diarrhoea Initiative in India"** accepted for - The Global Public Health Conference (Globe HEAL) - 2018 "Revitalizing Resilience towards the Emergence of Healthy Communities" held in February 2018 at Kuala Lumpur, Malaysia.

- Four papers accepted for presentation in International Conference on Public Health held on 28th-29th July, 2016 at Colombo, Sri Lanka

  a. A Quality Enquiry into Enablers and Barriers to Behaviors Related to 7 Point Plan on Comprehensive Diarrhoea Control in 4 districts of India

  b. Exploring Supply Chain Management issues in childhood diarrhoea prevention and treatment – research findings into Stop Diarrhoea Initiative of Save the Children in four States in India

  c. Exploring Capacity Building Needs for Comprehensive Diarrhoea Control in Four States in India under Save the Children 'Stop Diarrhoea Initiative'

  d. Is Mothers self-Reporting as good as Community Health Volunteers reported data for childhood diarrhoea?

Community Health Care Management Initiative. Focusing on: Strengthening of Gram Unnayan Samsads and Self-Help Groups through PRI in 5 districts of West Bengal

March 2010 - February 2013

Child In Need Institute

Website	:	www.cini-india.org.in
Founder of the Organization	:	Dr. Samir Narayan Chaudhuri
Project Budget	:	₹ 77067040/-
Coverage/ Geographical reach	:	The project was facilitated by CINI in 5 districts of West Bengal

Districts	Sub-divisions	Blocks	Gps	Sansads
Jalpaiguri	3	10	112	1292
Malda	2	9	93	938
Murshidabad	4	18	184	2215
South 24 Parganas	5	29	312	3590
Uttar Dinajpur	2	6	57	575
Total	16	72	758	8610

Project Brief

The Community Health Care Management Initiative (CHCMI) programme was launched jointly by the Panchayet & Rural Development Department and the Department of Health & Family Welfare in 2004."Community's health in Community's Hands" being the motto of the programme, the planned intervention sought to drive home a sense of responsibility among common people towards their own health care management under the leadership of Panchayati Raj Institutions. The role of PRI is viewed as crucial towards planning, implementing and monitoring of NRHM programmes. In March 2010, CHCMI was scaled up in ten districts covering 155 blocks and 1494 GPs in the state. With communitisation as the driving philosophy behind the inception of this programme, it was envisioned that by strengthening the Village Health Sanitation and Nutrition Committees (VHSNCs), a process of decentralized health planning could be initiated by creating a platform where the issues of the community could be resolved through micro-planning and local level resources. Emphasis was also placed on increased community monitoring and intersection of departments through strengthening of the various convergent platforms (3rd Saturday and 4th Saturday meetings) and capacity development of the self-help groups. The interplay of this facilitation and capability development, it was believed would heavily improve the overall public health-nutrition service delivery and consequently, its utilisation pattern by the communities. This approach forms the foundation philosophy of 'The CINI Method' which realizes that sustainable development is possible only by co-operation, collaboration and association with communities, service providers, government officials, elected representatives and civil society members. 'The CINI Method' through its mission of developing 'Child Friendly Communities '(CFC) played a predominant role in this facilitation since the method relies on giving a child a protected environment through the convergence of community, panchayet and the service providers. The objectives of the programme were:

a. To improve the capacity of elected members of PRI and Gram Unnayan Sansad (GUS) representatives for effectively managing and monitoring maternal and child health situations in their field

b. To sustainably Involve Self Help Group (SHG) members in advocating for basic Mother and Child Health (MCH) issues at the community level

In 2004 the CHCMI programme was launched by the Government of West Bengal. The one year pilot

study was done by CINI in 12 gram panchayats (GPs) in Murshidabad district and was supported by P&RD, Government of West Bengal. It was greatly influenced by the ongoing discussions on NRHM. The basic objective was to strengthen involvement of PRIs and women SHGs in planning, implementing and monitoring action on local health and nutrition issues and related determinants. It also promoted linkages with government service providers. Then followed by the findings of the pilot study by CINI, the Government of West Bengal decided to scale up the programme in 10 districts of the state. CINI was entrusted by the Government of West Bengal for scaling and facilitating the programme in 5 districts of West Bengal for a period of 3 years.

Implementation Model

The objectives could be achieved by generating a team of efficient people (Facilitator team) at the district and block level, who shall support the implementation of the CHCMI program at the districts, blocks, Gram panchayat and up to SHG level (village level) through facilitating coordination and inter-linkages of the PRI members, District Public Health Cell, NGOs and community. The strategy shall mainly include sensitization of elected representatives, rounds of trainings following participatory methods, handholding support at the field level, supportive supervision during implementation at field level, frequent discussion with policy makers at all level. The implementation model and the strategy included:

- SHGs will be oriented on basic MCH issues and they would be able to disseminate the same messages at their respective community.
- SHG mothers would then be able to contribute significantly during health plan preparation at the village level.
- GUS would be continuously oriented and sensitized so as to enable them to monitor the progress in MCH situation of their area and take necessary action.

The road map for implementation of these strategies were:

Step I: Need Assessment with concerned stakeholders

Step II: Module Development for Training in a cascading mode

Step III (A): Preparatory phase – Generation of Training team at State, district and Block level

Step III (B): Orientation of the Training team

Step IV: Preparation and finalization of participant list from GP level

Step V: Capacity Building process of the participants

Step VI: Post Training phases

An interplay of all these strategies and processes was carried out through the basic model of 'The CINI method' which emphasizes on acting as a facilitator by creating a bridge between the receivers and the providers for service delivery and consequently their utilisation. This entire programme stood on the basic premise of improving the overall quality of public health service delivery through community based monitoring and strengthening community based institutions.

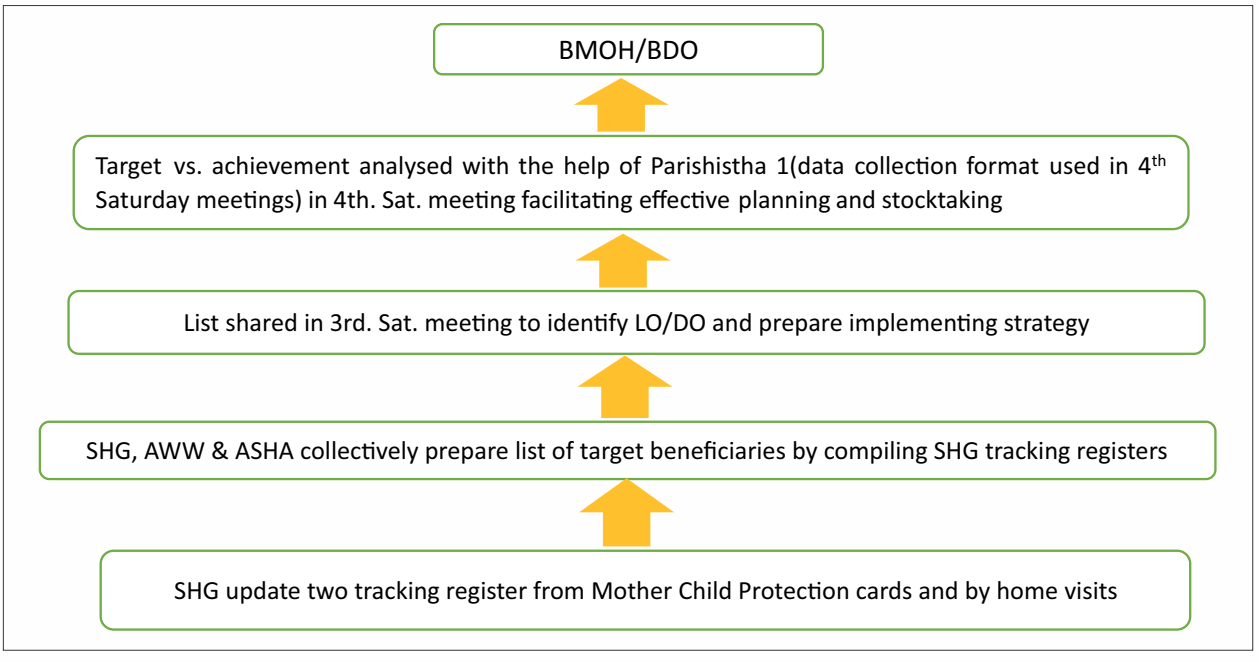
Community Outreach

The programme aimed at improving the service delivery of the health and nutrition services by strengthening the community based institutions for increased utilisation of the public services. This was achieved primarily through the process of communitisation which is the core emphasis of 'The CINI Method'. The programme sensitized the village women for forming self-help groups among themselves. This was facilitated at the GP level where the GP members were trained for forming of such groups. These SHGs were then capacitated and extensively trained regarding the various domains of health, nutrition and livelihood. They were made aware regarding the importance of maintenance of basic cleanliness and hygiene. They were also sensitized regarding the various entitlements from the system and the mode of service delivery from the public systems. These SHG women then reached out to the other group members and village women and generated awareness regarding the same. Moreover, the SHG women also tracked each and every pregnant & lactating women, new-borns and also were involved in household level surveys. The issues of the community were duly raised at the 3rd Saturday meetings and it was the responsibility of the GUS members to monitor that these issues were raised at the 4th Saturday meetings, facilitate the formation of VHSNCs and their functioning for resolution of local level health nutrition problems.

Uniqueness of the Project

Communitisation is an alternative approach in governance. It refers to a contract between the government and the community. Community becomes the owner of the government assets and is granted powers to manage and maintain institutions. Active involvement and participation of members ensures that people recognize their own needs and work towards fulfilling them. This was the primary ground-breaking feature of this programme that through community led processes and community based institutions an improvement in the overall public service delivery was obtained together with increased utilisation of services that led to a development in the health and nutrition indices of the community. Some of the promising initiatives of the programme were:

- **'Number to Name' Tracking Mechanism for Beneficiaries – A Pilot Initiative:**
- **Organising Nutrition Demonstration Camps Collectively:** Nutrition demonstration camps were organised across the five districts. Local communities were encouraged to provide the ingredients and other required items. Expenditure, if any, was covered through the VHSNC health plan budget. The SHG women also played a key role.
- **Initiation of Migration Card:** In December 2011, all the GPs in Sagardighi block in Murshidabad started issuing migration cards. This system was initiated with the support of CHCMI staffs who facilitated sansad, GP and block level meetings to evolve consensus on this issue. The BDO, in particular, encouraged the initiative. The local SHGs also pitched in at the sansad and GP levels. The response has been overwhelming. Moreover, it has proved to be a valuable aid in working on unsafe migration and combating trafficking of children and women.
- **SHGs as catalysts for change:** The trained SHG women acted as catalysts for change by directly intervening in cases of malnourishment and bringing changes, resolving changes with the SNP



service of the AWCs, promoting positive child caring and feeding practices and finally for preventing early marriages.

Role of Information and Communication Technologies (ICTs)

The project did not require the involvement of any technologies since it was a community based programme that relied on the basic premise of strengthening public health service delivery through community led processes and initiatives.

Challenges Faced

Several challenges and constraining factors continue to cast their effect. These are linked to topography, proximity and access issues related to service delivery points, local dynamics and ensuring that all the links in the decentralized planning and action chain (from the sansad to the district) are in place. CHCMI has certainly helped in laying the foundation for community led, convergent processes for improved outcomes. It is now important to hold on to the gains and build on this foundation.

Outcomes

It was found that by October 2012, VHSNCs had been formed for more than 95% of the sansads in the intervention blocks of Jalpaiguri, Uttar Dinajpur, Murshidabad, Malda and South 24 Parganas. Malda brought up the rear at 89.8%. The VHSNC members were given inputs through orientations, workshops and continuous handholding support. 7883 VHSNC were covered in a joint orientation with SHG members where key messages on health and nutrition and related determinants and functional aspects were discussed. Also, by October 2012, 8016 SHGs had been selected and trained through properly planned structured sessions across the five districts.

The project intervention saw a massive boost in regularization of monthly VHSNC meetings with 82% to 100% of the sansads across the five districts were engaged in developing the plans in October 2012. Implementation of these plans required financial assistance and accordingly fund utilisation was also improved to a massive extent in these districts.

The continuous facilitation also resulted in regularizing the convergent platform meetings. In March 2010, 41% to 73% of the GPs across the five districts were conducting the meeting. By, October 2012, more than 90% of the GPs were conducting this crucial meeting. This proved to be yet another success of the programme. Improved systemic functioning, increased demand from the community together with involvement of the PRIs resulted boosting up the overall indicators of health and nutrition. Key outcome indicators such as institutional delivery, weighing of children within 48 hours of birth and full immunization of children up to one year of age witnessed a positive trend. Overall, recording of birth weights showed most consistent improvement (value ranges for March 2010: 44%-57%, November 2011: 63%- 75%, October 2012: 75%-89%). Birth registration also showed a positive trend with Jalpaiguri as the sole exception. The role of SHGs in reiterating key messages and connecting families with service delivery points could be seen as a key contributory factor in most cases. Improvements in service delivery systems backed by a policy emphasis on maternal and child health issues also played a key role.

Outreach & Scalability

The programme was scaled up after the pilot initiative for 1 year in Murshidabad district of West Bengal by CINI. Following the success of the pilot initiative, the programme was scaled to 10 districts. This was a huge success for placing reliance on the strength of the community led processes and the role of community in developing ownership towards their own systems and institutions. The frameworks developed under this programme was also encouraged by the district administrations and used in their programmes.

Replicability

Since the basic premise of the programme is communitisation, this programme can very well be replicated in other locations and states and integrated with the existing processes.

Impact Achieved

The programme led to the overall strengthening of the public system through the ownership and involvement of the community based institutions. This programme was able to generate and imbibe the understanding that a concerted effort by the communities for improving their overall quality of life will definitely lead to improved service delivery by the systems. Thus, the evolvement and sustenance of community based monitoring processes was the main impact of this programme which resulted in achieving improved maternal health and nutrition indicators.

Moreover, the empowerment of the SHG women through continuous capacity development resulted in them involved in the communitisation process by generating a feeling of ownership towards the systemic entitlements within the community and also by sustained awareness generation regarding various health-nutrition indices. It also resulted in increased mobility of these women with them going

over to the block offices, panchayet set-up, interacting with officials and voicing their demands. Thus, together with developing their knowledge base regarding systemic entitlements regarding health and nutrition, this programme also managed to leverage their self-confidence playing a major role in their empowerment.

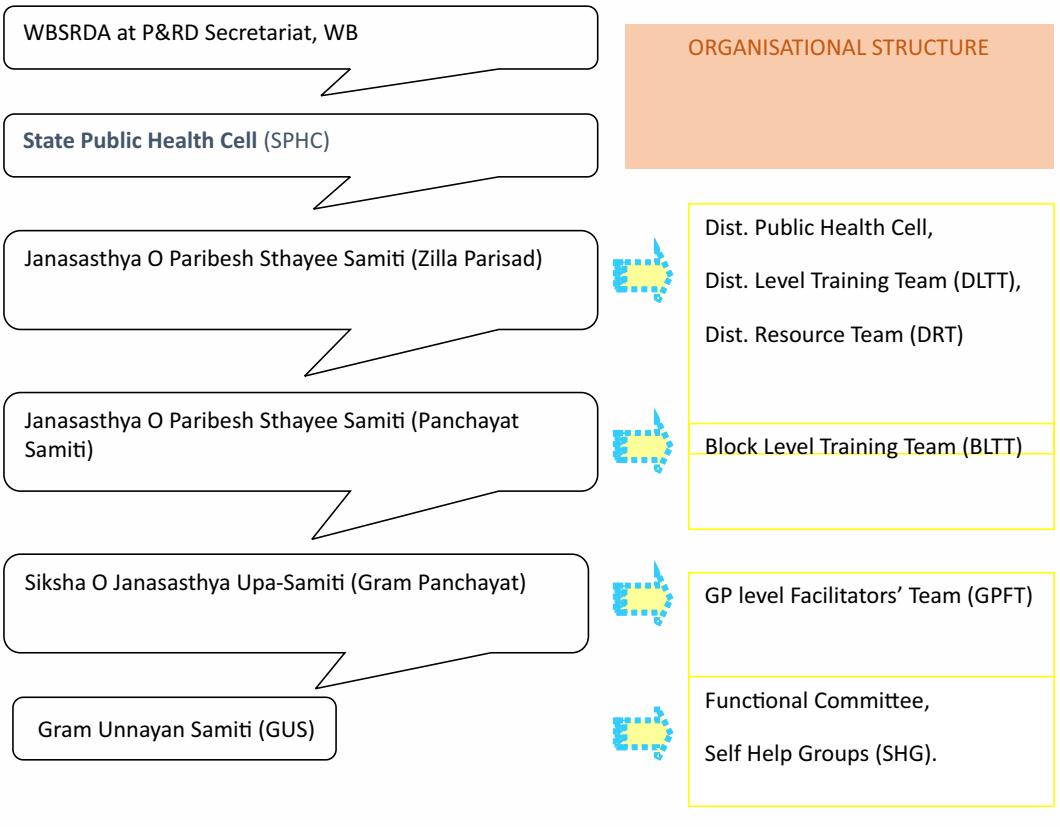
Capacity Building

This programme operated through extensive capacity building initiatives for successful implementation of the programme objectives. This involved:

- Intensive training to the GP members for facilitating formation of SHGs.
- At the GUS level, the members were trained for monitoring and supervising the functioning of the 4th Saturday meetings together with facilitating formation of VHSNC and their effective functioning.
- Exhaustive training of the SHG women for developing their basic knowledge on health and nutrition and sensitising them on ways to deal with the community for advocating on MCH issues.

Partners of the Project

This diagram provides a description of the engagement process of key stakeholders of the programme. The programme was managed and held by the Panchayat & Rural Development Department and facilitating partner was CARE, India.



Tiko Saathi

August 2015 - December 2017

Population Services International (PSI)/India

Website	:	www.psi.org.in
Project Budget	:	1 Million USD
Coverage/ Geographical reach	:	Alwar, Jaipur, Dausa, Ajmer (Raj) and Agra (UP)

Project Brief

Nearly a third of people in and around cities in India live in slums with poor hygiene, sanitation, and an absence of health services. Women and their families struggle to access basic, affordable health services and products. In India, 56,000 women die each year in childbirth – one every eight minutes. This accounts for 19% of maternal deaths around the world, 70% of which could be prevented with access to quality health care and skilled birth attendants. Many social businesses and NGOs are entering the market to improve access to healthcare, finance, and technology. These new market actors are developing impactful products, but are unable to deliver them to the last mile. There is a market gap to enable customers to access high quality, low cost, socially-impactful products that they want and need, and there are many women ready and able to take up that challenge.

In 2015, with private seed funding through Maverick Collective and working alongside mobile technology innovation partner Triggerise, PSI launched Tiko Saathi – a three-year pilot to develop a social entrepreneurship ecosystem in five districts in Rajasthan and Uttar Pradesh. ***The goal of Tiko is to deliver health products and services to the urban poor, specifically adolescent women and girls living in these areas***

PSI, in partnership with technology organization Triggerise India, developed an innovative pilot to address the health needs of women and their children focusing on the first 1,000 days of pregnancy, childbirth and infancy – a critical window of opportunity. With philanthropic seed investment from

Maverick Collective Founding Member Martha Darling, PSI and Triggerise built a network of local women social entrepreneurs to reach women in urban areas with a basket of health products and services, which is named/branded Tiko Saathi.

The vision is to create a health ecosystem that brings care to the front door wherever possible, providing accurate information and advice, and financial incentives in the form of subsidized clinic services and products and the ability to earn points (known as Tiko Miles) redeemable for health products. The ecosystem served as a testing ground for a novel business model that integrates health impact with economic empowerment, while leveraging the power of mobile technology.

Through this pilot, PSI sought to promote entrepreneurship, take a user-centered approach, prototype and iterate throughout the course of implementation, and integrate new products and services wherever possible – with a particular goal of increasing the number of ANCs.

In setting up the product basket under Tiko Saathi, PSI identified gaps in health products and services available prior to, during and after pregnancy from the consumer perspective. These included the expense of diagnostic tests recommended during antenatal care visits and post-partum family planning. As a result, these services were made available to holders of the Tiko Saathi card at a discounted rate from doctors and clinics who registered to be part of the network.

Implementation Model

Together PSI and Triggerise have been able to create a value proposition for all stakeholders and actors involved in the ecosystem. Both entities joined hands to create strategies for a sustainable model and they shared various resources to achieve positive results under this project. The Tiko Saathi ecosystem consists of a network of diverse users (from end-consumers to private clinics, pharmacists and wholesalers) who are registered via a mobile app and given the ability to perform "actions":

- **Consumers ("Sarita")** are at the center of the ecosystem. Women in the community have the ability to buy Tiko cards that provide discounts on a range of products and services before, during and following pregnancy. Tiko cards also offer the opportunity to earn points or Tiko Miles as an incentive for healthy actions (e.g. attending antenatal care visits) which can later be used to pay for products. Each of Sarita's interactions with the ecosystem is recorded via a mobile app, which helps the system to profile her behavior, providing customized offers and rewards
- **Providers** are selected based on the services offered and on a quality assessment. Each provider is

registered in the ecosystem based on a prior assessment and their willingness to participate in the program. The providers offer discounted fees directly to women in the community – Saritas

- **Pro Agents (Last Mile Distributors)** are local women entrepreneurs who earn an income for delivering health messages, referring clients to services, promoting special health offers and selling health impact products. Recruited from the community, they receive training on sales techniques as well as basic health messaging. They play a key role in the ecosystem as they proactively engage women at their doorstep and encourage them to adopt healthy behaviors
- **Wholesalers agree to** accept Tiko Miles as payment by Pro Agents when they restock their baskets of goods. At the end of the month, PSI redeems all points by transferring the corresponding monetary amount to the wholesaler.

Community Outreach

As mentioned above, Pro-agents are key stakeholders in this project who connect with Sarita (archetype of target group), Services Providers and Wholesalers. These pro-agent cater services in particular area and regularly interact with Sarita. The Pro Agents sell comprehensive health membership cards that link women with quality health care services in clinics during the critical 1000-day window of pregnancy (ante-natal care consultations, diagnostics and tests, ultrasonography, post-partum family planning options, and two consultations for the newborn). Women earn "Tiko Miles" for every service they access and for using their mobile phones to confirm pregnancy milestones – and

these points can then be used to buy products from the Pro Agents or to pay for services at the dedicated "Tiko Clinics" in the network.

Uniqueness of the Project

In order to increase the value flowing within the eco-system and ensure it reaches Sarita, three associated innovations are implemented around three pillars, based on three major assumptions:

1. ***Innovation around Women Entrepreneur (branded as Pro Agents)***

PSI India and Triggerise are developing a network of women entrepreneur (branded as Pro Agents) aimed at addressing these challenges, by:

- Delivering high quality health information as required by Sarita at right time with the help of standard tool.
- Promote high quality health impact products and referring to service providers as per the need of Sarita. Allowing real-time tracking of purchases within the network, enabling the passing of instant commissions to women entrepreneurs every time they purchase an impact commodity.
- Developing a lean supply chain, using existing small scale retailers and stockists; monitored through Movercado software.
- Developing a powerful brand, encouraging Women to join and grow the network.

2. **Loyalty Points (branded Tiko)**

PSI India and Triggerise introduced a social marketing loyalty program branded Tiko. Its aim it to encourage Sarita to become a consistent "client/user" by offering her direct discounts, rewards, and benefits in an eco-system made of different actors. This creates value for Sarita, as it gives her the opportunity to save, by accessing necessary products and services at a preferential price, using points rather than cash. On top of it, she can earn more, by registering her behavior – therefore feel "rewarded".

This creates also value for the providers and the stockiest, by increasing demand at low cost, providing them with an access to a Customer Relationship Management system – cell phone based – and offering innovative financing options (Health services in bulk, incremental incentive for service provision).

For PSI India, it gives a unique opportunity to "know more" Sarita by tracking her behavior and enabling direct contact (by sms or call). It provides the team will real time monitoring data, enabling dynamic project management through fast iterations, rapid tests and regular improvements.

3.Health service membership package (branded Tiko Saathi)

Using behavioral economics theories as well as agile project management principles, PSI India and Triggerise are implementing a selling of membership program branded Tiko Saathi card. It functions as a health service membership offer, made of a bundle of products and services. The subscriptions are defined around specific health needs, such as Ante-natal Check-up, Family Planning, non-communicable diseases etc. Its cost to Sara is low but plays an important role as it stresses the importance of the membership. It also helps to potentially segment the offer and propose several levels of memberships.

The memberships card (Tiko Saathi Card) distributed at first by PRO Agents, in order to leverage the power of interpersonal communication –based on how she uses her Tiko Saathi Card and what she decides to access, Sara will receive loyalty points – which she can use for follow up products and services, or to access a different subscription.

Role of Information and Communication Technologies (ICTs)

The eco-system was powered by Movercado, software capable of managing referral systems, monitoring, retailing, communication and virtual loyalty schemes to improve the health of bottom of the pyramid users. The access to Movercado is via any basic cell phone and uses SMS to trigger momentum.

Challenges Faced

Require regular follow up to keep pro-agents active and self-reliant- A major challenge: With increasing numbers of pro agents in the network, it has been observed that constant support is required on a daily basis with these pro agents by their program officers. This was causing difficulty in smooth implementation of project activities. Hence, a decision was taken to initiate facilitation of cluster meetings in particular areas where pro agents operate. Pro agents belong to different culture and community requires constant motivation and support to become active in the eco-system. They have been followed up with different strategy including sending SMS through movercado technology for ensuring participation in the regular cluster level meeting to update and addressing their challenges. The project also introduced variety of merchandise to motivate pro agents and sustain their behaviour for longer. Introduce new schemes for pro agents for increasing their income.

Use of Technology in Urban and peri urban areas – A major shift: The project initially introduced SMS based registration system for Sarita, which was not found very successful due to lack of knowledge of sending messages and the cost of SMS messages. To address this problem, the project introduced movercado technology to capture interactions and save SMS costs of Sarita. All key transactions like visit validation for ante-natal care check-ups requires the target group to only give a missed call. However pro agent faced challenges in using Movercado technology such as registering clients, sales transaction and knowing tiko balance. Thus project developed Apps for Pro-agents and Stockiest which provided solution to many operational challenges. To increase the use of App, the project tied up with the mobile vendor to supply the smart phone on discounted rates to Pro agents. The vendors were also prepared accepting Tiko Miles which boosted motivation among pro-agents. Through this initiative many pro agent started buying smartphones and now using new Pro-apps for their transactions.

Outcomes

Some of the key outcomes from the three-year pilot include:

- **Creation of an active network of more than 1,400 motivaterd Pro Agents across five districts in Rajasthan and Uttar Pradesh.** This exceeded our initial projection of 1,000 Pro Agents. Successful strategies that helped recruit and retain Pro Agents included offering specific incentives to Pro Agents for referring friends as potential Pros, capacity-building and skills training, cluster meetings and on-site support, and quarterly rewards and recognition.
- **8% of Pro Agents earn more than INR 2,500 per month.** This figure demonstrates substantial economic empowerment from the Tiko Saathi model and highlights the success of training and capacity-building efforts with the Pro Agents to give them the necessary business skills and knowledge to succeed as entrepreneurs and maximize their earnings.
- **More than 33,000 Tiko Saathi cards were sold during the pilot period** and more than 24,000 women benefited from discounted services as a result. The Tiko model has shown success in increasing monthly antenatal care visits at private clinics in the project districts, from 11 in 2015 to 4,292 in 2017, a substantial increase.

Outreach & Scalability

The model has been piloted as a component part of several other projects implemented by PSI in India. Movercado and Tiko was used for incentivizing toilet motivators for selling toilets at Bihar. The system was used by eight key actors – toilet motivators and cement ring manufacturers - and resulted into 188 toilet sales and 28,000+Tiko miles as incentive. Sanitation team has also shown interest to use the model in Fecal Sludge Management project.

PSI implemented Tuberculosis (TB) program where Union is prime donor. PSI has presented the Pro model to the Union and they liked it and are keen to adopt it in one of the TB project districts, where Pro can sell products and screen TB patients. In Jaipur, PSI rolled-out nutrition distribution to TB clients, which was linked to movercado for monitoring and reporting purpose.

The Tiko model has shown great promise as a model for social entrepreneurship that both empowers women to reach their full economic potential and has potential to deliver sustainable healthcare in future. Over the next three years, we have the opportunity to innovate and expand the model further to move towards a commercially sustainable and scalable business. To accomplish this, The Dutch Ministry of Foreign Affairs has funded our technology implementing partner (Triggerise) to create an "impact investment platform" that will allow traditional donors, foundations, and private donors to contribute to measurable impact by investing in Tiko -- therefore opening the door for further investments into the existing ecosystem in Rajasthan and Uttar Pradesh.

Future vision for Tiko Saathi Project:

- Expand the Pro network to 2,500 women entrepreneurs by 2020;
- Explore different funding options, such as commercialization; corporate investment; and integrating this approach into government-funded health schemes, to reduce reliance on traditional funding and philanthropy;

- Expand the network across Uttar Pradesh (horizontal) and volume in Rajasthan (depth);
- Expanding Tiko Miles to be a motivational tool for all actors of the ecosystem;
- Adopting an approach of self-enrolment and long-term health journeys;

Replicability

PSI and Triggerise continue to refine several elements of the model to work towards commercialization, corporate buyout, or takeover by the government. Through such a partner, particularly someone with experience with venture philanthropy and social enterprise, we believe there is a clear opportunity to take the Tiko model to the next level. Our vision is to create a proven model for how social entrepreneurship can deliver sustainable health impact for women and girls, and move countries towards universal health coverage.

Some of the key areas where we are looking for support and guidance from an experienced investor include:

- Developing a clear 'go to market' strategy;
- Gathering additional data on volume and coverage;
- Reducing dependency on tiko miles for Pro Agents;
- Creating an articulated value proposition and strategy for corporate partnerships; and
- Gathering data on standard coverage, such as the number of clinics per Pro Agent and socio-economic coverage of clients (toensure we continue to meet the needs of low-income women and girls).

With additional investment, we will expand the products and services that can be added to address women's health needs and expand Pro Agents' profit margins, such as non-communicable diseases (diabetes and high blood pressure); tuberculosis; adolescent sexual health; insurance (to address the issue of high out-of-pocket expenses for accessing healthcare); menstrual hygiene; screening for cervical cancer and breast cancer, and primary health care.

Impact Achieved

Delivering health care services with subsidized rates: Improved ANC registration in Private Health care Institutions: The goal of Tiko Saathi Project is to deliver health products and services to the urban poor, specifically adolescent women and girls living in these areas. At the heart of the ecosystem is a branded network of women entrepreneurs from the community (called “Pro Agents”) who sell quality health products and services door-to-door. Their basket includes a range of products:

Health Impact Products

- Oral Contraceptive Pills
- Pregnancy Test Kits
- Sanitary Pads
- Oral Rehydration Solutions
- Condoms

Baby Products

- Diapers & Wipes
- Oil, Soap & Shampoo

Generic Products

- Face Wash
- Mosquito Repellent
- Body Lotion
- Hand Sanitizer
- Glucose
- Antiseptic Cream
- Thermometers

In addition, the Pro Agents sell comprehensive health membership cards that link women with quality health care services in clinics during the critical 1000-day window of pregnancy (ante-natal care consultations, diagnostics and tests, ultrasonography, post-partum family planning options, and two consultations for the newborn). Women earn "Tiko Miles" for every service they access and for using their mobile phones to confirm pregnancy milestones – and these points can then be used to buy products from the Pro Agents or to pay for services at the dedicated "Tiko Clinics" in the network.

The pilot focused on combining social and health impacts and works under several key principles:

- Promoting entrepreneurship
- Employing a user-centered approach
- Iterating quickly and being agile
- Integrating related health areas

There are now 1,400 Tiko Pro Agents in the ecosystem; 63 clinics; and 14+5 stockists across five districts. These Pro Agents have reached to 1, 57,000 women with 45,000 + health membership cards; 1,36,617 sanitary pads; 2,67,348 oral rehydration solutions; 1,37,764 condoms. This distribution network has resulted in 34000+ antenatal care consultations. This model has not only provided health products to women's doorsteps, but also generated wealth for low-income women with a wide range of low margin, high-margin, fast-moving and high-impact products from local wholesalers. We have established this network of women entrepreneurs, but we need to innovate and continuously iterate to bring sustainability to the ecosystem, add diverse health solutions that cater to women's needs, and drive more income for women entrepreneurs.

Capacity Building

In order to capacitate pro-agents PSI made protocol to train Pro-Agents by creating a training plan and kit, which constituted a half-day classroom session on the project, product knowledge, technology, and selling techniques, and a second half on field training. Also providing hand holding support to each pro agent in field by PSI's program officer to motivate and providing on hand experience to pro agents.

Partners of the Project

a. Local Organization:

PSI/India: Population Services International (PSI) working on health issue in India since 1988. The programs mainly targeting reproductive health, child survival, tuberculosis, sanitation, HIV, malaria, gender based violence, and non-communicable diseases. Working in partnership with the private &

public sector and harnessing the power of the markets, PSI provides lifesaving products, clinical services and communications that empower the world's most vulnerable populations to lead healthier lives.

PSI tested Tiko Saathi model in five district of Rajasthan and Uttar Pradesh. PSI created eco system of 1400+ pro-agents, 60+ private providers and 12+ stockiest. More than 31,000 sarita have been provided health care services at private providers.

Triggerise India: Triggerise provided technological support through Movercado software for project operations, and is proprietary to Triggerise; Also Terms like "Tiko" and "Pro Agents" were already being used by Triggerise in other countries. Triggerise used it's platform to reward beneficiaries, agents, providers, retailers, stockist and any other relevant actor for adopting and promoting behaviours that lead to increased impact under PSI's project.

Martha's investment has been catalytic in demonstrating proof-of-concept for the Tiko model. The goal from the beginning has been for other donors or government to take up the program. In this case, Triggerise has taken up the model and is generating income to sustain the model, as well as securing further subsidy from the Dutch Government to sustain operations .

Private health care Provider: More than 60 private providers have become part of Tiko Saathi Network. The providers have played a key role in providing quality health care services to Sarita at subsidized rate. They have also supported the project by expanding the health care services.

Stockist: More than 12 stockiest have become part of the Tiko Saathi network. They have supported pro agents in providing different health and non-health impact products on good margin rates. They have also agreed to accept tiko miles against products.

b. Maverick Collective Member:

Martha Darling showed her interest in developing women entrepreneurship model that can provide health products and services at Sarita's door steps. Throughout the project period, together we tested a new model of philanthropic partnership. From the first country visit, it was evident that Martha was truly invested in the project, not just financially, but with her skills, passions, and personal connection. She was not interested in simply being a bystander. She wanted to be involved in all aspects of the project, including meeting with our partners, advocating on behalf of the project to key stakeholders and potential funders. She met Pro-agents, Sarita, Providers and stockiest in her two different visit in India. She gave her full time to meet and understand the project perspective.

health clinic USHA project

Urban Slum Health Action [USHA] Program

To reduce & Prevent Anemia and Malnutrition amongst mothers [15-49] yrs and Children [0-6] yrs through comprehensive approach.

September 2015 – August 2018

SUKARYA

Website	:	www.sukarya.org
Founder of the Organization	:	Mrs. Meera Satpathy
Project Budget	:	₹ 5000,000
Coverage/ Geographical reach	:	10 slum locations of Delhi /NCR, area population is approx.100.000 Coverage through this program- 10,000 mothers & children receives direct regular services on preventive and curative maternal and child health issues.

Benifits of lemon

Project Brief

Project is to help strengthen the detection, treatment, and prevention of malnutrition & Anemic conditioning amongst Mother & Children and to help combat some of the major causes of child mortality, through immunization and improved care at the community level. The project aims to support the provision of basic health services, contribute to the response to the nutrition issues and ensure that the marginalized population has access to basic health checkups, vaccines and essential medicines.

Key Services under the Project:

- Detection, treatment and prevention of Malnutrition & Anemic conditioning amongst mother & children.
- Providing basic health care services like Pregnancy, ANC & PNC health checkups along with counseling.
- Ensuring timely immunizations included in National Immunization Program.
- Promoting adequate Nutrition for mothers, infants and young children.
- Promote Basic Micro nutrients.
- Promoting home based and community based Nutrition solutions /Dietary interventions to combat Malnourishment and anemic conditioning amongst mothers and children

Key activities under the project:

- Monthly Health Clinic at each location
- Counselling by Doctor and Nutritionist
- Laboratory check ups
- Medicine disbursements /supplements
- Disbursement of Nutrition supplements
- Cooking demonstrations
- Health awareness sessions
- Sanitation drive/campaign
- Celebrating Mother and Child health day
- Home visits and Follow ups
- Referrals

Cooking demonstration session at JJ Bandhu

Implementation Model

It is a targeted direct implementation model in which maternal child health services are provided to the targeted group of mothers -15-49 yrs and children -0-6 yrs . Basic health services like Ante natal checkups, post natal checkups, pregnancy test and laboratory checkups like hemoglobin test, blood pressure, blood group and blood sugar test are done along with height & weight measurement during the Health clinic which is organized on monthly basis at each project locations. Counseling on Maternal child health & Nutrition is an important segment under the project. Further to it Home visit /Follow up of targeted patients are done by recruited /trained community health workers across each project location. And referral mechanism are developed and linked with government health system.

And Quarterly basis cooking demo /Nutrition classes are conducted with pregnant and lactating women by Nutritionist to promote locally available low cost adequate source of nutrition. The Nutrition food supplement is also provided to the identified anemic & malnourished mothers and children.

The monthly routine immunization by government health department is linked with our Health clinic and day is celebrated as Mothers and Child Health day in which targeted group /beneficiaries receive all services under one roof .Medical /Health services by Sukarya and Immunization is by Government.

Additionally every quarter sanitation drive like Community Cleanliness and Hand hygiene demo sessions are organized.

MIS system is established and regular capacity building trainings for project team & field staff is conducted.

Diagnosis of new born child by dr. Jethra

Community Outreach

The following processes are maintained while implementing this project

- Identification of location /community
- Community need assessment
- Basic data collection /indicator wise from Health & ICDS department
- Involving community, Stakeholder, PRIs and other local representatives while planning to execute the project.
- Focus group discussion [FGDs] with targeted groups e.g. pregnant women, Lactating women and Mother in Laws.
- Overall community assessment, KPA [Knowledge, practice and Attitude] on maternal child health & Nutrition and associated issues.
- Base line survey

Uniqueness of the Project

[1] Specialized medical health exclusively for targeted mothers and children. [No others]

[2] Designated trained Community health workers across all project locations

[3] Creation of Mother's group forum to learn, share and care about motherhood, pregnancy and lactation period across all project locations

[4] Convergence with government health system [Celebration of Mother and Child health day], Our Health clinic conducted with govt.routine immunization

Role of Information and Communication Technologies (ICTs)

mMitra voice call services that is technology intervention linked with this program to make the intervention more comprehensive.

Collaborated with mMitra Voice call program for maternal and child health .At each location targeted pregnant and lactating women receives customized voice call on preventive health measures .

Challenges Faced

- We faced challenges in setting up our health clinics along with government's routine immunization as they have same day for each location.
- Also faced challenges in setting fine tune between health & ICDS department
- Facing challenge in developing strong referral mechanism with government hospital

Learnings:

- Targeted intervention is very effective
- Trained community health workers are key for successful implementation particulary for follow ups and home visits
- Cooking demo/ nutrition classes are of great help making awareness about nutrition and food habits.
- Promotion of "Iron kadai "for cooking is of great impact for iron promotion

Outcomes

- Around 10,000 Mothers and Children are getting regular and sustained maternal and child health services across all project locations.
- Over all ANC [Ante natal care] & PNC [post natal care] services are increased
- Routine Immunization coverage increased
- Institutional Delivery increased
- Intake iron folic acid IFA increased
- TT vaccination increased
- Exclusive breastfeeding & colostrums feeding improved
- Reduction in anemia amongst pregnant and lactating women

Hc2

hb

- Better care and service solution for malnourished children
- Dietary food habits /cooking technique and adequate Nutrition recipe being adopted by targeted population
- Mother and Child health day along with Government routine immunization making services under one roof for community led improved immunization and maternal child health service coverage.
- Overall Knowledge practice and attitude of community /targeted population on MCH & Nutrition have been positively improved

Outreach & Scalability

- Program is on for up scaling.
- This project is an extension and replication of pilot project launched by Sukarya at 4 slums in 2014. Based on success, it was re-launched with extension in 2015.

Replicability

- It can be integrated with other location by providing health clinics across all location in linkage with PHCs
- mMitra Voice call services for MCH can be integrated other locations as well.

- Cooking demo/Nutrition classes should be integrated with ICDS

Impact Achieved

- Overall maternal child health & nutrition knowledge, awareness, attitude and practice have been improved
- Improved the overall engagement of Health & ICDS across project locations
- Enhanced demands for MCH & Nutrition services
- Improved supply of MCH & Nutrition services
- Greater awareness on Anemia & Malnutrition issues

Capacity Building

- Quarterly Capacity building sessions are kept for project team and field staff.
- Monthly Review & Planning meeting with field staff
- Supportive supervision

Partners of the Project

No partner. But mMitra [ARMMAN] voice call services are integrated to make it MCH intervention more comprehensive and target specific.

Awards/Endorsements

No

Health clinic under USHA project

ANM with Tablet

Khushi Baby: Wearable mHealth solution for Maternal and Child Health Tracking at Last Mile

Currently we are doing second Randomized Control Trial that started in September 2016 and going to be ended summer of 2018 but as a project we are going scale up from 365+ villages currently to 1000+ villages from Oct 2018

Khushi Baby

Website	:	www.khushibaby.org
Founder of the Organization	:	Mr. Ruchit Nagar, Founder & President and Current CEO Mr. Mohammed Shahnawaz, COO
Project Budget	:	For the second trial Approx 300,000 USD (excluding the cost of technology development)
Coverage/ Geographical reach	:	375 Villages in 5 administrative blocks of Udaipur district. Currently 14000+ mothers and children are being tracked through the system in past one year which is expected to reach 50000 by end of this year.

Project Brief

Khushi Baby (KB) is a novel technology platform to monitor and follow-up with maternal and child health at the last mile, based out of Udaipur, India. The platform consists of a culturally-symbolic, digital, wearable health record for the mother and child; an Android application for both planning and for point of care decision making for the community health worker; a dashboard for health officials to follow-up with supply side gaps and highest risk patients; a community outreach platform of programmable and personalized voice call reminders in the local dialect to improve awareness and adherence for patients and their families; and curated WhatsApp groups to facilitate communication between health workers, supervisors, and officials for data-driven responses.

The KB system centers around an innovative health record and health symbol for maternal and child health – the KB Necklace. The necklace is wearable, battery-free, waterproof, durable, less than $0.80, and tied with a culturally symbolic black thread known throughout India as kaala dhaaga to protect the child from evil eye. The KB necklace contains a Near Field Communication (NFC) chip, which stores complete health data of the pregnant women during her antenatal care and intranatal care periods. It further stores the history of immunization, growth, breastfeeding, and infection for the child as per the Government of India's centralized requirements. The health record is encrypted, only accessible via the Khushi Baby Android Application by authorized health workers, and only editable after unlocked with the mother's biometric.

Most importantly this system is decentralized and patient-centric: a patient can travel to any health provider with the KB App and present their most updated health history, regardless of which tablet the health worker is using, and regardless of if/when the health worker last synced her data. Doing so allows for continuity of care as the mother travels from village-health camp for antenatal care to community health center for delivery back to the village-health camp for her child's routine immunizations.

Implementation Model

We hypothesize:

- The KB Necklace can serve as a better-retained, physical reminder to improve awareness around child immunizations and thereby improve adherence

- The KB Necklace can recruit others within the community to attend village-based health camps for their children
- The KB App can improve due-list planning, point-of-care decision making, and accountability via internal data quality monitoring for the health worker
- The KB Voice Calls can help ensure patients are adherent to their follow-up throughout pregnancy and infancy
- KB Whatsapp Groups and KB Dashboard actionable reports can direct health workers and supervisors to better attend to dropout and high risk patients

We have employed a randomized, longitudinal prospective cohort analysis framework to assess how varied entry points and exposure to our whole intervention may predict health outcomes including: completion of four antenatal care checkups, completion of birth at a hospital, timely completion of infant immunizations through measles, as well as instances of stillbirth, infant death, and infant infection after adjusting for confounders related to supply-side failures, health worker performance, and invididual sociodemographic status. Sub-group analysis will also be performed to understand which patients benefitted the most by checking for interactions between factors.

These quantitative analyses are supported by mixed methods implementation research to understand mechanism, causaility, barriers, and scalability in a feasible, iterative, and ethical fashion. Specifically, we are conducting camp-level observations to record health worker preparedness, adherence to protocols, and use of the KB App before, at midline, and at endline of the study period. We have shadowed a sample block medical officers and health supervisors for a 1 week period to document their

workflow, identify gaps and barriers for integration of our new KB system modules at the community health center at baseline, midline, and endline. We are conducting focus-group interviews with health workers on a bi-monthly basis to improve the system's user interface and experience. We will additionally include key informant interviews of mothers, fathers, health workers, social workers, health supervisors, data entry operators, health officials, and supply managers who all touch the KB interface in their own respective manner at midline and endline.

Mother Baby

Community Outreach

Khushi Baby is an ecosystem attempting to address the challenges of effective healthcare delivery at the last mile, where the patient population is mostly illiterate and below poverty line. While developing this system we worked on understanding demand and the issues faced by people at the frontline.

We decided to use the form of a necklace for our digital medical record storage device as it is an integral part of the prevailing culture of the people we are trying to reach. The KB necklace uses a black thread which holds the relevance of protecting the child from nazar (evil eye). As a result, this wearable marries tradition with technology and attempts convert a superstitious belief into evidence-backed health seeking behavior.

The KB system also looks to build upon approaches to connect the data back to the community. We believe our dialect-specific automated voice-based reminders have an advantage over text-based approaches, given literacy and SMS usage patterns. We further believe we have improved upon the model of voice reminders. Instead of simply sending messages according to the time of pregnancy/infancy, we furthermore send automated, patient-specific calls, specific to their pattern of health care completion and risk stratification. For health worker engagement, instead of solely relying on Web-based dashboards for non-computer users, we have activated WhatsApp Group channels to not only complete the data loop, but to spark specific data-driven engagements and to-do-lists.

Uniqueness of the Project

- **Accountability:** use of Near Field Communication and Biometric Authentication to prevent fraudulent creation or manipulation of patient records. Every health care visit has a digital paper trail that can now be audited back to the patient (without needing connectivity). The Khushi Baby systems also employs GPS, time-tracking, and automated data quality checks to detect and prevent manipulative data entry behaviors by health workers, known to take place, yet seldom discussed, in paper and other digital systems.
- **Ease of use:** health workers no longer have to type to search for patients; simply scanning the Khushi Baby Pendant retrieves the record, and can even link the data between mother and child; the

application has been designed for 60+ year old Auxiliary Nurse Midwives (ANMs) with no prior smartphone experience and mimics the paper-based registers they already are accustomed to with relevant overlays to guide action.

- **Machine Learning/AI:** with process in place to strictly control data quality, accuracy, and completeness, for the first time we will be able to unlock big data analytical techniques to predict (and hopefully prevent) probable cases of stillbirth and early infant death.
- **Decentralization:** other mHealth apps require health workers to sync data before going into the field or run-the-risk of a duplication when a beneficiary comes from a different village; health workers and patients move and even cellular connectivity is never guaranteed. With KB, the data is always accessible by scanning the patients' KB Pendant. This remains true even as a high risk patient moves from the village camp to a government referral center and back.
- **Form factor:** use of a culturally appropriate and customizable pendant to shown to generate demand and curiosity around the health camps within vaccine-hesitant rural villages, supported by 3 years of field research and hundreds of interviews with mothers in rural Udaipur. The necklace is tied with a culturally symbolic black thread known throughout India as kaala dhaaga, worn to prevent "buri nazar" (the evil eye) across all major religious sects.
- **Engagement:** our dialect-specific automated voice-based reminders have an advantage over text-based approaches, given low literacy and SMS usage patterns. We further improved upon the model of voice reminders. Instead of simply sending messages according to the time of pregnancy/infancy, we additionally send automated, patient-specific calls, commensurate with their pattern of health care completion and risk stratification. To engage health workers and improve responsiveness, KB has integrated into an already sticky WhatsApp framework.

Role of Information and Communication Technologies (ICTs)

We are using electronic chip to hold the maternal and child health record. This interacts with android based application through Near Field Communication (NFC) technology. We are also using biometric tablets to make the system more accountable.

Challenges Faced

- Rebuilding our entire platform from scratch after 1 year of deploying a stable mobile app for infant immunization tracking. Upon presenting our work to the Chief Medical Health Officer, he took out a large book and put it in our arms. We were informed we had to incorporate the entire 200 columns of data required by the National Reproductive Child Health Register (covering the entire continuum of care for maternal and child health). We spent the next year redesigning our entire mobile and web platform. Along this time we also had to transition our tech team from student developers to probono developers to salaried offsite contractors.
- Working as a "pilot": given that we are not universally deployed across the district, our users are still completing regular required tasks on paper, and by defacto are doing double work where our

intervention has been rolled out. Only when we have full district approval can we standardize the data collection to be limited to our platform, eliminate the paperwork, automate reporting requirements to the State, and present the full potential of our analytics that takes advantage of the entire data set in real-time.

- Adjusting our mobile platform to a wide band of users - varying in age from 20-65 and also in their experience/exposure to smart phones

Outcomes

Our Midline Results already show process outcome improvements: 4 hour median time to sync data (vs. 30 days with PCTS), 82% retention of the KB Pendant (vs. 76% for the paper health card, p=0.2), 95% data consistent from field to database (vs. 71% on PCTS p<0.001), 96% data complete required fields (vs. 58% on PCTS, p<0.001), and improved proportion of maternal child health camps held with the KB system in place (up from 43% to 80% in the past 10mo).

We can do more. We hypothesize the KB system has the potential to achieve a 10 point IMR drop (40 to 30) across 24 months by predicting and preventing high risk pregnancies.

Outreach & Scalability

We have the approval of the District of Udaipur, Chief Medical and Health Officer to universally roll-out our platform across the District of cover 150,000 annual beneficiaries, as a Model District Project for Districts across India to replicate, adopt, and scale. We have built our platform according to National Health Mission guidelines, already followed by over 250,000 government ANMs servicing over 25M pregnancies and infancies annually, and to directly integrate into the State PCTS system.

Replicability

we estimate cost per beneficiary of the system and the human resources required to run to be 325 INR (5 USD, of which we would profit $0.50) to yield a net benefit to the State of 33 INR (0.50 USD), with savings from averted mortality, morbidity, and supply wastage alone. Our modeling does not factor in the net-benefits from digital inclusion or empowerment of these communities, which would suggest a higher yield. As a B2G-facing, Platform as a Service, we look to diversify our sales revenue from a sole large government customer via: integration of our core Near Field Communication technology into other scaled MCH apps (in talks with UNICEF), supporting generalized Health Cards (in talks with Udaipur District under Smart Cities Initiative), rural health tracking with CSR partners, health insights and consultancy services for Ministries of Health and rural chain hospitals.

Impact Achieved

In our current RCT, field monitors have observed several positive outcomes of the KB system in the field. For example, ANM absenteeism has decreased, even during the current monsoon season, because ANMs are held accountable for missed camps by KB monitors at regularly held block meetings. Phone call reminders to mothers prior to camp are successfully drawing unprecedented numbers of women to camps, and in one case, caused a mother to change her travel plans due to receiving a call reminder

about the camp the next day. Also, those ANMs who are actively using the KB application are more closely following the vaccination schedule through the app's 'Vaccinations Due for Today' page, thereby following the directions for each patient. ANMs are also making use of the 'Scan Mother Tag' feature, which reduces their time of data entry when registering the child while at the same time linking the mother and child record. Further, as a result of our application's supply side failure report, which is highlighted during block meetings, ANMs have received the equipment they require to carry out their duties. Finally, mothers are in fact starting to identify the pendant as their health card, which is an association that is critical for the success of the transition from a paper to a digital record. The pendant has become a desired object within the communities, thereby strengthening the aim for the necklace to become a widely-recognized symbol for good health.

In the one year since our launch:

- 14000+ beneficiaries across 300 villages have been registered
- 70,000+ voice call reminders and educational messages in the local Mewari dialect have been received by beneficiary families

Capacity Building

150+ health workers and officials have been trained on how to use the KB app and dashboard

Partners of the Project

We are supported by world-class partners, including: IDEMIA, the organization with the biometrics and hardware behind AADHAAR - India's completed campaign for 1 billion digital, biometric identities;

GAVI; the Vaccine Alliance: has selected Khushi Baby as one of the Pacesetter through GAVI Infuse programme. Funding KB's scale up strategy to make Udaipur a model district. Helping to link KB to CSR initiatives in India.

Johnson and Johnson: KB is the Grand winner of GenH Challenge, helping to overcome technology and management challenges

UNICEF Innovation: Helping with funding, initial incubation, and strategizing outreach in African and other LMICs

Awards/Endorsements

Awards to date:

- Johnson and Johnson GenH Grand Winner 2018
- Global South e-Health Observatory Awards 2017 (presented by the Pierre Fabre Foundation)
- SPO Emerging NGO Award 2017 (presented by Union Minister of Social Justice and Empowerment, Government of India)

- Digital India Summit presented by Times Network (with Chief Guest Minister of IT, RS Prasad): Tech for Good, E-healthcare category
- NFC Innovation Prize: Best Mobile App of 2017
- Aquent Design for Good Winner
- Canada Grand Challenges Stars in Reproductive Maternal Newborn and Child Health Grant
- Nominet Trust Top 100 Social Enterprises
- Digital India Trailblazer: National Award Winner (presented by Hon RS Prasad)
- UN Day Featured Innovation, Delhi, India, 2016
- Digital India Trailblazer: Rajasthan (presented by CM Vasundhara Raje)
- International Society Innovation Fund Technical Scale-up Grant
- Cisco Grand Innovation Challenge Semi Finalist
- Eric Mood New Professional Award from the Yale School of Public Health
- GAVI INFUSE Pacesetter
- Classy Awards Finalist 2016
- Forbes 30 under 30 Health care and Forbes 30 under 30 Asia for Health care and Life Sciences
- UNICEF Wearables For Good Winner
- 3ie Rapid Impact Evaluation Grantee
- Human Nature Lab, Yale Department of Sociology Summer Research Award
- Johns Hopkins Future Health Systems Young Researcher Award
- Yale Thorne Prize for Social Innovation in Health

Private provider accredited under Yukti Yojana counselling a woman on the available contraceptive options (2)

Yukti Yojana – Public Private Partnership for Expanding Availability of Safe Abortion Services in Bihar

2011-ongoing

Ipas Development Foundation

Website	:	www.ipasdevelopmentfoundation.org
Founder of the Organization	:	Mr. Vinoj Manning
Project Budget	:	Average annual budget: ₹ 2.65 crore Government investment: ₹ 2.05 crore Donor funds to IDF: ₹ 60 lacs
Coverage/ Geographical reach	:	Bihar

Project Brief

Bihar's maternal mortality ratio (MMR) of 208 (208 deaths per 100,000 births) is considerably higher than the national figure of 167.[1] Unsafe abortions continue to be a major contributor to maternal mortality and morbidity in the state. Approximately 3,96,956 induced abortions take place in Bihar every year,[1] yet data from the Government of Bihar (GoB) shows only 704 public-sector facilities that are eligible to offer abortion services.[3] However, many of these facilities are unable to provide CAC services because of a shortage of trained certified providers.[4] Given this lack of public-sector clinics, women frequently seek services from the private sector. However, private-sector abortion services are often inaccessible or inadequate, especially to the rural poor, for many reasons including :

- Services are not available everywhere, especially in rural areas
- Over-pricing of services
- Non-compliance with the law
- Provision of inadequate and/or inappropriate treatment

As a result, the majority of abortions in Bihar take place outside government-recognized health centers, often performed by untrained providers and/or under unhygienic conditions.

Recognizing the need to increase access to safe abortion services and thereby reduce MMR, the GoB decided to leverage the private sector to make available safe abortion services in the private sector free of cost. The GoB invited IDF to provide technical assistance for this initiative.

In 2011, IDF assisted the State Health Society Bihar (SHSB), GoB to conceptualize and initiate a public-private partnership (PPP) model for safe abortion services. Yukti Yojana is a unique PPP that makes available high-quality abortion care free-of-cost to women through accredited private clinics. These clinics are reimbursed by the state government for services provided.

Yukti Yojana aims to complement safe abortion services in the public-sector of Bihar by making available high-quality abortion services to women free-of-cost through accredited private clinics.

Community Outreach

- Launch event: The launch of Yukti Yojana in April 2011 was chaired by the State Health Minister and attended by more than 100 local stakeholders, including state and district officials, private providers, and the media, demonstrating commitment among stakeholders from the beginning. For the launch, IDF worked with the GoB to develop publicity materials—including newspaper advertisements, press releases, radio jingles—for the government to use to announce the program, as well as information, education and communication (IEC) materials - including signs, leaflets, and posters – for display at the private clinics.

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[1] *RGI SRS MMR for 2011-13*

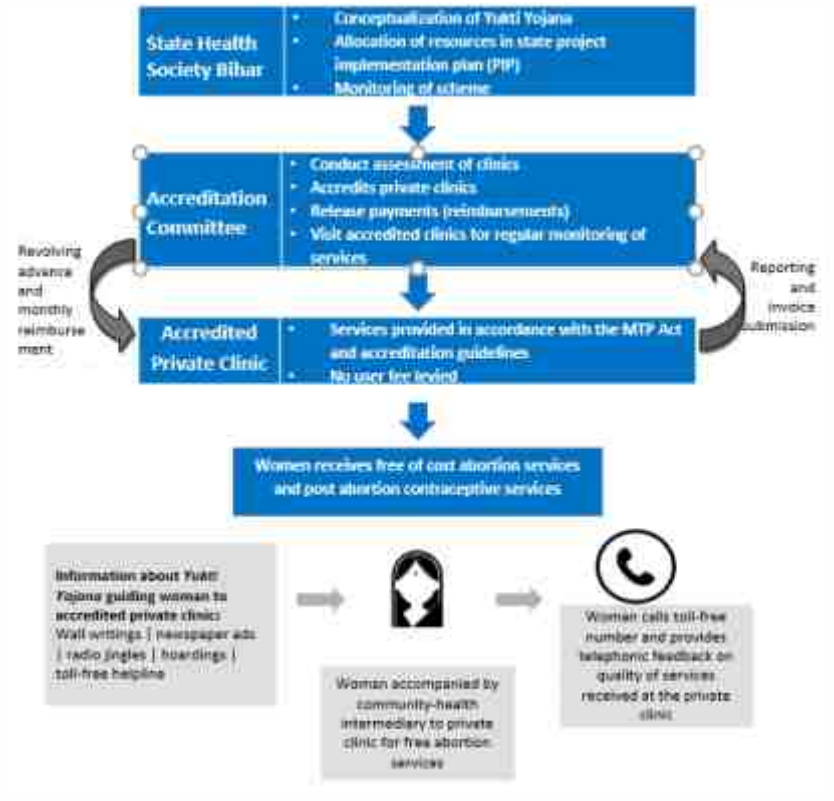
[2] *Banerjee SK. Estimating induced abortion through indirect method. 2015*

[3] *Aich P, Banerjee SK, Jha TK, Aggarwal A. Situation analysis of MTP services in Bihar. New Delhi: Ipas India; 2011.*

[4] *Banerjee et al. Expanding availability of safe abortion services through private sector accreditation: a case study of the Yukti Yojana program in Bihar, India. Reproductive Health (2015) 12:104*

- Helpline: Establishment of a toll-free helpline (1800-102-8464) to provide program related information and respond to queries from the community and providers, and to guide women in accessing services at accredited clinics.
- Initial publicity: Demonstrating their strong support for the program, the state government installed hoardings with a photograph of Nitish Kumar, Bihar's Chief Minister, endorsing the program, along with other informational outdoor advertisements. The government's IEC campaign played an important role in integrating the program with other state-run welfare programs.
- Ongoing communication and awareness-building activities: To encourage private providers to seek accreditation for their clinics and women to use the safe private-sector clinics, the state government:
  - Publicizes the program through newspaper advertisements on a periodic basis
  - Facilitates wall paintings with information about Yukti Yojana to reach the larger community and encourage more women to seek services at the clinics
  - Orients community-health intermediaries on Yukti Yojana – along with providing information about the program to women in the community, the intermediaries also accompany women to the accredited clinics to avail services and receive a transport subsidy to cover their travel cost
  - Prints leaflets with information about the program for distribution to women in the community through the community-health intermediaries

Implementation Model



Uniqueness of the Project

Billboard advertising the *Yukti Yojana* program with photograph of Chief Minister Nitish Kumar

- Ownership within the state: Providing technical assistance to GoB, IDF has been a catalyst, facilitating primary ownership by the state government, and ensuring sustainability and implementation at lower levels of the health system. IDF strengthened capacities of state officials to administer and monitor the program's progress, solidifying their continued commitment to the program.
- Local NGO partner: Our local NGO partner has facilitated our unique partnership between the state government, the district officials and private providers, who are supportive and committed to the program's success, and have helped in smoothening the reimbursement process.
- Increasing awareness: Community awareness directly influences utilization of services under the program and contributes to its success. The well-publicized launch of the program followed by development of communication materials, radio jingles, wall paintings, and newspaper advertisements led to increased awareness about the program.
- Regular monitoring and dissemination: Regular monitoring of services provided by the accredited private clinics ensures quality and helps assess the real impact of the services. Dissemination of evaluation study findings is necessary for informing all key stakeholders on program progress and is an important feedback mechanism for long-term success.
- Client feedback mechanism: To record women's perceptions on the quality of the services received at the Yukti Yojana facilities in Bihar, Interactive Voice Response System (IVRS) technology is being used. The primary purpose of this initiative is to understand the quality of services currently being given at the accredited facilities, and then use the feedback received to improve the quality further.
- IDF's efforts to publicize Yukti Yojana: in addition to IDF's continued advocacy with the GoB, we made efforts to improve visibility of Yukti Yojana at the national level (details in #19). We also facilitated visits by senior officials of the Ministry of Health & Family Welfare (MoHFW) to accredited clinics to introduce them to this innovative program.
- Cost effectiveness
  - <u>For the public health system:</u>
    - Only reimbursing the variable cost to the private clinics
    - Makes complementary services available for women reducing the burden on the public health system
    - Reduces the financial burden on the public health system by making safe abortion services available for poor, rural women who are at a greater likelihood of developing postabortion complications

- For women: Makes safe abortion services available for poor, rural women who would have otherwise sought services from untrained providers

Role of Information and Communication Technologies (ICTs)

As part of our efforts to capture women's perception/feedback of quality of abortion services provided at the accredited clinics, we worked towards developing an innovative technology-based system – the Interactive Voice Response System (IVRS). Using this IVRS technology, we developed a system to provide women the opportunity to give feedback on their experiences at private, accredited clinics by calling on a toll-free number. The primary purpose of this is to record women's perception on the quality of the services received, and then use the feedback received to improve the quality further.

This IVRS was launched on December 2015 – as per the latest available, 91% of the women who called reported being satisfied with the services under Yukti Yojana.

Challenges Faced

- Streamlining reimbursement to accredited clinics, especially in districts where the reimbursement totals accumulated to large amounts

  Some of our strategies to address this:

  - We do routine tracking of the claim amounts and share the information with the officials periodically
  - As the amounts start to accumulate, we alert concerned district officials on the status, and maintain regular follow-up to expedite the process

A woman as she receives information about Yukti Yojana through wall paintings and signages publizing the program

- Given the frequent transfer of the various officials involved in the reimbursement process, we conduct ongoing orientations of these officials on the program, the reimbursement process and on their specific role in the process.

- Limited pool of eligible private-sector providers, that is further reduced due to the state government's directives prohibiting the participation of private clinics operated by providers who also serve the public sector
  - Recognizing the shortfall in the available pool of providers, we collaborated with an external agency to conduct training of eligible and interested private providers. So far, we have conducted training of and certified 13 providers.
- Maintaining motivation levels of the private providers to ensure their long-term commitment to the program
  - We conducted regional workshops to brought together providers, support staff, and clinic owners to a series of zonal technical workshops where we felicitated selected clinics that consistently offered high-quality abortion services to women. We also used the platform to strengthen their technical skills and updated them on use of latest technologies.

Outcomes

Key outcomes:

- Yukti Yojana is currently active in 16 districts through 64 accredited clinics that regularly offer services under the program
- It has resulted in free CAC services for more than 88,000 women. Of these, 93% women received a modern contraceptive method after abortion and postabortion care
- The program captures client feedback on quality of services through an interactive voice response system where women call in to a toll-free number – as per the latest available data, 91% of the clients who called reported being satisfied with the services under Yukti Yojana
- As per the latest available data, private clinics received a total of ₹ 5.67 crore as reimbursements for expenses under Yukti Yojana

Outreach & Scalability

Some strategies for extension of the program to other districts with the state:

- Ongoing mapping of private sector clinics in districts with no accredited clinics under Yukti Yojana, and providing assistance to ensure that they meet the eligibility criteria to enrol into the program
- Training and certification private doctors as legal abortion providers to expand the pool of eligible providers in the private sector

Private provider accredited under Yukti Yojana providing information to a woman about the program

- Facilitating formation of and periodic meetings of the accreditation committees that are responsible for accreditation of private clinics as per requirements of the law

Replicability

Yukti Yojana has been firmly established into Bihar's health system and has gained national visibility. Along with comprehensive implementation guidelines to ensure standardized processes and quality of services, the program has robust systems that ensure smooth implementation and client satisfaction. Some key steps for integration of the program to other locations include:

- Needs assessment to gauge the need of the program in the new location
- Mapping of private clinics that meet the eligibility criteria for enrolment into the program
- Adapting the accreditation plan to suit the local context along with possible integration with already existing accreditation programs
- Planning and allocation of adequate financial resources for the program in the state's program implementation plan (PIP) under NHM
- Establishment and operationalization of the relevant committees to implement and monitor the program
- Forging partnership between the government across different levels – state, district and block – with the private providers

Impact Achieved

Yukti Yojana is the first-ever public-private partnership for abortion services that complements existing public-sector services and makes available high-quality abortion services free-of-cost to women in Bihar. Recognized at the national level as a good, replicable practice and innovation by the MoHFW (Please refer #19), the program makes the private sector accessible to poor women, thereby addressing a crucial gap for women in need of abortion services.

Yukti Yojana marks the successful collaboration of key public and private partners coming together for improving women's health. This partnership is a key factor in the growing success of this innovative program, as it greatly contributed to bridging a crucial gap that hindered poor women in need of abortion services to approach the private sector for services. Another key factor in the program thus far has been IDF's continued advocacy with the GoB. This advocacy has resulted in the state's annual plan including adequate funding levels for the reimbursement of services at accredited clinics.

Program outcomes clearly show that Yukti Yojana has been able to meet its primary objective of serving the poor women by making abortion services accessible and available for them in the private sector. In 2013, client exit interviews conducted to assess the profile of beneficiaries and perceived quality of abortion services under the program revealed:

- One-fourth of the beneficiaries were less than 25 years of age
- Majority of beneficiaries belonged to scheduled caste/ scheduled tribe (19%) or other backward class (65%)
- More than half of the beneficiaries reported holding a card identifying them as living below the poverty line
- Around 69% rated the quality of services as high or moderate, while more than 90% beneficiaries expressed very high or moderate levels of satisfaction.

In summary, the program serves women who are:

The study clearly demonstrated that Yukti Yojana is indeed successful in expanding CAC services, especially for poor women.

Capacity Building

Orientating key state and district officials to the initiative:

- IDF worked closely with the core team SHSB to orient key Society officials in one-on-one meetings and to improve their understanding of all aspects of the program, including implementation

POOR	53%(Women with BPL cards)
YOUNG	25%(<25years)
MARGINALIZED	84%(SC/SCT/OBC)

Woman providing feedback on services received at the Yukti Yojana accredited clinic by calling on toll-free number (the toll-free number has been cahnged now)

- We oriented civil surgeons and district magistrates of all 38 districts of Bihar on the program, especially on the reimbursement process, as they are the key functionaries facilitating release of payments to the clinics
- We orient district-level officials charged with the responsibility of managing Yukti Yojana across all districts having accredited clinics. This includes orientation of newly appointed/transferred district officials through one-to-one meetings; and other officials on an on-going basis to clarify their roles and emphasize the need for their active participation. In addition to improving the officials' understanding of the program and addressing queries around implementation for their continued focus on the program, these meetings are an opportunity to update the officials on the status of accreditations and reimbursements, and the importance of ensuring timely reimbursements for the smooth functioning of the program

Training of private-sector doctors:

To address the challenge of lack of certified abortion providers in the private sector, and thereby increase the base of private providers eligible to accredit their clinics under the program, we focused on creating training opportunities for private providers in accordance with the Medical Termination of Pregnancy (MTP) Act.

Partners of the Project

- State Health Society Bihar, Government of Bihar (SHSB): Implementing Agency Key role in:
  - Conceptualization of the program
  - Development and dissemination of comprehensive implementation guidelines
  - Budgeting of resources in state annual health plan under national health Mission
  - resource materials to publicize the program
  - Monitoring of the program
  - Accrediting clinics
  - Releasing payments
- Ipas Development Foundation: Technical Assistance
  - Technical assistance during conceptualization and roll out
  - Ongoing assistance to improve quality of service
  - Evaluation of scheme under the guidance of the Technical Advisory Group
  - Feedback to state on the status of scheme
  - Helpline to inform women about services
- Local NGO Partner- On Ground Facilitation
  - Motivate private providers for site accreditation
  - Support providers for accreditation, reimbursements & documentation
- Private Sector- Service Providers
  - Provide safe abortion services including post-abortion contraception to women as per Yukti Yojana guidelines
  - Ensure documentation in compliance with the MTP Act

Awards/Endorsements

- Yukti Yojana was showcased at the Third National Summit on Good, Replicable Practices & Innovations in Public Health Care Systems in India organised by MoHFW in August 2016
- Yukti Yojana also featured in the book 'Winds of Change: Good, Replicable, and Innovative Practices' released by the MoHFW (please see Figure 1). The book is a compendium of programs and innovations that are relevant to healthcare needs of the population, especially those who are

disadvantaged and marginalized; and those that facilitate better healthcare in terms of accessibility, affordability, quality, and equity. Importantly, these programs have been identified as having the potential for wide-scale application

- In August 2015, Yukti Yojana was featured in a compendium, titled Good Practices around the Globe (please see Figure 2, released by the Prime Minister of India, Narendra Modi, at a Call to Action summit in New Delhi, India – a global meeting aimed at ending preventable child and maternal deaths.

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