PROJECT IMPLEMENTATION REPORT
Community Based Healthcare Initiative in Uttar Pradesh

Rajiv Gandhi Mahila Vikas Pariyojana (RGMVP) in collaboration with the United Nations International Children’s Emergency Fund (UNICEF)
January 2011- December 2012
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Acknowledgments

The Rajiv Gandhi Mahila Vikas Pariyojana (RGMVP) and the United Nations International Children’s Emergency Fund (UNICEF) would like to thank everyone involved in this project for their constant support and hard work.

The project team would like is grateful to Ms. Adele Khudr the Chief of UNICEF’s field office in Uttar Pradesh for her invaluable support. Also Ms. Rajeshwari ChandraShekhar, Ms. Richa Singh Pandey, Ms. Rachna Sharma, Ms. Gayatri Singh, Dr. Gaurav Arya, Dr. Sanjay Pandey, Ms. Geetali Trivedi and Dr. Alok Ranjan’s guidance is much appreciated.

A special mention needs to be given to Mr. P. Sampath Kumar, CEO, RGMVP, his leadership has been vital to the successful completion of this project. Mr. K S Yadav, Mr. Arvind Kumar Singh, Mr. Anoop Pant, Dr. M. Arshad Saddique, Mr. Sushil Parihar and the entire programme team needs special recognition for the smooth implementation of this project.

This project would not have been possible without the undying efforts of RGMVP’s field staff. RGMVP’s Internal Social Capital, Community Health Trainers, Block Training Coordinators and Master Trainers have worked round the clock to operationalise this programme and their contributions are highly valued.

Lastly and most importantly we would like to thank the women from RGMVP’s SHGs and the community at large, who made the completion of this project possible.
### Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAA</td>
<td>ASHA, ANM, AWW</td>
</tr>
<tr>
<td>ADG</td>
<td>Adolescent Girls</td>
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<tr>
<td>ANC</td>
<td>Ante Natal Check-up</td>
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<tr>
<td>ANM</td>
<td>Auxiliary Nurse and Midwife</td>
</tr>
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<td>ASHA</td>
<td>Accredited Social Health Activist</td>
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<tr>
<td>AWC</td>
<td>Anganwadi Centre</td>
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<tr>
<td>AWW</td>
<td>Anganwadi Worker</td>
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<tr>
<td>BCG</td>
<td>Bacillus Calmette–Guérin</td>
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<tr>
<td>BO</td>
<td>Block Organisation</td>
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<tr>
<td>BP</td>
<td>Blood Pressure</td>
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<tr>
<td>BPP</td>
<td>Birth Preparedness Plan</td>
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<td>BTC</td>
<td>Block Training Coordinator</td>
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<tr>
<td>CDPO</td>
<td>Child Development Project Officer</td>
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<tr>
<td>CHC</td>
<td>Community Health Centre</td>
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<tr>
<td>CHT</td>
<td>Community Health Trainer</td>
</tr>
<tr>
<td>CRP</td>
<td>Community Resource Person</td>
</tr>
<tr>
<td>EDD</td>
<td>Expected Date of Delivery</td>
</tr>
<tr>
<td>FFL</td>
<td>Fact For Life</td>
</tr>
<tr>
<td>FLW</td>
<td>Front Line Worker</td>
</tr>
<tr>
<td>GP</td>
<td>Gram Panchayat</td>
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<tr>
<td>ICDS</td>
<td>Integrated Child Development Services</td>
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<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>ISC</td>
<td>Internal Social Capital</td>
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<tr>
<td>MCP</td>
<td>Maternal and Child Protection</td>
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<tr>
<td>MIS</td>
<td>Management Information System</td>
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<tr>
<td>MMR</td>
<td>Maternal Mortality Rate</td>
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<tr>
<td>MOIC</td>
<td>Medical Officer In Charge</td>
</tr>
<tr>
<td>MT</td>
<td>Master Trainer</td>
</tr>
<tr>
<td>NFHS</td>
<td>National Family Health Survey</td>
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<tr>
<td>OPV</td>
<td>Oral Polio Vaccine</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Centre</td>
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</table>
PIC: Programme In-charge from Community
PMO: Programme Management Office
PRI: Panchiyati Raj Institutions
RCH: Reproductive and Child Health
RGCT: Rajiv Gandhi Charitable Trust
RGMVP: Rajiv Gandhi Mahila Vikas Pariyojana
RI: Routine Immunisation
SHG: Self Help Group
SHGSS: Self Help Group Swasthya Sakhi
SS: Swasthya Sakhi
TC: Training Coordinator
TOT: Training of Trainers
TT: Tetanus Toxoid
UP: Uttar Pradesh
VHND: Village Health Nutrition Day
VO: Village Organisation
VOSS: Village Organisation Swasthya Sakhi
EXECUTIVE SUMMARY

Rajiv Gandhi Mahila Vikas Pariyojana (RGMVP), the flagship poverty reduction programme of the Rajiv Gandhi Charitable Trust (RGCT), has entered into a Programme Cooperation Agreement with The United Nations International Children’s Emergency Fund (UNICEF) to strengthen its community level efforts in improving the health, nutrition and development outcomes of children and women in 50 blocks of Uttar Pradesh. This partnership was guided by the core principles and strategies that inform RGMVP and UNICEF.

RGMVP in an attempt to reduce poverty is committed towards building and strengthening community institutions of the poor, through women’s Self-Help Groups and their Federations. RGMVP upholds a three tier institutional model; at RGMVP these institutions are regarded as enabling channels for strong social mobilization through which social and developmental programs can be executed effectively. As unifying platforms for the poor, these institutions play a vital role in securing rights and entitlements, changing behaviours and social norms and making better use of available structures and resources. Therefore, using these organisational mechanisms RGMVP has partnered with UNICEF to work on a community based healthcare initiative by leveraging the SHG platforms.

The overall objective of the project was to improve maternal and child survival and nutritional outcomes for children below five years in 50 blocks (spread across 13 underdeveloped districts of Uttar Pradesh). This objective was met through empowering communities in 1250 Gram Panchayats (GPs) and approximately 250,000+ families to initiate actions for improved care of children and women, along with measures to foster gender equality through the 3-tier institutional model of RGMVP. The joint project of UNICEF-RGMVP was undertaken between January 2011 and December 2012.

The partnership project was expected to deliver the following strategic results:

1) Improved knowledge and skills of community-based institutions (Block Organizations, Village Organizations, Self Help Groups, Adolescent Girls Groups and Farmers groups) related survival, growth and development for children and women.
2) Access to and utilization of public health, nutrition and sanitation services by all families in the programme areas.
3) Improved quality and enhanced responsiveness of health, nutrition, and sanitation systems.
4) Community monitoring and action systems instituted at all levels i.e. SHGs, Village Organisations (at gram panchayat level), and Block Organisations (at block level).

Some of the dominant results of this programme include a significant reduction in maternal mortality and child mortality, increased gender and social inclusion, increased contribution of community institutions like Block Organisations, Village Organisations and Swasthya Sakhis and finally, increase in collective ownership of the community and government systems.

The findings, conclusions, and recommendations are based on three primary methods: i) qualitative and quantitative evaluation of field activities undertaken, ii) desk review of existing process documents and iii) 10 thematic case studies.

The implementation of this project started in January 2011. The first phase of implementation included the training of community level trainers. These trainers were given extensive residential
trainings that gave them a comprehensive insight into practices that would save the lives of mothers and infants. These community level health trainers mainly drawn from SHG women, trained Swasthya Sakhis at the SHG level in every (project) village, to build their capacities in understanding issues of nutrition and mortality that would eventually help the women within villages to grasp these concepts in a holistic manner. All trainings conducted were in accordance with the aim of this project and aligned to fully utilise existing government services that were not reaching intended beneficiaries.

Women trained in the first phase of the project took responsibility to take health and nutritional messages to the community. Trainings were held at both the VO level as well as the SGH level.

The trainings conducted were a vital step towards achieving the goals set out at the beginning of the project. By constantly reinforcing the importance of small but significant practices like, pregnancy and birth registration, institutional deliveries, proper nutrition, and early and exclusive breast feeding, a visible change has been seen in the health of mothers and babies. Interventions need to be participatory and take into account the socio-cultural practices of a community in order to make a lasting impact. Traditions are not easy to break, nor are thought processes easy to change, however the team does see that sensitive support and training have started to change the way women look at traditional health practices.

Together with the regular trainings, and over and above the objectives of this project, RGMVP and UNICEF collaborated to operationalise four pilot interventions in four blocks of UP. These interventions looked at innovative ways to make government services more accountable and disseminate information through an approach that would make it more accessible to the community. The four pilot interventions implemented were Nutrition Surveillance, Birth Preparedness Plan (BPP), Community Monitoring System and Fact for Life (FFL) videos to disseminate health and nutrition messages. Each intervention focused on a different aspect of health and nutrition.

For Nutrition Surveillance all primary health centers were given growth-monitoring charts, which were colour coded and correlated to the child’s age, height and weight. This allowed parents to ascertain whether their baby was malnourished or not.

The BPP initiative ensured that pregnant women regularly went for their ANC check-ups and had got their immunisation shots.

The Community Monitoring System engaged the community in taking responsibility for monitoring the health services in their village. This system comprised of a two way process whereby first Government functionaries were sent an advocacy letter intended to remind them of their responsibilities regarding health services. Together with this the members of the community were given a checklist through which they could ascertain which services were functioning properly and where there was need to demand improvement.

Finally Fact for Life was an interactive knowledge dissemination tool. People from the community arranged for projectors and TVs and the fact for life videos were shown to all in the village. The most important aspect about FFL was that it included men in its purview. Through targeting a larger audience, FFL was able to bring forth issues of women and gender.

All the pilots were successful in engaging the community and having them take ownership of the interventions. Not only is the community taking these forward with enthusiasm but they have
also proved that government systems can be held accountable through community interventions.

Overall the project has had a significant impact on how communities in rural Uttar Pradesh view maternal and infant health and nutrition practices. What makes this project scalable, is the fact, that quality of interventions and information delivered through systematic platforms created under RGMVP, is not diluted by the time it saturates a village. Within SHGs today, one can see a 100% pregnancy and birth registration in the 50 blocks where the UNICEF project was active. This gives evidence for the fact that when processes are logically explained there is a high probability of them being accepted and practiced within rural communities.

A number of challenges came in the way of the project’s implementation. Convincing Government functionaries about the need to strengthen their service delivery mechanisms; equipping primary health facilities with adequate equipment to carry out their duties and engaging with entrenched traditional belief systems were challenges that only strengthened the project team’s resolve to implement this project successfully. The barriers faced during implementation will be taken in to account, to inform programme processes in the future and would help improve strategies adopted.

There is a need to acknowledge the necessity for stepping up the efforts in changing health and nutritional behaviours within communities. 50 blocks in Uttar Pradesh, cover only a little over 6% of the population of the state. The impact and change that has come through the implementation of this project is significant. However it is important to remember that there is a need to scale up and bring similar interventions to the state of UP as a whole.
CHAPTER 1. THE PROJECT’S BACKGROUND and STRATEGIC CONTEXT

1.1 CRITICAL INDICATORS

The state of Uttar Pradesh performs poorly on critical indicators of health, nutrition, education and women’s empowerment. The following are some of the broad reasons that led to the initiation of this project:

- While the average Maternal Mortality Rate in India is at 301, in Uttar Pradesh it is 45% higher at 440 per lakh live births.
- In UP, a woman dies every 5 minutes due to pregnancy or childbirth complications.
- The average Infant Mortality Rate in India is at 53, whereas in Uttar Pradesh it is 67 per thousand live births (SRS, 2009).
- Estimated one-third babies born in Uttar Pradesh are low birth weight babies.
- In Uttar Pradesh, the prevalence of anaemia is 51.6% in pregnant women (15-49), 50.8% in all married women (15-49), and in it is 48% in adolescent girls (15-19).
- Every second girl in Uttar Pradesh is anaemic.
- Three out of four children below the age of five years are anaemic.
- As per National Family Health Survey III (2005-06), 42.4% children below five years in Uttar Pradesh are underweight (thin for their age), 56.8% are stunted (short for their height) and 14.8% are wasted (thin for their height).

Additionally, in Uttar Pradesh the government infrastructure is not equipped and inadequate to provide quality services to the population. Preventive measures and correct health and nutritional behaviours, such as breastfeeding, complementary feeding, hygiene, sanitation, and timely visit to hospitals are not routinely observed.

Historically, the social order in UP has been deeply hierarchical. Caste and gender based exclusions are all pervasive. The poorest of the poor are landless, depending on wage labor for survival. The region witnesses large scale out-migration by males especially during non-agricultural seasons. Inaccessibility of formal financial institutions leads to the creation of an informal system of credit from local moneylenders, where the interest rates are as high as 10% per month. Several poor families are forced to mortgage their lands and homes or provide wageless labor, often for generations, in order to repay this debt.

Apart from poor health and education indicators, the mobility and decision making powers of women are also severely restricted. Those belonging to poorer families, work in their own or others’ agricultural farms in addition to running the household. Their contribution to economic activities mostly goes uncounted and unacknowledged. They continue to be subjected to discriminatory practices such as those of dowry\(^1\) and pardah\(^2\). Superstitious practices such as the “sauri pratha”\(^3\) pose a threat to their health and well-being.

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\(^1\) Dowry - Property or money brought by a bride to her husband on their marriage.

\(^2\) Pardah – Veil.

\(^3\) Sauri Pratha - The practice of not allowing women to take a bath or be exposed to sunlight for ten to fifteen days after delivering a child.
These alarming facts all indicate towards a dire need for an effective intervention plan. Therefore, a collective multi-faceted, cross-cutting approach, focusing on issues of health, nutrition, education, early childhood care, social empowerment and livelihood needs to be put in place. In the context of Uttar Pradesh, there is an urgent need for generating demand from the community, which will subsequently lead to an increase in accountability of service delivery both governmental and non-governmental. For any development programme to be successful it cannot simply aim to reduce income poverty but will also have to challenge the very root of existing rigidly hierarchical social system and unleash the potential of the poor.

1.2 ROLE OF RGMVP

Rajiv Gandhi Mahila Vikas Pariyojana as an initiative is dedicated solely to the mission of women’s empowerment and poverty reduction in UP. The programme has identified financial inclusion, health and education focused initiatives as critical components in designing any overarching women’s empowerment and poverty reduction strategy. The systemic relationships between health, education and poverty have been recognized by the Millenium Development Goals that emphasize the need for developing human capital as the first step towards holistic development.

With this fundamental belief, RGMVP initiated interventions on health focusing on reducing maternal and infant mortality through the institutions of Self Help Groups (SHGs) and its federations and Village Organisation (VOs). Other stakeholders included in the process are government health and Integrated Child Development Services (ICDS) frontline workers and Panchayati Raj Institutions (PRIs). RGMVP has developed an intensive strategy to address the Reproductive and Child Health (RCH) issues in its programme areas in UP. This strategy has been designed to complement government programmes through institutional coordination and collaboration; and the experiences show that RCH issues are an overriding concern across all the age groups. Besides improving the service delivery in the health sector, RGVMP’s health programme strives to increase women’s knowledge around health and child care issues so that they themselves can become active agents.

1.3 RGMVP’S COMMUNITY BASED HEALTH CARE INITIATIVE

Community Based Healthcare Initiative or the Swasthya Sakhi Programme is designed to address the issues of high MMR and IMR in program villages. Swasthya Sakhi is a SHG federation member who has got special training as a health volunteer. The Swasthya Sakhi programme is implemented through steps that include identification of volunteers by the community to assume the role of Community Health Activists (Swasthya Sakhi), training of the activists, regular meetings on health issues, awareness generation, facilitating community participation in regular ante-natal check-ups and enabling access to healthcare. Swasthya Sakhis have certain specific duties at the SHG level these are:

- Maintenance of information base on a regular basis of target groups (Pregnant Women, Lactating Mother, Children under 5, Adolescent Girls Group) for their SHG members and their families and ensuring their entitlements
- Facilitating health specific agenda points during SHG meetings
- Reporting to VO Swasthya Sakhis during VO meetings
In the 1250 GPs of the UNICEF project 20,000 SHG SSs have been trained on best practices of mother and child care, safe deliveries, nutrition and adolescent health. Under the initiative, groups discussed health issues as one of the important agendas of their SHG weekly meetings.

The VO have been playing an effective role in advancing immunisation, ante-natal checkups and accessing various services from healthcare institutions. These women’s groups have emerged as a platform through which government health professionals such as ANMs, ASHAs and AWWs have been able to reach the target group effectively. A separate carder of VOSS disseminate health and nutrition messages at this level, their responsibilities include:

- Maintenance of information base on a regular basis of target groups (Pregnant Women, Lactating Mother, Children under 5, Adolescent Girls Group) for all SHG members and their families connected to VO and ensuring their entitlements
- Joint home Visits with ASHA / ANM to Pregnant women.
- Facilitating health specific agenda points during village level meetings
- Reporting to the BO on month

Through this project partnership, UNICEF and RGMVP leveraged the existing network to reduce maternal and new born morbidity and mortality. The mechanism of doing so was by increasing the community’s knowledge, participation/demand and utilization of services via institutional model of SHGs and their federation at village and Block level i.e. Village Organization (VOs) and Block Organizations (BO) respectively in 50 blocks across 12 underdeveloped districts of Uttar Pradesh.
CHAPTER 2. PROJECT IMPLEMENTATION METHODOLOGY

2.1 PROJECT STRATEGIES

RGMVP and UNICEF’s collaborative project aimed to train women on safe health practices and empower them to take charge of their physical well-being. The trainings were also meant to serve a dual purpose of empowering women by providing knowledge about various aspects of the service delivery systems and hence being able to hold them accountable. The medium through which health and nutritional information would travel to the community was RGMVP’s Swasthya Sakhis. The project implementation strategy was to train women in an effective manner so they can in turn train the community and disseminate information and knowledge at the grass roots level.

RGMVP in collaboration with UNICEF formulated a list of trainings that would be essential in disseminating knowledge about health and nutrition practices and sanitation within the project area. The implementation methodology is chronologically listed below.

1) Three day induction trainings for Swasthya Sakhis conducted at Village Organisation Level. External Experts, Training Coordinators (TC), Block Training Coordinators (BTC) and Community Health Trainers (CHT) conducted this training. Apart from the External Experts, all other trainers are a part of the RGMVP Programme Management Office and Community Federations. These trainings were conducted between March 2011 and May 2012.

2) Extensive two-day trainings for Self-Help Groups and Swasthya Sakhis followed the first step. Training Coordinators (TC), Block Training Coordinators (BTC), Community Health Trainers (CHT), Master Trainer (MT) and Internal Social Capital (ISC) were responsible for conducting this training. These trainings were conducted between March 2011 and December 2012.

3) A set of two-day trainings was conducted exclusively for adolescent girls from ages 10-19 years. Training Coordinators (TC), Block Training Coordinators (BTC), Community Health Trainers (CHT), Master Trainer (MT) and Internal Social Capital (ISC) were responsible for conducting this training. Trainings were conducted from September 2011 through December 2012.

4) Special one-day sensitisation trainings of government functionaries such as Panchayati Raj Institutions (PRI), Auxiliary Nursing Midwives (ANM), Accredited Social Health Workers (ASHA), Ananwadi Workers (AWW) and VO members were conducted. Training Coordinators (TC), Block Training Coordinators (BTC), Community Health Trainers (CHT), Master Trainers (MT) and Internal Social Capital (ISC) were responsible for conducting these trainings. These were held from June 2011 through December 2012.

5) The basic trainings were then followed by refresher trainings. Refresher trainings essentially gave the trainees a brief synopsis of the extensive trainings they had gone through to ‘refresh’ and reiterate the learning the women had received. Refresher trainings covered the most important points of the training and clarified any doubts the trainees might have. These refresher trainings were extremely useful for trainees to share their experiences in the field and discuss obstacles they faced as well strategies they formulated to overcome hurdles of perception from the communities side. The refresher trainings held are as follows:
I. One-day refresher for VOSS’s held between June 2011 and December 2012. Conducted by BTC’s, CHT’s, MT’s and ISC’s.

II. Half-day refresher for SHG SS’s held between August 2011 and December 2012. Conducted by BTC’s, CHT’s, MT’s and ISC’s.

III. One-day refresher for adolescent girls held between April 2012 and December 2012. Conducted by BTC’s, CHT’s, MT’s and ISC’s.

6) Finally an Adolescent Girls Campaign was held for girls between the age of 10 and 19. Young girls who had learnt about reproductive health, fallacies of early pregnancy, issues of child marriage and gender discrimination felt the need to spread awareness and sensitize the communities they lived in. With this intent, these girls took out awareness rallies in their villages. Therefore the last activity held was an Adolescent Girls Campaign held between March 2012 and December 2012, with the support of the BTC’s, CHT’s, MT’s and ISC’s.
<table>
<thead>
<tr>
<th>S. N</th>
<th>Name of training</th>
<th>Trainee</th>
<th>Training Duration</th>
<th>Trainer</th>
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<tr>
<td>1</td>
<td>3 Days Induction training of VOSS</td>
<td>VOSS</td>
<td>May 2011 to May 2012</td>
<td>External experts, TC, BTC and CHT</td>
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<td>2</td>
<td>2 days training of SHG SS</td>
<td>SHG SS</td>
<td>May 2011 to December 2012</td>
<td>BTC, CHT, MT and ISC</td>
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<td>3</td>
<td>2 Days training of ADG</td>
<td>Adolescent Girls 10 to 19 Year</td>
<td>September 2011 to December 2012</td>
<td>BTC, CHT, MT and ISC</td>
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<td>4</td>
<td>One Day Sensitization Government functionaries</td>
<td>PRI, ANM, ASHA, AWW and VO Member</td>
<td>June 2011 to December 2012</td>
<td>BTC, CHT, MT and ISC</td>
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<tr>
<td>5</td>
<td>One Day Refresher VOSS</td>
<td>VOSS</td>
<td>June 2011 to December 2012</td>
<td>BTC, CHT, MT and ISC</td>
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<td>6</td>
<td>Half Day SHG SS</td>
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<td>One Day Refresher ADG</td>
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<td>April 2012 to December 2012</td>
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<td>8</td>
<td>ADG Campaign</td>
<td>Adolescent Girls 10 to 19 Year</td>
<td>March 2012 to December 2012</td>
<td>BTC, CHT, MT and ISC</td>
</tr>
</tbody>
</table>

Figure 1: Trainings Conducted

### 2.2 CAPACITY BUILDING

**Training of Trainers**

RGMVP undertook a rigorous process to recruit Block level Training Coordinators (BTC) and Community Health Trainers (CHT). The BTCs and CHTs were the first level of trainers and their responsibilities included:

**Block Training Coordinator**

- Organize Training at block level for Village Organization Swasthya Sakhis
- Field Visit and Support to Community Health Trainer, Village Organization Swasthya Sakhis to organize trainings at village level.
- Liaising and coordination at the block level to form a convergence forum
- Facilitating and organising block level meetings and field visits
- Logistical arrangements for the trainings
- Facilitate the development of BO as a community monitoring system

**Community Health Trainer**

- Organize Training at village level for SHG Swasthya Sakhis
- Responsible for initiating community Actions
- Formation of AGG groups

Additionally, an overall orientation was held for all the BTC’s, CHT’s and staff at the RGMVP Programme Management Office (PMO).

BTC’s and CHT’s were trained in three batches from April 2011 to June 2011. These trainings were extensive in their content and aimed to teach human resources that were being deployed in the field how to effectively communicate and train. A second round of these trainings which are referred to as “Training of the trainers” were held in November 2011 in order to fill any gaps left by CHTs and BTCs who dropped out of the programme.

**Induction Trainings**

Training took place using an extremely decentralised format. This made it essential to have induction trainings for leaders and programme staff at the block, village and SHG level. Once trainings commenced, BO leaders were asked to identify active VO members who would give their consent to becoming Community Health Volunteers. In this manner each GP had a Village Organisation Swasthya Sakhi (VOSS), who was given extensive trainings by the CHT to further disseminate knowledge at the SHG level.

A total of 2136 VOSS’s were identified and trained, throughout the project area. The VOSS’s in turn identified and provided induction trainings to volunteers at the SHG level. A total of 45596 SHG Swasthya Sakhis (SHGSS) were trained. Each SHGSS dealt exclusively with the members of her community and worked with them to adopt safer health and nutrition practices. The SHGSS was also instrumental in bridging the gap between existing health service providers like the ASHA, ANM and the Anganwadi Worker and the women of the community. Following this structure knowledge and information was dispersed down to the last person, through the 50 blocks in which the project was implemented.

**Sensitization Training**

While training on subject matter is extremely important for communities to be more accepting of new information, it is particularly important to sensitize them about the issues being discussed. Considering the fact that the information being disseminated through the programme would be radically different from what the community was used to, various techniques were adopted to sensitize community members. The core rationale for this approach was the belief that constant reiteration of the benefits of adopting safe health and nutrition practices, sharing real life experiences, along with constant counselling and support from health workers would go a long way in making communities more receptive to new ideas.

Weekly SHG meetings and monthly VO meetings were organised to exclusively discuss maternal health and nutritional issues. The SHGSS and VOSS made it a point to visit pregnant women and women with young children in their collectives to emphasise on the necessary steps that should be taken in the near future. Through having regular contact with women SS’s were able to facilitate a link between government FLW’s (ASHA, ANM & AWW) and women from the community.
Sensitisation was needed, not only at the community level but also for BO office bearers. BO office bearers went through a two-day sensitisation programme. The training enabled the BO leaders to plan and implement project activities effectively in their respective blocks.

Sensitisation programmes were also held with Government functionaries, by keeping them in the loop of interventions (especially pilot interventions), these were discussed with them before being rolled out. From a service delivery point of view, it was important to sensitise the government officials for their support.

Adolescent Girls Trainings

The health and nutrition needs of adolescent girls are very different from the needs of grown women. Recognizing this difference, the programme formulated specific trainings for girls between the age of 10 and 19. These trainings focused on menstrual health, issues of gender discrimination, puberty and adolescent health.

The adolescent girls groups were informal in nature; nevertheless they gave the girls a platform to discuss problems that faced them for example girls could freely discuss menstrual health issues, which is a subject of ‘shame’ within the house. Through these trainings the girls became aware of various benefits that they were entitled to receive from the government (eg: free iron pills, immunisations and take home ration) and took steps to access them.

![Figure 2: Number of Adolescent Girls trainings held up to December 2012](image)

2.3 HUMAN RESOURCE ENGAGED

A large number of human resources have been mobilised throughout the project period to aid and foster health and nutrition initiatives. To date 20,000 SHGSSs, 2036 VOSSs, 288 ISCs,
CHTs and BTCs, have been trained. Additionally 25,569 women have been directly trained by CHTs and BTCs. The women trained are actively involved in disseminating information about health services in their communities and beyond.

Human resources engaged from RGMVP’s side collaborated closely with all government facilities. All medical officials from the government’s side including Front Line Workers (FLW) were informed and integrated within the programme. This was done through bringing the community and the government together in the same space that officials could understand the problems being faced by the community.

2.4 MONITORING AND EVALUATION OF PROJECT ACTIVITIES

Monitoring of the programme was observed and captured through RGMVP’s Monitoring Information System (MIS), sections of which were specifically designed for the project. Through the project specific MIS, monthly progress of the project was monitored. Monthly reviews were held at the block level. Quarterly reviews were held at the Programme Management level. RGMVP now envisages adding important clauses for the project specific health and nutrition initiative MIS to the organisation’s MIS. Data collected at the community level was validated at the block office and was further analysed at the programme level.

Brief monthly reports of the project’s progress and evaluation were routinely sent to UNICEF. These reports were based on data collected by the community and then analysed at the
programme level at RGMVP. Quarterly financial reports were also prepared and submitted to UNICEF.

An important aspect of the monitoring system was joint field visits to programme areas by health staff, UNICEF and RGMVP functionaries. This allowed RGMVP to closely observe and keep track of situations at the community level.

It is foreseen that an independent external evaluation will be conducted to determine the value added by the project to health service delivery systems. The findings of this evaluation will be further analysed in a proposed workshop jointly organized by UNICEF and RGMVP.

2.5 PILOT INTERVENTION

RGMVP collaborated with UNICEF to devise four intensive interventions specifically addressing health and nutrition behaviours and service delivery. These interventions were implemented as pilot projects in three blocks, Gauriganj, Chhattao and Amawan in Uttar Pradesh. The projects were monitored and their progress charted. Monthly progress reports were shared with UNICEF. The four Pilot Interventions were Nutrition Surveillance, Community Monitoring System, Expected Date of Delivery and Fact for Life.

**Strategies and activities conducted**

The pilot interventions were strategies in themselves to introduce a more accountable system of service delivery.

In the Nutrition Surveillance programme the team monitored the height and weight of a child according to age. A growth chart was prepared, using which a parent could determine if their child was malnourished. Implementing Nutrition Surveillance was not easy, as health centres did not have weight monitoring machines. Community members got together and demanded that their local health centres be equipped with weighing machines. Once the Anganwadi Centres acquired weighing machines, Nutrition Surveillance was rolled out and has been instrumental in bringing down the cases of malnutrition in Gauriganj, the pilot block.

Community monitoring had three components; first, an advocacy letter was sent out by VO members to local Government health functionaries informing them of the various services the Government should be providing. Second, a “Red Alert” checklist was formed using which the community could ascertain which services were not reaching their village and in turn take up the issue with the concerned officials. Lastly, adequate service charts were devised aiding the women to determine whether the services they were receiving were being delivered in a timely and efficient manner.

The Expected Date of Delivery innovation aimed to track pregnancies and deliveries. The pilot was rolled out in Amawan with the collaboration of Government functionaries and various VOs. Through this pilot RGMVP was able to track the number of women who had institutional deliveries, and maintain a record of their immunisations and check-ups. It therefore became simpler to determine if there was an increase in adopting safe health and nutrition practices.

Fact for Life was an extremely informative and interactive innovation, involving a series of films shown to women at the SHG level. Through these films women learned about various safe health
practices. This visual medium made it easier for women to retain the information they were receiving. Because these films were screened in community areas of the village, the participants were not limited to women; the village as a whole took part and engaged in the learning experience.

These new community centric innovations displayed a potential to go a long way in bridging the gaps between health services, service providers and people at the community level.

The implementation of health centric projects in Uttar Pradesh demonstrates the receptiveness of communities to new and alternative ways of approaching health and nutritional issues. These innovations have shown the potential to challenge the traditional ways of thinking by using participatory trainings. Coupled with effective use of technology, it is possible to logically explain the benefits of alternative practices and bring in a sustainable behavioural change.
CHAPTER 3. PROJECT OUTCOMES

3.1 PROJECT OUTCOMES

From the outset it was the goal of the programme to empower communities and families to initiate actions for improved care for children and women contributing to a reduction in the levels of maternal and child mortality. This primary goal would coincide with an improvement in the levels of nutrition and would also help in fostering gender equality.

The data collected was based on eleven outcome targets, which included:

I. One-third reduction in maternal and under five mortality as compared to baseline of 2010.

II. One-third reduction in maternal and child under-nutrition as compared to baseline of 2010.

III. All interventions meet the gender and social inclusion criteria.

IV. 75% of the community institutions of BOs, VOs, SHGs and Swasthya Sakhis working effectively (as per pre-defined criteria).

V. 80% registration of pregnancies with quality ANC in the intervention villages.

VI. 75% of deliveries assisted by skilled personnel or at institutions (including SBAs)

VII. 80% registration of child birth with birth certificates

VIII. 80% of children complete RI by one year

IX. 80% children receive optimal infant and young child feeding

X. 80% of children below 3 years weighed and counseled

XI. 80% of children below 5 years receive required doses of Vitamin A and iron

It was envisaged that through the strategies we adopted meeting these targets would be an achievable goal. However even with the best intentions, and a process that validated that reaching our targets was possible there were certain challenges that the implementation team faced. These challenges will be discussed below.

Challenges Faced During Implementation

During the two year implementation of this project the team has faced numerous difficulties, which have proved to be significant barriers in reaching desired results. The first, and most significant hurdle was the delayed collection of base line data. Data collection started 12 months after the project commenced. Therefore, all data comparisons done with the base line data cannot be considered ‘actual’ in showing the true picture.
Second, during implementation, some issues and variables came up that the team could not control. For example while a mother who is trained believes in and wants to follow the practice of exclusive breast feeding, in the Indian setting a child is often left with relatives (grandparents, aunts and uncles) who have not been trained and do not understand the importance of exclusive breast feeding. They may, out of concern for a crying child, give her/him water or cow’s milk. It would be useful therefore as a strategy for the future to have a general training for community members and not just pregnant and lactating mothers.

Third, implementation faced various roadblocks due to Government service providers such as the ANM, ASHA and AWW. For example the Vitamin A syrup and Iron tablets were not available at government health centres and therefore the lack of availability affected the desired outcome of an increase in the intake of these supplements.

Fourth, the lack of required equipment at health centres also proved to be a hurdle. For example health centres (AWC, PHC and CHC’s) did not have weighing machines, therefore blocks had to advocate for the installation of weighing machines for the intervention to begin. Once the machines arrived FLW’s had to be trained in their use. A significant amount of time was lost in this process. It is also important to note in this context that only those blocks that advocated for facilities acquired them; therefore the non-availability of machinery is a major challenge in fulfilling certain objectives.

Fifth, organisationally the team faced a shortage of human resources. The number of dedicated personnel that were given to the pilot intervention blocks was not available for all 50 blocks where the project was implemented.

Lastly, the End Line Survey is yet to be conducted. Therefore the team ‘statistically’ cannot ascertain the final outcomes of this project. Any final analysis of this project is therefore incomplete.

It is important to bear in mind these challenges while going over the achieved results of this project. It will also be prudent to consider that while for the purpose of simplicity monitoring and evaluation formats reduce effectiveness and impact to numbers, these numbers however represent human beings and to statistically verify the positive changes in their quality of life through the course of this project is extremely difficult.

**Analysis of Data**

**Process**

A project specific MIS was designed for RGMVP’s collaboration with UNICEF. This MIS was operationalised in all UNICEF project blocks. This data format was divided into two parts; one that was to be filled by pregnant women and the other that would hold information about children aged between 0 and 5 years. The MIS had specific indicators that helped RGMVP observe and monitor the significant changes in maternal and infant health and nutrition as the project progressed.

The following section on data analysis will concentrate exclusively on the eleven outcome targets that were laid out in the project proposal. This analysis will also be primarily qualitative in nature, as the collection of quantitative data was not completed due to various reasons.
discussed in the challenges section. For a comprehensive analysis on all data collected please refer to the presentation attached with this report (Insert Appendix).

Before going into an in-depth analysis of the data it is important to note a few points.

1) All data collected is based on women within SHG’s. Women who are not part of RGMVP’s institutional model are not included in these data sets.

2) While analysing data specific to children it was realized that only 1264 children have crossed the age of five. Therefore assessing the change in nutrition and health and nutrition of all children registered at birth was not possible.

**Results and Analysis**

Assessing reduction in maternal and infant mortality according to the base line of 2011 does not present accurate results, as the actual base line data was not collected. However, based on the available data from October 2011 to December 2012 the number of recorded maternal deaths was **five** in all 50 blocks where the UNICEF project was implemented. Similarly for children, **all** children registered who have crossed the age of five are **alive**.

Likewise, the reduction in maternal and child under-nutrition was to be assessed with respect to the base line of 2010 and does not represent the true picture or impact. Through the programme it was observed that attendance and participation in Village Health and Nutrition Meetings (VHNDs) increased.

Beneficiaries were facilitated and encouraged by the VOSS and the SHGSS to attend VHNDs. During these meetings ‘Take Home Ration’ was distributed which augmented the nutrition of pregnant and lactating women. Post the Gauriganj pilot intervention on Nutrition Surveillance, all fifty blocks under the UNICEF project have been equipped with weighing machines and growth charts. Due to this all children between the ages of 0 and 5 are being weighed and their growth monitored. If a child is drastically under weight and comes within the red category of the growth chart he/she is immediately taken to a hospital. Falling in the yellow category leads to special attention being provided to their nutritional needs. Simultaneously the mother is counselled about the nutritional needs of the child. ‘Take Home Ration’ is also provided for children up to 3 years of age further supplementing their nutritional intake.

To bring to light gender issues in the villages that UNICEF was working in, all 1250 villages had a Government Sensitisation Programme facilitated by RGMVP and UNICEF. Pradhans, PRI members, VHSNC members, AAA’s and BO members, attended these programmes. Discussions on gender sensitivity and inclusiveness were at the core of this programme.

Over the two-year project period, 2136 VOSSs and 45847 SHGSSs and VO members have been trained. These women in turn are active in decimating information and supporting pregnant women and women with young children during times of difficulty.

According to the data collected, **100%** women within SHGs are registering their pregnancies as shown in figure 2. However, ANC check-ups depend on more than women’s willingness to change. It has been observed that ANM’s do not have urine test kits. There have been many
instances where BP machines do not work or are not available at the health centres. Similarly the facilities to test blood are not available with the ANM. Therefore, even though women were going for regular check-ups the lack of infrastructure made it impossible for them to complete the entire course of ANC check-ups. Procedures that did not require equipment were completed successfully, but those that were dependent on equipment were often left out. This has affected the over all results of ANC check-ups.

Figure 3: ANC Registrations
79% of all deliveries were either assisted by a Skilled Birth Attendant or were institutional deliveries. This is a significant number translates into the threat of mortality during delivery being exponentially reduced.

100% children were registered at birth and obtained birth certificates. The SHGSSs and VOSSs have been able to reach out to all corners of their target areas and dissemination of information has been complete for the same.

Figure 4: Pregnancy Registration, BCG injections and OPV Birth Dose.
It should be noted that over 50% children have successfully completed their Routine Immunisation (RI). It is important to note that this number could have been higher but for the difficulties encountered in terms of infrastructure. A significant number of ANM posts in most UNICEF blocks are vacant. Therefore immunisation is not possible in these villages and lack of resources prevents communities to travel to the next sub-centre to access required immunisation.

An infant being administered the BCG immunisation.

As elaborated in the section on challenges, women in the village found it difficult to stick to the rigid prescriptions given with regard to feeding. While they grasped the message and their intentions were correct a child in the village is not only cared for by the mother. The intervention’s grasp of socio-cultural realities at the community level was limited. Therefore assessing the impact of the intervention without discounting for these factors would be inaccurate.

The weight of children is regularly being taken. However, as weighing machines were only supplied to all 50 UNICEF blocks in June-July 2012 it has been difficult to chart the weighing of children throughout the duration of the project.

The supply of Vitamin A was not readily available at Government outlets. Therefore, even if women went to health centres, they were not able to obtain the Vitamin A syrup.

The above Results have to be seen in a holistic and comprehensive manner, they do not work on an exclusively cause-effect paradigm. Overall knowledge dissemination was the core idea behind this project. Above mentioned results indicate that knowledge has, through our various trainers filtered down to every SHG woman in all 50 blocks. Through local community interactions knowledge has also filtered to women who are not part of SHGs. It is in this complex web of interactions, that the real success and sustainability of the project is reflected.
3.2 EFFECTIVENESS

The project has been effective in disseminating messages of health and nutrition in 1250 villages to over 3 lakh families in 13 districts of Uttar Pradesh. Effectiveness is best analysed qualitatively that is in terms of what the women themselves feel they have gained from this project. As a collective outcome, women feel that through this programme they have gained knowledge and information that has helped them improve their own health as well as their children’s health. Asma an SHG member says “learning about danger signs, immunisation shots, nutritious food and institutional deliveries, helped me deliver a healthy baby who will not fall sick often”

Therefore women who have come in contact with the UNICEF project show that they actively try and translate the knowledge they have gained into practice. The effectiveness of these trainings and therefore the programme can be backed up by quantitative data. Data shows that 100% pregnant women are registering their pregnancies and 100% new borns are being registered and issued birth certificates at birth. There has been a phenomenal increase in the number of women who are going to institutions or have Skilled Birth Attendants present at the time of delivery. These indicators show that women have imbibed trainings and are utilising the acquired information in their daily lives.

3.3 RELIABILITY

A project specific Management Information System (MIS) was formulated for the UNICEF project. Data from the field was collected by RGMVP’s CHT’s and ISC’s and fed into the MIS database on a monthly basis. Women from the community collected information through monitoring MCP or Mother and Child Card, which was given to the women at the time of registration of pregnancy. Since the ANM herself would fill it out, the information in this card was therefore considered reliable.
CHAPTER 4. CONCLUSIONS, LESSONS LEARNT AND RECOMMENDATIONS

4.1 CONCLUSIONS

“...even when we leave we believe that our poor sisters are now so well informed that they themselves can properly look after their health and the health of their children.”

These are the words of an active Swasthya Sakhi Manju from Pachehari, in Amethi who is convinced that the knowledge given to the community will remain and continue to empower them in the coming years. In conclusion, the RGMVP-UNICEF partnership has empowered the women on health related issues by leveraging SHG platforms.

An extremely important aspect of this project has been the activation of and increasing accountability in government facilities like the AWC. Now having been revitalized through the programme, they have helped in active VHNDs that have enabled women to gain access to their rights and entitlements. By creating a strong knowledge base, women started demanding for their rights such as ‘take home ration’; pregnancy registrations, immunisations and various other services they were entitled to but were unaware of. The project aimed at strengthening both the demand and the supply side of health interventions. Government functionaries like the CDPO and MOIC were involved in the project and sensitized to the needs to the community. Working in tandem with government functionaries was a crucial aspect that made this project feasible as well as effective.

This project has demonstrated and provided access to an important avenue of empowerment – right to health. Case studies show that women were concerned about their own and their children’s health but did not know where to go or how to seek help. This project empowered women to believe that they themselves can save the lives of their children. Through simple tools like ANC check-ups, weighing their children, breast feeding and getting proper counselling during pregnancy, women saw that they had the power to save lives.

This project has demonstrated the capacity of the SHG institutions to deliver health interventions. It is not only economic activities that drive SHGs but it is the overall wellbeing of the community that brings them together. While RGMVP’s conviction about the capacity of SHG platforms always remained strong, this project proves the hypothesis that the community platforms are inclusive systems to connect to last mile population.

4.2 RECOMMENDATIONS

At the end of the project cycle, it is important for us to take stock of the lessons learnt in the last two years and see how these can be incorporated in our future endeavours. The recommendations discussed below all come from community members’ experiences and their perceptions of how these learnings can be translated into action.

Women from the community believe that for the sustenance of health related programmes, discussions on health related issues should continue on a regular basis in SHG meetings and not stop after the project duration. The same should also continue at the Village Organisation and Block Organisation level.
The VHNDs brings together people and professional health workers and are a crucial platform for identifying malnourished children who need special care. Therefore, members also feel that the active functioning of VHNDs is very important to sustain better health and nutritional outcomes. Women have also voiced a need for some formal communication mechanism that informs them about new government schemes. Most of the difficulties the community faced before the implementation of this project had to do with lack of access to best practices government services. Women do not want to fall into the same cycle of not knowing, and therefore not advancing. Most importantly women feel that it is essential for government functionaries and the people of the village to keep working side by side. It is vital that channels of interaction remain open for health and nutritional benefits to reach the poor.

Apart from this the community feels that routine practices like pregnancy identification and registration and routine immunisation should carry on without any lapse to ensure healthy mothers and babies. Recommendations given by the community show that they have the will to stay up to date with health practices and they see a need in continuing to incorporate the project learnings into their lives.

RGMVP believes that SHG federations as community institutions have the capacity be absolutely sustainable. An important step towards this sustainability is to empower community institutions with knowledge that will stay with them long after a project or a specific intervention is over.

Undeniably there is still a lot of work to be done and a long way to go before UP sees a significant drop in maternal and neonatal deaths. However, this project has shown that when approached in a systemic and logical manner, change is possible. The community is willing to adapt and support interventions that have direct benefits on their lives. Therefore, this project can become the basis to inform other interventions taking place in UP related to health and nutrition and be the catalyst for further change.