COLLECT RISK COMMUNICATION & COMMUNITY ENGAGEMENT - II

Facilitating Adoption of COVID Sensitive Behaviours and Linkages to Social Entitlements for Marginalised Communities across India

Abbreviations

ANM	Auxiliary Nurse and Midwife
ASH	Anti Sexual Harassment
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
DLSA	District Legal Service Authority
FGD	Focus Group Discussion
ICDS	Integrated Child Development Services
IEC	Information, Education and Communication
MCP	Mother and Child Protection
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
NHM	National Health Mission
OBC	Other Backward Castes
ODF	Open Defecation Free
PDS	Public Distribution System
PHC	Primary Health Centre
PMAY	Pradhan Mantri Awas Yojana
PMJAY	Pradhan Mantri Jan Arogya Yojana
PVTG	Particularly Vulnerable Tribal Groups
PwD	Persons with Disabilities
SC	Scheduled Caste
SECC	Socio Economic Caste Census
ST	Scheduled Tribe
THR	Take Home Ration
UHC	Universal Health Coverage
VHND	Village Health Nutrition Day

Table of Contents

1	Introduction
2	Overall Programme
3	Programme timeline with planned activities
4	Methodology and Sample
5	Overview of key findings
6	Covid-19 Vaccination
7	Sanitation and Toilet Use
8	Institutional Delivery, Breastfeeding and Immunization under overall ICDS scheme and Status of Village Health and Nutrition Day
9	Social Security Schemes and Entitlements
10	Conclusion

1. Introduction

The Collect Risk Communication & Community Engagement [C-RCCE] is a community led initiative spread across **11 states**, supported by UNICEF India. The initiative covers **70 districts**, rooted in **560 hamlets**, predominantly inhabited by **Dalit, Adivasi, De-notified and Nomadic Tribes** and **minority communities**. The programme is an extension of the journey started in 2021-2022 where the major focus has been COVID-19 appropriate behavior and community mobilisation to get COVID-19 vaccination. Primarily with similar objectives in thoughts, we realised that certain government services have widely been impacted during the COVID outbreak. Thereby in 2022-2023, we specifically chose themes that require immediate attention to cope with the adverse effects of pandemic on the communities and will eventually lead to behavioral change.

The programme particularly focuses on building a resource base at the community level for easy access to information and instituting a system of data flow, which can be used to create an evidence-based system of communication with local administration. This holds importance, particularly in the context that in these targeted hamlets of marginalised groups, access to digital tools is minimal and even when available, not everyone is able to access these tools owing to varied reasons ranging from ownership to access control. The behavioural shift is envisaged through creating awareness amongst community members, building the capacity of representatives from the community, and assessment of the current situation through data collation and engagement with decision-makers – service providers and key decision makers at village, block and district levels.

2. Overall Programme

After the second wave of the pandemic, access to government service deliveries seemed to be disrupted and laying this as a reference point – five major themes have been identified to build another 6 months engagement. These five themes are -

- COVID-19 vaccination of 12-17 years' children and booster dose for adults above 18 years
- Orientation on breastfeeding and allied ICDS services for pregnant and lactating women
- Immunization of 0-2 years' children
- Sanitation, hygiene and toilet use
- Central government schemes and state schemes for health services

The programme selected district level coordinators at each district and hamlet level volunteers in each intervention location from within the communities. Similar to the former approach of engagement and pattern of intervention (during 2021-2022) the main objectives of the second phase were -

- Orientation of the state and district level coordinators on various themes for dissemination of information among communities, induction meeting on themes with community members and representatives
- Exploring challenges and myths that act as barriers in accessing government services
- Spreading awareness and dissemination of new information embedded in different cultural contexts through various communication channels
- Strengthening existing linkages and liasoning with various stakeholders to create an enabling environment for the team and community to put forward the demands at panchayat, block and district level
- Establishing strong relationship and contact with frontline workers in order to seek support to spread awareness
- Ensuring community participation at hamlet level to highlight prevailing issues and take initiatives in spreading awareness

Based on these objectives, strategies were devised to effectively communicate with community members, understanding their concern and vulnerabilities, and strengthening volunteers’ capacities to design ways and modules to spread awareness. The focus on behavioural change ensured establishing and maintaining linkages with government services and departments at village, block and district level to put forward the demands raised by community members.

3. Programme timeline

Activity	Explanation	Month
Orientation and Capacity Building Session	Training and orientation on Covid Appropriate Behavior - by Doctors team Safeguarding, ASH Policy and contractual briefs by organization administrative representative/department	**November to December 2022**
Dissemination of Information and Awareness Outreach and Linkage with Community	Learnings from the training were disseminated with the wider community through creative mediums such as wall painting and Focused Group Discussion. Sharing the importance of behavioural change approach on specific themes to bring behavioral change in the community, increase the linkages with government schemes and ensure accountability of government institutions towards provision of services for the marginalised.	**Over period of project**
Data Collection Round	Introduction and induction of the Data Collection Format Data Collection	**January 2023 (Baseline)** **April 2023 (Endline)**
Capacity Building Session (Parallel to Data collection)	Social Entitlements a. Covid Appropriate Behaviour focusing on vaccination for 11-17 years b. Breastfeeding and Immunization c. Sustained toilet use	**January and April, 2023**
Physical Workshop (Regional Level)	Workshop was organized in Chennai and Delhi to build further critical understanding on the programmatic themes. Teams have been capacitated on various themes to understand the challenges and gather learnings. Attempts have been made to evolve district level action and work plans.	**February,2023**

Programme timeline

Activity	Explanation	Month
Dissemination of information at Location and Interaction with Government Service Provider	Community Level FGDs and linking with schemes and service providers	**Over the period of project**
Visibility Events	The purpose of organising the event was to provide a platform to the community and create a common space for government officials and the community to share existing concerns and further discuss result-oriented solutions besides showcasing teams' wider engagement at different levels.	**February - April,2023**

4. Methodology and Sample design

Methodology:

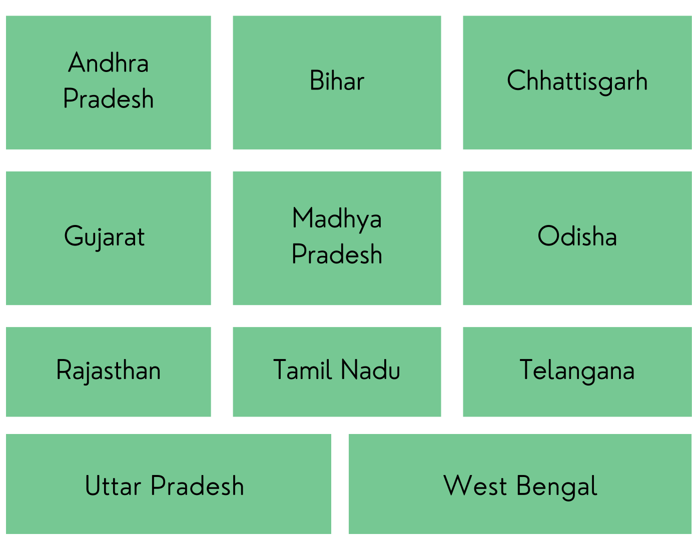
The foremost step to start the programme was to identify the locations and communities. Similar to the previous phase, a similar approach was taken where we selected 8 hamlets in a village of the identified district. 11 states and their districts were identified for this survey. To ensure participation of vulnerable groups in the sample selection process, the selection process for identification of hamlets was predominantly led by marginalized and vulnerable communities. The programme covered communities from Schedule Tribe, Schedule Caste, Denotified and Nomadic Tribe, minority and Other Backward Caste categories. After the identification of intervention locations, volunteers were onboarded including one district-level coordinator and 8 hamlet-level volunteers across 8 hamlets in each district. Regular trainings were organized updating knowledge-based information on themes and technical sessions on induction to online forms and data collection was conducted to orient the team of volunteers and district coordinators. Capacity-building sessions were also organised with expert doctors on the focused themes as well as to clarify people's doubts and misconceptions.

Household survey was conducted during the initial period of the project to retrieve the current on-ground situation as well as disseminate necessary information. As part of the programme, regular meetings and FGDs were conducted with communities to make them aware about various provisions of accessing government schemes. The tools were creatively utilised to engage with the communities to ensure behavioural change and spread of awareness. Communication has been key to the programme, including in-depth dialogues, the use of creative mediums like posters, videos, theatre, etc.

Frontline workers like ANM, AWW and ASHA immensely supported spreading awareness. The team also played an instrumental role in supported the frontline workers in linking the communities to available schemes. Based on the assessment from initial interaction and data collection, the team approached ANM, AWW and ASHA and sought support to periodically organise awareness-building sessions with community members besides other stakeholders like panchayat, block and district-level departments and officials to build linkages and potential partnerships.

Sample design:

The study was conducted in 11 states enlisted in the table beside. The data was collected from 52686 households in the baseline and from 46593 households in the end-line survey. The state-wise numbers of the districts, blocks, panchayats and villages are given below. The table shows that the maximum districts were identified from Bihar whereas the least number of districts were from Telangana and West Bengal. The baseline was carried out in January 2023 and the endline survey was conducted in April 2022. There is a decrease in the sample size in the endline as there have been cases of households migrating for work, or households members not present or unable to give survey information in set time as the community engages with other work.



States covered

Baseline and endline survey (District, Block, Panchayat and Hamlets)

States	Baseline				Endline			
	Districts	Blocks	Panchayats	Hamlets	Districts	Blocks	Panchayats	Hamlets
Andhra Pradesh	3	13	20	19	3	13	20	19
Bihar	12	36	75	98	12	34	69	89
Chhattisgarh	7	12	41	55	7	12	38	50
Gujarat	7	16	40	46	7	14	34	40
Madhya Pradesh	5	8	24	43	5	7	22	40
Odisha	11	11	38	88	11	11	38	82
Rajasthan	3	4	15	25	3	4	15	24
Tamil Nadu	11	19	81	87	11	19	81	87
Telangana	1	2	8	8	1	2	8	8
Uttar Pradesh	9	30	69	61	9	30	69	61
West Bengal	1	3	6	15	1	3	6	15
Total	**70**	**154**	**417**	**542**	**70**	**149**	**400**	**512**

Locations covered

The state wise distribution of sample in the baseline and end-line survey is given below:

State	Baseline	Endline
Andhra Pradesh	2428	2239
Bihar	9611	9337
Chhattisgarh	5107	4337
Gujarat	5136	3816
Madhya Pradesh	3475	3035
Odisha	7624	5962
Rajasthan	2282	1892
Tamil Nadu	8491	7902
Telangana	826	817
Uttar Pradesh	7375	6934
West Bengal	331	322
Total	**52686**	**46593**

Sample distribution

The social group distribution of the sample households is given below. The sample consisted of Scheduled Caste (SC), Schedule Tribe (ST), Other Backward Classes (OBC) and also covers households from the Denotified and Nomadic Tribes (DNT) and those from the minority communities. In terms of proportion of the sample, the highest proportion was of SC households, followed by ST and OBC households.

	SC	ST	OBC	Minority	DNT
Baseline (n=52686)	55.7%	22.2%	17.6%	9.1%	13.5%
Endline (n=46593)	59.1%	19.4%	16.9%	9.5%	13.5%

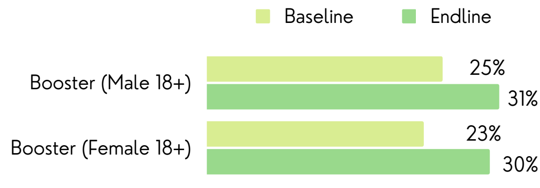
Social disaggregation of sample

5. Overview of Key Findings

In the short span of six-months, the project has had significant impact on the ground on the focus themes of COVID-19 Vaccination; Breastfeeding and immunization; Sustained toilet use and social schemes and entitlements.

Vaccination

Percentage of adult women taking booster doses increased by 7%, while for adult men it increased by 6%.



Vaccination rate among boys and girls (12-17 years) has remained mostly stagnant during the intervention period (44%). This was largely due to shortage of vaccines and the reduction in COVID-19 cases.

Among priority groups - trans/non-binary, persons with disability and pregnant women, there was an increase in those who have taken booster shots across all three categories.

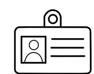
Sustained toilet use

There was a **4% increase** in access to toilet exclusively used by the families. People with no access to toilet **reduced by 6%** in endline.

Community meetings to promote collective behavioural shift towards toilet use.

Liaisoning with PRI member to ensure access to schemes for constructing toilets and clean water use.

Schemes and Entitlements



Trainings on social schemes and entitlements were held for fellows and coordinators, who then supported community members in applications and linkage to schemes.

Ayushman Bharat card

People possessing Ayushman card increased by 8%. While awareness of the insurance increased by 10%.

e-shram card

People possessing e-shram cards increased by 8% during the project period.

Awareness of the Rs. 2 lakh insurance for the workers under the e-shram card is increased by 14%.

Breastfeeding and Immunization

Fellows and coordinators attended awareness sessions with doctors. There was a 2% increase in feeding colostrum to the newborn in the first hour of birth (from 90% to 92%). It also shows that the rate of feeding colostrum to the new-born is quite high. The team worked with ANM, AWW and ASHA workers to dispel myths around the first milk of the mother.

Baseline to Endline

Mother Child Protection card awareness:87% to 92%
Take Home Ration for lactating mothers: 86% to 90%
Awareness of Take Home Ration: 20%

Based on the trainings, fellows sensitized the community on vaccination and mobilised parents, in collaboration with ASHAs, to bring their children to the centres for immunization on scheduled days.

Those who received all 8 immunizations: 4% (64% to 68%)

Those aware of the all 8 immunizations: 7% (55% to 61%)

Those not aware of 8 immunizations: 3% (12% to 9%)

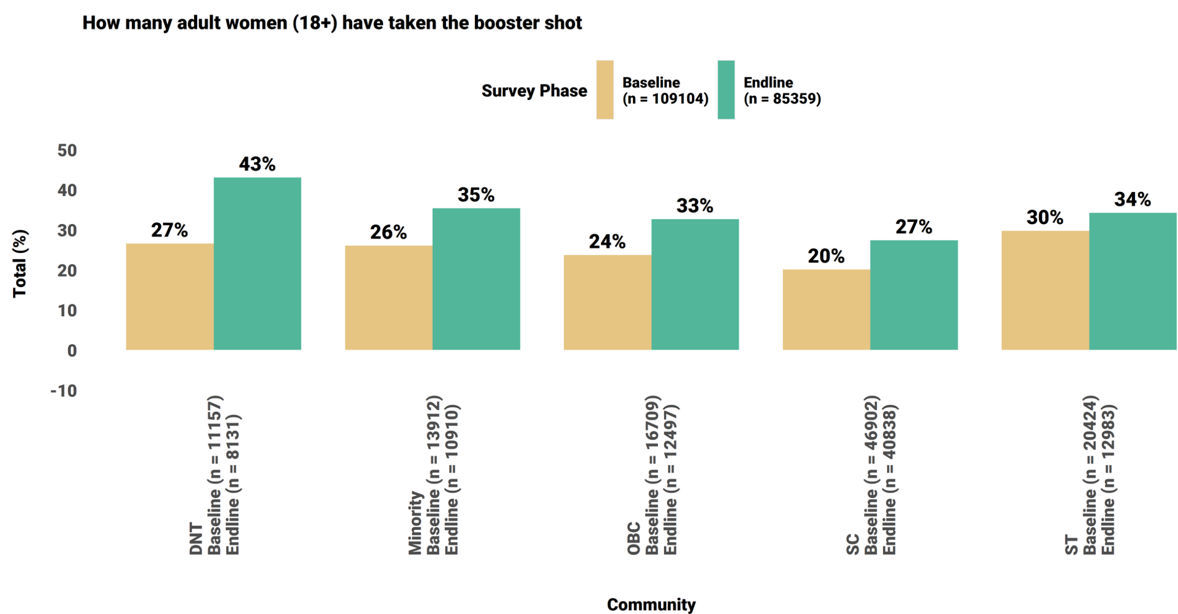
Gram Sabha Engagement

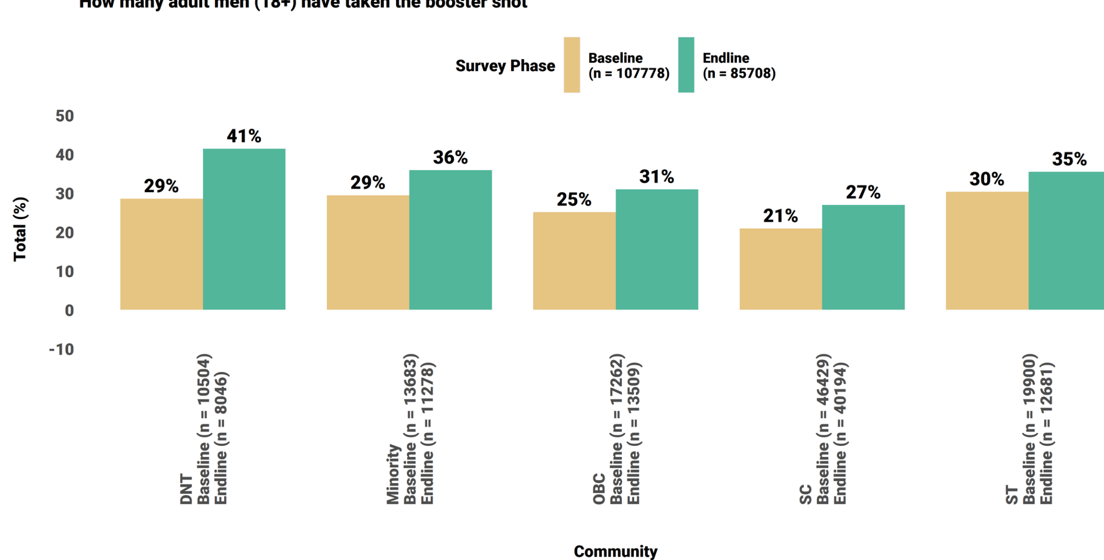
A key component of this programme has been linkage with the PRI bodies, including the engagement with gram sabha. During the programme, it was found that the awareness about the Gram Panchayat Development Plan increased by 5%. The number of people attending gram sabha increased by 3%, and the number of people who raised issue with any panchayat functionary increased by 3%.

6. Covid-19 Vaccination

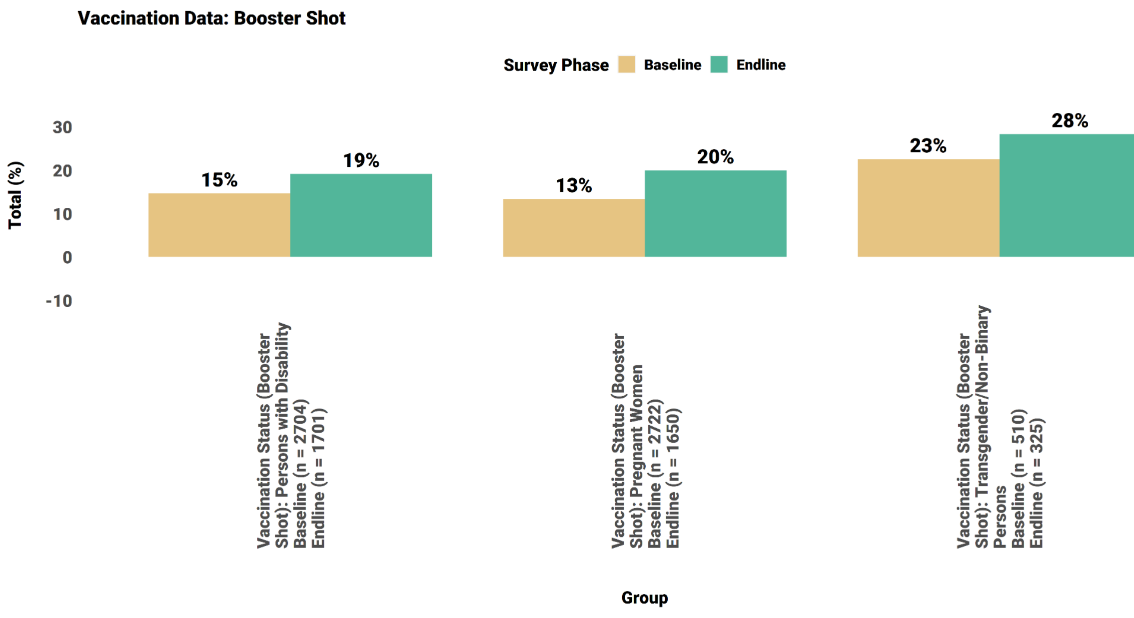
Importance of COVID-19 vaccination increased during and after the second wave of COVID-19. In the first phase of this programme the volunteers were trained on COVID Appropriate Behaviour (CAB). There have been attempts to address the prevailing myths and also encourage communities to get vaccinated. During the second phase of the programme, the volunteers have been trained by doctors on CAB and they spread awareness among the communities. ANM supported in the entire process of spreading awareness and sharing lists of those who were left with vaccination. With the understanding of new emerging variants of COVID-19 due to mutations, the volunteers focused on CAB and vaccination. This phase primarily focussed on building awareness, 12-17 years' children vaccination followed by adults' access to booster shots and those who were left out. Apart from prevailing myths that were observed during the first phase, another emerging myth was that people are suffering from brain stroke, heart and other diseases due to COVID-19 vaccination. The training sessions with doctors helped the team to clarify these doubts and convey right information to the communities.

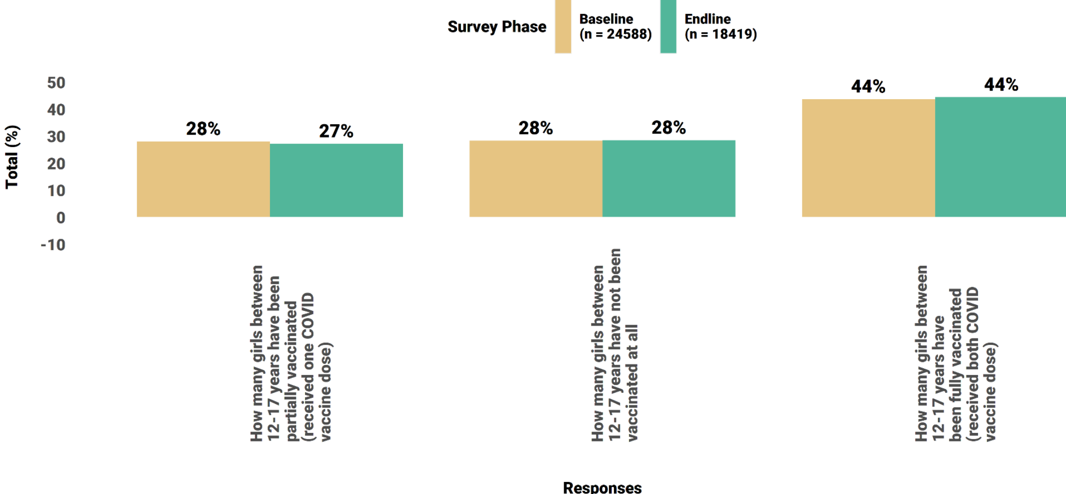
Percentage of adult women taking booster doses increased from 23% during baseline to 30% in end line. When it comes to booster doses taken by adult men it increased from 25% during baseline to 31% in the end line. If we look at booster shots vaccination status among different social groups – there is a substantial increase among DNT communities. Among the DNT women it increased from 27% to 43% whereas among DNT men it increased from 29% to 41%. The percentage among SC women increased from 20% to 27% and among SC men it increased from 21% to 27%. Despite an increase from the baseline, one of the concerning areas that needs to be looked into is the booster doses among both men and women that is mostly hovering around 35% or below except for the DNTs. The key challenges for the same are mentioned below.



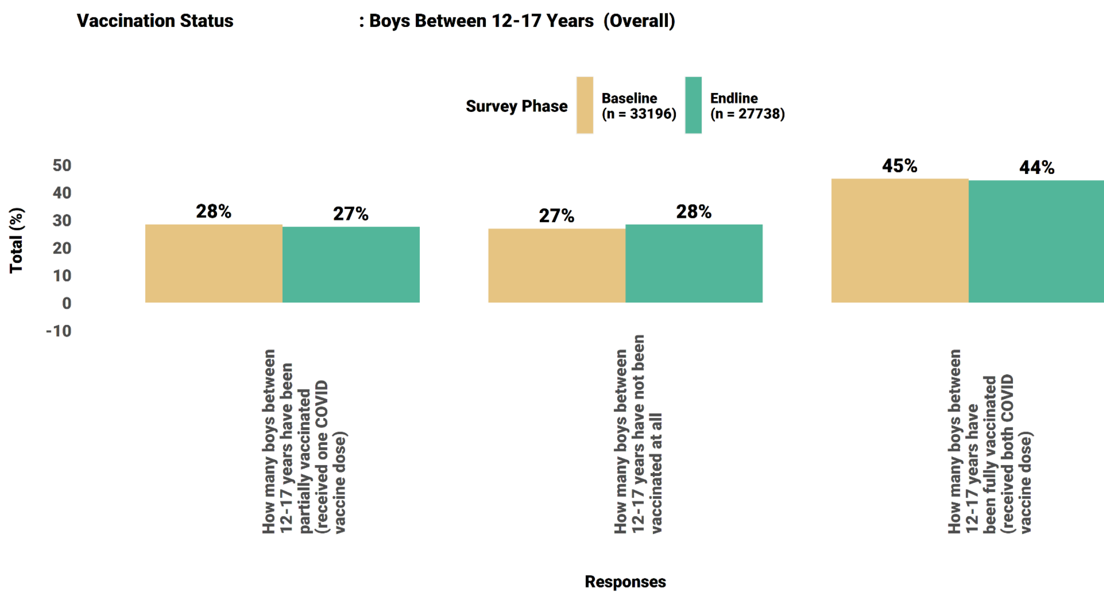


The survey has also captured the vaccination status among people with disabilities, pregnant women and transgender persons. The percentage of intake of booster shots has been highest among transgender persons i.e. 28%, whereas, the increase in booster doses between baseline to endline is highest among pregnant women – from 13% in the baseline to 20% in endline.





During the intervention period, efforts were made towards improving the access to vaccination by children in 12-17 years of age group. The data shows the overall vaccination rate among boys and girls in the mentioned age group has remained mostly stagnant during the intervention period. Among the OBC girls and boys, there has been some visible increase in vaccination from 39% to 44% and 42% to 47% respectively.



Challenges and Learnings from the ground

During community engagements, the team faced following challenges:

Vaccine Supply Shortage:

- Lack of vaccination supply from the government and Primary Health Centers (PHCs) or Community Health Centers (CHCs).
- Low vaccine supply creating a sense of relaxation and disbelief in the existence of the disease among the population, diminishing the seriousness towards vaccination.
- Issuance of certificates without administering the vaccine, leading to loss of hope among people in Gujarat.

Vaccine Hesitancy and Fear:

- Fear of the aftermath of COVID-19 and concerns about the impact of vaccination on life expectancy.
- Persistent myths and apprehensions about vaccines leading to reluctance in getting vaccinated.

Incomplete Vaccination:

- School enrolled children receiving the first dose of the vaccine but facing a shortage of supply for the second dose.
- Concerns about school dropouts due to children being left out from vaccination and potentially not having future access to vaccines.

Vaccination for Children:

- Unavailability or lack of supply of COVID-19 vaccines for children aged 12-17 in rural Community Health Centers (CHCs).
- Absence of vaccination awareness campaigns by the government specifically targeting children in rural areas.
- Requirement of a minimum number of children for vaccination from the same vial, leading to potential vaccine wastage.

Issues with Vaccine Certificates:

- Issues with vaccine certificates in Madhya Pradesh and Chhattisgarh, where people do not possess certificates specifying the vaccine received.

Actions on ground

Through the process attempts have been made to organise camps with support from local health in-charge and frontline workers so that people get access to booster doses and children in the age group of 12-17 years get fully vaccinated. Regular meetings and awareness sessions have been conducted on ensuring that people are able to overcome myths and misconception dissuading them to not take vaccines. Sessions conducted by doctors were helpful for the team to gain confidence, address the misconceptions and disseminate correct information to the communities.

Narratives from some state specific actions

Rajasthan

In Ajmer, Rajasthan - the team has been able to collaborate with the health department, organise and support vaccination camps for booster doses. The entire Rajasthan team has tried to approach the departments and stakeholders but despite efforts, the response was that vaccination is unavailable.

Odisha

In Odisha, the team held meetings to identify the scope for COVID vaccination, followed by engagements with Gram Panchayat. The biggest impediment proved to be fear of vaccines and therefore, efforts were directed towards familiarising the community with the process of vaccination and changing their mindset. Volunteers were mobilized and tasked with speaking with the community and dispelling myths around the side-effects of vaccination.

Uttar Pradesh

In Uttar Pradesh, a lot of myths existed regarding the side-effects of vaccine like – disruptions in the menstrual cycle, memory loss, and heart attacks. Efforts were made towards overcoming fears and anxiety among communities. A district-level task force was also created to increase vaccination coverage. As a result, most of the population has been inoculated, barring migrant workers. A petition was also submitted to the Chief Medical Officer for vaccination of 12-17 years' adolescents who were left out during the vaccination drive. Separate awareness meetings were conducted with school going children.

Tamil Nadu

Similar to other states, considerable efforts were made in Tamil Nadu towards myth-busting regarding COVID vaccines' side-effects with the help of medical officers. Since alcohol addiction is rampant in the region, a vast majority of men declined the vaccine since abstinence is advised for 72 hours following the dose. Awareness sessions were conducted with specific groups such as elderly, SHG women and children.

Chhattisgarh

In Gariyaband district, the organisation visited different schools to create awareness among children about COVID-19 vaccination. Information about COVID-19 has been shared, along with children's health checkup and motivating them for vaccination. Rallies, drawing competitions, wall writing and home visit have been useful to build awareness. Children's guardian meeting has also been conducted to spread the awareness on getting vaccinated. Along with this, blood pressure, sugar machine, oximeter, mask and necessary medicines were provided to schools. Meeting the pregnant women and their family members during home visits by volunteers and frontline workers helped in dispelling misconceptions. A number of influential people supported the team to disrupt the myths by sharing examples from other villages where pregnant women were vaccinated.

West Bengal

West Bengal has taken support from the health department to get people vaccinated in some locations though it is challenging as people are not ready on one hand and on other, there is lack of supply of vaccination. However, the effort has helped some people get vaccinated.

Andhra Pradesh, Telangana

In Andhra Pradesh and Telangana, attempts were made to organise vaccination camps for booster dose especially for pregnant women.

Madhya Pradesh

In Sagar, Madhya Pradesh attempts have been made to visit health departments and health officials with regards to vaccination but the response was negative in terms of unavailability of vaccine.

Bihar

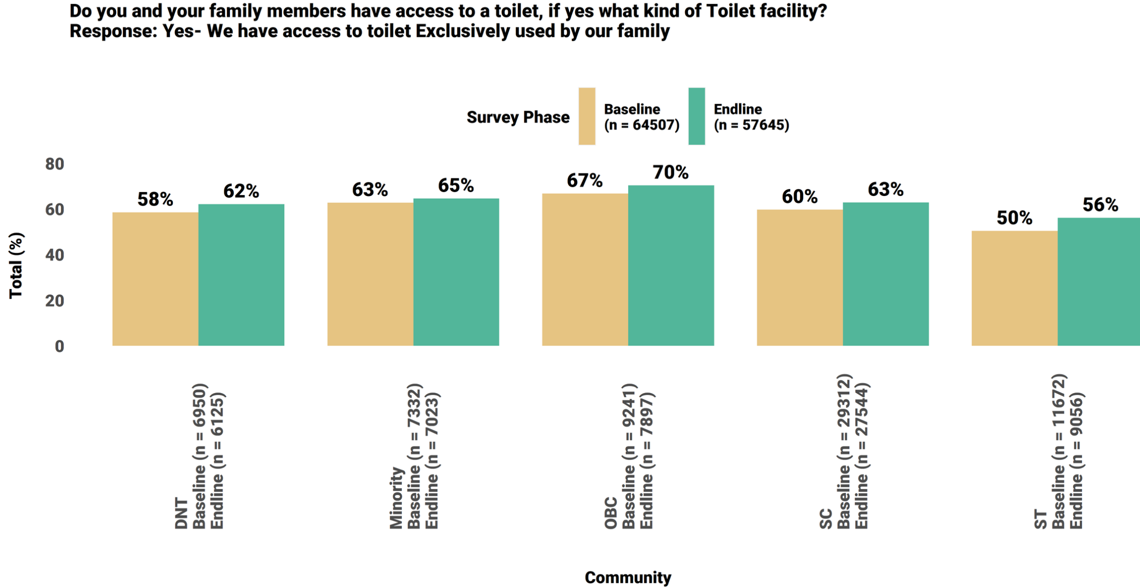
In Bihar, myth-busting was the most critical part, along with organising meetings and discussions with communities and doctors, which led to increased uptake for COVID vaccines.

7. Sanitation and Sustainable Toilet Use

One of the flagship and promising programmes of India is making open defecation free (ODF) India and ensuring cleanliness within community and surrounding areas. Many initiatives have been taken to make it a success such as the Swachh Bharat Mission launched in October 2014. The focus of the mission has been to support every household to have their own toilets in rural India. Around 100 million toilets have been constructed during the period of the mission. All villages in all states and Union Territories have declared themselves open defecation free by October 2, 2019. However, challenges have remained to ensure sustained behaviour towards sustainable, regular usage of toilets and to ensure that no one is left behind in accessing toilets and solid waste management. Along with access and usage of toilets, the focus of the government has been promotion of hand washing practices.

In the project intervention period, multiple online trainings were conducted for coordinators and hamlet level volunteers on the importance of sustainable toilet use and improving hand washing practices. Community level meetings and interactions were conducted by the volunteers to promote a collective behavioural shift towards utilisation of toilets. Volunteers and district coordinators have also liaisoned with PRI members and other administrative officials for ensuring access to schemes for constructing toilets and clean water use.

The survey shows that the practice of open defecation decreased from 31% to 25% which is a substantial decline. On the other hand, exclusive access to toilets by the households in the intervention location increased from 60% to 64%. The access to community toilets shared by a large number of households which is often a usual practice in urban slums has remained stagnant at 3% during the intervention period.



When it comes to handwashing practices it came out that the majority of households i.e. 61% use bar soap followed by 20% using liquid soap and 10% using mud. The use of soap increased from 17% to 20% during the intervention.

Challenges and Learnings from the ground

The popular narrative emerging from most of the intervention locations is that the government is constructing toilets and/or have declared the district as ODF, however, many challenges still remain. Initially, convincing people to use toilets instead of open defecation emerged as a challenge as people prefer open defecation at least once in a day despite their access to toilets in respective locations. The lack of financial resources and support from the panchayat has impacted construction of toilets and many are still non-functional. The absence of toilets creates problems for menstruating women and adolescent girls as it becomes further challenging to go out in the open and this also poses a risk to their safety. As the application process has shifted online in many locations, people also had difficultly in accessing this application. Certain concerns came out regarding toilet construction and use -

Lack of Access to Water

- In some areas of Rajasthan, Madhya Pradesh, and West Bengal, water scarcity was the main problem related to toilet water use and eventually resulted in open defecation, particularly in rural areas. The Gawariya Community of Ajmer, Rajasthan, who often struggle to earn a living, has to purchase tankers to get water facilities for daily use. Hence, purchasing water for toilet use is not an option for them.

Affordability and Maintenance

- The maintenance of toilets was not affordable for most community.
- Lack of funds for toilet construction in Tamil Nadu and Andhra Pradesh, as available funds are utilized by dominant castes.
- Lack of social norms and community self-surveillance systems to ensure the maintenance of Open Defecation Free (ODF) status.
- Maintaining toilets is considered a time-consuming activity.

Lack of Awareness and Behaviour Change

- A toilet can't be looked at in isolation as a structure. Once the toilet is made, there is discomfort, fear and uneasiness to use a close setup for sanitation purposes.
- A survey undertaken in Bihar by partner organisations to help identify needs and gaps in sanitation standards showed that many community members were not used to or familiar with toilet use. Building awareness around toilet use and highlighting the health impacts of open defecation was a critical task.
- The use of alternative materials like ashes or sand for handwashing in some states like Gujarat indicates a lack of awareness or access to proper handwashing facilities. Positive behaviour change was observed after the intervention, with increased handwashing with soap.

Insufficient toilet facilities

- Although Bihar is officially deemed ODF, nearly 50% of households do not have toilets.
- The use of toilets continues to be a big challenge since many do not even have proper homes. Land is a concern to those families who don't have land to build toilets. The concern appeared even more bothering in the absence of public toilet in places. For instance – in Ravidas Tola hamlet of Balbhadrapur Mahishi village, Samastipur Bihar, 75% families still don't have toilet. Cleanliness is also a concern as a larger population is settled in a small place. The team tried to speak to the Mukiya to address issues related to toilet and gram sabha.
- Single toilets for joint families make it challenging for multiple individuals to use.
- Lack of community toilets in areas where they are most needed.

Retrofitting and Accessibility

- Retrofitting existing structures to accommodate toilets is a concern.
- Challenges in using toilets for persons with disabilities (PwDs) and elderly individuals due to accessibility issues.

Actions on ground

Overall, the teams across states have tried to bring in behavioural change towards maximizing the use of toilets. The focus of the awareness programmes has been to keep the surroundings clean. The following key actions have been noticed during the intervention period.

- Awareness on keeping the toilet and surrounding clean.
- The survey revealed that everyone should be equally responsible for cleanliness of toilets and it is not the sole responsibility of women.
- People who don't have toilets were supported in the application procedure.
- Handwashing practice has been emphasised by the volunteers and the same has been adopted by majority of the community members.
- There are raising demands for construction of public toilets while people in urban locations are showing concern towards its repair and maintenance.
- In Surat, Gujarat advocacy efforts have been done for the retrofitting of community toilets (Sulabh). There is an emerging concern that landless people or people with minimal land are unable to construct toilets. Thereby in rural areas, people have put forward the demand for accessible public toilets.
- Awareness has been built in the community towards the use of toilets specifically to those families who have toilets but are not using it. Application for availing the toilet construction scheme benefits were also submitted.

Narratives from some state specific actions

Gujarat

Even though the families in urban Gujarat have toilets, the focus of discussion was cleanliness, sanitation and hand washing practices. It was also told that cleaning toilets and closing the toilet door after use were not the sole responsibilities of women but equal responsibilities of all in the house. Changing mindset towards handwashing with soap was also observed. There were emerging demands for the construction of community toilets in rural Gujarat. The team also emphasized hand-washing practices as an important component of sanitation and hygiene.

Rajasthan

In Rajasthan, the team attempted to build a dialogue between those having toilets at home and those who don't have toilets. As women are considered primary change-makers, they were central to the discussion. The team also enlisted those families who are in need of toilets and supported them to link with government schemes. A woman from Pali district took a loan from SHG to complete toilet construction at home as it was difficult and unsafe to go out at night for toilet use.

Uttar Pradesh

It was observed in Uttar Pradesh that women were solely responsible for fetching water for toilet use. This has been addressed by the team through FGDs with the community. They approached ASHA, ANM, AWW and Gram Pradhan to convince male members to ensure water availability in the toilets. With support from the Pradhan in Bareilly, the team managed to get a computer from the block office along with the computer operator and started filling out the application forms for toilet construction. The Pratapgarh team used a street play on ODF to create awareness among communities on the use of safe and clean toilets to resist negative health impacts. Community toilets in Ghazipur were left unused for months due to a lack of cleanliness. A group of sanitation workers was sent from the Block Development Office (BDO) to clean community toilets in 5 locations and then 50% of people started using the toilets. PHC and BDO also helped to get the bleaching powder. A Gram Pradhan of Ghazipur district appreciated the efforts, "Government officials didn't listen to our concerns but you managed to get things done." In Marali village of Lakhlauli Gram Panchayat, a person has to go very far to access a public toilet. To address this issue of inaccessibility, the community members and partner organizations discussed if a panchayat secretariate can be built by purchasing village land, then why can't a community toilet be built in the village itself? The proposal has been submitted but currently stands pending with the local government authority. Initiatives have also been taken in Jaunpur to collectively raise awareness in adjacent villages on sanitation and toilet use. With regular meetings with Gram Sabhas and Gram Pradhans in Uttar Pradesh, the organization has been able to cover 60%-70% of households while many others are in the process of applying for toilets at home. However, stable internet connectivity often proved to be an impediment in filing online applications for toilet construction in the villages. The Kishori Samuh in Jhansi shared, **"Working and educating others is necessary besides having an opportunity to understand and learn the use of clean and hygienic toilets."** The organization also promoted handwashing as part of its larger sanitation and hygiene drive.

Odisha

In Odisha, the team made an effort to ensure that existing toilets are repaired and made functional, followed by phase-wise planning for building additional toilets. The organisation also held meetings with Members of the Legislative Assembly (MLAs) regarding the same. In Sundergarh district, communities developed village-level plans for repairing toilets i.e., helping each other in the repair work on a rotational basis. Besides mobilising the communities and motivating them towards use of toilets, funds have been mobilised among the community members for repairing and upgrading toilets.

Tamil Nadu

In Tamil Nadu, communities from two villages came together to demand the construction of toilets in their hamlets. Earlier, toilets were not part of their priorities. However, with increased awareness of the pitfalls of open defecation, the communities sought information on government schemes for toilet construction.

It emerged from Tamil Nadu that making a village open defecation free is not only the responsibility of the individual or family but also that of Gram Panchayat and the entire community.

Bihar

The Musahar Tola of Sampatchak in Patna, Bihar does not have toilet as they don't own any land. The community has tried to build toilets for a few through the SHG. But there hasn't been any initiative towards construction of public toilet. Respectively in Ward 49 and Kamalpur villages of Sakhund and Jagdishpur block, very few families have access to toilets while most of the families from Ward 49 do not have access to PMAY (housing scheme) as well. The team supported in documents submission while the ward parshad helped in the process. The Mahadalit community in Kamalpur village also raised a demand for toilet. When the team enquired with the Vikas Mitra, the person said that application for toilet gets sanctioned with the application for PMAY and money is received after the toilet structure is established on ground. But the marginalized and vulnerable communities can't afford to build toilet till they receive an account transfer of money. The West Champaran team said, "People have to initially pay in constructing the toilet and then they will receive the entitled amount. This is an incorrect process and should not happen. Those who have built with own money haven't received timely payments. Toilet construction happened through a single model concept which should not be the case especially in flood prone areas of Bihar, thereby planning and context specific model shall accordingly be built depending on the topographical structure. The majority in Siwan district, Bihar required information about toilet use and construction and are in the process of applying for the scheme.

Chhattisgarh

Chhattisgarh teams have focused on hand washing after using toilet and before having food with use of sanitizer as well. Besides the awareness campaign, the team in Gariyaband district also pasted posters in villages to spread awareness on sanitation and toilet use. Applications from four hamlets have been submitted at the district level in Gariyaband, Chhattisgarh.

Andhra Pradesh and Telangana

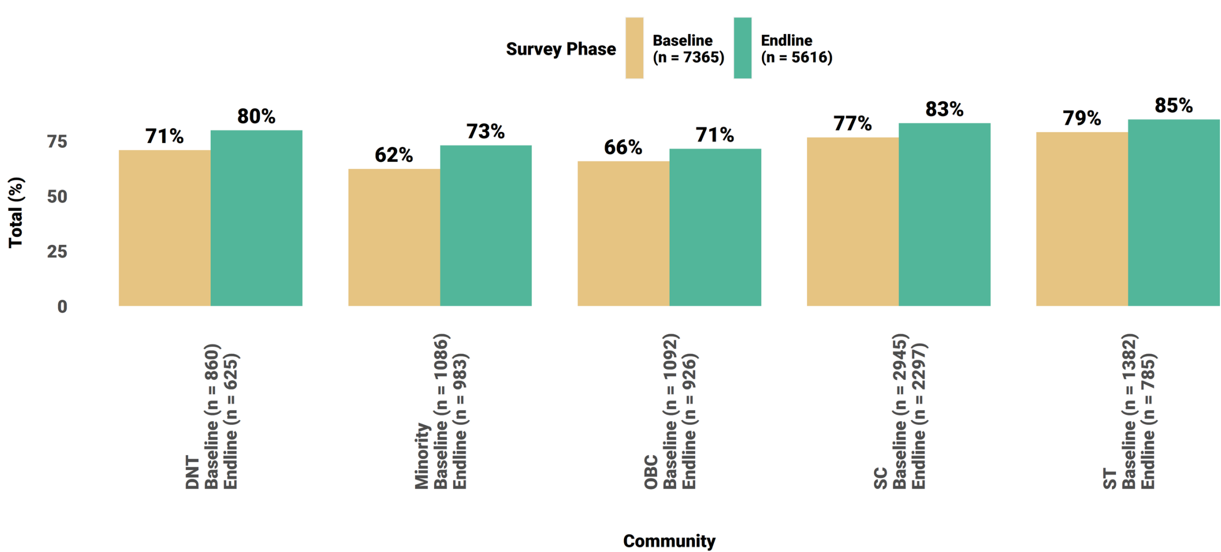
It emerged from Andhra Pradesh and Telangana that making a village open defecation free is not only the responsibility of the individual or family but also that of Gram Panchayat and the entire community.

8. Institutional Delivery, Breastfeeding and Immunization under the ICDS scheme

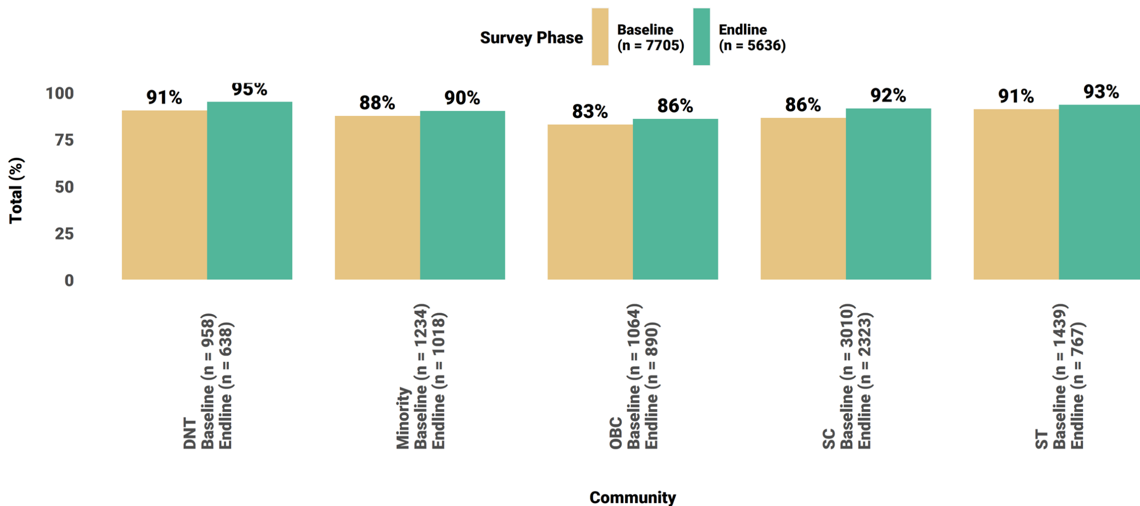
Institutional delivery and home visits by frontline health workers

The Integrated Child Development Services (ICDS) Scheme is one of the largest schemes in the world which provides early childhood care and development along with a range of health and nutrition support to pregnant and lactating women. The objective of the scheme is to reduce malnutrition and morbidity along with reducing maternal and child mortality. The pregnant and lactating women are provided nutrition and health education by the Anganwadi workers (AWW) through home visits of the respective beneficiaries. Along with AWWs, ASHA and ANM are also required to visit the homes of the women post-delivery of the child.

During the intervention period, the team sensitized communities on the importance of institutional delivery and worked in close collaboration with the local health service providers to support women on nutrition and health education after childbirth. According to the National Family Health Survey data (NFHS-5), the rate of institutional delivery in India is 88.6%. During the intervention period, the institutional delivery increased from 74% to 81%. While there has been a substantial increase from the baseline to endline due to the intervention of the programme, the rate of institutional delivery is low as compared to the national average. A major reason for the lower rate compared to the national average is the fact that the team's focus of this intervention has been on the most marginalized communities residing in some of the most remote pockets of the country. However, awareness sessions yielded a substantial increase in institutional delivery.



With regards to the home visits by the ANM/ASHA/AWW after childbirth, there was an increase seen across categories. The data revealed that in more than 90% of cases, home visits are taking place across different social groups except OBCs with 86%. Overall, it has emerged that awareness around institutional delivery and access to services from AWC has been built with the support of ANM, ASHA and AWW. It has also been observed that the community is now taking an interest in listening to AWW, ANM and ASHA instead of just taking the THR packets. Several reasons came up on why home visits were not taking place – 33% said that AWW stay far away from the village, and 20% said that AWC is closed. However there has been a fall from baseline to endline data in reasons like AWW, ANM are not present (13% to 9%), check-ups are not required (32% to 24%), they feel discriminated at AWC (9% to 8%), and prefer going to private centres (12% to 9%). Lactating women not requiring support came out as the major reason for the same.

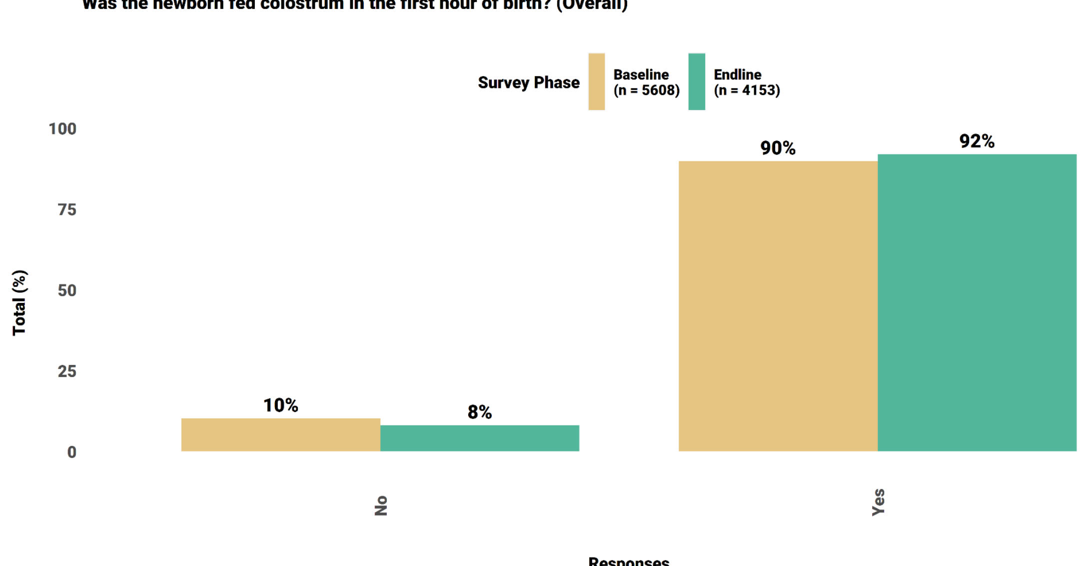


In the overall program it came out that awareness has been created in support of ANM, ASHA and AWW for sharing the importance of institutional delivery as well as access to Anganwadi and frontline workers is important has been the focus of the program. There are narrations coming forward where the community is now taking interest in listening to AWW, ANM and ASHA instead of just taking the THR packets. On the other hand, as the programme focused on linkage with frontline workers, there was also an increase in the people engaging with frontline workers. In the process, to an extent, the community has been made aware about listening to the frontline workers and the frontline workers are approaching the community too.

Breastfeeding and Natal Care

The importance of feeding colostrum to the new born baby immediately after birth has been scientifically established. However, there were prevailing myths and doubts among communities about its importance and health benefits for infants. Among many communities, colostrum is considered ill for child health and thereby the mother is discouraged to provide the same to the new-born.

During the intervention period, there was a 2% increase in feeding colostrum to the baby in the first hour of birth (from 90% to 92%). It also shows that the rate of feeding colostrum to the new-born is quite high.



Across the intervention states, substantial increase in feeding colostrum to the new born in the first hour of delivery has been observed – 74% to 96% in Rajasthan and 82% to 100% in West Bengal. Whereas in Gujarat and Odisha, a nominal decline in feeding colostrum is observed. However, the decline in these two states can be due to less sample of lactating mothers during the period of end line survey.

Communities believe in several myths so as to avoid giving colostrum to the new-born such as – colostrum is old milk left in mothers' breast, traditionally giving honey, jaggery paste or liquid as a first feed or the local alcohol is best for child health, the colostrum is impure and a waste, the child is kept away from the mother post-delivery due to social norms that need to be practiced etc. In cases where colostrum was not given to the child in the first hour of birth, several reasons came up such as – doctor's advice, medical complications and lack of awareness. Lack of awareness came out to be the main reason which declined from 76% to 62% during the intervention period. This also affirms the regular occurrence of community meetings and counselling of mothers and their families by the volunteers and frontline workers.

Myths and misinformation around breastfeeding is closely connected to and embedded in the gender discourse, which as a result also witnessed improvements. As in-laws pressurise lactating or new mothers to follow traditions with regards to breastfeeding, the programme focussed on integrating mothers-in-law and even the community at large to build awareness on breastfeeding practices and its importance. Myths such as providing goat milk, child getting thirsty have been well addressed by the frontline workers. The survey shows almost 90% of lactating women were affirmative to the question on counselling being given on feeding practices by ASHA/ANM/AWW. It is lowest among OBCs with 83% at the time of endline survey, however this was an increase in comparison to 80% during the baseline.

Challenges and Learnings from the ground

- Lack of awareness on breastfeeding emerged as one of the primary challenges.
- There were challenges with regards to best practices of breastfeeding to be adopted. Ensuring the right communication between community (specially lactating and pregnant women) and frontline workers was of main focus.
- Women were not comfortable in sharing the problems occurring during breastfeeding. There was lack of understanding such as if milk is not extracted then what should be done, whether complementary feeding is the only option or donor mother is an option too etc.
- There was a misconception that external feeding can be done during the first 6 months.
- Besides these, absence of PHC and frontline health workers for service delivery towards pregnant women, unavailability of nutrition supplements in AWC and lack of awareness among people regarding ICDS services for mothers and infants from AWC emerged as holistic challenges.

Actions on ground

- Trainings by doctors conducted for coordinators and volunteers helped them understand the importance of colostrum and clarify their doubts. Following this, volunteers organised community level meetings with expecting mothers and their families and sensitised them on the importance of colostrum and the need to feed it to the newborn immediately after birth. Additionally, the best practices of breastfeeding and key points of breastfeeding were also shared such as – child has to be only breastfed till 6 months and extra feeding along with breastfeeding can be done after 6 months till 2 years. The volunteers also involved AWWs and ASHA during the meetings.

- The trainings with doctors also helped to build awareness and bring in smaller changes such as – how to hold a baby while breastfeeding, not feeding milk while baby is sleeping, mother warmth is important for the baby etc.

- Linkages with AWW, ASHA and ANM has been one of the most important actions taken during the intervention. Their support has been immensely helpful to orient the community on breastfeeding practices and available service deliveries from AWC. The team have extended their support by accompanying the beneficiaries to AWCs where the lactating mothers have been oriented towards best practices.

- Awareness videos and photos have been used to spread awareness and thus the team has been able to bring in behavioural changes in breastfeeding practices. The volunteers also shared their personal experiences as being mothers who had to follow the social norms that were incorrect but later understood that right traits should be practiced to keep the child healthy.

- Myths among the Garasiya community regarding providing goat milk to the child right after birth and avoiding mother's milk for the next two days have been addressed by the frontline health workers and there has been a change in the traditional practice.

- The practice of feeding roti to the child once teeth start appearing was observed in Neemuch, Madhya Pradesh. The issue has been addressed as a wrong practice and awareness has been built by the team.

Narratives from some state specific actions

Rajasthan

To encourage breastfeeding in the villages of Ajmer, Rajasthan, efforts have been made to build dialogues between rural and urban women, where the latter spoke of its benefits and were able to dispel some of the commonly believed myths, especially regarding colostrum. Efforts were made to include the elders in the communities who could then convince and teach the younger generation the benefits of breastfeeding. These initiatives were taken to address the misconceptions. Changes have also been observed in Pali district and among Garasiya community due to regular counselling and awareness sessions.

Bihar

Bihar team specifically made the point that there is widespread stigma about mother's first milk colostrum which is often thrown away and there is only 20%-25% uptake on feeding colostrum to new-born babies. In order to encourage more mothers to breastfeed, ASHA and Anganwadi workers were roped in as main collaborators to effect change in mindset and practice. There continues to be taboos and customs around breastfeeding that are detrimental for the health and nourishment of new-born babies. Moreover, despite training imparted to ASHA and ANM, they were not well-equipped and unable to convince the community towards breastfeeding. Therefore, the organization held meetings and one-on-one interactions with ASHA workers and ANMs to increase their knowledge and awareness of the benefits of breastfeeding.

Madhya Pradesh

In Sagar district of Madhya Pradesh, the women volunteers first took the initiative to build rapport with the AWW, ANM and ASHA so that their support could be taken in orienting the community. Moreover, they have visited both private and government hospitals to interact with pregnant and lactating women on good practices of breastfeeding and post-birth child care.

West Bengal

In West Bengal, distribution of pamphlets showcasing nutrition related services from AWC under ICDS scheme has been one of the initiatives. Volunteers used these pamphlets to disseminate information among communities and this resulted in ensuring proper service deliveries to pregnant women and children. The 'Mata' committee has made ANM, AWW accountable for the services.

Uttar Pradesh

In Ballia Uttar Pradesh, ASHA and Grameen Swayam Sevika (GSS) supported the team in addressing the myths on breastfeeding prevailing among minority communities (specifically breast milk will get dried and children might get malnourished). IEC materials provided by the local government authorities were used as medium of communication during the process. A very unique strategy was used by the team where both the mother-in-law and daughter-in-law participated in the awareness meetings to learn good practices of breastfeeding. This worked well and created a ripple effect in the community. IEC materials extracted from NHM and UNICEF websites were used as well. In Bareilly district, a signature campaign was launched and a petition was submitted in the block health department regarding the closure of PHCs. In Ghazipur, free treatment for 30 days for both mother and child has been ensured in the government hospital with the help of local health workers and the partner organisation.

Odisha

In Odisha, good practices were highlighted by those within the community who had institutional deliveries and thereby were able to break the traditional myths and customs associated with breastfeeding. Secondly, learnings from trainings have been of immense help to the volunteers and thereby disseminate information with communities such as – the duration of breastfeeding, how to properly hold an infant, ensuring post-feed digestion etc.

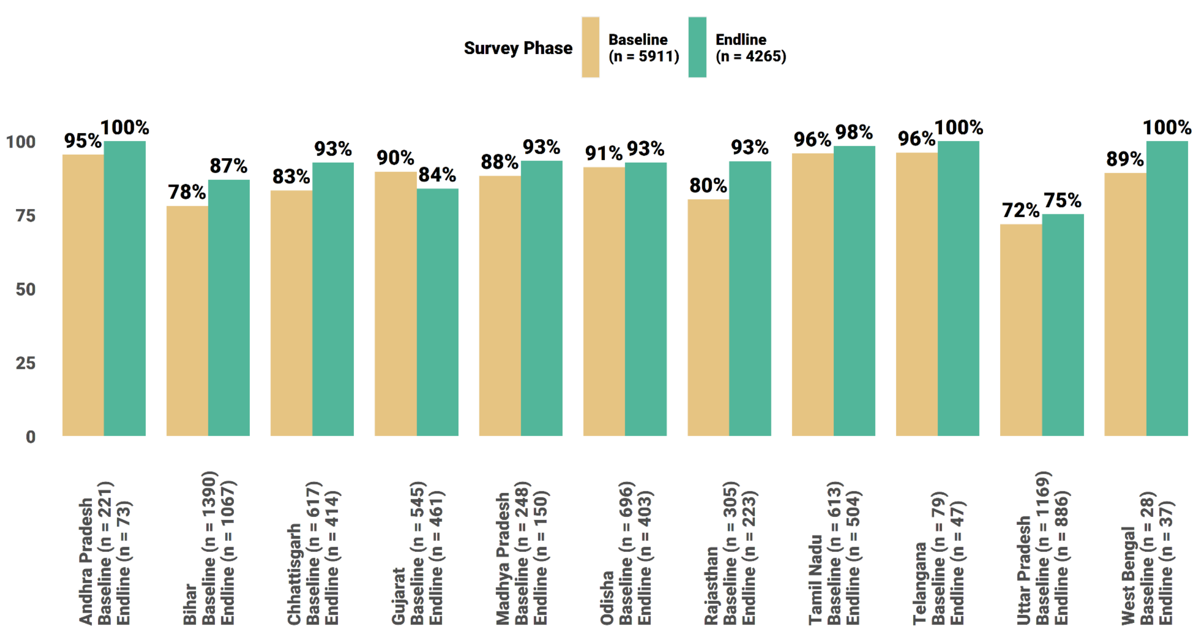
Tamil Nadu

In Tamil Nadu, with the support of Village Health, Sanitation and Nutrition committees (VHSNC), regular interactions were organized with pregnant women and lactating mothers, as well as their husbands and father regarding the harmful effects of malnutrition. The communities also became aware of monetary benefits through health schemes for pregnant women such as the Mutthulakshmi Reddy Scheme.

Attempts were also made to bring together mother-in-law and daughter-in-law with their husbands to make them aware about the breastfeeding practices and its importance. Lactating mothers were called in AWC for awareness sessions conducted by ANM/VHN and AWW.

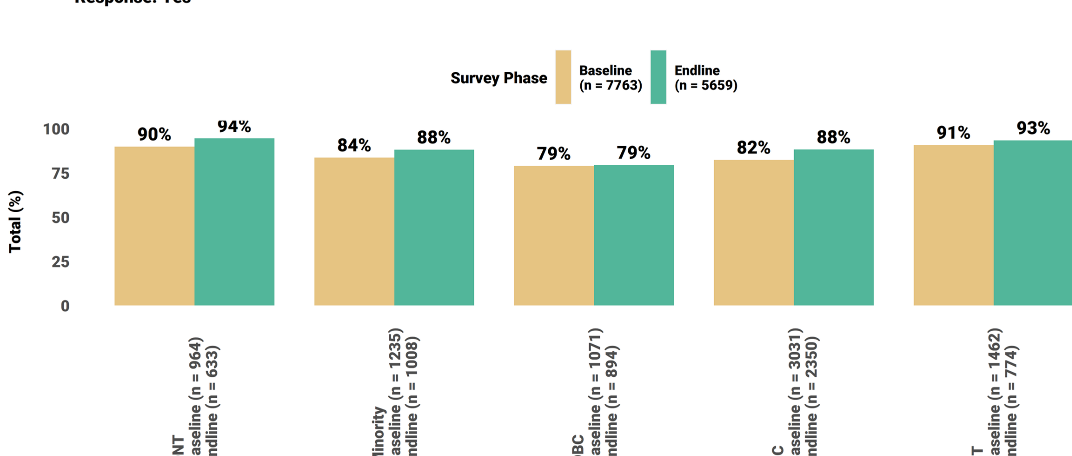
Status of MCP Card, Supplementary Nutrition Support to Lactating Women by AWC, THR for 6 months-3 years' Children and Status of VHND

Apart from ensuring good practice on breastfeeding, the programme highlighted other aspects of ICDS including – awareness on Mother Child Protection (MCP) card, understanding the situation of supplementary nutrition to lactating women and Take Home Ration (THR) for 6 months-3 years' children. The idea is to bring into discussion that such services also exist when we talk about pregnant women, lactating mothers and breastfeeding practices. The MCP card is issued to all pregnant women when they register their pregnancy at the AWC or health centre during the first trimester. The card contains various information on immunization, health and nutrition issues for the mother and the child. It also works as a tracking document for visits to AWC or local health centres for antenatal care, postnatal care check-up along with immunization to mother and children and growth measurement of children. This card comes handy both for the mother and service providers such as AWW, ASHA and ANM. It was found in the survey that 87% households were aware about the MCP card during the baseline and this increased to 92% in the endline. The awareness of MCP cards was lowest in Uttar Pradesh (75%) followed by Bihar (87%), however it should be noted that there was a significant increase in the awareness of MCP card in Bihar during the intervention period.



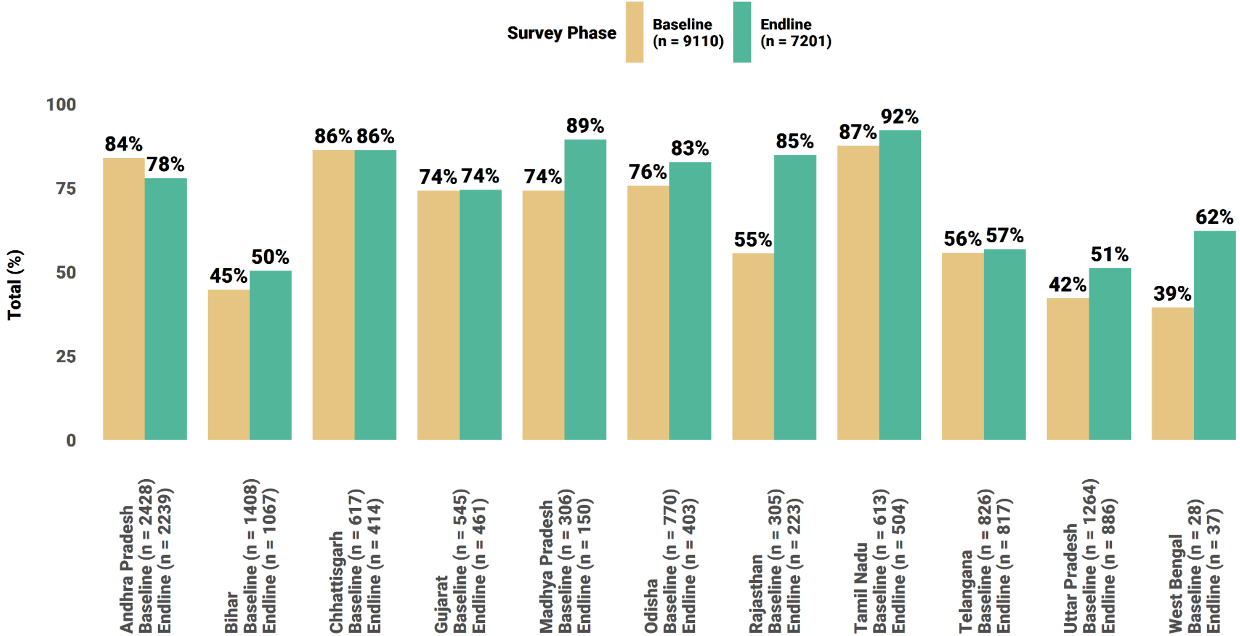
Supplementary nutrition support is one of the major services under the ICDS scheme. Under the service pregnant, lactating women, and children under 6 months till 6 years are provided with nutrition support by the AWC they are registered with. Pregnant and lactating women are provided with take home dry ration. Under the National Food Security Act (NFSA) 2013 Pregnant and Lactating women are entitled to 600 calories and 18-20 grams of protein per day. Training of the volunteers and coordinators made them aware of the supplementary nutrition support programme and provisions in different states. They played a crucial role in sensitizing pregnant, lactating women and their families on their entitlements. 86% lactating women reported to have received supplementary nutrition during baseline, which increased to 90% in the end line.

Like pregnant and lactating women, children in the age group of 6 months-3 years are entitled to **take home dry ration**. According to National Food Security Act (NFSA) 2013 they are entitled to 500 calories and 12-15 grams of protein per day. It was found that 84% children received take home ration support during baseline which increased to 87% by the end of the project. It came out that eligible beneficiaries/ entitled children who were not receiving dry ration were not in contact with the AWC. Some others reasons pertaining to non-receipt of take-home dry ration are – families not requiring take home ration, poor quality of ration and unaware of the scheme. One of the positive developments noticed from the survey is among those families who did not receive take home ration due to lack of awareness declined from 47% at the time of baseline to 27% during the end line. This is possibly because of the regular community meetings conducted by volunteers on the issue. The team in Bareilly, Uttar Pradesh visited all the AWCs to understand the status of Poshan distribution as the same wasn't getting distributed to the communities. The team also engaged the Pradhan and CDPO to look into the issue. One of the primary reasons as emerged from community meetings was that the AWC was distantly located and hence people restrain themselves from going there to access the services (this also implies that children are unable to visit the centre for their early development). Besides that, there were no AWCs in the most marginalised hamlets. This survey has been of extreme help to advocate for AWCs, such as the team in Mahesana district of Gujarat have submitted applications for the AWCs. In Ajmer district of Rajasthan, there was a demand for new AWC closer to the villages. The narratives from Samastipur Bihar was that timely distribution of THR was not happening for past three months and the THR service was not given. Thus distribution of THR was a concern where THR was a medium which attracts the community and if this too was not happening then the community loses hope which indirectly impact the immunization process too.



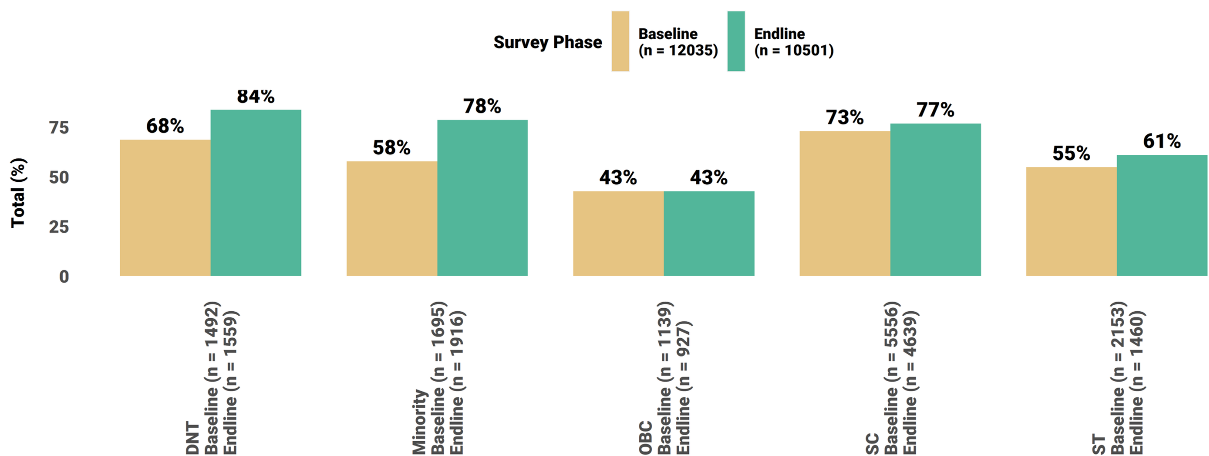
Village Health Nutrition Day

The VHND is supposed to be organized every month in the AWC of each village. VHND is seen as a platform for interaction between community and health service providers. The local service providers such as AWW, ASHA and ANM are required to be present during VHND where the community can interact freely with them on various health and nutrition issues and get necessary information. The major issues covered during the VHND are maternal and child health, family planning, reproductive tract infection and sexually transmitted diseases etc. The programme made an attempt to build awareness on VHND. Volunteers connected with the frontline health workers and attended VHND at the AWCs. They also worked in close collaboration with the AWWs to mobilise the pregnant and lactating women to come to the centre during VHND. It came out of the survey that there was an increase in awareness among respondents on the VHNDs being organised. While the increase in level of awareness remained stagnant in the majority of the states however, there is a substantial increase in Rajasthan from 56% to 85% and in West Bengal from 39% to 62%.



Immunization

The Universal Immunization Programme (UIP) run by the National Health Mission is one of the largest public health programmes targeting 2.67 crore new-born and 2.9 crore pregnant women across the country annually. The UIP provides immunization for 12 vaccine preventable diseases free of cost. A child is considered fully immunized if the child receives all due vaccines as per national immunization schedule within 1st year of birth. Online trainings were organised with doctors for project coordinators and fellows, on the routine immunization programme and the myths and fears associated with vaccination. With the learnings gained, the volunteers sensitized the community on vaccination and mobilised parents in close collaboration with ASHAs to bring their children to the centres for vaccination on the scheduled days. In the survey, 72% at the baseline responded affirmatively that children below 2 years of age are vaccinated which increased to 82% by the time of endline. With regards to parents' awareness about 8 mandatory vaccines for children, it was 55% during the baseline and it increased to 61% by the time of endline. Community meetings and mobilisation strategies worked in favour of the same. During the baseline, 64% parents having children below 2 years responded affirmatively that their children had completed immunization with 8 vaccines whereas it increased to 68% in the end line. There was a significant increase in minority groups - from 58% to 78%.



Challenges and Learnings from the ground

Children having certain symptoms post immunization has been one of the common concerns.

Though immunization is one of the largest public health programmes, many tribal and vulnerable communities were still unable to access immunizations. Besides that, many were unaware about its importance.

People were not aware about the pattern of immunization – they were under the impression that immunization can continue even if one vaccine is missed in between. Many believed that the child does not need immunization.

In some locations, immunization process had come to a complete stop due to the outbreak of COVID-19 pandemic.

When the expecting woman visits the maternal home or even stays back post-delivery, it becomes challenging to keep track of immunization record (Vellore, Tamil Nadu)

Unawareness and several doubts led to a very low response on routine immunization of children in Uttar Pradesh such as – lack of knowledge about the importance of routine immunization, duration of vaccine, lapse of time for the routine immunization etc. Minority communities face difficulty for immunization due to existing doubts.

Actions on ground

- With support from the AWW, ASHA and ANMs, the team has built awareness and shared the understanding on the benefits of immunization and ill effects of malnutrition. The detailed explanations on symptoms of diseases and its aftermath led to an uptake of vaccines within communities.
- Meetings with mothers on immunization and awareness on attending VHND led to the increase in vaccine uptake.
- The team approached health department officials and frontline service providers at the block and district level to collectively spread awareness on routine immunization.
- Use of posters, IEC materials and small booklets have been impactful in spreading awareness.
- The organizations worked towards providing immunization cards to the families across intervention villages, and followed up with periodic home visits to remind them of their next immunization visit. The encouragement from volunteers increased the communities' immunization coverage. Migrant workers were encouraged to carry their immunization cards when they travelled outside the state in order to continue their immunization programmes.

"You all have done a very good job. Now parents are coming for routine immunization of their children on a regular basis and it has increased by many folds."
– ANM, Jhansi, Uttar Pradesh

"This is a very good effort and kindly keep this process going on a regular basis to bring awareness to the community. We also do the process but our joint efforts could be more powerful and yield good results."
– ASHA and ANM, Bareilly, Uttar Pradesh

"If you need any help, we will be ready to help you in this effort and use all pamphlets of our department for awareness generation."
– ADO (block) and Assistant Medical Officer (PHC), Ghazipur, Uttar Pradesh

Narratives from some state specific actions

Chhattisgarh

In Chhattisgarh, the team tried to approach the targeted groups and maintain sustained involvement with children in schools, teachers and local health workers. Regular community meetings helped to dispel the popular myths regarding injections. In Gariyaband district, regular home visits have been done to ensure those children who are not immunized get immunized. Through these regular home visits, families have been oriented on timely immunization of children.

West Bengal

In West Bengal, pregnant women couldn't take prescribed immunization as they are either daily wage or migrant labourers or in some cases, missed out the government's announcement on the location of immunization centre. This led to the impression that vaccine can be taken later. The issue was addressed by the team through regular follow ups to remind the mothers about their children's immunization date. The ASHA workers have ensured follow-up with the pregnant women to get them vaccinated. This has also been shared that immunization cards can be taken during migration thus ensuring timely immunization of child and pregnant women.

Uttar Pradesh

In Jhansi Uttar Pradesh, educational videos on routine immunization received from block level health department were used as medium of communication. The immunization registration card was demonstrated with the mothers to disseminate information about different types of vaccines, its timings, and health impacts on children. In Ballia district, announcements have been made from the mosque by the Maulvi to request people from minority communities to attend the routine immunization camp besides taking COVID-19 vaccination.

Bihar

One Muslim woman from one of the intervention villages in Khagaria, Bihar was unwilling to get her child immunized. However, the team convinced her for child's immunization but the child got post-immunization symptoms which led her to worry. The team made her understand that these symptoms are natural, nothing to be afraid of and provided ice in the immunization spot. As the child started feeling better and was safe – she realised the importance of immunization. Now she gets called in the immunization camps to motivate other women for children's immunization. In Gandhar village of Bihar, the ANM and ASHA were not providing MCP cards to eligible women. As the team intervened, it was found that there were gaps in getting immunization records and the frontline workers were in process of updating the cards. On the other hand, the frontline workers mentioned about communities' indifference to take care of the cards hence they safely keep it with themselves. Team's intervention through orientation meetings with community and frontline workers ensured that the process was eventually back in place.

In Balbhadrapur Mahishi village of Samastipur, the community faces difficulties in getting their children immunized mainly due to the AWC being located far and the existing caste discrimination. With team's efforts, now a majority of people have started going to AWCs and even the ANM who belongs to an upper caste responded well towards the immunization of children. The ANM also began informing the hamlet members before the camp, and taking children to immunization centres and started making home visits. The team conveyed the message of keeping the surrounding clean for the ANM visit which was one of the reasons for ANM not visiting the village earlier. The chief medical officer has been approached to seek support in organizing village level immunization and health camp for those who are unable to reach the health centers.

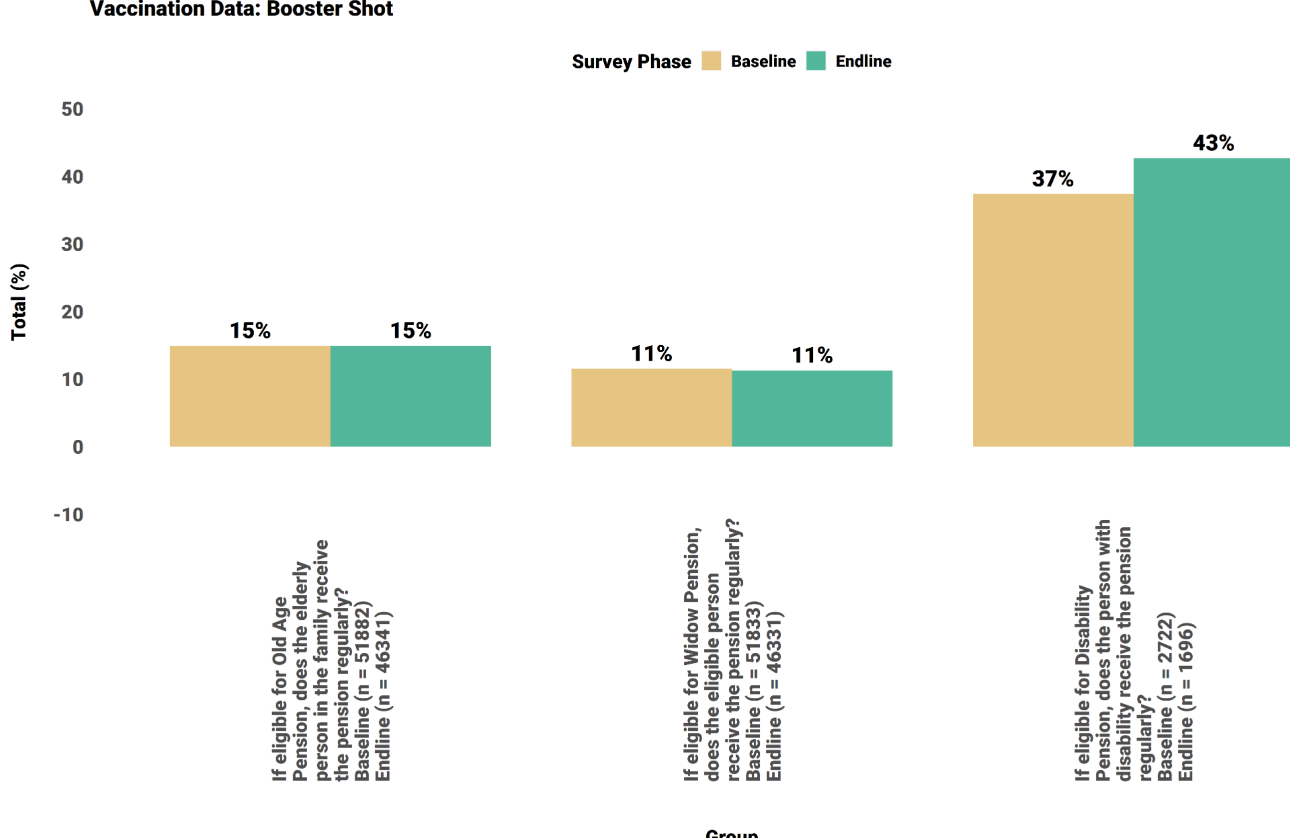
In West Champaran district of Bihar it is noticed that where the health center is nearby, the immunization process happens well and even the community is aware as well as take self-initiative to visit the center but where the centers are far away the immunization process is a challenge. One of the reasons for awareness and self-initiative at the centers which is near to the community is because the visit of ANM and AWW and ASHA is frequent. Even the Samistipur team of Bihar bring out the concern that distance of AWCs is a concern which somehow makes a distance between community and services. From Bihar West Champaran the team reported that the AWC barely has proper infrastructure in rooms, so putting up posters was not the priority for them. This also implies that if AWC is not in good condition then other services automatically not function well thus loose the interest of the community.

9. Social Security Schemes and Entitlements

State level online training programmes were organised for coordinators and volunteers of each state with experts and activists working on social security schemes. In some states even the experienced district coordinators took the initiative to train their team as well as other district or state teams on need basis. The district and village level teams also took initiatives to visit departmental offices to learn from the officers on duty. The training structure took into consideration practical challenges teams would face while assisting communities in linkage, hence ensured that teams visit department offices to develop an understanding on the application procedures as well as ways of addressing difficulties they might face. While the volunteers supported eligible yet left out beneficiaries to apply for entitlements, they also worked with the panchayats and local administration to ensure that necessary details of the applicants were submitted.

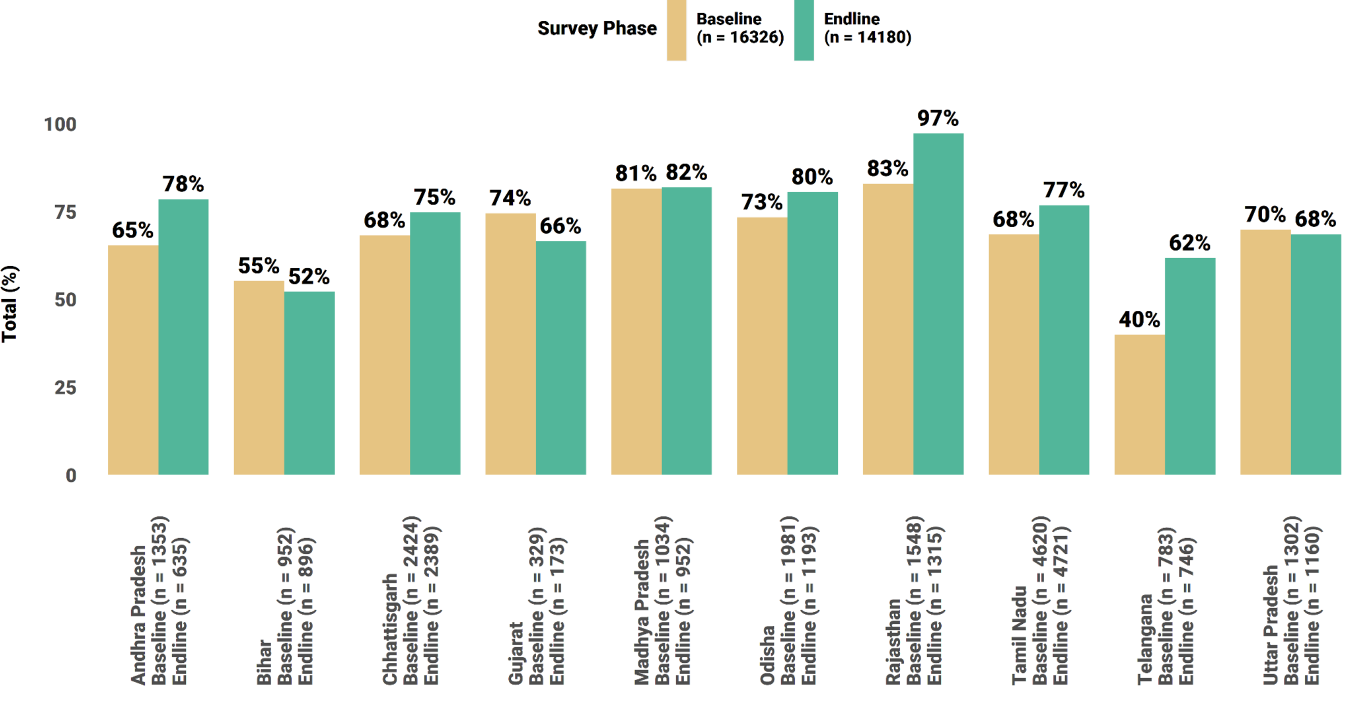
Pension schemes

The social security pension scheme, popularly known as the pension scheme is part of National Social Assistance Programme (NSAP) under Ministry of Rural Development. The pension scheme covers 3 major groups: aged (people over 60 years of age), widow and people with disability. To be eligible for any of the schemes, the household needs to be covered under Below Poverty Line (BPL) category. Majority of the state governments separately have their state-specific pension schemes drawing additional resources from their own budget. With regards to the receipt of old age and widow pension by the eligible beneficiaries, there hasn't been much change in the scenario but in case of disability pension – there has been an increase from 37% in baseline to 43% in end line. The team also explored the reasons for exclusion of certain eligible people in accessing pension schemes – 41% does not receive old age pension due to complicated documentation process, 28% does not receive due to incomplete documentation and 30% does not receive as there are no one to support them. Similarly in widow and disability pension schemes – the complicated application process emerged as a contributing factor for beneficiaries not receiving pensions regularly.

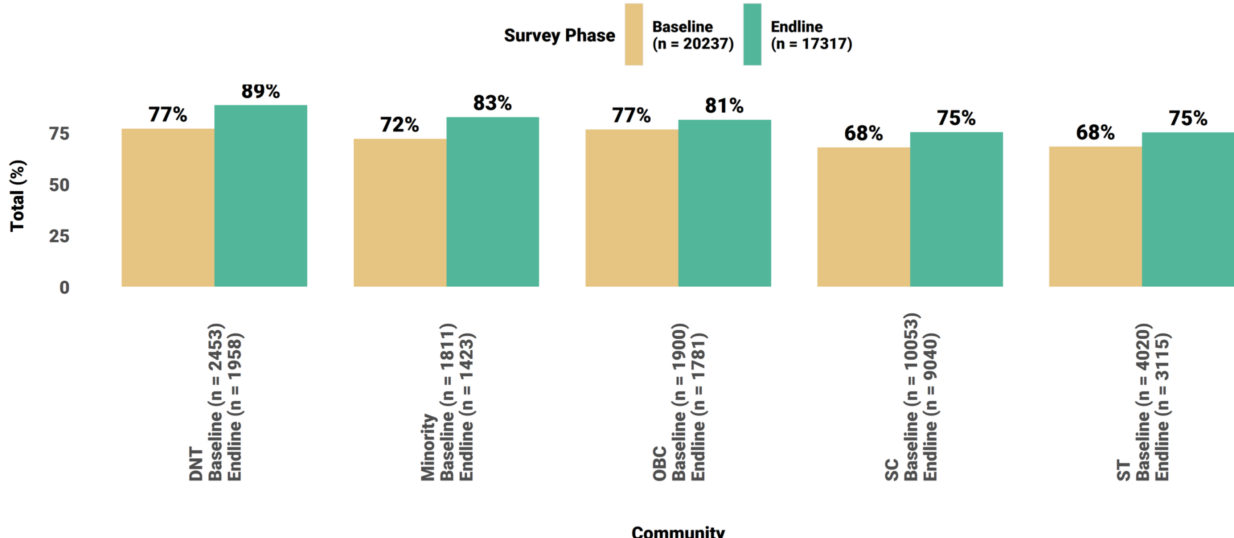


Mahatma Gandhi National Rural Employment Guarantee Act

MGNREGA is one of the most important rural employment programmes in the country. It aims to enhance livelihood security in rural areas by providing at least 100 days of wage employment in a financial year to at least one member of every household whose adult members volunteer to do unskilled manual work. The scheme guarantees to provide work to the worker within 15 days of demanding work. It also says wages have to be provided to the worker within 15 days of completion of the work. In the survey, participants were asked about the number of days of work they were assigned to after demanding the same. During the baseline, 30% got 1-25 days of work, 17% got 26- 50 days and 19% got 76-100 days. However, 22% of households didn't get a single day's work. There was a very nominal change of 1% between baseline and endline across all categories. In case of payment of wages for the work done, it was highest in Rajasthan with 83% and lowest in Telangana with 40% during the baseline. Similarly, in the endline, the percentage of wage payment was highest in Rajasthan with 97% but it was lowest in Bihar with 52%. The decline in percentage of households received wages for the work done has also been observed between baseline and endline – it was 55% to 52% in Bihar, 74% to 66% in Gujarat and 70% to 68% in Uttar Pradesh.



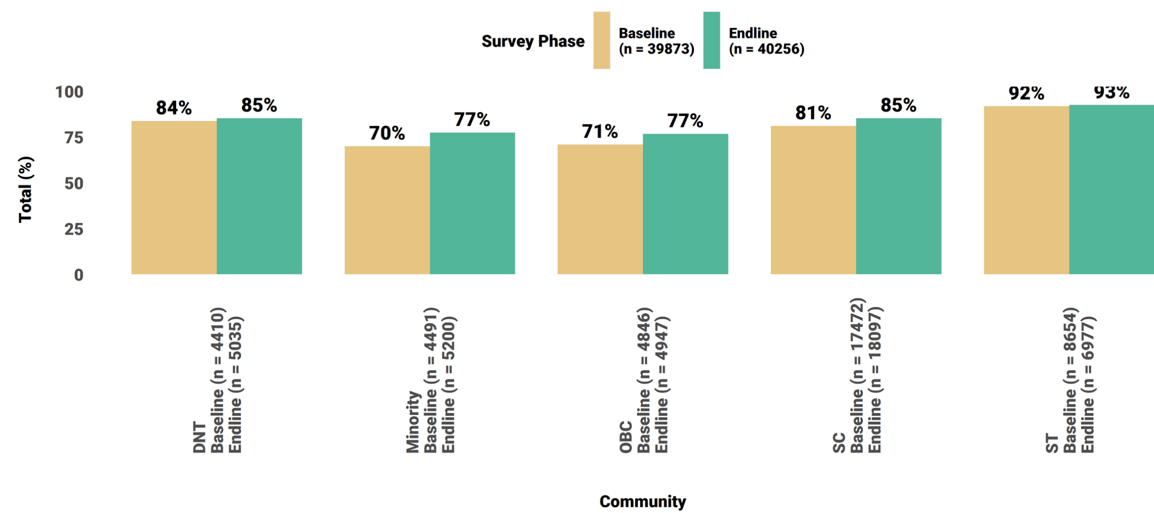
Did you receive the required wages for the work done?
Response: Yes fully



One of the challenges faced by the community in accessing work under MGNREGA is lack of knowledge and awareness on its application procedure. In Rajasthan, awareness has been built for filling form 6 and collection of receipts for the same. There have been instances where the women in Rajasthan demanded for receipt from panchayat after filling form 6 and also ensured that date is written on the receipt. One of the other challenges pertains to updation of KYC (Know Your Customer) of MGNREGA workers. If a single person's KYC is not updated – it impacts the entire group of people assigned to do a particular work in the MGNREGA site. Moreover, workers face difficulties with the online attendance system as it doesn't get updated due to bad network and people don't get their payments.

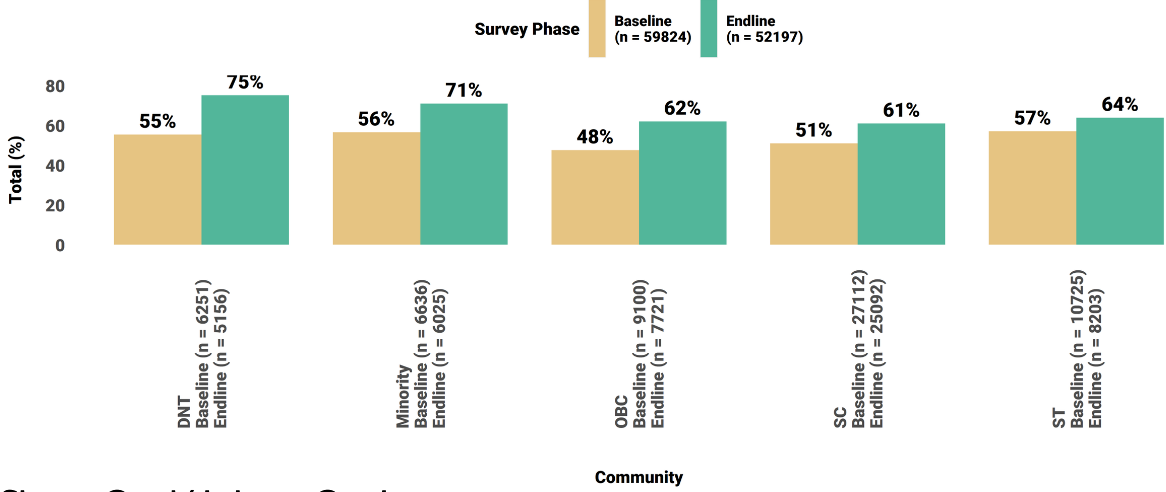
Ayushman Bharat

Ayushman Bharat, a flagship scheme of Government of India, was launched to achieve the vision of UHC. It has two major components: health and wellness centres and PMJAY. The PM-JAY which is also popularly known as Ayushman Bharat is primarily a health insurance scheme which covers Rs. 5 lakh per family per year for secondary and tertiary care hospitalization covering 12 crore families across the country. The eligibility of households for the scheme is based on the deprivation and occupational criteria under SECC 2011 respectively for rural and urban areas. With regards to the access to Ayushman Bharat card by various social groups, it is highest among ST communities (93%) and lowest among minorities and OBCs (both at 77%).



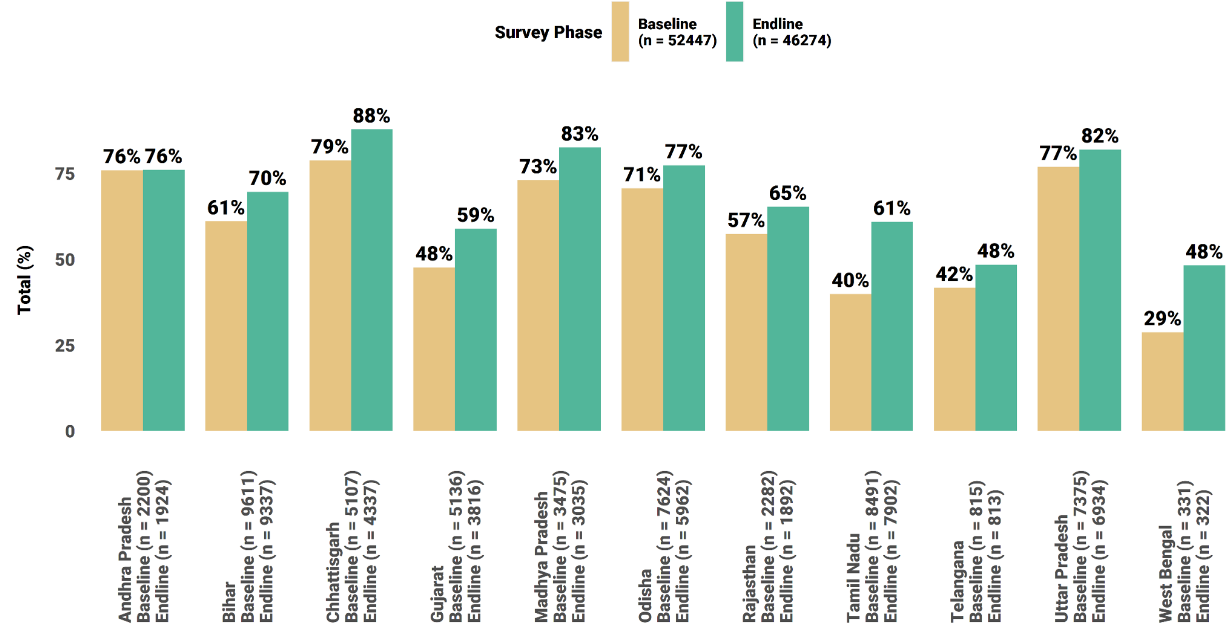
However, both in case of minorities and OBCs, it saw a substantial increase in the coverage of the card in between baseline and end line from 70% to 77% and 71% to 77% respectively. In rest of the social groups the increase was nominal between the two rounds of surveys. It has been observed that awareness about Ayushman Bharat scheme is highest among DNT groups (75%) followed by minorities (71%). Interestingly in these two social groups, level of awareness among households increased substantially in between the surveys. Even in the rest of the social groups an increase in awareness level has been observed but it is nominal. The community members with support from Community Health Centers and ANM in Jaunpur, Uttar Pradesh visited Panchayat Bhawan to make Ayushman cards for those who don't have it.

Are you aware of the Rs 5 lakh health coverage for economically weak families under the Ayumanbharat scheme?
Response: Yes

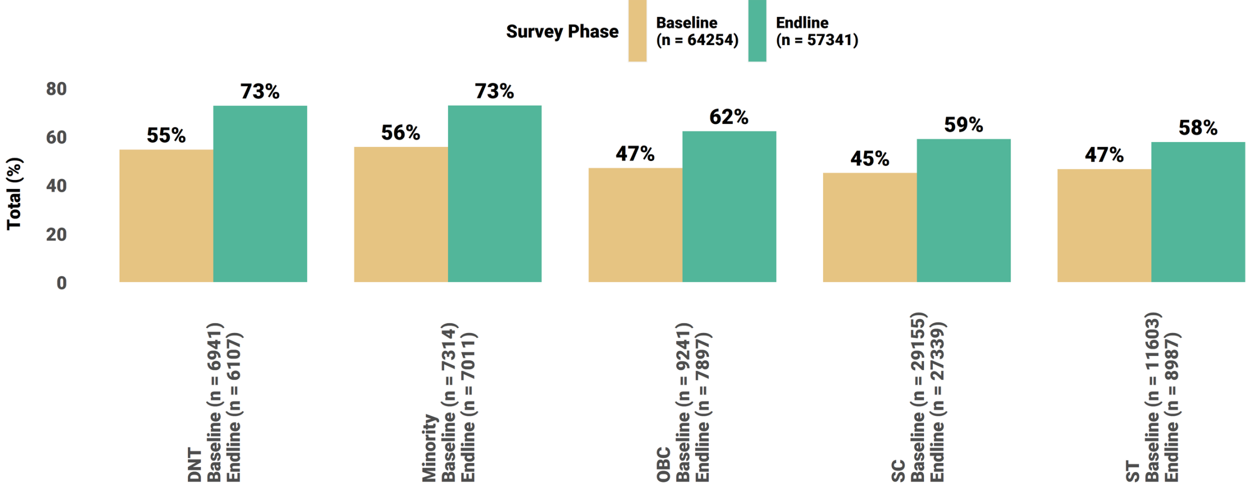


E-Shram Card/ Labour Card

The E-Sharm is a national database of unorganized sector workers developed and maintained by the Ministry of Labour and Employment. It is the first-ever national database of unorganized workers including migrant workers, construction workers, gig and platform workers etc. Any unorganized sector worker in the age group of 16-59 years is eligible to register under the E-Shram portal. A 12-digit unique number is assigned to the respective worker after registration which is known as Universal Account Number which is also known as E-Sharm card. With regards to possession of E-Shram card, the access to card is observed highest in Chhattisgarh (85%) followed by Madhya Pradesh (83%) and Uttar Pradesh (82%) at the time of endline. The states with lowest rate of possession of E-Shram cards are Gujarat (59%), Tamil Nadu (48%) and West Bengal (48%) during the endline. Between baseline and endline surveys, substantial increase in the receiving E-Shram cards has been observed in Tamil Nadu (40% to 61%) and West Bengal (29% to 48%).



Do you know there is a 2-lakh rupee insurance for workers under this e-shram card?
Response: Yes



With regards to the E-Shram card holders' knowledge on the insurance coverage of Rs. 2 lakhs, an increase in awareness level has been observed among all social groups between baseline and endline – the rate of increase is highest among minorities from 56% to 73% followed by DNTs from 65% to 73%.

Challenges and Learnings from the ground

Issues with dentification and Sanctioning

- Difficulty in identifying eligible widows.
- Lack of sanctioning of correctly submitted applications by government officials and requesting for repeated submissions.
- Non-approval of pensions due to absence or non-updation of KYC.

Tedious Application Procedures:

- Complex application procedures for schemes like Pradhan Mantri and Chief Minister child care scheme.
- Difficulty in online documentation and application processes.
- Unavailability of computer operators in Jan Sewa Kendra.
- Closure of online portals for government schemes in Uttar Pradesh.

Outdated Information and Beliefs:

- Outdated list of eligible people for social security schemes in Gujarat.
- Reluctance to register for Ayushman cards due to superstitious beliefs.

High Charges and Payments:

- Higher charges by agents assisting with online application submission.
- Applicants having to pay for support from other sources.

Livelihood Generation and Employment:

- Inadequate employment opportunities under MGNREGA.
- Insufficient wages for MGNREGA workers.
- Preference for daily wage labor over MGNREGA work in West Bengal.

Actions on ground

- The volunteers oriented the community members about different schemes and then supported in filing online/ offline application and submission processes with the panchayat and district officials.
- With support from volunteers, communities are taking own initiatives to learn online application procedures.
- Orientation of volunteers and communities on health and E-Shram cards helped them gain confidence and entitlement benefits. This learning has worked as a spill over effect as they encouraged other community members to avail the same.
- Teams were able to organise camps for availing the schemes' benefits. In several places, teams accompanied community members to visit respective centres for application process.

Gram Sabha engagement

One of the salient features of this programme was to promote community participation in Gram Sabha and increasing interaction with the panchayat. The baseline and endline survey show that there is a substantial understanding among communities about participating in Gram Sabha and linkages with Panchayat. There is an increase in women's participation (from 72% to 73%) as well as family members participating (3% increase in endline in comparison to baseline) in Gram Sabha. Awareness about the Gram Panchayat Development Plan increased by 5%, while the number of people who raised issue with any panchayat functionary also increased by 3%. After the baseline data collection in Madhya Pradesh and Tamil Nadu, based on the analysis of the data community-led signatory appeal was submitted and the issues were raised at Gram Sabha as well. In Odisha partners shared that while Gram Sabhas were happening in their area, most of the women who would attend the meeting would not raise any points. However, after multiple engagements with the fellows and district coordinators related to issues in the community, the women now felt more confident to raise their voices.

Narratives from some state specific actions

Odisha

In Odisha, eligible beneficiaries who were not receiving widow pension took own initiative to apply for the same. If ongoing entitlements are not renewed by the beneficiaries, they stop receiving the same. Such cases with regards to pension schemes have been addressed by the teams. The focus areas were access to PDS, health card and pension for PwD. Information and awareness about the uses of health card and its validity were shared with the community, and Community Based Organization (CBO) members were tasked with facilitating the drive across the villages. Furthermore, Grievance Day was utilized for fixing gaps in coverage and smoothing out obstacles faced by new applicants.

Tamil Nadu

In Tamil Nadu, areas where coverage still lacked, especially in Particularly Vulnerable Tribal Groups (PVTG) areas, representations were made at the Block level while organising camps at the district level for health cards. In Tirunelveli district, apart from providing PDS and health cards, emphasis was on labour cards for the communities since the Tamil Nadu Labour Welfare Card gives access to other schemes and benefits as well. With increased access to internet and information, 20 youth groups were able to apply for a National Bank for Agriculture and Rural Development (NABARD)-sponsored scheme to purchase coconut picking machines. The organisation also helped community members to apply and obtain worker's welfare cards, avail entitlements for marriage and compensation for unnatural deaths. Since the SC and ST communities do not get adequate opportunities for government jobs, increasing awareness about existing schemes and mechanisms for government employment was a notable component of the organization's work in the thematic area of schemes. Furthermore, majority of the volunteers were from the SC and ST communities, and their engagement in the programme and the use of ICT significantly bolstered their confidence.

West Bengal

In West Bengal, the team has made an attempt to visit the panchayat office after accumulating the list of those applicants who need to apply for respective schemes. Thereafter, they have followed up the status of application to ensure that the applicants receive entitled benefits. BDO has been approached to submit applications with respect to the demand for ration card.

Uttar Pradesh

At present in Uttar Pradesh, MGNREGA is almost non-existent at the village level and pension cards have been applied but not yet received. Nonetheless, due to the organizations' efforts towards increasing awareness about government sponsored schemes, there is demand arising from the ground level. Online application for availing benefits and entitlements has also contributed to the ground swell. Increasing awareness of schemes such as the Building and Other Construction Workers (BOCW) Act has led to increased demand for entitlements from the community. However, there continues to be irregular distribution of PDS and nutrition kits. In the case of Bal Sewa Yojana, volunteers have become very active in ensuring the benefits reach the communities. In Hardoi district, the team took printouts of the schemes (like social protection and toilet construction) to facilitate the awareness process with the community. In Jaunpur district, paralegal volunteer under DLSA was appointed in panchayat bhawan through the Pradhan and PDS dealer. The volunteer met food supply officer and put forth the issue of name in PDS. The officer asked them to come with all the required documents. This process was first done at the Tehsil level and thereafter replicated at the village level. One of the community members said, "If you were not there this would have not happened. Because of your help, our name got added in ration cards and there is an increase in the units received."

Gujarat

In Gujarat, activities were focused towards increasing access to government sponsored education aids and schemes. With the help of online information and applications, communities were able to bypass the inflated costs charged by agents. As a result of the organizations' interventions, access to schemes was made possible simply with an Aadhar card, as opposed to the need for multiple documents. It also organized E-Shram camps for migrant labourers.

Bihar

In Bihar, community level camps focused on old-age pension, widow pension and health cards. There was greater uptake for labour cards over Ayushman cards. Furthermore, increasing awareness and information about existing schemes also translated into greater accountability sought from government officials.

Rajasthan

In Rajasthan, the team has tried to explore the minor reasons for which the beneficiaries are not receiving benefits of the schemes. On the action point, the team guided the community members and also supported them to reach E-Mitra and banks.

10. Conclusion

As a conitnuation of phase 1, that focused on COVID vaccination, the aim for phase II of the ongoing Collect - Risk Communication & Community Engagement (RCCE) had been to focus on the delivery and sustainability of a number of health-related programmes. In this regard, the programme identified three key areas related to routine immunization, early initiation of breastfeeding and sustained toilet use. Following a similar engagement methodology to phase 1, the fellows underwent trainings on these key themes, following which they spent time understanding the challenges and key barriers at the community level. Equipped with the knowledge gained during capacity building sessions, the fellows were then involved in sharing this knowledge with community members, creating awareness and building linkages with administration across states.

Overall, the key findings reveal that the programme was able to initiate encouraging results towards awareness and access to these core themes. On the theme of vaccination, there was a 7% increase in the booster shots taken by adult women (18+) and 6% increase for adult men (18+). Considering the socially disadvantaged position of women, these results point to the fact that the programme had been effective in its outreach towards women. Other vulnerable identities such as Persons with Disabilities, pregnant women and transgender/non-binary population have reported increase of 4%, 7% and 5% respectively. While the vaccination rate among adolescents (between 12-17 years) remained the same through the baseline and end line due to the shortage of COVID vaccines across states, the fellows and coordinators played a key role in putting forth requests to the administration for Covid vaccines.

With regards to the three new themes in this phase (routine immunization, early initiation of breastfeeding and sustained toilet use), the programme deployed multiple strategies across states. To begin with, physical capacity building workshops were carried out with all state coordinators and fellows. Along with sharing of insights by experts, these workshops played an important role in creating a space for cross-learning across states. A space was created to share challenges in community mobilisation as well as the various myths across different states related to the three themes. In addition to these, online trainings and interactive sessions with doctors helped the coordinators and fellows grasp key concepts, dispel common myths and use this to disseminate information and build awareness among communities.

As there was a significant scope for community engagement compared to the earlier phase (due to the drastic reduction in the spread of COVID-19), the team across 11 states was able to engage more closely with the community as well as administration. The engagement strategy varied across states and included using IEC and dissemination through local networks, engaging with local panchayats, block and district level administration and key influencers. During the facilitation of meetings, the use of IEC materials that were culturally contextual and relevant were impactful for active engagement and in disseminating key messages. The use of local language as the medium of communication through skits, puppet shows, songs have been effective for larger outreach, the use of locally relevant art forms was also particularly impactful for spreading awareness. Positive case studies and practices were also used to convince and motivate other community members towards change, specifically with regards to behaviors such as toilet use, breastfeeding and immunization. Visibility events, for local-level awareness and engagement, emerged as another opportunity for communities to get together and deliberate on key themes in their areas.

Such multi-pronged messaging medium along with local level flexibility proved to be an effective method for engagement. Door-to-door engagement along with multiple community meetings were used to build awareness on key themes. Over the course of the two phases, the fellows have noted an increased participation of women in community meetings and the active engagement of local administration in supporting with key issues. In particular, results from the surveys reveal that there was a significant increase in awareness related to all themes, for instance the awareness about insurance under e-shram card increased by 14% and awareness about the insurance under Ayushman bharat card increased by 10% during the programme. As this phase had a stronger focus on access to entitlement, the team also made good progress in linkage with local stakeholders and panchayats. Fellows worked closely with Anganwadi workers, ASHA workers and ANMs across various states, leading to greater linkage with communities. A number of narratives have emerged of AWW, ASHA and ANM now visiting community members and providing more support in information dissemination.

Over the two rounds of surveys more than 52,000 households were physically visited and direct outreach was done with more than 2.5 lakh people which included 2 lakh adults. These efforts were complemented with 2005 hamlet level meetings, and 299 district level meetings. Though these concentrated efforts have led to positive results in certain aspects, some challenges are still persistent. For instance, while there has been a 4% increase in use of private toilets, a number of narratives from the ground reveal the difficulty in behaviour change related to toilet use, the lack of water and infrastructure access also remains a key issue. Similarly, myths surrounding breastfeeding still persist and require more focused interventions for greater impact.

To ensure effective and sustained behvaiour change, it is crucial to build local strength in the form of a trained cadre on the ground. Engaging in dialogues that address misconceptions, enhance knowledge and foster actionable change requires a long-term commitment of at least 2-3 years, during which a supportive ecosystem must be cultivated. The programme has played a role in demonstrating the pivotal role of local health workers as primary sources of information, emphasizing the importance of continuous engagement with them and facilitating their communication with communities to drive transformation. Throughout the two phases of this program, it has become evident that marginalised groups have faced significant barriers in accessing government programs. Therefore, ongoing efforts are necessary to establish linkages with the administration and raise awareness among the communities. Achieving this objective would entail a multi-faceted approach encompassing evidence generation, awareness-raising initiatives to foster an informed ecosystem, and the creation of community-led platforms.