PEKHRI VILLAGE

SOPHEA- SOCHARA
CHLP 2022-23

FELLOWSHIP FINAL REPORT
submitted in partial fulfilment of the
requirements for the
Postgraduate Diploma
In
Community Health

Shakti Singh Shekhawat
CHLP 2022

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CHLP Learning

Introduction and reason to join the fellowship

As state civil servant in Department of Women and Child Development, I developed a keen interest in Health, Nutrition and WASH Activities and awareness programmes. I was responsible for monitoring nutrition and health schemes for women and adolescent girls and executed awareness campaigns, facilitated supply of supplementary nutrition by supporting and strengthening local village-based Women SHGs and spearheaded Poshan Abhiyaan (programme to improve nutritional outcomes for children, adolescents, pregnant and lactating women) for which received Block Leadership award at National Level from NITI AYOG for effective implementation of Poshan Abhiyaan. Implementation of schemes and programs in the field like PMMVY (maternity benefit program by GOI), SAG (aimed at breaking the inter-generational life-cycle of nutritional and gender disadvantage and providing a supportive environment to out of school adolescent girls) and UNICEF backed "chuppi todo" programme for menstrual hygiene awareness in schools and villages were undertaken. Coordination with various stakeholders of development i.e. people, NGOs and SHGs, various government departments, private organizations, civil societies etc. to conduct WASH activities (Poshan Pakhwada) and awareness programmes (Swacchata Pakhwada, Suposhan Diwas, Swacch Bharat Programme) in Schools and Anganwadis were part of the job profile. I have also undertaken a research titled: “Women Empowerment – The Anganwadi Way – A case study of Northwestern Rajasthan, India” and presented it in the 3rd International Conference on Future of Women 2020 by TIIKM.

As part of the DRG (District Resource Group) I was responsible for training of all field functionaries in the district through ILA (Incremental Learning Approach) under Poshan Abhiyaan (flagship program of GOI), enhancing and encouraging public cooperation and participation so as to make project a self-sustaining, public driven movement, and raising resources was a major component. I was a part of several project initiation committees in the district like “Nutri-garden in the Anganwadi” & “Anganwadis for the brick kiln workers” in association with Tata Trusts.

I got interested in CHLP because it provided me an opportunity to explore Health and Nutrition sector further and identify the engagement and working models to work in the sector. I wished to combine the health and nutrition sector knowledge with the environmental aspects (which I learned through the PGD in Environmental law course by NLSIU, Bengaluru) to further work in the area of Health & Environment. This would not only involve consulting and Govt. advisory projects, but also private sector CSR Projects revolving around ESG (Environment, Social, Governance). Therefore, I wish to learn and apply the community health and environmental issues mitigation strategies towards a holistic developmental model.

Learning objectives

Learning Objectives

a) Acquire Knowledge – Basic concepts, success stories, challenges and changing trends in community health.
b) Attain Comprehension – Ideas, Models, Tools and techniques to study community health.
c) Application – Apply the knowledge and comprehension so gained to new areas and in solving community health problems.
d) Analysis – Draw connections between seemingly unrelated health issues, identify policy and implementation gaps, diagnostic studies, organise data and report on health issues.
e) Evaluation – Appraise, critique and recommend changes in policies, programmes and laws/guidelines related to health.
f) Develop ability to Synthesise – New ideas, techniques, models, design and innovation in health sector. Integrate community model of health in all livelihood, CSR, and community-based projects (both government and donor funded).

Areas of Interest

1. Environment and Health – interrelations
2. Policy analysis & formulation
3. Integration of community health models in donor and government sponsored projects.
4. Advocate, network and help disseminate community health concepts and ideas.

Module reflections and application

Module Name	**Key Concept/Takeaways*** *(directly quoted from reference material or modules)	**Reflections^** ^ (Personal)
Module 2 – Understanding Community Health	Community Health approach to solving public health issues • Recognises that the components of action are means and not ends • Flexible enough to reorient, reprioritize, disband • Change towards more relevant actions and directions • Evolve in the interactions at the community level	Equitable and Universal Health Care that encourages community health perspective & community participation in the monitoring and delivery of health services should be the aim of community health approach. Community participation should also be encouraged through dialogue and policy planning.
Module 4 – Right to Health and Access to Health Care	In the strategy of imposing the new right to health paradigm over the old and obsolete development paradigm, we have to get involved in a long-haul capacity building, advocacy, social mobilization and people's empowerment effort so as to influence short-, medium- and long-term health outcomes.	Wealth, education and occupation are important aspects to access health as a right. In addition, religion and caste (including tribal status) are other aspects of that influence health and health care access. All these factors above influence health through differences in access to resources, educational inequalities, specific sociocultural norms, discrimination and access to health services.

Module 5 – Social Determinants of Health	The CSDH framework departs from many previous models by conceptualizing the health system itself as a social determinant of health (SDH). The role of the health system becomes particularly relevant through the issue of access, which incorporates differences in exposure and vulnerability, and through intersectoral action led from within the health sector. The health system plays an important role in mediating the differential consequences of illness in people's lives.	The CSDH framework is probably the most difficult and most important learning from this course. It considers the entire health system as a social determinant of health and helps understand socio-economic setting influences health access and accentuates vulnerabilities.
Module 7 – Comprehensive Primary Health Care (CPHC)	Primary Health Care has an important role in the primary and secondary prevention of several disease conditions, including non-communicable diseases. The provision of Comprehensive Primary Health Care reduces morbidity and mortality at much lower costs and significantly reduces the need for secondary and tertiary care. For primary health care to be comprehensive, it needs to span preventive, promotive, curative, rehabilitative and palliative aspects of care. Primary Health Care goes beyond first contact care and is expected to mediate a two-way referral support to higher-level facilities and ensure follow up support for individual and population health interventions.	Comprehensive primary health care should include: • All services - geriatric health care, palliative care and rehabilitative care services • All aspects - reproductive, maternal, child and adolescent health • All diseases - communicable, non-communicable and occupational diseases
Module 8 – Equity in Health		Equity in Health goes beyond access to medical care, it has to be affordable and of good quality. Moreover, it includes safe drinking water and sanitation (WASH), adequate nutrition, clothing, shelter and decent livelihood opportunity. All of these should be available without any discrimination on any basis, be it caste, class, race, gender etc.
Module 9 – Health System in India	Dynamic Health Systems Framework - consisting of ten elements and their interactions 1) goals & outcomes; 2) values & principles; 3) service delivery; 4) the population; 5) the context; 6) leadership & governance; 7) the financial resources, 8) the human resources, 9) infrastructure & supplies, and 10) knowledge & information	• India is going through economic, demographic and epidemiological transition. • Individual health services is predominantly carried out by private providers. • Access to medicines, vaccines and diagnostic facilities is still an issue not just in rural but also in urban areas.

		Affordability and quality issues add to the concern.
Module 11 – Universal Health Care and Universal Health Coverage	• Health care services should be accessible and affordable to all sections of Indian society, especially the vulnerable section of the population. • Health care services should be equitably distributed between urban and rural India, between men and women, between rich and poor, between the castes and among the States. • Health care services should be aimed at maximizing health gain	Critical areas to promote UHC: • health financing and increasing public spending on health • health service norms ad guidelines • human resources for health – quality and standards • community participation and citizen engagement • access to medicines, vaccines and diagnostic technology • management and institutional reforms
Module 12 – Understanding Voluntary Health Sector	The focus of the voluntary health sector is to bring: • The People back into the centre of primary health care • The Public back into Public health systems • The Community back into the health policy discourse.	The information asymmetry that exists between the health care providers and community at large should be bridged through efforts from voluntary health sector.
Module 13 – Food and Nutrition	Community level: regular observation of village health sanitation and nutrition committee meetings, and village and health nutrition days, monitoring of the regular and good quality supply of supplementary food at Anganwadi centers and mid-day meals in schools, regular and continuous supply of safe drinking water, and strengthened open defecation free (ODF) campaign, sustainable and good animal farming and agricultural practices, and availability of nutritious, good quality, and fresh foods in the local markets	Undernutrition (wasting, stunting and underweight), overnutrition (imbalanced nutrition) along with iron and calcium deficiencies impacts health of women and children of all ages. No specific govt. programme addresses these holistically, only separate drives exist.
Module 15 – Women's Health	Antenatal care, Anaemia, Post-partum care still remain an issue in India. Heath policies and programmes have neglected several issues, especially for women from marginalized communities, and safe abortion. Institutional bias against migrants is yet another problem that affects women the most.	Status of women education and health outcomes closely interrelated. Malnutrition, food insecurity and specific nutritional deficiencies such as anaemia add to maternal and child health issues.
Module 17 – Mental Health	Key differentiation between abnormal mental health and 'off-moods'/ 'emotional upsets':	Mental health is probably the most significant addition to the health concerns of the country Post-

	1. Abnormal changes in one's thinking, feeling, memory, perceptions and judgements resulting in changes in talk and behaviour 2. These changes cause distress and suffering to the individual or others around him or both 3. The abnormal changes and the consequent distress cause disturbance in day to day activities, work and relationship with important others (social and vocational dysfunctioning)	COVID, which was hitherto ignored. It is no longer urban or a problem associated with urban lifestyle alone. I learnt about the various initiatives and agencies working in the area of mental health for decades.
Module 21 – Palliative Care	Difference between convention care and palliative care: Palliative care recognizes that people are much more than organs put together; their mind, spirit and emotions are all part of who they are. It also recognizes the patient's families and communities. So, the problems faced by a sick person and his/her family are not just confined to the disease; there may be pain and other symptoms in conjunction with psychological, social and spiritual concerns.	Palliative care interventions range from tertiary care services to community health services to care at the patient's home. They aim to provide patients with pain and symptom treatment along with counselling and psychosocial support.
Module 22 – Climate Change and Health	India is particularly vulnerable to health risks from climate change, given its large population, dependence on the monsoons for livelihood, and relatively low socioeconomic development.	Monsoons have become unpredictable and erratic, possibly due to climate change, and this has implications on food and nutritional security, diseases and thereby health.

Mentorship process and reflections

Mr. Sunil Kaul along with Karthik, Janelle and Radhika provided the perfect support and guidance. There were instances when I felt stuck, not able to grasp concepts, or felt left behind, and the mentors provided me that gentle nudge to keep going.

I found Mr. Sunil to be quite accessible and approachable. It was a long time ago when I was in a teacher-student setup, and I found the entire process to be quite engaging and fruitful.

I suggest that the mentors should be a part of the orientation CHCC, or if possible, should be assigned at the beginning of CHLP to provide enough time to deliberate and understand the nuances of field work.

Project learning experience

Project work offered immense satisfaction and learning experiences:

a) Conceptual clarity - contextualising CHLP module learning
b) Skills - leadership, teamwork and communication skills
c) Aesthetics – landscape, experiential learning, opportunity to observe ecological effects of environmental change, sustainable development
d) Social and personal development

Take away from CHLP

CHLP is not just about community health, it is much more comprehensive in terms of:

a) A different approach to co-learning
b) Innovative curriculum and delivery
c) Flexible programme of study
d) Application based
e) One providing great networking opportunity

PART- B

Community-Based Health Action-Reflection Project

Village Background

Geography

Pekhri, Panchayat Pekhri, Tehsil Banjaar, District Kullu
About 300-370 households live in the village, with the total population of 1338 (As per Census 2011).

Livelihoods

Agriculture and pastoralism are the two main livelihood sources. Most people have lands, wheat and corn are the two main grains and among fruits - apricots and apples, along with pears, plums, persimmons. Peas and french-beans also provide a secondary source and are grown as cash-crops. Other crops, vegetables, dairy and honey are for house-hold consumption only. Other sources of livelihood include handicrafts and collection of medicinal herbs. Goat and sheep rearing is the main practice, with a few cows in almost every household. A handful of families get work outside the village, running shops in the Gushaini market, or working in various government and private jobs.

Picture 1 Shepherd basks in the sun as the animals graze. Only a few continue in this profession

Tourism is seen as an emerging source of livelihood, to this effect, many have built homestays in anticipation. This is in keeping with the general trend in Tirthan valley. In fact, I stayed in one such home stay with proper toilets and heating facilities.

Infrastructure

Energy: Electrification is complete for almost all house-holds, and in addition to lights and device-charging, it is slowly being adopted for heating purposes; mainly water and room. Firewood is still very important for heating in winters and also for cooking to various degrees. Every house-hold also has LPG cylinders.

Water: Taps are shared by multiple (4-5) households, fed by one of two storage tanks, in turn fed by the two very small streams running through the village. They are used in a rough rotation through the day. Everyone manages a more continuous supply by using individual overhead storage tanks along with storage drums.

Other: Primary school is in the village. For Secondary school, children go to Gushaini, which is where there is a health center, veterinary doctor, market, panchayat office, etc.

Housing, Food (eating habits) and Daily Needs: Till a few decades ago, before the road came, people depended on their local ecology for almost all basic needs other than salt and perhaps metal vessels. Grains, flour, lentils, cooking oil, vegetable, dairy, fodder, meat, honey, firewood, timber, roof slates, other construction materials, medicine, community, religion, learning, entertainment, clothes, shoes, bags, and so on.

As the road has increased the connection to the public distribution system and distant markets, relationships with the local ecology have reduced. Traditional ecological knowledge has languished. There are still some customs like collecting rhododendron flowers when they're in bloom to adorn doorways of all houses that connect daily life to the seasonal rhythms of the forests in a non-utilitarian way. In terms of dependencies, the commons and forests are still the source of all fodder, firewood, grazing lands, timber, dairy, honey and also a partial source of animal feed, vegetables, lentils, meat and construction material.

People have to travel further and further for timber and even firewood as the population has increased and the local ecology degraded. People have responded by planting fast growing exotic firewood species like robinia and toona on their fields, and by planting patches of traditional timber trees like deodar and blue-pine in nearby commons. The latter has been successful only to a degree as it requires cooperation with respect to harvesting, fire-management, and grazing.

Local Ecology (One Health Perspective)

Based on the age of traditional houses, the village is more than 200 years old, since then, it has grown from a few households to its present form. There seems to be not much history remembered from before colonial times, when large tracts of forest were probably cleared. Since then, the areas around the village have been in a state of ecological degradation. In the last few decades there has been some awareness about the need to safeguard forests, augment them with planting native trees, checking wild-fires, etc.

Picture 2 Patch of old and regenerated forests. Pine and deodar are the main trees of the landscape

In the past this area had dense forests of oak along with other broadleaves (rhododendron, holly, horse-chestnut, maple, mulberry, wild apricot, wild pear, walnut, ash, celtis, cornus, elm, toon, alder, birch, willow, machilus) and mixed conifers (blue pine, deodar, yew, fir, rarely spruce).

Biodiversity (One Health Perspective)

Floral diversity: Along with the tree species mentioned above the natural heritage of these mountains also includes climbers, epiphytes and ferns, along with many shrubs and herbs.

Thorny shrub species of the genus Berberis and the family Rosaceae (rosehips, raspberry, black-berry, etc) dominate because of the grazing pressure. Additionally, there are shrubby species of legumes like Indigofera, Desmodium. There are also numerous species of the sage family and in the more moist understory areas there is sarcococca.

Herbaceous plants of the aster, mint and plantain family abound along with wild turmeric, the latter mostly in moist patches. Absence of bamboo-grass (Sinarundinaria), once in abundance and used for basket making, is conspicuous.

In terms of cultivated species, there are multiple species of amaranth, along with barley, wheat, and possibly buckwheat, and of course many species and varieties of lentils. While the crop diversity is decreasing, the diversity in fruit cultivars of apples, pears, plums, persimmon, etc is perhaps increasing.

S.No	Scientific name	Local name	English name	Uses
1	Cedrus deodara	Deodar	Himalayan Cedar	Timber for house-construction
2	Pinus wallichiana	Kayil	Blue Pine	Timber for house-construction
3	Quercus floribunda	Moru	Green Oak	Fodder, Firewood, Agroforestry
4	Prunus armeniaca	Khumani, Saadi	Wild Apricot	Fruit, Kernel Oil, Firewood
5	Rhododendron arboreum	Buransh	Rhododendron	Flowers
6	Juglans regia	Akhrot	Walnut	Nut, Furniture
7	Toona chinensis (mostly planted)	Lenth/Daral	Toon	Firewood, Fast growing
8	Robinia pseudoacacia (exotic, planted)	Ravinia	Robinia	Firewood, Fast growing
9	Morus serrata	Chimu	Himalayan Mulberry	Fodder, Fruit
10	Pyrus pashia	Shegul, Naak	Wild Pear	Wild fruit, Rootstock for Cultivated fruit
11	Quercus semecarpifolia	Kharsu	Brown Oak	Fodder, Firewood
12	Pinus roxburghii	Chil	Chil Pine	Firewood
13	Alnus sp.	Kosh	Alder	Timber, Fodder
14	Populus ciliata	Poplar	Poplar	Timber
15	Aesculus indica	Khnor	Horse-chestnut	Soap, Wild edible
16	Celtis australis	Khadak	Nettle Tree	Fodder, Agroforestry
17	Taxus wallichiana	Rakhal, Thuna	Himalayan Yew	Medicinal, Timber
18	Ilex dipyrena	Khadoocha	Himalayan Holly	

19	Cornus sp.	Chhoon	Dogwood	
20	Ficus palmata	Phoogu	Wild Fig	Vegetable, Fodder
21	Rhus/Toxicodendron punjabensis	Arkhol, Rikhal	Chinese Varnish Tree /Punjab Poison Oak	Medicine
22	Quercus leucotrichophora	Baanj	White Oak	Fodder, Firewood
23	Salix sp.	Madnu	Willow	Fodder

Table 1 Major tree species (excluding fruit trees)

S.no	**Local Name**
1	Chidchidi
2	Thalnu
3	Bandari
4	Saryara
5	Kupda
6	Pharan
7	Gada Saryaru
8	Garnala
9	Amarbel
10	Kathu

Table 2 Major shrubs and herbs

S.no	**Name**
1	Rajma
2	Corn
3	Jau (barley)
4	Soya Bean
5	Massal

Table 3 Major agriculture crops

Social Context

General Well-being

Most of the families are connected through matrimonial or familial ties and the social fabric is quite tightly woven. People support each other in daily domestic activities and spend a lot of time with each other.

Women

The culture in the village is patriarchal. While both men and women work in the fields, some men have jobs outside Pekhri, whereas for women, there is little to no outward mobility. Women are primarily tied to their household, cutting grass, collecting firewood, and looking after livestock. While men do share this work, they are not tied to it. The decision making is mostly concentrated with the male members of the family.

Mahila Mandal: For the last many months, the *Pragatisheel Mahila Mandal Pekhari* has been fairly active. There are regular meetings and now with HET's support, they are carrying out knitting activities (mainly woollen socks)

Marriage system: There is marriage within the village families. The reason behind the "same village marriage" is that the bride is already familiar with the landscape, natural resources and village system so she needn't spend time re-learning these.

Religion

Like most villages in the district, religion plays an important role in the functioning of the village. There are elements of animism in how certain trees are worshipped, certain landscape-features house gods, and each house has its own god residing in the upper floors which are out of bounds for outsiders and people of different castes. Feasts and ceremonies are organised by families in turn, idols are carried in processions, and there are committees that facilitate this rotation of responsibility. In fact these activities are what organise the village's collective decision making.

Caste: Pekhari village has mostly one dominant caste which is Rajput/ Thakur and non-dominant castes are not permitted in the dominant caste areas/inside their houses.

Governance and Politics

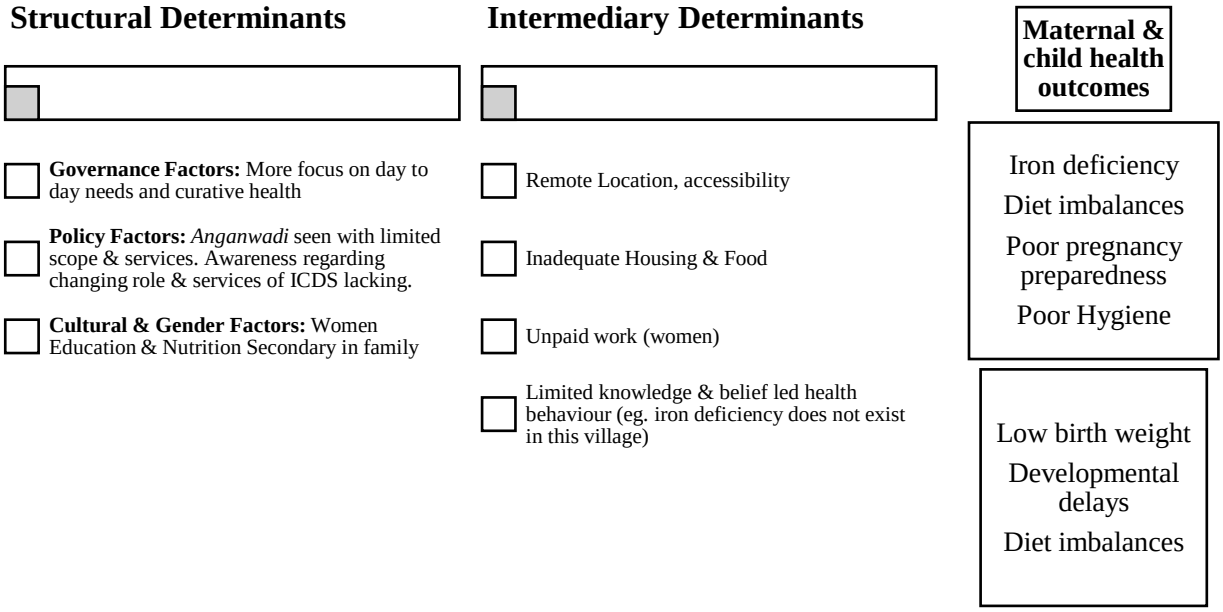
The committee involved in religious ceremonies is in a way the most active collective organisation. The village-level governance is a lot more haphazard though with mostly governed by elderly men. There is not much awareness about Govt. run programmes, even most common one's like de-worming, anaemia, other ICDS activities like Poshan Abhiyaan etc.

Education

There are very few who have studied up till the undergraduate level and even fewer up till postgraduation. I personally did not notice any special disregard for women education, in general there is a very not-so-serious attitude towards education.

In the current school-going generation all the male and female children go to school, but the lockdown caused a major discontinuity in their education which was furthered by the lack of facilities in the village.

Social Determinants of Health (CSDH conceptual framework)



Other Issues

School: The village has a primary school that is regularly attended. Post this, when children reach class 5 they have to travel long distances to Gushaini (which they often do on foot because there is only one bus) and Banjar. The distance and time taken to go and come back from school in Banjar is too much; parents rent rooms there for children to stay during the week.

Horticulture: Growing fruit has over time become a highly technical affair with multiple rounds of pesticide and fertilizer sprays, assisted pollination, various graft varieties, etc. Despite following protocol, the yields might be poor. This kind of high input, variable output agriculture is risky and costly and is the bane of small farmers throughout the country and globe. As in other places, the markets also don't offer steady prices. Often locals travel all the way to Delhi with the trucks to try and get a better price.

NTFP: The ecological degradation of the common lands close to the village has reduced the scope for earning through NTFPs. These lands only give fodder. Medicinal herbs are very rare now. Handicrafts based on other plants don't have a market, and these plants have also become rare. This reduces the incentive to repair the local ecology also.

Income: opportunities for steady income are limited within the village, and this puts a lot of pressure on people to travel out of the village everyday and even start staying in towns. Reforestation, education, handicraft and health related-services are all needed within the village and these can in turn provide good supplementary sources of income.

Veterinary Doctor: Many in the village voiced that requesting the veterinary doctors to come everytime they need them and then bearing their transport bill makes it difficult for them to ensure health care for their animals. More regular visits that are sponsored by the govt. can help with this.

Possible Interventions

1. Education Interventions
2. Animal health Interventions
3. Knowledge and awareness around women and child health and nutrition
4. Agriculture/Horticulture based livelihood interventions
5. Apiculture

During my first meeting with the Mahila Mandal, I quickly realised that the priority for women was health and nutrition. Also, this was one of the areas I was most comfortable with (agriculture was another area where my expertise lies), seeing my background. Additionally, other initiatives like agriculture or education were more time taking and could not be initiated during the short project work duration.

The first meeting focussed mainly on:

a) Mahila Mandal meetings and agenda
b) Main activities of Mahila Mandal – weaving, knitting
c) Getting to know their thoughts on nutrition and health
d) Identifying with them the main health issues
e) Discussion on Govt. institutions – Anganwadi, PHC, School etc.

Capacity Building:

Any transformation in a village will necessitate capacity building and behaviour change of the people to realise self-help, community work, health/nutritional improvements and activities and the belief that they can do. This would involve exposure visits, interaction and discourses with identified local leaders who show great potential in leading the intervention in the future. Behavioural changes were initiated as part of the capacity building initiatives for implementing the development initiatives.

One of the *Mahila Mandal* member was chosen as leader and co-facilitator for all the trainings/modules. Later, she is to give the remaining module trainings on her own, with a doubt-clearing online interaction with the facilitator before the session.

Project Planning Phase

This phase mainly consisted of compiling secondary information of the village, people, customs, natural resources, voluntary persons/organisations involved in the area, broad contours of schemes under implementation in the area of women and child health. Other activities in Preparatory/Project Planning Phase included:

- Establishing rapport with *Mahila Mandal* members and make contacts with other key people in the village.
- To get information about general layout of the community (location of specific groups/other infrastructure facilities/presence or absence of water sources /other useful general data concerning social groups).
- To identify and prioritise health issues and plan development activities accordingly.
- To identify interventional activities that are culturally relevant to the population.
- Identifying potential partners to facilitate the planned activities
- To identify leader(s) who would work and coordinate with the larger Mahila Mandal members for interventional activities and take the efforts forward.
- Understand different population groups (Women/Men/Youth/Old other key leaders in the village) for viewpoints and interests of different population groups.

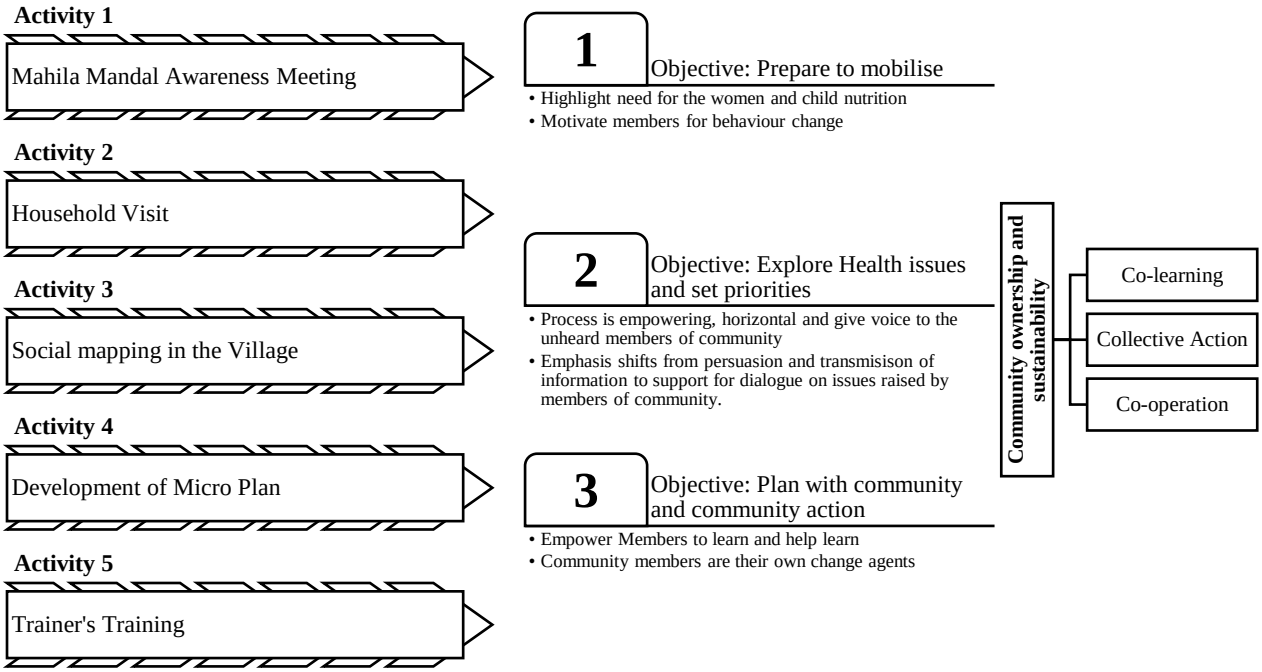
The timelines and scope needed to be worked out based on the socio cultural and demographic context of the village. Based on the preliminary understanding and priorities appropriate activity timelines were planned as below:

Components	**Scope/Timeline**
Preliminary Visit	September 10 days
Project Initiated	
October	15 days (2 Modules Delivered, Facilitation training)
November	10 days (2 Modules Delivered, Facilitation training 2)
Documentation	Village Profile etc.

Project Initiation

Preliminary Visit Activities

The preliminary visit focused on getting accustomed to the village culture and tradition; and getting acquainted with the Mahila Mandal members. The main objective was to explore the health issues and identify



Module Trainings

The content on the maternal, child health and nutrition umbrella under the POSHAN Abhiyaan have been organised in thematic modules (Figures 1 and 2 below) or flipbooks, which contain detailed technical information related to each topic. A total of 21 such modules exist, out of which 18 were of particular interest to the community/project. The key feature of these modules is the simple manner in which the technical information is explained. It also addresses locally prevalent myths and misconceptions.

The initially 4-6 modules were primarily conducted by me, as facilitator, with chosen *Mahila Mandal* member as co-facilitator. Each module was first discussed between facilitator and co-facilitator to build the capacity of the co-facilitator for taking future modules. As part of the project, total 6 modules were conducted through in-person trainings facilitated by me, further 2 more were conducted by the co-facilitator taking the lead, supported by me online.

Here onwards, all the remaining modules will be solely conducted by co-facilitator alone, with prior online doubt clearing session/discussion with me. Thus, community transfer of the entire project will be complete.

नवजात शिशुओं में स्तनपान का अवलोकन
क्यों और कैसे
महिला एवं बाल विकास मंत्रालय
भारत सरकार, 2018
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कमज़ोर नवजात शिशु की पहचान और देखभाल
महिला एवं बाल विकास मंत्रालय
भारत सरकार, 2018
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ऊपरी आहार – भोजन में विविधता
महिला एवं बाल विकास मंत्रालय
भारत सरकार, 2018
6

महिलाओं में एनीमिया की रोकथाम
महिला एवं बाल विकास मंत्रालय
भारत सरकार, 2018
7

शिशुओं में शारीरिक वृद्धि का आकलन
1 साल
2 साल
3 साल
4 साल
5 साल
महिला एवं बाल विकास मंत्रालय
भारत सरकार, 2018
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समय के साथ ऊपरी आहार में सुधार और वृद्धि
महिला एवं बाल विकास मंत्रालय
भारत सरकार, 2018
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केवल स्तनपान सुनिश्चित करना
महिला एवं बाल विकास मंत्रालय
भारत सरकार, 2018
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कमज़ोर नवजात शिशु की देखभाल –
आखिर कितने कमज़ोर बच्चे हम से छूट रहे हैं?
महिला एवं बाल विकास मंत्रालय
भारत सरकार, 2018
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हम ऊपरी आहार की शुरूआत समय से कैसे सुनिश्चित करें?
महिला एवं बाल विकास मंत्रालय
भारत सरकार, 2018
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Figure 1 The Poshan Abhiyaan Modules used for Mahila Mandal Trainings

Conducted by a facilitator (I, in this case) and a co-facilitator (member chosen from the Mahila mandal to be the future facilitator), each session encompassed three crucial steps, as illustrated below.

Review	Input	Planning
• Status of the topic in village • Problems & Challenges	• Discussion related to current status • Operational steps to address the problems	• Action plan to overcome the problem/challenge in question

At the start of the session, usually the status of the issue was discussed along with the associated problems and challenges. During this part of the session, real life examples and past-experience of the participants were brought to light and members were encouraged to share their stories.

This was followed by covering the content of the day, and focus would be on acquiring knowledge on the topic. Lastly, solutions and expected outputs were discussed with a concrete community action plan. At this stage of the session, the emphasis was laid on how over a period of time, these practices can lead to behaviour change and improvement in health indicators.

In order to make these sessions interactive and interesting, participatory methods of training, such as role-play, group discussion, and periodic question and answer sessions were conducted. The takeaways were extensively used for role-play and dramatization.

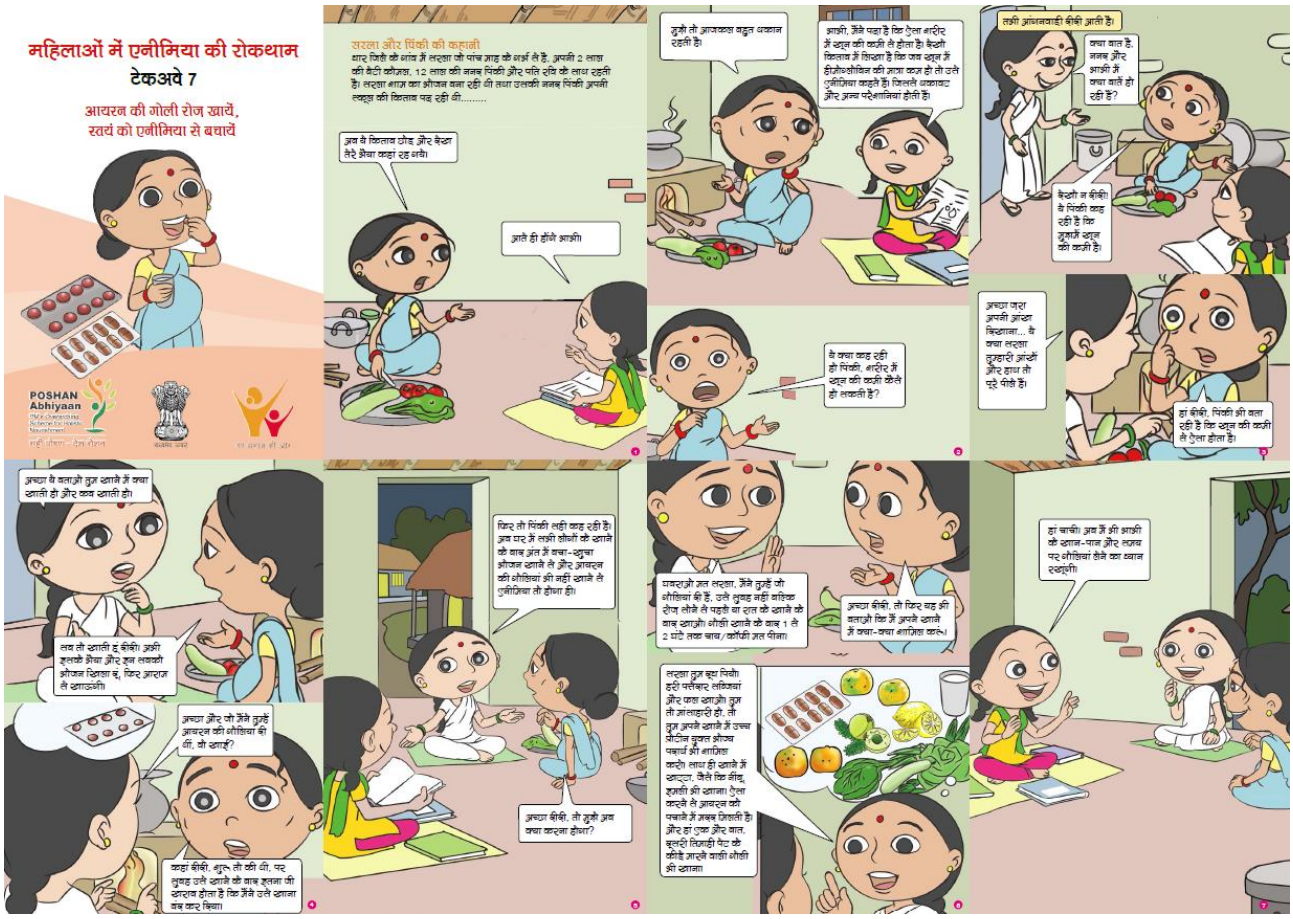

Figure 2 Takeaway used for role-play

Community Health Axioms

Rights & Responsibilities	It is not only a right of every villager to use resources and benefits according to their health needs, but also a responsibility which is shared between villagers and health care system
Integration of health & development activities	It is very important to align the health education/initiative with some economic activity. Ultimately, time spent on any activity should compensate for the income loss. In this case, mahila mandal was alreday engaged in knitting and weaving activities with the help of HET.
Building equity and empowering community beyond social conflicts	Through these module trainings we were able to address primarily **wealth or income, occupational, educational, rural-urban inequities.** We were not able to address caste inequities at this point of time, maybe, when the mahila mandal spreads the information and learnings further among the villagers, this will be addressed as well.
Confronting the existing super structure of medical/health care to be more people and community oriented	Information w.r.t. nutrition and best practices (for pregnant and lactating mothers) was so far limited to Anganwadi workers and ASHAs. Inadequate understanding of their roles and responsibilities, poor training and supervision, poor monetary compensation and inadequate incentive structure led to inefficient delivery of these services and information. This information asymmetry was somewhat addressed through these module trainings.

Results

Knowledge of the *Mahila Mandal* members regarding care of weak new-borns, care of pregnant women, exclusive breastfeeding and improved practice among lactating women on exclusive breastfeeding increased. The members felt that there has been improvement in terms of clarity on the subject matter, their approach to health, and perceived effectiveness of little behavioural changes/practices. They would give information to the right beneficiaries even if they met them on the way to cutting grass or community meeting. Also, they make sure to engage the family members in the discussion.

> *"Earlier we were not taking proper food, iron tablets, or rest during the day (during pregnancy). But now we would ensure that all the pregnant women of village practice it. I guess it is partly because we have now understood the importance of doing so, with proper reasoning."*
>
> *- Mahila Mandal member*

Further awareness regarding prevalent issues like Anaemia, Deworming, malnutrition has resulted in greater satisfaction among the participants as well as increased engagement during the trainings. This warrants an endline survey/perception/impact study towards the end of these trainings (by 2023 end) on their day-to-day well-being.

Lessons Learnt

1. Participatory method
   The modules include in-built questions, discussion points, and exercises to guide the facilitators. When followed, the sessions are delivered more effectively ensuring better understanding among the participants.
2. Community Action
3. Frequent Sessions
4. Strong Community Acceptance

In hindsight, one of the most crucial challenges is building trust. There is mistrust of outsiders. Although the tendency might be to build the program faster, ***we must work at the speed of trust.***

The following are some of my learnings on process:

1. As social workers we might tend to favour processes that are more neutral, inclusive and democratic, and that is as it should be. But special care is required to map the existing power structures (formal and informal) and include those that already enjoy influence.

   In the case of this village, these are the committees handling the deolis (ceremonies around local gods) that already are in the habit of calling meetings, facilitating collective decision making, getting signatures, etc. These are mostly the older men of the village.

2. The work should begin with a public meeting called and organised by these influential people after they have been briefed about the plan. They will have to be sensitized about the need to work exclusively with the women. This might be challenging.

3. The selected group (*Mahila Mandal* in this case) should be a part of the surveying, interviewing, and planning should be done with them.

4. There should be a basic plan drawn up based on the discussion that follows, and if possible, discussed with other villagers to build consensus.

5. Once a basic consensus has been reached, then the training sessions should start. If possible, involve authorities also at this stage (*Anganwadi* staff for instance in this case). This way hopefully petty politics is kept to a minimum.

6. The group should decide a rough timeline of the sessions. In this case it was easy because the *Mahila Mandal* was already meeting on a fixed date every month to discuss their own progress. Our sessions were held during the same meeting.