2022-2023

Community Health Learning Programme

A Report on the Community Health Learning Experience

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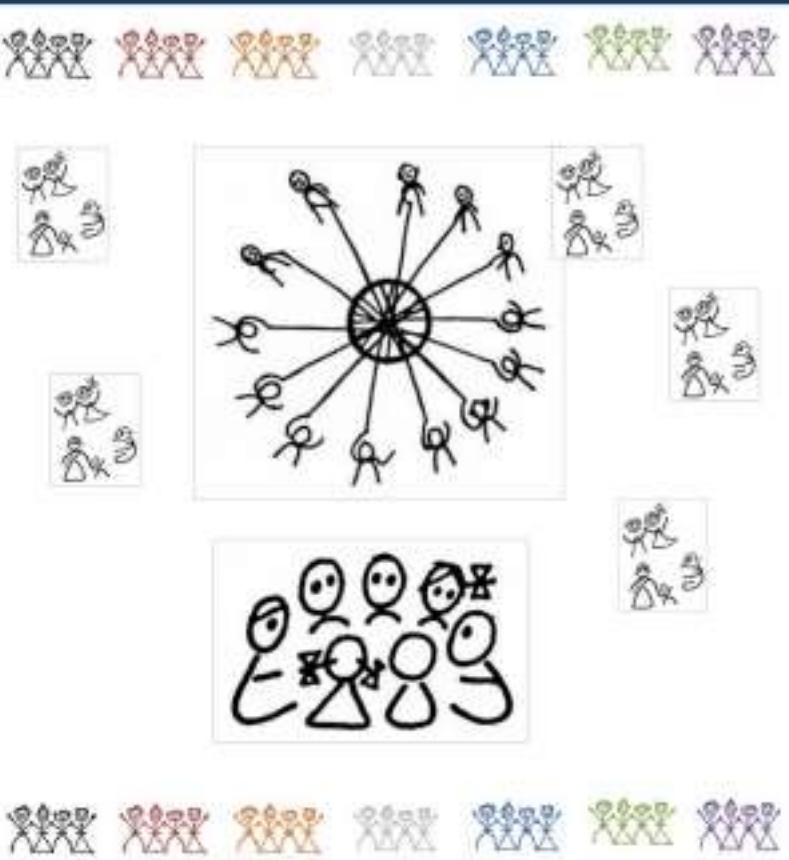
Guardians of Dreams



School of Public Health Equity and Action
(SOPHEA)

sochara

Society for Community Health Awareness Research and Action

Acknowledgments

My work and understanding of community health would not have been possible without the support and guidance of many individuals and organizations.

To begin with, I am deeply grateful to the community members who participated in my community health-action reflection project and shared their stories and experiences with me. Your contributions have been invaluable in helping me understand the health needs and challenges faced by your community. Having worked with childcare institutions for over five years now, I am acutely aware of the effort it takes to keep the wheels moving, and I'm grateful for your work, every single day, in keeping thousands of vulnerable children in safe environments.

I would also like to extend my sincere gratitude to the CHLP fellowship program at SOCHARA for providing us fellows with the opportunity to work on this project and for supporting us throughout the process. The knowledge and skills that I have gained through this fellowship have been instrumental in the success of this project. This includes a note of gratitude to every single instructor who contributed their time and expertise to painstakingly pass on their knowledge to us.

I would like to acknowledge the support and mentorship provided by my academic advisors Dr. Manjulika Vaz and Karthikeyan, and the entire CHLP administration team. The sheer amount of dedication they bring to their work is evident in every single interaction. It's equally important to stress the role of my co-fellows who have offered their support and time in offering sage advice and motivation, whenever needed.

This project is dedicated to the community of practitioners who work with children on a day-to-day basis - practitioners who are responsible for nurturing an incredible set of young adults to lead us into the next few decades.

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Executive Summary

The fellowship report details my learning experiences over the course of 9 months on different community health modules, as part of the Community Health Learning Program. My focus of the fellowship was to gain a deeper understanding of community health issues and to develop the qualitative and quantitative skills necessary to address these concerns, with a particular interest in exploring issues of children and adolescent health in India. Through the

completion of various modules, I have gained knowledge on topics such as health promotion, disease prevention, and the social determinants of health. In the first part of the report, I adopted a reflective approach in discussing my learning, thinking about larger changes in my mental models revolving around health and equity.

Crucially, I also had the opportunity to participate in a community health-action reflection project, which provided valuable hands-on experience and allowed for the application of learned concepts. In the second part of this report, I have elucidated my objectives and outcomes of the aforementioned report.

It is necessary to point out that my essential learning from the fellowship is of a community health approach that centres equity. Equity in health is a matter of life and death, a question of not just fairness, but survival. It is the recognition that where you are born, the color of your skin, and social location should not determine the length and quality of your life. It is the understanding that health is not just a personal responsibility, but a collective one, and that we all have a stake in ensuring that everyone has access to the resources they need to thrive.

I hope I've conveyed this sentiment in my reflection and in my community-action project. 6

PART- A

Introduction

What was my journey before CHLP?

- Academic Background: I have a background in science, with an undergraduate degree in biotechnology, chemistry, and zoology from Christ University, Bengaluru. In my undergraduate program, I had the opportunity to work on coursework in immunology and genetics. While we explored a deeper understanding of immunological mechanisms and genetic variations in detail, I was struck by the role of environmental stressors, psychosocial challenges, and nutrition in determining health outcomes through epigenetic regulation. This convinced me that I needed to move into

understanding social determinants of health, particularly in vulnerable populations, like children. With internships in cytogenetics at the Christian Medical College in Vellore and in molecular biology at the Vellore Institute of Technology, I learned extensively about the role of the environment in influencing the development and determining physiological growth patterns. I was convinced that it was essential to focus on providing nurturing environments for children to grow in, specifically in their younger years.

- Professional Background: For the past four and a half years, I've been working with a start-up non-profit in different roles- moving from roles in communication, fundraising, and community mobilization to now working on designing a capacity-building program for the staff and leadership at child care institutions in the country. For our children, health is a crucial aspect of this program. Health is rarely looked at from a holistic, preventative perspective with the focus almost always on treatment. For our kids, ensuring comprehensive health support is crucial to preparing them for the transition when they leave the institutions.

Why did I join the fellowship?

- Larger impact: As someone keen on creating positive change in communities that I care about, it is clear to me that community health focuses on the health of a larger 7 community versus offering individual, person-specific solutions. This allows me to support interventions that can have a much greater impact on many more people. ● Top-down development sector: Having worked in the development sector for five years now, I'm well aware of how most organizations look at social impact from the lens of hierarchy, often designing and implementing projects that take little to no information from the community they aim to serve. I believe that the community health approach's emphasis on treating community members as co-participants rather than beneficiaries allows for more nuanced, population-specific solutions. ● Focus on well-being: Community health relies on assessing larger well-being metrics instead of relying on a disease-first approach that often misses other crucial aspects of health
- Complex analytical frameworks: As someone who's often fascinated by what really makes people tick, community health offers multiple complex, multi-factorial frameworks to analyze problems and solutions. Understanding that health is so complex is the first step to working on ideas that are truly effective, efficient, and sustainable.
- Cohort-based learning: CHLP is truly an incredible opportunity to learn from the extensive knowledge and lived experiences of highly trained public health professionals from all walks of life. The sheer diversity of the past cohorts drew me to the program.

COVID-19 as an accelerant:

- With COVID-19, it is clear that vulnerable populations are influenced by social and environmental concerns.
- For instance, with high population density, COVID-19 particularly affects urban hamlets and people from lower socioeconomic backgrounds that struggle with overcrowding in their settlements and in accessing public transport.
- With high rates of poverty and poor social protection, COVID-19 measures like the lockdown tend to have disproportionate effects on populations in low-to-middle-income countries like India.
- Air pollution: Air pollution in India is a serious public health concern, and it could be affecting the severity of COVID-19 infections in the country.

COVID-19 and its role in my work:

While the Covid crisis has affected every single individual on the planet; the poor, marginalized and vulnerable are disproportionately impacted due to various socio-economic

reasons. Even worse are children who are outside the care and protection of families i.e children who rely entirely on the community to protect them.

In my role as a Senior Associate at a non-profit organization, we've been working closely with childcare institutions that were affected by COVID-19 and ensuring lockdowns.

About Guardians of Dreams:

Guardians of Dreams is a non-profit organization working to upgrade and transform the quality of care across Child Care Institutions (like orphanages/children's homes, open shelters, etc) across the country. We believe that Child Care Institutions (CCIs) are the bedrock of childcare in society, and their capacity & quality determines our ability to provide effective childcare to the millions of vulnerable children in India. We operate across Bangalore, Chennai, and Ernakulam through a network of 250+ children's homes.

Covid Response: A Covid Outreach conducted by Guardians of Dreams revealed that several Child Care Institutions (like orphanages, and shelter homes) that provide care and protection to our most vulnerable children have been hit badly due to this crisis. Their in-kind donations have been wiped clean and with zero walk-in donors -- they are struggling to make ends meet and provide for the large number of children under their roof.

Emergency Rapid Assessment across Children's Homes in 3 districts in Karnataka, Kerala and Tamilnadu revealed:

- 19% of Children's Homes (26/136) are Covid +ve.
- 63% of Children's Homes (86/136) are in immediate need either due to Covid +ve cases or due to financial distress.
- Lack of home care items like oximeters due to cost or lack of availability.
- Lack of space to isolate affected children & staff.
- Poor safety protocol, vaccination, or treatment plan in place.
- Noticing a dip of more than 80% in their cash & in-kind donations.

How does a community health approach allow for alternative solutions?

- Given that it concentrates on the general health and well-being of a particular group rather than just treating individual cases of the disease, a community health strategy is effective for combating COVID-19. In order to reduce the spread of COVID-19 and make it more challenging for people to receive testing and treatment, this strategy involves working with community members to identify and address the social determinants of health that may contribute to these problems. A community health strategy can also help to promote trust and compliance with public health measures like mask use and social seclusion by including locals in the pandemic response. In 9 the long run, this may result in more effective disease control measures and improved community health.
- Community health also allows for more social protective mechanisms in improving access to healthcare services and in increasing the number of trained personnel in micro-centers to treat local populations- thereby addressing prevention and immediate treatment needs.
- It is obvious in how the ASHA force was employed during COVID-19 that community workers have the ability to play multiple roles to improve access to essential healthcare services and in improving last-mile delivery of government services.

What were my learning objectives and were they met?

Stated Learning Objectives and Progress Evaluation:

- To better understand existing health-protective systems for children in need of care and protection including government provisions, existing health infrastructure, and its constraints.
    - This learning objective was *fully met* because of a dedicated module on Child Health (Module 26)
    - I want to draw attention to a particularly useful additional learning material, a document reference called the guidance note on Child-Friendly Local Governance published by UNICEF and the Child Resource Centre Kerala. This document highlights the significance of ensuring that local governments are acting to preserve and advance the rights of all children in Kerala and that

they have access to those rights. What's great about this note is that it contains suggestions for how local governments can involve kids and youth in decision-making, how to guarantee that all kids can access services and programs, and how to deal with gaps and injustices that might hinder kids from exercising their rights. The significance of data gathering, monitoring, and evaluation for tracking the development of child-friendly governance is also emphasized.

- To develop a rights-based, human-development-centered approach to child health; moving from a treatment-heavy model to a preventative model for improving child health outcomes.
    - This learning objective was *fully met* through CHLP.
    - The Right to Health Module (Module 4) was fantastic to help me develop my own ideas on what a rights-based approach to health looked like, and why this approach was essential to working in public health, focusing on equity to healthcare access.
    - I want to stress a principle of a Rights-based approach that I've adopted in my own work, an emphasis on Participation. People, including children (when in

the best interests of the child), have the right to be involved in decisions that affect their health and to be informed about their health status and treatment options.
        - This also applies to programs and social interventions that non-profits attempt with children in care because they directly tend to influence the outcomes for children.
- To identify key issues plaguing child health in vulnerable populations, dive deep into potential solutions, and target high-impact, cost-effective, and sustainable interventions.
    - This learning objective was only *partially met* because the dedicated module on Child Health did not cover all vulnerable groups of children, nor did it cover specific high-impact interventions that one could adopt in their own public health approach.
    - What would be useful is a discussion on a cost-effectiveness-impact analysis of childcare interventions in the country, stacked and ranked according to priority and the number of people working on these solutions.

Thoughts on the meta-learning experience:

- I really enjoyed the breadth of the program because you rarely get such a comprehensive picture of what health looks like in this country. The sheer diversity in modules is truly one of the biggest strengths of the CHLP program. While it does automatically prevent too much depth, I think that it is essential for a fellowship like the CHLP to provide an overview that gives fellows the opportunity to understand how different domains work together to impact the health outcomes of our country's population.

- It's also essential to discuss that what really came through in all the instructional videos is the passion and curiosity that the instructors managed to convey in a fairly static medium. I was surprised by how careful they were in designing their lecture, and in delivery. I want to call special attention to Prasanna Saligram's lectures on globalization and health, particularly his obvious interest in engaging deeply with the debates that govern this topic.

Identifying Gaps:

- As previously mentioned, what did I miss was the focus on evaluating public health campaigns, on how as future public health and community health workers, we would be able to evaluate and pick the right intervention to work on, based on considerations of impact, cost-effectiveness, feasibility, equity, and cultural acceptability, to name a few factors.
- Given that we're going to be working closely with different communities, a specialized module on culture, ethics, and challenges of working in communities where we lack context would have been very useful and highly practical. Bioethics is

a fascinating, highly relevant module that could have prompted some interesting discussions and real-time case studies from the cohort.

Celebrating Successes:

- One of my favourite modules was the module on Women's Health and I believe that our team's presentation on the life course approach gave us an opportunity to not just engage with the content of the module but it allowed us to critique the model, and add our own thoughts to how a life course approach could add unique value to current public health models.
    - We discussed the Young Lives Study as a proof of concept of the life course approach given that it talks extensively about epigenetic influences on the long-term health outcomes of young adults.
    - We also brought in an Ayurvedic perspective to the life course model, discussing how these models of medicine overlapped in approaches.
    - Link to our presentation here: Life Course Approach: Group 2

Reflections on the Digital Learning Platform

Successes of the CHLP's digital learning platform:

- Mixed-media Learning: The CHLP platform focusing on video content, PPTs, and

long-form additional reading materials is fantastic because it really allows for individual fellows to lean into their preferred learning styles. What's great about video content is that it's naturally a more interactive medium, with options to change speed and video quality based on the stability of your internet connection. Given that I was in the field for many months, a highly adaptable learning platform was necessary for me to continue my fellowship.

- Interactive Content: CHLP's platform also offered interactive content, specifically the presence of a discussion forum that was a great opportunity to interact with other fellows and learn from their own questions.
- Accessibility: The platform was accessible from anywhere and on any device, including a phone application allowing me to continue my learning at my own pace and on my own schedule. This is again crucial because of the travel that I was undertaking during the months of the fellowship.
- Support & Feedback loops: The platform provided a community of learners and a support system, including a way to provide feedback about each module. In fact, there

were consistent reminders on the Whatsapp groups to fill in the feedback form for all modules, indicative of such an active culture of getting feedback.

Ideas for improving CHLP's digital learning platform:

- Incorporating assessments: Incorporating assessments, such as quizzes and tests, into the platform would have helped me regularly evaluate my understanding of the material and identify points of improvement. I think that this also adds a layer of accountability to ensure a sound understanding of the module in question.
- Adding interactive elements: Adding interactive elements, such as interactive simulations and games, to the platform would make the learning experience more engaging and help me retain information better. Having worked on a few online courses, I think certain new platforms allow for more innovative tools of engagement including some custom-made games and simulated animations to learn from. While these definitely involve more effort and potential costs, they can markedly improve the learning experience. Given that we are in a cohort, gamification can be an excellent way to improve engagement numbers.
- Improving search functionality: Improving the search functionality of the platform would make it easier for me to find specific content and resources that I need. On the current CHLP platform, search functionality is nil and this does make it very hard to pick out specific modulus or additional learning materials to refer to.

Work-Life-CHLP Balance

Current analysis of how I balance time across different commitments

**involves a number of approximations to create a representation of how much time I spend on CHLP activities relative to other activities in a week*

Actviity	**Time (in hrs)**
Work	60
Sleep	56
Personal Care (Meals & Grooming)	22
CHLP (Video lectures & ALM)	10
CHLP (Live Sessions)	4
Other academic interests (reading & writing)	18
Family & Relationships	18
Relaxation & Down Time	15
Commuting	10
Total	***168 hours***

Strategies of time-management that worked for me:

- Identifying what's important to me: Prioritising became fairly important fairly quickly given the different projects I've undertaken, including a couple outside of work and CHLP. Setting aside regular time slots to work on CHLP modules, blocking out live sessions on calendars, and informing the team of this fellowship allowed me to manage my commitments while taking on additional intensive fellowship. ● Upward

communication: To whatever end was possible, I chose to inform the CHLP team and my mentor of potential delays in submitting assignments or first drafts (including this one). While it is understandable to have work commitments spill over, I believe that it was essential to keep the CHLP team appraised of my schedule, especially when I was doing fieldwork, and communication was hard.

- Timely consideration of stress levels and warning signs: Staying true to my own body was a necessary component of completing the course on time. If I had not identified early stressors and triggers when I was overwhelmed with multiple commitments, including an active project at CHLP - this could have potentially led to a much more prolonged issue. However, I quickly realized that I was overburdened and I chose to take time out, whenever necessary to focus on long-term sustainability in the fellowship.
- Using productivity tools: I am a firm believer in the use of Google Calendar for time blocking, Notion for database management of my knowledge and learning, and ToDoist for staying on top of tasks and projects. Learning to quickly capture ideas became crucial

while attending lectures and live sessions is a huge success, and I used Notion for doing this.

How did the CHLP team support me?

- Regular check-ins: I would like to stress the sheer amount of effort put in by the CHLP team, including Karthik, Janelle, and Ranjitha in following up with me and the rest of the fellows on live lectures, assignments, and other aspects of the fellowships. There were multiple reminders sent, and Karthik was available on call every single day to address queries and offer advice. The support from the team on the logistics front of the fellowship was invaluable.
- Adaptability: Based on feedback from the cohort, existing modules were adapted- this included additional doubt-clarifying sessions or new resource materials that were regularly sent to the cohort. It is rare to see feedback acted upon so quickly and in a format that allowed fellows to own their learning outcomes.
- Cohort-based support: In our small groups, fellows could open up about their struggles, support each other during assignments, and also offer solidarity when fellows were going through difficult times. Intimate problem-solving groups work extremely work and CHLP groups were no exception!

Mentorship Process and Reflections:

Why is the mentorship component so unique to CHLP?

- Presence of multiple mentors & advisors: With CHLP, mentorship is not a one-off, individual assignment. I've found that the culture of mentorship exists throughout the program, starting from Karthik's regular 1-1 check-ins, along with Dr. Thela and Dr. Ravi's regular conversations in the group and during live sessions. In fact, my introduction to the program was through a conversation with Dr. Akshay Dinesh, an active member of the SOCHARA community who continues to be someone I reach out to, to discuss matters of community health. Instructors leave themselves open to questions and collaborations, and this pervasive culture of mentorship is a huge part of the success of the fellowship.
- Carefully assigned mentor: My mentor was assigned to me by the CHLP team after careful consideration of my stated learning objectives. In the following paragraph, I've described why the choice of the mentor was a major contributor to my project's success. I've had multiple conversations with Karthik about how best to learn from my mentor's expertise.

- Open structured mentorship: At CHLP, apart from an option to set up an introductory phone call, the rest of the mentorship process is open to the interpretation of the mentor and the mentee. I was able to make use of this flexibility in working out a mentorship relationship that worked for me and my needs versus sticking to a pre-defined relationship pattern that might not have been conducive to my learning. We met in person, completed phone calls, and regularly communicated over email and Whatsapp to work on my project, and I'm glad that we had the opportunity to figure out a rhythm for our own custom needs.
- Integral fellowship component: It isn't often you find a fellowship or a learning platform that stresses mentorship as much as CHLP does. From expanding financial resources on the chosen mentors to regular reminders to fellows to actively engage with the mentors, CHLP has always centered the mentorship element in the whole program. It is also worth mentioning that regular interaction with the mentor is one of the prerequisites for successfully completing the CHLP fellowship.

Relevance of chosen mentor:

- Dr. Manjulika Vaz's bio: Manjulika Vaz is a Senior Resident at the St. John's Research Institute. She has a Ph.D. in Allied Health Sciences focusing on the Ethics and Public Perceptions of Biobanking Research. Her research interests range from promoting the humanities in medical education; environmental ethics; qualitative research methods of inquiry; gender rights and inclusiveness; and public engagement in research and governance.
- Working with Dr. Manjulika Vaz was a perfect fit for my interests given my experience and interest in qualitative research and development ethics, specifically focusing on health interventions in vulnerable communities.
- While reading more about her work, I found multiple articles (abstracts in some cases) discussing the value of public health, ethics, and reflection in medical education. While this isn't my primary focus, it's always uplifting to see people bring in the importance of humanities into STEM, particularly something as high stakes and high

reward as medicine. In fact, inspired by her work, I'm now collaborating with other health professionals to write about the state of medical education and what we can do to improve it.

Impact of the mentorship process:

- Clarity in project planning: Dr. Manjulika's advice was hugely important in influencing not just my topic of the project, but in narrowing down the scope of what I hoped to accomplish in these three months. In our conversations, I came in with multiple ideas across different disciplines of childcare, and Dr. Manjulika helped me figure out how best to focus on one or two ideas that I could dive deep into. Choosing

  breadth instead of depth will have affected the end outcome of my community action-reflection project, majorly impeding my understanding of the community's actual needs.
- A focus on ethics: It's to Dr. Manjulika's credit that I've now come to think about my own work using the lens of ethics and participation. She pointed out several instances where I needed to be mindful of my role as a development practitioner, especially in working with communities that I had a pre-existing relationship with. She constantly encouraged me to question the role of power in these relationships, and how it could affect consent. I will always remain thankful to her for providing this lens to look at my work.
- Respect and understanding: This might not feature as a defined impact of the mentorship process but it is important to highlight that Dr. Manjulika treated the relationship as one of mutual collaboration and learning. Her curiosity and willingness to listen to the work I do were important indicators of her style of mentorship - one that focused on conversations versus instructions. In a typically hierarchical set-up, a mentor often chooses to instruct versus listen, and I found Dr. Majulika's approach thoroughly refreshing. She was cognisant of my responsibilities at work and made multiple adjustments to our plan, a kindness that helped me keep going.

Feedback from the mentor, Dr. Manjulika Vaz:

Akshay is not a dependent professional but enjoys a stimulating conversation and engages actively with new ideas and perspectives. It was enjoyable and not a burden to mentor him. He is self-driven and has a good grasp of field realities and conceptual work. He will be an asset to community health and a trans-disciplinary way of impacting children's well-being.

The Takeaway from CHLP and Looking Ahead

I have multiple key takeaways from the fellowship and I want to take some time out to explain each key learning:

- Communtiy-first approach: As someone who has a few years of experience working in the development sector, I often come across initiatives and projects with the ability to transform a community (for better or for worse) designed and implemented in a room with no stakeholders from the community in question. If nothing else, CHLP has driven this possibility right out of my mind. I now understand that a community-first approach in public health is necessary because it recognizes that the health of individuals and communities is deeply interconnected and that addressing social determinants of health is crucial in improving overall health outcomes. By involving community members in the design and implementation of health programs and policies, a community-first approach can also help to increase trust and buy-in, leading to better program uptake and

sustainability. Given that I'm keen on using my time here to create impact, a community-first approach will definitely be my primary lens of looking at health. ● Socio-cultural modeling of health: In so many modules in CHLP, I've noticed that instructors often pay close attention to the traditions and cultural attributes of a particular community. I have to admit that this frame of thinking did not come naturally. However, even in conversations in live sessions, I could often see my co-fellows discussing how social location and cultural factors determine so much of what works and what doesn't work when it comes to public health. I'm now determined to understand these factors when I look at a population to work with, In fact, in my own project, it was Dr. Manjulika, my mentor who mentioned that nutritional outcomes can also be tied to cultural practices and beliefs around food. Food is a huge cultural phenomenon and any analysis of nutrition is incomplete without thinking about culture and customs.

- Value of intellectual humility: While public health tends to be a more top-down approach, it is impossible for someone to engage in community health without learning to listen. An open mind and a willingness to learn from the community you serve are pillars of community health. I have now learned that I may not have all the answers and that I can learn from the lived experiences and knowledge of community members. This is especially important when working in communities that have been historically marginalized or underserved, as these communities may have unique needs and perspectives that are not well understood by outsiders. Additionally, intellectual humility allows community health professionals to be more responsive to changing circumstances and more willing to adapt their approach as needed. One avenue of improving intellectual humility is through conversations and as I write this, I'm engaged in an active debate on the lived experience of informal medical providers in the CH Friends Circle group. I learn so much from the community of folks who think deeply about these problems and I will always value the power of being wrong and being able to accept when I'm wrong.

Continued Learning Pathway:

Themes I want to dive deep into, after the fellowship:

- Reform in medical education

    - From conversations with my co-fellows and with other medical professionals, I'm interested to understand why the current medical education system in India does not adequately address the social determinants of health, which are critical to understanding and addressing health disparities.
    - Reforms are needed to incorporate training on the social, economic, and environmental factors that impact health and to provide students with a more holistic understanding of health and healthcare.
    - I'm also interested in exploring how the strict hierarchies often observed in medical colleges tend to curb healthy questioning and changes to current practices based on improvements in evidence-based medicine
- Life-course approach to child health outcomes

    - Through modules on Gender and Child Health, we learned that a life-course model takes into account the different stages of a child's development, from conception to adulthood, and the impact that different experiences and exposures can have on their health at each stage.
    - As someone interested in the impact of institutionalization on a child's health, I want to understand how to control for some of the previously stated negative consequences of growing up in childcare institutions. I'm also interested in reading more about the impact of violence and parental separation on a child's health outcomes.
    - A life-course approach also recognizes that health and well-being are the results of complex interactions between a variety of factors, including genetics, biology, social and economic conditions, and the physical and social environment. By taking a holistic approach, a life-course model can help to identify the multiple factors that contribute to child health and the potential interventions that can improve it.

A career in public health:

- This fellowship has convinced me that I want to work in public health and has helped me confirm my decision to pursue a master's in Public Health in 2024.
- Within public health, I want to focus my efforts on community health education, health behavior, promotion initiatives, and health equity. I'm specifically interested in working with children in low-to-middle-income countries.
- I would like to take community health approaches and models to traditional quantitatively heavy public health interventions to bring nuance and community-centredness into how we design programs to improve health outcomes for underserved populations.
- I intend to apply a prism of rights-based, equity-first, and intersectional frameworks to what I learn in my public health degree. My journey in community health will continue in 202 and the years to come!

Community engagement:

- In my interview for the fellowship, I was asked if I had taken the time to be a member of the resident welfare association in my locality. I sheepishly answered no. This year, I'm keen on joining bodies that represent the needs of the community, to help support actions and changes from government and private service providers that serve our communities. I think it's impossible for me to discuss community health unless I focus heavily on participating on my own. From volunteering in community organizations that look at local governance to supporting the initiatives of my own

  public health centre, I hope to be more actively involved in activities in Namma Bengaluru.
- This year, I also hope to collaborate with other public health professionals and community activists to write opinion pieces and explainer articles for the general public focusing on different health-related issues. I want to communicate ideas about community health to a larger audience. This includes covering and writing about the excellent work of SOCHARA, Medico-Friends Circle, CHLP fellows, and other community health proponents.

PART-B

Community-Based Health Action Reflection Report

Building Capacity in Childcare Institutions to Improve Nutritional Outcomes for Children in Care.

(*CCI- Childcare Institutions)

Background to the community:

What are Child Care Institutions?

370,227 children are kept in about 9589 Child Care Institutions (CCIs) across India, according to a mapping review effort conducted by the Ministry of Women and Child Development and released in 2018. The country's final line of defense for vulnerable youngsters is these CCIs (estimated at around 2 crores according to some studies). In order to provide comprehensive services that set the bar for the level of care that children must get, CCIs must be able to accept all the children who require their assistance.

The timing of this project, when things are returning to normal following the Covid19 pandemic, has also highlighted the sector's vulnerability as a whole. CCIs have had to reevaluate their reliance on walk-in donors, on schools as the sole provider of education, on essential staff members for whom there are infrequent replacements, and on their emergency readiness. The necessity of providing a secure environment for vulnerable children who are raised outside of their families has only been more apparent over the past few years.

Who are the children in need of care and protection?

According to the Juvenile Justice (Care and Protection of Children) Act, 2000 in India, a child in need of care and protection is defined as a child who:

- is found without any home or settled place of abode and without any ostensible means of subsistence;

● is found wandering and not being able to give a satisfactory account of himself; ● is found in a destitute or helpless condition and is not being taken care of by any parent or guardian or another person who is under a legal obligation to do so; ● is

found begging;
- is found addicted to drugs or alcohol
- is found mentally or physically challenged and is not receiving proper care and treatment;
- is found to be a victim of child labor;
- is found to be a victim of sexual abuse or exploitation;
- is a child of a jailed parent and is not being taken care of by any other relative; ● is a child of a parent suffering from a terminal illness or HIV/AIDS. ● It includes children who are in conflict with the law and need care and protection.

Existing Policy Landscape for Vulnerable Children:

For all childcare institutions in India that house children in need of care and protection, there exists a legal framework to protect children's rights and provide legislative safeguards, in line with the objectives of the United Nations Convention on the Rights of Children.

Following are the relevant laws and statutes that apply to children growing up in childcare institutions:

- The Juvenile Justice (Care and Protection of Children) Act, 2015: This Act is concerned with children in conflict with the law and children in need of care and protection. It prescribes protocols for institutional care for children through shelter homes, children's homes, etc., and non-institutional care through foster care, adoption, sponsorships, and after-care organizations. All childcare institutions are mandated to be registered with the JJ Act.
- The Orphanages and Other Charitable Homes (Supervision and Control) Act, 1960 preceded the JJ Act in governing the functioning of orphanages. This Act empowers the state governments to monitor and supervise orphanages or childcare institutions and create a Board of Control for this purpose.
- The Immoral Traffic (Prevention) Act, 1956: This Act criminalizes prostitution and trafficking, particularly the keeping of certain premises as brothels and living on the income earned through prostitution, though it doesn't criminalize prostitution done independently and voluntarily. This Act is relevant as it protects children in need of care and protection from trafficking and prostitution.
- The Right of Children to Free and Compulsory Education Act, 2009: According to Article 21-A of the Indian Constitution, it is a fundamental right of every child from the age of six to fourteen, to receive free education. This Act guarantees the protection of that right and allocates responsibilities to the governments at different levels. The Child Labour (Prohibition and Regulation) Act, 1986: This Act was enacted to give

effect to the Constitutional provision enshrined in Article 24. According to Article 24 of the Indian Constitution, every child below the age of fourteen has the right to be protected from any sort of hazardous employment. It was enacted on the basis of Article 39(e), which empowers the state to make policies that protect children from

forced employment that is not suitable for their age and skills. If any childcare institution subjects orphans to any form of labour, a strict penalty will be imposed.

- The POCSO Act, 2012: The Protection of Children from Sexual Offences (POCSO) Act, 2012 was enacted to protect children from all forms of sexual abuse, regardless of their gender. The Act prescribes strict punishments for those who subject children to any kind of sexual harassment. This Act protects children in need of care and protection who are vulnerable to sexual exploitation.
- The Orphan Child (Provision for Social Security) Bill: The Orphan Child (Provision for Social Security) Bill was introduced in Lok Sabha in 2016. However, the bill has not been passed yet. It contains many provisions that were formulated with the intention of securing the welfare of orphan children. The following are the provisions formulated in the Bill:
    - According to Section 3, the central government has to conduct surveys on orphan children every ten years.
    - Section 4 provides for a national policy for the welfare of orphans to be formulated.
    - Section 6 states that the central government shall constitute a fund for the purpose.
    - Section 8 provides for the establishment of foster care homes.
- The Information and Technology Act of 2000, codifies the provisions against child pornography. Anyone who produces distributes, or causes to be published or transmitted any digital content portraying minors engaging in explicit sexual acts or behavior, would be held as a criminal by law and would face serious consequences.
- Besides these acts, the Indian government also issued various welfare schemes for destitute children. The Child Protection Services (CPS), is a scheme launched by the Ministry of Women and Child Development, which aims to support and provide for these children in need.
- Child Welfare Committee:
    - For the Children in need of care of protection, State Government may, by notification in Official Gazette, constitute for every district or group of districts, specified in the notification, one or more Child Welfare Committees for exercising the powers in relation to the child in need of care and protection under this Act.
    - The Committee shall consist of a Chairperson and four other members, of whom at least one shall be a woman and another, an expert on matters concerning children. The Committee shall function as a Bench of Magistrates.

    - A child in need of care and protection is produced before CWC for being placed in safety. The Committee has the final authority to dispose of cases for the care, protection, treatment, development, and rehabilitation of the children as well as to provide for their basic needs and protection of human rights.

Why is Nutrition a Key Focus Area for this project?

It is vital for children to be provided with a nutritionally sound diet because adequate nutrition is linked to positive outcomes for physical and cognitive development.

From the literature on the effects of malnutrition on child development, we know that malnutrition has far-reaching consequences on growth and development.

Immediate consequences:

- Malnutrition leads to failure in early physical growth, delayed motor skills, and cognitive and behavioral development. (Galler, 2021)
- Undernutrition diminishes immunity and increases morbidity and mortality.

Long-term consequences:

- Children who survive malnutrition in early childhood have physical and cognitive disadvantages compared to those who have had adequate nutritional inputs. - Multiple studies show that nutrition in a child's early years is linked to their health and academic performance in later years. (Nyaradi et al, 2013)

It is essential to understand the extent to which institutional nutritional practices affect the development and well-being of children in care. While early childhood (0-8 years) is critical for adequate health outcomes as adults, children in institutions have a second window, during middle childhood, and adolescence – the period from age 5 to 19 – for growth, psychosocial development, and establishing a healthy relationship with food.

Good nutrition during this period fuels growing brains and bodies, and has been shown to play a role in improving school attendance, academic performance, and cognition. Emphasis on nutrition may also allow children from disadvantaged backgrounds to experience catch-up growth after stunting in early childhood.

Community Stakeholders & Community Context:

Key stakeholders at an institution include the kitchen staff, leadership, caregiving staff, medical in-charge, donors, and children.

- Typically, in an institution, the primary stakeholders involved in nutrition are the cooks and cooking staff. They're responsible for the day-to-day meal preparation and quality of the food provided to children. Due to the need to cook for a large number of children and staff at the institution, a few instances of cooks being from professional backgrounds of event-catering experience or hospitality industry are noticed. Often, these cooks come from professional backgrounds of event-catering experience or the hospitality industry because they need to know how to cook for large numbers of

children and staff at the institution.

- Apart from the kitchen staff, the leadership of the institution plays a crucial role in planning the menu and in coordinating with donors for meal sponsorship. ● In well-organized homes, the medical staff works closely with the kitchen staff to provide regular feedback on the children's nutritional needs and to cater to children with special dietary requirements.
- In homes with an adequate caregiver-to-child ratio, we observe caregivers closely monitoring meal times to ensure that children do not waste food and that they eat diverse food items available. However, this is not a common practice, and children are often allowed to skip certain meals or dishes that they are not fond of.
- In a context unique to CCIs, donors play an active role in the nutritional outcomes of children, because institutions tend to engage with donors primarily through food as a donation. Donors can influence meal options, eating behavior, and children's relationships with food. Donor sensitivity is paramount to ensuring that institutions can establish positive eating routines for children.
- Most importantly, children need to play an active role in offering feedback to the leadership and the kitchen staff on the quality and variety of food on the menu through child participation methods like children's committees. However, from our observations, children have limited decision-making power in what they eat.
- In the context of the COVID pandemic, incomes have been impacted as well as the funds available to care homes for all their services and activities. Hence, there is a possibility of food choices, cooking practices and the ultimate nutrition to the child being impacted.

Field-based Organisation Background (if applicable: include complete Contact Information of the NGO along with the name of the Contact Person.)

Guardians of Dreams

Guardians of Dreams is a non-profit organization working to upgrade and transform the quality of care across Child Care Institutions (like orphanages/children's homes, open shelters, etc) across the country. We believe that Child Care Institutions (CCIs) are the bedrock of childcare in society, and their capacity & quality determines our ability to provide

effective childcare to the millions of vulnerable children in India. We operate across Bangalore, Chennai, and Ernakulam through a network of 250+ children's homes.

Rapport Building with the Community:

● 4+ years of experience working with children's homes in different capacities, managing different projects, primarily working with the leadership in CCIs ● On-ground field experience, having traveled and immersed in CCIs for two months in 2022, shadowing staff for 215+ hours cumulatively.
● Long-term trusted relationships developed over 7+ years by the organization with a set of 250 CCIs across the country

Objective of the Community-Health Action Initiative:

Identified Problems:

While institutions across the country have done relatively well to reduce obvious signs of hunger and malnutrition, it is clear that we now need to shift our focus to more "hidden" signs of malnutrition. According to the World Health Organization, the burden of malnutrition consists of both undernutrition and overweight and obesity, as well as diet-related noncommunicable diseases. Undernutrition manifests in four broad forms: wasting, stunting, underweight, and micronutrient deficiencies.

From extensive fieldwork, including conversations with key stakeholders in the CCI ecosystem like the cooking staff, the leadership of CCIs, and the children, we believe that there are a few reasons that underpin challenges in creating optimal nutritional outcomes for children in care.

- Lack of nutritional diversity: Limited access to diverse and nutritious foods can result in deficiencies in essential micronutrients, such as iron. Adolescent girls may be especially vulnerable because of increased demands for iron, folate, iodine, and Vitamin A during adolescence, heavy blood loss during menstruation, and parasitic infestations that are commonly reported. From conversations with the leadership, we understand that financial constraints influence access to a wide variety of food items. To illustrate this point, a CCI authority in Kochi, currently managing a home catering to 70 children highlighted that fresh fruits and vegetables are often more expensive than staple grains, not calorically dense to satiate children's appetite, and are influenced by seasonal variations in costs and quality. This often leads them to deprioritize fruits and vegetables in favor of more calorically dense grains and meat. (Affordability & Accessibility)

- Inefficient planning & tracking: Lack of expertise in planning out the menu for children results in nutritionally unbalanced meals, focusing on volume over quality. This includes the lack of regular checks and timely interventions. Cooking staff often are 1-2 cooks catering to 30-40 children, having to cook 4 meals every single day. The focus is on output versus efficiency and tracking because there is inadequate bandwidth to look at nutritional quality. It is also worth mentioning that the insufficient caregiver-to-child ratios in CCIs make it much harder to monitor if children are fully consuming what is available to them, and to help them improve their eating practices. In a field visit in Chennai, caregivers discussed that they noticed

children consistently discarding vegetables from their plates, often hiding this from the caregiver under supervision. (Acceptability). Palatability is a key factor in determining consumption.

- Inadequate cooking practices: Kitchens are not always designed to facilitate large-scale cooking. Gaps in the use of effective cooking equipment, storage spaces, and sanitation practices, are observed. Typical to large-scale cooking practices, reusing old oil and other stapes is a common practice, leading to the dangers of loss of vitamins and nutrients in food, and in the generation of free radicals that can pose harm to children's health. A common constraint that we hear from cooking staff is the lack of sufficient storage space that can allow for items to be bought in bulk, thus reducing associated costs. (Availability)

While these are some of the reasons identified through conversations with stakeholders, we acknowledge that nutritional practices are highly dynamic and multidisciplinary with financial, social, cultural, and religious axes. Through this project, we also hope to explore and better understand what drives these processes and resultant outcomes from the decades of experience and context that the stakeholders possess.

Goal and Objectives (Community-based action)

- Co-create and iterate standards and guidelines for nutritional inputs provided to 6-18-year-olds in the CCI
- Provide a toolkit with indicators and assessments for the CCI to track and monitor progress

These standards and assessment tools will be co-created closely with the community in practice, because they need to be sensitive to real logistical constraints from the CCI's end, and will also have to be culturally sensitive to the staff and children in care, understanding their beliefs, practices, and traditions that influence nutritional practices at the home.

Action Plan of the Community-Health Action Initiative:

Project Scope

Target CCI: A CCI in Chennai that caters to 92 children, supported by 13 staff members.

- Understanding social, economic, political, cultural, and ecological determinants that influence existing nutritional practices in the target CCI

- Co-creating target outcomes and outcome indicators (lagging) to clearly map out what we want young adults to have when graduating from CCIs
- Co-creating short-term impact indicators that help set out clear target achievements for processes at the CCI that will lead to ideal outputs/outcomes for children. This includes ways of incorporating child feedback actively in engaging them as equal stakeholders in the process.
- Co-creating and iterating target systems and processes at the CCI that cover the adequacy of food hygiene, positive attitudes towards food/prevalence of eating disorders, food awareness, and life skills by age, adequacy of daily food intake & macro/micronutrients, adequate need-based nutritional inputs, special diets, and diet-related medical conditions

Strategy:

- Identify and consult with a subject matter expert in nutrition and childhood development to ensure that the tool is based on the latest scientific evidence and best practices. (Preferably, focus on subject matter experts with experience in public health interventions)
- Run multiple focus groups with the staff and leadership of the institution to understand the current realities of nutritional inputs, outputs, and outcomes at the institution.
- Based on this understanding of current realities, define the objectives of the tool and the specific nutritional elements that need to be monitored and supported. ● With the objectives in mind, develop Standard Operating Procedures for different elements influencing nutritional outcomes in childcare institutions, including assessments and knowledge pieces.
- Develop a data collection plan that includes the types of data that will be collected, the methods for collecting the data, and the frequency of data collection. ● Design the tool in a user-friendly format that is easy to use by staff at the childcare institution.

- Test the tool with a small group of staff at the childcare institution to gather feedback and make any necessary revisions.

Community Participation:

Given that a major outcome of this project is an improved understanding of the institution's nutritional realities and current needs, community participation is an integral, entrenched part of this project. The facilitation of this participation included the following modes of communication

- Community advisory boards: I set up regular group check-ins with the key leadership

and staff of the institution to bring together community members to provide input and feedback on the tool, and to increase their buy-in and ownership of what we were trying to create

- Participatory research: I tried to ensure the involvement of all the staff of the CCI, particularly the kitchen staff in all aspects of the data collection process, from setting the agenda of conversations to collecting and analyzing their conversations, and in disseminating results.
- Community mobilization: This approach involved me working with the leadership of the institution and other advisory leaders of the institution (committee members) to mobilize and engage community members in the health-action initiative, and to leverage existing resources and networks.
- Choice of subject-matter expert: I chose to work with a nutritionist practitioner with experience in designing modules and tools customized for different communities, with experience in understanding and working with the different needs of vulnerable communities.

Activities & Resources:

With a short 3-month stint to work on this project, I had to split my time across different functions to complete the key goals of the project. I planned to prioritize activities that strengthened my understanding of the community and adequately proportioned more time for this activity. In a given week, my activities included:

- One-on-one or group discussions with the staff of the institutions to understand and capture existing practices, current challenges, and innovations in nutritional domains in the institution.

- Field visits to the institution for observational insights and shadowing opportunities with the kitchen staff of the institution.
- Weekly check-in with the subject matter expert, the nutritionist to translate learnings from the institution into ideas for the standard operating procedures and assessment manuals.
- Independent working time to co-create and review working drafts of SOPs and manuals for nutritional practices at the institution.
- Independent working time to review existing literature and government norms for institutions in the country.

Sustainability Planning:

Given that my organization is working on a capacity-building program for institutions, a key

part of my work is in conjunction with this program. We're building a knowledge repository, complete with best practices and guidelines across all domains of childcare for the use of staff and leadership at childcare institutions. While I spearheaded the beginning of the creation of these modules in nutrition as part of CHLP, I will have the opportunity and the resources to continue working with the Subject-Matter expert to finish the creation of the rest of the modules for nutritional outcomes, as this goal is in close alignment with my project at work.

I ensured that my work will not be in isolation and is part of our larger objective, a three-year project that is actively underway to build capacity for all childcare institutions in India.

Impact of the community health action:

A clearer picture of the community's needs:

Through extensive fieldwork and conversations with concerned stakeholders in childcare institutions, I am now able to report on nutritional elements in institutions with a far more nuanced understanding of factors that influence these outcomes, and the very nature of these outcomes themselves.

I would like to highlight a few key learnings about the current realities of nutrition in institutions from my work over the last three months:

Nutritional outcomes in care leavers:

- Care leavers (children who leave childcare institutions) are often unaware of their own nutritional needs and lack the ability to create structured & optimal meal plans for their optimal health.

- Care leavers (children who leave childcare institutions) often associate "good food" with donor-provided, high-calorie meals, and showcase little to no interest in different food groups, specifically avoiding vegetables and fruits.
- Care leavers (children who leave childcare institutions) show marked gender differences in receiving training for essential life skills like cooking, grocery shopping, cleaning, and maintaining their own meals. Care leavers are unable to self-identify and communicate symptoms of malnourishment and other deficiencies.

Nutritional outputs observed in children in care:

- Children are often not aware of diverse food types, the value they add, and associated life skills
- Children are prone to developing an inability to plan and maintain their own diets possibly due to food being served by CCI staff in standard quantities. Food portions are usually monitored while serving, with some homes taking a standard quantity

approach and others catering to children's individual preferences

- Children may develop complications in health conditions due to limited access to diverse specialized diets
- Children develop a taste preference for sweets, cakes, and ‘donor meals’. In some CCIs, there is an effort to shift focus from donor meals to in-house diets by ensuring outside food brought in is limited.
- Children are very aware and conscious of the role of donors in the food they eat; their relationship with ‘donor meals’ is often marked by a strong push to eat beyond typical satiety levels.

Nutritional inputs provided by the staff at institutions:

- Children are given at least 4 meals a day, allowing them to be satiated, with enough energy for the day.
- Meat & eggs, if provided on a regular basis can alleviate protein consumption concerns and prove to be an excellent source of nutrients for children.
- Children are fed diets that are carbohydrate heavy- with minimal emphasis on protein and fiber.
- Fruits and vegetables are quickly perishable and more expensive, dissuading caregivers from providing a diverse range of fresh produce.
- Lunch tends to be the most nutritionally dense meal of the day, tilting the balance of the diet plan- breakfast & dinner tend to be simple and nutritionally deficient.. ● Menu plans are not usually created with the help of registered nutritionists and doctors; nor are they updated regularly.
- Donors heavily influence meal timings, meal plans, and eating habits. ● Children are engaged in creating and updating the menu plan through children’s committees

- Children are often scolded and punished in response to eating habits, versus caregivers adopting a more encouraging, positive framework to help children improve their eating practices

Creation of tools for the community’s use

After surveys and conversations taught us about the current realities of how nutrition works in institutions, I moved on to creating a comprehensive check-list of SOPs and manuals that would be needed at an institution. This took most of the time allocated for the project because it involved extensive back-and-forth conversations with the subject matter expert and the staff, and leadership at the institution to co-create our idea of what a comprehensive nutrition manual would look like. Given that this was to be used in my organization’s project, I was also able to involve my own team members in reviewing and suggesting ideas for the manual.

Please find below the co-created outline for the nutritional manual:

Well-being of Children at CCIs

1 Growth & Nutritional Assessment of Children & Adolescents (6-18 years)	growth charts, how to use growth charts, Developmental milestones (6-12 years, 12-18 years), Age-wise immunization schedule, deworming, medical check-ups schedule, health care professional, nurse, planning, and execution, referrals, Growth charts, Immunization card, medical check up forms, referral forms,
SOP on how to assess general, health, growth and nutritional status of children at CCIs, details about schedule of immunization, deworming and medical check-ups	
Growth in children & adolescents, Determinants of growth & development, Indicators of growth, techniques of growth monitoring, precautions while assessing the growth, national growth standards,	

2 3	Nutritional Assessment, Requirements of Children (6-18 years) & Meal Planning Adapting Foundation Meal Plan for Children with Special Requirements	SOPs on Planning meals as per the nutrient requirements & the prescribed norms Meal register/Nutrition diet file (JJM), Nutrition & Diet Scale, involving children in meal planning SOP on how to adapt the basic meal plan for children with different medical conditions, food sensitivities, intolerances	Nutrition Assessment: ABCD Assessment by HCPs, screening children for malnutrition and referrals, Recommended Daily Intake- Children -NIN, Nutrition Timelines (Birth-18 years), Health-Nutrition Matrix (History-mental-social-PA-sleep), Foundational Meal Plan-Why the Foundational Meal Plan? - Attributes of the foundational Meal Plan-Understanding the foundational meal plan (Seasonal, regional)- FAQs Resources & Tools [Foundational Meal Plan Food List/Nutrition & Food Scale (JJM), Weekly Planner, Shopping list, Monthly Budget, Recipes, Meal Register/Nutrition Diet File, personalizing the foundational meal plan (Macronutrient distributions/adjusting calorie distribution as per the personal requirement), Ways to involve children in meal planning] Common medical conditions in children aged 6-18 years, descriptions, signs & symptoms, role of diet in the treatment, timelines for recovery, Catch-up growth in school children (Treating primary risk factors)	Data collection forms for ABCD assessment, RDI Table, Health-Nutritio n Matrix form, Foundational meal plan, Food list (Seasonal foods, regional foods, special occasion foods), Weekly planner, shopping list, Recipes, Meal register List of foods to be included/avoi de d
4	Implementing Age-Appropriate Fitness Protocol, FIT India, GOI at CCIs	SOP on how to implement the recommendations of Fitness protocol	What is 'Age-appropriate fitness protocol? How to implement and evaluate the protocol? How to ensure 60 Minutes of Moderate-to-vigorous Physical Activity (MVPA) Per Day, establish an age-appropriate, progressive fitness curriculum, fitness Assessment report card for every child, create a system for monitoring, regular feedback, and program re-evaluation strategy.	Test descriptionli nks to videos from FIT India Youtube channel, Fitness protocol, Benchmark tables, battery of tests

5	Nutrition Education to Children and Caretakers at CCIs	To improve health literacy, Teaching children and caretakers to cater to personalised nutrition-influenced issues when they leave care Part I: Target audience: Children (1) Food groups and nutrients (2) Food choices, food awareness, self-regulation and knowledge for children by age (3) How to cook healthy nutritious food from locally available foods within a budget, (4) Dissonance-based eating disorder prevention program targeted at adolescents (5) Involving children in the growing kitchen gardens, integrating nutrition education Part II: Target audience: Caretakers (1) How to handle picky eaters (Targeted at caretakers) (2) Dos and Donts of nutritional practices with children (caregiving standards) (3) Reporting feedback on children's behaviour around food (4) Guidelines on receiving sponsored cooked & uncooked foods (Restriction on fast foods (Adherence to Donor Guidelines) Guidelines on how to check sponsored food	Feedback form on meals/review system (Children & staff) Regular feedback cycles on food and food practices at the CCI?
6	TBD	Any missed content based on the review of the original outline	

7 TBD Any missed content based on the review of the original outline

Efficient KItchen Management Solutions

8 Kitchen Layout and Equipments
Dividing different preparation areas and counters so that no two operations are disturbed, number of wash stations, air ventilation, safety equipment,

maintaining kitchen garden, Buying good kitchen equipment, commercial kitchen equipment for large scale CCIs, maintaining kitchen equipment, servicing, cleaning checklist (After each use, every few hours, twice daily, Daily, Weekly, Monthly, Annually),
Kitchen/storage room cleaning, sanitation

checklist, pest control, annual deep cleaning schedules

9	Kitchen Inventory & Stock Managment	A detailed inventory list of raw materials and ingredients, Food storage (Dry/perishables), a Tracking system for food supplies, inventory stock audits to reduce kitchen waste, weekly prep sheets and notifications, Partnership with vendors, order schedules, quality check at the time of delivery,	

10	FoodandWater Safety,Hygiene andSanitation	Propersafetymeasurestoavoid contamination,foodhandling (raw/cooked)&watersafety,checklist forcleaningschedules,auditsand surprisechecks,assignedstafftocheck foodpreparationandhandling,howto reduceexposuretopesticidesand bacteria,safemealpreparation&best kitchenpractices	
11	Meal Management, Foodsafetyand hygeine& Scheduling	Foodcosting,Identifyinglocal,seasonal foodsandsuppliers(preferablyfrom growers),creatingingredientlistsasper themealplanning,involvingchildrenin creatinganddisplayingmealcharts, childrencanbeinvolvedhighlighting healthbenefitsoffoodsincludedin mealplans,incorporatingmealsfor specialoccasions. Runningtheprep sheetofthedaywiththestaff,making sureallingredientsneededfortheday areavailable,staffleave&replacement fortheday,keepingatrackofstaff shifts,organizingandreorganizingtheir schedulesoncertainspecialdaysand occasions,usingkitchendisplayboard, testingmealsbeforeserving	
12	Waste Management & Disposal	Typesofkitchenwaste(biodegradable, non-biodegradable),recycling/upcycling ofkitchenwaste,compostingkitchen waste,howtohandlekitchenwaste, maintainingfoodwastelogbook, monitoringplatewaste,initiatingzero platewasteawarenessprojecttargeted atchildren	

13	Hiringand managemento f kitchenstaffan d Guidelineson staffroles,jobs	Listofstaffneeded(fromheadcookto cleaninghelp),thehiringprocess, backgroundchecks,health-medical clearance,cookingskills,leadership skills,decidingthenumberofstaff(staff forspecificskills),older children/adolescentscanbeassignedfor basicskillssuchasvegetablechopping, servingfoodetc,clearlydefinedstaff rolesandresponsibilitiestoavoid friction,rotatingthestaff,preparing stafftofillinforothers,staffreview process,incentives/rewardstoreduce attrition,Setguidelinesforkitchenstaff regardingtheirrespectivejobsand commonruleswhileworkinginthe kitchen,stepstobefollowedbefore preparingthefood,andbasicsanitary	

		practices like washing/sanitizing hands before entering the kitchen and cooking food.	
14	TBD	Any missed content based on the review of the original outline	
15	TBD	Any missed content based on the review of the original outline	

Learning and Reflection:

What did I learn about the community that's noteworthy?

- Influence of external stakeholders:
    - In an ideal world, only the staff and the leadership of the institution will have influence over nutritional practices, given that they're the most in tune with the best interests of the child. However, I've come to realize that this is simply not the case. From the government to management bodies and external supporters, there are multiple conflicting factors that influence how nutrition plays out in a children's institution. I want to draw particular attention to the

influence of donors, an element of influence that became all the more important to me after my conversations for the health-action initiative.

- In many cases, donors may provide funding for the purchase of food and other supplies or may donate food items directly to the childcare institution. Meal sponsorship is one of the most common fundraising strategies that institutions employ. This can be beneficial as it allows the institution to provide healthy meals to the children, even if there is a limited budget.
- However, it's also important to consider that donors may have their own agenda or preferences, which may not align with the nutritional needs of the children or the institution's own goals. In such cases, it is important for the institution to have clear policies and guidelines in place to ensure that all donations are used in a way that is consistent with the institution's nutritional goals and standards. This is currently lacking in institutions as there is an unfair power dynamic and most donors come in with ideas that are not flexible. Donor awareness needs to improve for this situation to change.

- Intent to do good:
  - While this does not need to be stated, I would like to highlight the sheer sacrifice and effort that goes into planning, allocating budgets, and cooking for 90 children every single day.
  - While there are clear gaps in the nutritional outcomes achieved at the institution, it needs to be said that the staff and leadership in most institutions are always keen on improving child outcomes, and often come with an open mind to conversations around improvements.
  - However, the difficulties of behavior change also apply here. For staff that has followed practices that have stayed consistent for over two decades, any sort of behavior change is met with some resistance, and it is necessary to figure out the appropriate buy-in, training, and monitoring mechanisms to ensure the sustainability of change

- Misinformation is a threat:
  - Nutrition is a fairly complex topic with many layers of nuances and exceptions. Anecdotes cannot serve as evidence but unfortunately, institutions are not immune to believing certain myths propagated in society about nutritional facts.
  - A couple of myths I've heard from institutions include:
    - Consuming large amounts of ghee (clarified butter) is good for health: While ghee is a source of healthy fats, it is high in calories, and consuming large amounts can lead to weight gain and other health

problems.

- Eating spicy food can help you lose weight: While some spices have thermogenic properties, which can boost metabolism and help you burn calories, eating spicy food alone will not result in weight loss.
- Soy affects hormones and can be harmful to young boys.

- It is important to note that these are just examples of myths and every region might have different myths. It is important to seek credible information from qualified professionals, such as registered dietitians or nutritionists, to make sure that communities are making healthy and safe dietary choices. We need to actively encourage scientific communication and engagement with these institutions to give access to current evidence-based recommendations.

- Power dynamics and complicated consent:
  - This learning is primarily due to conversations with my mentor, Dr. Manjulika who pointed out that my presence as a funder for the institution, a long-time supporter of their work puts me in a position of power in all conversations I have with them. It is necessary to be cognizant of this power and to ensure that my work with the institution acknowledges my positionality and tries to validate any concerns that the institution might have in providing feedback or alternative opinions about my work.
  - Power imbalances, such as those based on socio-economic status, education, or cultural background, can make it more challenging for some community members to fully understand and participate in the informed consent process. I noticed this in conversations with the staff, in helping them understand that they could say no at any point in the conversation.
  - When working with communities, it is important to be aware of these power dynamics and to take steps to address them. This can include involving community members in the planning and implementation of the intervention, providing clear and easy-to-understand information about the project and its potential risks and benefits, and ensuring that all community members have the opportunity to ask questions and provide feedback.
  - Additionally, it became important for me to make sure that the informed consent process is culturally sensitive and appropriate. This included providing information in the community's preferred language (Tamil), and taking into account any cultural or religious beliefs that may impact the community

member's decision to participate.

- Importance of Regular Feedback:
    - With feedback, regular iterative feedback from the end-user of the tool (staff at the institution) was crucial for the success of this project.
    - To make this work, we adopted asynchronous work styles, sending in documents and voice notes as explanations for changes made from my end, and receiving feedback through comments or voice notes from the staff critiquing the documents in question.
    - It was also helpful to visit the institution on a regular basis to get feedback for some of the more complex decisions and changes to the manual.
    - Involving the community in multiple context-setting discussions helped a great deal because once alignment to the larger objective was established, the

changes were minimal and could easily be addressed over the quick phone or video calls.

Challenges faced during the Health-Action Initiative:

- With more time and resources, I would have liked to diversify the institutions I work with because geographical locations can make for different nutritional practices and traditions. Geography being a key factor in nutrition, my understanding of nutritional elements would have improved with variability in the institutions I worked with.
- I would have liked to include child participation elements in my understanding of nutritional practices in childcare institutions. Children's feedback is a crucial component of improving outcomes for any domain in an institution. However, given the limited time and a lack of appropriate permissions, I could not include children's opinions and ideas to form my understanding of nutritional practices at the institution.
- CCI staff and leadership are extremely busy and with the fairly oppressive caregiver-to-children ratios, it is difficult to find time for engagements outside of running the institution on a day-to-day basis. Often, coordinating these calls and visits required a number of conversations, and rescheduling was the norm.

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