Participatory Learning and Action for Health and Nutrition

Collaborative Work With Rural Community Volunteers in 6 States in India

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Sections

- Brief Description of the Reference Programme(s)
- Principles for Consideration,
- Pros and Cons
- Operational Comparisons of the Models
- Pedagogy and Curriculum
- Outcomes
Community Work on Nutrition:
The Projects and Partners

1. **Model 1**: Action Against Malnutrition (AAM) *(Seven blocks across four states)*

2. **Model 2**: Partnerships for Women's Empowerment & Rights (PoWER) *(Three blocks across two states)*

3. **Model 3**: PoWER; Partnerships for Rural Integrated Development and Empowerment (PRIDE 1); Women Collective Led Process for Impacting Poverty and Malnourishment (PRIDE 2) *(Thirteen blocks across five states)*
Existing (CHW) Programmes

• Health and nutrition considered technical, largely appropriated by ‘experts’

• Almost fully ‘top-down’, instructional, one-way rather than allowing community participation / ownership.

• Utilitarian approach to women – as (future) mothers, care providers, no attention to gendered power relations. Paternalistic and patriarchal.

• Focus on behaviour-change and individual-based solutions more than collective action / systems

• One-size-fits-all messages and methods

• The appointed CHW (ASHA) has the dual disadvantage of being coopted by the above system; thus hierarchically separated from community, and yet not supported by the same system for health action. Convenient paradox between worker and activist.

• Affecting the most vulnerable; the youngest children, very poor marginalised communities, women with no schooling. Vulnerabilities compounded in an intersectional and intergenerational way
Juxtaposed Underlying Principles
(our models)

*respect, dignity, equality, love and care, patience, non-discrimination, empathy and professionalism*

- Primacy to affected participants; their perspectives, knowledge, views and opinions. *Experiential learning*, adult learning
- *Technical* (scientific) validity
- Cyclically iterative between theory and practice, considering that science is not absolute
- Not just practical needs but strategic needs to be addressed; knowledge for transformative redistributions of power
- *Self-Community-Systems Approach*. ‘Demand-Side, Supply-Side’

*community-based organizations must remain centre-stage in transformative processes for these processes to be correctly aligned to the needs and rights of the people concerned, and be effective and sustainable*
<table>
<thead>
<tr>
<th>Positives</th>
<th>Negatives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Address inequity</strong> and social injustice</td>
<td>Reinforce the invisibility of women’s unpaid care work and gender roles as volunteer carers</td>
</tr>
<tr>
<td>Fulfill principles of <strong>local self-governance</strong>, right to participation, information, health and nutrition literacy and acknowledge existing knowledge</td>
<td></td>
</tr>
<tr>
<td><strong>Sustainable</strong>, across generations, mobilize a larger mass for leveraging larger long term gains, shifts at population level as compared to targeted interventions, impact on social determinants</td>
<td>Continuity cannot be ensured resulting in transmission losses and capacity investment losses (E.g: only 29/157 completed 3 rounds of capacity building from one cycle but all retained)</td>
</tr>
<tr>
<td>Fulfill our theory of change....</td>
<td></td>
</tr>
<tr>
<td><strong>Cost effective and efficacious</strong> (AAM eval unpublished, Alive and Thrive eval B’desh, PRIDE / PoWeR eval in process)</td>
<td>Labour and management intensive for appropriate capacity building and hand holding</td>
</tr>
</tbody>
</table>
### Community Volunteer Programmes: Pros and Cons contd.

<table>
<thead>
<tr>
<th>Positives</th>
<th>Negatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help to <strong>equalize power relations</strong> between system / community health worker and community</td>
<td>Suffer from the relative powerlessness of ‘civil society’ in the short term for acting on the system</td>
</tr>
<tr>
<td>Can engage in <strong>social audit</strong> and other processes of governance without constraint</td>
<td>Do not have direct access/ power to take corrective action on the basis of the social audit in the short term</td>
</tr>
<tr>
<td>If part of SHGs, <strong>can mobilize own resources</strong> for problem solving</td>
<td></td>
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</table>
Model 1: Action Against Malnutrition (AAM)

- Jharkhand
- Odisha
- Chhattisgarh
- Bihar
Models 2&3: PoWER , PRIDE 1 & PRIDE 2

**States** | **Blocks**
---|---
Jharkhand | • Kathikund  
          | • Sonua  
          | • Poraiyahat  
          | • Raidih  
          | • Torpa  
          | • Gola
Chhattisgarh | • Tokapal
Odisha | • Balliguda  
        | • Nuagaon  
        | • Kolnara
Madhya Pradesh | • Samnapur  
                  | • Mohagaon
West Bengal | • Jhalda
## Outreach

<table>
<thead>
<tr>
<th>Project</th>
<th>Blocks</th>
<th>States</th>
<th>Number of Women Reached</th>
<th>Number of Children Reached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1 (AAM)</td>
<td>7</td>
<td>4</td>
<td>20,000**</td>
<td>35985*</td>
</tr>
<tr>
<td>Model 3 (PoWER &amp; PRIDE -1)</td>
<td>9</td>
<td>5</td>
<td>90,000</td>
<td>-</td>
</tr>
<tr>
<td>Model 3 (PRIDE -2)</td>
<td>4</td>
<td>1</td>
<td>30,000</td>
<td>-</td>
</tr>
</tbody>
</table>

* 5250 children directly reached through a crèche programme –
** In three blocks ~ 12555 PLA meetings were organised of which 28% were attended by frontline workers as well
<table>
<thead>
<tr>
<th>Structure</th>
<th>Methods</th>
<th>Evaluation &amp; Scale</th>
<th>Costs</th>
</tr>
</thead>
</table>
| **Govt Programme (ASHA)**  
*PHRN ran an ASHA Resource Centre (Bihar) for 9 districts* | 1:400 – 1000 Remunerated for specific tasks  
Cluster Supervisor and Instt Facilitation (SHRC) | No specific training for PLA  
Specific tasks allocated | At universal scale through NHM. Not evaluated for nutrition.  
However, JOHAR (Jharkhand Odisha Health Action Research) Trial (Tripathy et al, EKJUT, shows positive results for neonatal mortality using PLA |
| **Model 1**  
AAM Consortium  
*PHRN as PMU* | Hamlet-level paid PLA facilitator  
Paid Cluster Supervisor  
Institutional (NGO) facilitation | Monthly meetings using games etc  
18+4+10 Malnutrition + Social Audit + ECCD + Rep Health | Positive results for primary indicators and pathway indicators  
Awaiting publication  
Scaled up Govt of Odisha (Shakti Varta) | $ 7.5 PC/PA  
Highly cost effective compared to WHO threshold |
| **Model 2**  
(P pilot)  
*PHRN as PMU* | Hamlet level volunteer CRP | Monthly meetings using picture cards |  |
| **Model 3**  
PoWER, PRIDE  
*PHRN as PMU* | Hamlet level volunteer CRP  
Supported by paid mentor at cluster level Instt Facilitation | Monthly meetings using complex stories (micromodules)  
Malnutrition+Reproductive Health + Common Diseases | Underway (WINGS- IFPRI Sambodhi)  
At large scale through civil society facilitated SHGs | $1.9- $ 3.3 PC/PA |
Structure Model 3

- 1 Mentor
- 20 CVs
- 1500 - 2000 HHs or Families

Diagram:

- Block (General, Health, ICDS etc.)
- Panchayat Level (HSC)
- AWC/ VHC
- Federation
- CLF
- VOs
- SHGs
- Mentors
- PHRN BPO + PRADAN anchor
- CVs
PLA Activities
PEDAGOGY, CURRICULUM, MATERIALS
Phases of the PLA Cycle

- **Phase 1**: Identify & Prioritise Problems
- **Phase 2**: Plan Strategies
- **Phase 3**: Put Strategies into Practice
- **Phase 4**: Evaluate Together

Slide Courtesy EKJUT, AAM Consortium
The Cyclical Programme Structure and Process; Experts, Practitioners, Community

Prasad, 2016 Cyclical Negotiations Between Theory And Practice For Building Knowledge In Nutrition, With Intent To Action
A Case Study of Collaboration; unpublished paper prepared for the 2nd Symposium on Transformation for Rural Development: Collaboration and Co-Production of Knowledge held on April 19-22 2016 by the Centre for Development Practice, Ambedkar University, Delhi.

Diagram:
- SC
- NARC
- PT
- Block Teams
- SHGs
- (Village And Federation)
- CRPs

Principles Guiding the Material

• Women’s health rights will be the over-arching frame. Own experience will be the take-off point.

• Each phase must have limited content.

• Minimal or no text to be used. Mode of transaction of content will be pictorial, audio-visual, demonstrative, repetitive, using games, cultural media etc.

• Reinforcement plus additional content in each cycle (70:30). Layering, reiteration.
Modules and Tools

- Picture cards
- PB modules
MODEL 2: Cascade Training Strategy

**1st level training**
- tNGO conducts training (PHRN, NARC)
- Master Trainers (State Level Resource Pool) PHRN, NARC
- 1 NARC + 1 PHRN
- Trainers (Block Level Resource Pool) Mentors, Block Coordinators

**2nd level training**
- PHRN, NARC, Block Coordinators, Mentors
- Trainers (Block Level Resource Pool) Mentors, Block Coordinators
- 1 Mentor + 1 Block Coordinator

**3rd level training**
- Federation Members, Change Vectors
- Change Vectors
- Each CV
- Handholding by mentors

**Training material Used**
- Facilitators module
- Field module

Village level meetings
SOME OUTCOMES
Outcomes: Wasting, Underweight
Model 1, (AAM)

PLA and Home visit versus control
OR: 0.72 (95% CI: 0.54-0.95), \( P = 0.022 \)
28% reduction in the odds of wasting

PLA and Home visit versus control
OR: 0.74 (95% CI: 0.58-0.94), \( P = 0.014 \)
26% reduction in odds of underweight

To Be Published
Outcomes for Most Marginalized
Model 1, (AAM)

<table>
<thead>
<tr>
<th>ARM 2 (PLA AND HOME VISITS)</th>
<th>% CHANGE</th>
<th>OR (95%% CI)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>All children</td>
<td>-28%</td>
<td>0.72 (0.54-0.95)</td>
<td>0.022</td>
</tr>
<tr>
<td>Most marginalized</td>
<td>-46%</td>
<td>0.54 (0.35-0.85)</td>
<td>0.007</td>
</tr>
</tbody>
</table>

* Most marginalized: belonging to Scheduled Tribes and to the two poorest wealth quintiles
<table>
<thead>
<tr>
<th>Indicators</th>
<th>PLA and Home Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early initiation of breastfeeding</td>
<td>✓</td>
</tr>
<tr>
<td>Minimum dietary diversity</td>
<td>✓</td>
</tr>
<tr>
<td>Minimum meal frequency (9-24)</td>
<td>✗</td>
</tr>
<tr>
<td>Minimum acceptable diet (6-9m and 9-24m)</td>
<td>✓</td>
</tr>
<tr>
<td>Consumption of iron rich foods</td>
<td>✓</td>
</tr>
<tr>
<td>Water treatment</td>
<td>✗</td>
</tr>
<tr>
<td>Handwashing with soap before feeding the child</td>
<td>✓</td>
</tr>
<tr>
<td>Advice sought for diarrhoea</td>
<td>✓</td>
</tr>
<tr>
<td>Use of ORS for diarrhoea</td>
<td>✓</td>
</tr>
<tr>
<td>Measles immunization</td>
<td>✗</td>
</tr>
<tr>
<td>Deworming in last 6 months</td>
<td>✓</td>
</tr>
<tr>
<td>Mosquito net use</td>
<td>✓</td>
</tr>
</tbody>
</table>

✓ Indicates an effect detected in the difference in difference analysis (p<0.05)

✗ Indicates an effect not detected in the difference in difference analysis (p<0.05)
From the Ground ....

Model 2, (PoWER)

• Rescuing babies from severe malnutrition
• Referring cases to the system
  • at least six children referred to health services and rescued from malnutrition as reported from a single field visit. In one case, the *samiti* (SHG) had paid for the extra costs of treatment.

  “*we saved a 1.8 Kg baby, didi!*”

• Improving village level services
• Eating better (not last and least)
• Improving their body mass index (BMIs)
• Looking after their own health and nutrition
  “*women are not permitted to go and buy meat... but now I do, and I eat it myself*”
We agree.....

...appropriate selection, continuing education, involvement and reorientation of health service staff and curricula, improvement supervision and support are non-negotiable requirements...

Lehmann and Sanders, 2007

www.who.int/hrh/documents/community_health_workers.pdf