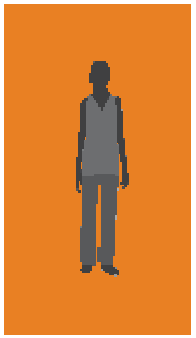
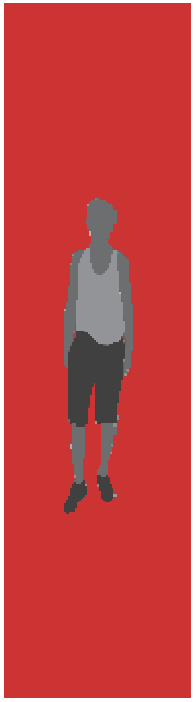
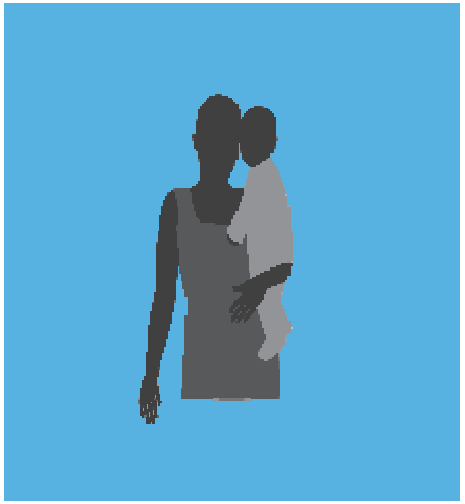
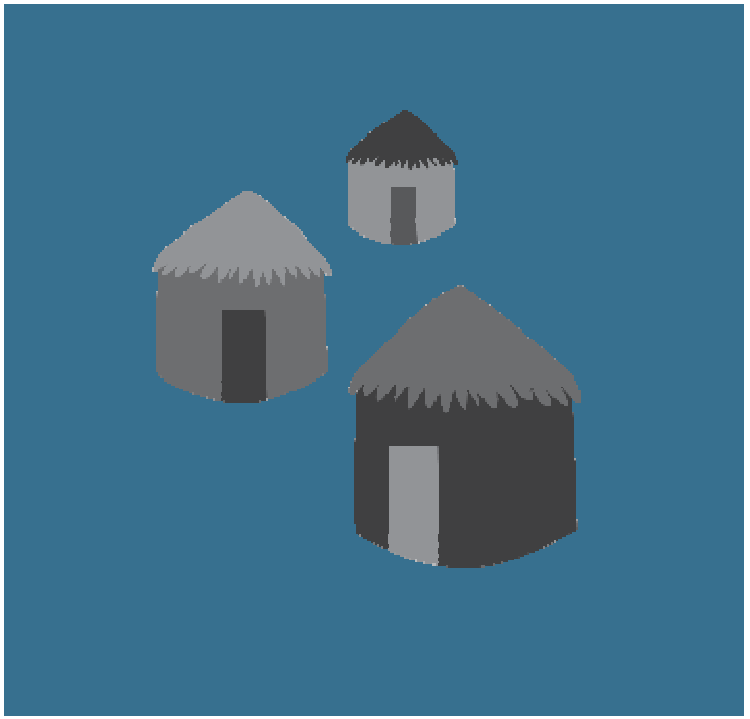







Institutionalizing Community Health Conference

27-30 March 2017 Johannesburg, South Africa

#HealthForAll

ichc2017.org

Participatory Learning and Action for Health and Nutrition

Collaborative Work With Rural Community Volunteers in 6 States in India

Dr Vandana Prasad
MBBS, MRCP (Pediatrics), MPH
Public Health Resource Network

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 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

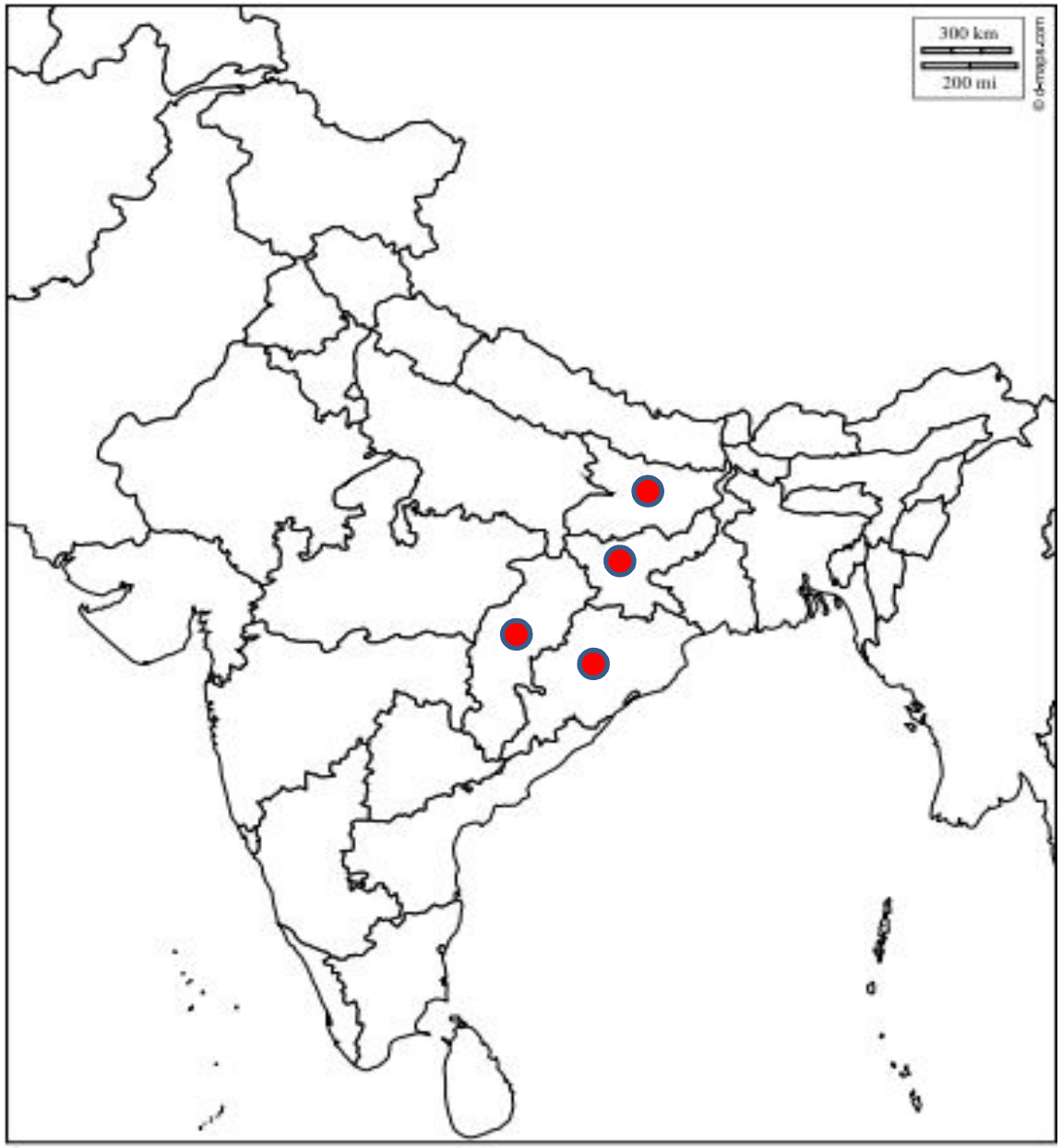
Community Volunteer Programmes: Pros and Cons

Positives	Negatives
Address inequity and social injustice Fulfill principles of local self-governance, right to participation, information, health and nutrition literacy AND acknowledge existing knowledge	Reinforce the invisibility of women's unpaid care work and gender roles as volunteer carers
Sustainable, 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 Fulfill our theory of change….	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)
Cost effective and efficacious (AAM eval unpublished, Alive and Thrive eval B'desh, PRIDE / PoWeR eval in process)	Labour and management intensive for appropriate capacity building and hand holding

Community Volunteer Programmes: Pros and Cons contd.

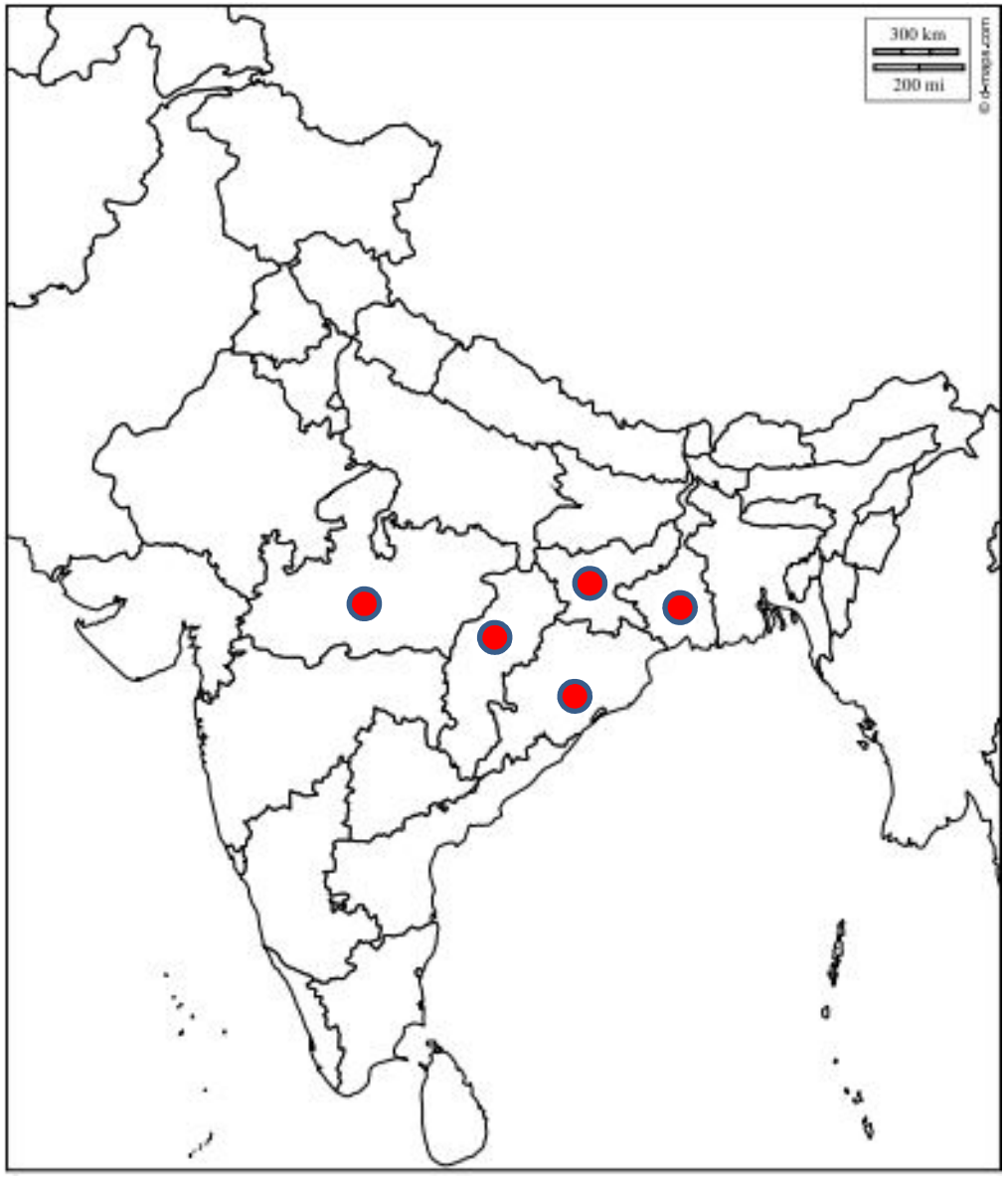
Positives	Negatives
Help to equalize power relations between system / community health worker and community	Suffer from the relative powerlessness of 'civil society' in the short term for acting on the system
Can engage in social audit and other processes of governance without constraint	Do not have direct access/ power to take corrective action on the basis of the social audit in the short term
If part of SHGs, can mobilize own resources for problem solving	
Thus, better for action at level of self and community on the whole, and system in the long term	

Model 1: Action Against Malnutrition (AAM)



States
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

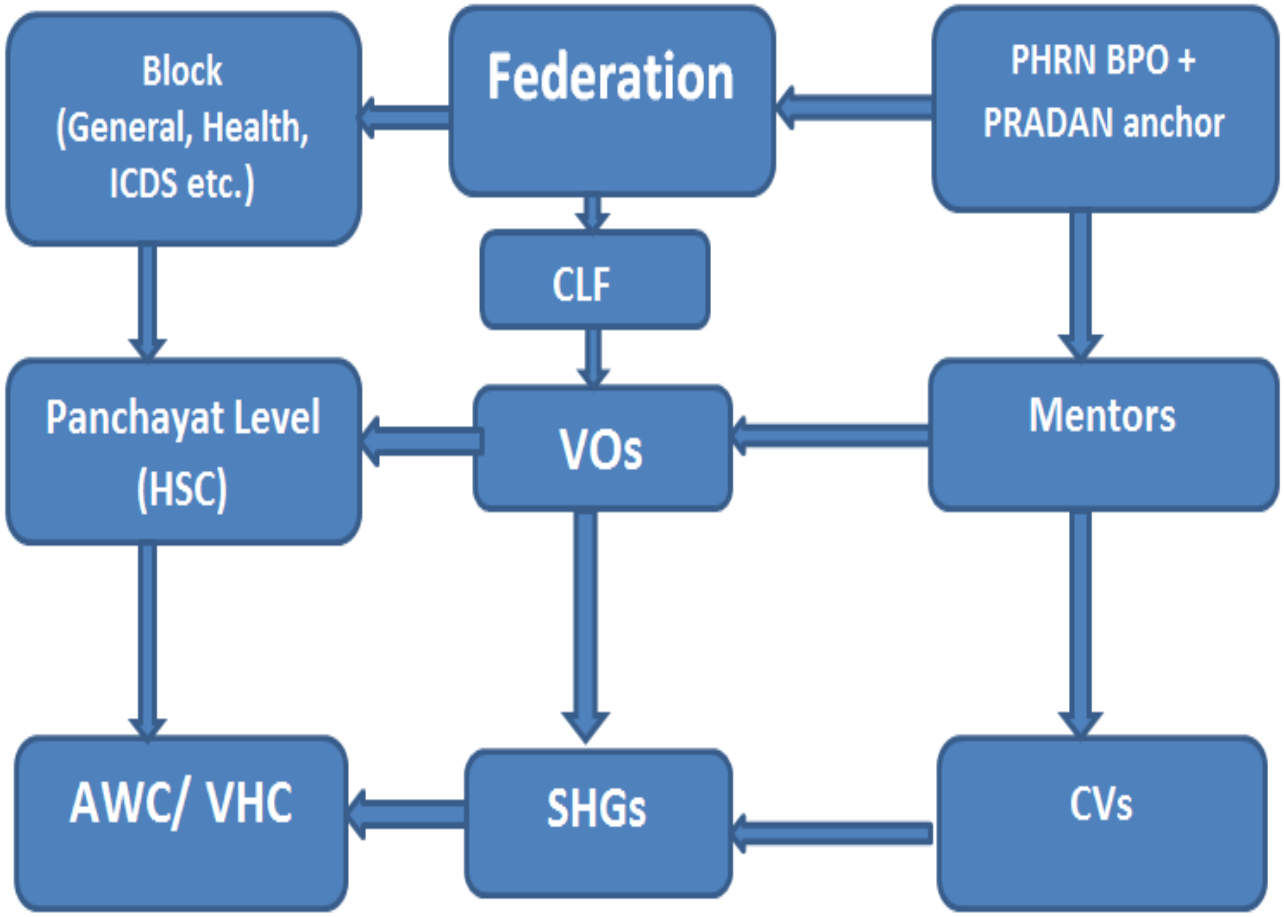
Project	Blocks	States	Number of Women Reached	Number of Children Reached
Model 1 (AAM)	7	4	20,000**	35985*
Model 3 (PoWER & PRIDE -1)	9	5	90,000	-
Model 3 (PRIDE -2)	4	1	30,000	-

* 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

	Structure	Methods	Evaluation & Scale	Costs
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 (pilot) ***PHRN as PMU***	Hamlet level volunteer CRP	Monthly meetings using picture cards		$ 0.7 PC/PA
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

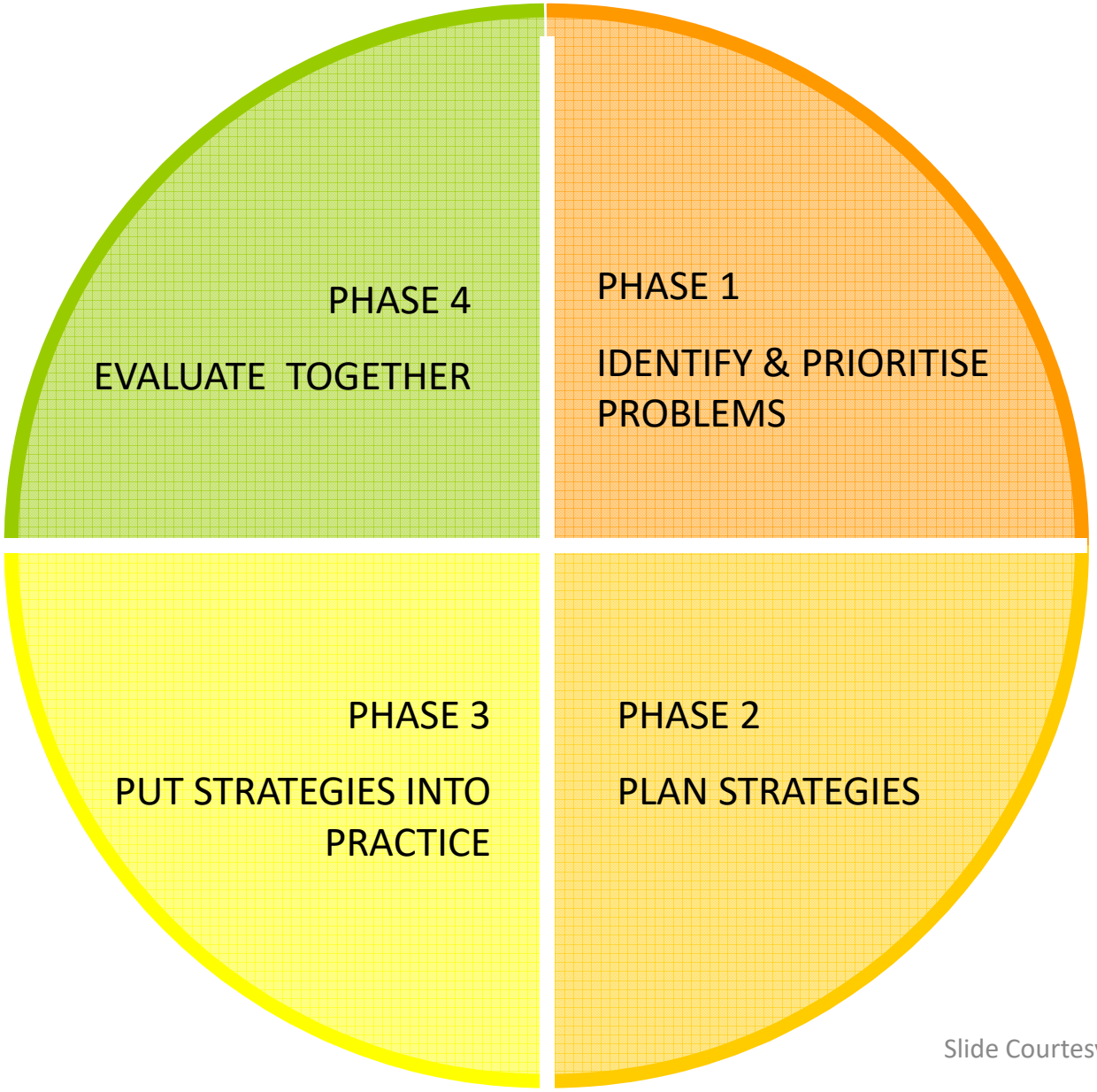
↓

1500 - 2000 HHs or Families

PLA Activities

PEDAGOGY, CURRICULUM, MATERIALS

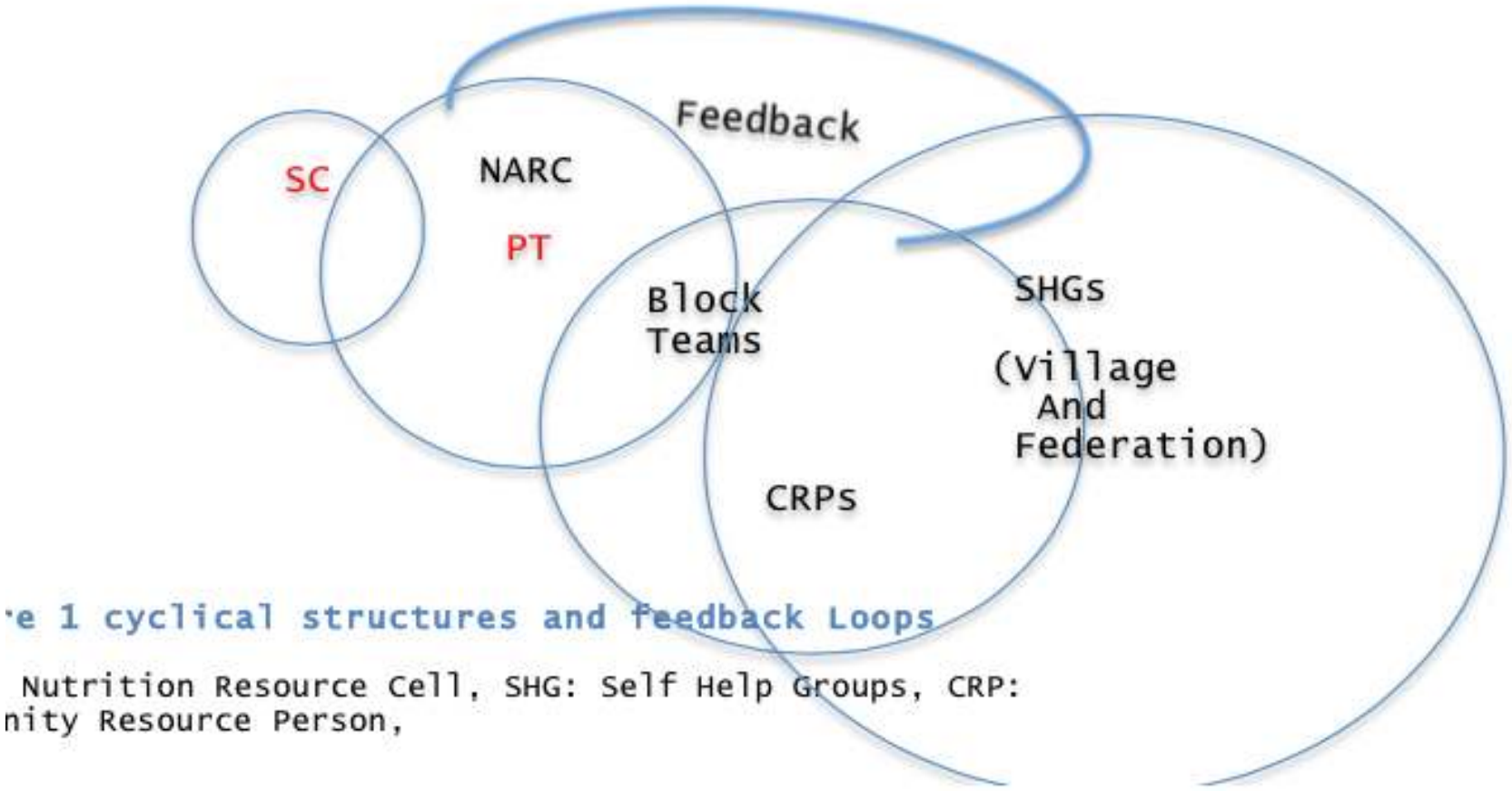
Phases of the PLA Cycle



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; unpublishedpaperpreparedforthe2nd Symposium on Transformation for Rural Development: Collaboration and Co-Production of Knowledge held on April 19-22 2016by the Centre for Development Practice, Ambedkar University, Delhi.



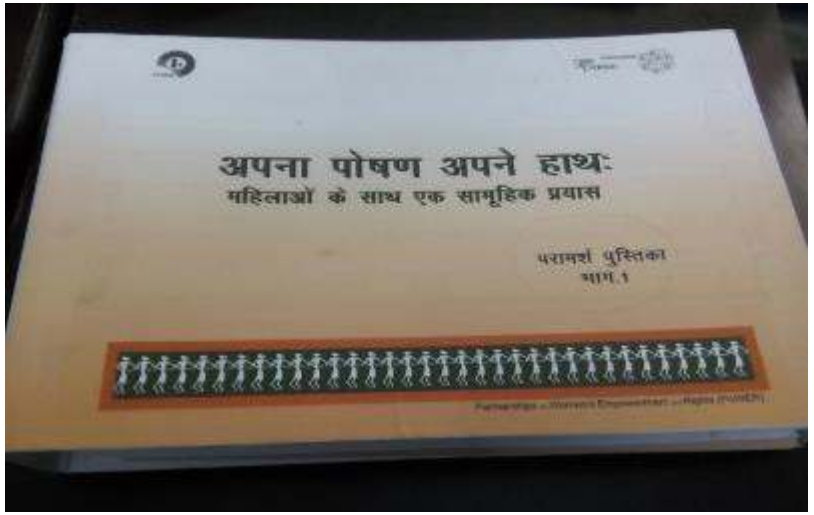
'e 1 cyclical structures and feedback Loops

Nutrition Resource Cell, SHG: Self Help Groups, CRP:
nity Resource Person,

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.

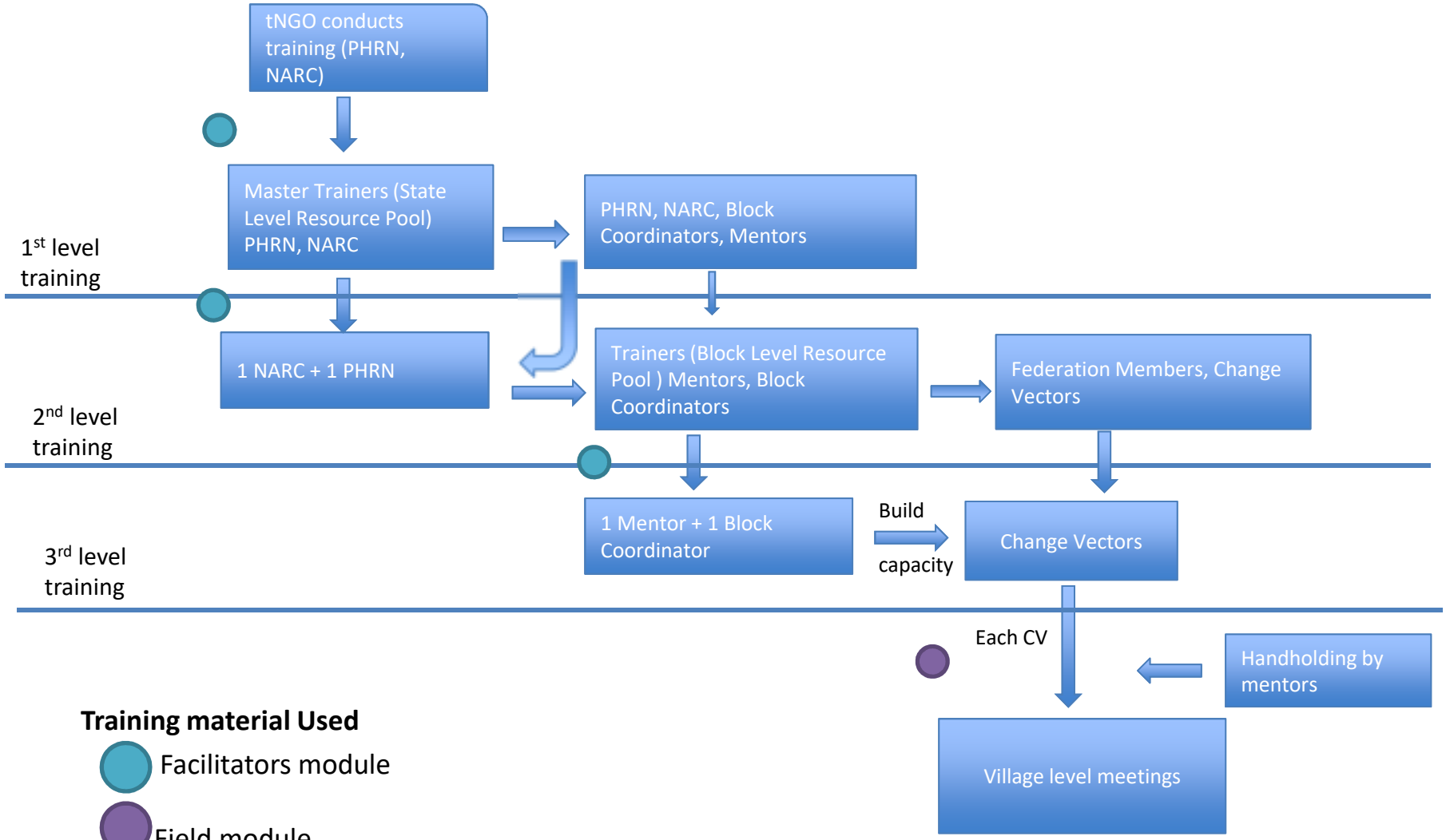
Modules and Tools



Picture cards

PB modules

MODEL 2: Cascade Training Strategy



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)

	% CHANGE	OR (95%% CI)	P value
ARM 2 **(PLA AND HOME VISITS)**			
All children	-28%	0.72 (0.54-0.95)	0.022
Most marginalized	**-46%**	0.54 (0.35-0.85)	0.007

* Most marginalized: belonging to Scheduled Tribes and to the two poorest wealth quintiles

Summary Of Positive Effects (AAM)

Indicators	PLA and Home Visits
Early initiation of breastfeeding	✓
Minimum dietary diversity	✓
Minimum meal frequency (9-24)	✗
Minimum acceptable diet (6-9m and 9-24m)	✓
Consumption of iron rich foods	✓
Water treatment	✗
Handwashing with soap before feeding the child	✓
Advice sought for diarrhoea	✓
Use of ORS for diarrhoea	✓
Measles immunization	✗
Deworming in last 6 months	✓
Mosquito net use	✓

✓ 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

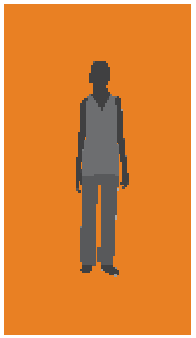
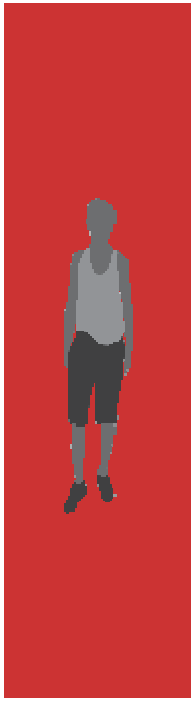
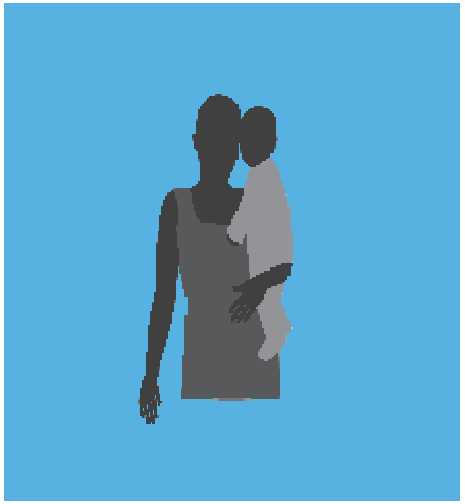
"women are not permitted to go and buy meat… but now I do, and I eat it myself"

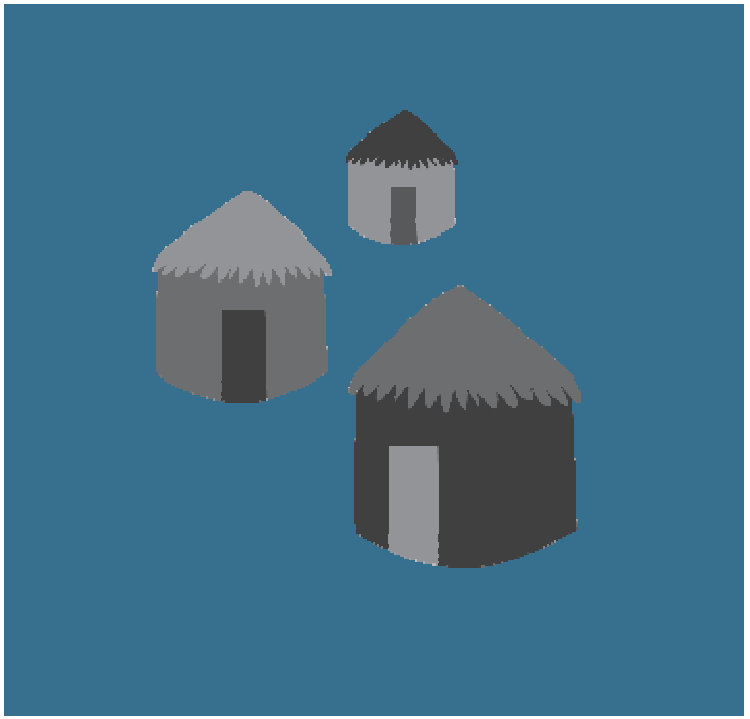
We agree…..

…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



Institutionalizing Community Health Conference

27-30 March 2017 Johannesburg, South Africa

#HealthForAll

ichc2017.org