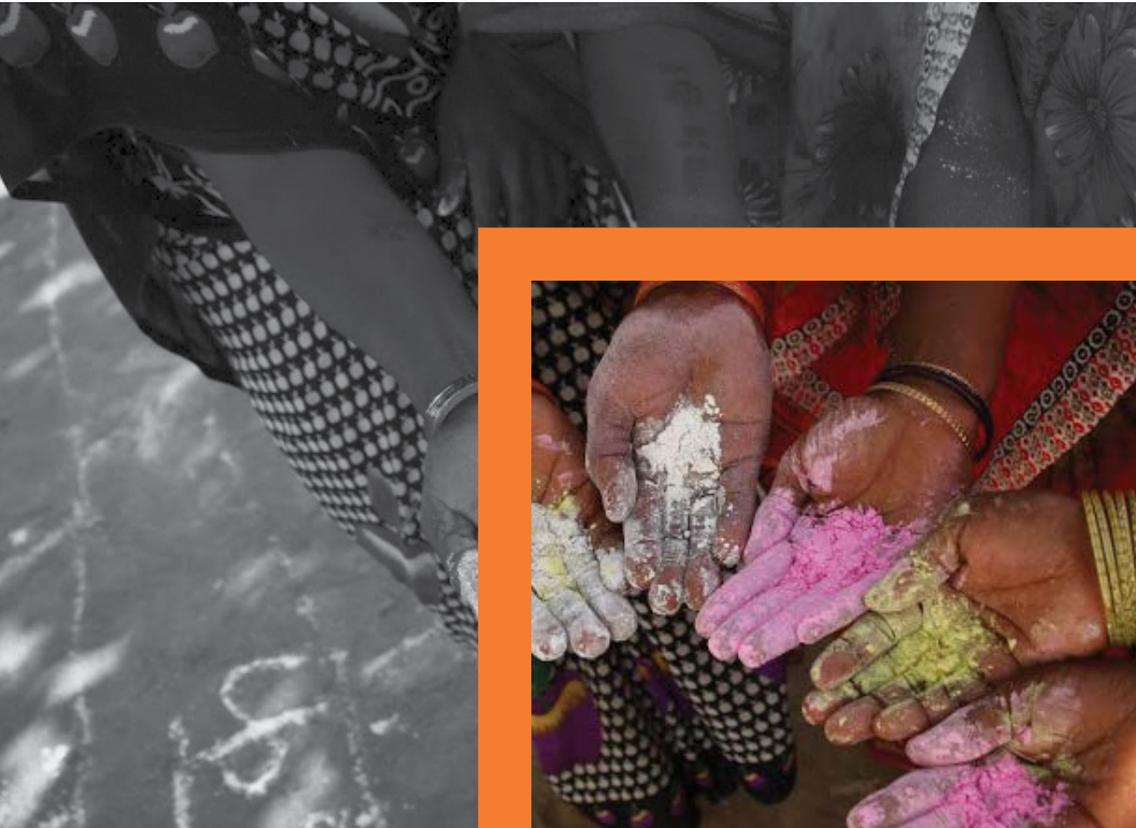




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Gram Varta *for*
Community Mobilisation and Behaviour Change

SUMMARY

Gram Varta is a Participatory Learning and Action (PLA) approach initiated under Sector-Wide Approach to Strengthen Health (SWASTH) in Bihar. It mobilises women through Self Help Groups (SHGs) to improve family health, nutrition, water, sanitation and hygiene (HN&WASH) practices and contain high neo-natal, maternal and under-5 mortality rate in the state. The PLA model supported SHG members in identifying the local HN&WASH problems and developing strategies for action. The approach not only nurtured women's self-confidence and developed group solidarity, it helped them negotiate healthy practices with family members, share information with their family and peer networks on health and hygiene, and foster community support for action. At a macro level, it mobilised the community to promote healthy habits, raised the demand for primary HN&WASH services, increased women's active participation, and stimulated local action for change.

SWASTH

SWASTH sought to improve the health and nutrition status of the people of Bihar, particularly targeting the poorest and excluded. It aimed to strengthen health, nutrition and water, sanitation and hygiene (WASH) outcomes across the state, and reduce child malnutrition, child mortality, maternal mortality, and raise contraceptive prevalence.

SWASTH worked on improving the state government-run systems and services in HN&WASH on the one hand, and raised community awareness and demand for these services on the other. To raise awareness and generate demand, it was important to empower women with the ability to take informed decisions for their own and their families' health and well-being, and to mobilise community leaders to engage in and lead community action for HN&WASH.

BACKGROUND

In the past two and a half decades, even as India made rapid strides in human development, Bihar has not always kept up. When SWASTH was introduced, the state had high rates of poverty, maternal and infant mortality, rampant gender inequality, and social exclusion based on caste and religion. Factors such as early marriage, low educational status, flood, drought and widespread prevalence of arsenic and fluoride in groundwater used for drinking, increased people's vulnerability to malnutrition and poor health – in short, social determinants of health were worrisome and difficult to shift. At a particular disadvantage were the poor, nearly 34% of the state's population (Planning

Commission of India, 2011-12). The state has the highest poverty ratio in India with over 35 million people officially living in poverty.

Low education among girls and women gave them a disadvantaged social status. Preference for sons is highlighted through the skewed sex ratio of 916 women to 1000 men (Census 2011), a decline from 924 in 2001. Evidence showed that low literacy rates and poor school attendance among women and girls had a correlation with their own and their families' health and well-being. The 2011 Census recorded female literacy rate in Bihar at 53%, and male literacy rate at 73%. With an aggregate rate of 63% in 2011, this was the lowest



literacy rate for any state in the country.

Of particular concern was early marriage. According to the District Level Household Survey –III (DLHS-III) (2007-2008), the mean age of marriage in the state was 21.6 years for men and 17.6



years for women, with 42% of boys and 45% of girls married before their legal minimum age for marriage. Early marriage led to high rates of school dropout for girls and put adolescent girls at the heightened risk of maternal health complications. Besides,

the state had high levels of domestic violence. Over 56% of women aged 15-49 years experienced physical or sexual violence, including 62% of ever-married women, higher than any other state in the country (National Family Health Survey (NFHS) 3, 2005-06). The majority of

abused women did not seek help or tell anyone about the violence they experienced as 57% of adults in the state believed a husband is justified in beating his wife. Such attitudes further perpetuated neglect of women's health.

Poor health and nutrition status: The NFHS-3 (2005-06) found stunting among 56% of children with girls as worst sufferers. The state had the second highest incidence of stunting in the country¹. The Annual Health Survey (AHS) 2012-13 found the under-five mortality rate to be 70. The maternal mortality rate was high too, though it had come down from 261 to 219 in 2007-2009. Contraceptive prevalence at 41% in 2012-13 had improved from 34% in 2005-2006, but was still low compared to other states.

Poor health and nutrition outcomes were due to low service utilisation and poor family health practices. As reported in the AHS 2012-13, just 36.7% of pregnant women received three or more ANC visits and only 55.4% of births took place in a health facility. Almost 20% of mothers received no postnatal check-up. Care of the new-born was miserably inadequate with

only 37% of new-borns breastfed within an hour of birth. Infant feeding practices were poor with only 31% of children aged 6-35 months exclusively breastfed for 6 months. Less than 70% of infants between 12-23 months were fully immunised and only 1 out of 10 children received some kind of service at the Anganwadi Centre, according to NFHS -3.

Need for a rigorous community mobilisation: Global evidence indicates that service strengthening is important, but service strengthening alone cannot improve nutrition and health status at scale. Effective nutrition and health policies need to recognise communities, particularly women, as key stakeholders in the process of improving health and nutrition conditions. The need for community mobilisation was emphasised in WHO's Global Strategy for Health for All by the Year 2000 framework adopted by over 150



countries, including India, in 1978. Since then attempts were made to include community mobilisation in national and state health and nutrition programmes. But these were either relatively less rigorous or limited in scale, or had little focus on

¹<http://unicef.in/Whatwedo/10/Stunting>



empowering communities to understand and take appropriate actions to address HN&WASH issues at their own level.

Open defecation and contaminated water undermine public health:

Only 22% of houses in Bihar had a toilet reflecting the dismal water and sanitation

situation of the state. The link between unsafe water, open defecation, and the incidence of diarrhoea and malnutrition is well established. Besides, the lack of toilets in schools adversely affects continuation of girls' education. With safe sanitation recognised as a key determinant of health and nutrition, tackling open defecation was a high priority.

Years of supply-driven sanitation programmes had weak results with just 39% households opting for a toilet (Swachh Bharat Mission Baseline Survey, 2012). This needed a push with community-led sanitation approaches for open defecation free environments.

GRAM VARTA - APPROACH

Gram Varta is a community mobilisation initiative pioneered by the Government of Bihar and UK's Department for International Development (DFID) under SWASTH (2011-2016). It leveraged the many thousands of women SHGs in Bihar for mobilising women and their families for:

- **Improved health, nutrition, water, sanitation and hygiene (HN&WASH) practices at the household and community level**
- **Increase in demand and uptake of HN&WASH services by households**
- **Accountability and responsiveness of service providers**

Gram Varta emerged as a state-wide initiative with high-level ownership of the Government of Bihar. Initially piloted in two gram panchayats of Maner Block in Patna District by the Women Development Corporation (WDC), the intervention was implemented through three major self-help promoting institutions: Women Development Corporation, Mahila Samakhya (a Government of India programme for the education and empowerment of rural women), and Jeevika, the Government's flagship rural livelihoods programme.

Through these three institutional structures, Gram Varta was implemented in 22 out of 38 districts within the state and reached:

78,261
Self Help
Groups

9,39,132
households

46,95,660
people

The government is aiming to reach 10% of the rural population (i.e. over 9 million people) through Gram Varta.

INTERVENTION

DEVELOPING THE CONCEPT OF GRAM VARTA

Gram Varta was designed as a community-based approach to empower women to promote better HN&WASH practices, and be the agents of change for their families and communities. Gram Varta followed an all-inclusive approach and reached out to the most marginalised and poorest groups. It built community solidarity to improve the health and nutrition outcomes for all.

Gram Varta integrated approaches to health, nutrition and WASH and drew frontline workers from the three sectors for community mobilisation. It promoted better linkages between communities and

basic services, and fostered convergence between the three sectors at the community level in a way that benefited the community. Gram Varta was designed for the specific context of improving health and nutrition outcomes in Bihar while drawing learnings from national and international evidence. It sought to mobilise the community by raising awareness and developing solidarity among members to address the social determinants of health, gender and social exclusion. Community mobilisation through women's groups included and empowered groups at risk of exclusion from development. The transformational potential of community mobilisation was particularly important in addressing the social determinants of malnutrition and the gendered social norms that underpin a

family's food distribution and child feeding practices.

EMPOWERING WOMEN WITH KNOWLEDGE OF 'HEALTHY BEHAVIOUR'

As women are often the primary care givers of their families, they influence decisions that impact the health and nutrition outcomes of their children and families. Gram Varta was designed to impart knowledge of healthy behaviour to rural women and foster their self-confidence in putting their knowledge into practice. Gram Varta was developed based on research findings that showed how empowerment of the community and women improve nutrition and health outcomes. For example, the Navrongo Health Research

Centre in northern Ghana saw a 60 % decline in deaths among children aged 2 to 5 years when traditional leaders and communities were engaged in planning and delivering health services.

SHGS AS AN EFFECTIVE PLATFORM FOR CHANGE

Evidence shows that community mobilisation through women's groups reduces neonatal mortality and improves maternal health. A randomised controlled trial by Ekjut in Jharkhand and Odisha had shown a 34% reduction in neonatal deaths, while a similar trial in Makwanpur, Nepal, found 30% reduction in neonatal mortality rates in intervention areas when compared to control areas. Working through women's groups improved health for mothers, their children, and other household members in large numbers in a relatively short time, particularly among disadvantaged groups. In India, women's self-help groups provide a ready

institutional platform for community action towards improving health, nutrition, water and sanitation outcomes. Though SHGs were traditionally engaged in loan and savings activities, experience from Kerala, Odisha and Jharkhand indicates their adaptability to initiate health and nutrition programmes, as well as their potential to scale up rapidly at a relatively low cost.

PARTICIPATORY LEARNING AND ACTION (PLA) APPROACH

The Ekjut trial in India and other such experiences from South Asia and Africa demonstrate the effectiveness of women-led PLA approach in stemming and reducing maternal and new-born mortality. Based on this evidence, in 2014, WHO had recommended participatory learning and action (PLA) cycles with women's groups as a means to improve maternal and new-born health, particularly in rural settings having low access to health services.

THE STRENGTHS OF A PLA CYCLE

- **The poorest and most marginalised groups benefit.**
- **It can be built on existing institutions and scaled up in a short duration.**
- **It is simple and cost effective.**
- **It increases the ability of the community to leverage and manage local and external resources for nutrition, health and other challenges.**
- **It empowers women to make decisions about their nutrition and health of self and their children by improving their problem solving and action taking skills.**
- **It helps in shifting traditional social and gender norms adversely affecting health and nutrition.**

THE GRAM VARTA PLA CYCLE

Gram Varta followed the PLA approach with the objective of reducing neonatal mortality and improving HN&WASH practices. It involved a community action cycle of 20 meetings including two meetings with the wider community, such as local government officials and health and nutrition service providers.

The meetings helped rural women in identifying and prioritising the local HN&WASH problems and developing strategies for action. The group meetings took a reflective approach that nurtured women's

self-confidence and group solidarity. The community approach developed peer networks, facilitated information exchange, and improved women's self-confidence in negotiating better health practices with their family members, and raising demands for primary HN&WASH services thus initiating local action for change.

The PLA cycle approach delivered messages that highlighted critical health, nutrition and WASH practices including breastfeeding, complementary feeding, feeding during and after

illness, nutrition intake of adolescents, pregnant and lactating women, immunisation, hand washing, safe storage of water, and sanitation. Messages were simple, culturally acceptable, and consistent across various mediums, including those provided by Anganwadi Workers (AWW) and Accredited Social Health Activists (ASHA). Practices that could lead to 'fast gains' in infection control and mortality reduction (e.g. hand washing) were emphasised in the early meeting cycles so that their impact was felt promptly.

Table 1: Sequence of PLA meetings

	MEETING	FOCUS	TOOLS
1	Introduction to Gram Varta.	Highlights the need to take initiative as a group, contact service providers and not be entirely dependent on the government.	Piggyback game Stick game
2	Social inequities, exclusion and discrimination.	Enables an understanding of equity issues at the village level, of exclusion of some groups and ways to foster social inclusion.	Power walk game

	MEETING	FOCUS	TOOLS
3	Intergenerational malnutrition cycle and current practices in nutrition of women and children.	Addresses the intergenerational nature of malnutrition; how the cycle can be broken and how to address issues of the girl child discrimination.	What is it game Voting game
4	Identification of the causes of the prioritised problems and solutions.	Leads to understanding the causes of malnutrition and how to find feasible community based solutions.	Story telling But why game
5	Identification of possible strategies for addressing issues.	Identifies ways to overcome barriers to implementation of strategies at the community level.	Bridge game
6	Allocation of responsibilities and plan for community meeting.	Assigns responsibilities for sharing progress with and involving all stakeholders at the village level.	Discussion
7	Community based strategies for improving nutrition. Review of implemented strategies.	Identifies locally available nutritionally-rich foods, stresses on a balanced diet during pregnancy and lactation.	Demonstration Mapping activities
8	Home care strategies for young infants and complementary feeding practices. Review of implementation of strategies.	Stresses complementary foods, demonstrates recipes. Highlights importance of hand washing before feeding.	Demonstration of recipes Demonstration of handwashing
9	Community screening of malnourished children under the age of 5.	Tracks nutritional status of children to identify MAM and SAM children through MUAC and regular weight taking.	Demonstration of MUAC

	MEETING	FOCUS	TOOLS
	Registration of vulnerable cases.		Weighing children
10	Identifying and prioritising problems leading to child and maternal malnutrition.	Identifies symptoms of malnutrition and related issues. Asks the group to identify the priority problems.	What is it game Voting game
11	Possible strategies for addressing malnutrition in women and children.	Identifies community based strategies for preventing malnutrition in women and children and improving nutrition and growth in children.	Circle game Card game
12	Reinforce strategies for preventing malnutrition in children.	Outlines underlying causes of maternal and child malnutrition, community based strategies for prevention.	Chain Game Janki ki Kahani
13	Management of low birth weight babies (born premature or twins or small for date)	To understand home-based management of low birth-weight babies.	Role play Demonstration of good care methods
14	Essential new-born care, hygienic home care practices.	Review of implemented strategies. Reinforce messages from Meeting No. 13.	Role play Demonstration Story and discussion on new-born care
15	Contraception: benefits and side effects of various methods.	To understand family planning and contraceptive methods in the context of maternal and child nutrition.	Story telling Role play Demonstration
16	Mapping of Open Defecation (OD) site in the village.	Highlights the prevalence and extent of OD in the village.	Social mapping Swatchta doot
17	Understanding the transmission cycle from faeces to food.	Demonstrates the transmission cycle from faeces to food.	Walk of shame

	MEETING	FOCUS	TOOLS
18	Actions to stop OD	Creates awareness of OD and highlights actions to stop the practice.	Swatchta ki Kadi, Swatchta ki Sirhi
19	Community monitoring	Members of community establish a Monitoring Committee to track progress on actions taken so far	Monitoring and follow up action plan
20	Community meeting	Community members initiate a process to evaluate achievements and set future course towards sustainability	

GRAM VARTA HUMAN RESOURCES AND INSTITUTIONAL STRUCTURES

The implementation of Gram Varta involved recruitment and training of local community women as facilitators, each responsible for facilitating six SHGs. During the course of the programme, over 3000 SHG facilitators were trained. Facilitators received training

and support from block level coordinators who also liaised with the block-level staff from health, nutrition and WASH sectors for the programme scale up.

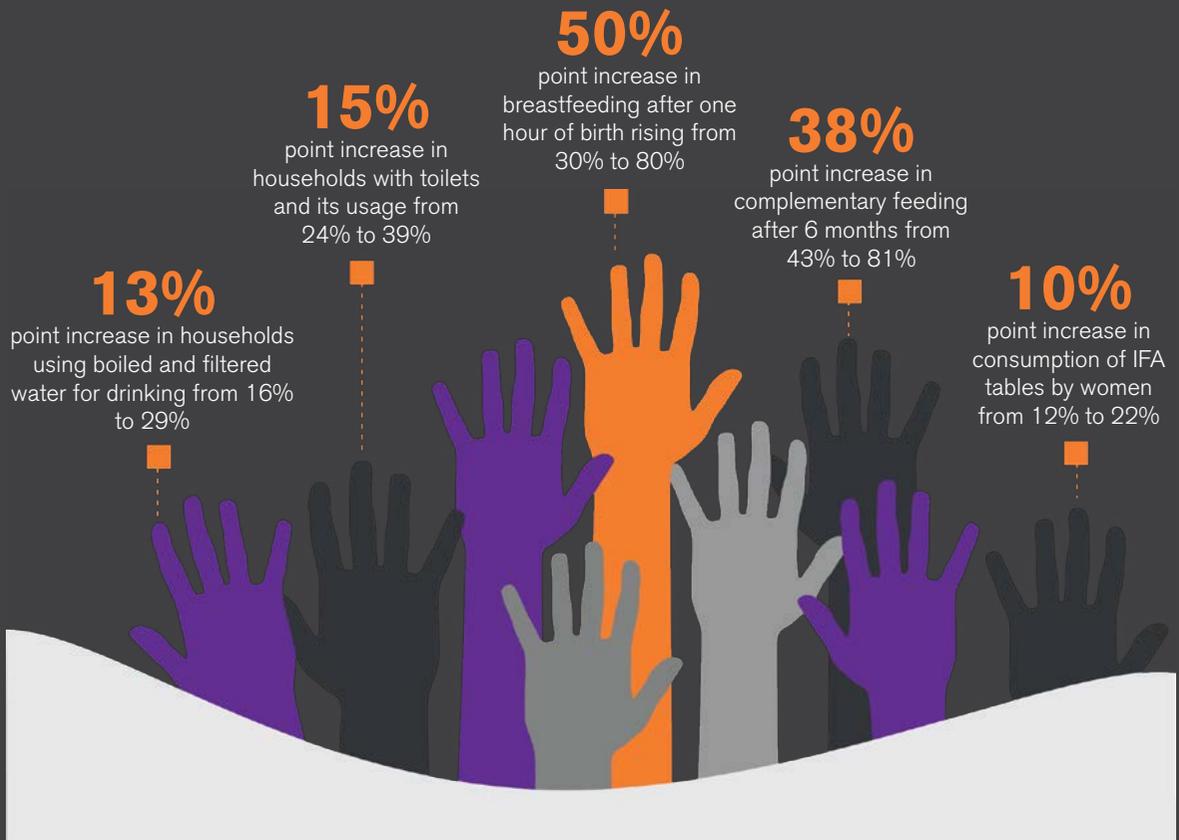
Gram Varta was implemented through three SHG promoting institutions – Women Development Corporation (WDC), Mahila Samakhya and Jeevika. Through close involvement of AWWs and ASHAs in the PLA meetings, it

strengthened the relationship between the community and the frontline workers, encouraged the community to use essential services, and improved the frontline workers' responsiveness to community's HN&WASH needs. Key messages delivered by Gram Varta motivated women to use health and nutrition services. Thus, it enabled the government to reach the last mile of service delivery.

RESULTS

The effect of Gram Varta in improving health outcomes can be understood from a comparison of baseline and end-line studies in the Maner block of the state.

Findings showed substantial improvement in key indicators between the baseline and end-line surveys²:



²Bihar Technical Assistance Support Team, n.d. "Evaluation Brief Gram Varta Intervention: Maner Block, Patna District".

The qualitative data collected from Maner illustrated transformational changes largely attributed to the community awareness and preventive health action through PLA meetings of Gram Varta. Improved awareness also helped in monitoring and mitigating malnutrition among children.

Gram Varta MIS data has also recorded increased demand for health services and toilets. It showed a significant improvement in demand for toilets after the WASH PLA meetings. As a result, 41,387 toilets were constructed in 29 blocks of the four districts (Gaya, Purnia, Madhubani and Supoul) where Gram Varta was implemented. In doing this, Gram Varta established linkages with Public Health Engineering Department (PHED) for converting the *kachcha* toilets into *pakka* toilets.



CONCLUSION

By leveraging existing government institutions and resources, Gram Varta not only mainstreamed HN&WASH objectives under government development programmes, it also raised government ownership of the programme, increased the political importance given to HN&WASH goals, and created a platform for sustaining the programme at a low cost.

But most importantly, Gram Varta demonstrated

its relevance in building human capacity, large-scale community mobilisation and behaviour change. Its main investments were in training, supervision and technical support, as it is built on the existing structures and institutions and leveraged their human resources to support programme implementation.

In a resource-poor setting like Bihar, the readymade and widespread presence of women's SHGs and

the institutional support structures of WDC, Mahila Samakhya and Jeevika provided an ideal platform for the rapid and large scale roll out of the SWASTH programme. The scalability of Gram Varta is evident from the fact that it grew from 87 groups in 2011 to 78,261 in 2015. With community frameworks like SHGs available, the intervention can be effectively adapted for any development programme.





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