



Report from the field

GRASSROOTS: Profiling Chetna Vikas' field work with CARE

Field date: February 21, 2008

Attendees: Kumar Ranjan (Secretary)
Amrandra Jha (CARE Program Coordinator)
Deepak (Block Coordinator)
Mamta (CCF Sponsorship Correspondent) as "interpreter"
Tanja Kisslinger (Communications Advisor)

Report by: Tanja Kisslinger *

As we set out by 4-wheeler on a day-long agenda, I read background information and took notes about the health-related CARE program in rural India, of which Chetna Vikas has been a strategic partner since 2005. Today, together with Kumar Ranjan (Chetna Vikas Secretary), Amrandra Jha (Chetna Vikas' CARE Program Coordinator), Deepak (a Chetna Vikas CARE Block Coordinator), and Mamta (as my interpreter), I was headed to several remote villages for observation and documentation of a weekly "Nutrition and Health Day". Each Thursday, government health workers provide immunizations and food supplementation to pregnant / lactating women and mothers with children aged 0 to 6 years.

During my brief opportunity for review, I learned that the RACHNA (Reproductive Child Health Nutrition & AIDS) of CARE India is operational in 8 states of the country with the objective of improving nutritional and health status of vulnerable families. I also learned that toward this goal, the RACHNA program actually achieved its INHP II sub-objectives in September 2007; namely: (1) to improve the quality and coverage of maternal and child health services and key systems, including training; and (2) to enable communities to sustain activities for improved maternal and child health survival. In this INHP II sub-project, Chetna Vikas' role included: sharing field observations / data with government; organizing health camps; ensuring nutrition and health services were properly provided and led to improved maternal and child health among beneficiaries; developing communication strategies for effective behavioral change at the community level; developing monitoring and evaluation mechanisms for periodic review of progress and corrective action.

Currently, under the new INHP III sub-project phase, Chetna Vikas' primary CARE program activities are to help scale-up and reinforce the previous accomplishments, and to do so through primary quality monitoring, community mobilization, documentation and coordination activities. As a strategic NGO partner, Chetna Vikas supports the CARE program team at all levels: Anganwari Center (AWC), Cluster, Block and District. For instance, at the AWC level, Chetna Vikas



regularly visits the Centers to monitor the immunization and home visit registers, and to ensure that the Anganwari workers are delivering high quality services to local village women. At the Cluster level, Chetna Vikas assesses the technical knowledge and counseling skills of Anganwari workers, recommends training, and facilitates peer learning. In addition to this type of tactical support, Chetna Vikas also ensures distribution and use of IEC material in rural communities, documentation, and knowledge-sharing.

Having absorbed at least this much of an introduction to the field visits that were just about to begin, we finally arrived at our first field stop – the Primary Health Center (PHC) in Saraiyhat Block. Block-level PHCs are responsible for the organization, monitoring and delivery of a variety of CARE program services (e.g. routine immunizations; family planning operations; treatment of filaria, TB, and malaria; PULSE polio program; Nutrition and Health Days), throughout the villages and communities within their jurisdiction. Notably, PHCs also regularly conduct “catch-up rounds”, whereby they find women and children who have dropped out of or are not benefiting from PHC services. Catch-up rounds are conducted by CARE NGO partners together with Auxiliary Nursing Midwives (ANMs) who regularly come together to discuss program targets and progress.

During a brief visit with the PHC staff, I was shown the detailed, hand-written “log book” in which they plan and record the Nutrition and Health Days for a full year of Thursdays (and sometimes Saturdays) – meticulously recording, scheduling and assigning the planned service delivery by ANMs and government workers throughout the area. It was explained to me that the ANM is a key figure in this process; each ANM is assigned to 8 PHCs, and for each of her assigned PHCs, she performs population surveys, and she provides data from the more rural Anganwari Centers. Although this system at the Saraiyhat Block PHC seemed to be well-organized and to show remarkable attention to detail, I was overwhelmed by the sheer magnitude of the Nutrition and Health Day exercise at the Block-level, and I wondered about the sustainability of this manual approach to record-keeping.

Before returning to the vehicle, I took the opportunity to venture inside the adjacent PHC Immunization Centre. I had spotted a jumble of dirty boxes at the doorway and asked if these were the immunization kits. They were – and, in fact, the immunizations of mothers and children were already underway inside. On one hand, it was encouraging and satisfying to see the line-up of women and babies awaiting immunization, as well as the professionalism of the ANM delivering the vaccines. However, on the other hand, I noted that the Immunization Center itself was sub-standard in terms of the sanitary conditions required for a medical facility. I also noted the haphazard storage of the immunization kits at the front of the center with some concern.

At this point, a long, bumpy ride over cavernous dirt roads was required to transport us to the remote AWC in Dindakoli Village. The Center itself loomed like a solitary cement icon in the midst of a wide expanse of brown, dusty earth marked only by a typical rural character – livestock, open spaces and distant, toiling figures. As my eyes slowly scanned the area, I also began to notice the small figures wrapped in brightly colored fabrics, many with a small baby on their hip, slowly making their way across the desolate roadways toward the Center. After all, today was an important opportunity for many local families to obtain their Take Home Ration (THR), a much-anticipated government food supplement comprised of 2kg rice, 900g daal, and 400g spices and salt. (Interestingly, in March 2007, the 400g soybean oil that had been offered in the THR was discontinued. Apparently, the oil was intended for direct consumption by oral



drops to combat child malnutrition; but mothers persisted to use it for general purpose cooking instead.)

The AWC itself proved to be a spacious and well-resourced facility, with generous and bright rooms. Upon arrival, we met the Center's ANM, and the 2 Anganwari workers (i.e. the "Sevika" or teacher, and the "Sahika" or assistant). Unfortunately, after just a few moments reviewing the immunization and home visit logs, and speaking to several villagers, it was apparent that administration and service delivery at this Center requires follow-up. In particular, the Anganwari workers require further training, and are not performing home visitations with the consistency and frequency required to generate community awareness and behavior change. Problematically, Dindakoli women are still showing a lack of understanding of the importance of feeding mother's milk to newborns (as opposed to goat's milk), and about the need for rest, nutrition and iron supplementation by pregnant mothers.

After a lengthy and lively discussion between the Dindakoli AWC staff and the Chetna Vikas CARE program team (which culminated in action points for follow-up), we were on the road again. This time, we were headed further into the rural landscape, toward the Kapsha Village AWC. It was immediately apparent, as we pulled off the treacherous roadways and veered into the location of the Center why these remote extensions of the Block-level PHC are so invaluable... without such local provision of PHC services, hundreds of rural villagers would simply be unable to make the grueling trip to the location of the nearest PHC.

Upon arrival at the Kapsha AWC, we met the ANM who was busily performing immunizations and updating the log, as well as the Sevika Anganwari worker. Both of these women demonstrated high quality service delivery and record keeping. In fact, we quickly discovered that the Sevika was actually performing the functions of both a Sevika and a Sahika – apparently, the government has yet to select a Sahika for this Center. Problematically, this means the Kapsha AWC Sevika is currently taking 2 to 3 days from her schedule each week to perform the community mobilizing that would otherwise be undertaken by the Sahika. The Sevika was gracious and humble about the extra workload that she seemed to be shouldering without difficulty; nonetheless, the Chetna Vikas CARE program team noted the discrepancy, knowing that both Sevika and Sahika functions should be filled to ensure highest quality service delivery.

Before we returned to our vehicle and began the journey from Kapsha to Deoghar, the Sevika showed us the preschool classroom used to deliver education and activities to almost 40 of the local children. We were all immediately struck by the inappropriately small, dirty and under-resourced area in which so many children were spending time learning and playing. The space was dusty, cramped and dark and the "blackboard" was a flimsy, tattered sheet that hung on a brick wall. It was also disturbing to see the unhygienic space at the back of this room wherein the children's lunchtime food is prepared daily.

With the field visits completed, our vehicle slowly lumbered toward Deoghar. I took the time to sit quietly, enjoy the light cast by the setting sun across the busy streets, and to reflect on all that I had seen and heard. Although I had only seen a fragment of the CARE initiative in rural India, I am now clearly cognizant of the magnitude and complexity of such undertakings. Programs like this require extreme cooperation among many government, non-government and community-based actors in order to move from plans and objectives to actual "on the



ground” and “in the field” improvements in health and nutrition. The keys, it seems to me from what I witnessed today, lie in a few critical elements required to bridge the gap between policy and practice... human resources, technical resources, community mobilization, and ultimately, behavior change at the village, family and individual level.

Findings / Recommendations:

- At the Saraiyachat Block PHC, I was impressed by the overall organization and procedure involved in the delivery of immunization services. The record keeping and annual planning showed an important level of attention to detail. However, I was struck by the sheer magnitude of the Nutrition and Health Day exercise and the annual plan required, and I wonder about the sustainability of this manual approach to record-keeping.
- At the Saraiyachat Block PHC’s Immunization Center, I was distressed by the crowded, cramped and unsanitary conditions in which mothers and children were being administered oral and needle vaccinations, and also by the storage / containment of the immunization containers themselves.
- At the AWC in Dindakoli Village, the Anganwari workers are not adequately communicating with the villagers, and they are not performing the “home visits” as frequently and as regularly as required. In particular, they need to provide more consistent and informed counseling to pregnant mothers about taking rest, iron tablet supplementation, overall nutrition, and hygiene.
- Notably, the Dindakoli Village women showed a misconception that giving a newborn baby mother’s milk would make the child ill; they are still giving newborns goat’s milk instead. Dindakoli Anganwari Workers must combat this misconception with home visits, and awareness raising. They should also raise awareness in the village that women can receive 1500 Rs. by having an institutional delivery.
- Dindakoli Anganwari Workers need further training in record-keeping, and also in effective ways to raise health-related awareness among villagers.
- While the ANM at the Dindakoli AWC was performing adequate record keeping and immunizations, it is problematic that she is not using a “Septi-box” for storage of used needles; apparently this box has not yet been provided to her by the PHC.
- The AWC in Dindakoli has good infrastructure and resources. The building was adequate and adequately maintained, although they did need to be reminded to hang the educational pre-school posters.
- At the AWC in Kapsha Village, it was found that the ANM had excellent work, immunization and record-keeping procedures. She was also, in fact, using the Septi-box for storage of used needles.
- The AWC in Kapsha has one Sevika who is working effectively and efficiently, but this Anganwari Worker is also doing the work of a Sahika, since the government has yet to select



a Sahika for Kapsha Village. Problematically, this means the Kapsha Sevika currently takes 2 to 3 days out of her weekly schedule to do the community mobilizing work that should be done by a Sahika.

- The Kapsha AWC facilities are inadequate and unsanitary. In particular, the “classroom” space used for the pre-school children is too small to accommodate 40 children, and it is dark, cramped and unsanitary.
- Both Dindakoli and Kapsha AWCs had prepared an adequate “rice pudding” lunch for the pre-school children.
- Overall, I’m left with the clear impression that the role of “Block Coordinator” is essential and demanding. This position occupies the gap between the government’s health-related objectives and the actual delivery, quality and monitoring of services and activities “on the ground” in more than 150 villages. With respect to the Block Coordinator’s monitoring and visiting of Nutrition and Health Days, I wonder if there is perhaps a human resource shortage of this vital link? That is, if 30 sessions are occurring each Thursday, but the Block Coordinator can only physically visit 2-3 villages on any given Thursday (due to travel required), then it seems many AWCs will go unvisited and unmonitored for long periods of time.

~~~~~

*Tanja Kisslinger worked with Chetna Vikas in Deoghar from January to April 2008 as a Communications Advisor Volunteer, focused on documentation, publishing and establishing organizational brand identity. Tanja’s photos, which accompany her field reports, are available as online slideshows at: [www.chetnavikas.in](http://www.chetnavikas.in)*

