

## Case Study: Sahbhagi Shikshan Kendra, Varanasi, Uttar Pradesh, India



### Key features:

This case study reports the work of Sahbhagi Shikshan Kendra (SSK) and communities in Varanasi, Uttar Pradesh. SSK supports citizens and builds citizen leaders and collective and community based organisations (CBOs) to make claims on the state, especially amongst women. It supports the formation of women's and adolescent groups, provides information on government schemes and builds functional literacy skills and capacities. The communities implement social audits, hold public hearings and dialogue with local authorities, and work with community health workers and panchayats to improve healthy environments, to make claims on services and benefits and to improve health service performance.

While context-specific, there is potential to adapt to other contexts the bottom up strategies and measures used by SSK to:

1. Encourage and organise participation of socially excluded people;
2. Carry out sensitisation meetings and disseminate information;
3. Build local individual and collective citizen leadership and social organisation in CBOs through functional literacy and training;
4. Carry out participatory audits and create multiple spaces for engaging local providers on services;
5. Build partnership with CHWs and frontline providers; and to manage conflict and power imbalances.

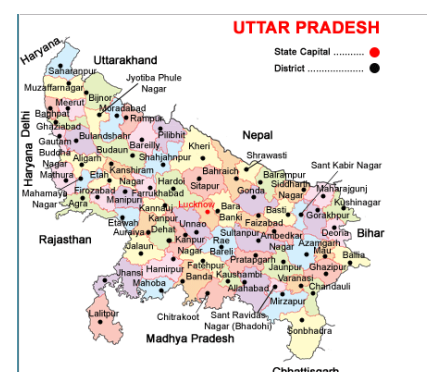
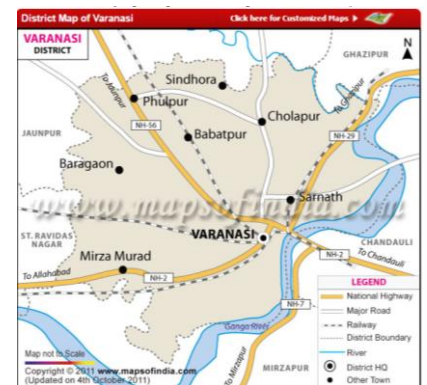
### Introduction to the site and its practices

This case study reports in villages adjacent to Varanasi city, Uttar Pradesh, India the work of the non government organisation (NGO) Sahbhagi Shikshan Kendra (SSK) to support citizen participation in the site in making claims on the state, including through formation of women's groups, information provision on government schemes, capacity building training, facilitation of interface with and support around claims for health related inputs. It reports how the community work with the village health workers and local mechanisms (panchayats) to secure health needs, healthy environments, make claims on services and benefits and improve performance of health services. See videos at Videos at <https://www.youtube.com/channel/UCgN0qjNj6dtxeTSG57RssLw>.

The case study was prepared by Rene Loewenson (TARSC) and Ranjita Mohanty, research consultant, New Delhi with input from Uttara Lal, Sahbhagi Shikshan Kendra (SSK). This draft was produced in February 2017. Valuable input came from key informants from three villages- Cholapur, Munari-Bakaini, Rauna Kala- in Cholapur Block. They included CBO members (scheduled case (SC) and Muslim women), Self Help Group (SHG) members, citizen leaders, Kishori Samuh (adolescent girl groups), members of an adult literacy group, Rashtriya Swasthya Bima Yojna (RSBY) group, panchayat members, Anganwadi workers, Accredited Social Health Activists and RSBY Mitra. Key informants from SSK Varanasi team - Uttara Lal, Sunil Kumar and Ramakant Dwivedi – shared their experience and learning.

### Context:

Uttar Pradesh (UP) is one of the most populous states in India, with a population of 199.6 million in the 2011 census of whom 80% live in rural villages. Varanasi, the case study area is in the Eastern region (see map).



UP has 71 districts, with and 107452 villages and 813 blocks. Blocks are middle level administrative units, where a panchayat is a cluster of villages, a block a cluster of panchayats and a district a cluster of blocks. The State has population density of 689 per sq. km. (against the national average of 312), and a faster population growth rate than the national rate (NHRM 2016). UP's population is diverse, primarily Hindu (80.6%) and Muslims (18.5%). Scheduled castes (SC) (that is lower castes, sometimes termed untouchable castes) form 21.2% of the State's population. There are sharp differences in the level of human development in the different social and religious groups in UP, with lower socio-economic status amongst Muslims and SCs (GoUP, UNDP 2008). While the state's per capita income is low, at half the national average, there are also wide differences in per capita income levels across different districts and social groups. The state has had low economic growth in the 2000s, and people depend heavily on land and agriculture for their income. However land pressures, a "small manufacturing sector, infrastructure deficiencies contribute to sluggish economic and income growth (GoUP, UNDP 2008).

Although Varanasi, the study district, is primarily non-agricultural (68%) and has had one of the lowest rates of employment in the state in 1991-2001, the work described largely takes place in the villages around the city and faces similar economic challenges to other rural areas of the state. Poverty levels, although declining, are relatively high in UP (32.8% in 2004-5 compared to national levels of 27.5%). While Varanasi's district level is much lower at 24.2%, there are social groups within the district with higher levels of poverty, particularly SCs, Muslims, agricultural labourers and artisans.

These economic conditions are reflected in social conditions that affect health: Although safe water is more widely available in UP, in 2001, only 28% of households had their own toilet, and 6% of the population, mainly rural, lived in "dilapidated" housing (GoUP, UNDP 2008). In 2005 using the updated human development index (HDI) methodology, UP's HDI was 0.57 and Varanasi's was 0.61 compared to the India average of 0.66. (GoUP, UNDP 2008). UP has low levels of literacy (69.7% in 2011 with female literacy only at 59,3%); high levels of infant mortality (50/1000 in 2013) and life expectancies in 2001-5 of 60.1 years for males and 59.3 years for females, amongst the lowest in India (GoUP, UNDP 2008; ORGCC 2013; NHRM 2016). Varanasi has better than state averages for literacy at 79.2% in 2013; but higher infant mortality at 72/1000 in 2013 (ORGCC 2013). The total fertility rate in 2012 was 3.3 in Uttar Pradesh as against 2.4 in India (NHRM 2016). Women face particular burdens in the face of these deficits. About a fifth of rural households are headed by women who are responsible for family survival.

*Women's work is statistically less visible, non-monetized and relegated to subsistence production and domestic side....Restriction on women's mobility, complete child care responsibility, ideology of female seclusion, vulnerability to abuse, low access to information and mass media, low literacy, assumption that women's work is supplementary and confined to largely manual untrained tasks, leads to women's poor access to income (GoUP, UNDP 2008).*

National surveys indicate that 44.3% of married women in rural areas and 36% of women in urban areas have experienced some form or other of spousal violence (GoUP, UNDP 2008). The gender development index (GDI) measures gender gaps in human development in terms of disparities between women and men in three dimensions—health, knowledge and living standards. UP's GDI improved from 0.49 in 2001 to 0.53 in 2005, suggesting that there has been a decline in gender disparities in the state. However while Varanasi's GDI at 0.57 was higher than the UP average, it had amongst the least improvement in GDI in UP between 2001 and 2005.

The social determinants in Varanasi have generated a mixed and poverty related disease profile: Pre term birth, pneumonia, sepsis and birth asphyxia, and birth injury are the biggest neonatal killers, while premature death and disability is largely caused by communicable diseases, malnutrition, and prenatal conditions, together with reproductive morbidity, malaria, tuberculosis, leprosy, AIDS, blindness, diarrhoea and measles. Healthy life conditions are also threatened by diabetes, hypertension and heart disease. While Varanasi has better outcomes on a number of these health indicators, it is amongst the districts with highest prevalence of HIV. SC, Muslim and other marginalised groups have higher morbidity and face barriers in access to services, as culture, caste, religion and gender deter participation in services. SC women as lowest in the caste hierarchy face intimidation from upper castes, while Muslim women often observe Purdha (veil system) restricting their interaction with outsiders.

The public health system in the State provides services at three levels:

1. District hospitals located in urban areas
2. Community Health Centres for every 100 000 people, (with a shortfall in UP of 778 noted on the total of 1293 required (NHRM 2016).
3. Primary Health Centres (PHCs) in remote rural areas (with a shortfall in UP of 1480 noted on the total required of 5172 (NHRM 2016).

#### 4. Sub centres for every 5,000 people

Public health services are reported to be important for health improvements, with much of the recent mortality reduction attributed to government-driven efforts, particularly, through immunization campaigns and services for specific challenges like TB (GoUP, UNDP 2008). People in the study area use the services provided under the Department of Health and Family Welfare (NHM), such as hospital care at sub centres (health centres for 5000 people that provide immunisation and normal delivery), primary health centres (PHCs) and community health centres (CHCs). Sub centres and PHCs are used by pregnant women for delivery. They are also the closest hospitals to get medicine for common ailments such as cough and cold, fever and dysentery. CHCs are mostly used for x-rays, blood, urine and other tests and for specialist care. The district hospitals are used for surgery, although there is a preference for private hospitals for this and for serious health problems. While the public health care system is widespread and free at point of care, funded by federal and state government, key informants report poor sanitation, interrupted electricity and staff, specialist and medicine shortfalls in some services. The health system is reported to have poor service delivery and poor sensitivity to patient needs, due in part to a shortage of healthcare professionals, increasing cost of healthcare, the mushrooming of private healthcare, poor health infrastructure (GoUP, UNDP 2008; Anand 2014). A shortfall of nursing staff at CHC and PHC levels of 4670 is over double those in post of 2627 and over half the 7297 required (NHRM 2016). Despite these deficits, U.P. belongs to the 'low expenditure category' States, spending less than 30% of its budget on social sectors (GoUP, UNDP 2008).

There are wide social differentials in access to and uptake of such key services: For antenatal care, for example, the geographical variation in service coverage in UP in 2005 ranged from 3% to 82%, with higher uptake is associated with urban residence and higher education levels. Varanasi district has better coverage data: By 2013, 48.6% of pregnant women in Varanasi had 3 or more ANC visits, compared to the state average of 37.8% and 66% of pregnant women in Varanasi had an institutional delivery, compared to the state average of 57% (ORGCC 2013).

Community health care provides an important means of improving access, with community health care provided through the sub centres, PHCs, and community health workers (CHWs). Four departments providing health and nutrition care in the NHM function separately but collaborate at village level. Key informants note that the panchayat not only creates space for participation at the community level, but also supports co-ordination of the different programmes at the village and block level.

A further measure supporting participation and uptake introduced by the Indian government is that of community health worker (CHW). There is one Anganwadi worker (AWW) and helper per village to provide nutrition, pre-school education, and health services to children under 6 years that continues to date. In 2006 the Accredited Social Health Activist (ASHA) programme was introduced nationally in the context of the National Health Mission (Bhatia 2014). AWWs work in close collaboration with ASHA. An ASHA is a woman selected from local villagers with a formal education up to 8th class by the local community and resident in the community. They are trained, deployed, and supported to function in their own villages to improve people's health and access to healthcare services and given fixed performance-based incentives per task by the government. In UP, ASHA workers came into existence after 2005. They each serve an average of 1431 people in 2 villages and work in line with principles of primary health care (Bajpai and Dholakia 2011). After an induction training of 23 days, they serve as a liaison between the community and the public health system. They are responsible for mother and infant care, pregnancy, delivery and post-delivery care including nutrition, communicable disease prevention and community health. If, for example, if she detects a case of tuberculosis, she takes the patient to the hospital for test, and if the case is diagnosed positive, she administers medicine making sure that the patient takes the full course. She keeps medicines for minor conditions cough and cold, fever, dysentery and supports the AWW in immunization. (The work of the ASHAs is further discussed in the next section).

There are formal mechanisms for people to make input to the organisation and performance of their services and the factors that affect their health. The Constitution of India formalises villages as self-governing bodies in Article 40. Panchayati Raj Institutions constitute the core of this decentralized planning. UPs 71 districts and 107452 villages have 51976 Gram Panchayats (that operate at village level) and 8135 Nyay Panchayats (comprising a few panchayats) (Mishra et al., 2011). Panchayat. literally means assembly (*yat*) of five (*panch*) wise and respected elders chosen and accepted by the village community. Panchayati Raj is a system of governance in which gram panchayats are the basic units of administration. The system is organised at 3 levels: village, block and district, and has been established by law in Uttar Pradesh since 1947. Gram panchayats are financed from the State Finance Commission and have a role to support improvements in safe water, sanitation and drainage systems,

maintenance of public infrastructure - lighting, roads, drainage, cleanliness programmes, primary schools and other public assets, and construction of meeting halls and markets. They meet, communicate with local communities, collect legally prescribed taxes and fees and report on their use of these funds. The public elect the members and participate in and monitor the programmes and activities. The gram panchayats control the local medical, health, family welfare and mother and child welfare centres, and the school, sport, welfare, and other development programmes and infrastructure (Mishra et al., 2011). The panchayats facilitate the appointment of CHWs, hire and pay primary health centre staff and organise land for local primary health care centres (Sinha et al., 2002; GoUP, UNDP 2008).

In SSK sites in Varanasi, people express their demands and views on health issues and health care

- directly - through community based organisation (CBO) meetings, citizen leader meetings, panchayat meetings, capacity building trainings organized by SSK and government departments, interface meetings with government officials organized by SSK, social audits and public hearing meetings; and
- indirectly - through SSK representation at the block, district and state level.

While women have faced barriers in political participation, they have also increased their presence as elected representatives to the Panchayati Raj Institutions at various levels in UP. Women gained more than the one-third seats reserved for women in the 2005 Panchayat elections. In areas where civil society organizations have empowered women at large, the elected women have been found to be articulate, vigilant and practical. Women have, for example, used the opportunity to improve Department of Women and Child Development (ICDS) centres, primary schools, sanitation and have also publicly dealt with issues of violence, including domestic violence, sexual abuse and alcoholism and other gender concerns (Sinha et al., 2002; GoUP, UNDP 2008).

The panchayat has a village health and sanitation committee, responsible for planning, implementation and monitoring of panchayat health plan, that involves the ASHA as a member. Panchayats hold a joint account under NHM and receive INR 10000 (approximately US\$150) annually to implement their health plan. The panchayat was viewed by key informants as an asset for participation. However, where Gram Pradhans (the head of panchayats) and other members are male, upper caste and non-cooperative, SC women get less support for their role. SSK is thus engaging on this, through CBOs, to get support from male members for issues raised by women. SSK does this through consulting and eliciting support from male members of families in CBO's; holding regular meetings with panchayat members and joint meetings of CBOs, citizen leaders and panchayat members to build consensus on issues. The Village Panchayat and Nyay Panchayat women members, who are also CBO members, also work closely with panchayats on community issues.

### **The participatory practices:**

While the mechanisms for decentralised governance exist in law and policy in UP, the continued centralisation of power at national level and limited meaningful decision making by communities had led to a level of disillusionment and alienation among citizens, especially amongst women and marginalised groups (Sinha et al., 2002). The panchayat raj and gram panchayat at village level and the 'gram sabha' or village assembly were set up to remedy this. Even with these formal mechanisms in place, further measures were needed for meaningful levels of participation to take place within them. This was particularly true in the health sector, where decisions over resource allocation are concentrated at central level, and where professionals do not draw on lay evidence in their decisions, and where communities are mobilised to implement decisions made by professionals or bureaucrats. Women particularly were found to have low power and roles, both due to gender status and their household responsibilities (Sinha et al., 2002). This is reported to have generated alienation amongst women in these mechanisms, as they feel their views are not taken seriously. At the same time female community level health workers, like ANM who visit women were dissatisfied due to no or low payment (Sinha et al., 2002).

SSK (with its head office in Lucknow, Uttar Pradesh and field office in Varanasi) was founded in 1990 as a hub that promotes participatory learning for civil society organisations to strengthen the voice of marginalised people in local level governance. Its existence *lies in the idea and philosophy of establishing a regional level support organization that can provide technical and knowledge and training support to grassroots organizations (especially in the Hindi speaking belt) for their capacity building and efficient functioning to ...strive for a society based on equity and justice... and to promote community owned and community managed developmental initiatives* (SSK 2015 p5).

SSK initiated its work in Varanasi in 2005 in Gazipur Block with capacity building of rural communities to strengthen the decentralized panchayat governance. It began through a Pre-Election Voter Awareness campaign (PEVAC), and training programmes for NGOs working on local governance. Its work expanded to Cholahpur Block with SC and Muslim communities, and particularly adolescent girls, through a fellowship programme to promote girl child education.

In 2009, in villages adjacent to Varanasi city, SSK launched a five year programme 'Our Rights, Our Voice' to organise and build capacity of poor women and socially excluded groups to engage on areas that are key to the women's health and lives, including effective service delivery, livelihoods, health, nutrition and education.

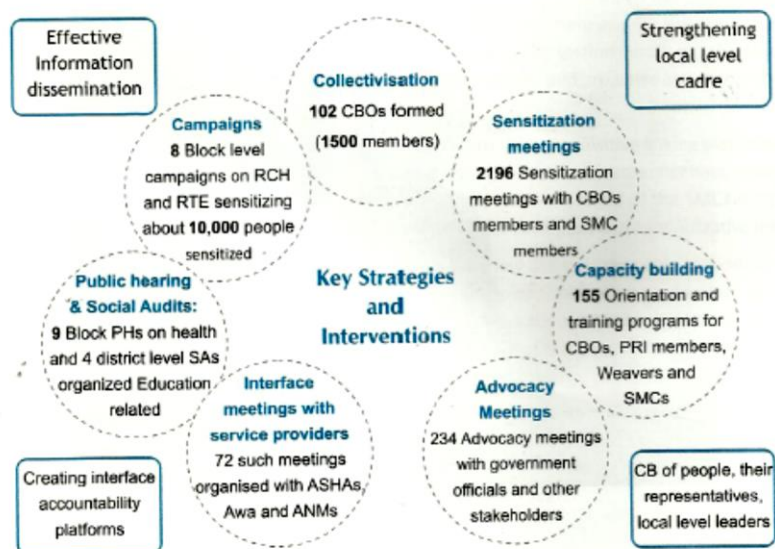


SSK has since mobilised and supported women for over a decade to engage with panchayat institutions, government departments and health care providers. It involves socially excluded women, such as low caste (Dalit) and Muslim women, directly and in groups, such as micro-finance, self-help and adult learning groups. The women members of these groups are poor, agriculture labour, landless, and many are low caste.

SSK is now working with 30 gram panchayats in 54 villages around Varanasi city. This work aims to strengthen a chain of change agents and women CBO leaders to enhance women literacy and life skills. It seeks to develop functional literacy centres for women and adolescent girls who have dropped out of school from the Muslim and dalit community, and to promote the links with and engagement of the Panchayati Raj Institutions and government departments; to facilitate and institutionalise adult literacy education in these communities and to claim their rights and entitlements on nutrition, education and health in Varanasi in a non-discriminatory manner.

The work is based on the understanding that improved health and health services for marginalised women depends on their being able to claim their rights and entitlements in areas relevant to their health. It aims to mobilize and strengthen women's capabilities for this through the groups that they themselves have formed. The various strategies it uses to strengthen community level cadres and institutions are shown in *Figure 1*, and cover four key areas: effective information dissemination; strengthening local level organisation and cadreship; strengthening links between people, their representatives and local level leaders and creating platforms for interface with services and for service accountability. SSK activities support one or more of these purposes. For example, the formation of CBOs enables information outreach and cadreship development, while public hearings and audits, support both information flow and accountability.

Figure 1: Strategies used to strengthen community engagement



Source: SSK 2015b

The work SSK does is based on an understanding that power in a village operates within caste dominance, panchayat systems, government functionaries and service providers. Power is negotiated, diffused, claimed or overcome in both formal and informal ways. For example, membership in panchayats and CBOs are seen as ways of diffusing power and vesting it within legitimate units in villages. SSK uses participatory processes and negotiation to break power imbalances. It engages all actors involved from the onset, including panchayat and service providers, adolescent girls and their families, married and other women.

These processes focus on health issues that are important for poor women and socially excluded groups. SSK raises a broad framework of issues it can provide input on, and the community members decide on the specific local issues for their own village or panchayat. For adolescent girls this includes nutrition, immunization, hygiene, personal and public sanitation including toilets and overall cleanliness in the village. For pregnant women, mothers and children it includes nutrition, immunization, safe delivery and post-delivery care. For wider communities it includes effective health services for immunization, epidemic prevention and care, effective hospital care and safe sanitation in village, including the staff, electricity, medicines and sanitation facilities needed for this. Community nutrition is addressed through food security initiatives. For example the Department of Food and Civil Supplies (PDS) and Department of Education are engaged to provide midday meals for school children.

Setting up community organisations and building community level cadres are identified as key. SSK has thus built **functional literacy and lifelong learning skills** for marginalized women. It has capacitated a cadre of 374 Muslim and SC women leaders through an Adult Functional Literacy Program. The women were chosen by SSK in dialogue with community members. The programme has established 10 functional literacy centres and run 20 courses. It has four modules: basic functional literacy; life –skill (child care, banking, cleanliness); vocational training for livelihood and sanitation and climate change. Refresher workshops build further tutor and counselling skills in women leaders to facilitate such literacy work in the community. These women leaders have also taken forward wider community activities and have played a key role in initiating and sustaining community action in other spheres. They have also built wider functional literacy and life skills. The curricula is shared and feedback obtained on the programme in district level workshops that involve different villages, academia, media and civil society (SSK 2015). SSK key informants note that these workshops and periodic dissemination events with NGOs and academia at district level provide a forum to share workplans and obtain support and input for interventions, such as the inclusion of vocational training in the adult literacy programme.

Excluded communities are **collectively organised in CBOs** to facilitate information flow to them on their rights and entitlements and on programmes being implemented in their locality. Under the *Our Rights, Our Voice* programme, SSK has organised CBOs of SC and Muslim women in 20 panchayats in Cholapur Block. The CBO members include beneficiaries of government schemes, members of the panchayat and local service providers. Each CBO has 17-20 members, who select three functionaries: a chairperson, deputy chairperson and a secretary. The former two set the agenda for and conduct meetings, while the latter keep the books and write meeting minutes. The CBOs and local weavers associations provide people with information on government schemes and engage various government departments on public services, while groups have been formed to mobilize people to access health insurance (described further below). Varanasi has a long tradition of weaving, but mechanisation has affected the weavers' livelihood. Weaver groups are formed by women village residents to address their issues. The CBOs and groups are not formally recognized entities and do not themselves make binding decisions on communities. However, including panchayat members and service providers in their membership gives the CBOs legitimacy and influence in formal spaces such as panchayats and social audits, where the decisions are binding.

Some examples of how the CBOs organise action on health determinants follow:

- Jagruti Mahila Samuh (JMS) is one such CBO formed by SSK in the district. It has membership from dalit and Muslim communities. JMS being a CBO enables SSK to organise capacity building for JMS members and enables the women collectively to interact with panchayat, block and district administrations. For example, JMS mobilised community members during the formation of the school management committee (SMC) in Palkahan Primary School. Six members of JMS were elected to the SMC and the JMS chairperson was selected as its chairperson. The JMS members helped the SMC to resolve many issues related to the functioning of the school, including paying adequate and equal wages to workers employed in painting the school building. SMCs play a role in the provision of midday meals to school children in school kitchens, preparing a weekly menu, ensuring adequate

nutrition and hygiene and that all children are served food on time. This type of organisation has enabled the women to collectively break the cultural gender barriers in the villages; by transcending both caste barriers and formal official barriers, where men hold positions (SSK 2014). This gender empowerment is enabled by SSK's work to strengthen women panchayat member capacities and to build female citizen leaders.

- CBOs have taken up economic issues affecting wellbeing. In the Cholapur block, the weaver community face livelihood challenges given the emergence of large scale weavers who control the market and profits from the trade. Small-scale weavers have become daily wage labourers and face acute challenges in meeting basic expenses. The activities have thus involved facilitating the constitution of weavers' groups / federations for small-scale weavers to strengthen their voice, meetings to build awareness on government schemes available, training of weavers groups to improve value added products for the market in partnership with public and private agencies, and strengthening links with government departments, public and private banks and credit agencies, to improve links supporting family incomes and sustaining the trade (SSK 2015).

Asha Mahila Samuh is one such CBO formed by SSK in Mahrumpur panchayat in Gazipur Block. In April 2015, the CBO members decided in their meeting that they would help those whose crop was destroyed due to rain to access a government compensation grant provided to farmers suffering crop failure. They gathered information about the relevant department, the documents required and the application process. They shared this information with the farmers engaged the block office to do the village survey to identify beneficiaries, and facilitated farmers submission of their applications. The block official assured them that they would get the grant within 10 days. However, when the list of approved beneficiaries was released, the people found 20 famers missing from it. The reason given was that they did not provide one item of bank account information. When the block official refused to consider revised applications, the CBO decided to consult higher officials, at which point the official conceded and all eligible farmers received the grant (SSK undated).



Discussion with women and health service providers in a SC hamlet, Munari-Burkaini, SSK 2017

- As a further example of cadreship development, SSK has since 2007 facilitated **adolescent girls groups** 'Kishori Samuh' to tackle adolescent vulnerability. Girls are more deeply marginalised within disadvantaged communities as decisions are taken by others for them, and they have difficulties with expressing their own views. This leads to problems such as early marriages and reproductive and other health risks. They may not attend school if they have to take care of siblings. The interventions have thus supported their education and discussion of their futures, and strengthened their literacy, networks and leadership. It gave special attention to female school dropouts to support collective learning in the school syllabus, in vocational skills, music, sport and in health, public health and other services for adolescents, such as provision of iron tablets and immunization. A forum for parents and guardians was formed, with members joining CBOs to support social claims of entitlements. The adolescents met with senior health service personnel to secure their support for local staff to provide these entitlements. They have taken up other health issues prioritised by the girls, such as their safety, or sanitation in schools. Key informants indicate that those involved now work as tutors in the SSK adult literacy program.



Participants in Tara Kishori Samuh in discussion with R Mohanty and Uttara Lal, Rauna kalan, SSK 2017

These processes in which community members group and play an active role in local services and other issues are identified as significant steps towards building **citizen leadership** and dalit and mulsim leadership at community level. SSK's Citizen Leadership Programme is building citizen leaders in villages to oversee and ensure effective implementation of various development schemes. Two citizen leaders were selected from each village, and a federation of citizen leaders was formed at the block

level. The CBOs and citizen leaders **engage with institutions such as panchayat, multiple government departments and healthcare providers** at village, block and district levels. The citizen leaders interface with the panchayat and other government functionaries present at the village level (including the ASHA, AWW, school headmaster and teachers, ration shops, and other functionaries). Their federation takes up issues with government functionaries at the block and district level. Citizen leader groups federate and meet as forums at block and regional level to network on common issues, share information, discuss strategies and share ways of resolving issues. These meetings are 'owned' and organised by the groups (as reported by key informants).



SSK 2015 P12 Womens campaigns, Varanasi

In the beginning, the issues taken on were those where there was a greater likelihood of early results, such as claiming entitlements to widows' pensions. Successes at the onset created confidence and an understanding of leadership and of the processes that could be built on for more complex issues. For example leaders took on active roles in ensuring entitlements for poor households to Rashtriya Swasthya Bima Yojna (RSBY), a national health insurance scheme that operated until 2014, covering the low income population. RSBY groups were formed in each village to mobilize people to access RSBY benefits. RSBY beneficiaries who had received the membership card (smart card) became members of RSBY group. The members selected one RSBY Mitra (RSBY friend) to work in the village. RSBY Mitras attended capacity building trainings; shared information with people in the village; and helped people to register, obtain their 'smart card', identify RSBY listed hospitals and claim insurance or access health services without charges. RSBY beneficiary groups took on information and accountability roles, through meetings with the community and the health services.

The **community health workers** - the AWW, ASHA and Auxiliary Nurse Midwife (ANM) - have played a key role in health services. The ASHAs are link-workers (facilitating access to healthcare facilities), CHWs (holding selected essential medicines and treating minor ailments), and health activists (creating health awareness and mobilizing communities on health) (Fatima et al., 2015). As link-workers, they make home-visits to the households of community members, and contribute to improvements in uptake of antenatal care, institutional deliveries and immunization. They are often the first point-of-contact for childhood illnesses, albeit with weaknesses on some disease areas (eg diarrhoea pneumonia and tuberculosis). In Varanasi, the ASHA comes from and is familiar in the community she works with, as a basis for the mutual trust between them and the community. She is referred to in some villages as ASHA bahu (bahu means- daughter-in law) giving her the connotation of a family member. She makes regular visits to households, keeps updated information about community and women's health and represents the community in sub centres and PHCs. Women in villages visited for this case study narrated how the ASHA is always accessible, is the first person people contact when they fall ill or when there is a medical emergency and has helped to improve service standards in health centres. She calls the ambulance for pregnant women and takes them to hospital for delivery. The ASHA and AWW - also from the community - together build the collaboration between the community and health systems.

The social activist role is reported in some settings to be the least currently developed, and one that faces challenges from social hierarchies in the rural community and healthcare system and from their lack of training (Fatima et al., 2015). In Varanasi, with SSK support, the CBOs, citizen leaders, ASHAs, AWWs and ANMs have **interacted with front line service providers** directly and through the panchayats on health and environment, on services promised but not delivered by the state and on health service performance. All ASHAs are involved in the Village Health and Sanitation Committee of the Panchayat either as members or as special invitees. They may coordinate with Gram Panchayat in developing the village health plan, and with the AWW to complete the village health register and organise monthly health and nutrition days in co-ordination with the AWW and ANM (Mane and Khandekar 2014). Community members engage them on concerns raised in the panchayats, establishing a process of demand and accountability for solutions at the local level (SSK 2015).

A further way of strengthening social accountability in service provision being applied in Varanasi is through **social audits and report cards**. Citizen leaders were trained by SSK to implement the social audits and to hold follow up public hearings using the results. In the social audit a meeting is held in an open space to



SSK 2014 P19 Social audit and public hearing



discuss service performance with providers. Detailed plans are prepared and citizen leaders lead the process for their blocks. An audit starts with the desired service (in policy or as an entitlement). Community members implement the audit by visiting key service locations to assess the deficits against desired practice. They talk with personnel and community members to understand the challenges of service providers, community concerns and proposed solutions. The evidence gathered is collated at block level and presented in a specially organised public hearing at which the citizen leaders play a visible role. This process is reported by SSK to have brought people's evidence to decisions and raised their role as change agents. Key informants reported, for example, on one social audit organized by SSK in Dharsua in Cholanpur block. It responded to community perceptions of PHC having become dysfunctional, as there was no ANM in the hospital. The key informants noted that after the social audit an ANM was recruited and the PHC is now functional.

Across these various processes there are common mechanisms, tools and resources, including:

- Building collective and individual leadership, for engagement by and partnership between the community and the panchayat
- Defining key constituencies (eg of SC and Muslim, adolescent girls and women) and organising village level CBOs drawn from community and service providers, with exchange across CBOs in federations at higher (block) level, and
- Regular community meetings at village /panchayat level as well as block level, that engage and strengthen and enhance the regularity of the community interface with government service officials and providers.

This means that there are multiple channels for articulation and action, many of which build on existing groups and actors, such as SHGs, panchayat, school teachers and CHWs. The activities also build alliances with NGO networks and academia and others, discussed further in the next subsection.

SSK has played an important role as a credible, competent and trusted organizer, facilitator, trainer, and negotiator, with processes supported by capacity building of community leaders and members. Formal curricula has been linked with health and functional literacy and vocational training to address different dimensions of wellbeing and to build community level awareness. The processes are largely face to face and social, but video has been used to provide information, and IT for data collection and management.

These activities demand time from women who also work as wage labour and share household responsibilities. Key informants from SSK and the community indicate that women are, however, motivated to participate by their perception and belief in their ability to bring positive change. That SSK is perceived as a credible agency that has built trust and confidence also supports the community's motivation. When positive outcomes are achieved from their actions community members are further motivated, gaining confidence and social recognition for their work. At the same time poor men and women from SC and Muslim communities taking leadership in villages and panchayats upsets the existing social power and control by wealthier upper caste men. They may face risks of violence and abuse, and women, especially from SC and Muslim communities, are more vulnerable.

### **Factors and inputs affecting the participatory practices:**

The practices described have, as raised earlier, been supported by capacity inputs, by the role of CHWs, by local level leaders and actors and by networking and alliances with wider social and official actors.

Local level actors – CBOs, adolescent girls groups, adult literacy groups, citizen leaders and health functionaries- have played a key role. Committed community members, individually, in their CBOs, as SHGs or in literacy groups demand, enhance and sustain the practices described. Two other **local actors have also contributed** to these participatory processes: school teachers including the headmasters and panchayat members including gram pradhans. School teachers and headmasters have supported the SMC intervention in the midday meals, and the adolescent girls' education and awareness activities. The panchayat members, particularly the women members are members of SHGs and CBOs, and have given vital support to the engagement on the functioning of health services.

**SSK has played a strategic role.** It has built new programmes on the existing ones, sustaining and strengthening community processes in the villages. For example, the cadre of village leaders developed in the Citizen Leadership programme played an important role in initiating the 'Our Rights, Our Voice' programme and have helped to sustain the practices. Members of Kishori Samuh are working as tutors in the adult literacy programme. The ASHA and AWW have become an integral part of community practices and play an important role in sustaining the practices. Even in those villages where SSK no longer works programmatically, it still responds to requests from citizen leaders or CBO members.

The **capacity inputs** have included training on rights and entitlements, roles of services and governance mechanisms and skills needed for engaging with them. The CBOs and citizen leaders have been trained in how local and state governments work. Key to the training was making clear how information is obtained, how decisions are made, also integrated into meetings with various institutions. Skills have been built in separate sessions, in meetings with panchayats and in post-meeting reviews.

The **community interaction with ASHAs** has contributed to the successful engagement with services. This success that has been reported to be highly dependent on the individual ASHAs education, aptitude, motivation, communication skills, leadership qualities, and their ability to reach out to community members (Bajpai and Dholakia 2011). The effectiveness of the interaction with ASHAs is affected by how far they understand their roles and responsibilities, whether they receive the minimum incentives they are entitled to and satisfaction of their own aspirations to acquire more health-related skills. Many in one survey were dissatisfied with non-receipt of their incentives. As community members ASHAs face their own burdens in implementing their work, including spending their own money for travel and related items, especially in rural areas. They also have high work burdens where their numbers do not match the increased populations (Bajpai and Dholakia 2011). They are reported to work without clear supervision to lack to clear organizational or reporting structures, and to rely on support from ANMs, who themselves are not formally recognized as mentors or supervisors of ASHAs (Bajpai and Dholakia 2011). Hence while ASHAs have played an important role in social participation in health and in improving service uptake and coverage for marginalised groups, their volunteer status and the flexibility of their tasks is observed to reduce their own power to negotiate for their rights (Bhatia 2014).

To widen recognition of these developments, **larger forums** and interaction with higher levels of government and other stakeholders are organised, For example a celebration was held on *Sensitizing the target community and stake holders on Girls and Women's Rights on education demand for Action* in urban Varansai to connect rural adolescent girls with urban areas and to interact with government officials concerned with rural development programs. Block level campaigns raise awareness on functional literacy programs for women to generate public support and mobilise resources for the work and to raise awareness on eliminating gender disparities in education (SSK 2015). The Citizen Leader's Federation described earlier has brought womens CBOs and leaders together to share experience and strengthen voice across the villages in the district. It has enabled leaders to take on wider issues, such as banking practices and charges, and to engage businesses and parliamentarians.

Key informants noted various **challenges** faced. Economic and social marginalisation due to poverty, illiteracy, caste, religion and gender make women powerless and invisible in their social role, especially when challenging power and dominance raises a risk of abuse and physical violence. Many households and women work as wage labour, limiting their time to organize and attend meetings and take up demands with officials. Assuming a public role was a challenge for women who had never been part of the public meetings in a village, let alone talking to government functionaries. Government officials at the higher level are mostly men, and this itself was enough to intimidate women. Further, the government officials had seldom encountered and experienced community demands so they too faced a challenge.

Nevertheless, key informants indicated that **various factors enabled** people to take up these processes and the power they imply. SSK has been working in the same villages for a long time, and has built trust in the villages. SSK has also built good working relationships with government functionaries at block and district levels and strategic alliances with academic actors and NGO networks, enabling them to bring officials and key capacities to meetings and training activities and facilitating and protecting communities in the community-government interface. People have built confidence when seeing the benefits from early programmes and achievements, decreasing social resistance to women's roles. At the village level, working collectively in CBOs was important to strengthen womens' confidence. Creating multiple – formal and informal- spaces for women to discuss issues and plan actions, and using these for training, information and discussion of interests created many opportunities for and strengthened participation.

### **Perceived or measured outcomes:**

The **outputs** of the multi-pronged work with Muslim and SC communities are shown in *Appendix 1*. The work described in the case study is reported to have led to a range of outcomes (SSK 2015), including:

- Strengthened leadership and networks for female literacy, with 374 Women CBO leaders, two block level adolescent girl's federations including 100 girls, all of whom are actively involved in creating awareness among community members on health and education issues, services and entitlements.
- Community and stakeholder sensitisation on issues and aspirations of women and adolescent girls.
- Strengthened networking, sharing of practices and support among local village committees.

- 98% children from the excluded community enrolled in schools from the intervention area.
- 280 CBOs members from excluded groups elected as SMC members in which 170 are women.
- Strong linkages between the education department and community, and improvements in schools (school development plans set; school mid-day meals in 90% schools; improved retention rate and prevention of drop out in 20-30% in primary schools and 15-20% in middle schools).
- A 90% increase in RSBY Smart card enrolment and 50% annual increase in the utilisation of smart cards as a result of regular sensitization workshop and hospital exposure visits.
- Increased institutional deliveries in the intervention area, especially in SC and Muslim communities.
- Regular interactions between the community and ASHA and ANM and increased household visits in remote and excluded communities.
- Collective organisation of excluded groups, adolescent girls, women and men citizen leaders sustaining efforts by marginalised communities' on their rights and entitlements (SSK 2015).

A 2016 SSK evaluation of the adult literacy programme in Varanasi found that community members involved reported an increased role in decision making (89%), increased awareness of their rights and actions on gender bias (98%) and of children's rights (84%). There was some impact on practices: with increased girl child enrolment in 69%, opening of bank accounts in 64%, SMC membership in 10% of respondents and 68% reporting that they attend panchayat meetings (SSK 2016).

Key informants also noted these social changes, seeing the strengthening of power, voice and commitment of male and female community leadership from poor and socially excluded communities as a critical outcome. They perceived that communities were more informed about health and about various government schemes, departments, systems and services related to health and nutrition, seen as key to their role in health. The increased awareness of young girls and women on health and nutrition was perceived to have led to improved nutrition and health behaviours and improved immunization uptake. The ASHAs, ANMs and AWWs were reported to be more effective in addressing community needs, and community appreciation of their role increased. Health services were seen to have improved, although the factors affecting this may be wider than the work described in the case study. Staff presence, supplies and electricity and sanitation conditions were seen to have improved at sub centres and PHCs and doctor and medicine availability to have improved at CHCs. Improvements were also identified by informants in the effective implementation of the midday meal scheme in the schools; the improved functioning of the food ration scheme by the PDS, with SC women reported to have also successfully pressed for a ration shop in their hamlet.

### **Areas for shared learning:**

SSK and key informants in Varanasi see various features of their work that could be applied in other settings. At a general level, as these need to be modified for specific contexts, these include:

- Encouraging, strengthening and organizing poor and socially excluded people to enhance their participation in processes for their development
- Building bottom up participatory models that build capacities, strengthen individual and collective leadership and social organisation for engaging local providers on effective service delivery;
- Engaging in ways that build partnership with governance agencies and health systems at the community level and that involve and work closely with CHWs and frontline providers;
- Creating multiple spaces, formal and informal, to allow for the articulation of interests, demand, for negotiation and to voice and manage resistance, and multi-layered channels for interfacing with service providers;
- Strengthening information to communities and using it as a key resource for building social power and engagement on issues;
- Identifying mechanisms for managing conflict and power imbalances, such as NGO intervention to enable resolution and power shifts, in ways that build community leadership, capacity and strength;
- Innovating and adapting new participatory approaches, methods, strategies, and technologies

The work and experiences from Varanasi described in this case study, such as the functional literacy programme, citizen leadership and, mobilization of CBOs, are being shared and applied by SSK in other SSK programs in other districts/blocks/ panchayats.

SSK would be interested in learning from other sites in this project on how they are implementing participatory methods for community mobilization, grassroots leadership, for training and capacity building and for interface with local government; and on participatory methods that are found to be effective in improving health systems and delivery of health services.

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## Appendix:

### Appendix 1: Strategy, interventions and outputs

Effective Information dissemination	Creating interface accountability platforms	Strengthening local level cadre	CB of people, their representatives, local level
<p><u>Campaigns</u> 8 Block level campaigns on RCH and RTE sensitizing about 10,000 people</p>	<p><u>Interface meetings with service providers</u> 72 such meetings organised with ASHAs, Awa and ANMs</p>	<p><u>Sensitization meetings</u> 2196 Sensitization meetings with CBOs members and SMC</p>	<p><u>Collectivisation</u> 102 CBOs formed (1500 members)</p>
<p><u>Publication of Relevant learning / IEC materials</u>  A number of folder, poster, booklet, pamphlets, leaflets of education, health, nutrition, schemes developed.</p>	<p><u>Public hearing &amp; Social Audits:</u>  9 Block PHs on health and 4 district level SAs organized Education related issues</p>	<p><u>Capacity building</u>  155 Orientation and training programs for CBOs, PRI members, Weavers and SMCs</p>	
	<p><u>Advocacy Meetings</u>  234 advocacy meetings with government officials and other stakeholders</p>	<p><u>Exposure Visit to Different Government department</u>  16 exposure visits of CLs and Women CBO members at different GOs</p>	

Source: SSK 2015 p13