Azim Premji University

STORIES OF CHANGE

2022-2023

VOLUME IV

Case Studies on
Development Action and Impact

Azim Premji University Publication

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Foreword

The development action space is abuzz with various kinds of interventions seeking to bring about desired social change and reducing inequalities in society. Social sector organisations, including grassroots organisations, non-governmental organisations, cooperatives, advocacy groups and networks, have historically played an important role in this endeavour through interventions of different scales and kinds to make an impact on people's lives, specifically those of the vulnerable groups. Development interventions, as one would surmise, are complex, as the problems these organisations seek to address are not simple and straightforward. Many of these problems are embedded in deep-rooted social structures (e.g., gender-based violence). One of the challenges in the development sector has been a limited opportunity for cross-learning on the nature, approaches, modalities, and impact of various kinds of interventions. While 'impact' (impact assessment, impact evaluation) is the keyword in the development sector, it usually gets limited to producing a compressed success story through specific quantifiable indicators for donors or others. Thus, such exercises potentially reduce a humane experience to a technical process. The other challenge is that interventions are rarely documented. The reasons may be due to several practical constraints including time and skill to document. The Stories of Change initiative at the Azim Premji University essentially attempts to fill in this gap and provides a forum where organisations get an opportunity to document the stories of their interventions, keeping people, processes, contexts, learnings, including challenges, at the core of this effort.

We are happy to bring out the fourth volume in this series of *Stories of Change: Case Studies on Development Action and Impact.* This volume, with its 10 stories of change, traverses several geographies in India, including Karnataka, Maharashtra, Gujarat, West Bengal, Madhya Pradesh, Tamil Nadu and northeast India. The stories pertain to different vulnerable groups ranging from Adivasi farmers in Nashik district in Maharashtra, to woman goat-rearers in Theni district in Tamil Nadu, adolescent girls in 24-South Parganas in West Bengal, and several others.

Four stories in this volume talk about interventions that address gender-based violence and abuse, including domestic violence, child abuse and human trafficking. These interventions adopt different approaches, including Dance Movement Therapy, legal empowerment (of women survivors), integrating health sector response, and promoting a responsive and ethical tourism space. Three interventions show how education and learning (including lifelong learning) can be reoriented to promote peace and harmony among communities perpetually riddled with ethnic conflict, as in northeast India, creating an inclusive space for people with disabilities and empowering a neglected group like the traditional woman goat-rearers to form and manage a farmer producers' organisation. This volume also discusses the promotion of livelihood and nutrition security through reviving the traditional crop 'nagali' (ragi) among the Adivasi farmers in Maharashtra.

Of the several public health concerns, addressing neonatal mortality and tuberculosis have been long-standing priority for the State. Two case studies offer us experiences of interventions which have sought to address these concerns in two different settings. One of these talks about promoting wider and sustainable uptake of the no-cost, low-resource life-saving technique of Kangaroo Mother Care (KMC) at a community level, while another organisation shares experiences of involving the private sector through establishing a Private Provider Interface Agency in achieving universal access to services in managing tuberculosis.

The combination of motivation, challenges, the processes of interventions and seeds of desirable outcomes make the stories in this volume compelling reads. We hope that development researchers, practitioners and policymakers benefit from these stories as these trigger thoughts, ideas and learnings for what, when and how to intervene. These stories would add immense value to development educators and students as they begin to realise the importance of transdisciplinary knowledge to equip themselves to imagine creative and constructive solutions to complex development problems, bringing theory and practice together.

Acknowledgements

This compendium is the result of Azim Premji University's 2022 – 23 'Stories of Change: Case Study Challenge'. We thank all organizations that submitted case studies based on their work. We deeply appreciate the time and effort they have spent in developing these cases.

We had a two-stage evaluation process to select the 10 submissions included in this compendium. We appreciate the colleagues who, along with the Stories of Change Team, agreed to review all 62 submissions and shortlist the best ones. Thank you so much Adithya Pradyumna, Amalendu Jyotishi, Arima Mishra, Ashok Sircar, Asim Siddiqui, Deepa E, Edward Pinto, Gayatri Menon, Geetisha Dasgupta, Juhi Tyagi, Manjula M, Manjunath SV, Mukta Gundi, Nazrul Haque, Nilanjana Sengupta, Pallavi Verma Patil, Porag Shome, Puja Guha, Rajesh Jospeh, Sapna Mishra, Sarbani Sharma, Saswati Paik, Seema Mundoli, Smitana Saikia, Umashanker Periodi and V Manikandan.

Multiple individuals from the 10 organisations selected for this compendium worked closely with our colleagues Anuradha Nagaraj and Aditi Sengupta to arrive at the final print-ready versions of their cases. We would also like to thank Madhurya Balan for the illustrations, which were created with great care following a detailed review of the case studies.

Throughout the entire initiative – from publicity and outreach to the final design and page layout of this compendium – the University Communication Team supported every step. Thank you, Palak Sharma, Silja Bansriyar, Krithika Santhosh Kumar, Divya Nambiar and Sachin Mulay for your cooperation.

We hope this compendium will reach the intended audience – educators, researchers, practitioners, policy makers, as well as students of development – and in time will be regarded as a persuasive and authentic account of the Indian social impact ecosystem.

Readers can write to us at case.study@apu.edu.in with their valuable comments, suggestions and reviews so that we can improve our next editions. Thank you for reading and look forward to hearing from you.

Team - Stories of Change

LIVELIHOODS

LIVELIHOODS

Livelihoods are essential for survival; for most people in this country, livelihoods form the backbone of economic stability. However, livelihoods could mean much more than economic survival. They may be intertwined with a community's culture and history or involve a set of activities that move beyond the economic and enable new social dynamics and experiences. The set of two stories on livelihoods in this volume of *Stories of Change* talks about livelihoods in this broader sense.

The first story by Pragati Abhiyan is about the revival of finger millet or *nagali* by Adivasi farmers in the Nashik district of Maharashtra. For the older generation of Adivasis in this region, *nagali* represented not just nutritious food, but a way of life and insurance against starvation. However, over time, *nagali* started disappearing from the plates of youngsters and from the fields due to low productivity and the changing tastes and preferences of the new generation. Pragati Abhiyan's project started as a pilot and then grew into a comprehensive millet revival programme in collaboration with the Tribal Development Department, leading to the adoption of new practices, enabling higher production and increased consumption of *nagali*. As a result, farmers and other members of the community came together to produce, care for, and celebrate *nagali* not only as the traditional way of life, but also as a superfood that could secure the health and wellness of their future generation.

The second story by Vidiyal brings to light the power of ICT-enabled services and lifelong learning in strengthening collectives and empowering traditional goat rearers to care for their goats and get the best returns from their enterprises. Vidiyal had initiated a Life-Long Learning for Farmers (L3F) through mobile technology as far back as 2008 to enable women members of a federation of Self-Help Groups (SHGs) to better manage enterprises set up with loans from banks. Further, they trained many members to develop businesses around goat-rearing enterprises. As a result of their efforts, the Theni District Farmers Goat Producer Company Limited was established with 1,050 women. Thus, this story of livelihoods is one of building a Farmer Producer Company from a Federation of SHGs; it is a story of learning to care for goats and earn the best returns on business; this is also a story of gaining access to technology and knowledge and emerging as successful

entrepreneurs.

The two stories together give a glimpse of the processes and challenges around building sustainable livelihoods, which are aligned with people's needs and aspirations and combine existing knowledge with new methods, technology and information.

I. Reviving *nagali* in Maharashtra with Adivasi farmers

Pragati Abhiyan[1]

Abstract

Adivasi farmers from the Nashik district of Maharashtra have been growing *nagali* or finger millet for generations. With 2023 declared the International Year of Millets, this is as good a time as any to focus on these cultivators. Recently, these millet farmers have been experiencing low yields due to crop diseases and the vagaries of nature. Reduced yield means they are unable to make ends meet and are compelled to consider the cultivation of non-staple grains such as rice. This not only diminishes their earnings but also compromises their nutritional security. *Nagali*, after all, is rich in nutrients and is perceived to be a superfood.

This story narrates the initiatives taken by a Nashik-based NGO, Pragati Abhiyan, with Adivasi farmers to reverse the declining trend of cultivating millets. To increase productivity, the organisation has formalised an agro-ecology-based 'Package of Practices', which includes a change in the cultivation practices, uses homemade organic manure, and ensures disease management. After a successful pilot with 100 farmers, the organisation upscaled the initiative with the Government of Maharashtra's (GoM) Tribal Development Department, involving over 2,000 farmers. By increasing the yield of the area under *nagali* cultivation, these farmers are today reviving a crop that is central to their culture and lifestyle.

Introduction

Farmer Shankar Choudhary looks around his *nagali* farm with content. Before him lies an expanse of tall, slender plants crowned with brownish panicles, dancing gently in the evening breeze. The quiet rhythm soothes his heart more than his eyes as he has yearned for a robust, healthy yield for years.

1 www.pragatiabhiyan.org

But his journey is also a story of hardship. Choudhary is an Adivasi from the Shivkhandi village in the Peth block of Nashik. *Nagali* is his staple. “Ten or 12 years ago, even a fistful of seeds would get us enough produce to meet our requirements. Gradually the yield declined. Even a bagful of seeds was not enough,” says Choudhary.

Choudhary was not alone. Most *nagali* farmers in Nashik would have poor yields due to crop pests, diseases and of course, the uncertainty of nature, despite back-breaking labour. Their desire to cultivate *nagali* fell due to poor crop yield year on year.

This downward spiral was halted in 2018 when the farmers tried a new method of cultivation with the support and encouragement of Pragati Abhiyan. They were initially hesitant to change, but after seeing the results of the new method, they were convinced they were onto something better. And they never looked back.

But first, let us understand the problems faced by these farmers before Pragati Abhiyan stepped in.

The *nagali* crisis

The Adivasi farmers in Maharashtra live in the northern part of the state and are small or marginal landholders. The area has high rainfall, and farming remains entirely rain-fed because there are no facilities for storing rainwater. The main crops grown are *nagali* and rice paddy, along with a few other pulses and oilseeds. Of these, the farmers sell rice in the open market, while the other crops are strictly for their own consumption.

So, *nagali* is grown primarily for household consumption. When stored correctly in traditional containers, *nagali* lasts for over two years. Thus, a better yield means greater food security for the farmers. Some portion of the yield is also preserved for seeds for the next season. In fact, farmers also give *nagali* as part of wages to their farmhands.

Adivasi families have a unique association with *nagali*. It is not just another crop for them but an intrinsic part of their culture. For instance, the freshly harvested *nagali* is offered to Kansara Devi, the *nagali* goddess, before it is consumed.

However, the Adivasi community has historically followed a conventional broadcast method of cultivation, which is scattering the seeds in the field instead of sowing them systematically. Scattering/broadcasting seeds has a low crop yield. The Adivasi farmers barely use fertiliser or manure, as it increases the input cost. This makes the crop vulnerable to disease and productivity is low. Harvesting and processing the crop is done manually by women and is labour-intensive.

Figure 1: *The harvesting and processing of nagali is done by women*

Despite the back-breaking labour, the yield was low, and with no redemption, they reduced the cultivation of *nagali*. It began disappearing from their farms and their plates. Smaller yield also meant *nagali* could not meet the demands of the farmer's family, and they had to increasingly rely on rice and wheat from the Public Distribution System (PDS) or buy from the market. Adivasis have never been familiar with nor fond of using wheat in their diet, and the absence of *nagali* caused a dent in their meagre earnings and compromised nutrition.

In the cities and for the affluent, *nagali* was gaining popularity as it helped mitigate lifestyle diseases, and a market opportunity was taking shape.

Until the emergence of the Indian government's Millet Mission, *nagali* was not seen as a crop worth investing in. The government's outlay in research and development or propagation of minor millets has been slim and ad hoc. Maharashtra has never benefitted from the Minimum Support Price (MSP) even though the government announces it every year. With no agricultural

support or incentive and no assurance of an MSP, *nagali* farmers were left to fend for themselves, and they continued with their traditional practices that were laborious and less productive. Consequently, cultivation of *nagali* shrank over the years. Farmers were aware they needed to reintroduce *nagali* to their farms and plates but did not know how to go about it.

Box 1: A superfood in neglect

One of the important members of the large millet family, *nagali* has several good qualities. *Nagali* is a sturdy crop that can grow on slopes and fields with low soil depth, needs little water and is drought resistant. It can withstand the vagaries of climate and can be grown with minimal input and is chemical-free by default. It is nutritionally superior to popular grains such as rice and wheat.

Nagali is considered a superfood because of its high nutritional features and health benefits. It is rich in protein, vitamins, minerals, fibre and energy as compared to other cereals. Being a natural source of micronutrients, it can ameliorate the epidemic of undernourishment and is therefore crucial for the health of children, pregnant women and lactating mothers.

Adivasis have always been aware of the nutritional benefits of *nagali*.

> ***I grew up eating nagali and it was always a part of my diet. I am still fit and can work in fields," says Sakhubai (58).***
> ***"By eating just one nagali bhakri in the morning, you can work the entire day. But if you eat two or three wheat rotis, you feel hungry after a few hours. Nothing is as wholesome as nagali," says Shravan Nirgude, an Adivasi farmer and Pragati Abhiyan's core team member in Aswali Harsh village, Trambakeshwar, Nashik.***

Scientifically explained, *nagali* releases a smaller percentage of glucose over a longer period and digests at a slower rate and keeps the stomach full for longer as compared to rice or wheat.

Sangita Jadhav, a Pragati Abhiyan team member, added, "We understood that to the Adivasis, *nagali* is divine, and essentially they believe it is their protector. And it is true because *nagali* is a rich source of calcium and other micronutrients that support their hardy lifestyle."

Starting from scratch

Pragati Abhiyan is a Nashik-based organisation formed in 2006. We are working with rural, marginal communities in Maharashtra. We decided to focus on poverty alleviation by strengthening local resources and developing sustainable livelihoods. We began work a year after the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) 2005 was passed. By making the Act, and its promise to provide 'work on demand' a rallying point, we created awareness and began allocating work to Adivasis in Nashik via MGNREGA. Our field team would travel from village to village to help people identify local work that would strengthen their livelihood. This meant that in the non-agricultural season, they could get work locally and did not have to migrate to cities.

During a visit to a village in 2018, we were confronted with the *nagali* issue. When asked to identify work for MGNREGA, the villagers began talking about the poor status of *nagali* cultivation and production, and asked for a concrete solution to the problem. To better understand the problems in cultivation, we then surveyed 109 *nagali* farmers from 25 villages in four blocks of Nashik district.

One of the reassuring findings of the survey was that *nagali* is still an important crop for farmers. For almost 98 percent of cultivators, *nagali* was also part of their daily diet. The average per acre yield was around two quintals, which was much lower than what they got earlier. Information such as the types of crop diseases, the traditional methods of cultivation, and the application of fertiliser, gave clarity on the changes required and the improvements needed in cultivation methods.

Eventually, we decided to take the plunge and develop a *nagali* revival programme but did not have any expertise in the field. So, we partnered with the national-level Revitalising Rainfed Agriculture Network (RRA), and it helped. A few RRA partners in Andhra Pradesh and Odisha were working specifically on reviving millets in their respective states. Odisha pioneered this process by promoting *nagali* cultivation, including setting up the Odisha State Millet Mission in 2017. Motivated by these efforts, we decided to run a pilot programme and developed the Adivasi Nagali Vikas Karyakram (ANAVIKA). Thus, the efforts that started in response to a perceived need developed into a full-fledged programme.

The pilot programme was carried out in 2018 on over 100 acres of land in nine villages in three blocks in Nashik district. The result was promising. Farmers realised that productivity increased when certain practices were adopted. While certain factors impacting crop yield are beyond the farmer's control, adopting the right practices, by replacing some of the ineffective traditional ones, was certainly in their hands (see Table 1).

Table 1: The alternatives promoted to replace the traditional method of nagali cultivation

Traditional method	Problems	Alternative
Raab Burning naturally available biomass such as branches and leaves of trees, cow dung, dry grass, and crop residue as the first step in land preparation	Time and labour-consuming process. Farmers start gathering biomass 3-4 months in advance	Land preparation by plowing for line translation and application of farmyard manure just before the plantation
Seed broadcasting Scattering the seeds over the farms and hurling the plants randomly in the main field	Uneven growth and low productivity	Promoting systematic practices: Seed selection, seed treatment, growing nursery, and spaced-out transplantation of the plants
Random use of fertilisers	Increase in the input cost sans benefit	Proper application of Jeevamrut and Matka Khat, home-made organic supplements prepared with locally available material
Processing Manual threshing or a tractor run over the ready crop	The farmers could not afford to buy or rent tools for processing and hence relied on what was within their means. But these ineffective practices led to wastage, less and poor quality produce	Small millet processing and necessary agricultural equipment, such as a cycle weeder were made available at the block level for shared use by the farmers
Consumption	*Nagali* is still part of the daily diet for elderly people who have grown up eating it. Children and the younger generation consume less. Limited recipes available	Introducing various recipes with the involvement of local women's groups and their distribution to children in Anganwadi centres, Ashram Shala, etc.

The farmers responded favourably and motivated us to upscale the programme. We approached a government department that is organically linked with Adivasi communities and is committed to uplifting them in all aspects of their life — the Tribal Development Department (TDD).

After TDD welcomed the idea, its focus was fine-tuned to develop the programme: Comprehensive Revival of Millets in Adivasi Areas of Maharashtra.

Keeping the goal of achieving nutritional security for Adivasi families, the programme focused on two specific objectives: 1) To revive *nagali* productivity, and 2) to increase *nagali* consumption.

In collaboration with TDD, ANAVIKA expanded in scale and reach and involved over 2,000 farmers from seven blocks in three districts. The progressive expansion of this programme can be understood from the following table:

Table 2: *Progressive expansion of Nagali Revival Programme*

Year	Initiative	Area (blocks and districts)	Participation (number of farmers)
2018	Pilot by Pragati Abhiyan	3 blocks in Nashik district	190 farmers
2019	Project with Tribal Development Department, GoM	7 blocks in three districts - Nashik (Kalwan, Nashik, Peth, Surgana and Trambak) Thane (Shahapur), and Palghar (Mokhada)	2,061 farmers
2020			
2021			

We started by setting up a programme implementation team: District coordinators, block coordinators and cluster resource persons (CRPs). CRPs formed the front-line team directly working with the farmers. Intensive six-day training was organised for the team to understand the objectives and key components of the programme, such as data collection, the practices adopted and their role in ensuring they are followed.

We also formed a team of farmer trainers to support the programme implementation and to ensure the knowledge and information reach farmers consistently and correctly. An in-depth training was organised for the trainers identified to explain the improved methods integral to the programme. These trainers were farmers who could easily reach out to other farmers struggling

to cope with a new method of *nagali* cultivation. The trainers played an important role as grassroots resource persons, who would provide necessary support and practical demo at different stages of cultivation.

The activities were rolled out once the programme team was ready. These included a series of training programmes for the farmers, such as block-level training to orient and familiarise farmers with the concept of the new methods and village-level training to demonstrate different practices to be used at different phases.

Farmers participated enthusiastically in these training programmes. Their eagerness to learn new methods, from making Bijamrut to treat the seeds to preparing organic fertiliser to boost the growth of plants, was evident. To translate their enthusiasm on the ground, the programme team geared up to put their efforts to fruition.

Figure 2: *Learning to make and use Bijamrut for seed treatment*

Practices to the rescue of *nagali*

We formalised a Package of Practices that is the core of the *nagali* revival programme. These agricultural practices have been tried and tested, ensuring the quality and quantity of the produce. Through extensive research and consultations with field experts, the Package of Practices was tailored for the region and the people we were going to work with.

The Package is essentially a systematic and user-friendly plan for cultivators, which is low-cost, uses local materials to prepare organic fertilisers and does not increase labour days of farmers (see Box 2).

Box 2: Millet revival step by step

Pragati Abhiyan focused on reducing the input cost by introducing low-cost home-grown organic manures and fertilisers.

Seed selection

- Selecting local varieties suitable for the respective soil conditions. Locally adapted seeds can withstand climate variations.
- Seed rate: Between three and four kilos per acre, but varies with the variety of *nagali* and the condition of the land.

Seed treatment

- Treating seeds with Bijamrut, a locally made organic solution of manure, cow urine, soil, lime and water.
- Treated seeds are left to dry in the shade before sowing.

Figure 3: *Seed treatment with Bijamrut*

Making a nursery bed

- Preparing a raised nursery bed of around 40 sq m, for one acre, by mixing vermicompost with soil for sowing treated seeds.
- Spraying neem oil as a precautionary measure to protect the seedlings in their delicate stage.

Figure 4: *Sowing seeds on the nursery bed*

Figure 5: *Making a raised nursery bed by mixing vermicompost with soil*

Land preparation

- Plowing land and preparing ridges and furrows.

Transplantation

- Marking the planting points with a 1-ft to 1.5-ft. interval with rope and stick, that is, using the SMI (System of Millet Intensification) or LT (Line Transplantation) method.
- Using plants between 12 and 18 days of age at the marked points.

Weed management

- First de-weeding between 10 and 12 days after transplantation using a cycle weeder .

Figure 6: *Weed management using cycle weeder*

- Applying Jeevamrit after weeding.
- Log rolling, that is, running a lightweight log, over the plants soon after weed management was recommended. This boosts the growth of more tillers, leading to more production.

Application of fertilisers

- ***Handi khat:*** This is a manure prepared with leaves (neem, *arakha* and *karanja*), cow dung, cow urine, and jaggery. Since the ingredients are mixed and fermented in an earthen pot (handi/matka), it is called *handi khat*.

Managing pests and diseases

- Spraying neem oil mixed with water

Figure 7: *Neem oil spraying by farmers to prevent pests*

To minimise the labour involved in crop management, the organisation provided basic equipment to farmers' groups, such as a cycle weeder for weed management, spray pumps, along with a thresher, harvester and a flour mill for primary processing.

Ushering change

Adopting new methods requires a shift from the conventional practices. For farmers, it was a process of learning and unlearning. While learning something new is easier, unlearning what you have practised for ages, can be challenging.

Therefore, an acceptance of the new practices did not come easily. While some farmers accepted a few new practices easily, others were hesitant, especially in the first year of the programme.

For instance, almost all farmers traditionally followed the practice of preserving the seeds, but very few were familiar with treating the seeds before they were sown. In cultivation, seed treatment is the first important step to increasing the germination rate and making plants less vulnerable to pest attacks. Hence, seed treatment with Bijamrut was introduced, and most farmers adopted the practice.

Traditionally, nursery and land preparation entailed growing a nursery on a small patch, which was readied after burning twigs, dry leaves and dry dung on the main farm. Instead, the programme suggested making nursery beds. This was a major change for farmers.

Their hesitation was evident when it came to transplantation. Transplantation of any crop with a specified distance has always resulted in more yield. This method of cultivation is known as the system of root intensification. Hence, SMI (system of millet intensification) and LT (line transplantation) were integral to the Package of Practices. This required planting the saplings at a specific distance.

In the conventional method, farmers broadcasted seeds and then threw the seedlings in the main field randomly instead of planting them. This was a major change for them, and acceptance of the new practice required a lot of persuasion and encouragement. But instead of pushing anyone to adopt and adapt, the programme let the farmers decide the way ahead by sharing relevant information to make them understand the significance of these practices, and thereby equipping them to make better decisions.

Emphasis on knowledge transfer

This combination of knowledge sharing combined with capacity building played a crucial role in inspiring and empowering farmers to make use of the improved practices. To facilitate this process, we organised a series of training sessions, including both classroom training and on-field training.

This training was facilitated by the farmer trainers, who were themselves *nagali* cultivators and were aware of the challenges they faced. They could reach out to farmers easily and were more trustworthy than any outsider. This peer exchange was the most effective part of the programme.

The *nagali* revival programme was implemented on the plots owned by these farmers. Most farmers tried out the new method in the demo plot while cultivating *nagali* with the conventional method in the other plot. Therefore, they could also see the results themselves by comparing plant growth and yield in both their plots.

What they saw, what they discovered

As they say, seeing is believing. The farmers were convinced the new practices they adopted were effective when they saw the results — there were differences between the demo plot and conventional plot — at every stage of plant growth.

Shantaram Choudhary, a farmer in Sadakwadi village from the Mokhada block in Palghar district, noted a considerable difference in plant growth when he planted the seedling instead of seed broadcasting. “When we plant the seedlings in intervals, the plant comes to life within a week, initial leaves look stronger and more tillers grow on the plant. More tillers mean more production,” said Choudhary.

Talking about the disadvantages of traditional *raab* (burning biomass on the field), he said, “*Raab* required a lot of preparation and we had to start six months ahead. We would gather twigs, leaves, and hay early to let them dry properly, and then it was mixed with dry cow dung, spread on the farm, and burnt. It was a lot of work. This new method saves labour and the wages to farmhands,” explains Choudhary.

Weed management is another labour-intensive task and it also impacts plant growth if done incorrectly. “Removing weeds is easier when the plants are spaced out and in a row. It can be done faster and with less effort,” observed Nirgude from Aswali Harsh village.

Farmers were happy with the generous harvest after the first crop cycle was completed.

Those who diligently followed the practices got an even better result. Motiram Bhangare, who has been involved in the revival programme since the pilot stage, is one of them. A farmer from Ghosali village, Pimpalwati Gram Panchayat, Peth block in Nashik district, harvested a bumper crop. His produce was 32 quintals per acre, almost 15 times more than the earlier 2.25 quintals per acre.

"Earlier, I would grow *nagali* without any expectations. I thought it was better to have at least some yield than keep the land fallow, and by broadcasting the seeds, I had to make do with whatever yield I got. After adopting the new method, I look at *nagali* cultivation differently. If I am a little systematic, I benefit. Therefore, I have been using the same method since 2018. With seasonal changes, production can vary, yet it is still more than earlier," Bhangare, who is now encouraging other farmers in his village to adopt the new method, says.

Women do a major share of work in *nagali* cultivation, from the planting stage right up to threshing. Many women suffer from lower back pain, an occupational hazard because of weeding or processing. Sumanbai from Aswali Harsh village compares the manual threshing with the mechanical one. "Earlier, the threshing was done by animal treading — we would work the bullock cart on the harvested crop three times. Women would help each other with threshing and work one field after another. It was hard work, but we knew no other method. The same work that would have taken four days earlier, can now be completed in half a day with a thresher," Sumanbai says.

Besides saving labour and time, mechanical threshing also reduced losses from broken or damaged grain caused by manual processing.

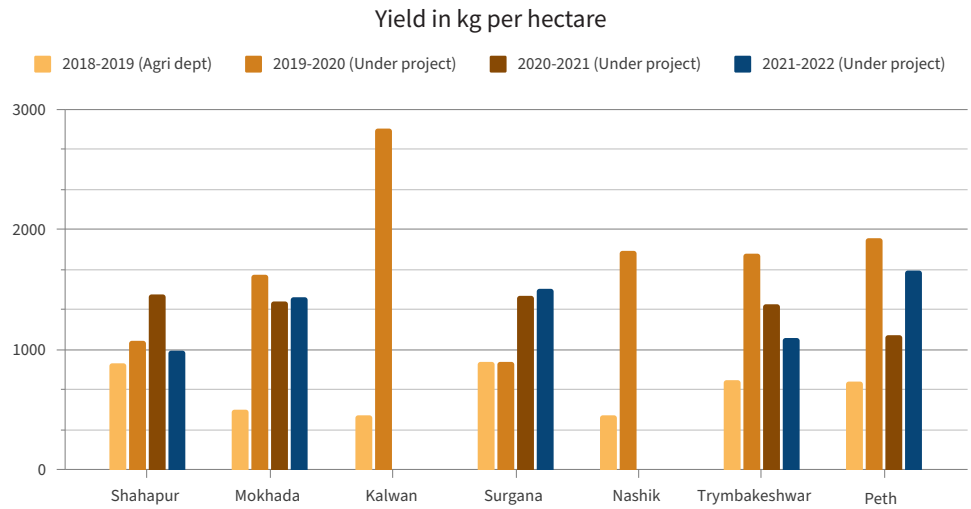
These life experiences were motivating and helped popularise the programme among the farmers. These experiences were shared with others through various meetings, training, and annual gatherings. They helped to establish acceptance and ownership of the Package of Practices adopted by *nagali* cultivators.

The following table and graph (Table 3) show the increased productivity of *nagali* over the period. The table presents crop cutting estimation (CCE), which is a common practice used to compare and assess the yield. Through this process, the crop is harvested from a 5x5 metre patch in the *nagali* field. After the harvest, the green weight (weight with the stems, leaves, and panicle) of the crop is taken, and the threshed grain weight is added to calculate the productivity per hectare or acre. Data sourced from the Department of Agriculture is used to compare the yield received by farmers in the project area. There is a variation, as shown in the last three columns, in the average yield despite using agronomic practices. This could be because of spells of drought, pest attacks, and less frequent field visits during the COVID-19 period.

Table 3: *Increased productivity over the programme period: CCE**

		Agri Dept. taluka average (kg per hectare)	Year-wise CCE yield in the programme area (kg per hectare)		
District	Block	2018-2019	2019-2020	2020-2021	2021-2022
Thane	Shahapur	886.5	1073.88	1464.68	986.67
Palghar	Mokhada	503.1	1618.2	1406.83	1440.00
Nashik	Kalwan	448.9	2836.89	**	**
Nashik	Surgana	903	892.85	1448.18	1508.18
Nashik	Nashik	456.4	1823.76	**	**
Nashik	Trymbakeshwar	739.7	1798.87	1374.18	1091.43
Nashik	Peth	729.5	1922.66	1119.65	1654.78

***In 2019, the first year of the project, the outreach was in three districts, seven blocks and 116 villages. From subsequent years, the project outreach area reduced (as per the project plan) to three districts, five blocks (two blocks from Nashik dropped) and 46 villages.*



Increased production; increased consumption

The revival of the *nagali* programme did not stop with increased productivity, but increased consumption. A campaign is organised every year with local self-help groups and Anganwadi centres to reintroduce *nagali* in the diet of children and young adults, who may have lost the taste for it. Women's groups experimented with a variety of *nagali* dishes, so that intake increases. Delicious *nagali* snacks, such as laddu, kheer and cake, were introduced in Anganwadi centres, so that children get a nutritious diet. This programme is popular among women who get to showcase their culinary skills and make nutritious recipes for children.

Chandrakala Jadhav, an Anganwadi Worker from Shirasgaon village in Palghar district, says, "Malnutrition among children is a common problem in our area and from my experience I know that it can be mitigated by eating *nagali*. *Nagali* laddus are given to underweight children and women because it is a rich source of iron and calcium. Introducing a variety in food such as laddus, kheer or vadi, will definitely make children eat it with delight."

Important insights and lessons learnt

We may have spearheaded the *nagali* revival initiative, but our approach to sharing correct knowledge and practices with farmers was not that of a traditional teacher or preacher. Instead, we learned alongside farmers and this approach has greatly enhanced our understanding of the communities we work with. Despite being economically disadvantaged, less educated and marginalised, these communities possess an unmatched wealth of cultural richness and traditional wisdom.

After the first crop cycle, when farmers were convinced of the benefits of the new Package of Practices, we suggested that they could expand their cultivation area if they desired. We explained that they could sell the surplus yield and this, along with ensuring food and nutritional security, would also lead to financial stability. However, most farmers were hesitant to pursue a surplus yield model. Interestingly, some of them even contemplated reducing their cultivation area since the increased productivity was sufficient to meet their family's needs. This mindset arises from the special place *nagali* holds in their culture and lifestyle. They were keen on preserving the cultural

significance of *nagali*, which provided us with valuable insight — any attempt to commercialise *nagali* must also consider its cultural value.

Figure 8: *Nagali sweets made by women for children*

Nagali is a valuable crop for Adivasis, meant for storage rather than sale, ensuring their food security, unlike any other crop. It can last for years when stored properly and has served as crop insurance during times of crisis like the pandemic. However, despite Adivasi farmers growing *nagali* and being interested in participating in the *nagali* revival programme, documentation proved to be a significant obstacle to increasing participation. The TDD has set criteria for farmer selection, including possession of clear land ownership documents, an Aadhaar-linked bank account and an Adivasi caste certificate. Unfortunately, obtaining a caste certificate is a difficult and time-consuming process and updating land documents can be tedious and expensive, which is not always feasible for Adivasis. Additionally, quite often they do not have land titles for lands received under the Forest Rights Act or other government benefits, as these processes can experience significant delays.

Consequently, only a small fraction of Adivasis possess all the necessary documents to be eligible for government programmes, leaving many needy individuals excluded despite being the intended beneficiaries of such schemes. Recognising these challenges, it is crucial that the obstacles in the documentation process be addressed, and the government takes necessary

measures to facilitate their smooth delivery. It is important to be sensitive to the needs of the Adivasi community and ensure that government programmes effectively reach and benefit those who need them most.

Conclusion: Change is possible

Adivasis need to be encouraged to grow more *nagali* and bring more land under cultivation. They deserve to be the first beneficiaries of the growing demand and market for *nagali*. But before this happens, other stakeholders must acknowledge and appreciate their efforts.

Adivasis are doing their bit to revive *nagali* but they seek support through policy and paradigm changes. It is an opportune time for the GoM to set up and activate the State Millet Mission to help them better. An assurance of market, especially government procurement of *nagali*, would encourage Adivasi cultivators to grow more. Farmers need to get incentives to cover the costs associated with growing millets, such as seed, fertiliser, and labour costs. The state can distribute *nagali* through ration shops, Anganwadi centres and ashram schools to ensure that *nagali* is reinstated in the meals of communities that grow it. Thereby, the benefits of this superfood can be enjoyed at the grassroots level, and the issue of malnutrition can be addressed.

Remember, change can neither happen nor survive in isolation.

II. Evolution of traditional women goat rearers into a corporate company: The role of mobile-based ODL and lifelong learning

K Kamaraj , founder - Vidiyal

Abstract

Vidiyal, which means 'dawn' in Tamil, is an NGO in the Theni district of Tamil Nadu, that deployed mobile telephones and information technology to empower poor women across 25 villages. These self-help groups were then formed into a federation. What distinguishes Vidiyal's approach is the reliance on (a) lifelong learning in partnership and (b) adoption of technology, particularly mobile phones. Vidiyal employed voice messages on mobile phones, mobile helplines, and helped the women negotiate bank loans and initiate collective action for common benefit. The fruitful partnership of women with Vidiyal helped them subvert poverty and empowered them to better their lives. The Vidiyal model is simple, successful, sustainable and replicable.

This chapter discusses how traditional women goat rearers formed a company called the 'Theni District farmers Goat Producer Company Ltd' and talks about how these women became corporate literate, formed a Farmer Producer Organisation (FPO) and became able managers of their company.

Introduction

This case study shows how a need-based Lifelong Learning for Farmers (L3F) project helped farming communities improve their livelihood, develop supplementary income sources and reduce the risk of overdependence on agricultural income, which allows them to repay their loans. Investment in rural training and extension services has to either precede or happen simultaneously with rural credit in order to improve agricultural productivity and increase farmers' incomes. But reaching out to about 7 crore rural

households of small, marginal farmers and landless labourers through traditional face-to-face training is expensive and time consuming.

Open and Distance Learning (ODL) with the help of Information and Communication Technology (ICT) achieves larger outreach at a low cost. The Commonwealth of Learning (COL), an intergovernmental organisation based in Canada, launched the L3F initiative in the Theni district of Tamil Nadu in January 2008, in collaboration with the NGO Vidiyal associated with women's Self-Help Groups (SHGs). This paper is based on the programme implemented among dairy and goat-rearing women farmers.

Apart from using mobile phones for access to information, it is well known that mobile phones can be used as effective learning tools. The pedagogy of learning is flexible in mobile learning, and it permits broader opportunities for time, location, accessibility and context learning, and thus promotes lifelong and flexible learning. However, use of mobile phones depends on the need, knowledge, skill and the resources of the rural community.

Strategy: Economic and social capital and mobilising for common prosperity

In 2000, various SHGs facilitated by Vidiyal came together as a federation called Vidivelli, which means 'a star that leads to light'. The federation, which is supported by Vidiyal, has well-defined byelaws, procedures and norms. There are 250 SHGs with 4,000 women as members in the Vidivelli SHG federation. For an idea to become an enterprise, it has to be discussed in the federation and the COL. The federation identified one enterprise – rearing goats.

Lifelong learning for farmers (L3F) and social capital

The L3F is a facilitation process that along with ICT, leads the rural community to knowledge empowerment, which translates into a secure livelihood, particularly among women and poor sections of the community.

The L3F project was started in 2008 by Vidiyal and has been implemented in the blocks of Bodinayakkanur and Chinamanur of Theni district. The region is agrarian, with over half the population as farmers (69 percent), who are small and marginal landholders, while the rest of the population is agricultural labourers (47.28 percent). Invariably, people in the region believe

the income from animal husbandry supports the family especially when there is a financial crisis. Nearly 30 percent of the female population in the district is illiterate.

The L3F project has been effectively using mobile phones as a tool to address the learning needs of women and men farmers, which is to educate them in the better management of the enterprises they set up with the loans received from the commercial banks. The L3F learners are small and marginal, illiterate and semi-literate women and men farmers. With more than 80 percent of farmers in the region cultivating an area of two acres or less, financial security is poor. It was therefore felt there should be an increasing and continuous need for training, skill and capacity building, access to information and capital, to promote both farm and non-farm activities.

The vision of the L3F project is to evolve a self-replicating and self-sustaining programme among the rural community using ICT. Vidiyal also established a network with agricultural and veterinary universities in India.

The women initially wanted to understand the business skills of rearing goats, so Vidiyal trained 300 women in conducting value-chain analysis and developing business proposals for goat-rearing. The women were also trained in negotiating skills with various stakeholders. In fact, it took nearly a year for the women to conduct the market feasibility studies and develop the business proposal.

With support from Vidiyal, the women developed a business proposal wherein each member got credit from a commercial bank. The bank accepts the proposals and supports the women farmers for buying goats and milch animals, and a mobile phone. With a loan of INR 43,500, the women get nine female and one male goat and a loan of INR 60,000 for two milch animals. The bank agreed to the proposal of the SHGs and federation and sanctioned INR 1.2 crore to the members. Vidiyal supports learning for the better management of enterprises through mobile phones. Through such continuous learning processes, the community members were able to raise the goats or manage the milch animals scientifically with better yields and profitability. The voice mail lessons are prepared based on the need analysis done by SHG leaders and Vidiyal staff periodically. The feedback received from the women at the SHG meetings and other review meetings conducted by Vidiyal was used to prepare lessons. Sharing and learning in such a social network becomes a

social process. Social capital helps learning, creates a way for new ideas and changes, and enhances the scale of outreach. Enabled people in the network are vibrant points and active facilitators in the sharing and learning process. The objective of learning is specific in a particular spatial and temporal context to meet the needs of the learners and changes continuously to meet the learners' requirements. Vidiyal entered into an agreement with IFFCO Kisan Sanchar Limited (IKSL) for sending audio messages of 60 seconds each on buying goats, feed management, disease and health management, and marketing management. Every day, contextual voice messages are sent through mobile phones.

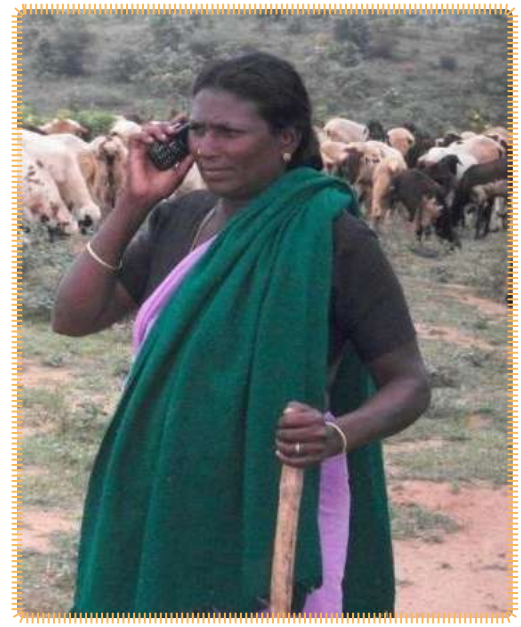


Figure 1: *The success of the Vidiyal project depended on the effective use of mobile phones as learning tools*

Vidiyal developed the learning materials in consultation with the Tamil Nadu Veterinary and Animal Sciences University (TANUVAS). The materials and suggestions given by TANUVAS were contextualised to suit the local culture and dialects. Vidiyal also encouraged the women to discuss the enterprise issues with one another using mobile phones, fostering horizontal learning. The women were also encouraged to contact Vidiyal and experts for clarifications using their mobile phones, fostering vertical learning with the expert. Thus, the distance barrier could be overcome, and the flexibility of participating in a learning environment using mobile phones was a major success. The poor women members who find it difficult to find time and personal space could become part of a movement to empower themselves and also work for the betterment of other women by leveraging mobile phones. All the services provided via mobile phones are free of cost, and the women pay only for personal phone calls.

Most of the women expressed a need for informational content and then shared it during the meeting with other women. Learnings on the careful selection of animal breeds, better feed for the animals and their health management etc., were discussed, which attracted the attention of other women members.

Through L3F upscaling, INR 129.17 lakh are linked to 43,038 farmers; INR 75.16 lakh are linked to 51,548 farmers through community-based organisations; while INR 205.9 lakh were given to 724 farmers through the Farmers Producer Company. A total of INR 20,638.88 lakh benefitted 95,310 farmers from August 2008 to June 2022. The details are given in Table 1.

Figure 2: *With support from Vidiyal, the women developed business plans for credit from banks*

Table 1: *Beneficiaries from August 2008 to June 2022*

Details of farmers linked with credits under L3F from August 2008 to June 2022										
Srl. No	Year	Bank		CBOs (Federation and SHGs)		FPC		Total		Learners enrolled
		Farmers	Amount (in lakhs)	Farmers	Amount (in lakhs)	Farmers	Amount (in lakhs)	Farmers	Amount (in lakhs)	
1	2008 August to June 2022	43038	129.17	51548	75.16	724	205.9	95310	20638.88	82045

A unique idea

The uniqueness of the project lies in the placement of an existing technology in the context of social, financial and human capital. The model replicated and leveraged 2,000 women who could use their learning for livelihood. The multi-stakeholder approach evolved by Vidiyal, with focused services based on mobile phones, has reaped dividends for the women.

Mobile-based advisory services through mobile and CD/DVD-based learning materials were provided to women and farmers via the Touchscreen Information Centres managed by Vidiyal. The mobile services include:

- Up to five voice messages by experts in one-minute capsules on credit literacy, best practices and contextual knowledge related to goat and milch animal rearing
- Facility to dial back and re-listen to the voice messages
- To receive additional clarifications or input from a dedicated helpline
- To participate in mobile-based quizzes to hone skills
- Interact with experts at designated hours through mobile conferences

The subjects covered include:

- Preparing business plans for banks
- Understanding the dimensions of markets in goat and sheep rearing
- Knowledge about various breeds and breeding practices
- Fodder management and stall-fed management
- Disease and health management, including first aid (Siddha, Ayurveda and allopathy)
- Links between Indigenous knowledge and modern science
- Grazing land management and the carrying capacity of the ecosystem
- Environmental impact assessment
- Insurance management
- Strengthening the federation as a marketing institution
- Legal rights in animal husbandry
- Value addition and quality standards

Box 1: The story of Valarmathi and empowerment

Valarmathi, 38, is from the Silamalai village, Bodinayakkanur block in Theni district. She is a primary school dropout.

Valarmathi used to work in a cottage industry, earning less than INR 100 a day for 10 hours of work. Her husband was also a labourer. With three children their life was a struggle. They had to borrow from the local moneylenders at high rates of interest and when they defaulted on payments, they were harassed and ostracised.

Then, Valarmathi heard of an SHG initiated by Vidiyal and was told about the advantages, functioning and responsibilities of SHG members. In 2002, she joined an SHG in her village, which had 14 members. She started saving small sums of money in the SHG and found the SHG activities interesting and actively participated in them. Recognising her interest and passion, the SHG members selected her as the treasurer.

She participated in the PCF 9 Conference in 2018 and shared her L3F experience and success story.

“We learnt financial management, credit management, agricultural production and marketing and livestock management. The bankers were surprised when we women who are semiliterate and illiterate gave proposals with calculations such as internal rate of return and debt service ratio. We learnt through mobile phones and CDs from experts. We also learnt from each other and each SHG meeting became a platform for not only saving and lending, but also for learning from each other,” she says.

Do the math.

Valarmathi had 45 goats in 2010. Despite selling 15 goats each year to meet her expenses, she now has 200 goats. She has built a house worth INR 20 lakh, bought 1 acre of land in her name and bought 25 gold sovereigns.
All her three children are graduates and more importantly, she and her family has gained the respect of the community.

Table 2: The details of ODLs developed for learning from August 2008 to June 2022

Srl. No.	Topics	Multi-media	Voice-mails	In print	Facebook	YouTube	Mobile app	OER
1	Goat	38	2193	2	91	54	190	30
2	Milch animal	18	2229	0	77	12	147	34
3	Agriculture	52	1665	2	55	55	0	46
4	Health	4	1030	1	0	0	0	0
5	General	2	1043	0	22	2	0	0
6	Environment	8	170	0	0	4	0	0
7	Legal	9	601	1	0	0	0	0
8	Financial inclusion	15	360	1	0	13	0	3
9	Poultry	2	75	0	9	0	0	1
10	Farmers Producer Company	75	1317	1	77	50	249	13
11	Micro enterprises	9	0	0	0	11	0	3
12	Capacity building of business correspondent agents	10	311	0	0	0	0	0
	Total	242	10994	8	331	201	586	130

Outcome and impact assessment of L3F

Experts have conducted different studies to assess the impact of L3F and these include:

1. Evaluation study: Lifelong Learning for Farmers' Activities in Tamil Nadu, and 2. Learning for Farming Initiative and Longitudinal Study Tracing the Lifelong Learning for Farmers' Activities in Tamil Nadu, India 2011.

The National Institute of Bank Management (NIBM), Pune, conducted an independent study in 2013 and assessed the outcomes and impact of the L3F project among women farmers who received credit from commercial banks for milch animals and were involved in the continuous learning programme. The average net returns have been quite high for L3F borrowers (INR 2,32,527) as compared to INR 1,31,850 for non-L3F borrowers. This clearly suggests that the L3F borrowers have greatly benefitted in terms of return on investment (NIBM study).

The L3F borrowers were regular in their repayment of bank loans and there were no nonperforming assets. Banks earn much higher income from L3F borrowers as compared to non-L3F borrowers. The average income across the L3F and non-L3F borrowers' accounts has a big difference – INR 84,923 and INR 9,223, respectively. The cost-benefit ratio (CBR) of the L3F project is 10.01, which indicates that for each rupee spent on the programme, INR 10 is generated as return benefit from the project. The rate of investment on the L3F project was 901 percent on dairy enterprises, which means the program yielded INR 9.01 for every rupee that the L3F project cost.

The results also reveal that the L3F members have made considerable progress economically and their business is sustainable. The members created higher asset value, incurred low management costs in running the enterprises and consumed more nutritious food.

Another independent study conducted by the Business School, New England University, Australia, in 2016, reveals that profit efficiency achieved in the L3F programme is higher in the case of L3F farmers. L3F dairy farmers have produced more milk per animal compared to SHG and non-L3F-non-SHG farmers. The expenses of running a dairy farm are higher on average per animal for farmers who are not L3F or SHG. Profit per animal on average is double for L3F farmers compared to SHG farmers. Also, non-L3F-non-SHG farmers incur an average cost of INR 5,000 per animal.

Empirical analysis of factors influencing dairy production and inefficiencies is undertaken with Stochastic Frontier Analysis and shows that younger participants in L3F benefit from efficient dairy operations. Analysis also indicates that L3F participation is helpful for dairy farmers as it makes formal education more relevant for dairy farming. Longer participation in SHGs has no influence on the cost inefficiencies of SHG and non-L3F-non-SHG

farmers. Five or more years of participation in L3F, on the other hand, leads to a reduction in the cost inefficiencies of L3F farmers..

Evolution of community-based groups into a corporate company

Farmer Producers Organisation (FPO) includes groups incorporated or registered either under Part IX A of the Companies Act or under the Cooperative Societies Act of the concerned states and formed for the purpose of leveraging collectives through economies of scale in production and marketing of agriculture and allied sectors (FPOs Operational Guidelines 2020). If we look at data, there are 73.2 percent of women employed in agriculture as compared to 55 percent of men, and approximately 80 percent of the women are economically active. But critics say women are neglected and efforts are not made either for their participation in a mixed FPO with men and women shareholders, and neither do they form women farmer-exclusive FPOs. An Azim Premji University study report (2019) estimated that out of the total of 7,374 FPOs in the country, only 3 percent (220 in numbers) were women FPOs. This reflects the poor representation of women in the FPO movement.

Genesis of the Theni Women Goat Rearers Company

The Theni Women Goat Rearers Company was registered in 2015 with 1,050 women goat rearers as the shareholders. Vidiyal NGO and the National Bank for Agriculture and Development (NABARD) mobilised these women and registered them as an FPO. The company is now managed by these women goat rearers.

Around 25 years ago, 12 to 15 women from a village came together and pooled their savings into an internal lending group and formed the SHG. Vidiyal, the local NGO, facilitated the process and trained the members in bookkeeping, leadership skills, conflict resolution and developing partnerships with banks. Social capital in the group is built through group culture, strong norms and collective social behaviour of the members. In 1995, when the number of groups scaled up, they were converted into an SHG Federation and called Vidivelli. A major portion of the federation members are traditional goat rearers. Each woman manages a few goats, which leads to a limited marketable surplus. This means they get only a few goats that can be sold, which depend on the vagaries of the local markets and middlemen.

The women did not get good prices for their goats and needed an institutional mechanism for scaling up and entering into direct marketing.

The farmers repaid the 5-year term loans of INR 40,000 to the bank in just three years, while making a profit of INR 1.52 lakh. The details of the income are given in Table 3.

Table 3: Data on goat-rearing profit for 3 years

Sources	Expenditure	Income
Goats (100 -2% mortality = 80 @ rate of 3000		2,40,000
Sale of manure & milk		7,200
Loan repayment @ INR 1150 X 36 months	40,000	
Cost of fodder INR 800 p.m X 36 months	28,800	
Medical expenses INR 200 p.m. x 36 months	7,200	
Mobile recharge INR 100 X 36 months	3,600	
Interest for 3 years @ 13%	10,000	
Insurance 4% for 3 years	4,800	
Expenditure	94,400	2,47,200
Total income		1,52,800

To increase the number of goats and strengthen the goat rearing practice, Vidiyal facilitated partnerships with banks. In 2009, around 300 women goat rearers who are members of SHGs received credit from a commercial bank for buying goats. Each woman got 11 goats (10 female and 1 male) on a loan of INR 43,000 each.

The trust and credibility strengthened the bond with the banks and helped the women receive continuous credit support. This helped them purchase more goats, and the number of goats owned by the group members increased rapidly. The basic asset-building behaviour of the women farmers also played a role in adding and expanding the number of goats in the farm. In general, the rate of default and non-performing assets (NPA) is nil. If there are a few defaulters, the SHG federation will support and rescue them for the moment and later collect the amount from the member.

Says a goat rearer, "Bank officials are now treating us with respect, which was not the case earlier. When we visited banks in the past, we were ignored and treated as ignorant, illiterate women. This has changed."

To address the need for capital, apart from bank loans, the company provides capital for the purchase of goats. A shareholder can get up to INR 2 lakh for buying goats, which is to be repaid in 10 instalments. The number of goats owned by the women has increased rapidly with support from the bank. The first batch of women groups received 3,100 goats in 2008, and now, the number of goats owned by the women shareholders of the company is a whopping 40,400!

Table 4: Statistics on the number of goats and sheep available

Goat			Sheep		
Goat	Shareholder	Total goats	Sheep	Shareholder	Total sheep
10	125	1250	10	110	1100
15	145	2175	20	120	2400
30	250	7500	25	195	4875
35	130	4550	35	110	3850
45	80	3600	50	26	1300
65	50	3250	70	65	4550
	780	22325		626	18075
Total members				1050	
Both goat and sheep (780 + 626)				1406	
Total goat and sheep available (22325 + 18075)					40400

Theni District Farmers Goat Producer Company Limited

Vidiyal promoted 1,050 goat farmers as an FPO in 2012. Vidiyal was registered as a Farmer Producer Company (FPC) in September 2015 and travelled all over India with 15 members to 15 FPOs. NABARD supported the company

for registration, and thereon, the goat company has been functioning as an FPC. Each member purchased 100 shares at the cost of INR 10 per share, and the company received an equity of INR 9,97,500 in December 2016. Each shareholder was given two share certificates of a total of INR 1,000 and INR 950 from the equity. Since then and for the past six years, INR 400 has been given as a dividend and 400 shareholders received around INR 5,000 as patronage bonus from the company.

Table 5: Theni Goat FPC business turnover

Business turnover from 2015 to 2022						
Srl.No	**Year**	**Turnover**	**Profit**	**Dividend**	**Patronage bonus**	**bonus**
01	2015-16	319211	1436.59	0	0	0
02	2016-17	1286389	18012.3	42000	33515	75515
03	2017-18	2300435	43068.2	84000	36497	120497
04	2018-19	4970058	84692.7	105000	39957	144957
05	2019-20	5210466	99821	21000	2993	23993
06	2020-21	4021432	28697	77000	13761	90761
07	2021-22	5943036	15950	45000	8965	53965
				3,74,000	1,35,688	5,09,688

Table 6: **Assets of Theni Goat FPC**

Srl.No	Asset	Cost	Source
1	Land (1.2 acres)	13,00,000	Share amount + Loan from directors

Table 6: **Assets of Theni Goat FPC**

Srl.No	Asset	Cost	Source
2	Seed processing unit		Grant from TNSFAC INR 6,00,000
	Building	81,12,000	
	Machineries	17,02,000	
3	Product outlet building	5,76,500	Grant INR 5,00,000 Business Development Assistant from NABARD
4	RAWA Cattle Feed Machine	90,500	Directors loan INR 54,300 Subsidy from Agriculture Engineering – INR 36,200
	Total	1,17,81,000	

ODL to promote goat rearing and corporate literacy

To better manage goat rearing and to ensure profit, these women said they were interested in learning about improved management practices. To meet the demands of the women goat rearers, Vidiyal and Vidivelli (the SHG Federation) introduced mobile-based L3F for farmers with the support of the Commonwealth of Learning. The lessons were disseminated through simple phones as voice messages on a daily basis. The loan application form submitted to the commercial banks includes a low cost and basic mobile phone for the women farmers as a part of the credit sanctioned for goat rearing. This helps the farmers buy and use mobile phones to address their learning needs -- for better farming practices and management of the enterprises.

To become a mobile learner, farmers have to enroll in the mobile network already created by Vidiyal. The lessons are for three minutes a day, divided into three one-minute voice messages, over five days a week. Thus, every month, a farmer listens to the content for 75 minutes. In addition to hearing voice messages daily, the members discuss other issues in the group meetings of SHGs or Joint Liability Groups (JLGs) held once a month. This process facilitates collective and collaborative learning among the women.

Some of the major learning needs identified during the meetings include the quality of animals, feeding practices and fodder management, increasing

productivity, disease management, and understanding markets at the local and regional level. The total number of voice mails prepared about goat rearing till now, based on the learning needs of the goat rearers and disseminated to the learners, is 10,994.

Mobile-based Massive Open Online Course (MobiMOOC) on corporate literacy was conducted to promote learning on the basics of the company for semi-literate and illiterate women shareholders of the FPO. It is a technology based on Interactive Voice Response (IVR) and helps cover a large number of learners. The course was delivered as a free structured course in the audio format. Before beginning the course, village-level awareness meetings were conducted for the shareholders with the technical support from the Indian Institute of Technology (IIT), Kanpur. The course contents were developed based on the learners' need assessments, while the topics covered are on the roles, responsibilities and duties of the shareholders, the benefits and services from the FPOs, the importance of a business plan for FPOs and support for selling farm produce.

The lessons are colloquial and have dialogues for easy comprehension. Each lesson is around a minute. To help learners, a handout in the vernacular language with step-by-step details on how to operate a mobile phone, how to activate, navigate and participate in quizzes etc., was printed and distributed to each learner. In a survey, it was found that 95 percent of the respondents answered that they are now aware of the benefits of FPOs, and 87 percent answered that they had learnt the roles and responsibilities of shareholders. A mobile phone app was also developed for the course for those who own a smartphone.

Table 7: Titles of MobiMOOC courses conducted from 2019 to 2022

Srl.No	Name of the course	Duration (6 week course)	No. of farmers enrolled	Name of Districts
01	Corporate literacy for the shareholders of Farmers Producers Organisations	01 October 2019 to 07 November 2019	2000	Theni, Madurai, Virudhnagar, and Ramnad
02	Corporate literacy for the shareholders of Farmers Producers Organisations	20 December 2019 to 28 January 2020	2000	Theni, Madurai, Virudhunagar, Ramnad, Sivagangai, Thanjavur
03	Integrated Pest and Disease management	08 March 2020 to 09 April 2020	1500	Theni, Madurai, Virudhnagar, Ramnad
04	Land preparation in summer	06 May 2020 to 14 June 2020	1500	Theni, Madurai
05	Fodder management for livestock in summer	08 April 2021 to 14 May 2021	1500	Theni, Namakkal
06	The importance of social capital in community mobilisation	15 July 2021 to 19 August 2021	1500	Theni, Namakkal, Ramnad
07	Livestock Management in winter season	16 November 2021 to 24 December 2021	1500	Theni, Madurai, Namakkal, Ramnad
08	Promoting Livestock as a profitable self-employment	23 March 2022 to April 27 2022	1500	Theni, Madurai, Namakkal, Ramnad

Says a woman goat rearer, “We now have self-confidence because we manage an enterprise. This helps us not only earn an income but also support others. Our fears about how to manage our basic needs in life are reduced, and we have created assets and feel secure that these assets will meet our future needs.”

For the farmers who own smartphones, other social media platforms such as Facebook, YouTube and WhatsApp were effectively integrated to promote learning. Printed booklets covering different topics related to these enterprises are distributed to the learners to support mobile learning. Voice messages used for mobile learning are reused for preparing audiovisual content with pictures and clippings taken from real-field conditions and distributed to the learners who own a video player or a computer.

In mobile learning, the learners are continuously engaged, and the process starts with the identification of learners' needs. This is done through several methods, like periodical Focus Group Discussions (FGD), preparing need lists during the SHG and JLG monthly meetings, observing problems and gathering information by the field staff of the company during field visits.

Content is prepared by collecting information from several sources and validating it by experts from agricultural and veterinary universities and training centres affiliated to these institutions. This process helps bring the current scientific ideas to address the needs of the learners and follow improved practices for change in content preparation. Selected learners are involved to give their opinion about the style and language to ensure it is farmer-friendly. The learners are requested to give their opinion and feedback in group meetings and later on with the NGO staff.

A study to delineate gender dimension in the use of mobile phones as a learning tool among women concludes that 'the appropriation of the mobile phone in the context of bank credit and lifelong learning has helped to create an identity for the phone as a learning and business tool. Using mobile phones while managing animals, listening to audio messages and voicemails and recording messages for discussion and peer review, sharing the messages in the neighborhood workplaces, and SGH meetings, discussing the various aspects of goat rearing -- all these have strengthened the objectification, intensification, and conversion processes (Balasubramanian K et al, 2010).

The SHGs introduced a new loan scheme for the purchase of Android phones. The woman member receives INR 10,000, interest free, and has to pay back INR 2,000 per month and close the loan in a 10-month period. Consequently, around 70 percent of the members now have Android phones.

The company's activities are more visible and have retail marketing points. Company leaders facilitate the collective marketing of goats for the merchants from outside and also to meet the local needs during festivals and functions. The FPO management believes their capacity to promote direct marketing of goats is still limited, and the main reason is the inadequate capacity for risk taking and mitigation.

Nearly three years ago, the Institute of Management (IIM), Ahmedabad, supported the FPO to prepare a business plan. It adopted an interactive method to help the management and staff of the FPO learn about the business

plan. Now the company is running successfully, making profits every year and has even provided dividends to its shareholders for the last four years.

Conclusion

The mobile phone has created a breakthrough for women to access information, and they are thereby able to establish independent links with external sources. The mobile phone is a strategic resource owned by the women SHG members. It also addresses other strategic areas such as ownership, access to information, independent communication link, direct marketing and horizontal mobilisation of women. With the help of the phone facilitating learning, the women helped the men in their families realise the importance of learning.

The project results show zero NPA; there was asset building by the L3F farming families, and in many families, the income earned was used for diversification into other economic activities. Thereby, the families reduced the risk of depending on a single source of income. Widespread adoption of evidence-based best practices often take a long time and can only be achieved through multiple efforts, such as creating networks, holding meetings, conferences, advocating for policy formulation/changes, etc. Credible business partnerships between the NGOs/CBOs and the banks operating in the region are the premise for the replication of L3F. The process facilitation and continuous capacity building help the NGOs internalise the principles of L3F and gradually increase the number of learners in the programme.

A goat rearer said, “Only men and those who are educated are respected in society, but we women are illiterate or school dropouts. But now, due to this new-found knowledge we have developed our skills in enterprise management and achieved financial security for our home. The men started respecting us and we were consulted for decisions, allowed to participate in and contribute to discussions and sometimes were even asked for advice.”

The impact of mobile learning shows that the women shareholders of the FPO are effectively using mobile phones for continuous learning, efficient management of the enterprise, increased productivity and profit, asset building of poor and marginalised households and asset ownership by women farmers. The majority have shifted from simple button phones to smartphones and have started using multiple methods for learning. Mobile

learning on good management practices, health and disease management, feed supply, and reducing the mortality of the goats, is helping the women farmers increase and expand their business.

The leaders of the FPO need to develop more knowledge and professional management of FPOs. Courses conducted on corporate literacy have helped, but this is an area of continuous capacity development.

Inadequate marketing linkage is one area the company needs to concentrate on in the future. The company, particularly the management, needs to build capacity, adopt more data on markets, prices of companies and retailers. The company is well versed in the use of ICT for outreach and continuous learning, and this should be used for improving the marketing of the products.

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GENDER

GENDER

Violence against women and children has been rampant and on the rise in India. According to the National Family Health Survey 2019-2021, 29.3 percent of married Indian women between the ages of 18 and 49 have experienced domestic/sexual violence.[1] Similarly, National Crime Records Bureau data from 2020 shows that approximately 28.9 percent of the entire child population experienced some form of sexual crime.[2]

In this context, the Association for Advocacy and Legal Initiatives Trust (AALI), Kolkata Sanved and Equitable Tourism Options (EQUATIONS) tell highly interesting and inspiring stories of building resistance, resilience, and solutions to prevent violence and support the survivors. AALI's story begins with an interesting narrative of two non-normative couples, one inter-caste and the other same-sex, who came to AALI's doors in Lucknow, Uttar Pradesh, to seek protection from coercion and violence. Working on these cases made AALI realise the need for establishing casework centres across the state and elsewhere because a single organisation at Lucknow cannot respond to the needs on the ground everywhere. AALI worked in collaboration with various community-based organisations across four states, Uttar Pradesh, Uttarakhand, Jharkhand and Bihar, to train caseworkers who could respond to gender and identity-based violence as well as cases of right to choice. Recognising that many survivors face hurdles in the legal system, AALI has also created a network of trained and sensitised lawyers in several districts, including those associated with the District Legal Service Authority.

Kolkata Sanved's story of responding to violence takes a different trajectory. For a long time, Kolkata Sanved has been specialising in Dance Movement Therapy (DMT) to create psychosocial skills of survivors of violence, many of whom have gone on to become leaders of this collective. In this story, Kolkata Sanved talks about the Sampoornata Club, where DMT was used to

1 Business Standard, May 14, 2023 *https://www.business-standard.com/india-news/nearly-30-of-married-indian-women-face-domestic-violence-shows-data-123051400486_1.html* accessed on 23 November 2023

2 India Today, August 4, 2023, *https://www.indiatoday.in/education-today/featurephilia/story/child-sexual-abuse-in-india-alarming-statistics-lifelong-impact-how-to-heal-2416285-2023-08-04* accessed on 23 November 2023.

build an aware and resilient community in the district of South 24 Parganas of West Bengal that showed a high incidence of human trafficking. Through the Sampoornata Club, adolescent girls were trained to understand, identify and feel confident to respond to and report the incidence of violence, including trafficking. Not only adolescents, but the youth at large, along with their families, became part of this journey, and together with the administration and police, they were able to establish a strong network capable of thwarting the menace of violence and trafficking.

EQUATIONS talks about a unique kind of network set up in Khajuraho, Madhya Pradesh. Identifying the high risk of child sexual abuse as part of the tourism industry in Khajuraho, EQUATIONS carried out research and advocacy and then painstakingly convinced various stakeholders of the tourism industry to take ownership for the protection of their children. In fact, a unique multi-stakeholder platform was created comprising local administration, NGOs, representatives of tourism service providers (such as guides, homestay and hotel owners, beach owners, eatery owners, boatmen and so on), police, department of tourism, youth and community representatives, local transport association and street vendors association. Thus, there were eyes and ears everywhere, enabling a safe space for children and immediate action in case of abuse.

The stories tell us not just about the success of the programmes, but about the bumps on the road and the way forward, thereby sharing with the readers incredible journeys of change.

III. Sampoornata Well-Being Club: Empowering adolescent girls in rural West Bengal to prevent human trafficking and gender-based violence

Kolkata Sanved

Abstract

This case study focuses on Sampoornata Well-Being Club, a programme designed and implemented by Kolkata Sanved (KS) that aims at empowering adolescent girls and their communities. It seeks to prevent and respond to human trafficking and gender-based violence (GBV). It was successfully piloted in the Mandirbazar block in the South 24-Parganas district of West Bengal. The core of the programme consisted of dance movement therapy (DMT) sessions for 120 adolescent girls who were at risk of human trafficking and GBV. DMT builds emotional, cognitive and social skills to respond to GBV, including emotional regulation, confidence, communication skills, critical thinking and decision-making abilities. The programme also created a network of stakeholders at the local level, who served as a resource base and safety net for the adolescent girls. The DMT sessions enabled the girls to access a sense of agency and build their leadership skills. They took an active role in orienting their families and communities to the risks of trafficking and GBV, and responding to cases of such violence in their communities.

Introduction

A model for survival and fulfilment

Kolkata Sanved (KS) is a woman-led NGO working towards the psychosocial rehabilitation of survivors of GBV, including human trafficking. It works towards preventing GBV and promoting well-being through the medium of dance movement therapy or DMT. DMT addresses four aspects: Physical, emotional, cognitive and social. KS has contextualised global DMT practice to the development sector through its approach, 'Sampoornata' (fulfilment). This community focused beyond-clinical approach is suited to resource-poor

environments, groups with low education or language skills, and integrates therapeutic elements of Indian contemporary, classical and folk dances, as well as other healing elements including yoga and meditation. The hallmark of Sampoornata is the 'survivors to leaders' model, through which individuals from marginalised communities are given the opportunity to train as leaders and DMT practitioners. In fact, four of the five founding members emerged from the grassroots, and 60 percent of the core team is from marginalised communities.

Figure 1: *Adolescent girls face a greater risk of abuse and violence in an environment of poverty, patriarchy and poor opportunities*

Founded in 2004, KS works in collaboration with partner NGOs, government departments and academic institutions. Its participants include survivors of trafficking and GBV, children and adults living in care institutions, at-risk children and adolescents in community settings, and people living with mental illness.

After working with GBV survivors for 16 years, in 2020, KS launched Sampoornata Well-Being Club — a pilot initiative aimed at enabling adolescent girls and their communities to respond to and prevent GBV.

Off to a start

Human trafficking is "the recruitment, transportation, transfer, harbouring or receipt of people through force, fraud or deception, with the aim of exploiting them for profit," says the United Nations Office on Drugs and Crime (UNODC). While victims of trafficking range across genders and ages, it has been found that women and girls are especially vulnerable to trafficking. Globally, 50 percent of the detected number of trafficked victims are women and 20 percent are girls (UNODC, 2020). According to an analysis of data from the National Crime Records Bureau (NCRB) of India, from 2019 to 2021, between 44 percent to 48 percent of persons being trafficked were children (NCRB, 2022, 2021, 2020). According to available data,[1] the highest number of children and adolescents trafficked for the purpose of sexual exploitation are from West Bengal. Several districts, such as South 24 Parganas, North 24 Parganas, Nadia, Murshidabad, Malda, Darjeeling, Coochbehar, Jalpaiguri and Uttar Dinajpur, Howrah, Midnapore and Birbhum, have been identified as major source areas (Pandey, 2014).

Individuals are especially vulnerable to trafficking and GBV during adolescence. There is a need for peer approval, an appetite for risks, coupled with poor emotional regulation and decision-making during adolescence (Lally and Valentine-French, 2019). In an environment of poverty, poor opportunities and patriarchy, adolescent girls face an increased risk of violence and abuse, including trafficking.

This case study focuses on KS's Sampoornata Well-Being Club intervention, which seeks to enable communities to respond to and prevent human trafficking and GBV. The intervention was piloted in West Bengal's Mandirbazar block in the Sundarbans, South 24 Parganas district. KS worked with 120 adolescent girls from four Gram Panchayats in this block, who are vulnerable to trafficking. The Gram Panchayats are Anchna, Dhanurhat, Gabberia and Ghateswar.[2]

1 Due to the multifaceted nature of human trafficking, it is difficult to get accurate estimates of the exact number of persons trafficked. (Seefar, 2021)

2 Due to the lack of availability of gram panchayat-level secondary data on trafficking, higher vulnerability to trafficking was understood through verbal reporting by local stakeholders and the partner organisation working at the block level.

The major events leading to trafficking in Mandirbazar and parts of West Bengal include child and early marriage and unsafe migration for employment. Child and early marriages are exacerbated by poverty and unemployment and some adolescent girls also migrate or elope and thereby fall prey to traffickers. Trafficking was also abetted by other factors such as the COVID-19 pandemic, which led to loss of livelihood; the geography of the Sundarbans, where small islands are separated by big rivers, making it difficult to track newly married or migrated girls; and by extreme weather events. Families are uprooted, causing widespread socio-economic distress.

Sampoornata Well-Being Club

The Sampoornata Well-Being Club was designed to address three factors that amplify the risks of trafficking and GBV:

a. Adolescent girls lack opportunities to build psychosocial skills to respond to the risks of trafficking and GBV. For example, the girls may agree to marry or elope without assessing their own safety due to patriarchy and a desire for romance. Their decisions are driven by emotion rather than critical thinking (**Lally and Valentine-French, 2019**). Through DMT sessions, the project sought to build the following psychosocial skills amongst adolescent girls:

    i. Emotional regulation,

    ii. Building confidence and a sense of agency,

    iii. Communication skills, and

    iv. Critical thinking and decision-making.

b. Community members lack awareness of trafficking and GBV-related risks and their prevention. The intervention sought to enable adolescent girls to act as leaders who would spread awareness of trafficking and GBV-related risks among their families and communities, and take the lead in responding to risks arising in their communities.

c. Lack of connection to local stakeholders puts adolescent girls at risk when they try to respond to trafficking and GBV alone. It exposes them to stigma and even physical or sexual violence. The support of local officials and key stakeholders is required, and therefore, the project involved the creation of a collaborative network of key stakeholders.

These include the Block Development Officer (BDO), police personnel, panchayat pradhans, school teachers, members of Village Level Child Protection Committee (VLCPC), community-based organisations (CBOs) and NGOs.

Table 1: Overview of the Sampoornata Well-Being Club intervention

Factors enhancing risk of trafficking and GBV	Adolescent girls lack opportunities to access knowledge and psychosocial skills to protect themselves	Community members lack awareness of trafficking	Lack of connection to local officials and stakeholders puts adolescent girls at risk when they try to respond to trafficking on their own
Activities	Dance Movement Therapy (DMT) for adolescent girls through enrolment in Sampoornata Well-Being Clubs	Facilitation of Community Awareness Building programmes led by adolescent girls	Creation of a collaborative network of key local officials and stakeholders that acts as a safety net for adolescent girls
Output	Adolescent girls acquire psychosocial skills and knowledge to respond to risks of trafficking: i. Emotional regulation ii. Building confidence and sense of agency iii. Communication skills iv. Decision-making and critical thinking	Through the leadership of adolescent girls, family and community members of adolescent girls build awareness of trafficking and GBV	Adolescent girls have access to stakeholders to whom they can report risks of trafficking and GBV
Outcome	Adolescent girls emerge as significant actors in protecting themselves, spreading awareness among others and responding to risks of trafficking and GBV in their communities		

The Sampoornata Well-Being Club programme began in January 2020 with the support of AWO International. This case study documents the intervention till July 2022, during which period activities were as per Table 1. From July 2022, KS has been working towards building the sustainability of the Well-Being Clubs in Mandirbazar through capacity building of 20 adolescent girls who have emerged as leaders.

Sampoornata Well-Being Club activities

Preparatory stage

Four major preparatory activities were conducted, which are listed below.

a. Recruitment of the project team

The project team was led by the Project Lead, whose role was to coordinate with the team members, partner organisations and the donor AWO International, monitor activities and take steps to mitigate crises. The Project Lead, along with the head of programmes at KS, played a major role in the creation of a network of stakeholders in order to create a safety net. The DMT sessions were conducted by four DMT practitioners. Two practitioners who are part of KS's core team had emerged from the grassroots, while the other two had mainstream academic education. The team of four was based out of Kolkata, but a crucial role was played by four social workers from the project area who were responsible for conducting visits to participants' homes, regular follow-ups and emergency crisis mitigation. The implementation process was supported by the project accountant and the finance and administrative manager at KS.

b. Communication with partner organisation

The Sampoornata Well-Being Club's intervention began with building collaboration with the partner organisation in Mandirbazar, the Sundarban Social Development Centre (SSDC). SSDC, an NGO that has been active in the Sundarbans area since 1986, works in the areas of disaster management, physical health (eye health), education support, livelihoods and sanitation in Mandirbazar, and has an existing connection with the local community (SSDC, n.d.). It was mutually agreed that the Sampoornata Well-Being Club project would be suited to the Mandirbazar area as it would actively build the capacities of adolescent girls and the community to combat trafficking and cater to unaddressed aspects of mental health. SSDC's role in the partnership would be to tap into its rapport with the community to assist KS in enlisting adolescent girls to participate in DMT sessions and to link KS with local stakeholders. In addition, SSDC supported KS in accessing a safe physical space to conduct DMT sessions.

c. Creation of DMT curriculum

The DMT curriculum was conceptualised and designed by the Founder Director of KS and a consultant expert. The core team members consisted of two DMT practitioners, the Project Lead, KS's Head of Programmes and a consulting mental health professional. The curriculum, titled 'Inside Outside' (Bengali title: *Ghare Baire: Bhalo Thakbo Bhalo Rakhbo*), was created over a series of meetings and discussions, and consisted of 72 DMT sessions of two hours each, divided into three thematic areas. Each thematic area was divided into sub-areas, and those sub-areas into a number of objective-based DMT sessions. Table 2 lists the three thematic areas and sub-areas that comprised the curriculum.

Table 2: DMT curriculum titled 'Inside Outside' (Ghare Baire: Bhalo Thakbo Bhalo Rakhbo)

Thematic area	Sub-areas
I. Why Am I Here?	1. What is DMT? 2. DMT and Me (self-expression and awareness through DMT) 3. DMT and the World (connecting self and society, visioning for life, methods of developing agency and becoming a changemaker) 4. Experience Dance and Movement (reducing inhibition, opening up) 5. Creative Imagination and Improvisation 6. Movement Laboratory (basic DMT session planning and facilitation)
II. My Body, My Self	7. Self-Portrait, Emotion Management, Growth and Confidence-Building 8. Body Awareness (sensing the body, positive body image, understanding good and bad touch) 9. Understanding Sex and Gender (gender roles and stressors, gender identity and sexual orientation, de-stigmatising sexuality and menstruation) 10. Relationships and Boundaries (navigating safety in personal relationships) 11. Self-Care and Healing (coping with stress) 12. Responding to Violence
III. Hello World!	13. Sexual and Reproductive Health and Rights 14. Mapping Safety and Protection Environment (learning about risks of trafficking and GBV and services available to respond to risk)

The curriculum was translated into Bengali and Hindi, and all DMT practitioners in the team went through capacity-building training on implementing the curriculum.

d. Baseline study with selected participants and key stakeholders

The baseline study was divided into three parts:

i. Focus group discussions with seven adolescent girls from the four selected Gram Panchayats of Mandirbazar and seven social workers with experience of working in the area, in order to get a more in-depth understanding of the trafficking and GBV situation in the area.

ii. In-depth interviews with five key stakeholders in the area, including a Panchayat Pradhan, an Anganwadi worker, a local self-help group (SHG) member and a member of a local CBO. There was also a teacher from a local high school. This was done to understand the patterns, trends and government provisions related to trafficking and GBV.

iii. One-on-one interviews through a multiple-choice questionnaire with the 120 adolescent girls who had enrolled in the Well-Being Clubs. It helped understand the details of participants' socio-economic and demographic backgrounds, physical and mental health and their knowledge of trafficking, GBV and related risks. A summary of the findings from the baseline survey is given in Table 3.

Table 3: Summary of Baseline Study findings	
Number of participating adolescent girls	120
Average age	16 (minimum: 13; maximum: 19)
Family composition	96% adolescent girls were part of joint family
Income source	In 87% families, male members reported as earning members; occupations included: agriculture, tailoring, cooking, daily wage labour
Religion	Muslim (57%), Hindu (43%)
Education level	98% were attending school at an average of Std IX
Trafficking and GBV awareness	• 23 (19.2%) shared that their friends or neighbours had been trafficked • 36 (30%) shared that they had witnessed violence such as domestic abuse, physical abuse and child labour • 110 (91.7%) were aware that trafficking takes place, through awareness programmes conducted by SHGs and Integrated Child Development Scheme (ICDS). However, they were not clear on how to respond to risks • The majority of participants were unaware of resources in the community to prevent trafficking. A few participants were aware of some names but not how to access them

Dance movement therapy (DMT) sessions

Social workers visited the homes of 200 adolescent girls, from which 120 girls were selected for the programme based on their need and willingness to engage in the DMT sessions. Once the participants were selected, a community mobilisation meeting with the participants' guardians (one meeting in each of the four Gram Panchayats) was held, to familiarise them with the Well-Being Clubs, the methods, timeline and expected outcomes. A major challenge was that dance was considered taboo, or *gunaah,* among many families. KS was not unfamiliar with this, and it continues to use DMT as a tool for social change for two major reasons. First, DMT enables participants to de-stigmatise and free the body from oppressive patriarchy; second, it facilitates learning of psychosocial skills on the embodied level, rather than just the cognitive level. KS has observed over several years that community members become open to DMT when they understand that the process is not about performance; rather, self-growth and wellbeing. The community mobilisation programmes,

therefore, focused on conveying the difference between dance and DMT. It was emphasised that adolescent girls would not be trained as dancers; rather, dance and movement would be used as a medium to enable them to build self-awareness, confidence and protect themselves from risks.

Figure 2: *A dance movement therapy (DMT) session in progress*

The DMT sessions were conducted with 120 adolescent girls in four groups of 30 participants each. Each group constituted a Well-Being Club. The Well-Being Club was not seen as a physical space, but a conceptual one. It could be created wherever its members gathered to participate in DMT and work to respond to risks of trafficking and GBV. Each Well-Being Club went through a total of 72 DMT sessions. Before DMT sessions began, assessments were done to understand physical, emotional and cognitive traits of participants, such as body awareness, flexibility, hesitation, eye contact, focus and attention span.

While DMT sessions began in person, a hybrid method was adopted during the pandemic. As most participants did not have access to mobile phones, a laptop, projector and sound system were arranged at Mandirbazar, and participants attended online sessions in smaller groups of 15 each. Modifications were made to the DMT curriculum: More theoretical inputs, understanding trafficking and analysing risks, were done online, while sessions that required more physical involvement were in person. Out of 72 sessions at each Well-Being Club, 23 were conducted online.

A safe space was created for participants to express themselves freely and overcome their hesitation through movement and verbal sharing at the DMT sessions. They explored ways to protect themselves and mitigate GBV-related

risks through movement, presentation, artwork, and role plays. (Table 2 outlines the thematic areas and objectives covered during the DMT sessions.) They also worked towards building leadership skills to prevent GBV in their communities.

Figure 3: *Every month, social workers visited the participants' homes to ensure attendance and feedback*

Since participants are adolescent girls living with their guardians, continuous engagement with family members was necessary to ensure attendance and feedback. Every month, social workers conducted one home visit with each participant's family, to gauge the girl's wellbeing, the socio-economic situation of the family and to inform them about the schedules of the upcoming sessions. This helped build a sense of trust and transparency with family members.

After the second wave of the pandemic, four project team members (Project Lead, 1 DMT practitioner and two social workers) conducted four sessions (one for the parents of participants in each Gram Panchayat), in order to orient participants' guardians to the progress of the project and understand the changes that guardians had observed in the participants.

Out of 120 adolescent girls who enrolled, 111 girls completed the 72 session-long DMT curriculum. Nine girls did not complete the curriculum, as some got married and their in-laws forbade attendance. Some were unable to balance dance with academics, while others were ill. The completion of the DMT curriculum was celebrated through a certificate ceremony in June 2022, where 120 participants, their family members and members of the collaborative network were present. The participants shared their experience of DMT sessions, and the members of each Well-Being Club performed as well.

Figure 4: *A participant receives her certificate of DMT completion from the Joint Block Development Officer*

a. Creation of a collaborative network

A collaborative network began with the creation of a channel of communication at the state level through meetings with representatives from the Department of Women and Child Development and Social Welfare, Government of West Bengal. Similarly, at the district level, meetings were held with the District Social Welfare Officer (DSWO) and District Child Protection Officer (DCPO) of South 24 Parganas. This was done to introduce the officials to the project and get the requisite permissions. In order to recruit members for the collaborative network, key stakeholders such as the BDO, Joint BDO, members of CBOs, Panchayat Pradhans, Accredited Social Health Activists (ASHAs), VLCPC, SHG members and local school teachers met. Social workers met these stakeholders every month and in due course, a collaborative network of 21 members was created. The designations of the collaborative network members are given in Table 4. A membership card was given to these members, and their names were registered in a logbook. Meetings were held where the members defined the structure, roles and functions of the network, and soon the network worked as a safety net where adolescent girls could report issues related to GBV in the community.

Table 4: Designations of collaborative network members

Designation	No. of members
Block Development Officer (BDO), Mandirbazar	1
Joint Block Development Officer, Mandirbazar	1
Child Development Project Officer (CDPO)	1
Panchayat Pradhan	5
Second Officer of Police	1
Supervisor of Integrated Child Development Scheme (ICDS)	1
Supervisor of Anganwadi Worker (AWW)	1
Accredited Social Health Activist (ASHA)	1
Members of Community Based Organisations (CBO)	2
Self-Help Group (SHG) president	1
Local schoolteachers	2
Staff members of Sundarban Social Development Centre (SSDC), partner NGO in the project	2
Staff members of Kolkata Sanved	2

While adolescent girls were attending DMT sessions, the collaborative network was envisioning and planning its functions, roles and processes. So far, when the girls needed to report issues, they had to approach the KS team or the staff of the partner organisation. But once the collaborative network's direct reporting mechanism was set up, all the 111 adolescent girls were given the names and numbers of the members of the network. The girls were encouraged to access them directly.

b. Community awareness campaigns

From January 2022 to June 2022, two awareness campaigns were held for community members to raise awareness about the risks of GBV and build trust and connections with the community. The campaigns involved a performance created by the participants on how trafficking takes place and the prevention and the ill-effects of child marriage. Community members were taken through an experiential DMT activity to understand the importance of the DMT process and its role in building skills and resilience amongst adolescent girls. Some participants spoke about their

own change stories, while members of the collaborative network spoke of the power of DMT sessions in building communities.

Figure 5: *Collaborative network members speaking at the community awareness campaign*

c. Monitoring and documentation

Monitoring the project enabled the team to understand whether everything was going as planned. Monitoring was done in the following ways:

i. Feedback from participants: This is the key to every DMT session, as it helps DMT practitioners to be constantly responsive to the needs of the participants. The Project Lead and head of programmes of KS also attended seven monitoring visits, where they held discussions with participants about the impact of the sessions and challenges faced.

Figure 6: *Four orientation programmes were held with families*

ii. Feedback from parents: Four orientation programmes were held with families one for each Gram Panchayat, and team members got

an idea of the changes that parents had seen in the adolescent girls.

iii. Quarterly review meetings: The entire project team met for a full-day meeting every three months, where they discussed what worked, challenges faced and how to overcome challenges.

Documentation took place through the following processes:

i. Regular written reporting: Reports for each DMT session, home visits and stakeholder meetings were created by the team members. The DMT session reports detailed the proceedings, feedback and observations of participants. The DMT practitioners also mapped the progress of each participant in each session by scoring indicators such as confidence, assertive communication, coping skills, focus, listening skills and critical thinking. The individual activity reports were compiled into monthly reports and were supported by monthly financial reports, which were sent to the donor.

ii. Audio-visual documentation was done during DMT sessions, home visits and community awareness programmes. All documentation was done with the informed consent of the participants and their guardians, and in accordance with the Safeguarding Policy of Kolkata Sanved.

Output of the DMT programme

a. Adolescent girls developed psychosocial skills to respond to risks of trafficking

> *Before attending DMT, I would parrot everything. I was locked up in a cage. I was scared of the outside world and had to abide by societal rules. Once I started attending DMT sessions, my thoughts changed, and it brought changes within me. I learned to accept myself and others, create safe boundaries and build self-confidence.*
>
> **- An adolescent girl who participated in the Well-Being Club programme**

i. Building confidence and enhancing a sense of agency

Initially, most participants were hesitant and did not make eye contact with the facilitators. As the DMT sessions progressed, with extensive exploration of movement and reflection on one's own strengths, there was a marked change in the participants. Participants were able to speak their minds, not only during the DMT sessions, but also outside them. A participant says, "I used to underestimate myself and was always anxious and shy. But after attending DMT sessions, I realised I can now love myself. I can talk to people freely and confidently. I feel ready and know my self-worth."

The participants' confidence enabled them to envision their own futures and forge their own paths. Another participant says, "I would like to apply all that I learned through these sessions to my everyday life and want to be self-dependent. It is my dream to open a big shop in the future. I will also help other women like me. It is from the DMT sessions that I learned to have a dream, and I will achieve it."

ii. Communication skills

DMT has enabled participants to build effective communication skills verbally, non-verbally, and through movement, theatre and art-based tools. They made posters on child marriage, trafficking and sexual harassment, as well as a map of safe and unsafe zones in their communities, which were distributed amongst their family members and the collaborative network. The father of a participant said his daughter, who would barely make eye contact, was now on stage, talking confidently to the community and even addressing local officials.

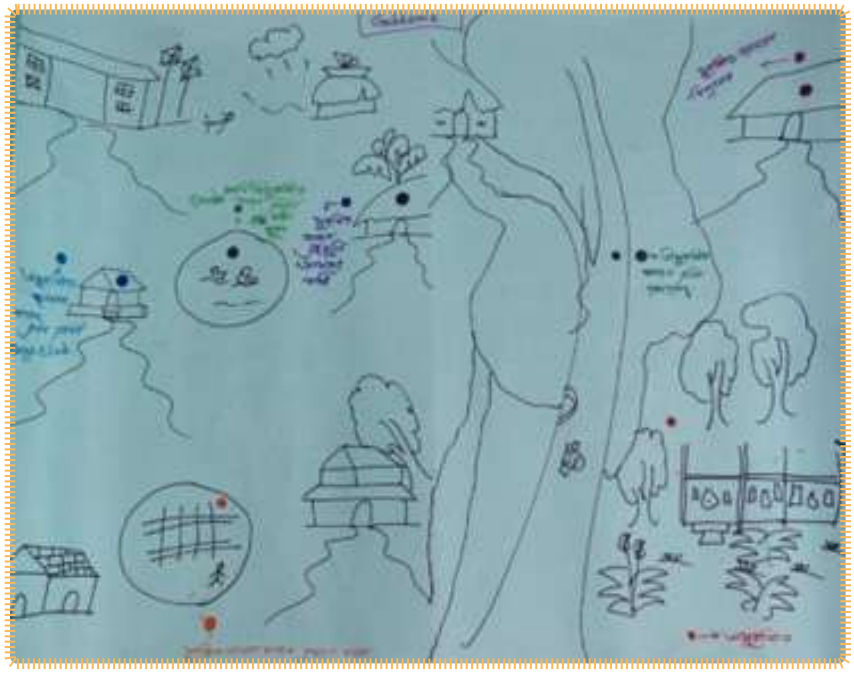

Figure 7: *Map of safe and unsafe zones at a gram panchayat made by the adolescent girls*

iii. Emotional regulation

Emotional regulation helps individuals handle their stage, and they are therefore less likely to take impulsive decisions endangering their safety. Emotional regulation gives them the space to be calm and make rational decisions. This is especially important as many adolescent girls fall prey to traffickers luring them with romance.

The DMT sessions created a safe and healing space for participants who could share their feelings and anxiety without being reprimanded. “DMT is just like medicine which keeps us healthy. Earlier, I wanted to die, but now I try to imagine that my sadness is like rain and will wash away. I do what I love doing and I practice it every day. I am in such a good place now that I sometimes think if I had given up on my life, I would have missed out on this,” a participant says.

The participants also reported that they now had tools for anger management. Parents said their daughters used to sulk, refusing to eat, talk, and even hit their family members. A participant said that

after a few sessions on anger management, she realised that she is in control of her anger switch and can express her rage in a healthier way. Participants have learnt deep breathing, relaxing the body, listening to calming music and using dance for self-care. “There were many issues with the family because I was angry. But after enrolling in DMT sessions, I am able to control my anger and do not make hasty decisions fueled by anger.”

iv. Critical thinking and decision-making

Participants were encouraged to reflect on their experiences and give feedback with special emphasis on critically analysing gender norms. They were given information about gender and sexual and reproductive health, destigmatised menstruation, sex and sexuality. “We had an activity where we were asked to draw our own body and put a tick mark against body parts we like and a cross against body parts we dislike. It was then explained that we need to respect and give importance to all parts of our body. We must love ourselves,” a participant said.

The girls also learnt to deconstruct patriarchal ideas about women. A participant said, “I used to think that women do not have rights, nor do they have the strength to achieve their goals. In these sessions, I have never heard any negativity, and I learned there is power inherent in women, which spurred me on to a new way to lead my life. I also learned about self-love and self-awareness.”

Participants began to articulate their own needs and make their own choices with their families. For example, all five participants who got married during the lockdown said that they had tried to convince their husbands and in-laws to allow them to attend the DMT sessions. Two participants succeeded and would bring their husbands along and make them meet the facilitators. They did not give up their rights after marriage, but harnessed their own resources to access their rights.

The sessions on relationships and boundaries enabled the participants to understand who they are safe with. “It is important to think through an action, consider your safety and that of others. I have also learned to create boundaries; I have learned to say ‘no’,” a participant said.

b. Adolescent girls have access to stakeholders

Adolescent girls were given direct access to the key service providers so they feel safe leaving home. A participant said, "I used to be eve-teased and did not know how to respond. People broke my trust. After DMT, I learned how to overcome my problems."

The participants began reporting cases of child marriage and the risks of trafficking either to the facilitators of the Well-Being Clubs, who then conveyed it to network members, or directly to stakeholders. In fact, the girls addressed three cases of child marriage.

c. Building awareness of trafficking and GBV through leadership

The experience of participating in the Well-Being Clubs gave adolescent girls the opportunity to build leadership skills and take an active part in organising initiatives against trafficking and GBV in their communities. Family members of adolescent girls gave feedback that the 10 posters designed by the girls on issues like trafficking, child marriage, sexual harassment, and the importance of children staying in school, increased awareness in the community. The participants also developed a resource map of safe and unsafe spaces in their gram panchayats, which was shared with other members. They also have gained the confidence to address officials such as the BDO and the police.

Figure 8: *Posters on community awareness made by participants*

Participants advocate against a wide range of issues, including trafficking, child marriage and child labour. A participant mentioned how a relative, a young boy, was not going to school and, instead, made bidis for a living. After participating in the Well-Being Club, she encouraged the boy to defend his right to education. When he was not convinced, she approached

his grandmother and explained that the boy was engaged in child labour, which is a violation of his rights. Consequently, the grandmother sent the boy back to school.

The adolescent girls want to work as leaders in preventing violence in their communities. “For cases of child labour, I meet the guardians and explain that it is illegal. I also let them know of the risk of young children being trafficked. In the case of child marriage, I explain why child marriage is a bad idea. Often, the child is not mentally or physically ready to get married and have a baby, leading to deaths of both the mother and baby during delivery,” said a participant.

The leadership and psychosocial skills of the participants have led to a remarkable transformation in their families. Their parents reported that the girls shared their learnings with family and neighbours, including community resources, and that this, along with home visits and care-providers meetings, has led to attitudinal changes. Earlier, family members were opposed to participants attending DMT sessions, but now they request KS to include other children in the community so that the safety net is widened. Several mothers and grandmothers want to engage in DMT and are extremely enthusiastic for their children to go forward as leaders. A guardian said, “I take care of my granddaughter after her parents died, and she is keen to become a community leader and create awareness in our villages where there is chronic human trafficking. She demonstrates the movements at home, and in fact, I would also want to enrol.”

Challenges along the way

a. Stigma around dance

Dance was stigmatised in many communities, and while the girls were enthusiastic about the sessions, parents thought DMT would make their daughters dancers, which they considered a taboo. In order to respond to this challenge, a community mobilisation programme was done with parents, before the DMT sessions began, which explained that DMT was different from dance. Parents were told that the aim of the programme was not to create dancers, but to enable adolescent girls secure their mental and physical safety. Even then, some participants continued to

face opposition from male members of the family, due to which their attendance was initially irregular. Interestingly, mothers and other female members would encourage the girls to attend the sessions.

b. Extreme weather events

Periodic flooding at Mandirbazar is a challenge. During the course of the programme, two major cyclones — Amphan (2020) and Yaas (2021) — took place. Amphan, in particular, led to grave damage in Mandirbazar with the loss of homes and access to potable water. KS provided relief to the families of the adolescent girls, sending dry rations, tarpaulin, and personal hygiene products such as masks, sanitisers and sanitary pads.

c. COVID-19 pandemic

The COVID-19 pandemic led to a disruption of DMT sessions. Families faced loss of livelihood due to lockdowns, and participants were distressed by the uncertainty, disruption of routine, and inability to go to school and meet their peers. KS worked towards providing psychosocial support and resumed DMT sessions online. These sessions were in small groups of 15 each, and 23 such online sessions took place for each of the four Well-Being Clubs.

What the programme taught

a. The in-depth engagement of a family through regular home visits, parents' meetings and community awareness programmes was crucial to ensuring that 92.5 percent (111) of the 120 participants were retained during the programme. The role of the partner organisation —SSDC— and four social workers with several years of experience in the area — was important as they had an existing rapport with the families of the adolescent girls.

b. While most participants were aware of trafficking before starting DMT sessions, they did not have a clear idea of how to respond to the risks. Through DMT, they could participate in activities, role plays and make real-life decisions. For instance, the adolescent girls decided the locations in which their posters would be displayed, and thereby it helped them use critical thinking and decision-making skills.

c. While the Sampoornata Well-Being Club was initially focused on the issue of human trafficking, in practice, the sessions had to address multiple forms of GBV arising in the community, including child marriage and child labour.

d. Apart from working with girls in the community, there is also a need to work with men and boys, as GBV is often perpetrated due to internalised patriarchal norms in males. Moreover, boys in Mandirbazar are also vulnerable to trafficking.

Figure 9: *While the initial focus on the intervention was on human trafficking, the session also addressed other issues in the community such as child marriage and child labour*

Conclusion: Moving forward

The Sampoornata Well-Being Club programme was successful in empowering 111 adolescent girls in Mandirbazar. The girls learnt to protect themselves from, and respond to, risks of trafficking and GBV in their communities, through building agency, psychosocial skills and links to stakeholders. Now, KS seeks to make the programme sustainable in Mandirbazar through training 20 adolescent girls as community leaders, who would actively interact with the collaborative network, with four selected leaders joining the network. They would thus create and run their own Well-Being Clubs, creating a ripple effect of change in their own communities and beyond.

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IV. A New Dawn: Survivors' Journey to Legal Empowerment

Association for Advocacy and Legal Initiatives Trust (AALI)

Abstract

The Association for Advocacy and Legal Initiatives Trust (AALI), established in 1998, is an organisation helmed by women and committed to the protection and advancement of rights of women, children and other marginalised communities. AALI's ideological framework is rooted in the United Nation's Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). CEDAW was adopted in 1979 by the UN General Assembly and is often described as an international bill of rights for women. It defines in very clear terms what constitutes discrimination against women and sets up an agenda for national action to end such discrimination. Based on the same ideology, AALI's vision is to create, "An egalitarian system which recognises women as equal human beings and promotes and protects their social, economic, and citizenship rights guaranteed in the Constitution of India and in the international human rights treaties."

Introduction

This is a story of two siblings, both of whom chose a love that was unconventional and unacceptable in the society where they lived. The brother, Ramesh*, loved Sana*, who was from a different caste and class. The sister, Renu*, loved a girl, Punita*. The four had grown up in the same neighbourhood in a city in Uttar Pradesh and were close friends.

However, when Ramesh and Sana wanted to get married, their families were completely against it. The bitter disapproval of their families and the fear of a community backlash forced the couple to run away. They fled their hometown along with Renu and Punita and landed up at the doors of the AALI office in Lucknow. The AALI team agreed to help them. The team also realised that this was a case of two couples, and it took a leap of faith for Renu and Punita to confess that they were, in fact, in a relationship.

* Name changed

Meanwhile, Sana's family filed a false FIR against Ramesh and his family for "kidnapping" their daughter. They also claimed that Sana was a minor.

AALI realised that the two cases had to be dissociated from one another. The lesbian duo was sent to a shelter home that accepted same-sex couples, a rarity at the time. Once that was taken care of, the team took Sana back to her hometown to record her statement before the magistrate. However, as soon as they reached the police station, they were surrounded by a mob demanding the arrest of the AALI team. The team was forced to flee to Lucknow fearing for their lives. Then, AALI heard that the magistrate had sent Sana to a shelter home and the organisation filed for a Habeas Corpus plea before the Allahabad High Court.

During the court proceedings, AALI conducted a bone ossification test that proved that Sana was over 18 years of age. At the same time, the judge also acknowledged the need for Sana to have an independent space so that she could decide without any pressure what she wanted to do with herself and her relationship.

Sana ultimately chose to return to her family.

AALI: Putting rights to the fore

This is not only the story of two couples from 17 years ago, but the story of many who do not have the right to choose their partners because of their families and their communities. There are innumerable stories of people who are forced to hide their sexuality for fear of death or couples who cannot always handle familial and societal pressures and quite often end up putting their family's wishes over their own.

The AALI team realised the need for a proper casework centre due to experiences like this.

At its initiation, AALI was set up as an advocacy resource group, which was supposed to liaise with the state government on feminist issues with a rights-based perspective at its core. The founders of AALI realised that various organisations working towards women's empowerment focused on forming self-help groups and providing employment, but none focused on the rights of women as individuals and citizens of this country.

AALI wanted to fill this gap and change the narrative from a need-based approach to a rights-based one. Since the founders of AALI were mostly practising lawyers, people also started approaching the organisation whenever they needed support in a court of law in cases of gender or domestic violence. AALI also began advocacy with government bodies. It believed in the right of access to justice for marginalised sections of society, and it began taking up such cases gratis. There was soon a barrage of cases which became difficult to handle for a small team of around five lawyers. So, after much discussion among the team, a separate unit was established under AALI between 2007 and 2008, to exclusively look after cases. Since then, AALI has been taking up cases related to violations of the rights of women, children, as well as marginalised sections of society, on a pro-bono basis.

The founders of the casework establishment programme ensured that those at the receiving end of gender-based violence (GBV) would be called survivors, not victims. AALI became a safe space where survivors of gender- and identity-based violence could feel comfortable and ask questions openly. The AALI team stood by them throughout the process, not just as a support system, but also as a confidante, listening to their stories of struggle without judgement. This was contrary to the existing system, where most lawyers were men and more often than not, approached cases from a patriarchal point of view. Consequently, women were unable to vocalise their doubts and seek remedy. AALI's role was not just restricted to providing correct information, but also to strategising and accompanying these survivors, wherever required.

At the time of its establishment, AALI was the only organisation in India that took on cases of GBV without charging any fee from its clients. It was also the only organisation in India that gave women a platform to put forth their views and get pro-bono socio-legal counselling.

Case work intervention: A new chapter unfolds

Planning

In 2011, AALI conducted a mapping of cases, whereby it was found that the organisation had been providing legal support in 56 districts in 21 states in India. AALI also gave technical advice over the phone to various feminist and rights-based organisations on the procedures involved in a case. For example, the sections under which an FIR is filed, which government officer to approach,

which application is to be submitted and to whom. But a major challenge in this process was that though the organisations which were approaching AALI for technical and legal support were able to understand the legal process, they were unable to execute the work. They were not completely equipped to face the real-life challenges in dealing with government and judicial bodies, including police, courts and other government authorities. It was then that they approached AALI for advice and resolution. Thus, it was evident that there was a lack of knowledge regarding law and its implications among the organisations, due to which they were not able to take up cases with full conviction.

Around 2011, in Jharkhand, at the conclusion of a flagship programme, a few organisations approached AALI for help in training in legal concepts, strategies and the rights-based approach to handling cases. It was also realised that while AALI had the legal knowledge and ability to build strategies to intervene effectively in these cases, the reach of AALI alone would be extremely restricted. The need to set up a system which would be efficient and equipped to work and provide such services in more places was realised. This gave AALI the idea to start Case Work Centres in different districts in partnership with other community-based organisations (CBOs) which work with the same feminist perspective as AALI. AALI would train them in handling cases, both practically and theoretically.

Collaboration & execution

Realising the need, in 2011, AALI started selecting organisations and training up to three employees from each. Training was provided to only those organisations which had committed to begin case work in their respective districts. The trainings were held in four phases of five days each spread across a period of six months. The training module started with sessions on topics such as gender, patriarchy, discrimination and violence against women and later covered all basic legislations related to women and children; for example, the Protection of Women from Domestic Violence Act, 2005 (PWDVA), among others. Apart from theoretical knowledge, practical understanding of processes — how to file an FIR and get a copy, knowledge of the proceedings of the criminal justice system as well as civil laws — were given. Training also included visits to police stations, courts and One Stop Centres, and discussions on various strategies that can be used while dealing with cases of GBV. In all, it was an exhaustive training covering an end-to-end process of accessing the justice system. Finally, they were trained to be paralegals so that they could intervene in cases at the Case Work Centres.

Figure 1: *Workshop with Community-based organisations in Lucknow, Uttar Pradesh*

After the training, one member from each CBO was selected after an interview, on the basis of her understanding of a rights-based approach and whether she was a feminist. These selected case workers then began working in their centres, taking up cases of survivors of GBV or any other form of

violence or discrimination. In cases that needed legal action, these Case Work Centres referred the cases to the District Legal Service Authority (DLSA), and they continued regular follow-ups with the authorities as well as the survivors.

Figure 2: *Case Worker at a refresher training in Lucknow, Uttar Pradesh*

> *I used to work with women and children earlier too, but I didn't know where to go and how to make them avail their rights. I was also scared of going to the police station alone. After getting associated with AALI and attending their workshops, I gained confidence and started working in my district. Women who had faced extreme violence for 20 years would come to me, with scars on their bodies. They had never registered a police complaint. I started accompanying them to the police, helping them register FIRs. They were initially hesitant; subsequently they started opening up and seeking support.*
>
> **-Anita Verma, case worker, Fatehpur, Uttar Pradesh**

AALI was very clear that these sessions would not be limited to just training. It was committed to a proper implementation on the ground. AALI ensured that the centres established under the casework establishment programme were equipped to provide psychological as well as legal counselling to survivors so that they are able to file FIRs for cases of GBV against them. It was also seen that between the years 2010 and 2013, the cases pertaining to the right to choose a partner in a relationship had increased immensely, and it was imperative that these cases were handled with a rights-based approach and sensitivity, as they were vulnerable to communal violence. It was during this period that a lot of young men were being falsely accused and detained in police custody, with abduction or kidnapping cases being slapped against them by the parents or guardians of their partners. This was due to the inter-caste or inter-religious nature of the relationships. There were also instances of custodial deaths in such cases. Therefore, it was important for AALI to effectively train and develop the capacities of the Case Work Centres on intervention, as well as train them on holding discussions in the communities that the couple came from and increase awareness and acceptance.

Scaling up

In 2011, along with training, AALI had also established five Case Work Centres in Uttar Pradesh. In 2013, AALI received more support and expanded to Jharkhand, first by establishing an office in Ranchi, and then by establishing eight Case Work Centres in Jharkhand. In 2018, after getting more funding, we expanded to Uttarakhand as well. By the end of that year, AALI had approximately 21 centres across Uttar Pradesh, Jharkhand and Uttarakhand. As of 2022, AALI has 52 established Case Work Centres across four states, including Bihar.

The reason why this programme was important and why AALI knew that it wanted to continue the programme and expand the target area was because the reach that this programme had was a lot more than AALI could have attained alone. The Case Work Centres became safe and accessible spaces for women where they had a voice and could get help. This was especially true because access to the AALI office was not always feasible.

The women also knew that the cases that were being handled by the Case Work Centres would not simply be referred to the DLSA, but instead would help the centres strategise and even if referred to the DLSA, regular follow-ups would be done.

The Case Work Centres across Uttar Pradesh, Jharkhand, Uttar Pradesh and Uttarakhand have intervened in a total of 5,496 cases between the years 2018 and 2022. It was seen that a majority of these cases — 71.23 percent or 7/10 cases —were of domestic violence.

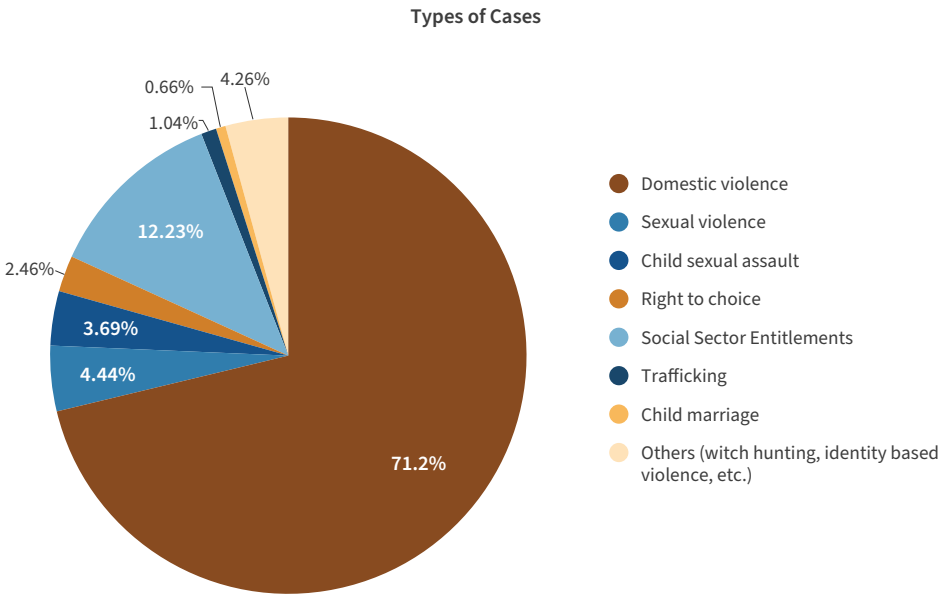

Figure 3: *Nature of cases handled by Case Work Centres between 2018 and 2022*

These numbers are proof that even though most of these centres were established in 2018, they did have the capacity to intervene in a large number of cases. This is something that AALI could not have done single-handedly.

Learnings and innovations along the way

Cases registered in AALI through AALI's Case Work Unit, as well as Case Work Centres, began increasing, and AALI realised that it was important to induct lawyers who are aware and have the sensitivity to take up cases of Violence against Women and Girls (VAWG). There are 52 Case Work Centres and whenever any case requiring legal intervention would arise, case workers

were required to connect the survivors to a lawyer in that district, either through the District Legal Services Authority (DLSA) or otherwise. Finding a lawyer with the requisite legal expertise and sensitivity was challenging, and so AALI thought of creating a network of lawyers and building capacities to deal with VAWG cases.

Now, AALI has several lawyers from Uttar Pradesh, Jharkhand, Uttarakhand and Bihar in its network whom the Case Workers contact for legal support while handling a case. AALI regularly conducts district-level as well as state-level workshops with these lawyers where they are provided with in-depth information on different legislations and acts related to women's rights.

Figure 4: *State Lawyers' Workshop in Lucknow, Uttar Pradesh*

Figure 5: *State Lawyers' Workshop in Ranchi, Jharkhand*

Courtroom strategies are discussed with them, and dockets of new and relevant cases are provided to them, which in turn help them effectively handle cases. Having a lawyers' network has helped AALI in expanding its reach and objective of increasing access to justice for women and children, especially those belonging to the marginalised communities.

> *Earlier in our district, for cases related to sexual offences, the statement of the survivors was taken in front of everyone at the court. After getting to know the right procedure from AALI, I, along with other advocates, submitted a written application to the Honourable Judge, after which the statement of survivors is now being taken in front of the judge in closed rooms.*
>
> **- Mukund Rao, advocate, Pratapgarh, Uttar Pradesh**

The transformation story

AALI has been providing support to many women survivors and has aided them to follow due process by helping record their statements under relevant sections of the law and ensuring that police do not coerce them into changing their statements. In one of the cases, the girl was sent to a Nari Niketan (Women's Home), despite her statement that she was an adult and that she had married of her own free will and volition. AALI moved court and secured her immediate release from the home. The court ordered that the girl remain in AALI's custody till such time her statement was recorded in court. The girl was allowed to leave along with her husband after her statement was recorded, sparing them further harassment. Another case involved a girl who wanted to marry someone of her own choice. AALI helped in registering the marriage, meeting senior officials and keeping them informed of the proceedings of the case, so as to ensure that the rights of the boy and the girl are not violated.

The State Women and Child Welfare Department handed over custody of a former inmate of a protection home to AALI. The organisation then helped her secure a job and become financially independent.

The right to choice and autonomy has been a recurring theme, wherein AALI has intervened to demand accountability from the state through a fact-finding team and media advocacy. Another important aspect of the work on this issue has been to support individuals exercising the right to choice in marriage. AALI also provides in-depth counselling for women undergoing stress and trauma in their personal lives and helps boost their self-confidence. AALI has also forged links with other organisations to ensure a holistic resolution of cases, including rehabilitation for survivors.

> *My husband had relations with other women but I could not say anything. He would beat me up. Sometime ago he married another woman. I did not know what to do. Then I got full support from AALI. I did not have the money, so AALI helped me file a case. After joining AALI, I realised that there are many things in life other than marriage.*
>
> **- Revati*, Ranchi, Jharkhand**

Figure 6: *Survivors at an event organised by AALI in Lucknow*

In the last few years, AALI's scope of intervention has expanded to include cases related to social sector entitlements, domestic violence, sexual abuse and child sexual abuse. More and more women are now able to approach

Case Work Centres from remote areas, including the Adivasi belts in Jharkhand. This has helped increase their ability to access the justice delivery system.

> *I learnt from AALI that we should never feel scared in any situation, we should openly speak about our problems. We should not feel that we can't do anything because We are women. We should fight for our rights and move ahead in life.*
>
> **- Sarita*, Lucknow, Uttar Pradesh**

> *I got a lot of clarity on the issue of 'consent' from the sessions organised by AALI, and I have been using this knowledge in my practice. In one of the cases, a woman had filed rape charges against her boyfriend and I had defended her in the court saying that giving 'consent' for sex once doesn't mean giving consent forever.*
>
> **- Priyanka Singh, advocate, Lucknow, Uttar Pradesh**

> *Before getting associated with AALI, I was scared of going anywhere alone or even talking to someone. But now I am not afraid of anything. I go everywhere on my own, even to court.*
>
> **- Shabnam*, Lucknow, Uttar Pradesh**

Lessons for life

To make sure that AALI's case workers are aligned to AALI's ideology and vision, the organisation provides regular handholding on a monthly, quarterly

* Name changed

and yearly basis. This is done through 'Monthly Planning & Review Meetings', 'Quarterly Feedback Calls' and 'Annual 360-degree Review Meetings'. A 360-degree review, for instance, seeks to provide actionable feedback to employees and gives them a better understanding of their contributions to the organisation. During these handholding sessions, AALI also tries to understand the challenges the staff face on the ground and collaborate on solutions. These meetings help enhance the potential of case workers and increase their interventions in a case. They also help build a better understanding of the law which enables them to take up cases of VAWG and other women's rights issues more efficiently.

Case workers also share their experiences as well as their expectations from AALI and learn from each other's experiences.

Hurdles crossed

The biggest challenge for AALI in establishing the Case Work Centres was 1) identifying other organisations which work for women's empowerment, 2) have a feminist philosophy, and 3) have a rights-based approach. Moreover, there were hardly any organisations which had a legal understanding of how to handle cases. Even if AALI was able to find an organisation that was willing to collaborate for training on handling GBV cases, they often did not have women employees. Most of these organisations had male employees on a full-time basis, while women staffers were volunteers. This was contrary to AALI's idea that women should fight their own battles because they are at the receiving end of the violence and discrimination.

Taking note of these differences, AALI started talking to the heads of these organisations and informed them that AALI would only consider working with female case workers. If the organisation wanted to work with AALI, it had to hire full-time female staff. AALI also decided that every partner organisation must send two women and only one man for the training sessions. The heads of these organisations wanted to continue getting training under AALI because they realised that few organisations take care of all the logistics, while also providing training and resource materials. Thus, though initially the training

* Name changed

sessions comprised men, gradually there was a shift with one man and one woman from each organisation attending the training. Presently, the ratio of women in the training sessions is much higher than that of men.

Another major challenge that AALI used to face was that the Case Work Centres were not taking up cases related to sexual and domestic violence because they are extremely sensitive in nature and thus difficult to handle. It also takes a lot of time and resources to get them resolved. It was also crucial to realise that the case workers intervening in cases of right to choice had to be freed from the pre-existing biases that were embedded in their psyche through years of social conditioning. So, AALI re-evaluated its own training modules and understood the gaps that existed and worked to bridge those gaps. Now, the case workers have started taking up cases of sexual as well as domestic violence and are able to handle them efficiently.

Another challenge with Case Work Centres was that the opinions of case workers and the head of the organisations clashed. This was because organisation heads sometimes decided that the matter did not fall in their purview, while case workers felt differently. To tackle this challenge, AALI started calling the heads of these organisations for network/coalition meetings, with the aim of helping build their capacities. Until then, AALI used to conduct capacity-building trainings for the case workers on a regular basis. With the network/coalition meetings, AALI started conducting training sessions for the heads of the organisations as well, with the aim of mitigating the gaps that had started to emerge.

COVID-19 and case work

In the initial phases of the COVID-19 pandemic, the biggest challenge for case workers was that they did not know how to cope with the lockdown. Case workers were used to being on the field every day, and for them to not go to the communities, made them helpless. On the other hand, they were constantly getting calls from the women in the communities, initially not for any particular purpose, but they were apprehensive about the future. Once cases started coming to the centres, they saw the rate of domestic violence spiralling up. Communities reached out to the centres requesting food and

* Name changed

ration and complaining of police atrocities. The bigger hurdle for case workers was that courts were shut during this time.

In the initial three months of the lockdown, the case workers as well as AALI's core team, realised they had to go digital to ensure work, to strategise and intervene in cases when courts were shut, and mobility was restricted and access to communities difficult. The case workers then started leveraging the existing networks of lawyers and partners that AALI had established over the years. The case workers approached these partners to help them get permissions and passes to help communities in need.

AALI started holding online meetings with its network of lawyers and partners with the aim of addressing the issues that were arising in the community and understanding how the law could be leveraged as a tool, and to compile a list of resources and helpline numbers that would be distributed in the community for emergencies. The lawyers also started giving legal advice and counselling over the phone and helped case workers develop requisite strategies.

What makes Case Work Intervention unique

According to NITI Aayog's 2021 MPI Index (Multidimensional Poverty Index, an international measure of acute multidimensional poverty covering over 100 developing countries), the three poorest states in India are Jharkhand, Bihar and Uttar Pradesh. It is in these conditions that women are the most exploited. Therefore, it becomes crucial for them to be made aware of their socio-economic and civil-political rights and make access to the legal system easier. This is how AALI's Case Work Intervention is unique and exclusive.

There is no other organisation in India that not only provides free socio-legal counselling to survivors of GBV, but also offers complete technical support in terms of accessing the justice system. AALI makes sure that survivors are provided support right from the first step, which could be going to the police station for filing an FIR, to the last step, which is the judgment in the case. Follow-ups with the survivors are done regularly by AALI's team of case workers and lawyers until justice is delivered to them. All this is provided on a pro-bono basis. In the Indian context, many women are economically dependent on their male family members, be it their fathers, brothers or husbands and availing legal services is a challenge. There are hardly any

lawyers who provide free legal service even if it is simply a counselling session. Thus, AALI's ideology of providing free legal aid to the survivors without preconditions fulfils this requirement.

AALI takes up about 1,800 to 2,000 cases every year pro bono.

Conclusion and the road ahead

Today, AALI has 52 established Case Work Centres across the Hindi-speaking states of Uttar Pradesh, Jharkhand, Bihar and Uttarakhand. The organisation is well known in these states for its work and expertise. However, in the coming years, AALI wants to expand to other parts of India, because it realises that the need to handle cases with a rights-based and feminist approach is paramount. And even though conditions of women might not be as poor in other parts of India as they are in the Hindi belt, the social conditioning as a result of patriarchy permeates almost every part of the country. Therefore, it is imperative that there are people equipped with the skills to ensure access to justice to the most remote communities as well.

P.S. After a few years, AALI followed up on Ramesh, Sana and their two female friends. AALI found that Sana was with her family and she had given birth to a baby. There was no news of Ramesh or of Renu and Punita, though the two women had returned to their hometown while the case was going on.

V. Making Khajuraho a safe place for children: Child protection and tourism

Equitable Tourism Options (EQUATIONS)

Abstract

A study done in 2013 by EQUATIONS, a research and advocacy organisation that focuses on tourism-related issues, and local non-governmental organisations (NGOs), revealed the prevalence of child sexual abuse in Khajuraho, a UNESCO World Heritage Site in Madhya Pradesh. Despite initial pushback from the community, a child protection intervention was initiated for responsible and ethical tourism discourse. The support of community influencers was enlisted, and awareness sessions were conducted for stakeholders on what constitutes child sexual abuse and how it can be addressed.

A multi-stakeholder platform with government actors and tourism authorities was created. EQUATIONS played the role of a catalyst. Tourism service providers and government functionaries played the role of enablers and change agents and were able to develop a process framework that engaged all actors in the tourism sector. Children and youth groups, as the primary stakeholders, were empowered to engage with the police and service providers without fear of being ignored or intimidated. The platform also empowered stakeholders to expand their activities to look at other issues related to tourism and focus on aspects of social engagement and change.

Introduction

States in India have welcomed the economic benefits of tourism, but ignored the social costs of child sex tourism (CST) intrinsic to it. Multiple factors, such as poverty, migration and unemployment, and the inadequacy of strict laws from abuse have contributed to the growth of child sex tourism.

Founded in 1985, EQUATIONS focuses on equitable tourism and development issues in India. It primarily uses research, policy and advocacy to understand the impact of tourism, particularly on people and communities living in and around tourism destinations. It examines the economic, environmental, social, cultural and political ramifications of tourism-related policies and practices, and collaborates closely with organisations and local movements to encourage tourism that is people-centred, equitable and democratic.

In 2013, EQUATIONS conducted a study[1] in conjunction with Vikas Samvad[2] to study the status of children in Madhya Pradesh with a focus on child sexual abuse and child labour in the context of tourism. EQUATIONS had worked on tourism and its links to child exploitation since the early 1990s.[3] Khajuraho, a heritage destination, was one of the places selected for the fieldwork.

The objective of the study was to investigate the extent, nature, scope and manifestation of exploitation of children in tourism in the form of sexual abuse and child labour, and to recommend actions, particularly at local and regional levels, to combat child exploitation in tourism.

The research indicated that poverty often forced children of migrant and marginalised families into sex and child labour. Service providers were aware of and sometimes indirectly involved in the sexual exploitation of children, but did little to prevent it. It was also found that there was little action being taken by the local governing authorities to address the problem. A general sense of apathy and malaise, lack of synergy and coordination, and poor awareness regarding child rights and sexual abuse were common among departments responsible for dealing with the issue.

In 2014, EQUATIONS started its intervention in Khajuraho. Child protection is one among many components that it focused on as part of its

1 Exploitation of children in Tourism: Child Sexual Abuse and Child Labour in Tourism in Madhya Pradesh conducted by EQUATIONS and partner NGOs

2 Vikas Samvad Samiti (*https://vssmp.org*) is a research, documentation, and capacity building organisation based in Bhopal, Madhya Pradesh, for building a team of socially sensitive cadre, communicators and organised groups with a child-centric perspective.

3 Several papers, namely, 'A contextual view of Tourism and Child Prostitution in India, 1990' and 'Situating the Role of Tourism in Child Prostitution', 1991, were written by EQUATIONS. The second was based on the case of Freddy Peats, who was convicted for abusing children in an orphanage in Goa, with EQUATIONS being a part of the campaign that involved civil society, activists, local people and concerned individuals.

programmes to promote equitable and responsible tourism. Child protection, while engaging with local communities and tourism authorities to develop more inclusive tourism policies, is used to build equitable and sustainable practices. The programme has played a role in making Khajuraho a safe space for children and their communities.

But first, let us talk about tourism and its impact on child rights, the exploitation of children for labour and sexual abuse. We begin with a profile of Khajuraho and its unique positioning as a heritage site with erotic imagery. The influx of international and domestic tourists has increased the incidence of child exploitation and sexual abuse.

Figure 1: *Most of the tourist footfall in Khajuraho is from abroad, except during the annual Khajuraho Dance Festival*

Heritage destination

Khajuraho is an ancient city known for magnificent temples and intricate, sensuous sculptures, and was built by the Chandela dynasty between AD 950-1050. A UNESCO site, it is located in the Chhatarpur district of Madhya Pradesh. The temples reflect the collective cultural heritage of Hinduism, Buddhism, and Jainism.[4] Khajuraho presents a unique synthesis of religious,

4 Madhya Pradesh Tourism website - https://www.mptourism.com/destination-khajuraho.php

cultural and sexual tourism. The temples were unknown to the world until the 19th century and opened to tourists only in the 1950s.[5]

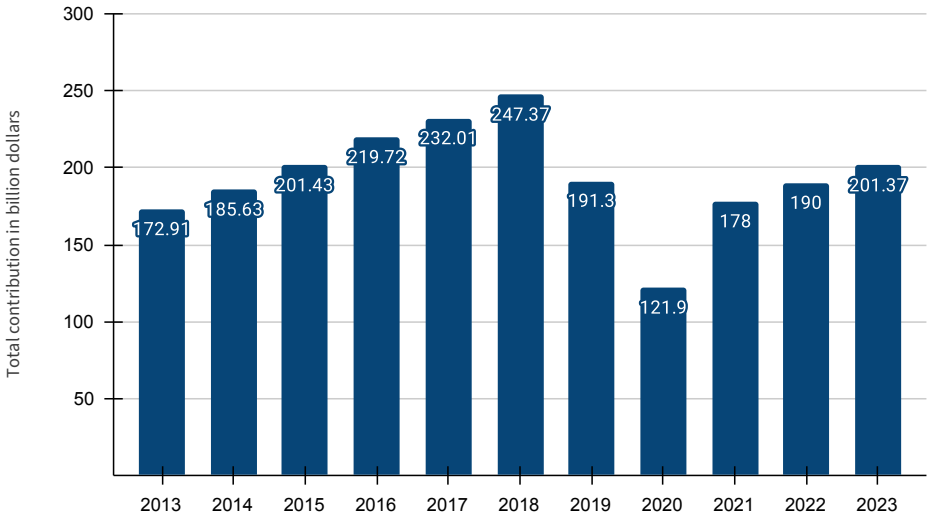

Figure 2: *Total contribution of travel and tourism to the GDP of India from 2013 to 2023*
Source: Statista 2024

Most of the tourist footfall is from abroad, except during the Khajuraho Dance Festival[6] which began in 1975 and takes place in February each year.

Tourism has helped reduce poverty with many locals engaging in various tourism and allied activities — guides, transport, shops, hotels, restaurants — among others[7] (ILO working paper, 2008). Khajuraho has a floating population of migrants, settlers and locals who depend on tourism for their livelihood. Tourism has led to an increase in infrastructure and better

5 The temple complex was forgotten and overgrown by the jungle until 1838, when Captain TS Burt, a British engineer, visited the complex and reported his findings in the Journal of the Asiatic Society of Bengal. It was, however, opened to the Indian public and tourists only in the 1950s.

6 This is an annual event organised at the heritage site. The main purpose of this event is to promote, preserve and spread knowledge about Indian culture and the classical dance forms of India (Kala Academy MP, 2020). The weeklong Khajuraho Dance Festival showcases various classical styles of Indian dance. It also provides craft artisans the opportunity to display their artefacts and crafts to visitors and tourists. This festival has become popular among both local and foreign tourists.

7 There is an overdependence on tourism in Khajuraho, as there are not many employment opportunities available other than in the tourism industry.

facilities for education and health for locals. However, this has also resulted in rampant development, increased pollution from excessive tourism, and the degeneration of monuments[8] and the environment due to weather and indifference of tourism authorities. Overcrowding has impacted the site's carrying capacity, and important resources such as water and fuel are scarce (Devalt Newsletter, March 2000).

An INTACH[9] study conducted in January 1998 on the sustainable development of Khajuraho suggested an integrated planning strategy for the next 30 years. The Conservation and Sustainable Development Strategy document for the Khajuraho Heritage Region included action proposals related to Integrated Heritage Management, Sustainable Tourism Development, and Integrated Community Development. In 2011, a comprehensive regional development plan of Khajuraho, which included a holistic development of tourism and preservation of temples, was prepared.

Despite all these efforts, Khajuraho now faces a situation similar to other heritage sites, in terms of tourism management and structure, with little benefit trickling down to the local community. There is tremendous pressure on resources and apathy among the populace about nurturing the heritage site despite their dependence on it. The low footfall of tourists due to COVID-19 has affected autorickshaw drivers, street vendors and guides.

Tourism and its impact

While tourism has the potential to make significant positive contributions to host communities, it can bring with it substantial social, cultural and environmental problems (World Vision Australia, 2012). Tourism does not offer job security, especially to those from unorganised sectors, as work may be informal and seasonal, and wages inadequate. Women make up the majority of the tourism workforce,[10] face gender discrimination and tend to

8 A study conducted by the Indian central archaeological department also found out that aircrafts flying over the temples produce a certain level of vibrations which could damage ancient monuments.

9 The Indian National Trust for Art and Cultural Heritage (INTACH) was founded in 1984 in New Delhi with the vision to spearhead heritage awareness and conservation in India.

10 Fifty-four percent of people employed in tourism are women compared to 39 percent in the broader economy (Second edition of the Global Report on Women in Tourism, 6th November 2019).

be concentrated in jobs that pay less than their male counterparts. Local communities are often not consulted, and their opinions and perspectives are not considered in developing tourism policies and plans.

Tourism harms the environment through increased pressure on the ecosystem's carrying capacity. There is sometimes large-scale deforestation, shrinking and repurposing of agricultural land, increased transport and construction activities, a greater generation of waste, and depletion of valuable resources due to increased tourist flow.

While the tourism industry has huge potential to positively impact children's rights to education, health and wellbeing, the growth of the industry has also resulted in increased child labour and sexual exploitation of children.

Children and tourism: India and Madhya Pradesh perspective

The growth of the tourism industry and the quantum of stakeholders dependent on it directly or indirectly, have not been matched with adequate focus and measures for child protection.[11]

Vulnerable children and their families, who live in or migrate to tourism destinations to make a living, end up working in the industry in conditions that are unsafe or harmful. Furthermore, children earning money from tourists are less likely to go to school and are vulnerable to exploitation, including sexual exploitation and abuse. Lax or non-existent protective mechanisms make children more susceptible and an easy target for paedophiles.

Madhya Pradesh's record concerning child safety has been dismal. The Ministry of Statistics and Programme Implementation's 'Children in India 2012 – A Statistical Appraisal' (October 2012), presented a grim picture of the status of India's children. As per the report, there was a 24 percent increase in reported crimes against children in 2011. Uttar Pradesh registered the most crimes against children at 16.6 percent followed by Madhya Pradesh and

11 According to the International Labour Organization, there are 13-19 million children working in an occupation tied to tourism – from selling goods on beaches, acting as informal guides, carrying the luggage of holidaymakers at transportation hubs or working as waiters in local restaurants. Child labour, however, also exists in associated industries such as contracted services and food sourcing. The tourism industry in many cases is unwilling to acknowledge that children in tourism destinations are victims of abuse.

Delhi. A large proportion of the victims were girl children.

EQUATIONS interventions in child protection and tourism span over eight states and 15 tourism destinations. The intervention in Khajuraho illustrates how stakeholders and service providers were able to work together to keep the children there safe.

The intervention

To return to our story, the report on sexual exploitation of children in Khajuraho was shared through a consultation in the city with stakeholders ranging from representatives of hotel associations, guide associations, transporters associations, vendors, local government representatives, police and media. The study created a controversy among stakeholders, who were unable to accept the prevalence of sexual exploitation of children in Khajuraho.

However, a few months after this event, in December 2014, the rape of a child shook Khajuraho. Tourism stakeholders shut their businesses for a day and protested before the police headquarters insisting that the perpetrator be identified and brought to justice swiftly. This incident proved to be the tipping point as it enabled initiating parties to build relationships with the community and other stakeholders.

Theory of change: intuitive, flexible, and organic

Unlike most grassroots programmes, which required a logical approach and multiple steps in addressing an issue, the processes of change for a research and advocacy organisation are complex. The approach evolved organically in response to the opinions, perceptions and vested interests of communities and the stakeholders in the tourism industry. It also resonated with and reflected the EQUATIONS approach in achieving the goal of equitable tourism. The framework positioned the community and local service providers as the fulcrum, which drove action with EQUATIONS and partner NGOs. This meant using subtle pressure on local authorities, the tourism board, law enforcement and legal agencies, and government departments.

The iterative process

The goal was to ensure that child protection was an integral part of tourism discourse. The process used was iterative, which involved the practice of

building, refining, and improving the initiative over a period of time. There was no prefixed trajectory of activities – it grew and developed along with strategies and was revised based on inputs and experiences of communities, service providers and stakeholders.

a. Response to naysayers

In 2015, the initial negative reactions from stakeholders and service providers and indifference and apathy from authorities proved to be a major roadblock to child protection. EQUATIONS was quick to rethink its strategy and responded in several innovative ways.

i. **Provided community members space and time:** Vast experience in dealing with communities, helped the NGOs understand the reasons for hesitancy and disbelief. They examined each barrier with an open mind and creatively came up with ways to overcome them.

ii. **Deleted names of communities mentioned in the report:** The report on child exploitation in Khajuraho had included the names of certain communities which engaged in child trafficking and prostitution. They were removed at the request of the community and service providers.

iii. **Use of government data:** It was decided to only utilise data from Childline and other government surveys that were in the public domain.

iv. **Utilised local influencers as agents of change:** A key initial step was to engage in discussions with local guides and other respected members of the community who were part of the local tourism industry in Khajuraho. Two guides, Mamaji and Gautam Balbir, who had worked in the industry for several decades and were figures of authority among the guide community, were able to persuade the guide associations to engage in a dialogue with the NGOs.

> *Children are our present and future. Tourists are welcome but travelling child sex offenders are not welcome to our place. We will act collectively to ensure Khajuraho is safe for all children — residents, migrants, tourists.*
>
> **- Mamaji, senior tourist guide in Khajuraho**

b. Dialogue with the community and service providers

In 2016, the nascent multi-stakeholder platform initiated a dialogue, facilitated by EQUATIONS and partner NGOs, with various stakeholders on the importance of developing a protection net for children in Khajuraho with an emphasis on their roles and responsibilities. After a year of

Figure 3: *Awareness workshops with service providers in 2015 (EQUATIONS)*

constant dialogue with various groups, a meeting with representatives of the Guide and Hotel Owners' Association in Khajuraho, was held in 2017.

c. Awareness sessions regarding child sexual abuse

The preliminary discussions were designed to make the community feel comfortable around the narrative of child sexual abuse and exploitation, and to acknowledge its existence. The discussion initially focused on the participants' understanding of what child protection meant to them. Most of the stakeholders were of the erroneous opinion that child protection encompassed only education, health, food and shelter. Child rights and the issue of sexual abuse and exploitation as issues of concern were not mentioned.

The process of demystifying child protection began with a focus on the rights of children. Knowledge and skills for personal safety were imparted, and stakeholders were familiarised with the dynamics of child sexual abuse. Concepts of safe childhood, the various forms of exploitation, and the need for a safe and secure environment for children were discussed. Case studies of sexual exploitation of children in travel and tourism from across the country were also shared. These discussions helped make

them understand that this was not a phenomenon unique to Khajuraho, but was prevalent across tourist sites in India and abroad.

d. Awareness workshops on child protection

Conversations were held to test the waters and the willingness of stakeholders to build an enabling environment for children. Initial efforts by the NGOs had prompted an internal discussion amongst the tourism service providers (guides associations) and other key influencers. The registered Guide's Association was willing to work with the initiators of the intervention.

In December 2017, additional orientation meetings and awareness workshops were conducted with individual stakeholder associations to provide an overview and the role of stakeholders in taking preventive child protection measures.

After a consensus-building process, the service providers were ready to embrace the process, securing the safety of children and preventing child exploitation and abuse in Khajuraho.

Several stakeholders, such as transporters, hoteliers and homestay owners were afraid to confront or report abuse as they risked losing income. So, their reputation was factored in and stressed upon to ensure accountability. A key aspect of the programme was to educate them that child protection is an essential component of ethical business practice.

Efforts were also made simultaneously to work with the unorganised sector and guide associations. A wide range of tourism service providers such as homestay and eatery owners, auto and taxi drivers, beach vendors, tourist guides, priests, horse-cart owners, boatmen and cameramen, among others, were trained. Educating school authorities and teachers on child sexual abuse and identifying abuse was also important. Training was also provided to non-profits that focused on child abuse, but lacked the awareness to address child protection through tourism.

Building relationships with government authorities and institutions

The Madhya Pradesh Tourism Board was one of the organisations to come on board due to the active interest and cooperation of the Regional Manager, Manoj Singh. He was able to connect the collaborating NGOs to various government agencies. Police became an integral part of the process. They also engaged with the child protection system of the government and its many actors – the District Child Protection Office (DCPO), the National Commission for Protection of Child Rights (NCPCR), and the Child Welfare Committee (CWC). Thus, a safe and positive ecosystem emerged with the collaboration of various government departments, who worked in tandem with service providers on the ground.

Educating primary stakeholders on rights

An integral component of the programme was to engage with the local communities, families and children who were part of the local tourist economy. With the service providers acknowledging and accepting the existence of sexual exploitation of children, the first step was to identify and connect with the most vulnerable communities by forming children's groups and activity centres. This was done with support from ADHAR and other local non-profits. With children, the focus was on helping them understand their rights and imparting the knowledge and skills to address the problem, if they or their peers were impacted. The programme also ensured that the child was schooled in contacting Childline services and lodging a complaint with the police. An interface was created between the local law enforcement agencies and children, where the police interacted with and participated in awareness sessions. With this, an important stumbling block was removed. Children who were unsure and reluctant to approach persons in positions of authority, due to fear of being reprimanded or not believed, now take the initiative to do so.

Figure 7: *Interactive sessions with children, educating them about their rights in 2015 (EQUATIONS)*

An important stakeholder group was family members who were reluctant to lodge a complaint and often blamed their child when abuse occurred. Youth and local leaders were used as ambassadors to sensitise families and the community regarding trafficking and abuse and trained them to identify potential warning signs and report the crime to authorities.

> *We believe protecting children from exploitation is our duty. We do not want our services to get a bad name. We joined hands with this organisation to strengthen our action and to train our members on… the role that we can play as part of our work.*
>
> **- Gautam Balbir, senior tourist guide in Khajuraho**

Role of stakeholders in spearheading the initiative

EQUATIONS has always played the role of a facilitator and is keen that communities and stakeholders take ownership of the intervention. The community and service providers were allowed the space to develop and drive the child protection intervention relevant to their communities. External support from the partner NGOs was only used to facilitate and support the stakeholders. When community members see the value of interventions, they take ownership and sustain the initiative. And so it was with stakeholders, who began this journey with scepticism and unwillingness to accept the incidence of child exploitation, but soon became

the flag bearers of child protection and agents of change in Khajuraho. The multi-stakeholder platform brought together representatives from different interest groups to discuss shared challenges and actions concerning not just child protection but also provided them with the leverage and legitimacy to address issues that impacted service providers from the unorganised sector.

Impact

Individual level:

Children and youth realise their rights and act as peer educators

With exposure to prevention training, children were able to learn and identify potentially abusive situations and were reassured that they were not to blame. The intervention made them aware of the various forms of sexual abuse and self-protection skills. Most importantly, it taught them to recognise and identify a potentially abusive situation. Children were encouraged to confide in their parents or other trusted adults. They were able to resist advances and report them to authorities. They also served as peer educators and were able to sensitise their friends about child sexual abuse and exploitation. Most importantly, trust was built between them and adults and other stakeholders in positions of authority. They were able to approach the police and report the incident without fear of being disbelieved or ignored.

Figure 4: *Himanshu, a youth volunteer, at the UNCRC discussion on child protection, which was conducted in Geneva in Switzerland in 2018 (EQUATIONS)*

Youth were mobilised to act as intermediaries between children and stakeholder groups and played a key role in reporting incidents of abuse. They also worked with the police to report drug peddling. They scouted locations that were likely to be used for prostitution and sexual abuse and ensured proper street lighting in the areas. They also advocated for a playground for migrant children and ensured that all children, irrespective of their caste, were treated similarly and not made to do menial jobs in schools.

A champion from the Madhya Pradesh Tourism Board

In late October-November 2017, a champion was found in Manoj Singh, Regional Manager of the Madhya Pradesh Tourism Board. He was keen to rid Khajuraho of child sexual abuse and expressed his willingness to help. He provided venues for awareness sessions and training of private sector stakeholders and participated in these sessions. He volunteered to speak to local children about the risks and threats of contacting and interacting with tourists. Singh also advised on approaching the government and helped install several Childline and child protection messages on the signboards along the roads and in public spaces, which are under MP Tourism's jurisdiction.

Community level:
Formation of a multi-tier multi-stakeholder platform

In 2018, a multi-stakeholder platform was formed to address child sexual exploitation and abuse. These included local administration, NGOs, representatives of varied tourism service providers, police, the department of tourism, youth and community representatives, local transport associations, and street vendor associations.

Local community stakeholders had the authority and ability to engage with varied groups of service providers and stakeholders. They were able to prioritise goals and targets relevant to local conditions and develop creative and community-appropriate solutions. The platform helped them acknowledge the correlation between their lives and occupations. They now had the potential to leverage a range of resources around a particular issue;

create innovative approaches from the diversity of the contributions and tackle complexity and implement changes. The multi-stakeholder platform garnered support for street vendors when they were displaced from their usual place of business. This resulted in the demarcation of space in the market for street vendors.

Tourism providers become enablers and change agents

Stakeholder meetings and awareness workshops led to service provider associations acknowledging and accepting the incidence of child sexual abuse. The Darohar guides association took on the responsibility of contacting the government bodies (panchayat, the local government and the sub-divisional magistrate) to inform them about the initiative. The service providers also requested the police to provide permission to display information/awareness materials on child protection in the form of posters and pamphlets in public areas such as railway stations, bus depots, airports, and the entrances of temples. In April 2017, a campaign to address child protection was developed in conjunction with all stakeholders. Material on child protection and the contact numbers were shared during the Khajuraho Dance Festival in 2019 by members of the platform.

Hoteliers and homestay owners became enablers of change. Hotels put up signs and messages about child protection in the reception areas (April 2018), while car drivers and auto drivers pasted stickers on their vehicles on child protection (June 2018).

Auto and car drivers and tourist guides, among others, reported suspected cases of child sexual exploitation by tourists. They helped with identifying hotels that were used for sexual exploitation and even helped authorities rescue children from these hotels. An action plan was developed in conjunction with the transporters and the law enforcement agencies to identify hotels that enabled the sexual exploitation of children and adults.

In May 2018, two luxury hotels that were part of the sensitisation workshops recruited four girls who were victims of commercial sexual exploitation in their housekeeping department, after training them for

three months.

> *When we first met this organisation, we did not think that guide association can play any role in addressing the exploitation of children. But as we started to discuss the matter among ourselves, we felt that the association could play an active role. We convinced hotel association members and the auto association, and invited EQUATIONS to conduct orientation sessions for tourism service providers on their role to address the exploitation of children in travel and tourism. Gradually, we prepared guidelines and a charter to act as a collective in Khajuraho.*
>
> **- Anurag Shukla, senior tourist guide in Khajuraho**

Systemic level:
Accountability from government agencies and local authorities

Collaborations were developed with various government departments to break the silence around sexual abuse and generate political and popular momentum to address the issue. In 2018, the Collector began to conduct quarterly meetings on child protection to ensure that all protocols and rules concerning child sexual abuse were being followed and that departments such as the Ministry of Women and Child Welfare and the Madhya Pradesh Tourism Board were collaborating with child protection and law enforcement agencies to prevent, report and address the commercial sexual exploitation of children. Legal agencies, like the district judge, also conducted meetings every three months to check if cases in Khajuraho were getting attention. Childline[12] was also started in 2018 in Khajuraho with ADHAR acting as a Childline sub-centre for Khajuraho and the Chhatarpur region.

12 CHILDLINE is a national, 24x7, emergency, free phone outreach service for children in need of care and protection, linking them to long term rehabilitation. Any child or concerned adult can call 1098 to access the CHILDLINE services any time of the day or night.

> *All of us have played a part in ensuring that children are protected in Khajuraho. Even the police and the courts came forward. It only works when all the departments and those who are working on the ground take an interest.*
>
> **- A senior guide in Khajuraho**

The local administration issued orders to all accommodation units in Khajuraho and tourism service providers to adopt and implement a child protection policy. They also ensured that the tourism operator, service providers, and accommodation units were following a reporting mechanism (quarterly meeting with the local administration) to ensure accountability.

The private sector (hoteliers and travel agencies) adopted and demonstrated 'zero tolerance' towards commercial sexual exploitation of children and integrated child protection mechanisms as part of their operations.

A survey was also conducted on the impact of COVID-19 on vendors and shared with the local government authorities. This has resulted in the registration of some of the vendors for job cards.

Replication in other states

EQUATIONS's work in Khajuraho, in collaboration with local organisations, resulted in building stronger communities and local-level support systems for preventing any form of child exploitation in travel and tourism. It ensured the institutionalisation of the guidelines on child protection for all tourism operations in Khajuraho. The same process is being replicated in Bihar, Odisha, Karnataka, and other locations at the Indo-Nepal border.

Developing resource materials on child protection

A toolkit, 'Bridging the gap'[13] was prepared and rolled out in late 2019 to support service providers to enhance their work with children who are at risk of, and/or affected by sexual violence, abuse, and exploitation, and their families and communities. They also developed a manual on Women in Tourism and Safety and conducted training on POSH[14] in collaboration with the Tourism Department of Madhya Pradesh for Hotel Employees. Madhya Pradesh Tourism Development Board and West Bengal State Commission for Protection of Child Rights adopted EQUATIONS' Child and Tourism campaign kit as part of resource materials for organisations and government departments.

An article on the sexual exploitation of children in travel and tourism was contributed to the first thematic report of the Special Rapporteur on the Sale and Sexual Exploitation of Children. A paper was also presented on the multi-stakeholder approach to address child protection in travel and tourism at the ITB – Singapore.[15] This resulted in engaging with the tourism professionals' network in India to orient them on the actions that the tourism industry can take to ensure that tourism services and facilities are not being misused by travelling child sex offenders.

13 Down to Zero network and ECPAT Netherlands

14 Prevention of Sexual Harassment

15 The ITB is the world's largest tourism trade fair. The companies represented at the fair include hotels, tourist boards, tour operators, system providers, airlines and car rental companies.

Ripple effect: From child protection to equitable tourism measures

Formation of the Homestay Owners Association in Madhya Pradesh

The registration of the Basera Homestay Owners Association at the end of January 2021 was a successful outcome of the meeting with members in December 2020. The body now strengthens its efforts through joint marketing and business promotion activities. In addition, as a group, they are in a better position to negotiate with customers and other stakeholders. Basera also trains its members on safety measures for women and children.

Collaboration between stakeholders during the pandemic

During the COVID-19 pandemic, the multi-stakeholder platform helped ensure that unorganised tourism workers and vulnerable communities did not starve or lose hope of restarting their lives. Essential food items, protective hygiene kits, and menstrual kits for adolescent girls were distributed. Families with infants received milk powder. This was done with the help of the volunteers of partner organisations. In Khajuraho, during the initial days of the lockdown, volunteers from ADHAR and guide association members distributed groceries and sanitation kits.

The local administration recognised tourism workers and ensured that they received social security benefits and a legitimised space for vending. The network played a key role in rejuvenating domestic tourism and ensuring safety and hygiene in accommodation units and restaurants. Restructuring of tourism services was initiated. The local administration is working on providing certification for small and medium tourism enterprises to restart tourism with guidelines on hygiene, waste management, water usage and other practices to ensure sustainable practices. Street vendors in Khajuraho have been mobilised to ensure that they are registered for the SVANidhi scheme. The platform has facilitated the registration of E Shram Cards for unorganised labourers in Madhya Pradesh to ensure they are eligible for social security schemes. The government mobilised youth and volunteers to encourage community members to get vaccinated during the third COVID-19 wave.

Empowering local women of Khajuraho

In 2019, women, who are mothers and spouses of those engaged in the tourism industry, expressed their intent to come together as a group and engaged with EQUATIONS to discuss their needs and aspirations. In December 2021, EQUATIONS conducted an exercise on gender mapping to understand women's knowledge and awareness about safety and its implications. Seventy-five women came together and discussed issues of access, safety and negotiation about tourist spaces in Khajuraho and the implications of spaces being gendered as opposed to neutral and the occupation of these spaces and how unsafe spaces can be negotiated. At the Khajuraho Dance Festival held in February, the women came together to sell local cuisine. Their interactions have empowered them and many of them have registered with the MP tourism board to get trained as cooks and confectioners, guides, security guards, e-rickshaw drivers, etc. and enabled them to be part of the tourism ecosystem services.

Learnings and the way forward

Through its previous experiences with child protection programmes in Goa, EQUATIONS was aware that the intervention process can be complex and difficult to pre-plan. Unless community members and their leaders are involved from the planning stage, ownership and sustainability of such interventions remain unsustainable.

The approach involved creative and innovative solutions that could dovetail with the problems. The multistakeholder platform was a decentralised mechanism that enabled the community and those invested in local tourism to take ownership of decisions that impacted them. Child protection served as the trigger to coalesce communities around common interest, but this soon multiplied into a network that came together to tackle sustainable development problems linked to tourism. Thus, EQUATIONS and partner NGOs were able to decentre themselves and the locus standi therefore rested with the people.

The platform initially focused on child protection and making Khajuraho a safe space for children, but evolved into social engagement and change as well. During COVID-19, several activities were set up that were beneficial to the community. They were able to convince the Subdivisional

Magistrate to provide a safe space for migrant children and their families. They were also able to support schools by providing drinking water via tankers and relief items to migrant families. The platform blossomed into a productive collaboration that addressed larger issues of the tourism and development landscape.

Meetings were held with members of the platform (guides, auto-rickshaw drivers and homestay owners) to understand their perspectives on rethinking tourism. This resulted in developing a cultural map of the town and the attractions around it. The map enabled the stakeholders, irrespective of their identity and position, to become a contributing and important voice in tourism renewal and development. They played a key role in curating tourism experiences that were innovative and participative. In 2022, EQUATIONS was in the process of conducting a study in Khajuraho to analyse the impact of their work on child security. It continues its engagement with the stakeholder groups, while government agencies provide support.

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HEALTH

HEALTH

For an underweight baby battling the odds to survive or for a daily wage worker with a persistent cough, the key to recovery is easy, accessible and prompt healthcare.

Similarly, for women facing domestic violence, to be able to access help and counselling at the doorstep can be a gamechanger.

The three case studies in this section demonstrate the importance and effectiveness of collaboration between existing government mechanisms and innovative civil society interventions in achieving this.

In Karnataka, a protocol laid down to encourage mothers to hold their babies in a warm skin-to-skin embrace, akin to the kangaroo, has given underweight newborns a fighting chance of survival.

In Mumbai, a unique public-private partnership for early detection of tuberculosis has helped the worker with a nagging cough and many more like him, whose first recourse to treatment would have otherwise been an expensive private health facility.

And in Gujarat, the training of ASHA workers to help identify cases of domestic violence in rural homes has given many women access to counselling and also changed the status quo in their homes.

At least 25 percent of India's newborn babies weigh less than 2,500 grams. They are tiny, fragile, and prone to illnesses that could lead to death.

In Karnataka's Koppal district, non-profit KHPT introduced the kangaroo mother care method – a low-cost, low resource method first suggested by two pediatricians in Colombia in the 70s – that gave these babies a fighting chance to survive.

The uptake was slow but steady and then Renuka and her triplets arrived. She celebrated the first birthday of her children with the hospital staff and became a brand ambassador for the seemingly simple intervention with a big impact.

In a different rural landscape in the Patan district of Gujarat, the Society for Women's Action and Training Initiative (SWATI) realised that women in villages who are survivors of domestic violence face unique challenges in accessing help.

They trained ASHA workers to identify and suspect zero in on suspected domestic violence based on health and social symptoms they see during monitoring visits, with data for the last two years indicating the effectiveness of the strategy.

In bustling Mumbai, PATH set up a mechanism to include private doctors, chemists and laboratories in achieving the goal of universal access to tuberculosis treatment.

The public-private partnership enabled private medical practitioners to ensure early and accurate diagnosis of tuberculosis, and provide prompt treatment. It enabled residents to access the nearest clinic, instead of taking time off from work and queueing up at already stretched government facilities.

Interventions by the three organisations featured in this section are testimony to the effectiveness of simple ideas, collaborations and need-based approaches to better healthcare and wellbeing.

VI. Rural Model for Health Sector Response to Domestic Violence

Society for Women's Action and Training Initiative

Abstract

Society for Women's Action and Training Initiative (SWATI), a Gujarat-based NGO, has over 20 years of experience working with rural women to prevent violence against women (VaW). It has been SWATI's experience that rural women who are victims of violence face different challenges in accessing help. Hence, the rural model for the health system response to VaW needs a different approach. To address the issues of mobility and anonymity, the rural model must actively involve the community-based Accredited Social Health Activist (ASHA), the sub-centre, primary health centres, and referral hospitals at the taluka and district levels so that women have access to a support cell at the hospital. As a part of this initiative, SWATI established violence prevention and support cells in three tertiary care hospitals in Patan district with permission from the Gujarat government. In the model, ASHAs are trained to suspect domestic violence based on health and social symptoms they see during monitoring visits. Data from June 2020 to May 2022 suggest this is an effective strategy that facilitates early detection and referral of survivors of violence. Over the period, the effectiveness of referrals by ASHAs has increased, suggesting the model is sustainable.

Introduction

Health symptoms of domestic violence

Shanti[1], a 28-year-old mother of two daughters, was pregnant with her third child when she visited the counsellor at a sub-centre (SC) in May 2022. She was referred by Ramilaben, an ASHA[2] who had been monitoring the health of women and children from 150 households in Shanti's village for over a

1 All names used in this chapter have been changed to ensure confidentiality of survivors and ASHAs

2 Accredited Social Health Activist, a frontline outreach worker with the Department of Health and Family Welfare, a part of India's National Rural Health Mission

decade. During her visits, Ramilaben noticed that Shanti looked stressed, pale and appeared to have lost weight. Shanti refused to tell Ramilaben what was bothering her and the ASHA suspected domestic violence. She referred Shanti to the SC in the village where Shanti met the counsellor from the Mahila Sahayta Kendra[3] (MSK) located at Dharpur GMERS Hospital. The counsellor found out that Shanti's family wanted a son and blamed her for giving birth to daughters. Shanti did not want this pregnancy. She wanted a good future for her daughters but her husband did not understand her.

The counsellor explained that genes from the father determined the sex of the child. She also reassured Shanti that if she so wished, the counsellor would help her communicate her desire for contraception to her husband and parents-in-law. After several follow-ups in-person and over the telephone, the counsellor facilitated meetings between Shanti, her husband and her mother-in-law. The counsellor explained the adverse effects of repeated pregnancies on Shanti's physical health and the harassment for a son on her mental health. In the counsellor's presence, Shanti spoke about the emotional violence she had been facing and conveyed her desire to use contraception. The husband eventually agreed to contraception and after the birth of their third daughter, Shanti underwent tubal ligation — surgery for female sterilisation. Ramilaben has been closely monitoring Shanti's health and that of her baby.

Ramilaben is one of the 144 ASHAs from Patan block of Patan district in northern Gujarat who were trained by Society for Women's Action and Training Initiative SWATI,[4] a Gujarat-based organisation, as part of the initiative to develop a model of health sector response to VaW in rural India.

Pressing need for a rural model

It has been SWATI's experience that in sparsely populated and distantly located rural areas, women victims of violence face challenges that are different from the ones experienced by urban women. Hence, the rural model for a health system response to VaW requires a different approach. The model must also involve all tiers of the public health system and healthcare providers, right from ASHA at the community level and the providers from the SC to the primary health centre (PHC), the community health centre (CHC) and referral

3 Violence prevention and support cell managed by SWATI, located at the hospital

4 http://www.swati.org.in/

hospitals. This referral system helps women access hospital-based violence prevention and support cell. Barriers such as lack of anonymity and social taboos that prevent rural women from seeking violence prevention support from formal institutions are overcome through the upward referral chain. This model has components common to other models and some that specifically respond to the needs of rural survivors.

In rural Gujarat, SWATI initiated the violence prevention and support cells known as MSK at the hospital level, worked towards creating a referral chain and employed sustained measures for the generation of awareness among the community.

The present case study describes SWATI's experience of developing the model and results obtained over the two years in one block of Patan district, where 144 ASHAs were trained to recognise domestic violence based on the health impact it has on women.

SWATI's journey thus far

Establishment of a community-upward referral system through ASHA and SCs is a culmination of SWATI's work over the past 20-plus years with rural women. Over a period, the work has evolved from organising women into Mahila Nyaay Panchayats (MNPs)[5] to strengthening the public health system response to VaW through hospital-based MSK and an upward referral chain involving ASHA.

The first MSK was set up at Radhanpur block in Patan with permissions from the state government. The MSK was to be run jointly by the hospital and SWATI staff, with the hospital providing space and SWATI providing training to the staff. Launched on July 10, 2012, it is the first-of-its-kind initiative in

5 Mahila Nyaay Panchayat (MNP)
The women members of the MNPs were oriented to laws pertaining to women and equipped with counselling and mediation skills to support women survivors of domestic violence. The MNPs also functioned as a local support system for women survivors by helping them escape violent homes when it threatened their lives, offering them shelter at the community level till alternatives could be worked out and by accompanying them to other support services such as the hospital, police station or the court. Through these interactions with the courts and the police, the SWATI team realised the injustice survivors had to live with. This was because of poor documentation at the healthcare facilities, which in turn, was a result of the doctors' lack of awareness of their role in responding to survivors of violence.

the state of Gujarat and perhaps the first formal, rural health system initiative in the country, jointly undertaken by the Department of Health and Family Welfare, Government of Gujarat, and an NGO specifically working on issues of violence against women and health.

It took SWATI almost three years to establish the Radhanpur MSK. However, in 2016, MSKs were established at two other referral hospitals — General Hospital, Siddhpur, and the GMERS Medical College and Hospital, Dharpur.

SWATI then focused on the systematic development of an upward referral chain as one of the strategies for early detection and referral of violence victims. Community-level screening by the frontline health worker — ASHA — is integral to this chain. The inclusion of domestic violence against women as one of the health issues into the guidelines and manuals for the ASHA (2015) provided legitimacy to this initiative.

Box 1: Training of ASHA

Objective

- To recognise links between health symptoms and domestic violence
- To understand an ASHA's role in responding to women survivors of domestic violence

Duration

- 7 hours

Contents

- Violence as a health issue
- Links between health symptoms and domestic violence
- Health system response to women survivors of violence
- Role of ASHA in health system response to VaW
- Empathetic communication
- Referral pathways to MSK

SWATI, with permissions from the Chief District Medical Officer, trained ASHAs from Patan block. It helped ASHAs recognise health symptoms noted during routine monitoring visits as the possible impact of domestic violence (DV) against women (Box 1).

SWATI's initiative was validated by the recognition of gender-based violence as a public health issue by the National Health Policy (2017) and emphasis on the need for treatment with dignity to women survivors of violence in public sector healthcare facilities.

By the first half of 2017, ASHAs from all six PHCs from Patan block had been oriented to domestic violence as a public health issue. They were asked to refer women suspected of facing such violence to the MSK at Dharpur Hospital. The counsellors also guided ASHAs in communicating with women in a non-threatening way about their experience of domestic violence. The counsellors followed up with ASHAs regularly and conducted refresher training courses. These interactions helped the counsellors establish rapport with ASHAs and do follow-ups on women they referred but did not reach the MSK. The counsellors would ask the ASHA to continue to monitor the women for the effects of violence. Initially, ASHAs referred only those women who would open up about domestic violence before a counsellor. Often, these women were victims of severe physical violence, had social symptoms of violence such as desertion, or had severe health consequences and had made up their minds about seeking help to escape the violence. Associations between common health symptoms and the experience of domestic violence were still secondary for the ASHAs.

Group discussions with ASHAs from Patan block, conducted six months after orientation training, showed that most ASHAs still regarded domestic violence as a social and personal issue (Box 2).

Box 2: Salient points from group discussions with ASHAs from Patan Block

Awareness of domestic violence or DV

- Initially, ASHAs denied cases of DV in their work area. Subsequent discussion revealed they were, in fact, aware that women from their area were beaten up by husbands or in-laws, often during pregnancy, blamed for the birth of daughters and emotionally and physically harassed. They also mentioned discrimination between a son and a daughter to be a form of violence.
- Initially, most ASHAs believed intervention was necessary only when victims of domestic violence could not protect themselves. Towards the end of the discussion, most participants agreed that all victims of

domestic violence needed to be supported because of the long-term impact on women's health. Thereafter, some agreed to refer them to the MSK.

Examples of cases shared by ASHAs

- A woman had to go through repeated pregnancies and abortions because her husband suspected her fidelity and did not want her to use contraception. Every time she became pregnant, he would purchase abortion pills from a private pharmacy and insist the woman abort at home. The ASHA was aware of at least four occasions when this took place and the toll it took on the woman's health, but had not intervened.
- When a pregnant woman was diagnosed with malaria, an ASHA perceived a threat of a miscarriage and intervened by confronting the reluctant family members to ensure that the woman received treatment at the PHC. She threatened the family members with a police case if the health of the woman or her child was compromised.

The pattern of weekly follow-up meetings at PHCs, quarterly refresher trainings and telephonic follow-up with ASHAs continued till 2020, once the pandemic hit.

During the pandemic, the healthcare system was focused only on COVID-19 care, and all OPDs were closed to all patients other than COVID-19 patients. VaW was the other pandemic that hit India and the rest of the world. With the shutdown of transport services, the distance to the MSK was a barrier for most women. Hence, counsellors started visiting SCs where they could meet around seven ASHAs from the villages catered to by the SC. Counsellors used the opportunity to interact with ASHAs and reiterate the links between violence (domestic, emotional, sexual, physical and economic) and commonly reported health symptoms such as stress, loss of weight, anaemia, self-neglect, unwanted pregnancies, repeated complaints of aches and pains. The counsellors would discuss ASHAs' work, challenging cases they saw, and explain the benefits of breaking the cycle of violence on women's reproductive health and thus on the indicators ASHAs monitor. At the end of the discussion, the ASHAs identified women whom they suspected could be victims of violence and referred them to the SC, where the counsellor interacted with them. They provided the survivors with health information

and counselled them on positive health behaviour. The contact details of the MSK and the counsellors were shared with the women who admitted to facing domestic violence. In the follow-up visit about two weeks later, the counsellors would call these women to the SC and follow up with them. This developed a relation of trust between the survivor and counsellors, and women sought out the counsellors when violence increased.

The response from ASHA during this period highlighted the importance of SC as a screening post for DV, and the periodic visits to SC were incorporated as a routine activity (Figure 1).

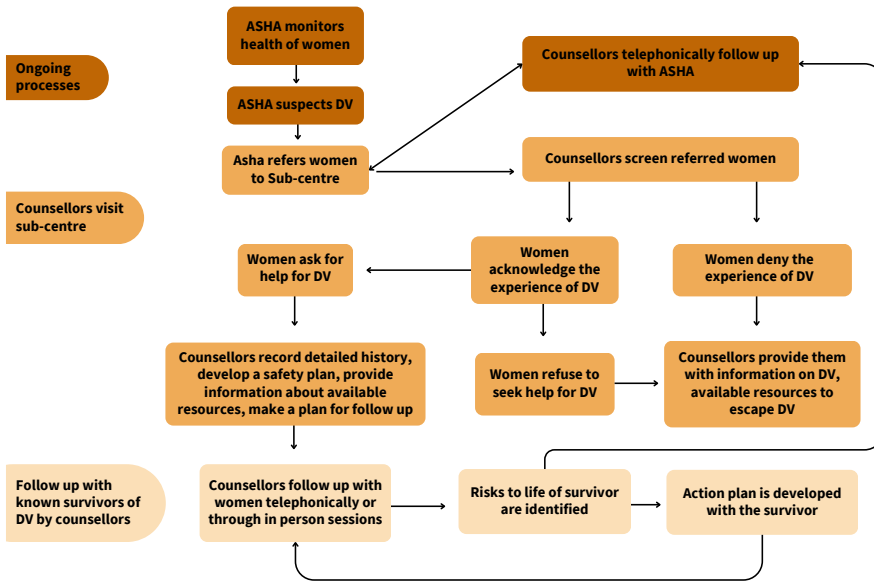


Figure 1: *A diagrammatic representation of ASHA's involvement in providing support to women facing violence*

Reality check

As ASHAs began recognising the link between domestic violence and the health of the women, they started referring cases they believed to be challenging — where the ASHA had been unable to influence health behaviour despite efforts. Rudiben's case was one such instance. Rudiben was 34 years old and refused contraception, fearing the wrath of the community's deity. She had four sons and six daughters and was pregnant, anaemic and frail. An ASHA worker was concerned about her health. Familiarity with local culture

enabled the counsellor to establish communication without threatening Rudiben's religious beliefs. A few sessions later, Rudiben agreed to speak to her husband about contraception and later accepted tubal ligation or TL (sterilisation surgery for women).

> *I did not want more children. Pregnancies were difficult for me, but I was scared of my husband, my in-laws and the community. I feared I would be blamed for bringing misfortune to the family by using contraception. ASHAben used to tell me to terminate the pregnancy and get an operation done; she even scolded me several times. But I really did not know what I could do and I only agreed to meet with the ben from the Mahila Sahayta Kendra because she had come to my village. She told me that I was right in not wanting more children. She also helped me talk to my husband about it and later convinced my mother-in-law as well.*

Rudiben's case proved to be a tipping point, and the ASHAs' faith in MSK increased, as did the number of referrals from ASHAs to the SCs.

Between May 2020 and April 2022, 96/144 (67 percent) ASHAs referred 980 women on suspicion of domestic violence to the SCs when MSK counsellors visited. These women, 579/980 (59 percent), admitted facing violence, and 262/980 (27 percent) sought help from the counsellors to end violence. Pregnancy with one or more health conditions, such as anaemia, weight loss, high-order pregnancy, symptoms suggestive of RTI/STI, anaemia, and mental health disorders, rank high among the symptoms for which ASHAs refer women to the SC. ASHAs also referred women suffering from long-term conditions such as diabetes, hypertension, TB, paralysis, paresis and disabilities, among others.

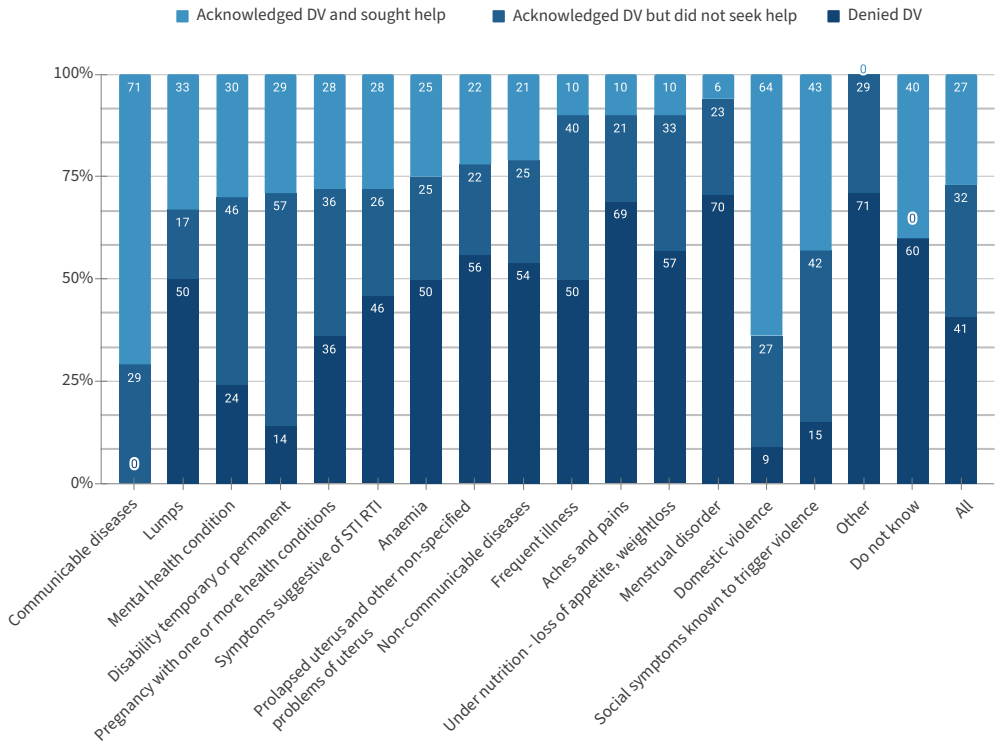


Figure 2: *Proportion of referred women who acknowledged being victims of violence and sought help from MSK for each of the categories depicting illnesses and other concerns*

For each group of symptoms, the proportion of women who acknowledged violence and sought help from the counsellor is presented in Figure 2.[6] More than 25 percent of women referred for chronic conditions, pregnancy with one or more health conditions, mental health conditions, RTI/STI and anaemia, sought help from the MSK to end the violence. The proportion of women seeking help was high among those referred with one or more social symptoms (childlessness, giving birth to daughters, those thrown out of marital homes, etc.) and among women who ASHAs knew to be victims of domestic violence. The efficacy of involving ASHAs for referring women to the MSK counsellors on suspicion of domestic violence was proven.

In SWATI's experience, this pathway has several advantages.

6 Figure 2 is based on data maintained by the MSK counsellors. These are about referrals from ASHA at SC, admittance by women facing domestic violence and subsequently seeking help. Nine hundred and eighty women were referred to SCs over May 2020-April 2022.

Figure 3: *Improved infrastructure has made it possible for MSK counsellors to carry out preliminary enquiries about women's experience of violence while maintaining privacy*

First, because of their presence and work as healthcare providers in villages, ASHAs play a unique role in the process of early detection and referral of survivors of VaW to MSK counsellors. The concept of early detection needs to be understood in the context of the experiences of women survivors of domestic violence seeking help at the hospital-based MSK. These women are largely referred to the MSK by hospital-based healthcare providers who suspect violence based on health conditions. Almost half of these women report health conditions that are serious and life-threatening. Many are destitute — thrown out of marital homes, staying with natal families or other relatives. All these are conditions where the reported distress is much higher, and women are forced to turn to additional survivor support services and the criminal justice system. In contrast, women referred by ASHA to the sub-centre report less severe health issues, are still living in marital homes, and a higher proportion of these cases are resolved through counselling and mediation. For instance, in the case of Shanti, counselling of the husband and influential members of the family helped.

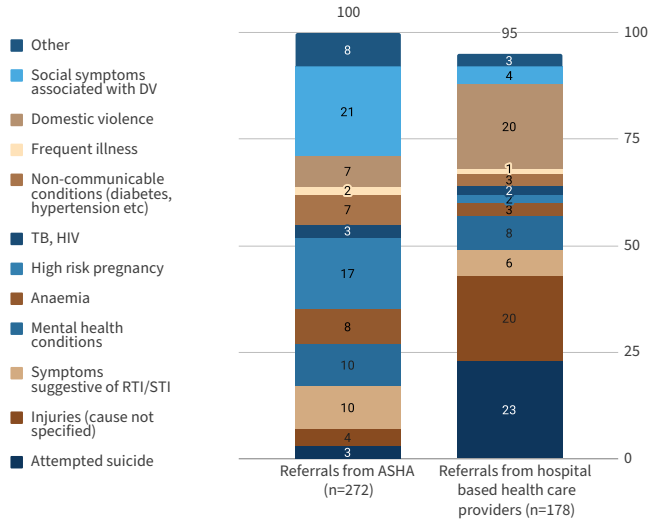


Figure 4: *Concerns among women referred to MSK on suspicion of experience of violence*

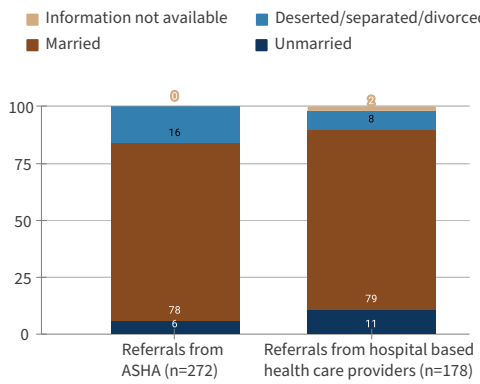


Figure 5: *Marital status of women referred to MSK*

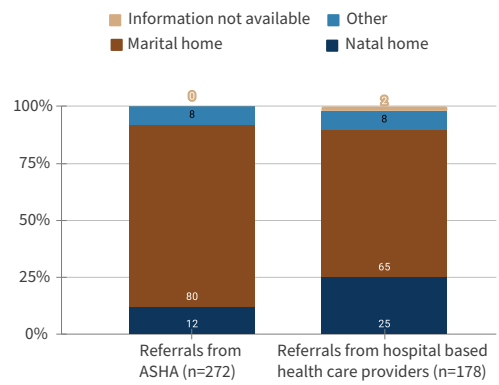


Figure 6: *Residence of women referred to MSK*

Referrals from ASHAs to SCs include women suffering from diseases such as TB and HIV, and those with disabilities, including paresis or paralysis of one or both limbs, which are known to increase the risk of domestic violence. Other referrals include women who were frequently unwell, and those who displayed or reported symptoms such as constantly thinking about or worrying about something, stress, self-neglect, looking unhappy, reluctance to communicate or

Figure 7: *At hospital-based Mahila Sahayta Kendras, survivors are provided counselling, information and referral to other support services*

excessive talking, inability to sleep or excess sleep, uncontrolled anger, etc., all of which are suggestive of common mental health disorders. These indicate increased awareness among ASHAs about the cause-and-effect relationship between violence and health.

Figure 8: *Healthcare facilities are more accessible for women compared to marketplaces or the homes of relatives. A relatively higher proportion of women (compared to those who can step out to go to a market) can reach a hospital for treatment for self or their children without restrictions from family*

Second, violence victims whose mobility is often restricted are allowed to visit the SC for treatment and hence can reach the counsellor. The villages from where ASHAs refer women to SCs are at a distance of 10 to 30 km from the hospital where the MSK is situated. Women find it convenient to seek services at an SC in their village or the next one. Contact with counsellors often helps them seek treatment at the hospital as well.

Third, though some women victims of violence may not want to seek help at that point, they receive validation from the counsellor for the violence they have experienced and are informed about available resources, which they can use whenever they want. The referral to an SC and interaction with the counsellor proved to be a lifesaver for Radhaben.

At the SC, 45-year-old Radhaben accepted that her husband had subjected her to physical and sexual violence, but she did not want to seek help at the time. She was worried about the future of her 14-year-old daughter. The counsellor worked on a safety plan with her, told her to step out of the house with her children if violence escalated, to always keep her

mobile phone with her, and to call 181[7] for emergencies. The counsellor also shared her own mobile number. Over the next seven months, the counsellor made five telephonic follow-ups with Radhaben. At 11 pm one night, the counsellor received a frantic call from Radhaben; her husband had beaten her badly and had threatened to kill her. Fearing for her life, she had escaped from her house with her children and hidden in an isolated location. When she could not reach the 181 helpline number, she called the counsellor to 'take her away from the village and save her'. The counsellor contacted the 181 helpline and facilitated Radhaben and her children's extraction from the village at around midnight. Her husband was arrested and placed in police custody. The next day, the counsellor contacted Radhaben's brother in Mehsana, 46 km from Dharpur. Radhaben chose to relocate to Mehsana and live independently with her children. Her brother supported her decision, helped her find accommodation and a job. It has been over a year and her husband occasionally visits her, but has not beaten her since. The support she received has boosted Radhaben's confidence and resolve to prevent further violence.

> *I did not seek help after I heard of the Mahila Sahayta Kendra. I have a daughter to think about and I was scared as my husband always threatened to harm me if I sought help. He said that even if the police took him away, he would be released and he would come home and kill me in my sleep. I was scared and I also hoped that everything would miraculously become alright and he would stop hurting me. But when he tried to attack me and my children with a sickle, I remembered what Ben (counsellor) had said. I left home with my children, my phone and some money. I knew she would help me so I called her and in my moment of need she supported me.*
>
> **- Radhaben (45), Aabopura**

7 181 Abhayam helpline for women is implemented in Gujarat by the Department of Women and Child Development and the Home Department of the Government of Gujarat.

The fourth advantage is a spill-over effect of sorts that has been observed. With increased awareness about domestic violence and about the availability of help, ASHAs have been referring women who are not their clientele.

Take the case of 45-year-old Rekhaben, who had already undergone TL. The ASHA worker who would visit Rekhaben's mother-in-law, a TB patient who lived across the street, noticed that Rekhaben looked unhappy. Her husband had a short temper. This led the ASHA to suspect domestic violence and help Rekhaben by her mother-in-law.

There is an increase in violence when women suffer from chronic conditions or disabilities. These women are often at the higher end of or beyond the reproductive age group and not among those regularly monitored by ASHAs. But the ASHAs' increased understanding about links between chronic conditions and violence resulted in referrals of women who suffered from conditions such as hypertension. Some of the women referred by ASHAs have in turn referred their relatives or friends from other villages to the MSK counsellors.

With increased awareness about domestic violence and its impact on the health of women, ASHAs have started recognising socially acceptable practices as acts of violence as well. For example, referrals include cases where a young girl is forced into a marriage in the *saam-saata*[8] practice, or where a 20-year-old woman is forced to marry a 60-year-old man.

Box 3: Social symptoms among women referred by ASHA

- Childlessness
- Having only daughters as children
- Widowhood
- Elderly woman neglected by family members
- *Saam-saata* marriage against the girl's wishes

8 *Saam-saata* exists in several communities from Patan where girls are married off to their sister-in-law's (brother's wife) brothers. Marriages are fixed by family elders and consent is not sought. In such marriages, if one marriage breaks – the community insists on breaking the other marriage as well.

Additionally, ASHA continues to routinely monitor the health of these women, and it proves to be a link between the MSK and the survivor while she negotiates for the end of domestic violence.

Challenges before ASHAs

Although ASHAs are confident of the advantages of recommending women survivors of domestic violence to MSK counsellors, there is a possibility that the family of the survivor referred by an ASHA would react negatively. There has only been one instance of this happening.

Kamlaben's niece faced physical violence from her mother-in-law for several years. After one severe episode, she was sent to her parents' home for treatment. The family elders decided to file for divorce. The woman, however, wanted to go back to her husband and requested Kamlaben for help. She returned to her husband's family after several sessions of counselling and joint meetings with her husband and mother-in-law. However, after this, the family turned hostile towards Kamlaben for bringing 'disgrace' to the family. Since then, Kamlaben has stopped referring women to the MSK.

> *"I referred Meenaben to the MSK during her second pregnancy. She was constantly stressed, looked pale, neglected herself, ate poorly, and forgot to take her medicines. I asked her what bothered her but she did not say anything. I then suspected domestic violence because she had a daughter. After she met with the MSK counsellor a couple of times, I noticed a change in her. She started taking care of herself. She would come to me and remind me to give her iron-folic acid tablets. She gained weight as well. In my seven years as ASHA, I have seen many cases like Meenaben whose health deteriorated because they would just stop looking after themselves. I wanted to help, but other than telling them repeatedly to take medicines I could not do anything. Referring them to an MSK is useful as they get the help they need and I get the satisfaction of having provided care."*
>
> **- Bhartiben, ASHA for seven years, Dharpur**

Conclusion: Learnings and sustainability

Suspecting domestic violence based on health symptoms noted during routine visits by ASHAs and referrals to counsellors visiting the SC appears to be an effective strategy to ensure early intervention. As the ASHAs' understanding of the health impact of domestic violence deepened, the proportion of referred women acknowledging experience of domestic violence and seeking help from the MSK increased. Some ASHAs suspected domestic violence more accurately compared to others. Over the study period, 96/144 ASHAs from 72 villages from Patan block referred at least one case. At least 51 percent of women referred by ASHAs from 43/72 villages acknowledged domestic violence.

The data gathered through SWATI's initiative has highlighted the difference in the health impact of violence observed at the level of the community and hospitals. It has also provided evidence of early detection and timely intervention through referrals by ASHAs. This has enabled SWATI to develop algorithms for ASHAs to follow, which are included in a training manual developed by SWATI.

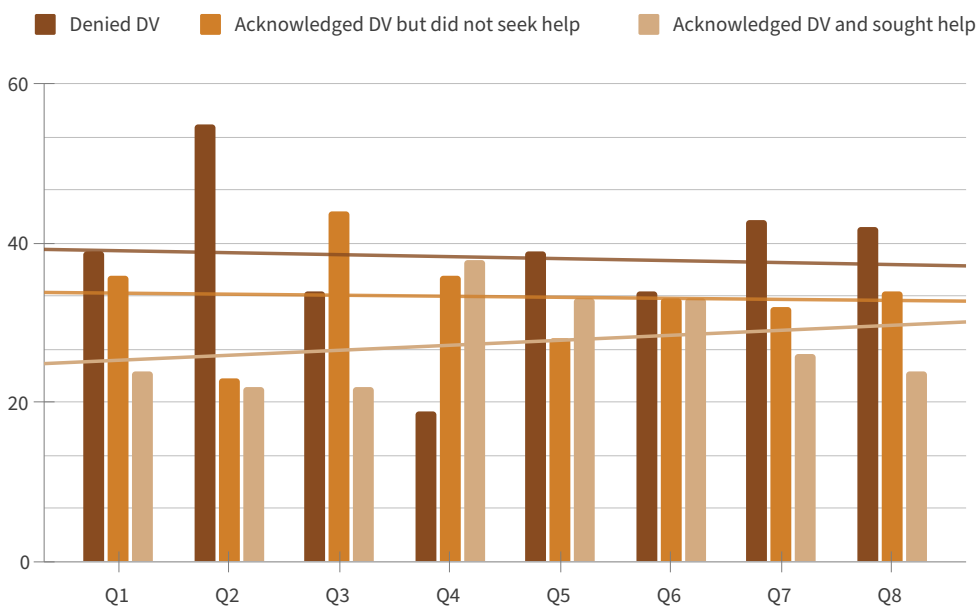


Figure 9: *Proportion of women who admitted facing DV and sought help (May 2020 - April 2022)*

The model developed by SWATI has demonstrated the way to link women victims of violence from the most remote villages to hospital-based violence prevention and support services.

Interactions with ASHAs showed that most of them who referred saw merit in the early referral of suspected cases of domestic violence to the SCs. They believed it helped them achieve better health outcomes for women. ASHAs who refer cases believe this activity to be organically linked with initiatives for the improvement of the health of women.

VII. Kangaroo Mother Care: Accelerating the uptake of a low-cost lifesaving method for low birthweight babies in Koppal district, Karnataka

Vrinda Manocha, Manager- Knowledge Codification and Analysis, Karnataka Health Promotion Trust

Abstract

At least 25 percent of newborn babies in India weigh less than 2,500 grams, which is considered normal weight. These babies are therefore prone to illnesses — respiratory disorders, hypothermia and sepsis — that often lead to death. Kangaroo Mother Care (KMC) is a no-cost, low-resource technique for such babies. A mother only needs to keep her baby warm through skin-to-skin contact on her chest. This, coupled with exclusive breastfeeding, is considered to be a game-changer in neonatal health. If practised in a sustained manner, KMC improves the baby's weight, reduces risk of infections, and neonatal mortality. While it is not a new innovation, KMC's uptake has been limited for decades, despite its immense potential to prevent neonatal deaths, especially in poor and under-resourced areas. Karnataka Health Promotion Trust (KHPT), in collaboration with St John's Research Institute and the Government of Karnataka, conducted a two-year pilot intervention of KMC in Koppal, a high-priority district in Karnataka with poor neonatal mortality indicators. The goal of the implementation research study was to develop a delivery model that would result in high coverage and quality of KMC for all low birthweight (LBW) babies. This case study details the interventions at the facility and community level to ensure maximum coverage of this life-saving intervention.

Introduction

KMC — a low-cost intervention with limited uptake

KMC draws its inspiration from its namesake marsupial from Australia, which delivers a pre-term baby, the size of an INR 5 coin, and places the baby in her pouch in skin-to-skin contact for several months. All the while, the mother

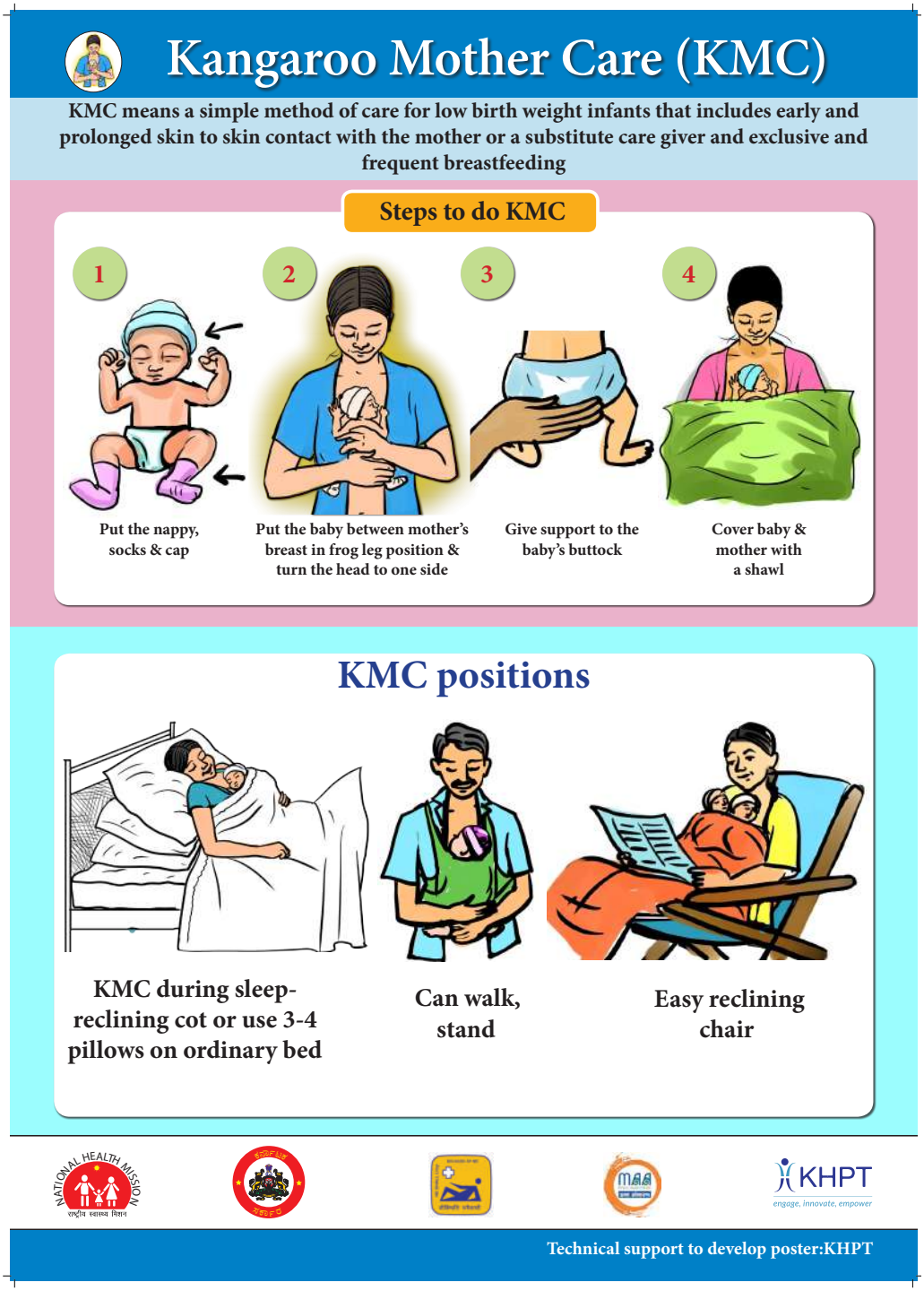


Figure 1: *A quick guide to KMC, through posters developed by the project*

kangaroo nurses the joey on her milk. The joey gains weight until it is ready to leave the pouch and enter the world. The method was proposed by two paediatricians in Colombia in 1978, as a low-cost, low-resource intervention in a crowded maternity care unit, which delivered 11,000 babies a year, several of whom were underweight.[1] Since the 1970s, KMC has been widely studied to show that the relatively simple act of keeping an LBW baby in skin-to-skin contact for prolonged periods of time, coupled with exclusive breastfeeding, can help the baby gain weight, prevent hospital-borne infections, and reduce infant mortality.

What are LBW babies?

Infants are considered to be low birthweight if they weigh less than 2,500 grams at birth. These babies are often born pre-term (before 37 weeks of pregnancy). LBW babies have not yet developed the brown fat that allows them to produce body heat. As newborns are unable to shiver to produce heat, they risk a drop in their body temperature, which can prove fatal. These babies are often unable to feed well and are at increased risk of infections, even later in life.[2]

KMC was introduced in India in 1994, and despite being a seemingly ideal method, especially in rural areas, its uptake was limited. In 2014, the Child Health Division of the Ministry of Health and Family Welfare released operational guidelines for KMC and optimal feeding of LBW infants.[3] The focus was on making KMC operational at health facilities by setting up KMC units near Sick Newborn Care Units (SNCU) at district hospitals. The guidelines provided details on the process, but did not specify how to go about increasing the uptake of KMC. The guidelines also did not mention what would happen after the mother was discharged with her baby, whether KMC was to be continued at home, or the modalities.

1 https://des.karnataka.gov.in/storage/pdf-files/KARNATAKA%20ECONOMIC%20SURVEY%202021-22-M2_ENG_FINAL.pdf

2 https://pubmed.ncbi.nlm.nih.gov/17344508/

3 https://www.nhm.gov.in/images/pdf/programmes/child-health/guidelines/Operational_Guidelines-KMC_&_Optimal_feeding_of_Low_Birth_Weight_Infants.pdf

First steps of the KMC project

KHPT and St John's Research Institute, Bengaluru, collaborated on a two-year implementation research project (2016-2018) to ensure the uptake of KMC in Koppal district, Karnataka. The initiative was supported by the World Health Organization (WHO) and conducted in collaboration with the Government of Karnataka. The project was concurrently implemented across two additional sites in Haryana and Uttar Pradesh in India, as well as in Ethiopia.

Koppal, a district in north Karnataka, lies close to the UNESCO World Heritage Site of Hampi. There are four taluks in Koppal district, namely Kushtagi, Yalaburga, Gangavathi and Koppal. Agriculture and industries such as iron, steel and tourism form the economy of the district.

According to the Karnataka Economic Survey 2021-2022,[4] Koppal ranked 23rd in the state's human development index in 2015, among the bottom five districts in the rankings, which also include Raichur, Kalburgi, Ballari and Chitradurga. Koppal's human development indicators have consistently been below the state's average. According to the National Family Health Survey-5, 54.8 percent of women in Koppal in the reproductive age group of 15-49 years have anaemia, a condition which is associated with pre-term birth and LBW newborns. Koppal, at the time, had a low birth weight prevalence of about 25 percent, with a neonatal mortality rate of 42/1000. The state government had designated Koppal a high-priority district and, in early discussions with KHPT, had suggested that the pilot take place in Koppal.

The project included a three-month research period to identify barriers to the uptake of KMC at the facility and community level, and to develop a model that would be tested in one block and five health facilities to achieve a high KMC coverage (over 80 percent). This meant providing KMC for a minimum of eight hours, with exclusive breastfeeding of babies weighing less than 2,000 grams.

The project implemented three more models and developed iterations for all the health facilities in one block, before expanding to the entire district in the last 12 months of the project period. The study used a mixed-methods design with applied principles of implementation science. Three teams were constituted from St John's Research Institute, Bengaluru, and KHPT: A

4 *https://des.karnataka.gov.in/info-4/Economics+Survey/Reports/en*

Program Learning team for formative research, an Implementation Support team and an Outcome Evaluation team.

"Interestingly, the project did not exactly have a Theory of Change when it started," says Arin Kar, currently Monitoring Evaluation Research and Learning Lead (MERL) at KHPT, who headed the project and KHPT's research activities. The donor (WHO) said, "We don't know enough about KMC in Koppal. Go find out". So we had a formative research period, where we tried to understand the gaps in the facilities, in the health system. We tried some pilots at that stage based on the research that we had, and then had multiple cycles of model development."

In the formative phase, the teams spoke to mothers, frontline workers, and healthcare providers both in the public and private sectors to understand potential barriers to KMC. Two levels of intervention were planned:

- To train staff nurses and doctors in KMC healthcare facilities, both public and private, and integrate KMC into their routines.
- To ensure that babies discharged from facilities could continue to receive KMC at home.

The project spanned about 90 health facilities in Koppal and covered the entire district, aiming to bridge the gaps in the healthcare system and overcome the barriers at the community level. Over three years, the group would test three models, composed of numerous interventions, discarding those that had limited applicability and rigorously testing those with potential to be scaled up across the state. The aim was to integrate this model into existing health facilities and into the existing routine of health staff and frontline workers to ensure that the implementation of KMC would not be considered too much of an additional responsibility

KMC at the facility

The team established that KMC was not being practised in any of the health facilities in Koppal, and newborns were not being weighed accurately. Most hospitals had an analogue scale, and a wiggling baby made accurate reading difficult. An audit of the hospital registers found that baby weights tended to be 'heaped' at 2,000 or 2,500 grams, and this ran the risk of missing out on the identification of babies to receive more intensive care and observation.

Figure 2: *A mother being helped into the KMC position at the District Hospital, Koppal*

When an LBW baby was identified at the district hospital or arrived there after being referred from a Community Health Centre, they were usually taken away from the mother and placed in a radiant warmer in the SNCU. This separation would be incredibly stressful for the mothers, who were not allowed to see their newborns, sometimes for days at a time. “We often found that nurses did not want mothers in the SNCU. They thought they were unhygienic and would bring infections to the baby. That just isn’t true. Mothers were missing out on the opportunity to bond with their newborns,” says Dr Maryann Washington, Professor - Nursing and Training Coordinator-MNCHA projects at St John’s Research Institute.

The team knew that selecting facilities for KMC implementation was not enough. “We realised that deliveries were happening everywhere, at the taluka hospitals, district hospitals and at Primary Health Centres. We couldn’t just focus on a few high-load facilities,” says Dr Washington. “We also realised that discharges were happening very early. Mothers would prefer to go home. You cannot get a mother to stay for one week to give KMC if the baby is stable. I would say that 40 percent of the mothers went home before three days of the birth had elapsed.”

The window for providing KMC at the facility was very small, but providing KMC at the facility itself was a challenge. Many doctors were not convinced of the efficacy of KMC and were worried about the liability if something were to go wrong while giving KMC. Radiant warmers in the SNCU were preferred to maintain the body temperature of LBW babies. Even nurses at these hospitals were unwilling to start KMC without a doctor's 'prescription'.

Government hospitals were bound to accept and implement the Centre's operational guidelines, but not private hospitals. Private hospitals would refer LBW babies in need of further care to another private hospital with a Neonatal Intensive Care Unit. Many private doctors were not convinced about the benefits of KMC, and even if it was given, it would be just before discharge. A different approach would be required to involve them.

Even if these issues had been addressed, hospitals are not necessarily the most conducive spaces for mothers to give KMC. Wards were crowded, with family members coming and going, mobile phones would ring, and conversations were loud. A new mother would rarely be afforded privacy to keep her newborn in an open-front gown on her chest and breastfeed.

All these barriers at health facilities highlighted the need for the following:

- Identifying LBW babies through accurate weighing
- Orienting hospital staff on KMC as an evidence-based intervention
- Demonstrations of KMC for nursing staff
- Establishing a KMC unit in line with government guidelines as a safe space for mothers
- Engaging with private hospitals to provide KMC

Facility-level interventions

- **Capacity building of hospital staff:** A team from St John's Medical College and Hospital, Bengaluru, including a professor of nursing, a neonatologist, two nurses and nurse mentors trained to supervise staff nurses, were employed by the project at the district hospital and taluka hospitals with a high delivery load. The nurse mentors would support the facility staff to provide KMC and help them monitor the number of hours of KMC given daily by the mothers, using a case sheet developed by the project team.

  The team prepared a demonstration-based curriculum for staff nurses to help mothers place the baby in the KMC position and to monitor the babies using the case sheet. The training involved an assessment both prior to commencement and after completion. "One year later, the knowledge, skills and attitude towards KMC by the staff nurses had improved," says Dr Washington.

  For doctors, there were Continuing Medical Education (CME) programmes that presented the evidence for KMC and expanded on its benefits. "It wasn't easy in government hospitals, as there were a number of specialists coming in on different days. The baby would not always be in the care of one specialist," says Dr Swaroop N, who is currently Thematic Lead of Maternal Neonatal and Child Health and Comprehensive Primary Health Care, and led facility interventions and government engagement for the KMC project. "We faced resistance from some paediatricians who had previously had no training on KMC and no conviction that it would work. The CMEs helped. We brought in senior specialists, and many of them had taught these paediatricians in college! That really helped convince them."

  In addition to doctors and nurses, counsellors were trained to help the mother and family members understand KMC and the benefits of providing prolonged KMC.

- **Accurate weighing of newborns:** The project provided digital weighing scales to the health facility, and nurse mentors provided handholding support to ensure that the babies were weighed correctly.

- **Establishing KMC rooms in health facilities:**

Figure 3: *The KMC room at the SNCU, District Hospital, Koppal*

The specifications for KMC units were in the operational guidelines. The project supported the establishment of separate KMC rooms in the district hospital, taluka hospitals, and ensured that even at Community Health Centres and Primary Health Centres, one or two beds were set aside for mothers to provide KMC. “We needed to provide a safe, secure and pleasant space, with reclining beds and chairs, curtains and informational material for mothers to give KMC,” says Dr Swaroop. “We even arranged for an additional meal from the hospital for the mothers giving KMC to supplement their nutrition.”

Figure 4: *The Snakes and Ladders game developed for mothers to learn about KMC*

Some facilities arranged for a screen to play educational videos for mothers, and a human-centred design firm was engaged to develop a board game along the lines of Snakes and Ladders to make mothers aware of the dangers and benefits to a newborn. The original prototype featured light and sound, but was expensive and so a printed version was used.

A KMC ward allowed mothers to interact with each other and to learn from mothers already providing KMC. It allowed sceptical mothers to see other babies putting on weight each day when kept in prolonged KMC.

The project team formalised these interactions through '*Akka*' (elder sister) groups, through which experienced KMC mothers encouraged new mothers to discuss their concerns, especially while holding such fragile babies.

Figure 5: *An Akka group, with an experienced mother explaining KMC to newer mothers*

With the long hours implicit in KMC, nurses encouraged relatives, including fathers, to give 'foster KMC' for prolonged KMC. This also increased bonding with the babies.

- **Private facility engagement:** After months of building a rapport with private hospitals and NICUs, data on LBW babies was finally made available. "With private hospitals, there was more acceptance as the benefits of KMC started to become visible. There was also a sense of pride in being a hospital providing KMC," says Dr Swaroop.

KMC in the community

LBW babies may gain up to 15 to 20 grams per day, according to the Government of India's operational guidelines, and such babies are usually discharged when weighing about 1,500 grams to 1,600 grams. They may be discharged, the guidelines say, when they are able to maintain their body temperature as well as gain weight for three consecutive days, and accept breastfeeding or

feeding from a spoon or cup. The guidelines say the mother and baby should not be discharged in a hurry, but it was difficult to have mothers stay in the hospital. It was therefore important for mothers to continue KMC after they went home until their babies had gained weight.

"Some families in Koppal had a ritual of burying the placenta, so they would be anxious to go home. I would say that most KMC occurred at home, after about one to seven days in the hospital," says Dr Washington.

Community-based KMC came with its own barriers. Mothers would often discontinue KMC after coming home. The teams observed that it was generally acceptable for mothers to focus on caring for their babies for about the first three months, before resuming household duties. However, frequent visits from neighbours and families would often interrupt the provision of KMC. Several mothers found it difficult to sit endlessly with their babies to their chests. Well-meaning relatives told mothers that keeping the baby in skin-to-skin contact would cause them to overheat and result in physical deformities. Outside the KMC unit, with its reclining chairs and beds, single room and single-bed households found the prospect of providing prolonged KMC daunting. "To keep the baby warm, they would use hot water bottles, wrap the baby in cotton cloth or keep it close to the heat of (incandescent) bulbs," says Shivaleela, a Community Coordinator with the KMC project. A problem also arose at households in Koppal where the mother had delivered outside the district before travelling back home. Convincing those mothers to give KMC was difficult, because not only had they not heard of KMC, but their doctors had not recommended it.

Enter Accredited Social Health Activists or ASHAs, who are frontline health staff linking the community to the health system and the services and schemes offered by the government. ASHAs are the feet on the ground for the public health system, providing a wide range of services related to maternal and child health, immunisation and communicable diseases such as tuberculosis. Although KMC had been part of their training, it had been clubbed with numerous other subjects and had not been demonstrated.

"The ASHAs didn't know the science behind KMC, they just knew that it was about keeping the baby warm next to the mother. If you would ask them what KMC was, they would say that keeping a baby warm with a hot water bottle or wrapping up the baby warmly in cloth was KMC," says Prathibha

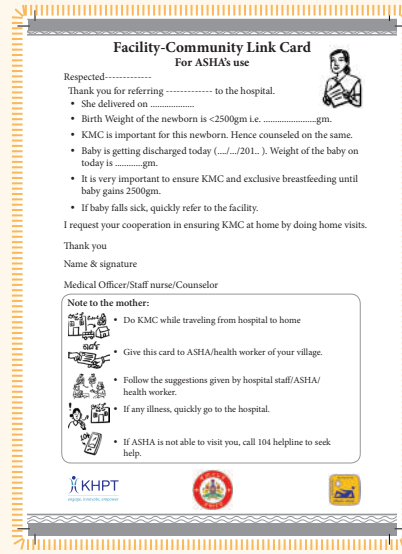
Rai, Community Manager at KMC, who led community interventions during the project.

ASHAs would make home visits on days 3, 7, 14, 21, 28 and 42 after the birth. However, these timelines often varied because the ASHA would often not know when the baby was discharged. The first few days after coming home are crucial to ensure that the practice of KMC is sustained by a confident mother, and ASHAs are needed to support the baby's positioning and monitor its health.

To be practised and be accepted in the community, KMC would need to be understood by women, their families, frontline workers and the community at large.

Box 1: Ensuring facility-community linkages

The formative research showed a distinct lack of connect between the communities and the facility, which contributed to the discontinuation of KMC at home and delayed initiation of community KMC. Initially, the team tried to have nurses at the hospital call the ASHAs during discharge, but this did not work as the nurses were caught up in discharge formalities as well as their other duties, and would not always have the time to make the call. So, the team developed a Facility-Community Link Card, which was signed by the Medical Officer, staff nurse or counsellor, and given to the family of the newborn at the time of discharge. "The Link Card was a sign of respect to the ASHAs, addressed to them by health facility staff and acknowledging their contribution to the care of the babies and ensuring KMC at home," says Dr Swaroop. The families would call the ASHAs upon their return home and give them the Link Card, and the ASHA could begin home visits.



Facility-Community Link Card
For ASHA's use

Respected----------
Thank you for referring ---------- to the hospital.

- She delivered on .....
- Birth Weight of the newborn is <2500gm i.e. .....gm.
- KMC is important for this newborn. Hence counseled on the same.
- Baby is getting discharged today (...../...../201..). Weight of the baby on today is .....gm.
- It is very important to ensure KMC and exclusive breastfeeding until baby gains 2500gm.
- If baby falls sick, quickly refer to the facility.

I request your cooperation in ensuring KMC at home by doing home visits.

Thank you

Name & signature

Medical Officer/Staff nurse/Counselor

Note to the mother:

- Do KMC while traveling from hospital to home
- Give this card to ASHA/health worker of your village.
- Follow the suggestions given by hospital staff/ASHA/ health worker.
- If any illness, quickly go to the hospital.
- If ASHA is not able to visit you, call 104 helpline to seek help.

KHPT

Figure 6: *The Facility-Community Link Card developed by the project team*

Community-level interventions

- **Training of ASHA facilitators:** Each of the four blocks in Koppal had around 10-14 ASHA facilitators and about 200-250 ASHAs. The KHPT team trained ASHA Facilitators, Auxiliary Nurse Midwives (ANMs) and the Community Coordinators as master trainers on KMC. They, in turn, would train the ASHAs on enabling KMC at home. The training included a 'perspective-building' component, which is a hallmark of all KHPT's training of programme and field staff. The training focused on LBW babies and the role they could play in ensuring the child's wellbeing, apart from the practical demonstration of KMC. Over the course of the pilot, 1,232 ASHAs, 48 ASHA Facilitators, six Community Coordinators and 11 Outreach Workers were trained.

  The Community Coordinators would accompany ASHA Facilitators during visits to LBW babies in the community until the ASHA felt confident to conduct independent visits. The Community Coordinators would classify ASHA Facilitators as Grade 1, Grade 2 or Grade 3, and focus their efforts on Grade 2 and Grade 3 ASHA Facilitators who needed more support.

  ASHAs bear a great deal of responsibility, so the teams had to assure them that it would not add to their burden. The project team calculated that in each ASHA area, there would be about two LBW babies weighing less than 2,000 grams, and five to six babies weighing less than 2,500 grams, per year. The team explained that they would only have to provide KMC support once a month or once in two months, and this would involve visiting the mother once every day for at least three days after discharge until she was comfortable with giving KMC.

  Since supporting KMC at the community level would not necessarily be a routine activity for all ASHAs, it was important to keep the knowledge of KMC fresh in their minds. Community Coordinators would attend ASHAs' monthly meetings at the health facilities and encourage them to talk about their experiences with facilitating KMC. This helped the other ASHAs understand how to manage different scenarios in the community and also created a platform for appreciation.

- **Interventions prior to birth:** The Community Coordinators worked with ASHA facilitators to track women with high-risk pregnancies, including women with anaemia, a history of complications with

pregnancy, or hypertension. They received the list of high-risk pregnancies from the Junior Health Assistant, and also attended high-risk pregnancy clinics held on the ninth of every month. “We also attended mothers’ meetings at the anganwadi centre, as well as Village Health and Nutrition Days to raise awareness on the risks faced by LBW babies, and to talk about KMC,” says Uma, who was a Community Coordinator at the time. The aim was to enable new mothers to ask about KMC if their babies were low birth weight.

Box 2: Communications tools and job aids for ASHAs

With KMC involving a number of steps in positioning the baby, helping the mother express breastmilk, and addressing the hesitations of the families, the ASHAs needed tools and job aids to help them and the KHPT team developed the following:

Figure 7: *A Community Coordinator shows ASHAs how to use the reminder cards on a keychain*

A microplanning tool that would help ASHAs follow-up with LBW babies after they returned home. This included details of the child, a guide to the barriers and potential solutions to giving KMC at home, and a record for each home visit, tracking the number of hours of KMC given per day, as reported by the mother, and the number of times the baby was breastfed.
A set of reminder cards on a keychain for the ASHA, which covered the causes of a low birth weight, steps for KMC and breastfeeding, and danger signs in newborns, including physical inactivity, refusing breastmilk, and extremities such as turning blue and difficulty in breathing.

- **Facilitating community-level KMC through family interactions and counselling:** After discharge, the ASHAs would talk to the family and the new mother to help facilitate KMC at home, where the environment was very different from the KMC unit in the hospital. “Mothers would not always have a reclining chair, but they would improvise. I have seen mothers leaning against a sack of rice, or a stack of pillows to give KMC,” says Dr Washington.

  The team at St John’s also developed different types of cloth baby wraps to help mothers keep the babies secured to their chests, even while walking around. Babies being discharged from the district hospital were given a KMC kit, containing socks, a cap, a wrap for the mother and a cloth to cover the baby’s back while in the KMC position. “We had an NGO make the kit for us, and we still use it at St John’s today,” says Dr Washington. “The (wraps) could later be made into towels, so there was no wastage.”

  “The challenge for us was out-of-district deliveries,” says Pundalik Bharamagoudar, who was District Coordinator of the project at the time. “They had never heard of KMC, and since no doctor had suggested it, they did not want to do it. We would arrange joint visits with the Junior Health Assistant (JHA) and the ASHA if they were not convinced, and they would counsel them to begin KMC.”

  “Many families had never seen a kangaroo before,” says Uma. “We would give examples of monkeys holding their babies close, and hens sitting on their eggs to keep them warm, to make them understand. Soon, they would know it just as KMC.”

  ASHAs would also counsel families on exclusive breastfeeding, since it was a tradition among many to feed babies honey. Some did not want to give the nutrient-rich colostrum, perceiving it to be indigestible.

  Mothers who had trouble producing breast milk would ask the doctor to provide infant formula powders such as Lactogen. The ASHAs were trained on how to facilitate breastfeeding. “Most mothers don’t know that babies should first be fed from one breast for about 20 to 30 minutes and then be taken to the other breast,” says Prathibha Rai. “Once the ASHAs were trained on the science of breastfeeding, they could help the mothers and also explain that KMC helps the flow of milk.”

To ensure babies received KMC for as long as possible, the concept of foster KMC was continued in the community. Fathers, grandmothers and aunts stepped up to give KMC to the babies. Durgappa, a father from Kushtagi, stepped in to give his baby KMC when his wife could not. Born at just 1,850 grams, the baby needed skin-to-skin contact, and Durgappa stepped up to take responsibility. Initially, he would keep the baby on his shirt, but he saw no change in the baby's weight. Then he put on his wife's nightgown and kept the baby in skin-to-skin contact on his chest. Within 20 days, the baby's weight was up to 2.5 kg. Within three months, the baby was healthy. His story was shared widely through the community to encourage other fathers to give KMC.

Figure 8: *A father giving KMC at home to his baby*

The team would conduct Intimate Interactive Theatre programmes for the semi-nomadic Hakki Pikki tribe, where the audience was made to reflect on the issues of LBW babies falling ill through the enactment of two stories — one in which a mother gave her baby KMC, and one in which she did not.

"There was a great deal of acceptance of KMC once the community understood why it was important," says Prathibha Rai. "The families could see the benefits as the babies gained weight."

Koppal's international acclaim

The KMC project initially covered five health facilities in one block of Koppal, and after three months, all health facilities, public and private, in a block were added, as part of the second iteration of the model. Models 3 and 4 scaled the project up to all facilities and communities in the four blocks of Koppal. The scale-up of activities in the latter implementation cycles brought a widespread community acceptance of KMC.

"In the first few months, it was difficult to work in the community," says Shivaleela. "Once we scaled up activities, KMC began to be widely known, and our work became easier. Older KMC mothers would help newer mothers; neighbours would step in to provide foster KMC."

"Everyone was talking about KMC," says Uma. "We used to be known as 'KMC Uma' and 'KMC Shivaleela'. Once, I remember, there was a mother in the ward in one of the hospitals, and the community leaders called the doctors to ask if she was getting KMC!" says Shivaleela.

The media began to pick up stories of LBW babies surviving due to KMC, but there was one story that propelled Koppal and the KMC intervention into the international limelight. Renuka Hadapad, a daily wager, had given birth to triplet girls, weighing just 1,200, 1,300 and 1,500 grams respectively. With two

Figure 9: *Renuka giving her triplets KMC together, shortly after their birth*

Figure 10: *Renuka Hadapad and her triplets all grown up, photographed in 2023*

little daughters already at home, Renuka's husband and family were extremely upset with the arrival of three more girls, especially in such a weak state. Her husband left her in the hospital and returned home.

The staff rallied around Renuka and encouraged her to provide KMC. Despite the uncertainty about her future, Renuka put aside her worries to take care of the triplets. She went to her mother's home with the triplets, and her sister supported her to give KMC until the babies had reached a healthy weight. One year later, the hospital staff threw a birthday party for the triplets and she proudly shared her experience with KMC and thanked the staff for their support.

Figure 11: *Renuka, her husband and their triplets at their first birthday party, organised by hospital staff*

Renuka's husband was invited to the birthday party, and his perception of a girl child began to change when he saw the reception given to his daughters. The WHO broadcast Renuka's experience with KMC[5] internationally, and numerous news outlets picked up the story.[6,7,8] A photo of her healthy babies was also published in The Lancet.

The triplets are now six years old and are well and happy, Renuka says. "And so naughty!" she adds. "I still talk about KMC in my village and my

5 https://www.who.int/news-room/feature-stories/detail/-kangaroo-mother-care-programme-in-india-helps-premature-triplets-thrive

6 https://timesofindia.indiatimes.com/city/bengaluru/triplets-mom-is-whos-face-for-kangaroo-mother-care/articleshow/62546211.cms

7 https://www.thequint.com/news/india/indian-triplets-mom-who-kangaroo-mother-care-face

8 https://www.deccanherald.com/content/654174/karnataka-triplets-survive-tough-odds.html

Figure 12: *Renuka with her healthy babies*

mother's village. Six months ago, my co-worker mentioned that their relative had a low birth weight baby. They were just going to buy the baby a warmer bag. I said, "Give them KMC! I gave KMC to triplets, you can give it to one baby!"

Results and outcomes

The KMC study was rigorously evaluated using data from case sheets in the hospitals, as well as data from ASHAs' community monitoring, and visits by the evaluation team on the 7th and 20th days after discharge. Programme monitoring data was presented at monthly meetings with the field teams to see how approaches and interventions could be modified and which interventions could be pared back in favour of more scalable interventions.

From the March-December 2018 evaluation period, 23,667 babies were born, of which 1,148 weighed less than 2,000 grams. More than 95 percent of them were born in health facilities. Of the 1,148 babies, 1,002 were considered for evaluation as their mothers were from the same district. 616 (87.6 percent) of eligible babies were initiated on KMC in health facilities. One week after discharge, 565 (85 percent) of babies available at home had received skin-to-skin care, with eight hours of skin-to-skin care on average. At least 417 (63.5 percent) had been exclusively breastfed. The study showed a high level

of KMC coverage in Koppal district, and the findings were presented to the Government of Karnataka during a dissemination workshop on 30 April 2019.

Table 1: LBW newborn characteristics and KMC outcomes in the health facilities (March to December 2018)

Newborn characteristics	Total		Government hospital (referral)		Government health centres		Private hospitals (referral)	
	No.	%	No.	%	No.	%	No.	%
Total live births	23667	100	10177	43	9940	42	42	15
LBW <2000 g	1148	4.9	596	52	200	17	352	31
Mother's not from the study area/ newborn not born in the study area	146							
LBW <2000 g included in analysis	1002	87.3						
Median birth weight of LBW newborns (g)	1700		1700		1800		1700	
LBW newborns eligible for KMC	703	70.2	353	59	111	55	239	68
LBW newborns Inititated on KMC	616	87.6	303	86	105	95	208	87
Median day of initiation & interquartile range	2 (1-6)		1 (1-7.5)		1 (1-1)		5 (3-7)	
LBW <2000 g died in the hospital	38							
No. of LBW <2000 g at discharge	665							

Source: Jayanna, K., Rao, S., Kar, A., Gowda, P. D., Thomas, T., Swaroop, N., Washington, M., Shashidhar, A.R., Rai, P., Chitrapu, S., Mohan, H. L., Martines, J., & Mony, P. (2022). Accelerated scale-up of kangaroo mother care: Evidence and experience from an implementation-research initiative in South India. Acta Paediatrica. https://doi.org/10.1111/apa.16236

Table 2: KMC outcomes of babies alive at discharge and available at home 7 days post-discharge

No.	Indicator	At discharge (N = 665)	7 days post discharge (N = 657)
1	Any duration of skin-to-skin care	85.0% (565)	67.9% (446)
2	Average of skin-to-skin care in hours (mean and standard deviation)	9.6 (4 4)	8.0 (3.1)
3	Minimum 8 hours of skin-to-skin care	59.8% (398)	41.6% (273)
4	Proportion of newborns that were exclusively breastfed (EBF)	75.0% (500)	63.5% (417)
5	Proportion of newborns that received effective KMC (8 hours of skin-to-skin contact per day +EBF)	53.4% (355)	36.4% (239)

Source: Same as Table 1

Karnataka has since scaled up KMC across the state. KHPT and St John's Research Institute conducted five workshops for representatives from different districts, including doctors and nurses. The Government of Karnataka established KMC wards adjacent to all SNCUs across the districts. In its guidelines for utilisation of funds for Facility-Based Newborn Care, the National Health Mission allotted INR 1 lakh per KMC ward in 2020-2021 for the maintenance of the wards, procuring gowns for mothers, kits and clothing for the newborns, and registers for monitoring.

Former Community Coordinators say that prolonged KMC coverage at the community and facility level has fallen in Koppal in the absence of rigorous follow-up and interactions with facility staff, but KMC continues to be initiated at the district hospital. St John's Research Institute is conducting a study to compare nutritional, neuro-developmental and healthcare outcomes of LBW children with and without KMC, in Koppal district during the year 2017-18.

Sustainability is key to any intervention, and even though the nurse mentors were withdrawn after the project closed, the counsellors and staff nurses, especially at the district hospital, continue to ensure the provision of KMC. There are other factors that can help sustain the intervention going forward. "The Janani Suraksha Yojana brought institutional delivery into focus. In the same way, if KMC were to be associated with a scheme and to have indicators in the government's health management information system,

that would really help to sustain the initiative and keep the focus on it," says Arin Kar. "In the end, we had all the facilities on board, because who doesn't want a newborn baby to be healthy?"

"Government buy-in was essential for the intervention to work," adds Dr Swaroop.

Conclusion: Key learnings

- Project design and implementation took into account the inputs of stakeholders for the development of context-specific solutions with potential for scale.
- An assessment of gaps along the continuum of care and bridging those gaps, especially those between the facility and the community, was essential for the successful transition of KMC practice from facility to home.
- Government support and engagement throughout the implementation process was essential to get inputs about the integration of KMC components into the existing program and receive their buy-in.
- Continuous iterations of various interventions based on inputs from the field staff, frontline staff and evaluation teams allowed real-time responses to challenges.
- A rigorous evaluation component provided strong evidence for the models created to enable their uptake.

Acknowledgements

This case study is built upon the invaluable inputs of several persons who remember the KMC project fondly. Many thanks are due to Dr Swaroop N, Dr Maryann Washington, Arin Kar and Prathibha Rai for making time for interviews that provided varied perspectives on an extensive project. Special thanks are due to the Koppal field staff, Pundalik Brahmagoudar, Shivaleela and Uma, as well as KMC mother Renuka for bringing the case study to life with their anecdotes. Heartfelt thanks go to Prathibha Rai for her support in facilitating these interviews. The case study has its foundation on the research from the KMC project, and thanks are due to the authors of the studies listed under References.

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VIII. Eliminating tuberculosis: A case study on Mumbai PPIA model

Sushmita Das, Rishabh Chopra, Vaishnavi Jondhale, KG Venkateswaran, PATH

Abstract

Tuberculosis is a major public health concern in India. According to the TB Report 2022, India reported a 19 percent increase in TB cases in 2021, over the previous year. Between 2019 and 2020, the mortality rate from all forms of tuberculosis increased significantly to 11 percent. The government is committed to eliminating tuberculosis by 2025 and has made significant progress in controlling disease transmission and spread through the Revised National Tuberculosis Control Programme (RNTCP).

PATH, an international NGO working in the field of public health, has contributed to the establishment of a Private Provider Interface Agency (PPIA) in Mumbai to expand the role of the private sector in achieving universal access to services controlling TB. The programme identified 8,789 private doctors, 3,438 chemists, and 985 labs. Over three-and-a-half years, the programme collected data on 60,366 privately reported tuberculosis patients, 24,146 (40 percent) of whom were confirmed microbiologically. The PPIA increased the capacity of private practitioners serving slum residents to ensure early, accurate diagnosis of tuberculosis, including drug-resistant forms, effective case management and successful treatment. This programme influenced national policy and was adapted and funded on a nationwide scale. This unique public-private partnership model could be adapted to meet the rapidly increasing demand for services for other public health diseases as well.

Introduction

Newspapers were awash with reports of the prevalence of drug-resistant tuberculosis in a few patients in Mumbai in 2012. A daily wager, Lokesh, had been ignoring a persistent cough and an unusual spinal pain for about a month. He lives in poverty and is the sole breadwinner for his family. When

the pain and the cough became unbearable, Lokesh skipped work and approached Dr Imran Sheikh, who has a clinic in his neighbourhood. Sheikh has a two-room consulting office with patients waiting outside his door. Lokesh spent a day's wages as consultation fees, but despite Sheikh's prescribed medicines, the cough persisted. Lokesh then happened to meet Sameena, a field officer for a community-based organisation (CBO), who told him about the TB Public-Private Interface Agency (PPIA) programme and got him enrolled under it. After undergoing a few months of treatment, Lokesh is now healthy.

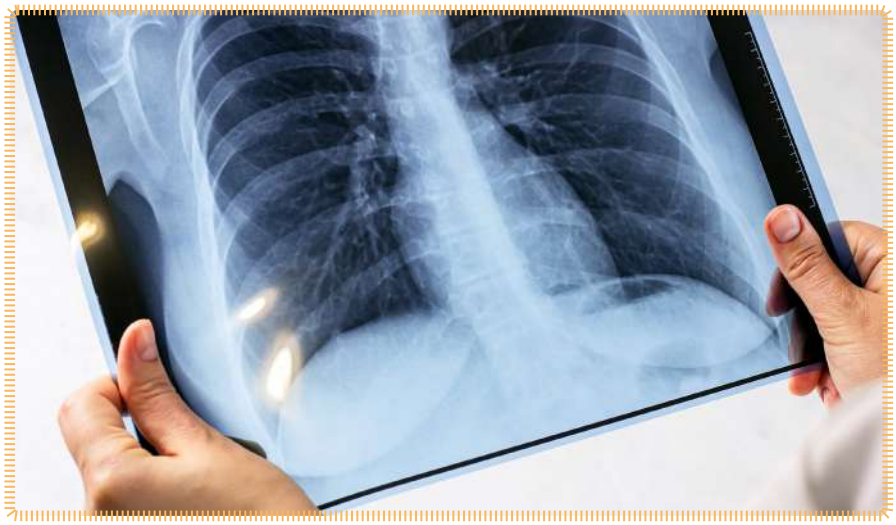


Figure 1: *Tuberculosis continues to be a major public health concern in India*

Indians across socio-economic divides visit private medical practitioners. Studies show that in the case of diseases such as TB, where the initial symptoms are mild, private practitioners are the first point of contact for most presumptive patients.[1-3] But these doctors seldom have adequate training in TB screening, diagnosis and care, and do not fully adhere to the Standards of Tuberculosis Care in India (STCI). TB patients consult at least three providers on an average, which delays diagnosis and treatment, and leads to an increase in expenditure. The stigma associated with TB further delays and deters many from seeking treatment.[4]

So, why do so many TB patients continue to seek treatment in the private sector? A major reason is that the government's investment in public health systems has focused on rural health at the cost of urban health facilities which are understaffed and overburdened.

Furthermore, private healthcare providers or facilities are located within the communities, reducing the time and effort needed to access healthcare. Consequently, the Centre identified private sector engagement as a key driver in notifying, treating and eliminating TB.[5]

This case study highlights PATH's work in designing, implementing and scaling a people-centric PPIA programme for TB in Mumbai. India's biggest slum, Dharavi, is in Mumbai, and residents have limited access to civic services such as water and drainage, healthcare and education. This makes Dharavi a breeding ground for many diseases, including TB. The model has management principles, data, research, information and communication technology (ICT), and stakeholder inputs to improvise and achieve the following goals in the private sector:

The PPIA project is a good example of a Build-Operate-Transfer model. PATH demonstrated how disruptive innovations and leveraging market forces were intrinsic to developing a collaborative relationship with the private sector for controlling TB in Mumbai.

- Increasing tuberculosis case notifications across society
- Driving the utilisation of the World Health Organization (WHO) endorsed TB diagnostics
- Tracking and improving patients' adherence to treatment
- Recording treatment outcomes of tuberculosis patients seeking treatment from private practitioners

> *The private sector is not sensitised enough to tackle TB, and hence we wanted a systematic approach to enrol the private sector into the programme.*
>
> **- Dr Daksha Shah, Mumbai TB Officer, Municipal Corporation of Greater Mumbai**

Finding the 'missing' millions

Reports show that an estimated one million cases of TB a year are 'missing' or not reported as 'accountably treated', and only a fraction of cases of notifiable disease are reported to the government. As a result, prompt prevention and initiation of control measures are delayed.

PATH, through the PPIA programme and under the aegis of the Municipal Corporation of Greater Mumbai (MCGM), engaged with private health care providers to support early diagnosis, prompt treatment, and timely notification of TB patients and strategies to facilitate treatment completion. PATH pursued the following approaches:

- Accelerating action through multi-stakeholder involvement, commitment and coordination
- Mapping private providers in the administrative wards in Mumbai
- Changing the behaviour of key stakeholders, especially private practitioners
- Implementing the PPIA service delivery approach through hub-and-spoke model
- Leveraging information technology to manage patient care and provider reimbursements
- Ensuring stringent quality adherence and regular evaluation

Accelerated action through multi-stakeholder involvement

Mumbai's local government, MCGM, devised the 'Mumbai Mission for TB Control' programme and engaged private practitioners for TB care. PATH contributed to this multi-focus initiative by implementing the intervention along with the following key stakeholders:[7]

- **Government, development and implementation partners:** These include, but are not limited to, the Revised National Tuberculosis Control Programme (RNTCP)'s Central TB Division (CTD), the MCGM, the Office of the WHO representative to India, the Bill & Melinda Gates Foundation

(BMGF), including PATH.

- **Community-based organisations:** PATH partnered with two CBOs — Maharashtra Janvikas Kendra (MJK) and the Association for Leprosy Education, Rehabilitation, and Treatment India (ALERT India). Both these organisations mapped private providers initially and provided services to patients through voucher logistics management, sputum sample collection and transportation, distribution of diagnostic test reports from the GeneXpert laboratory, and adherence to treatment. This was supported by the CBOs. Field officers from these CBOs conducted regular home visits where they counselled, monitored, and supported patients to complete the TB treatment regimen.

- **Technology and other partners:** PATH collaborated with technology partner Accenture plc., which helped develop the web application, 'Universal Access to TB Care (UATBC)' for patient registration and related services. Another partner, Vertex, through their call centre, helped patients with online registration, e-voucher disbursements, and system-generated services, such as daily SMS reminders to take medicine, weekly calls to the patient from the contact centre to check if they have taken their medicine, tracking medicine refills, among others. PATH also collaborated with several other partners for ICT, diagnostics, modelling, evaluation and advocacy, among others.

- **Institutions:** The Indian School of Business provided support to PATH on operational modelling and ensured that interventions were having an impact. The intervention's field officers then pitched the model to private providers, inviting them to join the PPIA network and receive diagnostic and treatment subsidies for patients. These officers also coordinated the referral systems, in which patients were referred to private practitioners from the community, which in turn offered the added benefit of ensuring a consistent patient flow to the private practitioners. Additionally, McGill University provided support for ethnographers who spent time with TB patients, private practitioners, and pharmacies to improve service delivery. Besides, the World Bank devised "standardized patient" methodologies to evaluate the quality of care.

- **Professional medical associations:** PATH partnered with the Indian Medical Association (IMA), Indian Association of Paediatricians (IAP), and Indian Pharmaceutical Association (IPA) and utilised provider engagement platforms.

Mapping private providers

Mumbai averages roughly 30,000 TB cases annually.[5] Although it has never been quantified, it is believed that the TB burden in this area is disproportionately high. This assumption is based on local studies, population conditions, and disproportionately high TB notifications from limited public services. Moreover, in 2012, there was an alarming hike in anti-TB drug resistance and extensively drug-resistant (XDR) cases. This led to efforts both by government and non-government entities to control the TB situation in Mumbai.

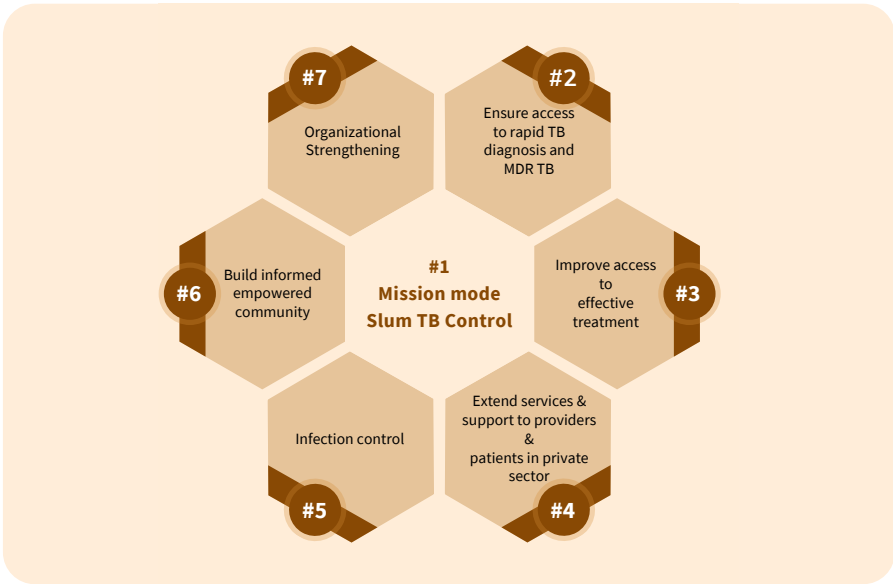


Figure 2: *A seven-pronged strategy developed for TB control and private sector engagement in Mumbai*

Mapping and profiling of private providers were crucial to engaging them before the actual initiation of the intervention. Hence, from January to April 2014, the exercise was conducted in 15 wards — 12 in high-TB burden administrative wards and in three other wards in Mumbai. The city is divided into 24 administrative wards, which are centrally administered by the MCGM.

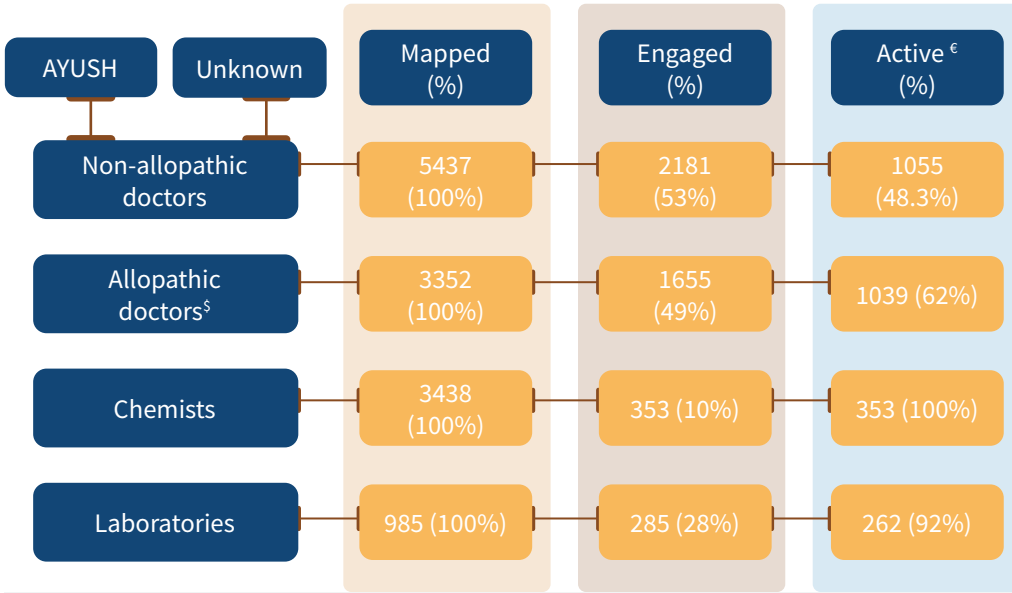
The PPIA intervention focused on these 15 wards as they have contributed to the biggest TB case load from the city in the past. Information was collected from private sector providers — doctors, hospitals, chemists and laboratories in Mumbai. Provider types were listed by collecting information on the names of health facilities, addresses and operating hours. The entire exercise of mapping the private providers was conducted by two CBOs — MJK and ALERT India — in partnership with PATH.

Figure 3: *A private clinic in Dharavi, Mumbai, which is India's biggest slum. Source: PATH*

Box 1: A day in the life of a field officer

A typical day in the life of Sameena, a field officer, involves identifying all the healthcare providers in the area using the signboards, displays, and clinic boards, as as reference points and then manually filling out a pre-tested mapping form. She collects details of the health providers, including their title, qualification, and clinic timings, as displayed on the name boards. She prepares a list of mapped doctors (allopathic or otherwise, individual or multi-clinic/hospitals), chemists and laboratories. Next, Sameena visits these mapped facilities to study their client load. She networks with other doctors and laboratories for referrals, clinic timings, linkage with chemists for dispensing medicines, all with a special focus on TB. She takes notes on outpatient loads, proximity to slums, and pre-engagement with RNTCP and takes suggestions from the public-sector TB managers.

Thus, probable facilities were identified for engagement after deliberation by the PPIA staff, and those ready to comply with the model of care under PPIA were contracted with an agreement. Feedback from these providers and field staff further helped PPIA in understanding the factors influencing the network dynamics and led to effective engagement of private health providers in the project. Figure 4 shows the results of mapping and engagement of private providers for the PPIA programme.



Allopathic doctors: Doctors with modern system of medicine, registered under the Indian Medical Council

AYUSH: Health providers with the Indian system of Medicine - Ayurveda, Yoga, Unani, Siddha and Homeopathic

Unknown: Health providers with a qualification or degree which is not identified in India or without any known accreditation.

Mapped: Number of providers identified and line-listed by the PPIA staff as denominators for inclusion under the initiative

Engaged: Number of providers formally signed memorandum of understanding for inclusion in the initiative

Active: Active is defined as the utilisation of at least one service during the reporting period

Figure 4: *Practitioners mapped and engaged during the intervention. Source: Shibu V, et.al. 2020. Indian Journal of Tuberculosis. 67(2), 189-201; link: https://www.sciencedirect.com/science/article/abs/pii/S001957072030007X*

Behaviour changes among stakeholders

PATH involved a team of highly motivated field officers who had years of experience as medical representatives and had worked with the communities.

- **Provider engagement and behaviour change:** To sensitise the provider and onboard them to the TB PPIA programme, the PATH team, along with its partners, initiated a multipronged approach. It deployed an exclusive behavioural change communication (BCC) team of pharma-marketing specialists to motivate the doctors engaged in the PPIA network. The BCC team adopted marketing techniques including relation-building and 'low-intensity, high-frequency' sensitisation in the clinics. Another feature was prioritising private practitioners who were involved in treating a large number of patients (see Figure 5)

- **In-clinic visits:** The field officers would visit all the clinics in their designated areas and explain the PPIA programme to the private providers with crisp and easy-to-understand flyers. A summary of the STCI, along with action items for specific provider groups (formal and informal), was also developed. In this case, BCC focused specifically on microbiological confirmation of TB and treatment regimen as per STCI. Feedback also helped the programme strategy team to course correct.

- **Provider workshops:** PATH collaborated with the public sector MCGM to conduct joint provider training workshops for quick outreach to a vast group of providers. It brought awareness about the National TB Program among providers and increased provider registration to the PPIA intervention. PATH also leveraged provider associations such as the IMA, the Indian Academy of Paediatricians, and the Mumbai Ward Medical Associations to maximise the reach of PPIA.

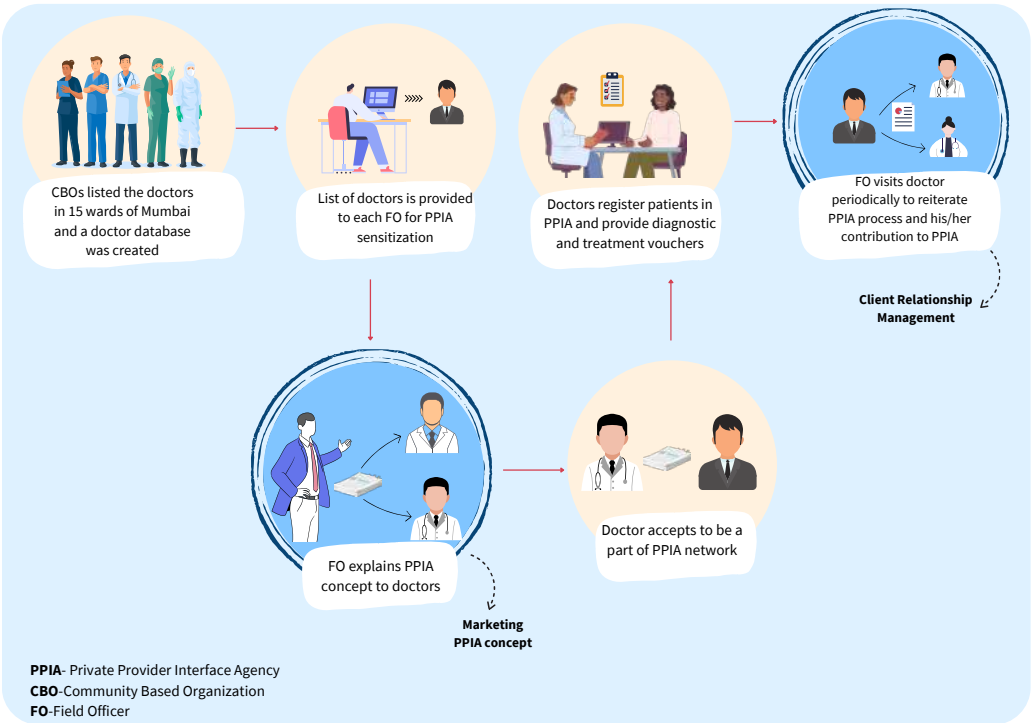


Figure 5: *Diagrammatic representation of the private practitioner engagement process*

- **Hub hospital provider engagement:** The PPIA programme conducted sensitisation sessions for all staff members. TB patients in other departments of the multispecialty hub were also notified to the programme.
- **Community engagement and behaviour change:** Community-level interventions were targeted to generate interest from a service-access perspective, and customised provider-level communication was developed to motivate formal and informal providers. It helped reaffirm support for doctors and field officers to carry out the service delivery process.

PPIA service delivery approach – the hub-and-spoke model

After mapping the private providers and onboarding them to the programme, PATH designated a hub-and-spoke approach to service. In this model, general practitioners (spokes) referred cases to the specialist clinics (hubs). In order to optimise patient coverage, the PPIA intervention prioritised private providers who were known to diagnose and treat large numbers of TB cases through the mapping exercise.

> *We call it a hub-and-spoke model. So PPIA is a one-stop-shop for all the services and that helps in early diagnosis.*
>
> **- Ravdeep Gandhi, Marketing Manager, PPIA, PATH**

The general practitioners comprise non-allopathic practitioners or Ayurveda, Yoga, Unani, Siddha and Homeopathic (AYUSH) doctors. They screen the cases verbally or through a chest X-ray. These general practitioners who practise non-allopathic medicine are known as spokes in the PPIA intervention. The practitioners from these spokes would then refer the cases to doctors who prescribe allopathic medicine, located at clinics or hospitals. These hospitals are known as hubs, and they refer the patients for advanced diagnostic tests in the form of the cartridge-based nucleic acid amplification test (CBNAAT) under the brand name GeneXpert (https://www.cepheid.com/en/systems/GeneXpert-Family-of-Systems/GeneXpert-System). It is a widely accepted diagnostic test for TB. After confirmation of TB through the diagnostic test, patients are provided with treatment only by doctors from the hubs.

The other nodes within the PPIA service delivery model are:

- Field officers acting as marketing agents and relationship managers offered low-intensity, high frequency in-clinic sensitisation. This motivated doctors and ensured optimal uptake of the services.

- Field officers monitoring engagement with community NGOs to support sputum transportation, treatment adherence and facilitate reporting. Deployment of NGO staff as in-clinic service coordinators in hub hospitals and clinics that had a high incoming patient load.

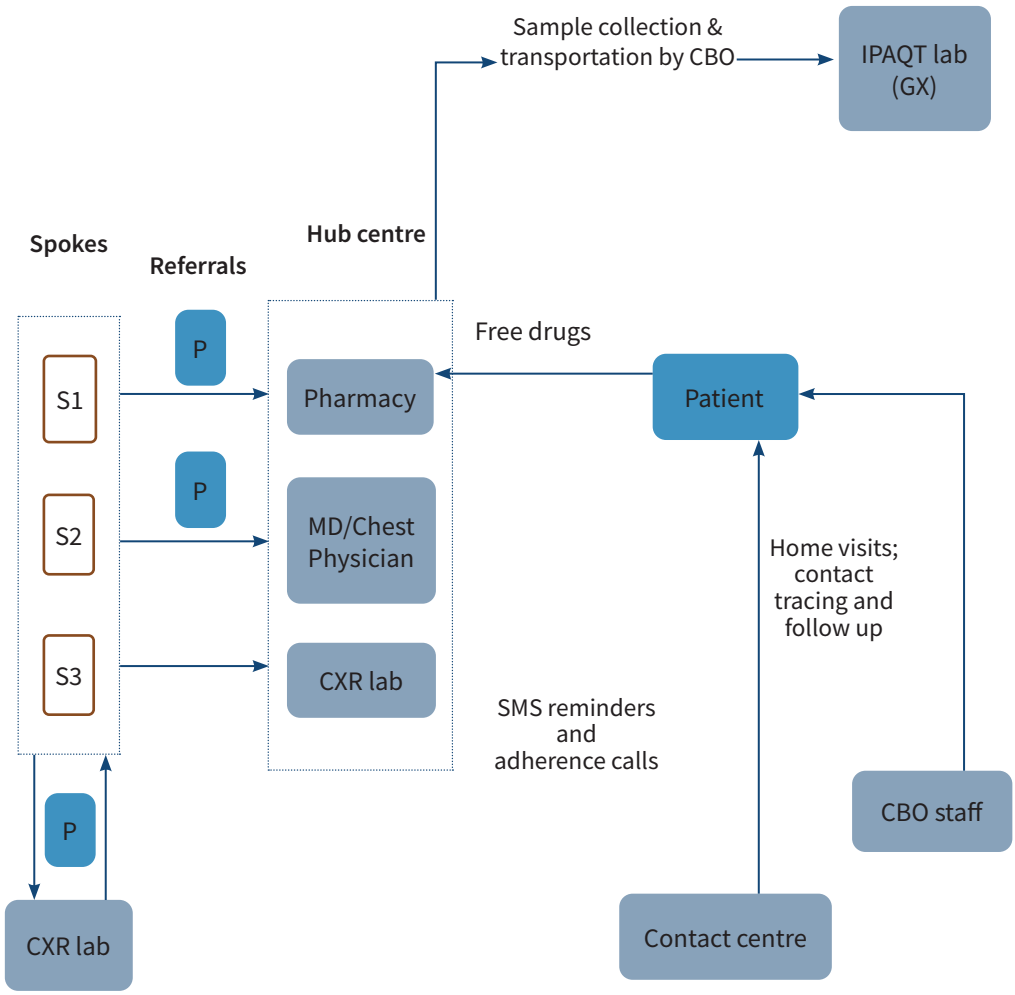


Figure 6: *Diagrammatic representation of activities within 'hub-and-spoke' model*

Figure 7: *Services provided through 'hub-and-spoke' model*

The model explained

- The first step is to create a network of doctors and engage with them. This is done by a team of highly motivated field officers who have experience as medical representatives.
- Once the doctor is on board, patients are given access to diagnostic and treatment services. While informal doctors can only give X-ray vouchers, formal doctors provide microbiological (CBNAAT or GX) test vouchers to confirm TB, as well as treatment vouchers. Digital vouchers were issued later in the project, but paper vouchers were used for reimbursements.
- A patient is registered under the project the moment he/she utilises a service under the PPIA scheme. The field staff registering the patient informs the project's contact centre, which in turn creates a unique patient ID through the 'universal access to TB care' software. The programme allows access to the patient's details and treatment report.
- The patient then consults an in-house chest or MD physician at an engaged hub hospital. The doctors charge a subsidised fee and recommend a GeneXpert test for confirmation and resistance testing.

- GeneXpert uses a sputum sample which is packed and delivered directly to the accredited labs by the PPIA staff. Here, the sample is loaded into cartridges, and the result is available in less than two hours.
- The doctor initiates treatment if the patient tests positive. The patient receives a treatment e-voucher on the phone, which is taken to the chemist.
- The chemist provides free anti-TB treatment drugs stipulated by STCI monthly. Laboratories and chemists validate the voucher numbers by calling the contact centre and then dispensing drugs to the patient.
- Thus, patients receive hassle-free service delivery, reminders about treatment via text messages and phone calls. Patients detected with multidrug-resistant TB are referred to the public sector for treatment.

Technology at work

Since the project involved the collection, storage and monitoring of data related to private providers and TB patients, manual databases were not feasible. Hence, in 2015, Accenture plc. developed a web-based platform to host end-to-end patient journey, starting with the identification of presumptive TB till the outcome of treatment. Vertex helped the patients with details such as e-vouchers.

The platform was named Universal Access to Tuberculosis Care (UATBC) and the services included notifying confirmed TB cases to Nikshay. Nikshay is a composite Hindi word – 'Ni' means end and 'Kshay' means tuberculosis. It generates electronic vouchers for X-ray, provides GeneXpert and first-line anti-TB drugs, sends reminder messages to patients, and calls patients for periodic monitoring. UATBC is enabled to generate payment invoices and link electronic payment portals to service providers.

The advantages of the e-voucher system were three-fold: Easy and faster referral to practitioners, more robust patient tracking, and seamless payment and reimbursement. Easy referrals reduce administrative barriers, support high-quality service delivery, and motivate private providers to comply. Since

the e-voucher system links directly to the national case notification and drug regimen, tracking databases, providers, programme managers, chemists, laboratories, and healthcare administrators get access to superior data for making decisions. Linking the patient through the e-voucher to these critical metrics also allowed PPIA to follow up with patients directly.

Lokesh was allotted a beneficiary identification (BID) after registration with the PPIA programme. The BID number will be used throughout his treatment cycle. He says that he shared the number with the chest physician and received an e-voucher on his mobile phone. He presented the e-voucher to the diagnostic laboratory where his chest X-ray was done free of cost. He received the report in two days — it was positive — and the doctor prescribed medicines. Lokesh showed the e-voucher to the hospital pharmacy and received free medicines for a month.

Lokesh says that he received a phone call and SMS text reminders for his mediation and staff from local CBOs visited him regularly to motivate him to complete the treatment.

The use of ICT tools in the PPIA model has been very effective as it captured events in a patient's treatment pathway and provided insights into a community's preferences and its adherence to treatment. The tools also enabled quicker entry of case notifications from the private sector into public sector health systems.

Quality check and evaluation

The quality of the programme was maintained, and regular audits ensured there was a balance in both quality and timely outcomes. Some of the evaluations conducted during the programme involved the following:

- **Quality of Tuberculosis Care (QuTub) study:** A standardised patient survey was conducted in two wards in Mumbai, and the results indicated that providers enrolled under PPIA prescribed diagnostic tests for their patients more frequently, as compared to non-PPIA providers. The evaluation showed an increased use of microbiological tests to confirm TB in patients.

- **Internal and Central TB Division Evaluation:** The objective was to improve the quality of PPIA services by understanding the operational gaps. Non-partisan external evaluators conducted the evaluation, which was followed by another evaluation by the CTD team, comprising eminent panellists from RNTCP, WHO and MCGM. The overall response to PPIA operations emphasised the need for rapid expansion at all levels.
- **Finance audit:** Quarterly financial audits were conducted through external auditors to ensure financial hygiene of the reimbursements to laboratories and chemists. No major non-compliance or fraudulent practices were reported.
- **Prescription audit:** TB prescription audits were performed quarterly for drug-sensitive TB prescriptions written between 2015 and 2016. Prescriptions were examined at random and found to be in accordance with standard tuberculosis treatment procedures.

Challenges overcome by PPIA

The programme engaged in innovative approaches, so achieving its objective was not easy. The following are some of the challenges and their solutions:

A reluctant and unengaged provider

- The initial interactions for engagement raised several concerns among private health providers and they were reluctant to join the project. The most prominent concern was the return of benefits, in terms of cash or kind. There was also apprehension about the credibility, legality and viability of funding, as these providers had unpleasant experiences with NGOs in the past. The private providers were also apprehensive about working with the government, as they felt that the notification process was time consuming and may lead to loss of patients to the public sector and a possible breach of patient confidentiality. They also felt they would be tagged as TB specialists.
- To overcome these concerns, the programme team designed a marketing strategy and field officers were trained in behaviour change and communication skills. The officers would periodically meet the doctors and explain the indirect incentives like goodwill and an assured inflow of patients. The team also developed a package for reimbursing

the expenditure of supportive services like laboratories and chemists based on pre-negotiated rates. The diagnostic and treatment follow-up calls to the patients ensured that, unlike earlier, they visited the provider throughout the treatment.

Reluctance to undertake microbiological confirmation of TB

- The programme has focused on orienting private providers to follow the Centre's Standards of TB Care in India, especially with respect to diagnosis and treatment. It was recommended that TB cases should be confirmed based on microbiological tests. However, private providers relied on clinical diagnosis.

  In a bid to overcome this challenge, the PPIA intervention, along with the Initiative for Promoting Affordable and Quality TB Tests (IPAQT - https://www.ipaqt.org/) initiative, took a few steps, some of which are:

  - Adequate sputum sample collection and transportation capacity were built with the local NGOs. The project engaged labs conducting GeneXpert tests in Mumbai.
  - Initially, the project offered a differential subsidy for GeneXpert tests depending on the patients' willingness to pay. But it was unwieldy, and the price was pegged at INR 500.
  - The uptake of GeneXpert tests by patients at this price declined and the cost was lowered to INR 250.
  - The test was free twice during 2015 for a limited period and GeneXpert test uptake spiked during the time. As a result, from November 2015 onwards, the GeneXpert test was offered free in the programme.

- **Reducing paper-based reporting**

  At the initial stages of the programme, most activities, such as reporting case notifications and issuing vouchers to patients, were paper based. This became cumbersome as multiple verifications and notifications were mandatory and multiple stakeholders were involved. This challenge

was overcome by introducing the UATBC platform and e-vouchers. Moreover, as the platform arrived eight months after the initiation of the programme, the engaged providers were assisted by the project staff in transitioning from paper-based reporting to a digital version of the administrative procedures for generating patient ID, payment vouchers and notification.

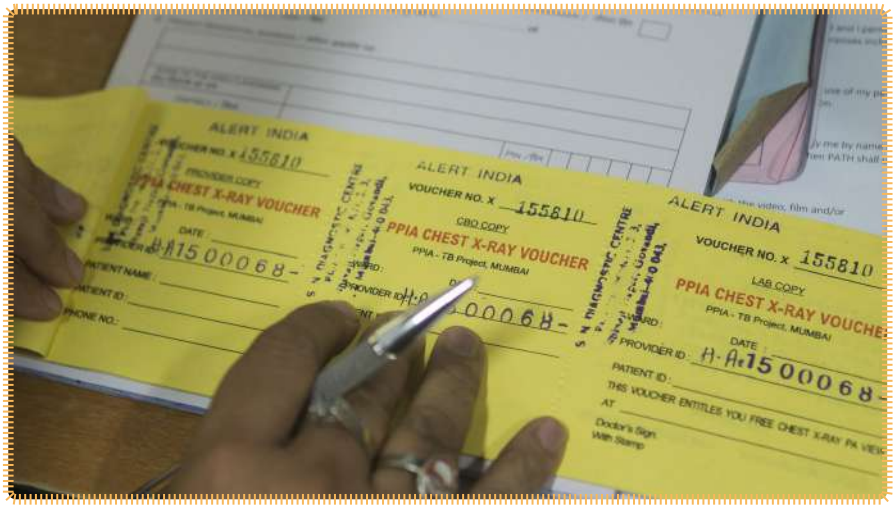


Figure 8: *Paper based voucher here. Source: PATH - https://www.path.org/articles/finding-missing-millions-importance-private-sector-engagement-eliminating-tuberculosis/; accessed in September 2022*

Key findings: The key findings of the PPIA programme are depicted in the infographic below:

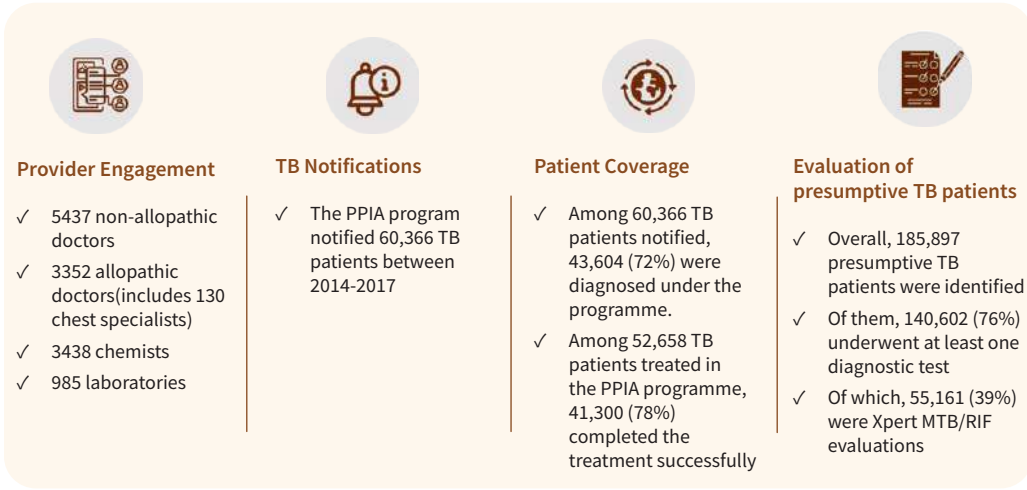


Figure 9: *Key results of TB PPIA model. Source: Compiled from Shibu V, et.al. 2020. Indian Journal of Tuberculosis. 67(2), 189-201; link: https://www.sciencedirect.com/science/article/abs/pii/S001957072030007X*

Achievements of the PPIA model

- **Acceptance:** The success of this model has been recognised by the local and national governments, with MCGM completely funding the operations. It was renamed as the Patient Provider Support Agency (PPSA) as suggested in the CTD's National Strategic Plan 2017-2025. This programme has influenced national policy and was adapted and funded for a nationwide scale-up.

> *In 2017, when I visited the largest slum in Mumbai with over 1 million people, I saw a model of care that seems to work. Private practitioners are empowered to detect and report TB cases through the support of an NGO, and patients are mobilised to access TB services through the incentive of vouchers.*
>
> **- Dr Mario Raviglione,**
> **Director of WHO's Global TB Programme**

- **Awards and recognition:** The PPIA model received the prestigious Porter Prize in 2018. It was showcased at the first-ever UN General Assembly meeting on tuberculosis. PATH also won an award for best poster presentation in the 2016 National Conference on Tuberculosis and Chest Diseases in Chandigarh. PATH presented more than 10 abstracts on PPIA at Lung Health conferences over the years, with four oral presentations.
- **Scaling up:** A pan-India scale-up of the private sector engagement model is now being rolled out by the Government of India. Additionally, the transition from PPIA to PPSA success story was also instrumental in the genesis of the Joint Effort for Elimination of Tuberculosis (JEET) project.
- **Validation studies:** The Government of India and WHO did a costing analysis of the PPIA intervention and found that the expense of engaging the private sector and public sector for TB case diagnosis and notification is similar, indicating that this is a cost-efficient model that can be scaled up through public health systems.[8]

Lessons learnt

Several lessons came out of this innovative multi-stakeholder intervention. Some of these are:

- **The private provider-centric approach:** Many study reports showed that private providers are the first point of contact for many patients seeking health care, particularly in urban India. Hence, the PPIA model was designed in such a way that the maximum number of providers are enrolled in the programme. Involving medical representatives to cater to doctors and other health service providers played a significant role. Relevant experience in the pharmaceutical industry ensured that the field teams had the right skills to approach the doctors and engage them. The deployment of an exclusive behavioural change communication team of pharma-marketing specialists helped motivate the doctors engaged in the PPIA intervention. Performance data of private practitioners were regularly shared and feedback was provided to them. The intervention also facilitated multiple platforms for private provider and government engagement that helped build trust.

- **A holistic patient-centric approach:** The model made sure that each patient who came with symptoms of TB was registered in a centralised system (UATBC) and provided with all the diagnostic and medicine-related facilities under one roof for early diagnosis and treatment. The monitoring through e-vouchers and other digital tools made it possible to track treatment, which in turn helped in curbing the spread of TB. The psychosocial well-being of these patients was taken care of by regular visits from CBO healthcare workers.
- **Regular communication and involvement:** The PPIA team ensured that the government was kept informed about the key activities and members of MCGM were on-boarded during all the key decisions and updates of the programme. This increased the confidence of the government to support and facilitate activities. Government support will play a crucial role during the next integration stage of the programme.
- **Leveraging technology and digital tools:** Use of technology not only improved the goal of increased notifications to UATBC and the government portal Nikshay, but it also reduced paper-based work. Digital tools also ensured that the patients are reminded of their treatment schedules, medicine and follow-ups with chest physicians.
- **Third party audit and evaluation:** Evaluation and auditing mechanisms were introduced in almost all aspects of the programme, right from quality of care to financial and prescription audits. This helped in keeping the programme on track and achieving the desired outcome.

Conclusion: Scaling up

Based on the success achieved through the PPIA model in Mumbai, a large-scale, pan-India version called the Joint Effort for Elimination of Tuberculosis project has been created with the support of The Global Fund to fight TB, AIDS and Malaria (GFTAM). The JEET project is being implemented by the Centre for Health Research and Innovation (PATH's India affiliate) in partnership with the William J Clinton Foundation and FIND and is currently being rolled out across the country in stages. Within three years, JEET is projected to impact 3.5 million lives across 23 states and 406 cities.

> *TB is the first step for us. The basic premise of this model is to tap into the private health system and partner with them and help conquer one disease at a time, maybe all of them together.*
>
> *I think conquering all of them together will be best.*
>
> **- Shibu Vijayan, PPIA Programme Director, PATH**

> *Now that we have done a decent job in Mumbai, we can replicate the model in other cities and geographies by tweaking certain aspects.*
>
> *And not just for TB, but for other diseases as well.*
>
> **- Rishabh Chopra, Lead,**
> **Strategy & Communications, PATH**

The successful implementation of PPIA attracted other donors such as USAID and CDC. PATH was involved in new drug-resistant TB and TB-HIV project activities in Mumbai, Thane, Pune and a few cities in Uttar Pradesh and Odisha, which were successfully completed in 2019-2020. A few more pilot projects using artificial intelligence for diagnostic screening were also conducted successfully.

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EDUCATION

EDUCATION

Going to school for any child in India is a given. The government guarantees access, and several stakeholders, including teachers and parents, play a role to varying degrees in educating their children. The challenge of dropouts, poor infrastructure, lack of teachers, teaching pedagogies and curriculum changes are issues that often find themselves at the heart of discussions on learning.

But a decade ago, Gitanjali G Govindarajan and Colonel Christopher Rego (Retd.), in keeping with author credit, came across children in two different parts of India who were finding it a challenge to even access a school because of the biases and conflict that existed around them. The challenge was not about the quality of education but the total lack of it.

Govindarajan found the idea of children with special needs not finding inclusive learning spaces both astounding and unacceptable in equal measure.

The United Nations Sustainable Development Goal 4 asks states to ensure "inclusive and equitable quality education for all". And yet, despite overall progress in ensuring education for all, children with disabilities remain marginalised and are less likely to "participate in and complete their education compared to their peers without disabilities".

It was an encounter with one such young girl, Sneha, that spurred Gitanjali to start the Snehadhara Foundation, an organisation whose Uhuru programme is one of the two case studies in this section.

The spirit of 'Uhuru' or 'freedom' in Swahili has guided the Snehadhara Foundation programme, giving its students the opportunity to make choices, learn and grow through arts, which is at the centre of its unique curriculum.

A semi-residential school is part of the programme – a joyous learning space for children with special needs that runs out of a leafy Bengaluru neighbourhood.

Thousands of miles away, in northeast India, Col Rego began work on setting-up schools in conflict zones.

The founder of the Sunbird Trust had seen first-hand the impact years

of insurgency and violent ethnic clashes had had on children caught in the crossfire. Their initiative to spread “peace through education” in the northeastern states is the second case study in this section.

Pointing to the fact that the net enrolment rate of students in most of northeast India is below the national average of 67 percent, with years of strife impacting access to resources to basic education, the Sunbird Trust developed a multi-pronged approach to address some of the issues.

Their ‘peace through education’ intervention keeps the community at its centre, building schools, resources and friendships as they strive to educate 25,000 children in the next two years.

The two case studies underline the challenges faced by the organisations, not in building resources, but in changing thought processes while creating equitable spaces for learning.

Both also share the triumph of arts, music and learning that transcends their school premises and spills into the community, creating more empathetic and inclusive spaces.

And finally, they give a glimpse into the immense possibilities that an inclusive and innovative approach can bring to ensuring every child learns.

IX. Sunbird Trust: Spreading peace through education in conflict-affected parts of northeast India

Col Christopher Rego (Retd), founder & CEO, Sunbird Trust

Abstract

Many regions of northeast India have been home to separatist and ethnic conflict for several decades. The lack of adequate educational institutions, along with entrenched poverty, has precluded many children from accessing education. With poor employment opportunities, there is a proclivity for youth getting radicalised or becoming criminals. Sunbird Trust's multi-layered 'Peace through Education' initiative seeks to unite stakeholders towards access to education and thereby build peace and prosperity.

Founded in 2014, Sunbird Trust works towards a positive mindset, a change from the suspicion and hatred of the past, and is a people-friendly and sustainable solution to conflict. This is a story of leveraging education to build peace, better livelihoods and development in remote, conflict-affected areas.

Today, Sunbird Trust is impacting the lives and destinies of over 10,000 people from six states in northeast India.

Introduction

The work of Sunbird Trust

Thousands of civilians and uniformed personnel have been killed and livelihoods impacted in several states in northeast India due to decades of conflict, internecine struggles and lack of development. The resultant instability has led to poor development, unemployment and poverty. Among the worst impacted are children, many of whom do not have access to education. Without education, employability and empowerment, youth are easy prey for radicalisation, crime and drugs. This, in turn, further fuels conflict and the cycle of violence.

The personal experiences of the conflict and violence by Sunbird Trust's founder, Colonel Christopher Rego (Retd), who served for over seven years in Manipur and Mizoram, and his wife Myrna led to the idea of peace through education. Since the founding of Sunbird Trust in December 2014, this endeavour has been taken forward by the trustees of Sunbird Trust, the team, donors, mentors, and the supported children and their families.

Box 1: Sunbird Trust

Vision

Building peace through education and empowerment of children and youth in conflict-affected areas of northeast India.

Mission

To educate 25,000 underserved children from insurgency, conflict-affected areas of northeast India up to Class X and empower their choices by 2025.

To raise 50 schools/hostels in these remote, conflict-affected parts by 2025.

The author's vast experience of working in northeast India has shown that the region is not a single cultural or political entity. The eight states (including Sikkim) have over 100 distinct tribes and many sub-tribes and identities.

During the years of his stay and work in northeast India, the author has seen that the sheer complexity of ethnicities, as well as language and culture, leads to many schools and even civil society organisations (CSOs) being run along communal lines. Urban migration, vanishing forests and the quest for employment have also impacted the rural landscape, livelihoods and priorities of the next generation.

Sunbird Trust, a non-denominational, non-religious CSO, works on the motto of 'Peace through Education' in remote, conflict-affected parts of northeast India. It provides access to education either physically (raising schools, hostels and educational infrastructure) or financially (through child

Box 2: Tragedy of conflict

Since Independence, thousands of civilians in conflict zones of northeast India have lost their lives either in ethnic conflict or through separatist violence. Hundreds of members of the security forces too have lost their lives. On 4 June 2015, 20 army soldiers were killed and over a dozen severely injured in an ambush on a convoy in Chandel District of Manipur. On November 13 2021, an army colonel, his wife and young son along with four soldiers were killed in a deadly ambush in Churachandpur District of Manipur. The colonel was associated with Sunbird Trust's work – a partner school, Lyzon Friendship School, Singngat, fell in his area of responsibility.

sponsorship) as well as through community engagement. The ultimate objective is to achieve a positive 'mindset change' in people impacted by conflict and militancy by transcending violence, hatred and suspicion and moving towards amity, pluralism and inclusivity. This contributes to development, livelihood sustainability and a better quality of life.

The state of education and educational infrastructure in northeast India

The development and education in the eight northeast Indian states with respect to the rest of the country can be understood from available data. For instance, the net enrolment rate for schoolchildren in India stood at 67 percent during 2019–2020. With the exception of Tripura and Manipur, all the other states in northeast India were below this average (see Figure 1).

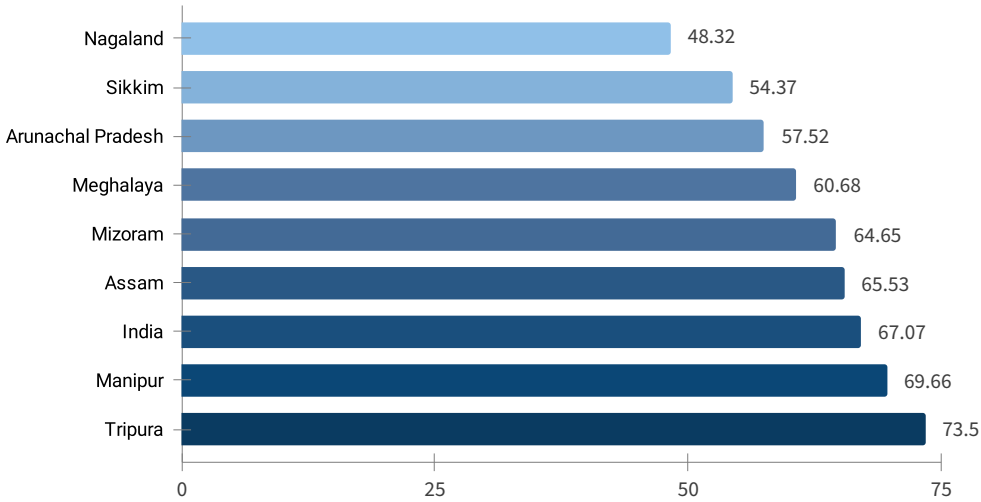

Figure 1: *Net enrolment for schoolchildren in northeast India 2019-2020*

Source *(India Data Insights) © Sattva Consulting*

Note: *Adjusted net enrolment rate is the number of pupils of the school age group for primary education, enrolled either in primary or secondary education expressed as a percentage of the total population of that age group*

The national percentage of students in Class VII achieving at least a minimum proficiency level in terms of nationally defined learning outcomes stood at 71.90. Only Assam and Manipur stood above this average (see Figure 2).

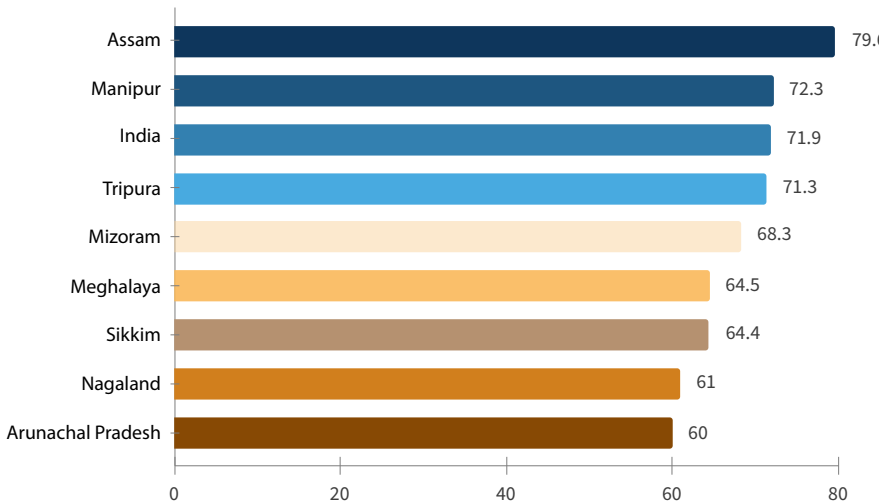

Figure 2: *Percentage of Class VII students in northeast India achieving a minimum proficiency level in terms of nationally defined learning outcomes*

Tellingly, six northeast Indian states (Manipur, Nagaland, Assam, Arunachal Pradesh, Meghalaya and Tripura) were among the worst seven in the country as far as the percentage of schools with access to basic infrastructure such as electricity and drinking water.[1]

The problem: Impact of environmental factors on education

Access to education in remote, conflict-affected areas of northeast India is impacted by several factors:

- Schools and hostels are expensive.
- Differing tribal identities, language and past conflict limit the choice of schools.
- Many government schools in remote areas are barely functional and understaffed.
- Right to Education (RTE), which is being implemented in most other states, has not been effectively implemented in most of northeast India.

Figure 3: *As part of the Sunbird philosophy, students are considered equal stakeholders in the school structure to voice their concerns (Photos: Sunbird Trust)*

1 Source: Sattva Consulting 2020-21

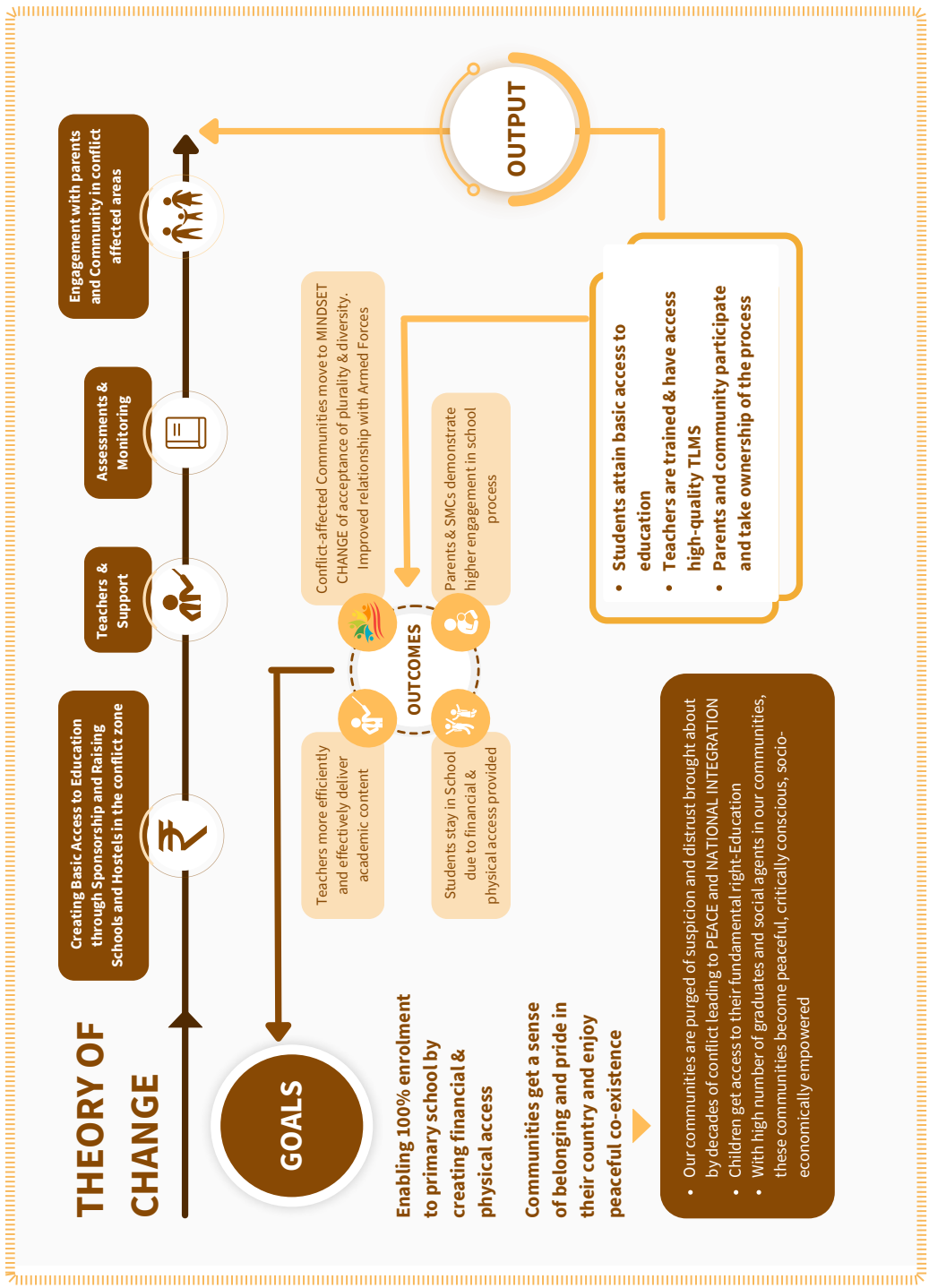

Figure 4: *Sunbird Trust's 'Theory of Change'*

Theory of change

Sunbird Trust implements its Peace through Education endeavour through multi-layered interventions. A critical objective beyond education is a sustainable mindset change in conflict-affected communities. Sunbird Trust's Theory of Change is expounded in Figure 4.

Planning

Holistic planning is required for:

- Building educational infrastructure
- Child sponsorship
- The HR element and recruitment
- Capacity building in schools
- Community outreach work
- Peacebuilding activities

Any intervention in a conflict zone needs to be pertinent to the needs of the local communities. Educational infrastructure is capital intensive and requires long-term financial commitment, and due diligence is essential before plunging into any partnership or project. Factors for selecting partners include remoteness, need for educational infrastructure, track record of the founders and a strong match with Sunbird Trust's 'for-all' ethic. The findings help customise the proposed intervention.

Resourcing

The focus on fundraising changed from retail funding in the initial years to corporate donors and High Networth Individuals (HNI). Sunbird Trust's selection in March 2022 by the Edelgive Foundation amongst the top 100 NGOs across India helped enhance the image of the organisation.

Operationalising and execution

Staff is recruited after the intervention is designed. Qualified professionals from varied background including Masters of Education/ Development, Teach for India and Gandhi Fellows, and Masters of Social Work are preferred. Most of the current team of 32 people are embedded in the villages of the partner institutions and join the school staff. They stay with local families so that they can connect with the community and acclimatise to the way of life. At the time of writing of this case study, Sunbird had 10 base locations (where team members are posted) across the states of Manipur, Assam and Arunachal Pradesh (see Figure 5). A starting point with the partner organisation is an MoU articulating the duties and responsibilities of both and including criteria for transparent financial management.

Some important aspects towards achieving Sunbird Trust's Mission are mentioned below:

- **Digital literacy:** Computer centres are set up in remote areas and digital education is introduced in the curriculum.
- **Creative and cognitive skill development:** These skills enable students to efficiently read, think, prioritise, understand, plan, remember and solve problems.
- **Language literacy and numeracy:** Focused literacy and numeracy programmes are incorporated in school systems. A play-learning approach through card games, alphabet games and number charts is employed.

Figure 5: *A computer centre at Lyzon Friendship School, Singngat*

- **Student voice:** Students are considered equal stakeholders in the school structure and voicing their concerns helps them with leadership skills, accountability and responsibility. In some schools, student representatives are elected through a democratic process.
- **Co-curricular activities:** Sports, music, cultural and nature conservation activities are promoted. Child-suitable movies that bring out values of trust, peace and compassion, as well as nature films, are screened every week.
- **Awareness sessions and workshops:** Personal development workshops are conducted on a host of issues, including menstrual hygiene, nature conservation and storytelling.

Beyond the classroom

Building friendships: Education/empowerment is a means to the end of building amity and peace, and not an end in itself. Weaving in openness and acceptance to diversity does not happen by edict, but is a slow, organic and continuous process. The steps involved are:

- Partners sign MoUs stating that there will be no bias towards any tribe, community or religion.
- Embedding Sunbird team members from other parts of India or the northeast in the village of the partner school. This ensures diversity and plurality.
- Organising visits for children to other parts of the state and the country. These educational tours give them a broader perspective of life beyond their villages.

Box 3: Friendship Tours: Partnership with Assam Rifles

In May 2020, Assam Rifles, in partnership with Sunbird Trust, organised a Friendship Tour in Kohima for children from the Meitei, Kuki and Naga communities of Sunbird Trust partner schools. The communities have historically been competitors for identity, land and resources. Months later, the children visited the homes of children of the other communities. The children gave the most positive feedback on their learnings about the other communities.

Figure 6: *A Friendship Tour in Kohima jointly organised by Assam Rifles and Sunbird Trust. May 2020*

- Sensitivity to other cultures by celebrating festivals of other religions. Similarly, acceptance of other languages through songs, dance and films.
- Humanising the armed forces by creating opportunities for school children and community members to interact with the army and Assam Rifles. This includes medical camps, career guidance for children, sponsorship of humanitarian projects and cultural and sporting events.

Box 4: Going to college in Bengaluru

In 2017, Sunbird sponsored 25 students from remote villages in Manipur and Nagaland to Karnataka for their intermediate and undergraduate studies. They were admitted to colleges in Bengaluru and Kolar in various disciplines including engineering, law, social work, science and humanities. Language and food and the vastly different cultural background posed initial difficulties, but they adapted rapidly and made a mark at their educational institutions, excelling in co-curricular activities, social work and sports. Most of these students have since completed their graduation. One student has obtained a scholarship for postgraduation at the University of Padova in Italy. Six students are now pursuing postgraduate studies, while 15 students interned with Sunbird Trust. The rest are either employed or preparing for competitive examinations.

Collaboration

In areas of conflict, Sunbird Trust has, through its all-inclusive agenda and empowering approach, gained the trust of villages. Major initiatives in collaboration include:

- **The community:** Critical to the Peace through Education strategy is a deep connection with local communities. Local knowledge of other stakeholders and sharing responsibility helps foster the community participation that Sunbird needs.
- **Interdisciplinary approach:** Sunbird seeks an interdisciplinary collaborative approach to making the intervention more beneficial. A holistic approach to community empowerment to include disciplines such as livelihoods, health and environmental sustainability is being employed. For instance, Sunbird is partnering with other NGOs in diverse fields – from raising educational infrastructure to solar electrification,

environment-friendly farming practices such as SALT (Sloping Agricultural Land Technique), mushroom and roselle tea cultivation, and creating awareness on health-related issues such as menstrual hygiene.

Figure 7: *Parents of schoolchildren perform voluntary work for the school*

Box 5: Building of Sunbird Friendship Hostel, Ijeirong

In 2014, residents of the tiny Ijeirong village, now in Noney District of Manipur, requested Col Rego to build a hostel for the village school to facilitate children from faraway villages to attend school. Till then, all children from neighbouring villages were 'self-help', which meant they cooked their own meals in tiny kitchenettes provided by the school. The village contributed wood, stone and skilled voluntary labour for the construction. Assam Rifles provided roof sheets and logistical support by transporting building materials, while private donors pitched in with miscellaneous expenses. The first Sunbird Friendship Hostel was raised in six months.

Monitoring and evaluation (M&E)

This is an important part of Sunbird's project management and the organisation now has a full-fledged M&E manager whose role is to help improve current and future management outputs, outcomes and impact. The

objective is continuous assessment of ongoing programmes based on detailed information regarding the progression and quality. Several computerised tools are also being adopted.

Training: Constant upgrading of skills and knowledge of the team is of critical importance. Learning capsules include strategies on education philosophies, building teacher motivation, conflict resolution, problem solving, school leadership and increasing learning outcomes.

Scaling: At the time of writing of this case study, over 10,000 students were recipients of the Sunbird Trust's work. The image of the organisation as being without agenda, trustworthy, committed and dependable is helping scale up work.

Team of teams approach: Partner institutions are assisted to form their own self-sustainable trusts or societies and create a 'team of teams' whereby all such partner organisations collaborate, share learnings and work to the common objective of empowering children and spreading amity.

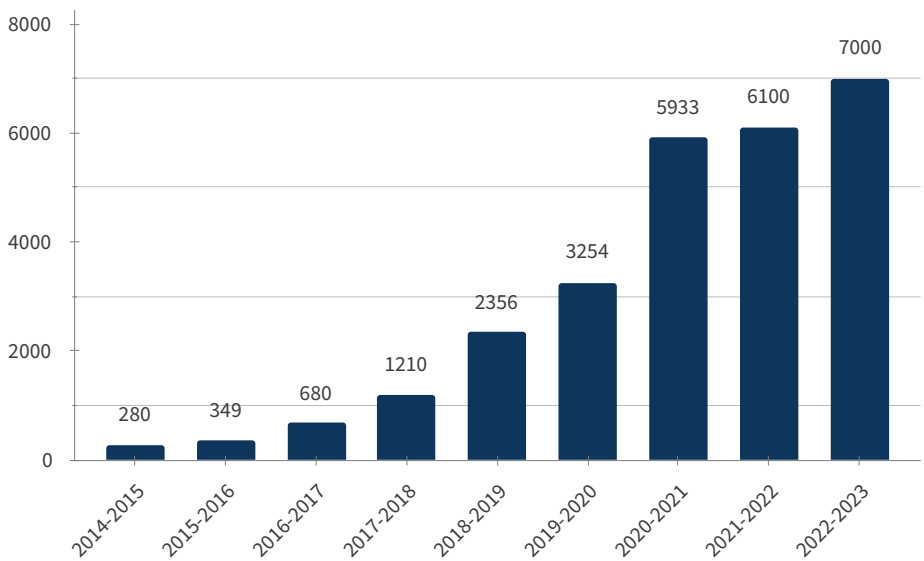

Figure 8: *Number of sponsored students since 2014*

Table 1: Project growth since 2014

Item	No.	Remarks
Sponsored students	6333	7,000 projected by end of 2022 -2023
Schools (built or under construction)	10	
Hostels (built or under construction)	10	
Base locations (Team members posted)	9	Ijeirong, Puichi, Singhat, Kachai, Langmai and Oinam, Ngarian in Manipur and Mualdam and Majuli in Assam
Partner Institutions	47	In Manipur, Assam, Nagaland, Meghalaya, Arunachal Pradesh and Sikkim
Computer Centres	7	
Multipurpose Halls	5	
Individual buildings/ infrastructure constructed	82	Classrooms, hostels, computer centres, multipurpose halls, toilets, playfields
Directly impacted persons	Approx 10,000	Includes sponsored and those studying in institutions built by Sunbird Trust
Number of villages of sponsored children	597	From Manipur, Assam, Nagaland, Meghalaya, Arunachal Pradesh

Key challenges and constraints

Working in remote, conflict-affected areas across different states, ethnicities and cultures gives rise to a multitude of challenges. These could be classified under the heads of individual and systemic.

Individual and interpersonal

Sunbird team members encounter a host of challenges across domains, some of which are:

- Team members come from different backgrounds, have varying perspectives and have to find common ground for location-specific actions.
- Many Sunbird members work in isolation in very remote areas. Collaborating on strategies, challenges and engaging in coordinated upskilling activities is difficult.

- When members stay in close proximity with host families and other team members, the lack of personal space causes attrition and burnout.
- Due to the vast diversity of roles in Sunbird Trust, upskilling in specialised aspects and focusing on career growth can be a challenge.
- Cultural differences in cuisine, daily rhythm and language, coupled with lack of electricity, poor connectivity and water shortage, take their toll.

Systemic problems

Sunbird is a first mover cutting its own path through security, social, cultural and economic challenges. These challenges can be broadly categorised as:

1. **Geographical challenges**

   Security: Over 70 percent of Sunbird's work is in conflict zones, especially in Manipur. In some remote project areas, militant groups are interspersed amidst village communities. They are not averse to taking recourse to violence for their vested interests and occasional ambushes on security forces occur. Sunbird team members have encountered such elements, but draw support for their security from the host communities. However, many eligible applicants choose not to join the organisation due to security concerns.

   Ethnic diversity: A dimension of conflict is vast ethnic diversity and varied aspirations. Amazingly, Manipur state with a population of barely three million people (Mumbai has approximately 20 million) has over 30 separate ethnic identities. Desire for autonomy and fear of loss of identity besides conflict over land, immigration, settlement and resources have kept distrust between communities simmering.

   Remoteness and accessibility: Sunbird seeks to serve the most marginalised and underserved communities. Many of these villages do not have electricity and mobile connectivity. The nearest Primary Health Centre or PHC could be several hours away, if transport is available. Sourcing basic groceries, fresh vegetables and cooking gas can be difficult.

2. **Organisational challenges**

Dispersion: Sunbird projects areas lie in Manipur, Nagaland, Assam, Meghalaya, Arunachal Pradesh and Sikkim, with expansion likely to Mizoram. This throws up challenges of administration, logistics and communication.

Youth vs experience: There is a challenge of striking a balance between energetic, unencumbered, low-salaried, but relatively inexperienced young team members, and older, married, more experienced but higher-salaried professionals beyond the reach of Sunbird Trust. The net result is that younger team members face immense challenges in dealing with sometimes manipulative and stubborn community people.

Funding: Consistent access to funding remains an enduring challenge with the growth of the organisation. The COVID-19 pandemic threw up the unpredictability and inconsistency of funding.

3. **Community-related challenges**

Building trust: This is perhaps the most vital component for a successful community transformation project. Given the history of bloodshed, hatred and suspicion, it is difficult for people to shed their mental baggage.

Rhythm of life: Village life across rural India has its own unique rhythm and northeast India is no different. Work normally comes to a standstill as early as 4 pm with the early sunset in the region. Working after 4 pm is not the norm, and families generally congregate around the kitchen fire till dinner time and then it is early to bed. Given their own workload, team members find the slow pace of life to be a challenge.

Corruption: The combination of militancy, remoteness and administrative factors in many northeast states breeds corruption. In many government schools, funds for uniforms, classroom equipment and midday meals are grossly misappropriated.

Sense of entitlement, dependency: Local communities frequently view NGOs as moneybags. All interventions have to be carefully executed to avoid dependency, or worse still, a sense of entitlement.

4. **Operational challenges**

School and classroom challenges: A school transformation system requires immense patience and time, especially as many teachers lack training and basic soft and hard skills. Building competencies such as communication, leadership and time management are major challenges. Deeply ingrained social, cultural, religious and even educational practices can sometimes be inhibitors to change. Trying to incorporate critical thinking as opposed to rote learning can be difficult, with some teachers loath to change. Female team members sometimes encounter resistance from older and patriarchal male teachers.

Remuneration: A major challenge is maintaining salaries for the teachers amidst poorly resourced communities that are barely able to pay fees. Underpaid teachers avoid any extra effort like after-class tuitions and can leave midterm at any opportunity.

Measurement and evaluation: While M&E builds stakeholder relationships and a collaborative approach, the challenge for a young organisation like Sunbird Trust, as well as partner organisations, is to find the time and resources for effective M&E. It requires commitment from the stakeholders, which is not always forthcoming.

Innovations

A venture launched amidst untested and hostile waters requires a liberal dose of risk-taking abilities and innovation. The concept is unique, innovative and many-layered as expounded in subsequent paragraphs:

Target students/participants: Sunbird Trust's specific endeavour to empower students impacted by violence through education gives them the opportunity to make better choices for their career and livelihoods, and helps foster peace.

Cross-cultural sponsorship: Cross-cultural/external sponsorship of students in northeast India by people from the 'mainland', another unique feature of the Sunbird initiative, builds bridges of trust between these communities and the rest of India.

Friendship schools and hostels: Sunbird's 'Friendship' schools and hostels bring together sponsored children of different communities. This facilitates understanding, dialogue and co-existence and helps overcome conflict.

Families of sponsored students as agents of change: They become a part of the venture and help enlarge the circles of amity through entire villages.

Humanising the armed forces and building bridges: Engaging security forces with the sponsored students through visits, medical camps in villages and contributing to educational infrastructure helps build confidence and trust.

Sponsored students as ambassadors and anchors for 'Peace through Education': Alumni of the scheme act as drivers of change contributing materially or supporting the next generation of beneficiaries.

Partner institutions as hubs for change: Sunbird is able to scale up its work to several neighbouring villages for building peace and livelihood intervention work.

Sustainability

A question frequently posed to Sunbird Trust by donors is about the sustainability of schools where there is little or no scope of income for operational expenditure. But sustainability can be seen through a different lens. The first is in terms of the mindset change, and the second is the stability generated through educated and empowered students, who, once employed, lift their entire families out of poverty.

> *The Sunbird family came to my rescue at a critical time in my career. Their timely and sustained assistance helped me complete my studies despite financial constraints. I will remain an active and lifelong contributor to this humanistic endeavour.*
>
> **- Dr Benjamine Khiangte**

Third, is when graduate or postgraduate alumni return to work in their own communities, and some, like alumnus Dr Benjamine Khiangte, MD (who was partially sponsored for his medical studies), begin to sponsor children of their own. Today, there are over 100 graduate alumni of the Sunbird Trust or pre-Sunbird initiative, and they include doctors and graduates and postgraduates in social work, law, engineering, agriculture, management and hotel management. Sunbird is now experimenting with eco-tourism in its partner villages and marketing of local produce such as roselle tea and mushroom.

Impact

Working in remote and conflict-affected zones with active militants was risky from inception. However, eight years down the line, Sunbird positively impacts the lives and destinies of over 10,000 children, including over 8,400 of whom are directly sponsored. These children hail from as many as 597 villages across six states in northeast India. In addition, there are 30,000 people who have benefitted from the COVID-19 relief work of the Sunbird Trust.

Mindset change: The overall impact of the measures goes beyond empowerment and financial stability to mindset change from suspicion and distrust to acceptance and unity.

Box 6: From swords to ploughshares

Transformation of an army camp into the village school

In 2017, an army camp at Puichi/Octan Village in Noney District of Manipur was vacated by the army and the troops deployed elsewhere. Seeing the transformational work of Sunbird Trust, the army handed over the entire camp to Sunbird Trust through the local village authority to raise a primary school, the only one in this village of about 730 residents. Thanks to sponsorships, the army camp is now a school and a centre of learning. The village has totally embraced the concept and hosts three Sunbird team members. In fact, the village has even gifted four acres of land to Sunbird Trust for an agriculture project. This is one of the areas where a comprehensive mindset change has been achieved.

From Operation Bluebird to Operation Sunbird

In July 1987, armed insurgents attacked an Assam Rifles camp in Oinam Hill Village in Manipur and killed nine soldiers and injured several others. For the next two months, the army launched Operation Bluebird, "ostensibly aimed at catching the rebels" and "recovering the firearms". Some civilians were killed in the course of action from both sides.[1] The consequent resentment among the local population prevails even today. What started in Oinam Hill Village is one of the seminal events that was a catalyst in perpetuating insurgency in Manipur and Nagaland. Since Operation Bluebird, the Oinam Hill community has avoided any major official contact with the army and Assam Rifles.

In April 2021, seeing the impact of Sunbird Trust's work, the villagers from Oinam Hill Village invited Sunbird to work for the development of the village. Sunbird is now bringing manifold improvements to the local government high school and a village primary school. And so, 35 years after Operation Bluebird, the first major contact with the Assam Rifles was established and Class X students in the local government high school went on an Assam Rifles sponsored six-day tour to Shillong and Meghalaya. The students were hosted at camps by the Assam Rifles and treated warmly. This was a life-changing experience for the children and helped many shed the mental baggage of the past. This event led to open communication and reconciliation between local villages and the Assam Rifles.

> *"Compliments to Sunbird Trust on execution of Operation Sunbird in the aftermath of Operation Bluebird. After 35 years, their work of Peace through Education is helping rebuild trust and reconciliation between Oinam Hill and neighbouring villages and the armed forces."*
>
> *A senior army officer*

1 https://www.hindustantimes.com/india/manipur-s-horror-when-operation-bluebird-struck-terror/story-0FTWgabR6PJesb9dd9xMUL.html

Sunbird Trust alumni: While this case study covers Sunbird Trust's work since its founding in December 2014, the real start began a decade earlier in Mizoram when the founders, Col Rego and Myrna Rego, sponsored needy students with the help of family and friends. From then till now, Sunbird's alumni include three doctors (including a super specialist), and graduates across multiple disciplines including law, engineering, social work, hotel management, nursing, agriculture and business management. While some alumni have found employment in India, others moved abroad to the US, Italy, the UK, Australia and Dubai for employment or higher education. Fifteen graduate alumni have returned to intern with Sunbird Trust in their own communities for a few years.

Organisational learnings and limitations

Limitations of partner communities: CSOs like Sunbird have to work in communities steeped in tradition, that are resistant to change and orthodox, while encouraging ownership and participation. The learning is that organic community participation and ownership is more important than any intervention by an NGO.

Assumption of community ownership: Farming and livelihood-related activities leave little time for villagers to attend meetings. Some assume the institution to be the administrative headache of Sunbird or the local founders. Lesson learnt is that sponsorship and contributions to the institution are now linked to community partnership.

Harvesting social profit: Despite sponsorship, some partners, sponsored students and their families contribute minimally to Sunbird Trust's activities. Through setting of expectations through MoUs, visits to homes of sponsored children and liaison with partner communities, the gaps in garnering SROI (Social Return on Investment) are being closed.

Patience, persistence, tenacity: Deep frustration at the slow pace of change, coupled with already difficult environmental conditions, has taken a toll on many Sunbird team members. Exposure to globally proven modern pedagogical practices takes considerable time to reach the classroom. This is because teachers find it difficult to trust the process and apply the new learnings on a consistent basis. A major lesson learnt is that enduring change needs persistence and patience.

Embedding team members: To be perceived as part of the community, team members should be seen to be sharing the same challenges and living simply. This is instilled across locations and is frequently achieved through ensuring that team members live with host families in the village. This avoids the perception that the Sunbird team is privileged.

Recruitment: Given the extremely difficult living, operational and environmental conditions, it is imperative that prospective team members are resilient, adaptable and tenacious. A fairly rigorous selection process is undertaken, filtering candidates who have romantic notions of 'village life'.

No one size fits all: Immense economic, cultural, social and political differences across Sunbird's project areas mean solutions and strategies need to be tailored accordingly.

Setting expectations and deliverables: When partnerships begin solely on trust without setting out clear-cut expectations and deliverables on both sides, there is a tendency for misunderstanding and acrimony. The learning is that professional expectations, deliverables and boundaries lead to better relationships.

Listening to stakeholders: A 'we know best' attitude is a killer for ownership and partnership. The learning is that the stakeholders should always feel empowered to make suggestions. It is also critically important to respect the dignity of the children and community members through scrupulously avoiding the 'saviour' approach.

Gap in need analysis survey: Gaps in knowledge have occurred in previous surveys regarding prioritisation of work, information on educational interventions and formulating strategy. This has led to an incorrect approach.

Sustainability: To avoid a loss of knowledge within the organisation through the transience of team members, scrupulous documentation is critical.

Creating ownership: Creating ownership is critical to avoiding the crutch of dependency or, worse still, entitlement. Therefore, teacher training, soft-skill building and adherence to MoUs before making any infrastructure investments are helpful.

Autonomy to team members: Relative autonomy allows team members to bring forward the most contextual interventions. However, too much autonomy without overview could go wrong; therefore, the ideal combination is found to be autonomy coupled with strong structures and processes.

Conclusion

Figure 9: *Engagement with local communities, in matters beyond the classroom, is crucial to the success of Sunbird's initiatives*

> *My three-year journey in Sunbird Trust from assistant school leader to COO through incredible challenges and opportunities was a life-changing experience. It helped me live the Sunbird maxim of 'be all you can be' and helped me learn and unlearn about peace building with and through our children and communities.*
>
> **- Dr Sonal Sethia**
> **COO, Sunbird Trust, July 2018 to August 2021**

Figure 10: *Figure: Team Sunbird Trust and graduate alumni interns (front row) 2022*

Choosing to work in remote conflict zones with security issues involves risk. It requires a team of passionate and tenacious members willing to take this risk and endure challenges. Collaboration and building ownership in the ventures, not easy under normal circumstances, is far worse amidst a potpourri of cultures and varied aspirations. Team Sunbird feels rewarded when host communities accept the concept of Peace through Education.

Eight years since the founding of Sunbird Trust, the rewards of the work are now being enjoyed with tangible proof of positive mindset change across numerous villages. More and more empowered alumni of the Sunbird scheme are crossing the threshold to self-sufficiency and pulling their entire families out of poverty. Better still is that many are returning to intern with or even join the organisation.

Acknowledgement

This case study has been written exclusively from inputs of Sunbird Trust team members posted at Sunbird base schools in remote parts of northeast India and stakeholders including partner institutions, children, their parents, mentors and donors.

X. Uhuru: A unique curriculum of inclusive education in Bengaluru

Vibha Bhat, Gitanjali G Govindarajan, Yashaswini Gupta, Snehadhara Foundation

Abstract

Snehadhara Foundation (SF) is a non-profit organisation that seeks to create and advocate for inclusionary spaces as a foundation for a compassionate society. Our model stems from the belief that all children and young adults, despite disabilities, should have access to an inclusive learning environment. This is possible only if we think of inclusion differently.

Inclusion cannot only be applied as a response to an apparent exclusion. Inclusion must be woven into the fabric of any effort so that it deflects the possibility of exclusion itself. The arts have an important role to play in achieving this. Therefore, Snehadhara chose to take the mainstream world and build inclusion into it using the arts.

Uhuru in Swahili, Arabic, Urdu, Turkish and some other languages means freedom, which defines the heart and soul of our work with our beneficiaries. The programme Uhuru has allowed us to re-imagine learning for children from vulnerable backgrounds. It works with twin advantages of: 1) helping steer the learning of the students, and 2) enabling them to be more inclusive of children with special needs.

The Uhuru programme has over 135 direct beneficiaries today and houses the first-of-its-kind semi-residential facility for children and adults with special needs. It also works with parents, caregivers and communities in neighbouring villages and schools. This programme has also birthed the first Arts Practices for Inclusion certification course. The origins of this programme and its journey are detailed here.

Introduction

Stream of love: From genesis to growth

When five-year-old Sneha walked into a classroom, she did not know it then, but the girl would birth an idea that would lead to a revolution — Snehadhara. The Snehadhara Foundation or SF was established in 2012 as a response by Dr Gitanjali Sarangan when Sneha, who had Down Syndrome, was denied admission in schools or any learning space.

Snehadhara literally means 'stream of love'. It became apparent from the experience with Sneha that inclusion is not only about the person at the risk of exclusion, but also about stakeholders, or as Sarangan sees it, the community.

Sneha passed away as we were writing this story and became the genesis of change and development of this space. What began with one child years ago and a movement using multi-arts as therapeutic and inclusive practices, has impacted many lives across and beyond the country.

The pioneers of Arts Practices for Inclusion, SF, believe that inclusion is the bedrock of a more compassionate and empathetic society. Our aim is to create an environment which welcomes, acknowledges, affirms and celebrates the value of all learners.

We at SF believe that every child requires meaningful and holistic learning spaces which need to be created by those who engage with the children. The formula and the guide are service and community-based principles and policy advocacy. The service delivery model also trains educators, practitioners and psychologists across schools and learning spaces in the country. SF has three initiatives — Direct Care, impART and Prajnadhara — which help achieve these goals.

SF, over 10 years, has become one of the only semi-residential facilities with its own campus in Nelamangala on the suburbs of Bengaluru. In 2012, we catered to 35 children with 23 adults facilitating and supporting them at the centre in the Uhuru programme. This has grown to 135 children!

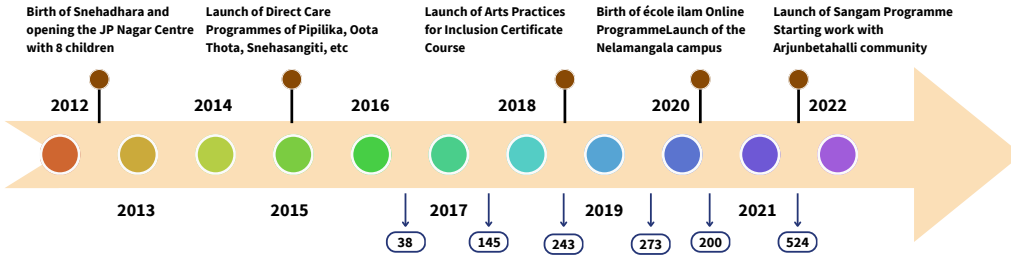

Figure 1: *Snehadhara journey from 2012-22*

The beneficiaries of SF's direct care programme are children and adults with disabilities, including those with Autism Spectrum Disorder, ADHD, Down Syndrome, Cerebral Palsy and other neurodevelopmental disabilities. We also cater to the well-being of parent groups through programmes on 'caring for the caregiver'.

A parent of a child on the autism spectrum once told us, "I do not have the skill or the strength to take my child to multiple therapies. And I do not know of any other programme that allows him to stay the night and gives him a wholesome approach to learning."

The Uhuru programme encompasses:

- A semi-residential programme for children and adults with special needs.
- One-on-one and group sessions for children in other learning centres
- Group Sangam sessions inviting children from various backgrounds on campus
- Inclusive learning spaces created for children from marginalised backgrounds, including the Arjunabetahalli community and government schools.

Arts-based interventions are the primary methodology for the curriculum, focusing on the motor, attention, cognition, social, therapeutic and learning domains. The entire programme is based on the belief that children who have been marginalised have immense potential to learn, experience and relate to the world.

The idea behind SF was envisaged in a three-bedroom apartment in a residential area in JP Nagar, Bengaluru, in 2012. The space saw children and adults with varied disabilities being taught with arts as the primary methodology. The 'arts' or multi-arts, relates to using more than one art form or a grouping of art forms such as visual arts, music, dance, drama and play. The learning centre had a whole-day format for its students. Today, the same programme is run through a residential learning format from Monday to Thursday at a learning facility located in an expanse of green, away from the bustle of the city.

The Uhuru curriculum enables children to acquire the tools to navigate everyday life while also focusing on larger issues. Our focus has been on:

- Creating a space where compassion is an integral part of daily living
- Building resilience to deal with problems
- Honing attention and observation skills
- Ensuring that emotions are acknowledged and negotiated
- Facilitating learning through working with relationships
- Enabling an understanding of the interconnections of all

Uhuru seeks to meet the mission statement of inclusion. The goal has been to create an environment where children and adults with special needs can find independence, dignity, build relationships and inclusive spaces for themselves and others. Our aim is to address the social and independent goals of the children so that their aspirations in life, vocation, and livelihood are met.

The arts practices evolved and became a methodology of working with multi-modal arts. It is aptly named Arts Practices for Inclusion (API). API has travelled all over the country and abroad to Argentina, Bangladesh, Brazil, Nepal and Sri Lanka, and has been lauded by both organisations and beneficiary groups.

The children stay on the campus without their parents and gradually learn to be independent under supervisors and practitioners. They also interact with other children from disadvantaged backgrounds (children from government schools and shelter homes), who are a part of some of the sessions in and around campus.

Figure 2: *Snehadhara methodology step by step*

Circle of inclusion

"The goal of any parent of a child with special needs is independence. The child should be able to manage with minimal support," says a parent.

Self-dependence and inclusion are probably the most important goals of parents of children with special needs. Inclusion means that Sneha, who had Down Syndrome, was present with children in a play home where they learnt from each other.

But parents are often in denial and forcibly enrol their special child in a regular school. This is because they perceive that special schools or therapy centres come with an unwanted label. Consequently, the child loses identity, interests and happiness, as the parent seeks a 'cure' for the disability.

Sarangan wanted to attempt a model where the child or adult was at a centre of learning, but had the freedom to choose how and when they learnt and who they wanted to learn from. Simply put, it is a model where the learner or the student leads the learning process. And so, the journey began.

The home-centre at the heart of the city

The centre had 35 children and a team of 20 adults, including Arts-based Therapy or ABT practitioners, facilitators, psychologists and support staff, aimed at maintaining a student-facilitator ratio of 2:1. The children reached the centre in the morning and left in the evening with the flexibility of a half-day programme. They learnt through music, visual arts, outdoor play and cooking. While our target was achieving the same therapeutic goals of other settings, the approach taken was creative and non-threatening. The children were given the opportunity to engage in multi-sensory activities.

The Uhuru learning programme was supported by in-house and external research that reinforced the benefit of peer-to-peer and buddy learning formats. The senior children were empowered to buddy the younger children, therefore, the relationships so forged transcended the boundaries of language, inhibitions and prejudice.

The Uhuru goal was to build a semi-residential space but the children had to be prepped. This is what Uhuru did:

- **Overnighters:** The children spent the night at the centre and got a taste of independence and freedom while the parents got an evening for self-care. In the process, parents grew with the children by learning to trust their child's adaptive ability while keeping an open channel of communication with the staff. The team underwent continuous training with skill updates including first-aid and seizure protocols.
- **Kala Samvaad:** This is a space for parents to meet other parents once a month to talk about and share their experiences through the arts.
- **Home visits:** Children took turns to visit their classmates' homes for meals and sleepovers and were exposed to a larger ecosystem of special needs.
- **Snehasangiti:** This is a programme in which children with special needs and neurotypical children shared a learning space while playing together using the arts.
- Regular outdoor sessions in parks and playgrounds such as 'Dhan dhana dhan goal', 'Unboxing' and 'Travelling', where children travelled to public spaces where they could connect with nature, engage in physical exercise in a sports complex or roam freely in parks.
- **Oota Thota:** This began as an exercise of going to the market to buy groceries and returning to cook a meal together. But it gradually morphed into a weekly Café Obattoo that sold the exotic yet simple dishes, made by the children and staff, to parents and facilitators. It was an exercise in learning to handle vegetables, count, peel, clean and stir the pot. Café Obattoo was run by one of the adults with special needs. In fact, she designed the delectable menus, too.

All these projects helped us understand what inclusion encompasses; deepened our awareness about diversity; and opened the door to the joys of co-learning. The 'what after me' question that plagued parents of these children began to be answered. These questions were the bedrock of the curriculum then and formed the basis of what the Uhuru programme is today.

A parent whose child is on the autism spectrum asked, “Any parent with a child like ours will ask the same thing – what happens after me? What happens when we are gone and our child does not have us?”

Figure 3: *In the three-bedroom house in Bengaluru that was the centre for eight years*

Figure 4: *A visit for Snehadhara members to a park*

Figure 5: *Children in session at the semi-residential campus in Nelamangala*

Figure 6: *Inauguration of the Nelamangala campus*

Snehadhara has worked with around 2,000 children through direct interventions, 50,000 children through indirect interventions in schools and other receptive environments, and trained over 2,000 professionals in about 400 organisations across the country.

Building the parent community

We at SF soon realised that the inclusive world we had envisioned is a multi-stakeholder model. Facilitators and children alone cannot create a space which is accepting, non-threatening and empowering for children with needs. The parents are key stakeholders in the process.

Towards the beginning of the Uhuru programme, a model called ‘Pipilika’ was launched, which invited parents, children and volunteers to learn together. Parents were also called for periodic meetings where everyone who

worked with their child shared a progress report. From understanding the learning process to helping each other with the Unique Disability ID or UDID registrations of the children through the Snehadhara's Centre for Inclusive Policy (CIP), the parent community has come a long way.

> *"We have stayed with the foundation for long and we want to continue our association because our relationship has been based on communication and trust. We leave him [the child] at the bus stop to be with them and we know he is going to be safe."*
>
> *A parent of a child with autism*

The benefits were obvious when the pandemic hit and overnight parents became buddies and co-facilitators. Parents felt energised and happy when they realised the extent of their own abilities. As their children alternated between the roles of hosts, teachers and guests, the parents had a newfound understanding of other children and their needs and a greater appreciation for the facilitators and support staff.

Story of ADL (Activities of Daily Living)

One of the aspirations of the Uhuru programme and its semi-residential component was to work on the functional learning of the children — brushing teeth, eating, dressing/undressing, ablutions among others. For working parents, ADL meant the anxieties of having their child away from them, eased.

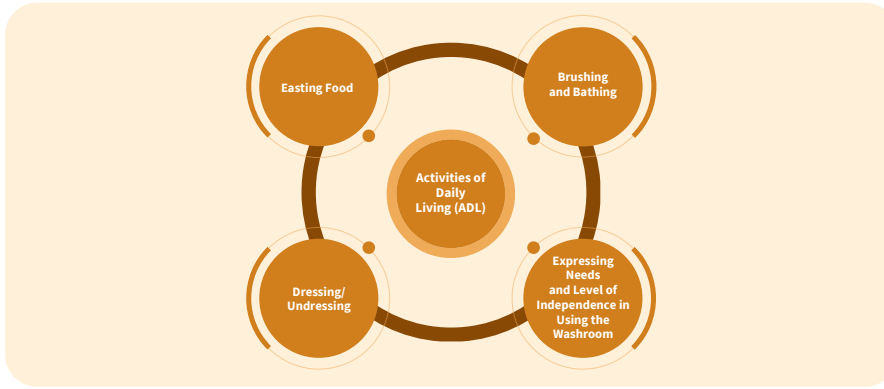

Figure 7: *The ADL must-dos*

The COVID-19 era

Figure 8: *Online arts-based interventions during the pandemic*

Unprecedented in scale, unnerving in thought and uncertain in planning, the year 2020 made every person and every sector get back to the drawing board to recalibrate fundamentals. Children had been holed up at home, witnesses to their family's distress, and had to come to terms with not meeting their friends or going to school.

Within the education sector, the move to online learning has been widespread and for those in the field of therapeutic learning and special needs, this transition had uprooted everything that was standard practice until the lockdown.

The Uhuru programme was moved online, starting with the Summer School programme and one-on-one sessions. Gradually, the group lessons were conjoined with the arts-based methodology. Soon, we launched Digi Akshara — an online training programme for educators.

Uhuru transformed into a virtual school (école அllam) so that children could use the multi-arts-based sessions at home. École is French for school and அllam means home in Tamil. Parents co-opting to being buddies and co-facilitators was a monumental shift, especially within mainstream education systems. For children with special needs, making the transition to an online space when the country had no precedent of virtual learning was extraordinary. Five months later, in November 2020, the Uhuru programme moved onto a trajectory that truly made it unique.

The Nelamangala campus — a new home

> *My child was a different person the very first time he visited the campus. Something changed. He roamed around like it was his own home and I could feel the energy of that space even today.*
>
> *The parent of a child with special needs currently enrolled in the Uhuru programme.*

One of the board members had donated a vacant plot in a resort community to the Uhuru programme. It was in the middle of lush greenery on the outskirts of Bengaluru. Since April 2020, the Uhuru Programme has had its own campus in the Nelamangala taluk, on the outskirts of Bangalore. The campus is surrounded by trees; it's quiet, spacious, and offers a better quality of life than the city. It is a unique semi-residential facility that provides care, comfort and nourishment, at many levels, to children and adults with special needs.

The architects had initially conceptualised the campus as a small hamlet of spaces, each having its own experiential quality in terms of shape, size, volume, orientation, light, ventilation and view.

The campus, however, expressed its own shape rather differently. They wondered if they could make a building that would inspire curiosity in the children and adults about how things are made and buildings constructed. What if the space could create openings for the inhabitants to feel, observe and understand the techniques and materials used?

The architects wanted to embrace construction that had a low carbon footprint and so every block was made from the mud excavated while laying the plinth of the building. They adopted eco-friendly techniques with the use of solar panels, rainwater harvesting, and the use of grey water for gardening and washrooms.

The transition into open spaces can be as daunting as it is exciting, but the children and adults embraced the wall-free spaces that the new centre offered. They also adapted from an overnighter programme once a month, to

spending two nights every week, at the new campus.

The programme's greatest achievements for the year has been the success of transitioning children and adults from a day programme to a virtual school, and from there to a new campus for semi-residential learning. The research into the effects of such a set-up was carried out by the in-house vertical. When the second COVID-19 wave hit in 2021, the campus had to be shut and Uhuru went online again. This time, there were learnings from the past.

Parents were apprehensive about letting their children go to a campus 50 kilometres away in a bus and that they would be away from home for days at a time.

Previously, these children were subject to prejudices, gawking neighbours, and a feeling of being disliked and unwelcome in public spaces. The Nelamangala campus was built to address these issues and the space made everyone feel at home instantly. The visitors often remarked on how serene the campus was with its gardens, wall-less corridors, community living and its profusion of chikoo, papaya and mango trees. The idol of Tara Maa, the Buddhist goddess of feminine energy, which was gifted to SF, only added to the feeling of calm.

There are routines at the campus. The dedicated kitchen and support staff are up at daybreak to ensure that the children wake up to a sanitised space and a piping hot meal. After breakfast there is Circle Time, where everyone gathers around to discuss the day's events, make announcements and sing. After this they go to activity rooms. The day's sessions are interspersed with short tea/snack breaks and a longer lunch break that includes a nap. Using a combination of art forms such as dance and movement, rhythm and music, theatre and play, cooking and visual arts, we engage with the children and stimulate their curiosity and creativity.

> *We were sure that it was the right place for our son when we saw the manner in which the onboarding and the SOPs were done..*
>
> *A parent reflecting on their journey from the centre to campus*

> *When you walk into the space, the vibes are different. It doesn't feel like a facility, but a home.*
>
> *A parent*

After the last session in the evening, the children move on to their one-on-one sessions to work on individual projects. They then go for their much-awaited evening walk. Some children and facilitators also volunteer to help the kitchen team with dinner preparations.

After they return to the campus, the children have a period of quiet introspection before heading to their rooms to change and get ready for dinner at 6.45 pm. Yoga sessions for the team and weekly picnics — trips to markets, temples, parks — have also been added to the programme. The children also participate in the Sangam programme once a month where they interact with children from the Arjunabetahalli community government schools nearby and share space with them through the week.

For the children and adults who are not a part of the semi-residential set-up, one-on-one sessions are conducted in the city centre. The programme is designed to meet the goals of each child and uses API.

The Uhuru programme on campus began with children staying for two nights a week. They would arrive on campus on Monday morning and leave on Tuesday evening. Then they would arrive on Wednesday morning and leave the next evening and so on. Today, children arrive on Monday mornings and leave on Thursday evening.

"It [Monday-Thursday format] came as a blessing and we were genuinely happy to send our child to the campus for four days. Getting up early for two days to drop him off at the campus was getting difficult for us and we are, in fact, looking for longer duration stays. Hopefully, that happens soon," says a parent.

Features of the Uhuru programme

The arts and inclusion

Sessions conducted at the Uhuru daily learning programme, both on campus and in the city, as one-on-ones are based on multi-arts and are designed keeping in mind the learning goals of each individual. It is essential that the child's abilities, needs and goals are assessed initially and a plan put in place to go forward gradually. The programme intensively works on the cognitive domains for strengthening memory and comprehension, language acquisition, and building a robust attention system for the participants. Using API, the programme caters to the needs of building social skills for interpersonal and intra-personal growth. Likewise, we work on building stamina for fine and gross motor manipulation.

We began in-house certification courses with ABT, providing the base and arts practices that were curated specifically for special needs and other at-risk populations to become what it is today – Arts Practices for Inclusion or API.

The sessions include:

1. Awaaz - Music

Participants listen to different ragas, and other forms of music, and associate those with the feelings and emotions triggered. Starting with vocalisation exercises, making vowel sounds and warming up their throats, the children learn new songs in several languages.

2. Tabula Rasa – our canvas

The children use hands and feet as art applicators, apart from different forms of painting, which include sponge painting, vegetable stamping and toothbrush spray-painting. They aim at improving attention span, fine motor skills and symbol recognition, among other things.

3. Saaz – working with sounds and instruments

The children are exposed to a variety of musical instruments and day-to-day objects that produce sound. The focus is to improve lung capacity using wind instruments and impulse control using percussion instruments.

4. Thakadimitha – dance and movement

These sessions embody kinaesthetic awareness through movement, music and play.

5. Mannu Honnu - toil the soil

The activities involve establishing gardening rules, clearing up and preparing the soil, creating pathways and beds and creating a kitchen garden with water and nutrients. They work on composting, planting in pots, caring for their potted plants and learn to clear up.

6. Bhaag Milkha Bhaag – fitness and sports

The focus is to work on breath, fitness, building stamina and agility. The sessions introduce the participants to a range of physical exercises, from simple stretches and warm-ups, to different types of walking and obstacle courses.

7. Kairuchi - kitchen and food

Children are involved in sorting vegetables, cleaning and chopping. They assist in cooking and setting up the table, serving food, and cleaning up after meals. Goals in the science curriculum are met through these sessions.

8. Kuthoohalam - sensory integration

These sessions involve working with three basic sensory experiences – visual, auditory and tactile. Colour, presence/absence of light, effect of volume, pitch and rhythm, different textures, movement, and wet vs. dry surface exposure are explored.

9. Culture and arts

These sessions engage children with different art forms of India and encompass the diversity in music, languages, dance, visual arts, and storytelling.

10. Functional academics

Academics are tailored to suit a group's needs and facilitate comprehension, composition and application in language, math and science. The goal is to develop reasoning skills, creative thinking, abstract or spatial thinking, problem-solving and critical thinking.

11. Kathaashaala - storytelling

These sessions work on language, narrative and descriptive speech. Children are exposed to different stories through reading, read-aloud and drama. Depending on the child's ability, the sessions are designed to encourage vocalisation and build basic vocabulary and simple sentences.

Figure 9: *The Uhuru approach*

The Uhuru programme also includes several other activities to provide alternative ways of learning.

1. **Sangam programme:** Sangam is an inclusion programme that aims to give a platform to adolescents and adults with varied needs, a place to make and meet new friends, explore their social world, and use different artistic mediums to collaborate. Through these meetings adolescents and adults may be able to build greater strength and resilience.

2. **Sessions with children from Arjunabetahalli:** The children from Arjunabetahalli, a nearby rural community, have been a part of the journey of Uhuru's on-campus programmes for a long time. Sessions with them include arts-based activities for academic goals.

3. **Peer-to-peer learning:** Special-needs children are often isolated and have 'curated' one-on-one sessions that limit their access to the social opportunities a conventional school set-up offers. However, in SF, out of the five sessions in a day, four are group-based. All the children are divided into two groups named after flowers — Mallige and Jaaji. The groups differ in their levels of independence at tasks, which is a

function of their attention as well as cognitive and motor skills. Children from Sangam and from nearby communities are integrated into these community session models on a week-by-week basis.

4. **Picnics or field trips:** The children made it clear that picnics should be an integral part of the curriculum. They visit neighbouring villages, parks, markets or temples every Monday and learn social skills and teach the world inclusion.

5. **Building independence:** Making children independent and self-reliant is one of the primary goals of Uhuru. Specific activities such as evening walks, washing their own plates, getting ready in the morning, working in the kitchen and community, help the children move towards self-reliance.

6. **Community living:** The values of living in a community are manifested in the sheer amount of space available, the involvement of support staff, and the everyday work that each person does. This helps the children understand what it takes to live on their own.

Figure 10: *Glimpses of a functional academics session in progress*

Figure 11: *We cook together, we serve together, we eat together. Glimpses of the community kitchen*

Challenges and learnings

Often, challenges come, not from within, but from outside. Neighbours slapped a court case complaining about the 'kind of children' and 'noisy' children at the centre. Often the children were thrown out of malls or public spaces and told that they 'did not belong'. Some parents of children with milder or no disabilities would often want to keep their children away because they did not want their children to 'learn to be like those children'.

Consequently, outdoor visits have been challenging. In November 2022, the children from the semi-residential programme visited the local railway station in Gollahalli, Nelamangala, as part of their Monday field trip. The railway staff curtly told them to leave immediately and said the group would 'ruin the sanctity of the place' and if they did not leave, the Railway Police Force would beat them up. Team members captured some of this on video, which caught the attention of local and regional newspapers. Despite the widespread attention, the complaint with the Bangalore Disability Commissioner's office has gone unaddressed for months. Such encounters in public spaces have more often been the norm than the exception. On this occasion, however, the children did enter the platform and achieved their goals for the day.

Another challenge to the implementation of the semi-residential programme was the COVID-19 pandemic. The programme had to be taken online for five months in 2021 and then again for a month at the beginning of 2022, and the opening of the campus facility was delayed.

The restrictions on group gatherings and travel were an obstacle, but we embraced them and modified the duration of the stay in our semi-residential space from two days to three days and now to a full four-day residential programme.

Conclusion: Uhuru impact

A study conducted on the direct beneficiaries of the Uhuru programme by Vibha Bhat, Athira Maria Somy and Dr Sarangan concludes that there are positive results from various domains of measurement and therapeutic goals. We have begun building an inclusive world free of prejudice. A paper on social inclusion using arts practices was recently presented and published at the International Conference on Inclusive Collaborative Practices (ICICP) by Vibha Bhat, Yashaswini Gupta, Dr Gitanjali Govindarajan and Vigya Jain.

Figure 12: *Proof in numbers*

Some of the examples of tangible impact are:

1. Ahan (name changed) came as a four-year-old, completely non-verbal child on the spectrum. He is 14 today. After being with Uhuru, Ahan can read and write, and share his thoughts in English and Hindi.

2. Tanya (name changed) started her journey as a student at the centre, battling learning difficulties. She is now an intern and buddies with the girls at the Nelamangala campus.

3. The children were invited to the inauguration of the community temple next to the Nelamangala campus, making the world a more inclusive space.

4. The Sangam programme has given an opportunity to children with disabilities and from underprivileged backgrounds to participate in an inclusive learning space where they are allowed to just be themselves.

5. Children and families from the nearby Arjunabetahalli community were actively involved in the sessions and welcomed the team with open arms and responded incredibly well to the multi-arts. Through the on-campus programmes and interactions with children with special needs, the levels of sensitivity and awareness in the children has increased tremendously. Over a few months, a scared child transformed to being a buddy to other children.

The classroom sessions have new approaches with different styles of working even while using Arts Practices as the primary methodology. While Uhuru on campus boasts more than reasonable success, the way ahead is long and there is much to achieve.

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