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Scaling up the use of PLA in a pilot health and nutrition programme, India

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Introduction

The Integrated Child Development Scheme (ICDS) is the world's largest government programme of its kind and an 'initiative unparalleled in the history of India'.[1] The ICDS converges various sectoral services into a holistic women and child development scheme. It aims to improve the nutrition and health of children below six years and of pregnant women, nursing mothers and adolescent girls. The programme gives preference to areas predominantly inhabited by the most vulnerable and the poorest of the poor, where there are no provisions for healthcare. The programme offers services such as pre-school education, supplementary nutrition, growth monitoring, immunisation and health check ups, health and nutrition education, and referral.

The ICDS works with communities consisting predominantly of:

- families of landless labourers;
- families of marginal farmers (having less than 1 hectare land);
- families of scheduled castes/tribes (underprivileged class of people due to prevailing caste system in society); and
- families living below the poverty line.

"In spite of efforts for holistic children's development, one of the major constraints and bottlenecks experienced during the implementation of the ICDS programme, is the poor level of community participation"

The whole state is covered under the ICDS programme, with one *Anganwadi* centre (AWC) per 1,000 people, but a selection of 101 direct beneficiaries is based on the above criteria. These beneficiaries receive supplementary nutrition, growth monitoring and pre-school education from the AWCs. However, preference is given to the most needy, poorest of poor and vulnerable.

In ICDS, *Anganwadi* centres are established in the villages. They are run by *Anganwadi* workers (AWWs) and *Anganwadi* helpers (AWH). The workers and helpers are drawn from the community and both are paid an honorarium as a token of the services rendered by them. They are not regular government employees. The centres are courtyard play

[1] Published document: Ministry of Human Resource Development (1995) 'Integrated Child Development Services of Department of Women and Child Development.' Government of India: New Delhi.

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Box 1: Cause and effect tree: causing action

In Gadia village, Ramnagar block in the Barabanki District, the majority of the population are from *dalit* castes households. *Dalit* castes are identified and defined by the Indian Constitution as disadvantaged groups of people. Most of the children were malnourished due to poverty. Their parents used to work as farm labourers, leaving small children at home, in the care of female relatives (usually sisters). The village AWW sought to encourage the parents of these children to come to the AWC, to get the children weighed so that their growth could be monitored, and for counselling for treatment and immunisation. But they resisted because of their belief, *humare bacche ko nazar lag jayegi* – that their child would be exposed to the evil eye of others (i.e. non-family members) if the child was brought in front of them. Other AWWs were also facing a similar situation in their villages. Although parents knew that weighing and immunisation etc. was necessary, they were not able to overcome their fear/misapprehension of the effects.

The AWWs facilitated meetings with these parents, to discuss and analyse malnutrition using a **cause and effect tree** tool. The groups made a tree on the floor showing roots, stem and branches etc. Roots were defined as causes and the branches as the effects of malnutrition. Ultimately, the whole group agreed that if they took proper care before and after birth, children would be safer and they would also be saving their money on treatment. The women in this group immediately came forward to weigh their children for growth monitoring and also showed willingness for immunisation.

Box 2: The changing trends tool: for initiating discussion and analysis

In Bargadia village, AWW helped the community to analyse social practices followed by their grandparents, parents and now, using a PLA tool called 'changing trends'. Women identified trends such as marriageable ages, pre- and post-care for mothers, feeding newborn babies and other feeding habits, diseases, crops, agricultural practices, occupations, pet animals etc. and how these trends had changed. They then discussed the benefits of and problems caused by these changes and drew up an action plan to overcome the present situation. Accordingly four women decided to convince their husbands not to marry off their adolescent daughters. Five mothers immediately requested that the AWW vaccinate their babies during their next visit. As explained in Box 1, the process showed that vaccinations could benefit their children and prevent the high cost of treatment.

centres and are the focal point for delivering services at community level. The workers conduct surveys to identify the beneficiaries and provide various services to them.

The World Bank has given a loan to the government of India for the ICDS project. However, the government has made this money available to the state government of Uttar Pradesh as grants for running the programme in 33 districts. In the remaining 27 districts, the state government uses its own resources to run the ICDS programme.

The problem

In spite of efforts towards the holistic development of children, one of the major constraints and bottlenecks experienced during the implementation of the ICDS programme is the poor level of community participation. Another constraint is the supply-driven mindset of the grassroots functionaries (AWWs) and their supervisors. The focus has remained on distributing supplementary nutrition, rather than using effective communication to seek positive behavioural changes to child bearing and rearing practices with the targeted communities. Communication for behavioural change is a complicated process of human actions, reactions and integration. It involves looking at situations from the viewpoint of other people and understanding what they are looking for. It means understanding obstacles to change and presenting relevant and practical options and telling people what the effects will be of the choices they make. People tend to change when they understand the nature of change and view it as beneficial, so that they can make informed and conscious choices to include it in their list of priorities. Unless their circumstances are taken into account, no effort for change will be successful.

Facilitating qualitative change in the mindsets of functionaries towards role reversal and enabling them to acquire participatory skills would be the first priority in overcoming the above constraints. As the ICDS Programme in Uttar Pradesh employs more than 100,000 grassroots and supervisory functionaries, it is a big challenge to build up the capacities of these functionaries for the application PLA in their day-to-day work. The situation calls for developing appropriate in-house capacity-building mechanisms, with initial help from a specialist agency, to establish demand-responsive services.

Piloting the experiment for scaling up

In 1992, the article 'Participatory rural appraisal: potential applications in family planning, health and nutrition programmes' by Richard Heaver advocated the potential use of PRA in ICDS and Family Welfare programmes in India.[2] Yet no headway was made in any state in India in this direction.

In line with above mentioned article, ICDS in Uttar Pradesh, in partnership with the Centre for Symbiosis of Technology, Environment and Management (STEM) decided to experiment with the use of participatory methodologies for

[2] In: *RRA Notes* 16: *Applications for health* (1992), pp.13–21, IIED: London

Box 3: Selecting beneficiaries

In Tirlokpur village, while villagers were making a village map of their homes on the ground and showing the houses where pregnant and lactating mothers, children aged 0-3 and 3-6 years of age, and immunised children lived, a few women belonging to very poor households came and sat at a distance nearby. They were quietly looking at the map being drawn. When they were asked to recognise their house, they told us that their houses would not be there, as they did not possess a Below Poverty Line card (BPL) in spite of being the poorest of poor. AWWs confirmed that the selected ICDS beneficiary families had BPL cards. So it was decided to enable the community to select beneficiaries on the basis of wealth ranking done by them. After facilitating the community to select beneficiaries by using wealth ranking, the AWWs realised how faulty their perceptions were – and the limitations of using BPL cards as a means of identifying beneficiaries.

Box 4: A new dimension

Whilst using a daily routine activity tool with the women of Beria village to arrange meeting times for Mahila Mandal, many men were observing this exercise very keenly.[3] They demanded that their daily routine activity should also be worked out to ascertain whether women worked more or men. When the men's daily routine activity was also assessed, it was found that the women worked more hours. Not accepting this result, the men tried to increase the work hours of men and reduce work hours of women. But after repeated efforts they could not reduce women's work time by any more than 1.5 hours. They still could not increase their own work hours, which were still lower than the women's. The whole discussion took on a new dimension and the men started saying that as women worked more than men did, they needed to eat more nutritious food and have more rest.
Ultimately it helped to:
- change the men's belief that women do less work;
- show the women that they work more than men; and
- enable the field workers to understand that working only with women does not produce any result unless their husbands are also included in the process.

community mobilisation and information education and communication (IEC) interventions. The pilot was held in Barabanki district, falling under ICDS-III. The strategy for scaling up the use of PLA in the remaining 31 districts under the ICDS–III Programme would be drawn and implemented based on experiences and lessons learnt from this pilot study.

The following objectives were set:

- Role reversal: a positive change in the mindsets of the AWWs and supervisors. Changing from a supply-driven mindset and from being in 'directive' mode to a more responsive mindset and being in 'enabler' mode.
- AWWs and supervisors should be able to facilitate with the community to identify the target population, non-users of services and high-risk individuals to select the beneficiaries.
- AWWs and supervisors should acquire participatory skills to organise nutrition and health education sessions for women in such a way that women can articulate their own situations, analyse their own problems, find opportunities and make decisions to overcome these situations.
- An appropriate in-house capacity-building framework should be developed in which minimum help from an outside resource agency is required.

The process

Phase one

A seven-day training of trainers' session was carried out with the identified supervisor, the Child Development Programme Officer (CDPO) of Ramnagar block, and trainers of a district-level training institution involved in organising induction and refresher training courses for AWWs of ICDS. It was decided to also include some AWWs in the training so that regular feedback about the relevance and utility of various participatory tools and techniques in performing their role was continuously available during the training. The training started with a participatory job analysis, using a tool called 'card sorting', so that competencies required by these functionaries could be identified and practised with the community.

The next step involved a thorough analysis of knowledge, skills and attitudes, and the effect that attitude and behaviour have on interpersonal relations. It analysed the outcome of various efforts undertaken by individuals, groups or society through various exercises. The participants appreciated the importance that attitude and behaviour had in the context of their role in ICDS. Next followed some intensive sessions involving in-house and field practice of various relevant PLA tools and techniques. These included mapping, cause and effect trees, changing trends, daily routine, scoring and matrix ranking. Then participants shared their experiences and reflections. One SARAR tool called the Snakes and Ladders Game was adapted to examine nutrition. It was also demonstrated as a possible means of joyful learning so that participants could identify and use local games and plays for dissemination.[4] During practice in the villages, various local games were identified and adapted

[3] Mahila Mandal: a women's group.
[4] Self-Esteem, Associative Strength, Responsibility, Action Planning, and Resources. SARAR is a participatory approach to training that builds on local knowledge and strengthens local ability to assess, prioritise, plan, create, organise, and evaluate. The concept was first developed through field-based training in Indonesia, India, and the Philippines in the early 1970s.

Box 5: Appreciative Planning and Action (APA)

APA is a participatory technique for motivating the community to action. It involves four stages:
- Discovery
- Dreaming
- Designing
- Delivery

In the discovery stage, the community identifies immediate problems, which can be solved in the shortest time using available resources. In the dreaming stage, the community is helped to visualise the benefits if the problem is solved. Once the community has visualised the dream, they plan for immediate action in the designing stage. Action is initiated immediately in the delivery stage.

In Baheriakhurd village, while conducting APA, the community identified two major health problems:
- GHENGA (a goitre caused by a deficiency of iodine);[5] and
- a mental disorder prevalent in many children and adults.

As an immediate community action plan, the majority of households in the village donated available salt (solid crystals) and procured iodised salt. They decided not to use non-iodised salt in future.

according to dissemination topics like immunisation, nutrition, and care for mothers and newborn babies after delivery etc. During the last day, participants were asked to make presentations and relate their learning about concepts and the philosophy of participation. They also made action plans for conducting a seven-day action-oriented training on participatory methodologies for AWWs.

Phase two

A seven-day training was held in the Ram Nagar Block. Four supervisors (already trained in phase one) trained all 21 AWWs from the Tirlokpur sector. During the first day, exercises enabled participants to appreciate that PLA requires not only the technical understanding of tools but also the capacity to listen, to stay in the background, to be critically self-aware, to facilitate women's participation in discussions, and to learn to be taught rather than to teach.

The next step was to divide the participants into five groups. The groups mapped all the AWCs in the Tirlokpur sector to identify the five AWCs which were most convenient to group together in respect of the distance from their own village.[6] Each group was led by one of the supervisors and took up the responsibility of practising PLA tools at selected AWCs during the whole training programme. During the next two days these groups practised using relevant PLA tools in the selected AWC villages. On the fourth day, the groups got together and presented their experiences, showing:
- objectives;
- methodologies followed;
- any difficulties faced (to demonstrate problems related with Dos and Don'ts of PLA facilitation, such as arranging sessions to suit the convenience of the community; assigning roles to group members like gatekeeping, recording, facilitating and triangulation etc.);
- outputs;
- personal lessons learnt (individually); and
- where else these tools can be applied.

During the next two days they conducted more field exercises and made further presentations to share their learning.

Finally, the Tirlokpur supervisor and AWWs prepared an action plan for conducting PLA training in the remaining AWCs so that they would have the opportunity to practice, learn together and internalise participatory concepts, philosophy, tools and techniques. Similarly, the remaining three supervisors prepared an action plan to initiate the same training interventions in their own respective blocks.

Reflections

Some reflections expressed by AWWs, supervisors and trainers are given below.
- We learnt how community participation can be facilitated. ICDS is already in the process of revising AWW induction and refresher-training modules based on the learning of the pilot experiment. The World Bank has also concurred with the strategy of scaling up the use of PLA, proposed after this pilot experiment. Accordingly, the state's ICDS authorities have initiated the scaling up process.
- The community can identify and select beneficiaries without any difficulties. This should demonstrate that ICDS does not show partiality or favour some families over others.
- We learnt how to work and communicate with communities.
- We learnt how we ourselves and the community can learn together in a joyful manner through local games.
- Instead of directly telling a community what they need to do to improve nutrition and health, we can enable them to analyse and reach their own conclusions, resulting in better realisation.
- We learnt how to help illiterate women to express, analyse

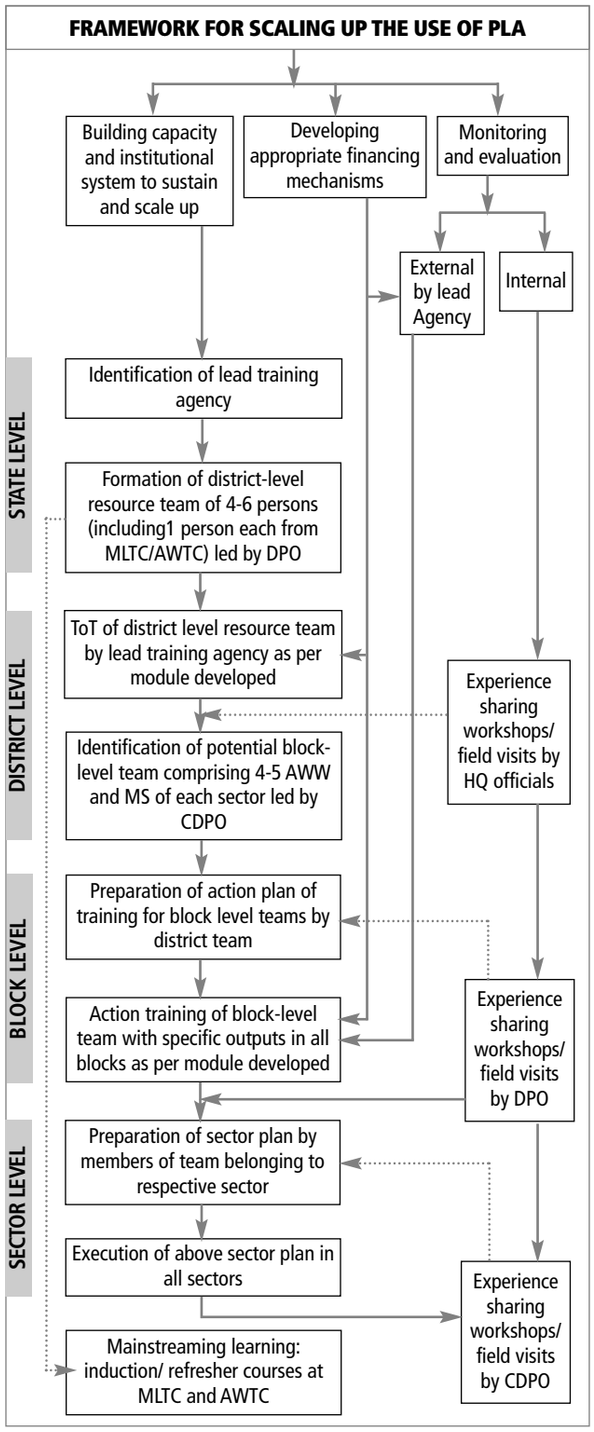
[5] Goitre is a non-specific term describing the enlargement of the thyroid gland
[6] An ICDS sector is a cluster of about 20 villages; a block is a cluster of 4-6 sectors and a district is a cluster of 20-26 blocks. The Child Development Programme Officer (CDPO) is in charge of blocks, and the District Programme Officer (DPO) is in charge of districts.

and learn by using locally available materials like flowers, leaves, stones, colours etc.
- By using village mapping, there is less possibility of malnourished children being left out.
- Experiential learning has no substitute.

Regarding professional/experiential learning, there were several interesting points relating to changing professional mindsets.
- Self-analysis through written individual exercises enables participants to realise the change required in their way of thinking and behaviour.
- Storytelling is the most effective way of helping people to internalise in the same depth and frequency which is otherwise very difficult.
- The focus of changing mindsets and attitudes needs to start in participant's personal lives (other than work environment) as it helps them to relate and realise consequences and benefits of positive or negative attitudes in a better way.
- Many people think that they are unlucky in life but the exercise of enumerating good and bad incidents has helped 90% of participants to conclude that their perceptions about themselves were wrong.

Following up the pilot exercise

After the pilot exercise, regular follow-ups by ICDS officials through personal interaction and meetings at sector and block-level resulted in the growing use of participatory methodologies by field workers. It was further decided to use half of sector/block-level meeting time to share experiences or by making presentations of participatory tools/techniques used by AWWs and supervisors so that the learning process continues. Sharing and presentation sessions were found to work as catalysts for competition and to create enabling environments. ICDS had identified one model AWC in each sector based on certain performance indicators. The lessons shared during such sessions were:
- The use of PLA helped AWWs to change their mindsets, so that they saw the community as a partner instead of a recipient.
- It is easy to create demand for services by following this approach.
- Conducting nutrition and health education sessions for women has become easier. Earlier they used to face difficulties in lecturing whereas now they work with women to analyse situations and to find solutions.
- Because women have limited opportunities to express themselves in public, the process helps them to articulate



using their traditional skills of drawing on the ground. Hence the approach is more women-friendly.
- The AWWs' confidence in dealing with communities has increased.

Framework for scaling up

Based on experience and lessons learnt during the pilot experiment, a framework was developed for scaling up the use participatory methodologies in the remaining districts of Uttar Pradesh, under the ICDS–III Programme. This was accepted by the ICDS authorities.

Outcome

- International NGO partners like CARE International, Catholic Relief Services (CRS), the United Nation's World Food Programme (WFP) and the United Nations Children's Fund (UNICEF) are also hoping to initiate similar interventions for ICDS functionaries in remaining districts.
- ICDS-III has decided to use participatory methodologies even for conducting free expression for quality improvement (FREQI) workshops at sector, block, district, and state level so that an enabling environment is created to have better results.
- ICDS has started developing process-monitoring indicators (very unusual in a government programme in Uttar Pradesh).

Conclusions

For the process of scaling up following the pilot experiment, the following problems, challenges and implications were identified:

- the need to shift the focus from supplementary nutrition distribution to positive behavioural changes;
- the need to bring functionaries to an enabling mode from a directive mode;
- the importance of developing in-house mechanisms and capacity to train 50,000 AWWs and supervisory staff;
- the importance of changing the mindsets and attitudes of government functionaries about the appropriate facilitation, learning and application of PLA (i.e. involving people in decision-making, accessing people's views, listening to others, and sharing ideas etc.);
- keeping these mechanism working even after the transfer of senior ICDS officials; and
- identifying and selecting an agency to facilitate the scaling up process following government procedures.

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NOTES

In the scaling up framework, a middle-level training centre (MLTC) is for induction/refresher training of supervisors while an Anganwadi training centre (AWTC) is for AWWs. HQ stands for the state headquarters of ICDS.

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