

Ensuring Continuum of Quality Care for Healthy Lives and Wellbeing

Organised by



International Conference on 'Education as
Driver of Sustainable Development Goals'

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Context

In September 2015, global agreement was reached to pursue a sustainable development path for humanity via an historic set of Sustainable Development Goals (SDG's). Achieving this development path requires wide scale societal transformation, and a transition away from actions, systems, mindsets and lifestyle choices that have eroded and degraded the systems that sustain life on Earth. It requires ongoing expansion and urgent amplification of a new, more socially just and sustainable world order characterised by practices, processes and systems that *contribute* pro-actively to the well-being of all people, and all life on Earth. This new emerging world order is a necessity and urgent action is needed to amplify and expand those actions, systems and life-style choices that characterise a more just, sustainable world order.

Business as usual is no longer an option. Education and all institutions involved in sustainable development need to urgently transform to act accordingly in a sustainable world. Education is a driver of change for facilitating the effective implementation of the Sustainable Development Goals in formal, non-formal, informal and life-long learning contexts and should be inclusive of all people. As such, education should be recognised within each of the goals; and as a cross cutting, integrating force and enabler necessary for realising all of the Sustainable Development Goals. Education for Sustainable Development empowers learners to transform themselves and the society they live in.

In the World Education Forum in Incheon in May 2015, the world agreed that Education for Sustainable Development (ESD) has a key role to play in strengthening the quality and relevance of all forms of education, and that education is a key enabler for sustainable development.

With a mobilising vision of action towards sustainability, with education as a driver, over 750 participants from 22 Countries met at the Centre for Environmental Education in Ahmedabad on 11th- 13th January, 2016.

The International Conference on Education for Sustainable Goals, aimed at bringing together global experience and expertise to highlight and strengthen the role of education in realizing the SDGs. It was an opportunity to build upon the learnings from the United Nations Decade for Education for Sustainable Development (UNDESD) and recognize Education as a key enabler.

The expected outcomes of the conference were-

- To apply the learnings of the UN Decade of Education for Sustainable Development to develop programmes to achieve the SDGs
- To look at how the Global Action Programme (GAP) on ESD can play a major role in the SDG strategy
- To develop synergies and partnerships

Workshop on Sustainable Goal 3

“Ensure healthy lives and promote well-being for all at all stages”

Background

In September 2015, the UN launched Sustainable Development Goals (SDGs), an outcome of global consultative processes. The SDGs are applicable to the world as a whole. Increasingly, the emphasis has moved away from a solely economic view of development to a larger view that includes the three pillars of sustainability – environmental, social and economic. The survival, health and well being of women, children and adolescents are recognized as essential to ending extreme poverty, promoting development and resiliencies and achieving all the SDGs.

With this new emphasis comes also the recognition that policy instruments or technological solutions are not going to be enough and that ensuring behavioral change is critical to achieving Sustainable Development. Thus the role of education in its broadest sense including training and capacity building, communication and creating public awareness, scientific research, sharing and access to information and networking; and partnerships becomes a key strategy for achieving the SDGs. With this in view, an international conference titled ‘Education as a Driver for Sustainable Development Goals’ was organized by the Centre for Environment Education (CEE), in partnership with UNESCO, UNEP and the Government of India. The Conference was organized from January 11-13, 2016.

The main objective of the conference was to bring together global experience and expertise of using Education as a way of achieving SDGs.

Expected Outcomes

- To apply the learnings of the UN Decade of Education for Sustainable Development to develop programmes to achieve the SDGs
- To look at how the Global Action Programme (GAP) on Education for Sustainable Development (ESD) can play a major role in the SDG strategy
- To develop synergies and partnerships

The conference organized around workshop themes to address the 17 goals of SDGs.

CHETNA anchored the deliberations for Goal 3: Health and wellbeing for all at all ages.

Workshop Theme

Ensuring Continuum of Quality Care for Healthy Lives and Wellbeing

For ensuring continuum of quality health and nutrition entitlements throughout the life cycle and across various locations, particularly among marginalised communities, it is important to address issues of maternal, newborn, child mortality and morbidity and improve adolescents and young people's access to health care. Empowering and educating communities is a key strategy towards achieving Sustainable Development Goals (SDGs). There is a need to ensure alignment and communication with a stronger focus on equity and rights. To reduce health inequities social determinants of health and Universal Health Coverage (UHC) need to be globally acknowledged as a critical component of the Sustainable Development agenda, which needs to be addressed in an integrated and systematic manner.

In this regard, three workshops were organised for sharing evidence based practices, workable models, strategies and approaches that will contribute to global wisdom towards a shared vision. The workshops provided an opportunity to dialogue and discuss the scalability and challenges related to approaches of improving health and well being of the marginalised communities. Believing in empowering women, children and young people, especially from the marginalized social sections so that they become capable of gaining control over their own, their families and communities nutrition, health and wellbeing, CHETNA proposed a call for action for empowering and engaging communities in health programmes and policies for achieving Goal 3: "Ensure healthy lives and promote well-being for all at all ages"

Themes of the workshops were:

- Empowering Adolescents for Healthy Lives
- Community based approaches for improving maternal and new born health
- Addressing social determinants for improving child health

Session 1- Empowering Adolescents for Healthy Lives

11th January 2016

Chairperson- Ms. Indu Capoor, Founder Director, CHETNA and Director, CHETNA Outreach



At the outset, Ms. Indu Capoor provided the background of the workshop. She said that in the context of SDGs, it is important to see how education can try to achieve these goals. She also gave brief introduction to the work of CHETNA. Please refer Annexure I for details about CHETNA.

Ms. Indu Capoor highlighted the interconnectedness between all the SDGs for achieving health and wellbeing of all. She said that it is not that only goal 3 influences health but several other goals impact goal 3. For example, Goal 1: End poverty in all its forms everywhere, Goal 5: on gender equality Goal 2- End hunger, achieve food security and improved nutrition and promote sustainable agriculture. She also informed the participants that the purpose of the workshop is to come up with recommendations about how education can help achieve goal 3.

The discussions in the first session focussed on target 3.7 of Goal-3

By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Health Status of Young people across the Globe: Ms. Sunayana Walia

Ms. Sunayana, an independent public health consultant pursuing Ph.D. from Tata Institute of Social Sciences started her presentation by providing statistics about status of adolescent and youth across the globe. Some of the key statistics regarding adolescents shared by her were as follows-

- 1.8 billion people are in the age of 10-24 years making them slightly less than one quarter of world population of



7.3 billion.

- More than half of the world's adolescents 10-19 years old live either the South Asia or the East Asia and Pacific region, nearly 665 million adolescents.
- India has highest number of 10-24 year-olds, with 356 million (30% of country's population). This is often referred to as the **demographic dividend for India**.

Subsequently she spoke about the **health vulnerabilities** faced by adolescents and Youth, which are complications during pregnancy and childbirth, high prevalence of Child Marriage, unwanted pregnancies, unsafe abortions, sexually transmitted infections (STIs) and HIV, spousal violence and risks from childbirth. Anaemia is another significant risk for adolescent girls (15–19) in sub-Saharan Africa and South Asia. Anaemia is the main indirect cause of maternal mortality, which stood at 230 maternal deaths per 100,000 live births in 2008. Suicide is also leading cause of death in young girls age 15-19 worldwide. Violence and civil conflict are among other important causes of death among young men. More than 2 Million adolescents age 10-19 are living with HIV or AIDS. Ms. Sunayana also mentioned about the alcohol consumption and substance abuse as one of the problems among adolescents and young people.

In terms of access to other determinants, Ms. Sunayana pointed out that 26% of girls (39 million) and 17% of boys of secondary school age (11-15) were not enrolled in school in 2008. About 215 million underage children work full or part-time, while 75 million older youth (15-24) cannot find work.

After discussing about the key issues of concern among adolescents, she enunciated some of the strategic interventions under SDGs. She said that there is lack of agency among adolescents, there are several unmet needs and they lack the opportunity to make informed choices. It is important to build the capacity of the youth responsive health system. Giving an example of child marriage, she mentioned that along with having a law to prohibit child marriage, it is necessary to effectively implement the schemes such as Kishori Shakti Yojana/ Sabla yojana/ Rashtriya Kishor Swasthya karyakram (RKSK). She also mentioned about the schemes like Apni Beti Apna Dhan where conditional cash transfer is done to promote the higher education of girl child and increasing the value of girl child. She also mentioned about some of the strategic interventions under 2030 SDGs, such as-

- Specific investments related to employment
- Focused and result based interventions to improve adolescent health
- Structural, environmental and social changes required such as infrastructure changes to increase access to education, improve safety and security, gendered social norms, greater taxation on alcohol and tobacco.
- Adolescent – responsive health systems are necessary that facilitate healthy promoting and protecting policies, prevents exposure to harms and risks, enables adolescents to adopt healthy lifestyles and strengthens capacity of primary and referral level facilities to deliver responsive services

She stressed the need for interventions such as youth development programs which include vocational skills training, community-based programs to improve neighbourhoods and create safe spaces, clinic settings where youth participate in clinic management, mentoring or tutoring. Youth development programs should focus on life options, educational aspirations, employment considerations and psychosocial development needs, as well as promote a safe environment for youth to develop. She said that these programs need to focus on gender norms which are inhibiting the access to services for girls as well as boys.

Health of Migrant Youth in Southern Rajasthan - Mr. Om, Jatan



Mr. Om informed the group that Jatan is an organization working at field level since 2001 in Rajsamand, Udaipur and Bhilwara districts of Rajasthan. They address the issues of health; reproductive health including HIV/AIDS, education, migration and livelihood with the youth along with Maternal Health and Care for the better living of women and children. Strengthening Panchayati Raj institutions is one of the key strategies.

At the outset, Mr. Om provided background information such as status and indicators of South Eastern Rajasthan, where Jatan is working. He shared information collated from different reports and documents¹.

He shared that in 69% of the labour intensive work in this area, 65% of the youth are involved. Main sources of income for the people residing in this area are agriculture (21%), animal breeding (6%), jobs (2%), business (2%), migration (49%) and local labour (20%). While sharing the information about migration in the area where Jatan is working he shared that in Railmagra block 47%, in Rajsamand 38% and in Raipur 81% families have migrated.

It was mentioned that the youth who migrate to the cities generally take up jobs in occupations such as construction, Ice cream vendors, in hotels, dhabas, driving, namkeen making and such. Mostly the young people migrate to Ahmadabad, Mumbai Surat and Indore, however some also migrate to other states like Andhra Pradesh, Punjab, Orissa and Karnataka. Some of the key risks during migration are child marriages, HIV/AIDS, STDs, occupational hazards, socio- mental health, neglected family health and school drop outs. He cited the reasons behind migration such as pressure to earn, insufficient education, lack of awareness and crucial information and such.

Jatan works with adolescents in districts viz., Udaipur, Bhilwara, Rajsamand and Jhalawar. Some of the key activities with these migrant workers are providing registration & identification cards, conducting Gram Panchayat survey, providing counseling services, training and placements and information campaigns. In addition, for building sensitivity, trainings with various partner organisations were conducted, resource material was developed. Also health care facilities, financial facilities and legal facilities are provided to these migrant workers.

Mr. Om shared about their innovative idea of 'wallet'. Jatan has developed resource material for awareness regarding STIs and other health related messages. This material fits into wallet and thus is very user friendly. They have also prepared a counseling kit. Services are

¹ Education Survey ,2013 2012 Railmagra ,Rajasthan Migration Profile, Aajivika Bureau ,2014Jatan- Uger studies, Udaipur and Rajasamand and Jatan adolescents survey, Udaipur and Jhalawar .2014

provided to the wives of migrant workers as well. These young women cannot discuss their reproductive health issues with the in laws.

With the help of inputs from CHETNA, surveys are conducted and work on maternal health issues has been initiated.

Different audio-visual materials are used to create awareness. For example, the cloth apron developed by CHETNA is used for discussing menstruation. It was also shared that women are being trained to make the menstrual pads which are environmental friendly. They have initiated a healthy menstrual hygiene campaign, to provide women with bio-degradable sanitary napkins and to break the culture of silence around menstruation.

Under health counseling program, services are provided at places where the youth have migrated as well as at the source from where they migrate. Health check-up camps are organized for the families of the migrant workers. Awareness is spread to prevent occupational health hazards. The para-health workers trained by Jatan are called as '*Sanjeevani*'. They keep records of each and every migrant family. In the end, Mr. Om shared some of the challenges faced in working with migrant youth. They are-

- Lack of suitable sources for the understanding of occupational health hazards
- Lack of technically skilled workers
- Impolite behavior of the health service providers
- Difficulties in organization of regular health checkup and counseling camps at the destination places
- Issue of regular follow up after organization of health related workshops
- Hesitation in the region to discuss on the subjects related to reproductive health

Gender Equity Movement in Schools (GEMS)

Ms. Pranita Achyut (ICRW- International Center for Research on Women)



Ms. Pranita started her presentation by narrating a story from Jharkhand. In Ranchi, few days after sessions on body changes, a concerned father had complained that the teachers were teaching abusive language to students. The concerned teacher, principal and the GEMS facilitator discussed and pacified the father. But it was not enough for the teacher. Without naming any student, she asked her class for opinion on the session. The teacher reported that she

was overwhelmed to see that the entire class supported her belief and understanding as the students said that there was nothing wrong in the body mapping session. They said that had they not known the right language to address body parts, they would have continued to use the abusive words.

Ms. Pranita spoke about three important aspects of GEMS viz. engaging, receptivity and reflection. Ms. Pranita shared that positive shifts in gender attitudes were seen in the intervention areas.

Ms. Pranita elaborated about *Gender Equity Movement in Schools* (GEMS). GEMS aims at promoting gender equality, redefining masculinity and opposing and preventing all forms of violence. She said that the concepts of sexuality and health find their roots in the formation of notions of gender, inequitable gender norms affect the health and lives of boys, girls, men and women, notions of gender, attitude towards the opposite sex, and validation of the use of violence to resolve conflicts set-in early through various socialization processes. Hence, in this programme these fundamental constructs are challenged at ages when they are being constructed.

Second important aspect is that it is necessary to work with boys and men, as well as girls and women. Men should be viewed as partners not obstacles. It is necessary to understand that men are also constrained by rigid norms, thus masculinity needs to be reexamined and challenged. There are men who are challenging these norms. They need to be made visible (positive deviant approach)

GEMS takes gender transformative approach which changes social relations between men and women. It insists on reflecting on our realities, going beyond giving and receiving information to changing the way we process information. It creates dissonance as an approach for critical thinking. Some of the key strategies in GEMS are such as establishing safe spaces and a supportive environment for group reflection and focusing on institutions and platforms that are key to socialization. Since school environment is characterized by norms that directly or indirectly promote aggression and conflict, it is uniquely placed to influence and share thought processes and understanding of norms, values and stereotypes.

Group Education Activities (25 sessions) are conducted as part of GEMS. These modules are transacted in classrooms, during school hours and using participatory methodology. There is a week- long series of events, forums such as school assembly, essay competition. Community campaigns and teachers meetings are organized. In these sessions, 5 themes are covered, they are gender, violence, relationships, emotions and communication.

Ms. Pranita emphasised the need to engage with the teachers as they are an important constituency. She said that unless the teachers believe in gender, it is difficult for them to take it up, the lines between professional and personal sphere are quite blurred when it comes to gender issues.

‘Communicating reproductive and sexual health issues among adolescents’ - Ms. Susan Thomas, Coordinator, Lok Swasthya Sewa Trust



Ms. Susan informed the gathering that SEWA is working with women in informal sector for last forty years- empowering them through cooperatives. She shared the experience of action research project of SEWA. The project entitled, “Empowering young people

in Gujarat through their own *Mandals* – (groups) for advancing their sexual and reproductive health (SRH) and rights and overall well-being and by promoting their participation in community action was presented during the session.

The project's objective was to empower young people, so that they take leadership in the community. Other objectives were to improve access to services, including health care, nutrition, education and skill-building, to increase participation of young people in promoting community action and to develop strong evidence for a model of engaging young people in community action through their own groups to address these issues.

Key Interventions of the project were as follows-

- Providing health education and information for awareness on sexual and reproductive health within a framework of gender equality and rights
- Organizing groups or *Mandals* of girls, boys and young people, between 15 and 19 years of age, as safe spaces for support and solidarity, and for promoting their empowerment and leadership, thus enabling them to act on health and related developmental issues.

For communicating with adolescents, different strategies such as door-to-door education (direct and personal contacts), group education, exposure visits, use of visual and print media, debates, games, technology, street play/ role plays were used. Parents as well as the local leaders are also involved. For giving information, different tools such as visual and print media, debates, games, smart phones, competitions, street plays, role-plays etc are used.

The project also had counselors as lot of issues of adolescents that needed counseling. These are community counselors, thus, there is comfort, which proved very helpful. Health workers with experience are trained as counselors which is a very effective strategy. Refresher trainings are required for these counselors.

In the end Ms. Susan shared the key learnings of their project-

- Identifying young people who are interested and want to join the *Mandals* is significant. They help gather others.
- It's important to work closely with local leaders like Health workers, Accredited Social Health Activists (ASHA), Anganwadi worker² (AWW), Auxiliary Nurse Midwife (ANM), *Sarpanch* (elected village leader) , Link Worker and build strong rapport with the community
- Need to identify common public places to bring together young people from all communities
- Methods and tools used should be interesting and easy to comprehend like use of technology, visual and print media, street plays/role plays for education and awareness is effective
- Use of locally used terminology and language is necessary
- Games and other social activities are the best way to bring them together

² Crèche worker

- Gain the confidence of the parents of young people prior to venturing into any such intervention
- Regular meetings with the parents of young people is necessary
- It is helpful to encourage parents to join in the initial meetings and training sessions
- It is not easy to talk to young people straight away on topics related to sexual and reproductive health but general topics like nutrition, anaemia, etc. are easily accepted by them and their parents
- Simple messages and prioritising them is important
- Regular meetings and contacts with the young people should be maintained
- Young people should be prepared in advance for active participation and involvement in various activities
- A local health worker with good relationship with all stakeholders as well as the trust of the community is key component in such interventions
- Repeated sessions on various topics are necessary as they are not able to retain all the information given to them

‘Creating spaces for adolescents, spaces in policy formulation and program planning’- Ms. Pallavi Patel, Director, CHETNA



Ms. Pallavi shared the experience of Project ‘Sangam’ of CHETNA. The objective of this project was to make nutrition and sexual reproductive health information and services accessible to adolescents and young people in the state of Gujarat. The

intervention area in Sabarkantha District of Gujarat. A total of 126 villages of Prantij, Khedhbrahma and Talod blocks were covered. The program reached out to more than 10,000 adolescents (10-19 years) boys girls, in school out of school married and unmarried. The project was implemented in collaboration with Department of Health and Family, Department of Women and Child Development and Department of Education, Government of Gujarat.

Ms. Pallavi Patel further provided details of the context such as adolescents are a diverse group and mobile too. Adolescents have extremely poor access to sexual and reproductive health information and services. Beliefs and social norms are the key barriers for accessing services especially related to reproductive and sexual health.

In the project, home visits were conducted to ensure one to one communication with parents about the programme and need to address adolescents’ health and nutrition need. In addition, outdoor Media (Hoardings/Wall paintings) and display of posters at village level were used to

inform communities about the health and nutrition entitlements of adolescents from government programmes.

School Management Committees (SMC) were activated and parents meeting were conducted. These forums provided an effective platform to communicate with parents and teachers about the issues related to adolescents and to effectively implement the programme at school level.

The program organized monthly health education sessions with non-school going adolescents and one to one interaction for counseling of adolescents at village level. In the school, there were sessions through teachers on adolescent health issues

Participation, recognition and skill building were the key aspects of this intervention.

The program provided an enabling platform to exhibit the learning at community and with stakeholders, it included Life Skill education to empower the adolescents (Communication, Decision Making and Negotiation)

Another strategy was to create a cadre of peer educators. Peer Educators reached out to other adolescents to disseminate information about health and nutrition. Ms Pallavi shared that the adolescents need long term mentoring support to develop communication skills to deliver the health messages.

Peer educators were working voluntarily. Another challenge was to sustain their interest to play this role of peer educator. One of the approaches CHETNA used was to provide them platform in front of the community and the government officials to talk about their knowledge and efforts as a peer educators. Adolescents are mobile, they are not stationary population. Therefore turn over in peer educators is also a challenge in reality. Thus, constant handholding and mentoring support is crucial for better results.

Another practical difficulty mentioned by her was that the adolescents needed information at the village level. They could not go to counsellor who is located at the health facilities or at Adolescent Friendly Health Centre. Thus, building human resource at the community level was very important in the program. Local person from the intervention area was trained on nutrition and sexual reproductive health issues. Regular and frequent contact was maintained with the adolescents throughout the intervention and participation. Referral mechanism was developed for the complains which required medical treatment. The frontline workers were extensively trained in adolescent health and health communication. Training of Village committees e.g. Village Health, Nutrition and Sanitation Committee (VHNSC) helped in mobilizing communities around Adolescent health and development issues; creating an enabling environment at the community level for adolescents to access services

The outcome of the project was that there was significant increase in awareness among the adolescents as well as significant increase in access to reproductive and sexual health services including contraception and condom for safer sex.

Ms. Pallavi raised issues regarding Peer Educators approach. She ended her presentation with recommendations for ensuring a healthy life for adolescents. These were-

- Recognize the need for making information and services accessible to adolescents by allocating designated human resource and budget
- Integrate the component of empowerment and gender equality in all health education programme
- Involvement of community and stakeholders are non negotiable

- Inter Departmental Convergence is required for successful implementation of adolescent health programs
- Make health information and counseling accessible at a village level by building the capacity of the frontline workers and other young leaders.
- Inform the community about their entitlements, loudly and clearly
- Capacity building should be done on a regular basis with regular mentoring support and should not be a one-time event.
- Regularity in sharing information and contact to solve queries is necessary
- Peer educators approach may not be ideal to disseminate information at the village level.
- One to one contact, group discussions, educational classes are non negotiable. Technology to disseminate information has limited reach.

Discussion

After these presentations, there was open discussion about the various aspects and interventions discussed in the presentations.

Some of the key questions and comments on the presentations were as follows-

There were questions regarding the underlying causes of anaemia, type of anaemia and the causes of underweight among the adolescent girls. It was discussed that the anaemia is mainly iron deficiency anaemia is observed among adolescents. The underlying causes are poverty, less availability of food, gender discriminatory practices where women and girls eat last in the family. Sickle cell anaemia is also prevalent among tribal populations. Anaemia-myths and misconceptions about food items also contribute to anaemia. Lack of awareness about locally available iron rich foods was cited as another underlying cause of anaemia

It was queried if Jatan has any programs in schools. Mr. Om responded by saying that they do not advocate for preventing migration. 47 % of their beneficiaries are school drop outs. They work with the school going children as well but for school drop outs; there is no source of information. Mr. Om was also asked that since they are working at source and destination- what is the process of identification at sources and what is the training at destination? Household survey in each village is done, when the migrants come to source villages for festivals, they build rapport. At destination, they contact key informants and snowball method is used for identifying migrants in bastis. Sexual health, reproductive health also discussed in workshops. They faced dilemma while working with people who are involved in unskilled labour as there is little scope for skill enhancement. Only marketing skills can be given.

Ms. Susan was requested to throw light on the strategies to make the *Mandals* sustainable. She responded that they are trying to link the *Mandals* with other groups/ Self Help Groups (SHGs), also working closely with Anganwadi workers, ASHAs, girls are married early so now they focus more on married young women.

Question was raised regarding the changes in indicators- Ms. Susan responded that evaluation is underway. The objective of the intervention was to increase awareness, through mandals, to empower young people, to help others in their own locality. The young group is now also part of other than project activities, they are helping to mobilize, call 108 in emergency.

Ms. Susan was asked if they had mixed group discussions or the discussions with boys and girls separately. She said that this was the first time SEWA was working with boys. In one day workshops, boys and girls were sitting together, where they realized that boys were

comfortable but girls were shy. Initially health workers were hesitant, gradually they overcome the problem, *Mandals* are for both boys and girls

There was considerable discussion about the peer educators. Ms. Pallavi Patel recommended that to facilitate health education sessions by peer educators is challenging. They are good at convincing other peers and their parents to participate in the programme and also to attend the educational classes. She put forward the recommendation that the responsibility of health education session can be given to young married woman of the village. It can be given to ASHA or Anganwadi worker. Peer educators are unpaid workers, which could be a problem for sustaining them in the program. Need for regular training of health service providers was reiterated. Similarly it was underscored that the peer led programs need constant hand holding.

Questions were raised about consent of adolescents while discussing issues like sexual harassment and the issues related to implementation of Protection of Children from Sexual Offence Act (POCSO Act). This concern was acknowledged by all. They said that the counselors do mentioned that adolescents do share about violence but handling complaint of sexual violence is a challenge. With teachers, there are issues around maintaining confidentiality. Teachers' training does not cover this component strongly; they prefer to push these issues under the carpet.

Recommendations:

Greater attention on Adolescents (age 10-19 yrs) and young people, who are a diverse group and fulfillment of sexual and reproductive health-care services, including for family planning, information and education is essential to ensure universal access. A comprehensive approach, within dynamic sociological, cultural and economic realities, is required to respond effectively to the health and development needs of adolescents and young people. The specific recommendations by the group are-

1. Educational interventions for adolescent and young people needs to be interactive, participatory, non- judgmental, creative and gender sensitive.
2. Information and education packages must be designed to equip them with life skills like communication, decision making, negotiation, relationship building etc. Gender equality and empowerment of women and girls need to be integrated (SDG5)
3. Design gender sensitive, technically sound, tools to impart messages keeping the local reality, customs, literacy level etc in view.
4. Appropriate budget/resource allocations need to be made for making information and services more accessible to adolescents and young people. Develop a cadre of community-based trained individuals who can increase access to information available to young people. Designated human resource and budget needs to be ensured in all the existing development programmes.
5. Plan and design customized educational interventions rather than “one size fits all”, based on evidences and disaggregated data by income, sex, age, caste, ethnicity, migration status, disability and geographic location etc.
6. As a part of educational intervention provide space for young people to come together to share, learn and support each other.

7. Community and stakeholders' including parents or guardians' participation and mobilization are non-negotiable to ensure support for adolescent and young people's access to reproductive and sexual health and services. Continuous capacity building of frontline workers and educators for educating adolescents and young people is a non-negotiable with regular review and extensive mentoring support.
8. Reproductive and sexual health education needs to be provided at all spaces and institutions where adolescents and young people are located such as: schools, colleges, orphanages, workplace etc. For this to happen convergence with other Government Departments- Education, Social security, Social justice, livelihoods etc. is critical.
9. Educate, train and empower youth to monitor the delivery of public services



Session II- Community Based Approaches for Improving Maternal and Newborn Health

12th January 2016

Chair person – Dr. Leela Visaria, National Professor and Former Director, Gujarat Institute of Development Research (GIDR)



The discussion of second day focussed on target 3.1 and 3.2 of Goal 3. Target 3.1 Reducing the global maternal mortality ratio to less than 70 per 100,000 live births by 2030. Target 3.2: ending preventable deaths of newborns and children under 5 years of age by 2030.

Dr. Leela is a Governing Council Member of CHETNA and was the

former Director of GIDR. Dr. Leela Visaria initiated the workshop by presenting the overall context of maternal health in India. She informed the group that there is definite reduction in maternal mortality as well as infant mortality in India, hence there is a sense of achievement. MMR is down from 450 to 178 per 100,000 births where as IMR is down from 80 to 42 per 1000 that it is almost halved in 25 years. However, there are regional disparities in India, for example IMR in Madhya Pradesh is over 50 whereas in Kerala it is around 12. MMR in India ranges between 320 (Assam) to 60 (Kerala).

Another important trend is fertility decline, couples all over the world opt for not more than 2 or 3 children and thus there is reduced risk of children dying and hence there would be decline in both MMR and IMR irrespective of the efforts made. In addition, there is increase in health seeking, which has contributed to decline in infant mortality.

While talking about indicators for SDGs, Dr. Leela mentioned that along with indicators of mortality, it is important to include process indicators and morbidity indicators in the measurement. Morbidity indicators are important as recurring morbidities such as malaria, diarrhoea among children impact their cognitive development. Subsequently, Dr. Leela gave an overview of health services in India highlighting that around 60 to 70% use private health sector services today. In the private sector, the doctors are easily available; the distance is convenient and there is perceived better quality of treatment.

Community based approaches which are prevalent are providing health care to people, training of link workers, providing training material and influencing policies. Dr. Leela talked about the limitations of up scaling some of the NGO interventions at the national level. Some of the key ingredients behind the success of these interventions such as empathy, willingness to work for less money, commitment, accountability to community cannot be scaled up.

While pointing out another limitation of community based approach, she said that the communities are not homogeneous; hence welfare of entire community is difficult. She also emphasised the need to educate people in their own language explaining cause and effect.

Merely generating awareness has not shown to work a lot. We need to generate demand for services. In the end, Dr. Leela spoke about the lack of regulation of health services in India. Quality of care and exorbitant prices are other major issues. The staff in the public health system lacks empathy.

‘Participatory Learning and Action (PLA) to Improve Maternal and Newborn Health - Dr. Prasanta Tripathy, Director, Ekjut



Dr. Prasanta narrated his experience based on work done by Ekjut³. Ekjut is a voluntary organization with a strong field presence in the underserved villages of the three states, viz. Jharkhand, Orissa and Madhya Pradesh. Ekjut means ‘coming together’ in several Indian languages. He said that the work of Ekjut is based on three pillars, viz., tracking change, empowerment and influencing advocacy.

The intervention focused on capacity building process through which community members, groups or organizations **plan, carry out and evaluate activities in a participatory and sustained basis** to improve their health and other conditions, either on their own initiative or stimulated by others.

Dr. Tripathy mentioned about the concept of ‘Critical Consciousness’ proposed by Paulo Friere. He said that the poor people have a culture of silence. When they go through the process of building critical consciousness, together they can make a difference. Later he explained how monthly meetings of women’s groups helped reduced perinatal deaths. He said that the process has to be sustained community capacity building. He also emphasized on actionable learning that is learning is leading to action. He mentioned that in Ekjut project, they have collaborated with University College of London. The project was implemented in Jharkhand and Odisha. Ekjut surveillance system has been set up in 36 clusters. 36 monitors are selected who conduct household visits. In the study, there are 18 clusters in the intervention arm and 18 clusters in the control arm. Stratified random sampling was used for selection of clusters. In the intervention arm, monthly meetings were conducted. There were no incentives for these meetings to the facilitator. Facilitators used manuals to guide their meetings. Focus was on understanding causes and finding solutions to the prioritized problems. In the intervention area, there is one local woman facilitator per cluster. Each facilitator was responsible for 10-16 groups. There were total 244 groups. Each group met monthly where facilitators used manuals to guide their meetings. Methods such as picture cards or use of pebbles were employed to prioritize problems.

The phases of intervention were as follows-

Phase I- identifying and prioritizing problems

Phase II- planning

Phase III- implementation

³ <http://www.ekjutindia.org/main.html>

Phase IV- evaluation

A total of 23467 mothers were interviewed in the study where participation criteria were all women of reproductive age (15-49). Trained interviewers visited women and administered a structured questionnaire around 6 weeks after birth and data was collected on events in pregnancy, delivery, post partum period and mental health.

Starting a Saving & Credit group, arranging for transport (Mamta vahan), institutional delivery, immediate wiping, wrapping, not bathing the child for 3 days after birth, delaying age of marriage, encouraging pregnant mothers to visit health facility, early initiation breastfeeding and no pre-lacteals, giving knowledge about danger signs were some of the interventions.

Emergency preparedness was an important aspect where the objective was to identify emergency problems, to discuss possible delays in responding to emergencies - '**Emergency drill**', to discuss how these delays could be reduced.

PHASE - IV EVALUATION – The impact was that from year 1 to 3, there was 32% reduction in NMR. There was 57% reduction in moderate depression among mothers. Increase in women's agency in intervention area was evident from increases care seeking, visiting a provider unaccompanied, going to the shops unaccompanied, expenditure for daily necessities and such.

Overall learnings from the work of Ekjut were as follows-

For successful participatory interventions, it is necessary to recognize people as assets, build on people's capabilities, promote mutuality and reciprocity, develop peer support networks, break down barriers between professionals and users and be a facilitator rather than focusing on delivering. Dr. Tripathy also emphasized on the need of health system strengthening along with PLA.

Educating Women's Groups for Ensuring access to Maternal Health Services- Ms. Neeta Hardikar, Programme Executive, ANANDI⁴



Ms. Neeta Hardikar spoke about process of learning with Bhil, Rathwa and Miyana women's collectives in Dahod, Panchmahaals and Little Ran of Kutch in Gujarat state.

At the outset, she briefly introduced her organization ANANDI- Area Networking and Development Initiatives,

which is working since 1995. ANANDI is a Feminist Collective, which combines the 'Empowerment' and 'Livelihood' approach. Their key strategy is to organize women's Collectives. It believes in investing in women's leadership and partnership with women's

⁴ www.anandi-india.org

collectives for sustainability of their work. Field Work Area of ANANDI is Dahod, Panchmahal, Morbi and Bhavnagar districts.

Ms. Neeta elaborated upon Participatory Action Learning Systems to understand women's voice and agency. She explained that women's perspectives about safe delivery were captured through 60 small group exercises. Pebble mapping exercise was done. Based on this exercise, a poster was developed which depicted women's perspectives about safe delivery.

She said that the IEC material prepared by the Government shows several different food items to be consumed during antenatal period and post delivery. However, in reality women are mostly given maize porridge. Deliveries are actually conducted in unsafe conditions. Women's discussions have shown their nuanced understanding about the quality of care. A pictorial checklist has been prepared to assess the quality of services received by pregnant women. This pictorial tool has several other aspects. Data generated is used to prepare a monitoring report card about the services.

In this entire process of from awareness to action, various Adivasi art forms are used for education, such as *Devgadh no rankar* and *Andhare Atvaya* audio music tapes capture all social determinants that affect women's health, street plays based on "theatre for oppressed" questioning disempowering patriarchal systems to gain greater control over own body, puppetry to talk about child marriage, young mothers and risks and accessing maternal health care services.

On the basis of data generated using these checklists, dialogues are held with Medical Officers, ASHAs and women's groups. Range of issues are discussed and also action taken on these issues. For example, posters regarding what to do in emergency were displayed in the villages. There were several positive outcomes of this process, such as increase in pregnancy registration from 23% to 83%, increase in checking weight from 2% to 28%, increase in abdominal examination from 0% to 54%, increase in blood pressure checking from 4% to 23%, increase in anaemia testing from 4% to 39% and home deliveries declined from 64% to 47%.

Regular dialogue provided legitimate space for women to discuss their issues. There is a need to include *Panchayat* (Local village level elected body) members as well. Report cards can be discussed with them. Comparison with the control area clearly shows the improvement in the quality of services in the intervention area.

In the end, Ms. Neeta summarized the strategies used in the intervention area, which were as follows-

- Regularly generate monitoring Report Card regarding the quality of the services through collective agency of women
- Using mandated local institutions as well as community based formations
- Preparation for local negotiating parties and capacity building
- Consistent follow up by women's Sangathan
- Empowerment of communities/users to neutralise power of the organised formal health system
- Engaging in actions to help and support local service providers in addition to monitoring them and the GP members
- District, State and National advocacy

‘Reaching Out to Families for Birth Preparedness and Complication Readiness’
 Vaidya Smita Bajpai (State Coordinator, SUMA and Project Director-CHETNA)

At the outset, Vd. Smita pointed out to the group that to achieve the target 3.1 which is about reduction in maternal mortality, timely access to continuum of quality care is essential. She said that “universal barriers” of awareness, cost, distance and transport reduce skilled care seeking by women and families. It is recognized globally that improving birth preparedness and complication readiness (BPCR) helps mitigate some of these barriers and reduce delay in accessing skilled services. Birth preparedness promotes active participation preparation and decision – making for births including pregnancy/postpartum periods, by providers, pregnant women and their families.



Rajasthan is a state with high MMR and high NMR. The Maternal Mortality Ratio (MMR) of the state is estimated at 208 per 100,000 live births (Annual Health Survey, 2012-13)

Vd. Smita informed about efforts by the Government of Rajasthan (GOR) to address these issues such as ASHA-Sahyogni to link women and children to health services etc., Janani Shishu Suraksha Yojana (maternity benefit scheme which provided cash incentives for institutional delivery), Free Ambulance services-(104/ 108), Free Medicines scheme, ASHA-SOFT, an online payment and monitoring system to track performance of ASHAs and Mother and Child Tracking System (MCTS) to track services.

In the context, the objectives of the intervention, in partnership with the White Ribbon Alliance India, was to introduce a model of birth preparedness and complication readiness in Osian block of Jodhpur district, Rajasthan and conduct operation research and compare the changes in experimental and control groups to gather evidence that community based birth preparedness and complication readiness works at scale.

In the Osian block, villages included in the project were Badla Basini, Bhesar-chavandiyali, Ghevada, Malunga, Khabada, Khetasar, Beh charana, Binjwadia, Mandiyai-kala and Gopasaria. Total Population covered was 37,200. GRAVIS and White Ribbon Alliance-India were the partners in the program. This area is mostly dessert and houses are quite scattered. The health facilities are located quite far away. Thus birth preparedness is quite necessary in these villages.

The intervention has two pronged strategy, which are-

- Educating and Mobilizing Families and Community Stake holders, and
- Advocacy with officials for availability of Services

The program took broader approach to involve all the stakeholders such as Frontline Workers (Dais /ASHAs/ AWW/ANMs to introduce Birth Preparedness and Complication Readiness (BPCR) at household level), Village Health Committees (VHSNCS) for their role in mobilising and monitoring of services, Jeep drivers to provide transport support during labour/emergencies, Women’s Group members for creating financial linkages for poor

families, and Family members for blood donation in emergencies. Village awareness meetings were conducted for community support.

Total 414 Pregnant Women, 338 lactating women and 389 family members (husbands and mother-in-laws) were involved in Birth Planning and Counselling. Meetings were held every Thursday at Anganwadi centres and at work sites as well. Sometimes evening village meetings were conducted. Health day was celebrated at sub-centre and also home visits were conducted.

Pictorial training materials were used in these meetings such as picture book/poster on entitlements during pregnancy and self monitoring of services, picture book on Safe Delivery, picture book on danger signs of mother and new born. Birth Plan Calendar was used to monitor health services. All details of birth were filed out, all important phone numbers are noted on the calendar.

Vd Smita further shared the findings of the external evaluation of this intervention. External evaluation was done using quasi- experimental design. First level of evaluation was to measure the changes before and after the intervention, and second level was to see whether the change is because of the project and how the interventions had contributed to the change.

While discussing the evaluation process she shared that for evaluation, Osian was the intervention block and Baleshar was the control block. Baleshar was selected considering - geographical spread, population demographics, health facilities, etc. From each block, 10 villages were selected randomly. List of Recently Delivered Women and Currently Pregnant Women were collected from Anganwadi Centre (AWC). From the list, required numbers of respondents were selected systematically, ensuring the representation from different Tola or Dhani. Semi structured tool was used for quantitative survey and for qualitative survey, Focus Group Discussion (FGDs) were conducted with mother-in-laws while In-Depth Interviews were conducted with husbands, Traditional Birth Attendance (TBAs) and ANMs.

The evaluation revealed that the knowledge level of women about danger signs during pregnancy, about danger signs during labour and delivery, danger signs during postpartum phase and danger signs in newborn had increased significantly over baseline. Also, women receiving 3 postnatal checkups had increased drastically over baseline.

In addition, planning about birth preparedness and complications readiness had increased over baseline. About three-fourth of RDW and four-fifth of CPW in Osian block reported to have planned the place of delivery. About four-fifth of RDW and CPW reported to have pre-identified skilled birth attendant. It was observed that couple planning for emergency transportation during pregnancy increased significantly over baseline and couples having saved money for emergency and birth also increased significantly. About three-fourth of the RDW and four-fifth of CPW in Osian block reported to have pre-identified blood donor. In addition, overall registration of pregnancy increased significantly, however, the programme has slow impact in the early registration pregnancy.

The evaluation also confirmed that the programme had impact on increasing the institutional delivery. Findings of the evaluation show a significant increase in institutional delivery in Osian block over baseline, where the couple had jointly taken the decision about place of delivery. There is also increase in the decision by parent-in-laws. There was significant increase in institutional delivery accompanied by Dai over baseline. In case of home deliveries, a significant increase was observed in the home deliveries attended by trained dai. However, use of disposable delivery kit in home delivery was very low.

Vd. Smita shared the key lessons learnt from this intervention, which are as follows-

- There is culture of silence around pregnancy/childbirth which is one of the barriers in accessing timely health services/ household level care. Birth Preparedness helped breaking the silence.
- Substantial efforts are required to educate members of the household including men and elders
- Role of service providers in educating families and communities needs to be strengthened and supported
- An enabling environment for open and frank discussion needs to be created to ensure community participation and support
- Communication aids have to be culturally sensitive.
- Adequate resources such as time, skills and enough money are essential
- Culturally, preparations are not made during pregnancy. Engaging women and families to plan for birth and mitigate emergencies requires significant efforts at the family level.
- Mobility of women is controlled and it is difficult for them to stay out of homes for considerable time. Engaging with elders- mother in laws is important
- People's knowledge and practices, often categorised as myths at times stem from an adverse experience with the public health services. This needs to be understood in depth.
- Decision making and access to finance is largely in hands of men and mother in laws. To engage them in the birth planning process is important and also challenging.
- Organizing financial support to women from disadvantaged section is a challenge:

Vd. Smita concluded her presentation by providing concrete recommendations as follows-

1. Education for Birth preparedness and complication readiness needs to be introduced at the family and at the health system level.
2. Culture and gender sensitive communication strategy with appropriately designed tools must be provided to communities and providers
3. In areas where men migrate for work, women- Mother in laws (other family members) and in other situations, men play a key decision making role. Maternal Health Programmes need to reach out and include them.
4. The role of frontline workers ASHAs/ANMS needs to be recognised, promoted and strengthened to provide education through regular home visits.

‘Community Action for Health- A National Initiative’ Mr. Bijit Roy, Coordinator, Population Foundation of India (PFI)



In his presentation, Mr. Bijit shared that PFI is a secretariat for Advisory Group on Community Action (AGCA). He initially gave an overview of community action for health under the National Health Mission.

He informed the gathering that there are mainly three types of accountability mechanisms in the public health system. First is internal monitoring, second is through Public Surveys and Studies and third is community monitoring.

Mr. Bijit informed about the Advisory Group on Community Action (AGCA). Mandate of AGCA is to advise to develop community partnership and ownership for the Mission and provide feedback based on ground realities to inform policy decisions, which is done through Community Monitoring, participation in Common Review Mission (CRM) and fact finding missions. Another role is to develop models on community action and recommend for further adoption/extension to national and state governments- pilot and technical assistance for scaling up. Community monitoring is currently being implemented in 19 states of country.

Mr. Bijit further delineated the steps of community monitoring process, which are as follows-

1. Structured trainings for VHNSC members and block and district planning and monitoring committees
2. Use of folk media and communication materials for dissemination of information on NRHM and its health entitlements
3. Display of citizens charters and minimum service guarantees (including roles and responsibilities of service providers, timings of services) at the village and in health facilities
4. Community enquiries were done through community meetings and information was collected for health facilities through direct observation and exit interviews. This was done at an interval of six months.
5. Multi-stakeholder committees were formed and trained to feed inputs emerging from the community enquiry and facility surveys for planning and corrective actions.
6. Block, District and State Level Jan Samwads (Social audits) were organized to share instances of denial of services and outcomes of the community monitoring process.

Mr. Bijit shared the results from community enquiry on maternal health in Bihar which was conducted between March, 2012 and April, 2013.

Interview of 1500 women who delivered in last 3 months (5 from each intervention village) were conducted. Data for this enquiry was collected on following aspects-

1. Antenatal care (ANC) registrations
2. Receipt of Iron Folic Acid Tablets
3. Tetanus Toxoid (TT) Injections
4. Urine and blood examination

5. Referral services
6. Supplementary nutrition
7. Post partum contacts by ANM and ASHA

Community monitoring of maternal health services led to improvement in range of ANC services, streamlining of payments of Janani Suraksha Yojana reimbursements, increasing reach of ambulance services – time, difficult to reach villages, improvement in responsive behavior of health care providers and reduction in informal payments. However, there are certain services such as Post partum visits by ANM and ASHA, appropriate **referral** from PHC to CHC and District Hospital, or examinations during ante-natal check up (Urine and Blood) which did not show much improvement.

Following recommendations emerged from this community monitoring process-

1. There are certain prerequisites for strengthening democracy through process such as community monitoring. Investments and institutional structures for strengthening community process interventions are necessary. One time investment is not enough. Active facilitation of community volunteers, village committees, elected representatives is required. Initially, the VHNSCs need hand holding.
2. Pushing too far can be counter-productive
3. Communication campaigns on entitlements and service guarantees- television, radio, mobiles
4. Empowering youth to monitor services at the local level- example is monitoring of Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA) in Andhra Pradesh by young people.
5. Need to institutionalize grievance redressal mechanisms and corrective action- community, facility based death and morbidity audits. Given the unequal power relations between health care providers and the community, at times there could be backlash and thus open dialogues are a challenge.
6. Appropriate level services at each tier – time to care

Discussion

The issues raised during these presentations were subsequently discussed by the group.

Some of the **key issues, which were raised by the participants during the discussion**, were as follows-

There is a need to address social norms for which community mobilization is required along with health system strengthening. If there is a problem of quality service at Primary Health Centre (PHC) women do not prefer to go for institutional deliveries. Therefore community awareness and health system strengthening should be concurrent actions.

Another important point was regarding the pace of work. It was suggested that any change requires time and needs to be slow in pace. There is no point in pushing several issues at a time. Even challenging gender norms have to be dealt with the pace the people feel confident and comfortable. For example men need to be consciously involved in the discussions regarding care during women members of their family rather than blaming them about their non participation. Similarly, Panchayat members are gradually involved and made

accountable. Naming, shaming does not bring accountability, thus the presentations during the health dialogues should be made appropriately.

Regarding the communitization it was discussed that building awareness may not always lead to action taking. For example, a survey showed that out of 92% people who had knowledge about contraceptives, only 4% were actually using contraceptives. Social systems/ cultural factors play an important role in deciding whether a particular practice would be adopted or not.

While up scaling the community monitoring, basic features need to be preserved. The point that approach can be up scaled but the spirit cannot be was reiterated. It was said that it is very important to feed the information back to the community. There was some discussion about the data collection in community monitoring process. Mr Bijit informed that earlier the data collection was done manually, now mobile phones are mostly being used to generate data. Interactive Voice Response (IVR) system is used in some places like Maharashtra to collect data.

Recommendations

After this discussion, participants were requested to give their specific recommendations regarding education for achieving target 3.1 and 3.2 of Goal 3. These recommendations are as follows-

For achieving this target, people need to be active partners in reducing maternal mortality and accessing quality maternal health services. This can be achieved by engaging, educating and empowering people to access their entitlements and take care of their own health. Active and responsible engagement of men and family members needs to be ensured. The culture of silence around pregnancy and childbirth needs to be broken. Educating and informing women, families and communities help breaking this silence. It is therefore recommended that

1. Culture and gender sensitive communication strategy with appropriately designed tools for communities and providers must be developed and implemented to educate and empower women, men and community members for saving mother's lives.
2. Education for Birth Preparedness and Complication Readiness (BPCR) needs to be introduced at the family and at the health system level.
3. Maternal Health Policies need to be recognized the critical role of BPCR and make appropriate provisions in maternal health programmes/interventions.
4. Special efforts need to be made to reach out to migrant populations.
5. In areas where men migrate for work, women- Mother in laws (other family members) need to be actively engaged in BPCR
6. Men, as responsible partners need to be an integral part of the Maternal Health Programmes.
7. The role of frontline workers ASHAs/ANMs must be recognized, promoted and strengthened to provide education and counseling through regular home visits.
8. Include violence against women as an important topic in the training of the health service providers.
9. Training on birth preparedness of the FHW and ensure its implementation.

Session III- Addressing Social Determinants for Improving Child Health

13th January 2016

Addressing social determinants for improving children's health and wellbeing

Social determinants such as poverty, nutrition, gender discrimination, water and sanitation play a key role in achieving this target. The strategies for ending preventable deaths of newborns and children under 5 years therefore must address the underlying causes responsible for low birth weight, too many, too close pregnancies and child birth, feeding practices, infant and young child diseases such as diarrhoea and acute respiratory tract infections. Educating communities to address the social determinants and child care is the key.

The workshop facilitated by CHETNA brought together a total of 30 international, national and field level experts having experience of implementing community based approaches to addressing gender discrimination, poverty and nutrition among children.

Welcome and introduction

Ms. Indu Capoor Founder Director, CHETNA and Director CHETNA Outreach extended a warm welcome to the participants. She said that during the workshop focus will be laid on target 3.2 with special emphasis on addressing social determinants for improving child health.



Ms Capoor welcomed Ms Mirai Chatterjee, Director of Social security at SEWA (Self Employed Women's Association) who has been working since 32 years in the field. This session began with the presentation by Ms Mirai Chatterjee, Director, Head- Health Unit, Self-Employed Women's Association (SEWA). She has also worked as a member on the WHO commission for social determinants of health.

Keynote Address-Ms. Mirai Chatterjee, Director, Sewa Social Security

Ms. Mirai began her presentation by setting the context in which children are living today. She said that most of the parents are engaged in informal economy. Most children are children of poor labourers. 94% women workforce is in informal economy. Poverty is one of the major social determinants. There is overlap between poverty, gender and informal economy. No fixed employer-employee relationship, no work and income security and no food, social security are the characteristics of the informal economy.



Ms. Mirai further enlisted the social determinants of health (SDH) such as Early childhood; first 1000 days, work, livelihoods, housing, water and sanitation, food, nutrition, gender, social protection, climate change and policies, laws, regulations. She said that even the WHO commission on SDH faced the challenge of enlisting the determinants as practically everything impacts health in one or the other way. Early childhood is the first determinant of health as brain development and cognitive development is rapid in first 6 years and within that period, maximum development takes place in first 2 years. Thus this period is very critical. She also emphasized the need to act on all the determinants.

Ms. Mirai subsequently shared the experience of SEWA's Early Childhood Care Centers.

Comprehensive care is provided through following activities at these child care centers:

1. **Nutrition;** 2 meals a day are provided and special attention to malnourished children is paid. She stressed the importance of feeding children with love.
2. **Health Care** services such as regular check-ups, growth monitoring, immunization and referral are also provided through these centers. She said that these centers have become hub for public health system as all the children in the village can be found at one place.
3. **Education** is provided through recreational and educational activities, including exposure trips. Older children learn to read and write. Ms Mirai pointed out that preschool education is one of the critical gaps in current ICDS program. It is important that the learning is joyful.
4. **Parents meetings** Regular meetings with mothers and fathers are conducted about their children; educational sessions on parenting, health, nutrition, gender equality etc. are covered during these meetings.
5. **Capacity-building** Teachers at these child care centers are exposed to new ideas and approaches to parenting, education, health. Local women are provided training to work as teachers at these centers. The advantage of having local women as teachers is that they are trusted by the community and they also know the social context of children well as they themselves are living in that context. Therefore they can think holistically.
6. **School Education:** Linking with neighbourhood schools where most of our children get admission. The focus is to address the sexual and reproductive health, nutrition, career counselling for children studying in Std. VIII & IX.
7. **Parents Counselling** is also done by In-house doctor
8. **Festival Celebrations and Outings:** Ms Mirai said that post 2002 riots, children were very traumatized and it was important to ensure safety and peace. All the festivals are celebrated at the centres. This creates communal harmony. Children visit parks and places of interest.

After providing the gist of activities conducted by the child care centres, Ms Mirai later shared about the impact of the child care centres. Following points were enunciated regarding the impact of the child care centres-

1. Since the childcare centres were organised according to the timings of mothers' work hours, they could work leading to increase in income. The incomes of the mothers

increased by 50% and above; thus, they can afford food items such as lentils, fruits and vegetables. Better nutrition has also led to better health.

2. None of the children are in Severe Acute Malnutrition (SAM) or Grade III category; few in Grade II.
3. There is 100% immunization and better health indicators in the intervention areas.
4. Continuing education: All the children who pass out from these centres join formal schools.
5. There is increase in number of girls going to school. Since the younger siblings are in childcare centre, the elder sisters could go to school as their responsibility of looking after younger siblings got relinquished.
6. During the monthly feedback session with parents, nearly 50% are fathers of the children. This has helped to break the gender stereotype that child care is mother's responsibility.

In the end Ms. Mirai highlighted the lessons learnt through implementation of these child care centres. These are as follows-

1. Young children need to be cared for in a holistic and comprehensive manner (health and nutrition, loving custodial care, early childhood education). Emotional and spiritual development is also important.
2. Improved child health and nutrition occurs in child care centres. Need to focus on social determinants of health (SDH) for improved health outcomes.
3. SDH approach means systems and processes need to be organised according to child's reality. This mirrors parents, especially mothers' reality – her world of work (informal)
4. The child care centres become focal points for organising and development, uniting families across caste, religious and community lines.
5. Child care centres attract all sorts of government and private services and partnerships at the door-steps of low income families; these can have positive impact on child health and wellbeing.
6. When parents experience impact of child care they readily engage in action concerning their children, especially on SDH.
7. When fathers are engaged, they take responsibility, breaking stereotypes and changing gender roles. Take keen interest in child health.
8. Informal women workers when trained become most appropriate child care workers. Mothers trust other women like themselves with their young children. These local women act effectively on the SDH.
10. Child care helps to reduce malnutrition, improve child health.
11. Early childhood education must be part of child care (a neglected area in India) and has impact on child health.

12. Child care centres can be focal point for education on gender equality – early start for equitable health outcomes.
13. Child care must be an essential investment of society in general (not just parents). Parents and communities can contribute up to 20-25% of the cost. Rest of the costs have to be borne by government, external funding.

Children's health of Migrant Population, - Ms. Vrishali Pispati, CEO of Mumbai Mobile Creches (MMC)

Ms. Vrishali talked about health of migrant children. Her presentation was based on the experience of MMC. In the beginning of her presentation, Ms. Vrishali spoke about the scenario of internal migration in India. Construction sites, Brick kilns, Stone quarries, Agriculture, Domestic work and Allied services are some of the



occupations where the migrant workers mainly find employment. Out of these, construction industry is the main employment source for the migrant workers in urban areas.

Mumbai Mobile Creches works with the children on construction sites. These children are most vulnerable as the surrounding environment is unsafe, prone to accidents. Children are often neglected as the parents are busy working.

Some of the factors which impact health of migrants are environment related; Poor housing conditions, Inadequate sanitation facilities, over-burdened public health system, limited spending capacity, low awareness and delays in seeking services due to opportunity cost. It is seen that on construction sites, toilets and water are the amenities, which are provided very late.

Some of the health issues observed in these migrant children are pre-natal under-nutrition, malnutrition, micronutrient deficiency, lowered immunity, communicable diseases, injuries and accidents. Despite serious efforts by MMC, there are not many changes in the situation at the sites.

Further Ms. Vrishali described the program of MMC. Set up in 1972 in Mumbai, MMC has reached over one lakh children on construction sites till date. MMC runs 20 – 25 centres reaching over 4500 children annually, 60% of them are below 6 years. **MMC model is simple – go directly to a site and set up the centre.**

MMC's Comprehensive Day Care Model



As part of the MMC program, they also conduct Teachers' Training Program. It is a year- long programme (Bal Palika Training (BPT)) for construction workers and other vulnerable communities which provide practical internship (4 days) + theoretical learning (2 days). Emphasis is on importance of community and parental involvement. 30 % of MMC teachers are BPT alumni. Needs based training programs are also organised for Anganwadi personnel and other non – profit professionals. MMC works with service delivery approach. In this program, the nutrition and health care interventions are as follows-

- Four nutritious meals provided which include freshly prepared breakfast, mid-morning snack, lunch and evening snack
- Micro-nutrient supplementation on a daily basis along with regular de-worming
- Special diet for under-nourished children as per doctors' recommendations
- Food served to children observed by parents when they pick up or drop their children at the centre
- Growth Monitoring and Promotion – Monthly for < 5 years and quarterly for > 5 years children
- Age appropriate immunization in the presence of parents by networking with PHC's
- Regular follow up of under – nourished children and counselling of parents through home visits
- Regular Health screening through camps
- Treatment of common illnesses by regular doctor visits
- Referral services for children requiring medical attention- example one child required surgery for cleft lip. However, the parents were apprehensive about surgery. The MMC worker took the mother to the hospital, where the mother saw that other children were doing fine after the surgery, she agreed for surgery of her child.
- MMC staff accompany parents for referral services

- MMC supports with hospital/surgical expenses where required.

MMC acts as a bridge between local urban health centre and the children of migrant workers. Their access to health care services is facilitated by MMC. Similarly, severely malnourished children are taken to Nutrition Rehabilitation centre in Mumbai.

Education and awareness is an important part of work of MMC. There are street plays about HIV/AIDS. Puppetry is also used as one of the mediums for creating awareness. Language is one of the barriers in teaching children because children come from different parts of the country.

Ms. Vrishali concluded her presentation by giving following recommendations-

- Convergence and partnerships are critical in tackling marginalization of vulnerable children
- Partnerships are also needed between civil society, private sector and public sector
- Health education and beyond
- Strengthen various models of healthcare based on local needs
- Quality ECCE programmes with strong emphasis on health and well-being

She said that most of the growth in GDP is due to the contribution of these migrant workers, yet their children are denied their rights.

Following these two presentations, there was discussion on the various issues and recommendations emerging from these presentations. Given here is the gist of these discussions.

Some of the questions asked about the MMC model were

- regarding the cost of running one centre- cost is 1800 rupees per child per month
- about health of children when they go back
- about the training of teachers as they also migrate- she said that there has been very little attrition as the teachers once trained remain with the program when they are in Mumbai
- how is the language barrier overcome
- whether parents can stay at the NRC for 21 days- MMC worker accompanies the parents in the NRC
- how is the follow up with NRC managed
- about the role of fathers in this program- for engaging fathers, home visits are made. It needs patience and persistence to involve them in the program. Meetings are convened late night or on holiday so that it becomes convenient for them to attend
- what are the criteria for selection of construction site- there is no criteria as such only that there should be at least 20 to 25 children at the site. If there are less children then commitment from the builder is required
- how are pregnant mothers involved in the program- meetings with pregnant women are held
- how is the problem of lack of identity for migrant workers managed- construction workers have I-cards. Rashtriya Suraksha Bima Yojna (RSBY) cards are portable
- about the sustainability of the program

- the nature of engagement with private sector-

Questions related to sustainability were also asked for SEWA model. Ms. Mirai responded that the community contribution is important in the SEWA model. Sometimes the local merchants contribute grains. In case of MMC model, Ms. Vrishali informed that though the builders are mandated to contribute, they do not adhere to it. Since the migrant workers are not well organized, they do not demand their rights. Builders say that they already pay the construction worker cess.

Ms. Mirai was asked about the overlap between ICDS and SEWA childcare centers. She said that the timings of the ICDS anganwadi were not suitable for most of the working women, hence they prefer SEWA centers. Women are willing to pay 100 rupees per child per month as they are sure about the quality of care that is being provided.

Ms. Vrishali also shared her experience about approaching ICDS to run a centre jointly with MMC at construction site, however, the response was negative in the beginning. Now they provide *Take home rations and cooked meals* to MMC centres. Responding to the language barrier, she said that the children acquire new language quickly. On the ground solutions are required to tackle these problems.

Cultural Approaches for Health Education - Ms. Minaxi Shukla, Additional Director, CHETNA



For third session on *Cultural approaches to health education*, Ms. Minaxi Shukla, Additional Director, CHETNA took the participants through 35 years of CHETNA's journey in the areas of empowering children,

women and young people for health and nutrition through Health education. She presented a brief about CHETNA's efforts to health education in improving health of children, young people and women; in a life cycle and gender equity approach. CHETNA works with marginalized populations for positive behaviour change for health and wellbeing using culturally appropriate health education which aims to promote inclusive and sustainable solutions. Ms. Shukla talked about three key strategies; Community awareness, Capacity building of service providers and Advocacy. Need based participatory health communication methods are used for various stakeholders; including policy makers/influencers, elected members at parliament, state Assemblies and Panchayat i.e. Village-local governance, community based organizations (CBO); both constituted by the government and communities such as Village Health Sanitation and Nutrition Committees, Mothers' Groups, School Management Committees, Youth and women's groups, parents, teachers etc. Needs based, field tested and gender sensitive behaviour change communication (BCC) material have been developed, disseminated and used to strengthen awareness about nutrition and health

entitlements and inculcate life skills in communities. Folk dance, songs, fairs, rallies etc. are used to break stereotypes in communities. Talking about importance and ways of ensuring active involvement of children, she shared about the Child-to-Child approach that focuses on linking learning with taking action through enabling children with health knowledge and inculcating life skills; communication, negotiation etc. Creating conducive environment for learning through activity based and joyful learning experiences is the central idea of Child-to-Child where teachers and educators/parents play the catalytic role. She also emphasised focusing on being gender sensitive while developing and designing learning resource material; text and illustrations/design. Ms. Minaxi concluded her presentation with recommendations.

Recommendations target 3.2

1. Health Education is a powerful tool to improving the accessibility and utilization of health and nutrition services from the Public Health System. Integrate parents' and family education and awareness in all children's programmes.
2. Promote strong partnerships and strengthen capabilities of communities and families in order to improve the quality of care and education of children through institutional and programmatic measures.
3. Health education/communication should be needs based and culturally appropriate and should go beyond creating awareness about technical aspects.
4. Mechanisms to be created for sustained convergent and synergetic action among all concerned agencies that is Government, Civil Society, Corporate Sector for child health, well-being and development.
5. All child care and health programmes, such as Integrated Child Development Scheme (ICDS) (Govt. of India flagship programme for comprehensive development of children below 6 years of age, pregnant women and nursing mothers) should be converted in to Crèche and Day care centre to suit the needs of working mothers.
6. Sensitise/educate employers, especially the building contractors to provide crèche and day care facilities in the work premises; space, funds to workers and at least two-three breaks to nursing mothers for breastfeeding their infants.
7. Allocate and use at least 75 per cent of income generated from the tax on commercial food products on programmes to prevent under nutrition.
8. Educate stakeholders to identify, recognize and address underlying social causes of child ill health such as gender inequality.
9. Educate all stakeholders on Acts and Laws protecting survival, health and development of children.
10. Promote and use the local foods at the day care and child care centre, including Integrated Child Development Scheme.
11. Recognise groups with special needs such as migrant population, natural and man-made disasters and take measures to address their health needs.
12. Lack of Day care and crèche services affect girls' education. They are not enrolled or drop out of school for taking care of younger siblings when their parents work outside home. It is crucial to educate Policy makers, programme planners and implementers

to ensure allocation and mechanisms of their optimum utilization in providing Day care and crèche services at workplace or at place of residence, particularly for vulnerable groups, children in difficult circumstances, migrant populations, salt-pan workers and working in informal sector.

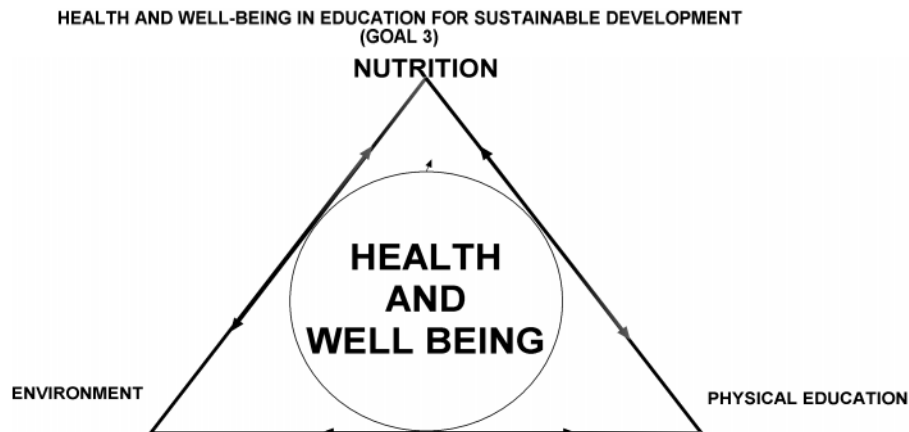
13. Children have tremendous potential of contributing in health and wellbeing of themselves, their families' and communities', so enable and involve children as partners in health, wellbeing and development through age appropriate activities.
14. Make nutrition and health education compulsory in formal, informal and non-formal education, at all levels.
15. Strengthen the component of Child Health and Nutrition, including identification and addressing disabilities in pre-service and in-service trainings of frontline workers, service providers and educators.

'Health and Well Being SDG No.3 and Education for Sustainable development (ESD)', Dr. Nguka Gordon (MD, PhD)



Dr. Gordon began his presentation by providing the definition of health given by World Health Organization (WHO), which is "Health is a state of complete physical, mental, and social well being, and not merely the absence of disease or infirmity." Health is a dynamic condition resulting from a body's constant adjustment and adaptation in response to stresses and changes in the environment for maintaining an inner equilibrium called homeostasis.

He spoke about the structural framework for education for good life, health and wellbeing.



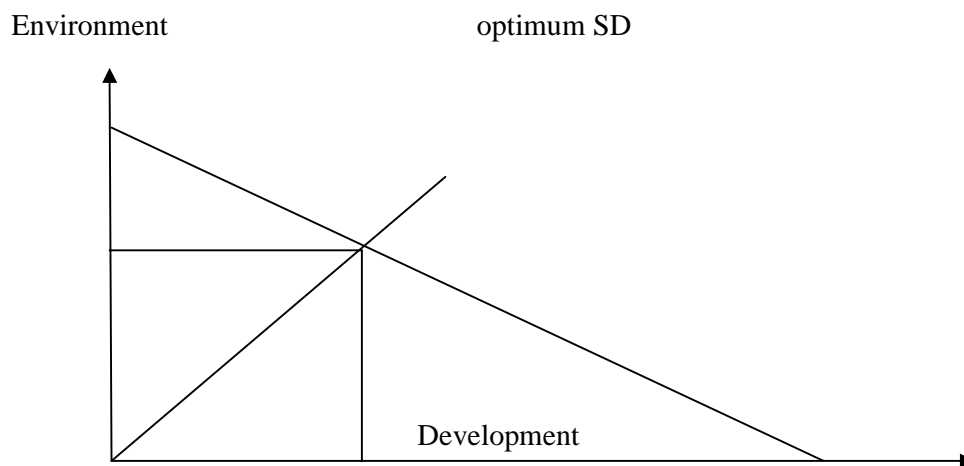
He mentioned that rather than striving for health equality, we should aim at health equity. For example, equal allocation for men and women will not be appropriate, but equitable

distribution of resources considering women's health needs is required. Subsequently, he elaborated the concept of health and wellbeing thrusts in ESD. These are as follows-

- Medium Thrust = surrounding = Environment
- Input Thrust = Nutrients, Water, In-organic Ions
- Output Thrust - Excretion, Worn out epithelial Cell layer, Unabsorbed material

He said that in Kenya, there is double burden of under-nutrition as well as over-nutrition. Improper nutrition is leading to increase in cancer. He explained about the above triangular relationship between nutrition, environment and physical education. He said that pressure between nutrition and environment is economic pressure, between nutrition and physical education is social pressure and the pressure between environment and physical education is environmental pressure. If education is imparted at every corner, we can come up with tripartite approach. Environmental prudence, nutrition prudence and physical activity prudence is necessary for sustainable development. For example, he the teacher has knowledge about the opportunity for first 1000 days for the growth of child, then he/she will have to look at each child differently. Similarly, the health care providers should be aware about the environmental aspects.

He then explained about the environment and development balance.



Point of meeting of environment and development is the point of optimum SD. He emphasized the need to integrate the environmental concepts in education. He then explained the five action arms of health promotion and well-being based on Ottawa charter.

In the end, he underscored the need for inter-sectoral convergence for achieving sustainable growth.

Discussion and recommendations



After these two presentations, there was open discussion on the issues raised during these two presentations. The key points from the open discussion are enlisted below-

There were questions regarding the role of panchayat members in child nutrition programs and also about the ways to engage Village Health Sanitation and Nutrition Committees. Ms. Minaxi responded that

panchayat members are part of various committees, however issues related to nutrition and health are seldom discussed in these committee meetings. Issues related to infrastructure such as building of roads, digging wells etc. are discussed. Thus it is essential to train these members about the social determinants of health. It was seen that after training, women sarpanch took initiative in Rajasthan where CHETNA is working.

Then there was discussion about Resource Centre for Education-Regional Centre for Expertise (RCEs)⁵, UNESCO. It was highlighted that there are 3 major outputs of RCEs such as social determinants, economic determinants and environmental determinants. RCE reports are used for policy dialogues as well as by government.

The general discussion about Goal 3 critiqued the lack of mention of environmental determinants in Goal 3. It was said that RCE is useful to review local actions through multiple sectors.

Question was asked whether child trafficking, sexual abuse etc. It was shared that these issues are included in sensitization programs for police. Ms Minaxi informed that though the focus of CHETNA's work is on health and nutrition, we collaborate with other organizations for work on other issues. In Mehsana, CHETNA is working on 'Save the Girl Child' campaign with the National Service Scheme (NSS) unit of colleges. Around 50 colleges are involved.

The discussion also highlighted the need for specially trained cadre for imparting education about health and nutrition.

Dr. Gordon shared that in Kenya, the curriculum of medical education was modified to include social determinants of health. Need to train doctors as well as frontline health workers.

In response to the query regarding efforts to integrate and promote traditional medicine, Dr. Gordon said that in Kenya they are also working on indigenous knowledge of health and traditional health system. They had received help from World Bank to carry out research with herbal medical practitioners. There is a parliamentary document in Kenya to promote and protect herbal medicine. Protection of plant species is very important. There are efforts from the universities as well to integrate, promote and sustain herbal medicine for future. There is a network on traditional medicine in RCE. He said that relevant traditional medicine should be preserved for future generations. India has a scope for pluralistic healthcare. In India, the present government is promoting Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy (AYUSH). In the report by WHO-environment division, there is a chapter on traditional medicine. Care should be taken that the discussion on traditional medicine and modern medicine is not polarized. The choice of health system should be with people.

The session concluded with specific recommendations about education and social determinants of child health, such as include environmental concepts into health education, increase policy dialogue, engage government officials at various levels for equity, inclusiveness in health education were given.

⁵ RCE are needed to develop as guiding instrument for actors around the world to promote education fro SDG.

Annexure I

About CHETNA

Vision

CHETNA envisions an equitable society where disadvantaged people are empowered to live creative, fulfilling and healthy lives.

Mission

CHETNA works to empower children, young people and women, especially those from marginalized social groups, to take control of their own health and that of their families and their communities.

CHETNA recognizes the health, nutrition and other development needs of children, young people and women at the critical stages of life viz. children (0-10 years), adolescents and young people (11-24 years), and women (+25 years). CHETNA believes that women's empowerment is a process of reflection and action aimed at raising self-esteem, confidence and consciousness, encouraging women to access their entitlements and to improve the health and quality of community life.

Thrust Areas

- Enhancing the value of girl children, improving access to nutrition, health, education and development entitlements
- Optimizing health and development in early childhood
- Ensuring equitable nutrition and health initiatives for school-age children
- Promoting nutrition, reproductive and sexual health rights and responsibilities of adolescent and young people
- Improving maternal health (reducing death, disease and disability linked to and pregnancy and childbirth)
- Building food security and improving nutrition

A Unique Resource Organization

The activities in the area of nutrition and health, which were initiated in 1980 developed into the creation of CHETNA as a separate entity in 1984. CHETNA has evolved into a unique resource agency which provides support to Government, Civil Society Organizations and Corporates (Corporate Social Responsibility).

CHETNA is designated state resource agency for Department of Health and Family Welfare of the Government of Gujarat for implementing community process and capacity building of government stakeholders. As a resource agency, CHETNA builds capacity of Civil Society Organizations to make health and nutrition services accessible to the people most marginalized from the public health system.

CHETNA is also designated as a State Training Resource Agency by National AIDS Control Organization (NACO) from July 2014 to March 2016, to train stakeholders of the Targeted Intervention programmes in the state of Gujarat.

Activities of CHETNA

Strengthening Capacity

CHETNA organizes need-based training programmes for programme managers and implementers from nongovernmental and government organisations as well as corporate institutions to support them to implement gender sensitive and comprehensive health programmes. As follow-up support, CHETNA provides regular mentoring for planning and demonstrating village-level strategies and approaches to ensure equitable access to health and nutrition services for the underprivileged community.

Communicating Health and Nutrition Information

CHETNA develops innovative, interactive and creative Behavior Change Communication (BCC) material. Based on CHETNA's rich experience of communicating with semi-literate and non-literate communities and being extensively field tested, the materials are audience appropriate and user-friendly. Several of CHETNA's materials have been printed in large numbers and used in existing programmes of the government as well as of non-government organizations.

CHETNA has been a pioneer in using traditional media to communicate health and nutrition related messages. Some of the tested and successful approaches in this are Health Mela (fair), Bhavai (a traditional form of drama), Gujarati folk songs, Poshan Mela (nutrition fair). CHETNA also organizes special training programmes on Behaviour Change Communication.

Demonstrating Workable Models

CHETNA develops and demonstrates workable, people - centered implementation models and approaches which can be mainstreamed through existing government health and nutrition programmes at the state and national level. The team takes pride in showcasing approaches to empower community and village level committees to monitor the access and quality of services etc. CHETNA has also showcased training strategies to train large number of frontline workers.

Networking and Advocacy

CHETNA contributes in and facilitates networking to collectively advocate for people centered, gender-sensitive policies and programmes at the state and national level. CHETNA ensures that the voices of the community are reflected in formulation of policy and programmes. CHETNA has been actively involved in the formulation of the National Youth Policy, National Adolescent Health Strategy, Early Childhood Care and Education Policy and National Policy for Children.

CHETNA Outreach

CHETNA Outreach has been initiated as an effort to take forward the learning and experiences of 35 years of working in the area of health and nutrition. This aims to extend the reach of CHETNA's activities to diverse geographical areas at the state, national and international levels by systematic facilitation, co-creation and mainstreaming of effective evidence-based models, promising practices and effective strategies towards holistic gender-sensitive approaches in health, nutrition and education through collective advocacy.

Annexure II

List of Participants

SN	Name	Designation	Organization
1	Ms. Carola Birzele	Student	Ausburg university
2	Mr. Jasper Bockmann	Student	Ausburg university
3	Ms. Lena Wiedemann	Student	Ausburg university
4	Ms. Michael Seufot	Student	Ausburg university
5	Ms. Miriam Walleth	Student	Ausburg university
6	Ms. Roesch Florian	Student	Ausburg university
7	Ms. Valerie Augburger	Student	Ausburg university
8	Ms. Hayley Pannells	Student	C Q university
9	Ms. Allison Evans	Student	C Q university
10	Ms. Aditi Jani	Rapporteur	Centre for Environment Education (CEE)
11	Ms. Khushboo Shah	Rapporteur	Centre for Environment Education (CEE)
12	Dr. Indrani Bhattacharya	Assistant Director, Adolescent Resource Centre	Child In Need Institute (CINI). Kolkata
13	Ms. Nilangi Sardeshpande	Consultant	Commonhealth
14	Mr. Gajanan Kale		Dream
15	Dr. Dileep Mavalankar	Director	Indian Institute of Public Health Gandhinagar (IIPHG)
16	Mr. Shashwat Ravi		Indian Institute of Public Health Gandhinagar (IIPHG)
17	Dr. Kailash Brijwasi	Director	Jatan Santhan, Railmarga, Rajasthan
18	Mr. Ranveer singh	Deputy Director, Jeeva Project	Pyxera Global, USA
19	Ms. Asmita Naik		Mumbai Mobile Creches
20	Ms. Shinny Verghese	Health Coordinator	Mumbai Mobile Creches
21	Mr. Jeet Kodinariya	Student	Nand Vidya Niketan School, Jamnagar
22	Ms. Pooja Shrivastav	Student	Nand Vidya Niketan School, Jamnagar
23	Ms. Archana Mukesh	Teacher	Nand Vidya Niketan School, Jamnagar
24	Ms. Betsan Martin		RCE Waikato
25	Ms. Fumiko Noguchi	Student	Royal Melbourne Institute of Technology (RMIT), Australia
26	Ms. Kapil Dave		SEWA Rural
27	Mr. Vickram Kumaar		Shrushti Seva Samiti
28	Mr. Shyam K. Verma	Principal	Shree Vasishth Vidyalaya, Surat
29	Mr. Amar J Vyas	Director	The Young Citizen Charitable Trust
30	Dr. Unnikrishanan PM		United Nations University (UNU)
31	Ms. Ikuno Suzuki		United Nations University (UNU)- IAS
32	Dr. Alka Barua	Independant Researcher	
33	Mr. Bimal C. Aggrawal	Retired and Former Director	TALEEM
34	Mr. Anil Gajjar	Senior Graphic Designer	CHETNA
35	Ms. Antara Trivedi	Project Associate	CHETNA

CHETNA

36	Ms. Hemali Chotani	Field Coordinator	CHETNA
37	Ms. Hetvi Shah	Project Associate	CHETNA
38	Dr. Neeta Shah	Programme Officer	CHETNA
39	Ms. Tarnishta Ray	Project Coordinator	CHETNA

List of Resource Persons

SN	Name	Designation	Organization
1	Dr. Leela Visaria	National Professor and Former Director	Gujarat Institute for Development Research (GIDR)
2	Ms. Mirai Chatterji	Director	Social security at SEWA
3	Ms. Neeta Hardikar	Programme Executive	Area Networking And Development Initiatives (ANANDI), Ahmedabad
4	Dr. Prasanta Tripathy	Director	Ekjut, Keonjhar, Odisha
5	Mr. Bijit Roy	Coordinator AGCA	Population Foundation of India, New Delhi
6	Mr. Om Prakash	Programme Manager	Jatan Santhan, Railmarga, Rajasthan
7	Ms. Sunayana Walia	Independan Researcher	
8	Ms. Pranita Achyut	Senior Technical Specialist – Adolescent & Gender	International Centre for Research on Women (ICRW), New Delhi
9	Ms. Susan Thomas	Coordinator	Lok Swasthya Sewa Trust
10	Ms. Vrishali Pispati	CEO	Mumbai Mobile Creches
11	Dr. Nguka Gordon	MD, Ph.d	Masinde Muliro University of Science and Technology, Kakamega Western RCE (Kenya)
12	Ms. Indu Capoor	Founder Director	CHETNA
13	Ms. Pallavi Patel	Director	CHETNA
14	Ms. Minaxi Shukla	Additional Director	CHETNA
15	Vd. Smita Bajpai	Project Director	CHETNA

Annexure III

Overall Recommendations


Invest to Educate: For achieving Sustainable Development Goals: Recommendations to achieve the Sustainable Goal 3: Ensure healthy lives and promote well-being for all at all ages

At the ESDG conference, 11-13th January 2016, CHETNA brought together experts working at the global, national, state and field level and shared its own experiences to showcase their experiments and experiences to educate women, children and young people and recommend evidence base strategies promoting education for achieving the Sustainable Development Goal-3. Based on the deliberations, the following is recommended.

Overall Recommendations

1. Education needs to be viewed as a tool for empowering people. Empowerment of marginalized people is the driver for sustainable development.
2. Greater Investments for educating people to take care of their own health and access their health and nutrition entitlements is the key to achieving SDG 3.
3. Allocations need to be made so that adequate Time, Money and Skilled Human Resources are available for uninterrupted/continued educational interventions.
4. Health and nutrition education need to be at the centre stage of all national policies and programmes.
5. Community Health Education needs to be institutionalized in all development programmes and policies related to adolescents, women and children
6. Context specific, people centered, culturally and gender sensitive education strategies need to be implemented for universal outreach.
7. Social determinants such as nutrition, poverty, gender, water and sanitation need to be integrated in educational interventions.
8. Priorities educational interventions for marginalized and vulnerable groups, tribal population, migrant population and people living in difficult situations.
9. Regular communication campaign on entitlements and service grantees need to be planned with appropriate provision of the budget.
10. Train the community leaders or members of the existing monitoring structure to regularly monitor the programmes to increase accountability and responsiveness of public system.
11. Strengthen and validate community based traditional knowledge related to health so as to ensure healthy life style, for example revive the traditional complementary feeding practice.
12. Inform, educate and empower the community and the community leaders about their right to health so as to demand for grievance and redressal mechanism in place and demand for the corrective actions.

Target 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

For achieving this target, people need to be active partners in reducing maternal mortality and accessing quality maternal health services. This can be achieved by engaging, educating and empowering people to access their entitlements and take care of their own health. Active and responsible engagement of men and family members need to be ensured. The culture of silence around pregnancy and childbirth needs to be broken. Educating and informing women, families and communities help breaking this silence. It is therefore recommended that

1. Culture and gender sensitive communication strategy with appropriately designed tools for communities and providers must be developed and implemented to educate and empower women, men and community members for saving mother's lives.
2. Education for Birth preparedness and complication readiness needs to be introduced at the family and at the health system level.
3. Maternal Health Policies need to be recognized the critical role of BPCR and make appropriate provisions in maternal health programmes/interventions.
4. Special efforts need to be made to reach out to migrant populations.
5. In areas where men migrate for work, women- Mother in laws (other family members) need to be actively engaged in BPCR
6. Men, as responsible partners need to be an integral part of the Maternal Health Programmes.
7. The role of frontline workers ASHAs/ANMs must be recognized, promoted and strengthened to provide education and counseling through regular home visits.
8. Include violence against women as an important topic in the training of the health service providers.
9. Training on birth preparedness of the FHW and ensure its implementation.

Target 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

Addressing social determinants for improving children's health and wellbeing

Social determinants such as poverty, nutrition, gender discrimination, water and sanitation play a key role in achieving this target. The strategies for ending preventable deaths of newborns and children under 5 years therefore must address the underlying causes responsible for low birth weight, too many, too close pregnancies and child birth, feeding practices, infant and young child diseases such as diarrhea and acute respiratory tract infections. Educating communities to address the social determinants and child care is the key.

1. Health Education is a powerful tool to improving the accessibility and utilization of health and nutrition services from the Public Health System. Integrate parents' and family education and awareness in all children's programmes.
2. Promote strong partnerships and strengthen capabilities of communities and families in order to improve the quality of care and education of children through institutional and programmatic measures.
3. Health education/communication should be needs based and culturally appropriate and should go beyond creating awareness about technical aspects.
4. Mechanisms to be created for sustained convergent and synergetic action among all concerned agencies that is Government, Civil Society, and Corporate Sector for child health, well-being and development.
5. All child care and health programmes, such as Integrated Child Development Scheme (Govt. of India flagship programme for comprehensive development of children below 6 years of age, pregnant women and nursing mothers) should be converted in to Crèche and Day care centre to suit the needs of working mothers.
6. Sensitize/educate employers, especially the building contractors to provide crèche and day care facilities in the work premises; space, funds to workers and at least two-three breaks to nursing mothers for breastfeeding their infants.
7. Allocate and use at least 75 per cent of income generated from the tax on commercial food products on programmes to prevent under nutrition.
8. Educate stakeholders to identify, recognize and address underlying social causes of child ill health such as gender inequality.
9. Educate all stakeholders on Acts and Laws protecting survival, health and development of children.
10. Promote and use the local foods at the day care and child care centre, including Integrated Child Development Scheme.
11. Recognize groups with special needs such as migrant population, natural and man-made disasters and take measures to address their health needs.
12. Lack of Day care and crèche services affect girls' education. They are not enrolled or drop out of school for taking care of younger siblings when their parents work outside home. It is crucial to educate Policy makers, programme planners and implementers to ensure allocation and mechanisms of their optimum utilization in providing Day care and crèche services at workplace or at place of residence, particularly for vulnerable groups, children in difficult circumstances, migrant populations, salt-pan workers and working in informal sector.
13. Children have tremendous potential of contributing in health and wellbeing of themselves, their families' and communities', so enable and involve children as partners in health, wellbeing and development through age appropriate activities.
14. Make nutrition and health education compulsory in formal, informal and non-formal education, at all levels.
15. Strengthen the component of Child Health and Nutrition, including identification and addressing disabilities in pre-service and in-service trainings of frontline workers, service providers and educators.

Target 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

Greater attention on Adolescents (age 10-19 yrs) and young people, who are a diverse group and fulfillment of sexual and reproductive health-care services, including for family planning, information and education is essential to ensure universal access. A comprehensive approach, within dynamic sociological, cultural and economic realities, is required to respond effectively to the health and development needs of adolescents and young people. The specific recommendations are-

1. Educational interventions for adolescent and young people need to be interactive, participatory, non-judgmental, creative and gender sensitive.
2. Information and education packages must be designed to equip them with life skills like communication, decision making, negotiation, relationship building etc. Gender equality and empowerment of women and girls need to be integrated (SDG5)
3. Design gender sensitive, technically sound, tools to impart messages keeping the local reality, customs, literacy level etc in view.
4. Appropriate budget/resource allocations need to be made for making information and services accessible to adolescents and young people. Develop a cadre of community-based trained individuals who can make access to information available to young people. Designated human resource and budget needs to be ensured in all the existing development programmes.
5. Plan and design customized educational interventions rather than “one size fits all”, based on evidences and disaggregated data by income, sex, age, caste, ethnicity, migration status, disability and geographic location etc.
6. As a part of educational intervention provide space for young people to come together to share, learn and support each other.
7. Community and stakeholders’ including parents or guardians’ participation and mobilization are non-negotiable to ensure support for adolescent and young people’s access to reproductive and sexual health and services. Continuous capacity building of frontline workers and educators for educating adolescents and young people is a non-negotiable with regular review and extensive mentoring support.
8. Reproductive and sexual health education needs to be provided at all spaces and institutions where adolescents and young people are located such as: schools, colleges, orphanages, workplace etc. For this to happen convergence with other Government Departments- Education, Social security, Social justice, livelihoods etc. is critical.
9. Educate, train and empower youth to monitor the delivery of public services



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