TO THE VERY LAST MILE

PART - I

Improving Maternal and Child Health in Tribal Communities

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The Kiawah Trust is a UK family foundation that is committed to improving the lives of vulnerable and disadvantaged adolescent girls in India. The Kiawah Trust believes that educating adolescent girls from poor communities allows them to thrive, to have greater choice in their life and a louder voice in their community. This leads to healthier, more prosperous and more stable families, communities and nations.

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FOREWORD

Dr. Anand Bang
Health Advisor, Tata Trust

"As a single leaf turns not yellow but with the silent knowledge of the whole tree" - Kahlil Gibran

Neils Bohr once said, "Nothing exists until measured". This perfectly applies to the tribal conundrum, whose very existence is not recorded. And as Kahlil Gibran points out, this has happened with the tacit understanding of the larger society. The scarcity of information available about tribal communities in the larger domain makes them almost invisible to our conscience, creating a huge chasm between 'us' and 'them' that results in the abdication of our duty to uphold the principle of equity in development. A perceptive Collector of the tribal Gadchiroli district in Maharashtra (to which I belong), once pointed out to me that the district suffers from a unique PPP model of governance: administration by personnel who were posted there as a punishment, by those who were on probation, or those posted there as pensioners!

The governance vacuum is of course one of many systemic challenges that must be overcome. Tribal communities face severe social, cultural and economic obstacles that contribute to poor maternal and child health outcomes: only 49% of tribal women are literate compared to the national average of 65%. These barriers may overwhelm even a die-hard optimist; however, the trick is not to expect or wait for a complete socio – economic revolution, but instead, look to create an evolution by tackling each gap incrementally. Viewing the challenges experienced by the tribal community, not as a whole, but instead as components, allows us to identify smaller segments that can be tackled with strengths we already have.

Where should one begin?

Consider this story: In 1987 my mother participated in the traditional 'Rela' dance of the Gond tribe in Gadchiroli district. This simple gesture established a relationship which is still going strong after three decades. The tendency of tribal communities to revel in song, dance and theatre gives us a unique opportunity. Their familiarity with these forms of self-expression creates a readily available platform which can be used to relate to them, better understand their communities and teach best practices.

Collecting hard data about the lives of tribal communities and related challenges is of course, the logical next step. But this also needs to be balanced through documenting the ways and practices of tribal life. Tribal culture also has its own share of paradoxes. Take for example the contradiction present in a women's decision making capacity: unmarried women are considerably empowered and in control of their lives and choices, something that ceases to exist significantly when they choose a life partner. Recording tribal cultures makes one aware of these discrepancies, allowing for more effective program design and implementation.

Of paramount importance is the program's sustainability, through the prism of values and cultural appropriateness, over its economic viability. Working with tribal communities is a long journey – don't be focused on an exit policy before you even enter. Finally, it is impossible to overstate the power and potential of empowering frontline Community Health Workers (CHWs). Ultimately, through the process of solving the problem, the people with whom you are working must be left empowered. CHWs play this role, serving, educating and empowering the communities they work in.

How can you help? Supporters to the cause should not underestimate the value of their support. There is so much to be done and so much good work that you can support. Be an active advocate and work with non-profits that are already embedded deep within remote tribal communities. Over decades, such organizations have been the link between the larger society, government, funders and tribal communities. These are non-profits who are truly vested in the development of the tribal communities they serve and have proven models of success.

Margaret Mead once said, "Caring for is the earliest symbol of civilization." I believe as an Indian how we take care of our tribal communities is the test of our civilization.

EXECUTIVE SUMMARY

Waiting in the Wings

As India enters its eighth decade of independence, the fruits of development are yet to reach the most disadvantaged. On society's fringes are 700 tribal communities that have only been further marginalized by India's growth story. State-led projects for progress have trampled over the property, rights and lives of India's tribes who constitute only 8.2% of India's population but account for 40% of those displaced. Tribal communities fall behind the national population on all measures—economic standing, health and education—held back by decades of discrimination and rights violations.[1]

If we were to measure how far behind these communities rank on health indicators alone, the statistics paint a bleak picture. Compared to the rest of the country, tribal women struggle to access adequate maternal health services across the continuum of care. Full antenatal care and institutional deliveries are recognized determinants to reducing maternal mortality, yet only 10% of tribal women meet the recommended protocol of four antenatal visits and a mere 18% have institutional deliveries.[2] Consequently, more than half of all maternal deaths in India occur in tribal communities.[3]

Poor health plagues not just tribal mothers, but also their children. Mortality rates among tribal children are among the highest in the nation by a significant margin. The Infant Mortality Rate (IMR) among tribal children is 30% higher than the national average and 61% higher for tribal children under five.[4] Between 1992 and 1998, tribal areas recorded only a 10% reduction in IMR, as opposed to a 25% reduction logged for the rest of the nation.[5] Thus, not only do tribal children lag behind, but they are also the slowest to benefit from any progress on the health front.

Understanding Square One

Although the government has formulated special programs for tribal communities and allocated significant resources to bring them from margins to center, they still occupy the fringes. Research highlights three systemic factors that enhance the vulnerability of India's tribes and result in disproportionate health outcomes:

Practitioners: A staggering 72% shortfall of specialists at health centers in tribal areas is indicative of the reluctance of practitioners to work in these areas.[6] The burden then falls on ill-trained and over-burdened health workers who oversee 15 to 20 villages each.[7][8]

Service Delivery: The availability of labor rooms, functional operation theaters, newborn care corners and medical supplies at primary healthcare centers is dismal across most tribal states.[9] Tribal women repeatedly recount experiences of being turned away from poorly equipped medical facilities.[10]

Finance: Since only 2.6% of tribal households have family members with health insurance, they often borrow money, mortgage property and pawn their belongings during health emergencies. Often, a single medical emergency can put an entire tribal family in debt, for generations.[11]

In addition to these systemic barriers to accessing quality healthcare, there are socio-economic factors that impact tribal maternal and child health. For instance, since only 1% of tribal women seeking health services speak non-tribal languages, they are unable to communicate effectively with health practitioners.[12] Besides language, traditional beliefs impede a tribal woman's access to healthcare. In some communities, pregnant women are not allowed to travel outside the village, are cautioned against receiving treatment from health professionals and left to deliver by themselves—because they are deemed more vulnerable to evil spirits.[13] Language, traditional beliefs and ethnic tensions—among other socio-economic factors—compound the issue of access to health facilities and contribute to high maternal mortality rates.
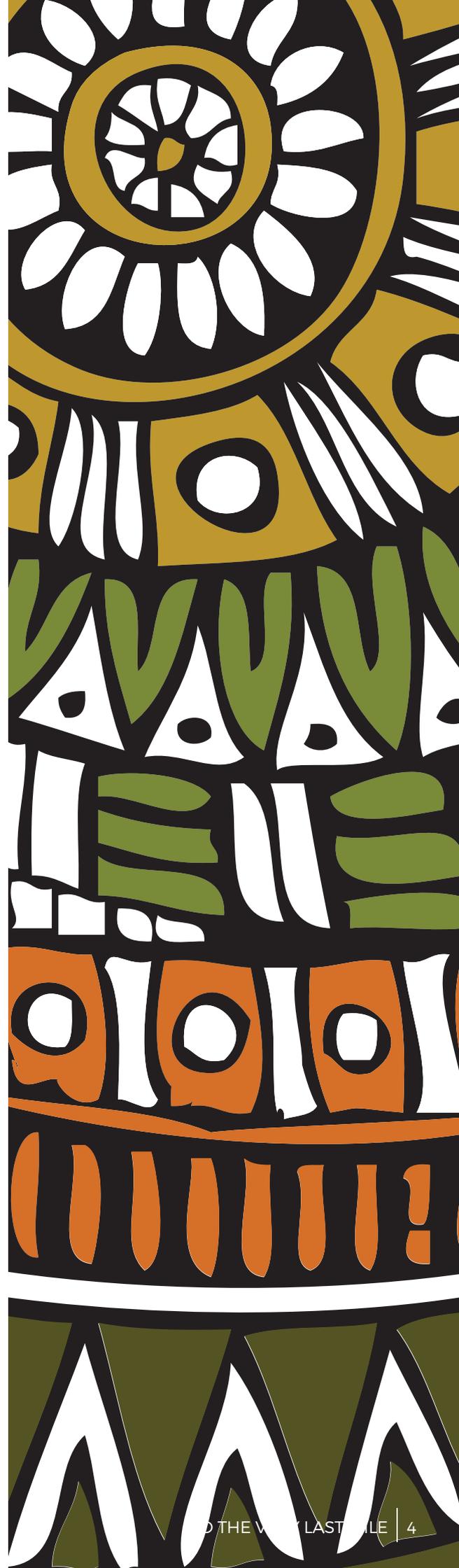
From Margins to Center

To address the issue of poor maternal and child health in tribal communities, one must overcome several interlocking barriers to accessing health services. A tribal woman who manages to push beyond traditional beliefs, leave her village and reach out to a health provider might find an ill-trained, over-burdened health worker who doesn't speak the same language, harbors discriminatory biases and works out of a poorly-equipped health center. Dasra's research highlights four pivotal cornerstones that have the potential to safeguard tribal health:

1. Enhance Nutrition: Poor nutrition weakens a woman's ability to survive childbirth. Malnourished mothers are more likely to bear low birth-weight babies, who in turn are more likely to die in infancy.[14] Poor nutrition thus debilitates the health of tribal women and children across generations. Experts recommend that the best times to improve nutrition levels are at infancy, adolescence and pregnancy, where the consequences of poor nutrition—if left unaddressed—are magnified. This report profiles organizations that implement programs such as nutrition counseling, home-based childcare and kitchen gardens to improve community and child nutrition levels.

2. Promote Hyper-Local Solutions: Decades of discrimination have made tribal communities wary of outsiders.[15] Therefore the most successful and sustainable health programs are those that are community-led. At tribal health assemblies, service providers listen to the community's health problems and priorities, get their approval on proposed health solutions and—only then—implement related activities.[16] Health services that emerge through such processes have a local flavor, match a given community's needs and are therefore backed by the community itself. Thus, a key insight from Dasra's research is the need for hyper-local solutions that empower communities to take charge of their health needs.

3. Train a Local Healthcare Workforce: Given their remote locations, a limited referral system and scarcity of trained health workers—tribal women and children have limited access to health services.[17] This oftentimes proves fatal, especially during medical emergencies. Building a cadre of local community workers is therefore pivotal to bridging gaps in the public healthcare workforce. Some organizations, profiled in this report, train traditional birth attendants and community-based health providers who are often the first point of access for tribal women and children.

4. Improve the Implementation of Government Schemes: Government programs—such as the Janani Suraksha Yojana that provides cash incentives for institutional deliveries and the Janani Shishu Suraksha Karyakaram that provides free-of-cost healthcare services—were designed to enhance tribal health outcomes. Unfortunately, they are poorly implemented and benefits rarely reach those for whom they are intended.[18] Some shortlisted organizations audit government health service provision and have consequently improved the quality of care tribal mothers and children receive.

Curtains Up on Progress

This report concludes by profiling the work of eight organizations (from a universe of over 200) that effectively adhere to these four cornerstones through their interventions. These include: Action Research and Training for Health (ARTH), Association for Health Welfare in the Nilgiris (ASHWINI), Ekjut, Jan Swasthya Sahyog (JSS), Society for Education, Action and Research in Community Health (SEARCH), SEWA Rural, Swami Vivekananda Youth Movement (SVYM) and Swasthya Swaraj.

Amplifying the efforts of these eight organizations, through institutional and programmatic funding, would extend their reach to India's forgotten tribal communities. For those interested in eradicating poverty, progress of society's most excluded is the litmus test. Development efforts can be deemed successful only if they reach those with the greatest need. We have an obligation to support organizations that enable the hardest-to-reach communities in India to advance their wellbeing.

CHAPTER 1
TRIBAL TRIBULATIONS

In Santhali villages in Godda, along Jharkhand's border with Bihar, many community graves are those of young women who died during childbirth in recent years. Tribal families in the hamlets scattered in Sundarpahari and Poreyhat recount desperate struggles for medical help when women in advanced stages of pregnancy experienced complications.

At Paharpur in Sundarpahari, Gopin Soren spoke haltingly as rain fell over the hut where his 19-year-old daughter Sadbeeti, pregnant for the first time, died last year. "On Thursday we went to my son-in-law's home at Borhwa and everything was fine. The next morning my wife and I got a message that my daughter had fainted. We reached there and called a local medical practitioner. He tried to give her a saline drip but he just could not find her vein." At 5 p.m., Gopin, his son-in-law and two relatives carried Sadbeeti six kilometers on a cot to Paharpur.

Back in their village, Gopin asked the village sahiya (health worker) Phool Marandi for help to reach the health subcentre at Sundarpahari, 20 km away. The sahiya called the call centre to request a Mamta Vahan — a free-of-cost ambulance service for rural women started in Jharkhand in 2011. By now, Sadbeeti was having convulsions, caused by a condition called eclampsia. "I decided to call vehicle owner Pintu directly. I called him thrice between 7 and 9 p.m. He said he was out. I understood that he did not want to come. The villagers had attacked a person caught stealing the electricity transformer in the village a day earlier. Maybe he feared that there would be more violence," he said. **Sadbeeti died at 2 a.m. She was eight and a half months pregnant.**

Source: The Hindu, (2013). Santhali women caught between birth and death—sans medical help.

Disproportionately Affected by Health Challenges

Gopin's story represents the plight of many tribal women and their families. While most marginalized communities in India struggle to access quality healthcare, the challenges of tribal communities are magnified due to their socio-eonomic status, geographical remoteness and low literacy. Development indicators for these communities consistently lag behind the national average on account of decades of discrimination, violation of rights and a major trust deficit towards 'outsiders'. There is an urgent need to address the challenges of this disproportionately affected and largely neglected population, particularly of tribal women and children who bear the brunt of marginalization.

Tribal communities lag behind the national average on several vital public health indicators, with women and children being the most vulnerable.[19] UNICEF findings suggest that more than half of all maternal deaths in India occur in tribal and Dalit communities.[20] Other research data indicates that only 10% of tribal women meet the recommended protocol of four antenatal visits.[21] Across the continuum of care, tribal women have poorer access to adequate maternal and child health (MCH) services than their counterparts elsewhere in India.[22]

LAGGING BEHIND

Maternal Health Indicators

Obstetric Care During Delivery
- TRIBAL: 18%
- NATIONAL: 48%

Institutional Deliveries
- TRIBAL: 18%
- NATIONAL: 51%

Antenatal Care
- TRIBAL: 33%
- NATIONAL: 50%
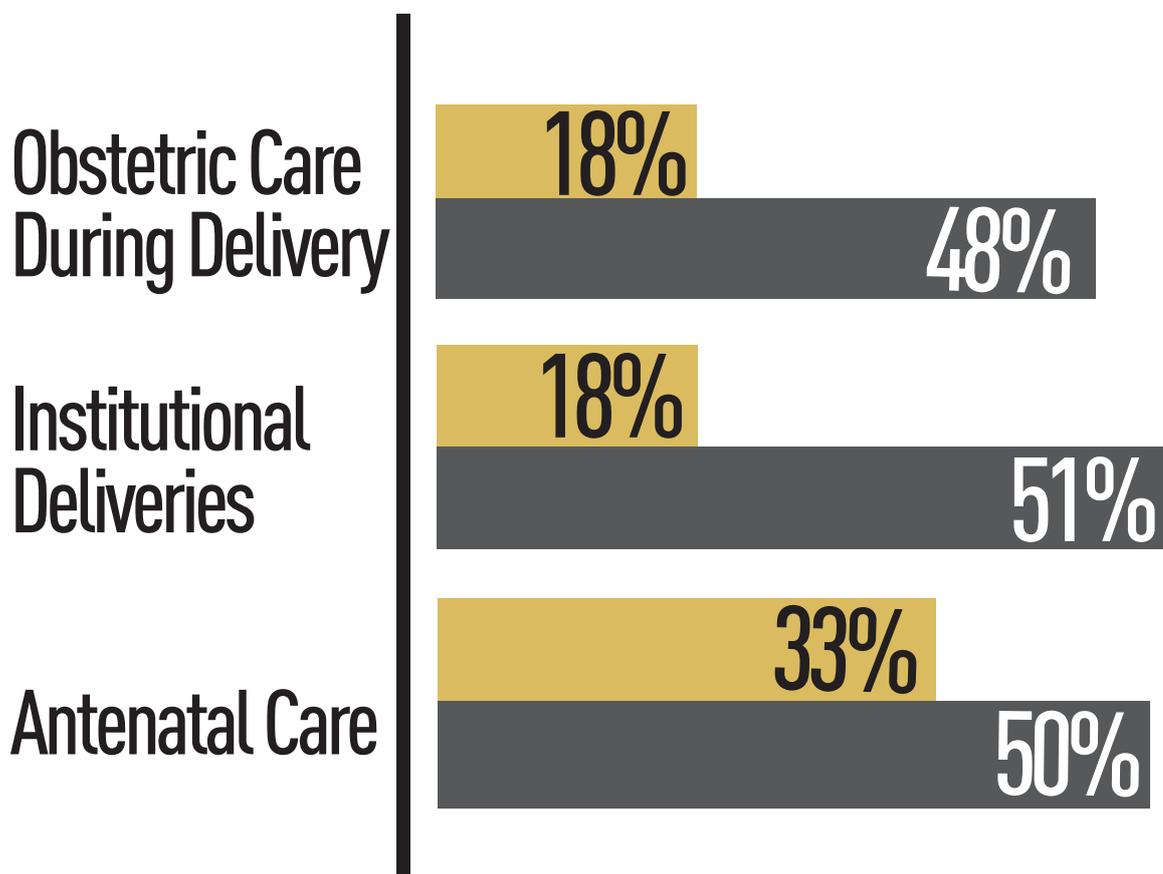
TRIBAL **NATIONAL**

Source: National Family Health Survey (NFHS-3), 2005–06: India.

Child Mortality Rates

TRIBAL

NATIONAL

Poor health plagues not just tribal mothers, but also their children. The Infant Mortality Rate (IMR) among tribal children is significantly higher than the national average.[23] Between 1992 and 1998, tribal areas recorded only a 10% reduction in IMR as opposed to a 25% reduction logged for the rest of the nation.[24] Thus, not only do tribal children lag behind, but they are also the slowest to benefit from any progress on the health front.

62

57

36

18

96

74

INFANT

CHILD

UNDER-5
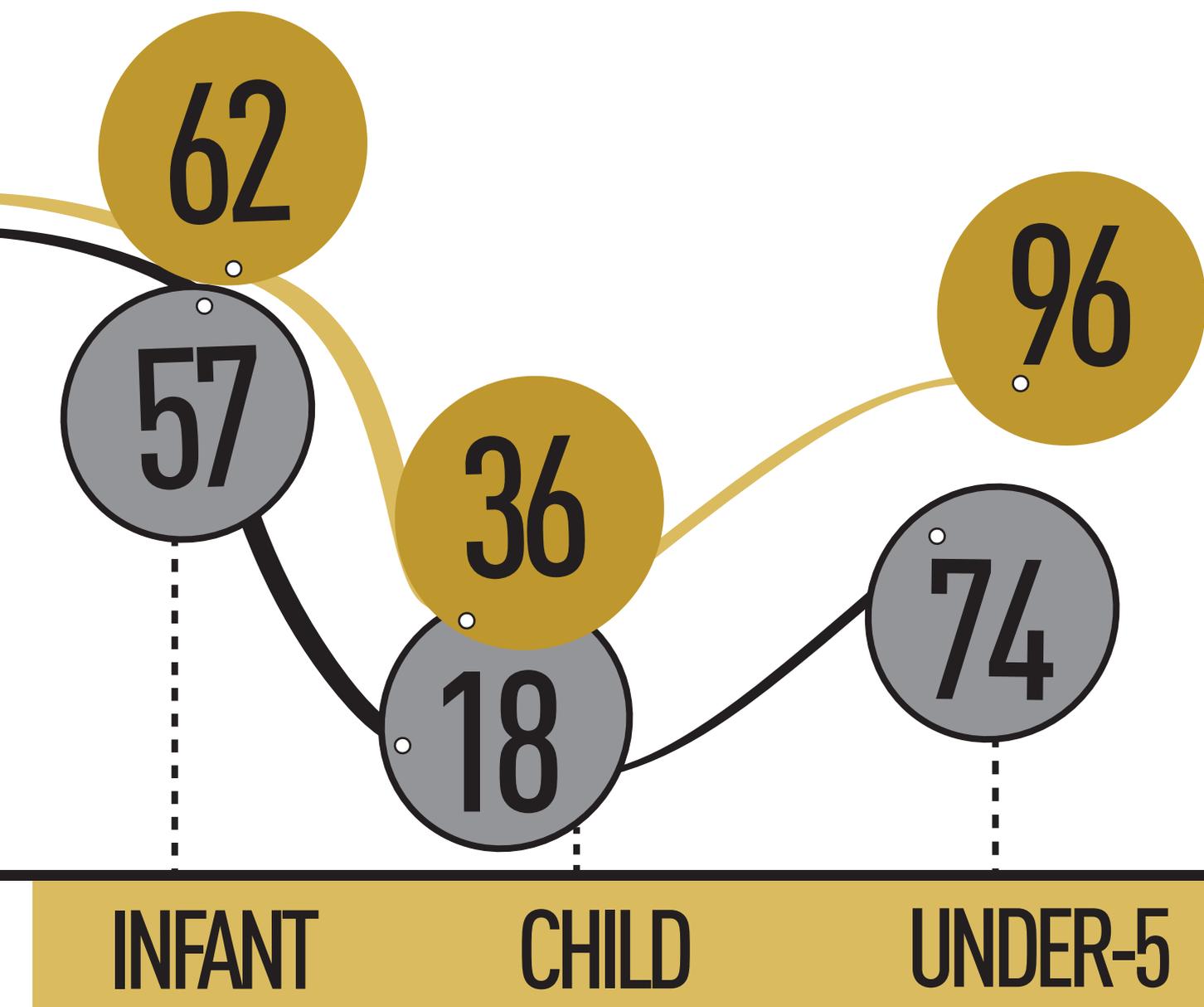
All numbers represent deaths per 1,000 births.

Source: National Family Health Survey (NFHS-3), 2005–06: India.

Systemic Determinants of Poor Maternal and Child Health

Although the government has formulated special programs for tribal communities and allocated significant resources to bring them from margins to center, they still occupy the fringes.

Systemic challenges that impact healthcare delivery are best demonstrated through this framework, adapted from the World Health Organization that identifies health system building blocks: practitioners, service delivery, health financing and governance.

1. Practitioners

1.1 Health Worker Shortfall

Doctors' shortfall at the Primary Health Center (PHC) level in tribal areas is particularly significant in states like Assam, Chhattisgarh, Gujarat, Madhya Pradesh, West Bengal and Orissa.[25] There is a 72% shortfall of specialists against required posts at Community Health Centers (CHCs) in tribal areas.[26] Doctors do not want to work in tribal regions or stay there for long periods of time, leading to a deficit of health providers. One study, drawing on data from the National Family Health Survey-3 (NFHS-3), indicated that this was a major barrier to accessing health facilities for 35% of tribal women.[27]

1.2 Ill-Equipped Health Workers

Accredited Social Health Activists (ASHAs) only get 23 days of training over four years.[28] Studies show that such condensed training results in low knowledge retention and needs ongoing support to sustain quality care and reinforce messages. Besides insufficient training and limited tools, health workers are overburdened: 15 to 20 villages fall under the jurisdiction of one Auxiliary Nurse Midwife (ANM), since tribal populations are generally scattered across difficult terrains.[29] Experts interviewed by Dasra highlighted that health workers from non-tribal backgrounds often hesitate to enter tribal homes and need to be sensitized to serve all tribal communities within their coverage areas.[30][31]

"I remembered that in a Santhal village in Birbhum, when I asked why no one had a birth certificate, I was told everyone delivered at home. The tribal women said they hated going to the local hospital because the staff there treated them like animals. She told me that they handled their goats and buffaloes with more care."

– Sohini Chattopadhyay, a reporter with Scroll.in, on a site visit

2. Service Delivery

2.1 Inadequate Health Facilities

Health sub-centers, PHCs and CHCs often remain dysfunctional resulting in poor delivery of public healthcare services. According to a report by the Ministry of Tribal Affairs, the availability of labor rooms, functional operation theaters and newborn care corners at primary healthcare centers was dismal in all tribal states, except Maharashtra.[32] Delivery of medical supplies to health centers and repair of medical equipment is often delayed in tribal areas that are remote and difficult to access. Inadequate health facilities impact the delivery of crucial maternal and child health services in tribal areas. For instance, only 18% of deliveries among Scheduled Tribes are institutional.[33] Several organizations that Dasra visited served communities that have no reliable access to the public health system.[34][35] This is significant, given that over 70% of tribal communities depend entirely on government-run public health facilities.[36]

2.2 Poor Referral Linkages Between Health Facilities

An analysis of 124 tribal maternal deaths indicated that 84% of them sought some form of care when they experienced an obstetric emergency. However, 29% of the women visited two facilities and another 29% visited three or more facilities, before they could get care. Constant referrals to a higher facility, lack of first-aid, poor transportation and no communication of case details between facilities were major drivers of high mortality rates.[37] NFHS data shows that almost 44% of tribal women reported long distances to health facilities as being an obstacle to accessing health facilities.[38]
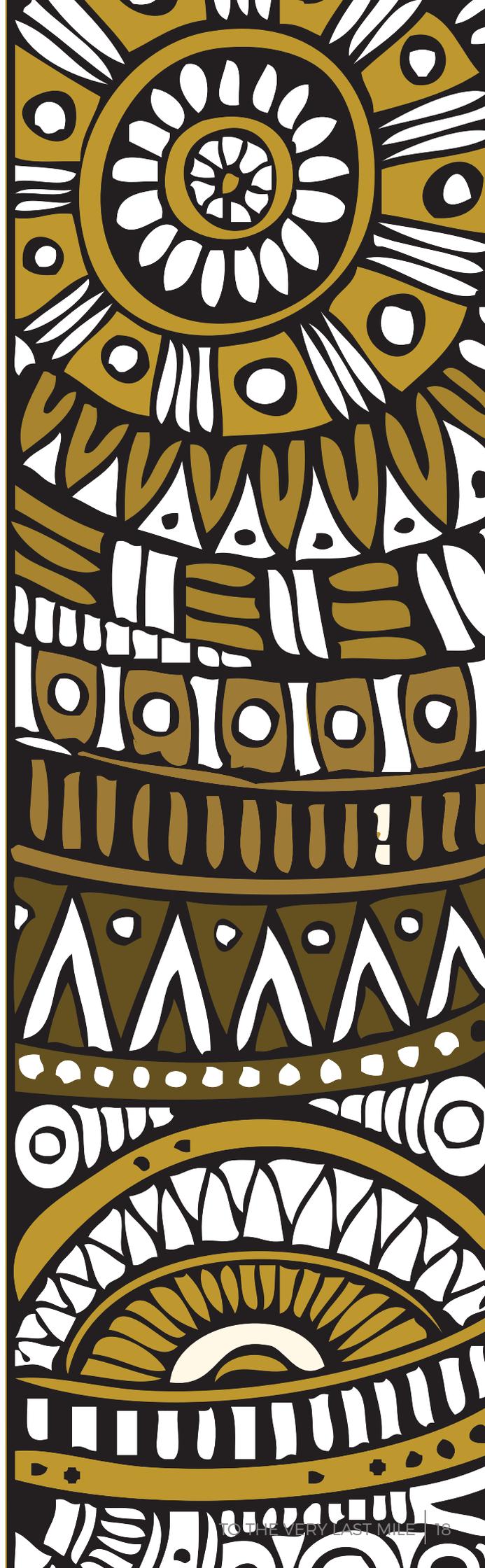
3. Health Financing

3.1 Unaffordable Healthcare

Though Scheduled Tribes (ST) comprise nearly 9% of India's total population, they account for 47% of those living below the poverty line in rural regions and are unable to afford adequate healthcare.[39] Since only 2.6% of ST households have family members with health insurance, they often must borrow money, mortgage property, and pawn their belongings to address health emergencies.[40]

3.2 Difficulty Accessing Funds

Although the Ministry of Tribal Affairs earmarked grants amounting to INR 190 crore (USD 28 million) for tribal schemes between 2009 and 2011, funds were misused or under-utilized. Even when funds were actually deployed towards schemes for tribal communities, their use was not monitored and evaluated. Ineffective disbursement of funds limits the ability of tribal women to afford adequate healthcare during pregnancy and delivery. For example, the Janani Suraksha Yojana incentivizes pregnant women to give birth in registered health institutions by providing them with monetary support. However, there are significant delays (about 3-7 months) in delivering these incentives to tribal mothers.[41]

4. Governance

4.1 Lack of Monitoring and Accountability

A three-year audit of over 500 NGO-run projects, which were funded by the Ministry of Tribal Affairs, revealed shocking irregularities in a large majority of projects. In some cases, non-profits took grants to run health centers and charged poor tribal populations instead of providing free treatment.[42] Another report drafted by CommonHealth and Jan Swasthya Abhiyan, shows that although the government runs several programs, there is a great gap in accountability and governance and most of the programs have been poorly implemented on the ground.[43] Data also indicates that utilization of funds for tribal communities was not monitored or evaluated.[44]

In 2011, a government enquiry was conducted after 25-year-old Mary Hasda of Tetaria village reported that staff at the district hospital left a cloth inside her birth canal after she delivered a stillborn baby and demanded a bribe of INR 500. The researcher who documented the case reported, "The enquiry team interrogated the family—which spoke only Santhali—as if it had committed a crime. In April, another five-member team came on a one day-visit after a public interest litigation petition by the All India Progressive Women's Association, but they did not meet all the family members or hold any officer accountable." Soumik Banerjee, also documented 22 additional maternal deaths in the area, of women (ages 18-23) between April 2011 and March 2012, an average of nearly two deaths a month. Nine families had reported spending an average of INR 4,917 on transportation, bribes and medication.

Source: The Hindu, (2013). Santhali women caught between birth and death — sans medical help.

HEALTH PRACTITIONER

Under-staffed

There is a 72% shortfall of specialists at Community Health Centers in India.

Under-trained

Accredited Social Health Activists (ASHAs) receive only 23 days of training over four years.

Over-burdened

One Auxiliary Nurse Midwife (ANMs) serves 15-20 villages.

Can't communicate

A large majority of ASHAs and ANMs do not speak tribal languages and therefore cannot communicate effectively with health seekers.

TRIBAL WOMAN

Isolated

Often health professionals are prevented from examining postnatal women or neonatal babies.

Restricted

Some communities believe that women should not leave the village during pregnancy.

Over-worked

Most tribal women work throughout their pregnancy and cannot access healthcare during work hours.

Social, Cultural and Economic

Factors that Impact Health Outcomes

In addition to systemic barriers to accessing quality healthcare, there are also certain socio-economic factors that impact tribal maternal and child health. These include: language barriers, isolation, low levels of literacy, traditional health beliefs and practices, hereditary diseases, heavy workloads, insurgency, outsider trust deficit and poor nutrition.[45]

1. Language

Approximately 75% of the Indian population speaks languages belonging to the Indo-European family. However, only a little over 1% of the tribal population speak these languages. This hinders their communication with doctors and health workers.[46] Language and cultural differences have led to discrimination of tribal populations at healthcare facilities. Tribal women are therefore reluctant to access health services in public health facilities.

"Language is a big barrier when tribal communities visit hospitals. Tribal women are treated badly. The big buildings make them feel isolated and they are often scared to visit hospitals."

- Program manager, NEEDS, a non-profit.

2. Traditional Practices

In certain tribal communities, traditional beliefs and superstitions are the chief causes of high maternal mortality rates. For example, in the Kutia Khondh tribe of Odisha, a delivery was conducted by the mother herself in a half-squatting position, holding a rope tied down from the roof of the hut, a practice that could lead to maternal and child death.[47] In another tribal region, women need to deliver by themselves in the backyard of their homes and are left there post-delivery for a few days since they are considered vulnerable to evil spirits.[48]

Local customs and traditions also prevent health professionals from examining postnatal women or neonatal babies. In one of the tribal villages Dasra visited, the tribal population believes that women should not leave the village during pregnancy. This belief impedes women from accessing health services that require some amount of travel and subsequently limits the number of institutional deliveries.[49]

Many tribal communities believe that illness and death are God's will, or caused by some form of black magic, and hesitate to avail medical help in the initial stage of a disease.[50 51] Healthcare challenges are thus aggravated by the fact that medical care among tribal communities is curative not preventive.[52] In a survey, nearly 69% of the respondents visited hospitals only in case of emergencies.[53]

3. Heavy Workload

Heavy workload on pregnant women in tribal communities acts as a deterrent to care-seeking: a study on the Kutia Khondh tribe revealed that women put in an average of 14 working hours per day, as compared to nine hours put in by men. Experts pointed out that tribal women often don't stop working during pregnancy and have long-distance commutes. Even women in advanced stages of pregnancy are required to work in agricultural fields or walk long distances to collect fuel and minor forest produce.[54] Since most of them work in construction or agriculture on daily wages, they are less likely to visit a healthcare center during working hours.

4. Poor Nutrition

The overall intake of various foods and nutrients by Scheduled Tribe populations is less than the Recommended Daily Allowance.[55] Only about 7% of tribal households were found to be food-secure year-round.[56] In some states, acute food shortages result in dietary changes such as reducing the number and quantity of meals. Poor nutrition is the root cause of malnutrition, stunting and low-birth weight among tribal children, and they lag behind the general population on these health indicators.

"A major reason for poor maternal and child health is bad nutrition. Over time, due to a lack of hunting opportunities, tribal populations began to depend only on rice for nutrition. There is no source of proteins, vitamins or any other nutrients. On an average, they work on a 50% deficit in calories."

– Dr. Aquinas, Swasthya Swaraj

5. Insurgency

Insurgency within tribal regions aggravates healthcare challenges. Of the nine states affected by left wing extremism, six are states with Scheduled districts. Increasing levels of violence across India due to ethnic tensions and armed insurgencies cut off access to crucial reproductive health services for tribal women. Experts agree that conflict compounds the issue of access to clinics and facilities.[57]

6. Low Literacy

Low literacy levels hinder tribal women from accessing care for themselves and their children. Experts highlight low literacy rates among tribal populations, especially women, as a major driver of poor utilization of maternal and child health (MCH) services. The National Family Health Survey-3 indicated that approximately 88% of women with 12 years or more of complete education received at least one ante-natal care visit as opposed to 29% of women with no education.

7. Hereditary Diseases

High vulnerability of tribal communities to hereditary diseases amplifies MCH challenges. Marriages between blood-relatives within tribal communities causes suseptibility to genetic abnormalities such as sickle cell anemia. These hereditary diseases quadruple tribal women's vulnerability to maternal deaths.[58]

Conclusion

Tribal populations are among the poorest and most marginalized groups in India and face extreme levels of health deprivation. This community lags behind the national average on several vital public health indicators, with women and children being the most vulnerable. [59]

Tribal communities have been unable to fully accrue the benefits of various tribal health schemes and policies due to specific systemic and socio-economic barriers. As India increasingly focuses on improving the status of its mothers and children, addressing the needs of this population will be indispensable to moving the needle on any of the national and global maternal and child health (MCH) indicators.

Given the complexity of the tribal MCH ecosystem, in the next chapter 'Cornerstones', Dasra has highlighted the top four areas that stakeholders need to focus on, which can improve the status of India's tribal mothers and children.

These focus areas are backed by experts in the field, as well as anecdotal and empirical evidence, and serve as a starting point for funders to evaluate non-profits in the sector.

CHAPTER 2

FROM MARGINS TO CENTER

Cornerstones

As illustrated, tribal communities have been unable to fully accrue the benefits of various health programs and policies due to specific systemic and socio-economic barriers. To address the issue of poor maternal and child health, tribal communities must overcome several interlocking barriers to accessing health services.

A tribal woman who manages to push beyond traditional beliefs, leave her village and reach out to a health provider might find an ill-trained, over-burdened health worker who doesn't speak the same language, harbors discriminatory biases and works out of a poorly-equipped health center.

Dasra's research highlights four pivotal cornerstones that have the potential to safeguard tribal health:

1. Improve Nutrition

2. Create Hyper-Local Solutions

3. Create a Local, Tribal Healthcare Workforce

4. Improve Implementation of Government Programs

1. Improve Nutrition

Malnutrition among tribal communities is inextricably and cyclically linked to poor maternal and child health. Poor nutrition weakens women's ability to survive childbirth and malnourished mothers are more likely to bear low-birth-weight babies, who are more likely to die in infancy.[60] Additionally, stunting in mothers is a known risk factor for obstetric complications such as obstructed labor and requires skilled intervention during delivery. These complications often lead to injury or death for mothers and their newborns.[61] Malnutrition can be addressed at three points of a community's life cycle:

A. Infancy and Childhood: Infants aged 0-36 months are in a window of opportunity, after which the effects of malnutrition on cognitive and physical growth are largely irreversible.[62] A study covering tribal children under-five in 11 Indian states where 85% of the tribal population lives, showed that a quarter of surveyed tribal children aged 0-5 months were stunted, with the proportion of stunted children increasing with age. This proportion doubled in the 6-11 month age group and had tripled by 18 months. It is therefore critical to focus on children within this age group, as improvements in feeding practices for children in the 6-11 month period can halt this decline. At the time of the study, only 2% of tribal children aged 6-11 months were fed complementary foods at recommended levels of quality and frequency.[63]

B. Adolescence: Adolescence is the next big opportunity to tackle malnutrition. It is the second period of rapid growth and could compensate for any early childhood growth failure.[64] Additionally, research suggests that pregnant adolescents are further at risk, as the body of a still-growing adolescent mother and her fetus may compete for nutrients.[65] This is especially worrying because data shows that up to 36% of tribal women were 19 or younger at the time of their first pregnancy.[66]

C. Pregnancy: Among grown women, malnutrition during pregnancy perpetuates a cycle of deprivation and malnourishment gets passed on from generation to generation. Even mild maternal micronutrient deficiencies can impair the fetus from receiving essential nutrients from its mother.[67]

CASE STUDY: JSS

In order to combat malnutrition at all three life-stages, it is important to educate communities on the nutritional value of different foods and ensure sufficient access to a diverse diet. Community-based programs must include nutrition counseling and education, and encourage adoption of good childcare practices such as exclusive breastfeeding for the first six months and supplementing a child's diet with complementary food thereafter. It is also important to counter harmful traditional beliefs—for example, some tribal women reduce their food intake during pregnancy to ensure that the baby remains small and ease their delivery. There are a variety of different strategies to tackle malnutrition that have proven effective, including nutritional counseling and education, establishment of kitchen gardens and provision for a more diverse range of food items through the Public Distribution System (PDS).[68]

Jan Swasthya Sahayog (JSS)

A 2002 study conducted in Bilaspur, Chattisgarh, a region with a significant population of the Gond and Baiga tribes, found that 41% of men and 31% of women were underweight and almost 65% of children below five years were undernourished due to poor food intake and a lack of awareness of healthcare and childcare practices. This was due to a dependence on existing food grain subsidies distributed through the PDS, which at the time proved insufficient to provide food security to the poor. The situation was compounded by a lack of understanding of the nutritional value of different foods. Furthermore, mothers were often forced back to work soon after childbirth, due to economic pressures and this impacted the level of nutrition they provided their children.[69]

As representatives of the organization describe it, "One possible reason [for undernutrition in the region] may be inadequate knowledge, but the most important reason is probably that the child is not looked after for a better part of the day when both parents, who are often poor, are out working. As a result, the child gets very little food, mostly given by an older brother or sister or an old grandparent."[70]

In response to this discouraging situation, JSS carried out several community-based initiatives to improve nutrition in the region. It provided cooking demonstrations at community gatherings and taught people how to prepare nutritious meals, explained the nutritional value of these meals and provided nutrition counseling at clinical check-ups, community health centers and through community workers. JSS also set up 'Phulwari's', or rural crèches in tribal villages, that were run by women of the village, whom JSS trained. In order to combat malnutrition, children received a cooked meal and two snacks of a high protein energy mixture called 'sattu' during their time at the crèche. This provided up to 70% of their daily nutrition needs.

The crèches have proven to be a success, with over 85% eligible children in the poorest, most remote villages, attending regularly. This allows mothers to work, enables older children to go back to school, improves the community's nutrition levels and decreases childhood illness. The average weight of children attending the crèche is significantly higher than those who are not.

2. Create Hyper -Local Solutions

Dasra has found through expert interviews and site visits that when working with tribal communities, it is important that the community itself is an active participant in designing and implementing the program to ensure that it is area and tribe specific. Given the vast diversity among India's 700 tribes, programs must be customized to suit local needs.[71][72] The frequent discrimination tribal communities face when they try to access healthcare services often perpetuates a trust deficit between these communities and service providers. Programs should therefore be designed to build trust between tribal communities and 'outsiders'.[73] In addition, tribal populations have historically had limited political participation, as a result of which their priorities haven't taken precedence in government health programs.[74] Tribal communities must therefore actively participate in the program planning process to ensure that their priorities get due place in healthcare programs meant for them.

Additionally, research has shown that community involvement can make health services more accessible and sustainable, and that enabling communities to explore the consequences of certain behaviour can yield lasting improvements in health outcomes.[75] Communities learn to plan for and care for their own healthcare needs in the long run. This is done by building health literacy and holding different public forums. For instance, at a tribal health assembly, service providers listen to the health problems and priorities of the people, get approval on proposed health solutions and activities and receive feedback on ongoing activities.

CASE STUDY:
EKJUT

Ekjut, a non-profit organization, has been working in Jharkhand and Odisha to improve health and nutrition outcomes of tribal communities since 2004. It works with women and adolescent girls, facilitating women's groups at the village level through a Participatory Learning and Action (PLA) methodology. A process evaluation of Ekjut's work examined the implementation of the PLA method over three years in 193 villages and 254 hamlets.[76] These villages had little to no access to health services and the maternal and child health outcomes in these areas were extremely poor. The neonatal mortality rate during the baseline study period (2004-2005) was 58 per 1,000 live births. More than 80% of women delivered their newborns at home without skilled attendance.[77] Of these home deliveries, 37% were attended only by the family itself. Additionally, healthcare provision was often delayed because many health problems were attributed to supernatural causes and local diviners were the first to be consulted.

Through the PLA method, Ekjut selects women facilitators from local communities and trains them to facilitate monthly meetings among women and adolescent girls. It is important that the women are from the community. As one group participant explains, "She is from our community. She is a friend. She helps us in solving our problems and makes us aware of the problems we suffer from using picture cards and games. We consider her as a part of us and trust her."[78]

These facilitators prompt the women at the meeting to discuss issues related to pregnancy, childbirth and newborn health, nutrition, adolescent health, gender-based violence and non-communicable diseases. The meetings emphasize collective problem solving and planning, and three key principles: local acceptability, a participatory approach and community involvement.

The program has proven to have a substantial impact—with a 45% reduction in neonatal mortality in the last two years of the intervention—caused largely by improvements in safe delivery practices such as hand washing, clean cord care and the use of safe delivery kits for home deliveries.[79] As another participant describes, "Through storytelling we learned about some harmful practices and realized that because of some traditional practices, many mothers and newborns might have lost their lives."[80]

At the end of 10 meetings, the women are able to prioritize their problems and identify appropriate strategies and solutions. Ekjut found that the PLA program led to a progressive increase in community participation in health programs and health literacy, consequently reducing neonatal mortality and maternal postnatal depression rates by 45% and 57% respectively, between 2005 and 2008.

3. Create a Local, Tribal Healthcare Workforce

In order to overcome the severe paucity of trained healthcare professionals willing to live and work in remote tribal areas and the unwillingness of many tribal communities to accept healthcare from outsiders, it is important to build a cadre of local community healthcare workers who are able to bridge gaps in the public healthcare workforce. This cadre should comprise traditional healthcare providers such as birth attendants or dais who are trained as frontline workers. They should monitor the health and nutrition status of pregnant women and newborn children, administer vaccines, and provide antenatal and postnatal care as well as health and nutrition counseling.

Training these healthcare workers has the effect of involving the community and empowering them to take ownership of their own healthcare needs, ensuring non-discriminatory access to healthcare provision at the village and district level, and spreading health literacy and health-seeking behavior.[81] Healthcare workers are often respected and trusted for their service to the community. They are able to obtain buy-in from leaders and the community and allow government healthcare providers, such as Accredited Social Health Activists (ASHAs), to access these communities. When these healthcare workers work alongside government-employed workers, it ensures that women and children are able to access quality healthcare, no matter where they go first. This is particularly important given that traditional healthcare providers are often the first care provider a pregnant woman reaches out to, despite being ill-equipped to deal with many health emergencies. On average, this results in a two-day delay in seeking medical help.[82] Besides enhancing access to health services, local health providers also facilitate the holistic development of tribal communities by providing guidance on issues such as education, employment and domestic violence.

CASE STUDY: ASHWINI

The Community Healthcare Program run by non-profit organization ASHWINI in Tamil Nadu is an example of a program run by a tribal community for the community. Established in 1987, at a time when there was absolutely no healthcare provision in the region, the organization began training local healthcare workers to identify and treat issues related to maternal and child health, tuberculosis and malaria. It also ran training programs for nurses and administrative staff to operate the ASHWINI Gudalur Adivasi hospital, founded soon after.

Today, the Community Healthcare program is run by trained tribal men and women—health animators—and covers more than 300 hamlets in the Gudalur Valley. Health animators run eight area centers that offer preventive and palliative maternal and child healthcare services. They also treat and monitor patients with chronic illnesses such as epilepsy, diabetes, hypertension and mental illness.[83] Almost 300 health volunteers from each village assist these health animators. They encourage health-seeking behavior among community members, spread basic health literacy and maintain a stock of over-the-counter medical supplies. Health animators also work closely with Accredited Social Health Activists (ASHAs) and share information and medical records, as well as accompany the ASHA (who is often a non-tribal) so that the community does not turn her away.

Over the years, this community-based healthcare model has drastically improved health indicators in the area. When ASHWINI began working in the region in 1998, less than 2% of pregnant women received antenatal check-ups (ANC), 100% of women delivered at home, and the infant mortality rate (IMR) was well over the national average at 250 deaths per 1,000 live births. In 2011, 90% of pregnant women received more than three ANCs, 80% of births were institutional deliveries and the IMR was brought down to 24 deaths per 1,000 live births—less than half the national average of 49.[84]

4. Improve Implementation of Government Programs

Tribal populations living in remote areas are cut-off from mainstream society and cannot access government-provided healthcare services, which are often their only source of healthcare. Studies from various parts of the country show us that tribal women are disproportionately represented among maternal death statistics, despite special provisions for scheduled areas under the National Rural Health Mission.

It is crucial to strengthen the implementation of several existing government services and schemes, which is especially poor in tribal areas. For instance, health services provided under the Integrated Child Development Services program are adapted to Scheduled areas and allow healthcare providers to focus on a small population in tribal areas. Thus, a government provided Accredited Social Health Activist (ASHA) services only 300-500 people in tribal areas, compared to 5,000 in rural areas. Similarly, a Primary Health Centre serves 20,000 people in tribal areas, compared to 30,000 in rural areas.[85]

Other schemes such as the Janani Suraksha Yojana that provides cash incentives to women who deliver in health facilities, and the Janani Shishu Suraksha Karyakaram that provides free-of-cost healthcare services to pregnant women and new mothers have also had a lower impact in tribal areas.[86]

Thus across the board, the problem is less to do with government provisions for tribal communities and more about the implementation of these schemes. It is in this area that nonprofits can have a significant impact. Well-integrated as they are with communities, non-profit organizations are best-placed to audit government healthcare service provision and help communities demand adequate services.

CASE STUDY:
Action Research and Training for Health (ARTH)

ARTH is a non-profit organization working to strengthen health systems in Rajasthan. It does this by monitoring the implementation of government services and by testing innovations in service provision that make healthcare more accessible. It has several projects that work to strengthen government service delivery in tribal areas.

One example is the Udai Project, run through a combination of call centers and community healthcare workers termed Udai Mitras and Udai Preraks who educate and mobilize the community. The program is carried out in three steps. First, the Udai Mitra visits healthcare facilities in a given area to record all deliveries, and educates mothers on routine newborn care and danger signs for newborns, as well as on what she should expect from the local ASHA. The call center then uses the Udai Mitra's records to notify ASHAs that a woman in their area has delivered, ensuring that they are aware of their responsibility to conduct home visits. The call center checks-in with the family after a critical period of 42 days, to ascertain maternal and child health outcomes. It also serves as a resource for families, and is available to guide those that call in to report newborns with danger signs.

Subsequently, the Udai Prerak visits the family seven days and 42 days post-delivery to monitor the condition of the mother and child, and reinforce the use of the Udai Kit for low-birth-weight newborns. The Prerak also inquires about ASHA visits up to that point, attends ASHA sector meetings to provide feedback from the community and holds community meetings on the importance of newborn care and of calling the ASHA for home visits.

The Mitras and Preraks educate the community and empower them to demand the healthcare services due to them. As a follow up to this intervention, in the case of newborn deaths, ARTH also carries out verbal autopsies to ascertain the cause of death and level of care received, to provide feedback to the health system in the region.

In the short time the intervention has been operational, ARTH has found a reduction in cases of maternal and child mortality, as well as an increase in critical newborn care practices such as kangaroo care for low-birth-weight babies. Additionally, ASHA workers in the area have found a rise in demand for their work, with the community itself acting as a check against negligence, thus improving service delivery in the area.

Action Research and Training for Health (ARTH)

Call Center Worker

STEP 2

- Uses the community healthcare worker's records to notify Accredited Social Health Activists (ASHAs) that a woman in their area has delivered.

- Ensures that ASHAs are aware of their responsibility to conduct home visits and check-ins.

- Serves as a resource for families and is available to guide those that call in to report newborns with danger signs.

UDAI PROJECT RESULTS

- Reduction in cases of maternal and child mortality.

- Increase in critical newborn care practices such as kangaroo care for low-birth-weight babies.

- ASHAs in the area have found a rise in demand for their work.

Community Healthcare Worker

STEP 1

- Visits the healthcare facilities in a given area to record all deliveries that have taken place.

- Educates tribal mothers on routine newborn care, danger signs for newborns and what to expect from the local ASHA.

STEP 3

- Visits the family seven days and 42 days post-delivery to monitor the condition of mother and child.

- Inquires about ASHA visits up to that point, attends ASHA-sector meetings to provide feedback from the community and holds community meetings on the importance of newborn care.

CHAPTER 3

CURTAINS UP ON PROGRESS

India will only move the needle on maternal and child health (MCH), when it specifically tackles related challenges for tribal communities. With the Prime Minister and a high-level committee report recently drawing attention to the welfare of this population, this is the time for funders and non-profits to ramp up their efforts to address health concerns of one of India's most marginalized populations.

Non-profit organizations working within tribal communities need sustained engagement over long periods of time to drive impact. Funders interested in reducing maternal and child mortality or improving reproductive health indicators must focus on the worst affected populations to accelerate progress.

Key pointers for stakeholders as they address tribal MCH in India include:

- Customize solutions to address unique challenges of each tribal community.

- Leverage technology to overcome access barriers and improve service delivery.

- Disaggregate national data on development parameters and document best practices.

- Address interlinked socio-economic and health challenges affecting tribal communities.

- Tackle discrimination towards tribal communities by sensitizing health providers.

- Focus on generating demand for and sustained adoption of healthcare services.

- Acknowledge and address integration challenges.
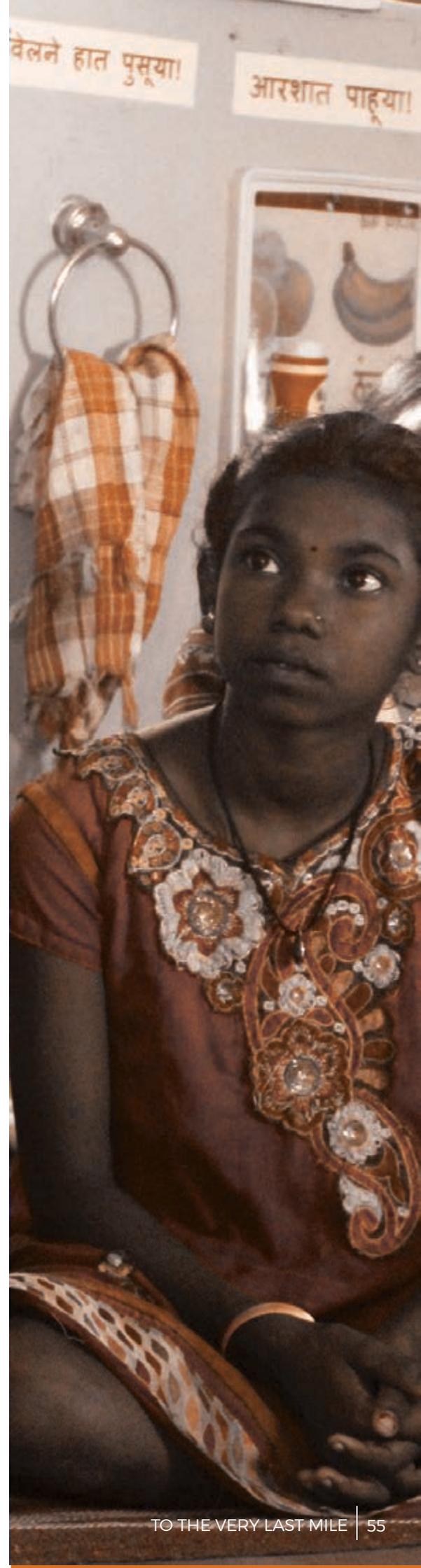
Customize solutions to address unique challenges of each tribal community

Localizing programs by accounting for softer aspects such as traditions, beliefs and attitudes and health-seeking behavior, is critical to effectively deliver solutions. Rolling out national programs or replicating successful interventions across regions is difficult given the unique attributes and challenges of various tribal communities. Obtaining buy-in from communities is largely driven by offering solutions that reflect a deep understanding of and appreciation for the diversity of each tribe. As a UNICEF report highlights, "Communication respecting tribal beliefs, local festivals, customs and traditional systems of medicine, diet and healers will be crucial while influencing tribal behaviors. Discourse should be folk-based, visually attractive and through trusted local women and key influencers, such as traditional healers." [87]

Leverage technology to overcome access barriers and improve service delivery

There is a huge untapped potential to leverage technology to reach tribal communities. Specifically, using audio-visual aids to enable health workers to better communicate health messages. While low mobile penetration and network issues have led to limited scale-up of mobile-health models, the trend is improving. Some organizations Dasra met leverage technology to collect data and feed it back into government health records, while others tap into the mobile phones of health workers to effectively deliver messages to women's groups, thereby facilitating peer discussion and learning.

Disaggregate national data on development parameters and document best practices

Lack of data on tribal communities forms the crux of the challenges faced while addressing their needs. Disaggregating data on various socio-economic parameters of development is necessary for effective program and policy design and implementation. Additionally, the sector will benefit from auditing deaths, evaluating programs and monitoring the implementation of government schemes. Documenting knowledge on traditional medicine and its applications, and indigenous midwife practices, can help identify areas where traditional medicine could complement modern medicine and, in some cases, offer better solutions.

Address interlinked socio-economic and health challenges affecting tribal communities

Maternal and child health (MCH) problems of tribal communities cannot be addressed in isolation. Programs need to account for the socio-economic determinants of health. As highlighted in a UNICEF report on nutrition for tribal children, addressing determinants of severe stunting in tribal children calls for an integrated approach, addressing issues related to women's empowerment, family planning, poverty alleviation, along with health, food, water and sanitation, and infant and child feeding practices.[88] Most non-profit organizations Dasra visited have spent several years studying the challenges of a specific community and shared the merit of 'engaging deeper' within the same communities to cover the entire spectrum of inter-linked drivers of tribal welfare—rather than scaling up a successful MCH model to other parts of the country.

Tackle discrimination towards tribal communities by sensitizing health providers

Through its research, Dasra learned about several cases of discrimination against tribal women at government hospitals. Some non-profits ensure that local government hospitals have tribal representatives to advocate for and assist tribal communities. While distance is a major deterrent for government health workers to cover tribal districts, in several cases an inherent bias against these communities prevents them from reaching out. It is therefore crucial to sensitize health workers given that discrimination adversely affects tribal health-seeking behavior and health outcomes.

Focus on generating demand for and sustained adoption of healthcare services

A study on the disease burden of tribal communities points out that tribal communities living in natural environments have a traditional healthcare system that depends on herbal and psychosomatic treatment.[89] Enhanced access to various health services doesn't necessarily alter the health culture of a community. While a large number of programs disproportionately focus on creating access by building clinics and hospitals, the most successful ones focus on demand generation and behavior change through community-based solutions and participatory learning approaches.

Acknowledge and address integration challenges

Experts believe that integration of tribal communities has hampered their traditional way of life, leading to poorer development indicators. Gender equality, lower fertility and mortality patterns among tribal groups are gradually eroding, as they get more integrated into non-tribal society and as their traditionally sustainable livelihoods are encroached upon.[90] Thus, while creating opportunities for tribal communities to benefit from development, efforts must also be made to preserve their identity. Although this is a very challenging proposition, it must be carefully considered while funding and designing programs.

The opening story of this report is one of many such stories that are not told enough. In most cases, there is no monitoring of tribal maternal deaths or of the invisible deaths of newborns who enter and leave the world without any record. Through this report, Dasra hopes to partially address the knowledge gap in the sector by highlighting critical areas of focus, effective non-profit models, and successful interventions driving change in this sector.

APPENDICES

APPENDIX-I

Dasra's expertise lies in recognizing and working with non-profits that have the potential to create impact at scale. Dasra strongly believes that the strength of an organization comes from its people, and has ingrained this philosophy in its due diligence process. Consequently, an organization is assessed not just on the basis of its program, but also on the potential of its leadership and management team. In order to identify such organizations, Dasra follows a comprehensive three stage due diligence process.

Phase I – Sector Mapping

· The process involves undertaking an exhaustive sector mapping and compiling a list of non-profit organizations working in the sector.

· Based on quantitative and qualitative secondary research, references from previous experience, and inputs from sector experts, the work carried out by the organizations is categorized under specific interventions.

· Organizations implementing programs with the most scalable and impactful interventions are screened from this universe against criteria such as – program focus, outreach, team, budget, scale, impact and growth plan.

Through sector mapping for this report, Dasra mapped over 200 non-profits across India.

The design for this report is inspired by Indian tribal motifs but is not meant to be representative of all tribal art.

Conversion Rate (used for this report):
1USD = INR 67

Phase II – Detailed Assessment of Organizations Based on Phone Calls and Site Visits

Dasra conducts a detailed assessment of the screened organizations by making a one- to two-day site visit to understand the work being done on the ground and spend time with the leadership and management team of the organization.

An organization profile is prepared to capture the current work and achievements of each organization and provide a sense of the future growth of the organization as a whole.

Organizations are evaluated using the Dasra Capacity Assessment Framework (DCAF), a tool that Dasra has developed to assess organizations against three key areas – leadership potential, organization strength and program effectiveness.

Dasra conducted phone calls with 40 non-profits that work to improve maternal and child health outcomes in tribal communities and identified 12 organizations on whom detailed diligence was conducted – either through site visits to these organizations or by building on Dasra's existing knowledge about these organizations.

Phase III – Final Shortlisting

· Dasra Capacity Assessment Framework (DCAF) and organization profiles are used to evaluate the program strength, organization potential and areas where Dasra can add value through its capacity building support.

· Members from Dasra's advisory research and diligence team, as well as senior management, participate in the shortlisting process to identify eight to ten high impact and scalable non-profits to be profiled in the report.

Eight non-profits were shortlisted to be profiled in this report, based on the strength of their programs to improve maternal and child health outcomes in tribal communities, the potential of their organization and the vision of their leadership.

Dasra re-engages with the final shortlisted organizations to create robust growth plans, and works with the organizations to explore funding opportunities. Dasra also offers peer-learning and capacity building opportunities to these organizations through two-three day, residential workshops.

APPENDIX-II

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APPENDIX-III

Acronyms

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
CHC	Community Health Center
ICDS	Integrated Child Development Services
IMR	Infant Mortality Rate
MMR	Maternal Mortality Rate
MCH	Maternal and Child Health
NRHM	National Rural Health Mission
PHC	Primary Health Center
PLA	Participatory Learning and Action
RDA	Recommended Daily Allowance
ST	Schedules Tribes
UNICEF	The United Nations Children's Emergency Fund
WHO	World Health Organization

Glossary

Accredited Social Health Activist (ASHA) is a community health workers instituted by India's Ministry of Health and Family Welfare as part of its National Rural Health Mission.

Anganwadi Worker (AWW) is a health worker chosen from the community and given four months of training in health, nutrition and childcare. She is in charge of an Anganwadi or daycare center for children.

Auxiliary Nurse Midwife (ANW) is a trained healthcare provider who conducts outreach and provides services to women and children in the community.

Community Health Center (CHC) is the third tier of the network of rural health care institutions, required to act primarily as a referral center for the neighboring primary health centers for patients requiring specialized health care services.

Integrated Child Development Services (ICDS) is an Indian government welfare program, which provides food, preschool education, and primary healthcare to children less than six years of age and their mothers. These services are provided through Anganwadi centres established mainly in rural areas and staffed with frontline workers.

Primary Health Center (PHC) is the first point of contact between individuals and a qualified medical doctor. Each PHC is linked to approximately six sub centers (a population of approximately 30,000) and is typically a single-doctor clinic with about six inpatient beds as well as facilities for delivery, family planning (including sterilizations), minor surgeries and limited laboratory testing.

Stunting is a measure of height to age. A stunted person will be significantly shorter than is expected for their age. It is the long-term cumulative effect of malnutrition, and increases the likelihood of illness and poor health, reduces cognitive development, and lowers economic productivity.

Underweight is a measure of weight to age. This indicator is often used as a basic indicator of the health status of a population.

Wasting is a measure of weight to height. Because weight can change more quickly than height, wasting measures the current nutritional status of an individual, and can be an indicator of both acute short-term reduction of food intake and stunting.

APPENDIX-IV

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TO THE VERY LAST MILE

Improving Maternal and Child Health in Tribal Communities

PART - II

The United States Agency for International Development (USAID) is the United States federal government agency that provides economic development and humanitarian assistance around the world in support of the foreign policy goals of the United States. USAID works in over 100 countries around the world to promote broadly shared economic prosperity, strengthen democracy and good governance, protect human rights, improve global health, further education and provide humanitarian assistance. This report is made possible by the support of the American People through the United States Agency for International Development (USAID). The contents of this report are the sole responsibility of Dasra and do not necessarily reflect the views of USAID or the United States government.

Piramal Foundation strongly believes that there are untapped innovative solutions that can address India's most pressing problems. Each social project that is chosen to be funded and nurtured by the Piramal Foundation lies within one of four broad areas - healthcare, education, livelihood creation and youth empowerment. The Foundation believes in developing innovative solutions to issues that are critical roadblocks towards unlocking India's economic potential. Leveraging technology, building sustainable and long term partnerships and forming scalable solutions for large impact are key to their approach.

The Kiawah Trust is a UK family foundation that is committed to improving the lives of vulnerable and disadvantaged adolescent girls in India. The Kiawah Trust believes that educating adolescent girls from poor communities allows them to thrive, to have greater choice in their life and a louder voice in their community. This leads to healthier, more prosperous and more stable families, communities and nations.

Dasra meaning 'enlightened giving' in Sanskrit, is a pioneering strategic philanthropic organization that aims to transform India where a billion thrive with dignity and equity. Since its inception in 1999, Dasra has accelerated social change by driving collaborative action through powerful partnerships among a trust-based network of stakeholders (corporates, foundations, families, non-profits, social businesses, government and media). Over the years, Dasra has deepened social impact in focused fields that include adolescents, urban sanitation and governance and has built social capital by leading a strategic philanthropy movement in the country. For more information, visit www.dasra.org

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CHAPTER 1

SHIFTING GROUND REALITIES

INTERVENTIONS

Through its interactions with and visits to non-profits working with tribal populations, Dasra has identified the following eleven interventions that are being implemented to improve maternal and child health outcomes for these communities:

1. Train Community-Based Health Workers

2. Fill Gaps in Government Health Service Provision

3. Train Traditional Birth Attendants

4. Run Mobile Health Clinics

5. Deliver Nutrition Programs for Children

6. Improve Nutrition at the Community Level

7. Run Maternal and Child Health Awareness Programs

8. Build the Government's Capacity to Deliver Services

9. Improve Referral Care

10. Audit Government Health Service Provision

11. Conduct Research for Advocacy

1.

Train Community-Based Health Workers

Non-profits mobilize and train community members to promote health-seeking behavior and provide primary health services to the community. Cultivating a cadre of community-based health workers is particularly significant in tribal areas which suffer from limited access to health information and a shortage of trained medical personnel. To secure buy-in from the community, these health workers are often selected from and by the community itself. Health workers typically receive ongoing training on basic diagnostic and treatment skills and are responsible for:

- Registering pregnant women, providing antenatal and postnatal care and monitoring the health, immunization and nutrition status of mothers, infants and children.

- Diagnosing and managing communicable diseases such as malaria, diarrheal diseases, tuberculosis and scabies.

- Providing counseling and advice on a range of health related issues such as nutrition, family planning, first aid and alcoholism.

These home-grown health workers act as the first point of contact to address community healthcare needs. In areas where the public health system is operational, community health workers work closely with government frontline workers, complementing their service delivery and ensuring better coverage of tribal communities' access to health services.

Some non-profits will engage and train an additional cadre of community workers, who are primarily responsible for supporting health workers by mobilizing the community, creating awareness about available services and promoting health-seeking behavior. The ultimate goal of this intervention is to empower communities to take responsibility for their health and wellbeing.

Photo Credit: Impact India Foundation

CASE STUDY

Swasthya Swaraj works in the predominantly tribal Thuamal Rampur block in Odisha's Kalahandi district, where maternal and child health indicators are amongst the poorest in the country. With a view to create a community-owned model of healthcare and education, it trains village-level health workers to act as primary healthcare providers. Every village selects one woman to be a Swasthya Sathi (health friend), who is trained by the organization over a three-year duration on basic investigatory, diagnostic, treatment and health education skills. At the end of the training period, Swasthya Sathis are able to provide basic antenatal and postnatal care, advise on health-related issues such as family planning, newborn care and nutrition, as well as diagnose and manage common communicable diseases.

The organization also selects and trains local boys to act as community mobilizers, and to promote health-seeking behavior within the community. Known as Shikhya Sathis (education friends), these boys are trained in mass health education and implement community-based malaria and tuberculosis control programs. Shikhya Sathis create awareness about the dangers associated with these diseases, train the community to recognize symptoms and promote preventive measures to control the spread of these diseases.

2.

Fill Gaps in Government Health Service Provision

Tribal populations are often located in areas that are grossly underserved by the public healthcare system, with service provision being non-existent, inadequate, intermittent or of poor quality. Consequently, non-profits typically implement a community health program and establish clinics that function as primary health centers and a hospital that serves as a referral center. These two or three tier systems mirror the government's service provision structure. In some cases, the services provided at these facilities are integrated with the public healthcare referral system.

Primary health centers function as daily clinics, staffed by nurses or senior health workers. Doctors visit these clinics once or twice every week. Non-profits usually establish multiple primary health centers, to ensure better coverage of the tribal population that they serve. Therefore, each center is strategically located to serve a cluster of villages. Community health workers, from each village, refer cases to a specific center. These centers provide a range of services including outpatient services, antenatal checks for pregnant women, pharmacy and diagnostic services. If necessary, patients will be referred to a hospital for a higher level of medical care. Sometimes, non-profits will also establish a referral center or hospital to provide tertiary-level healthcare services. This includes inpatient and outpatient services covering pediatrics, obstetrics and gynecology, general surgery and internal medicine.

CASE STUDY

ASHWINI works with tribal communities in Tamil Nadu's Gudalur Valley. At the core of its work is a community healthcare program which is implemented across two blocks of the Gudalur Valley. This geographic area is further divided into eight administrative zones, each of which comprises 20-40 tribal villages.

Community-based outreach at the village level comprises the first tier of service provision. Each of the eight zones also has an Area Center that acts as a primary health center. This comprises the second tier of service provision. Trained Health Animators manage the Area Centers. Their role includes maintaining extensive medical records of each village that they serve and running a pharmacy and an outpatient clinic for the community.

Area Centers seek to complement the government's service provision in order to avoid duplication, but are often considered the first recourse to care by the tribal community, who do not fully trust government-run centers. When appropriate, ASHWINI's Health Animators will refer cases to the hospital that ASHWINI has established or larger hospitals in Mysore or Kozhikode, which are the closest towns with good medical facilities.

When ASHWINI began working with tribes in Gudalur, cases that needed hospitalization, such as high-risk pregnancies or acute cases of diarrhea and fever among children used to be referred to the local government hospital or to private clinics. However, due to the high cost of treatment and the discrimination that tribal communities faced at these hospitals and clinics, the community called for the establishment of its own hospital to supplement the government's healthcare program.

This led to the establishment of the Gudalur Adivasi Hospital in 1990. The hospital represents a third tier of service provision and provides outpatient and inpatient services. The facilities available include a pharmacy, an investigative unit, a sickle cell anemia treatment center, an eye and ear screening and testing center, a labor and delivery room, a blood bank, an operating theatre, general wards and a training center.

As ASHWINI firmly believes in promoting a community-owned model of healthcare, it has steadily built the community's capacity to manage the hospital. Over 75% of the hospital's administrative and nursing staff is tribal. Only doctors are actively recruited from outside the community.

3.
Train Traditional Birth Attendants

In many tribal communities, the dai or traditional birth attendant is the primary healthcare provider for women during pregnancy and childbirth. She is usually an older woman from the community who draws on traditional knowledge and experience to provide primary maternal care, advice and support to mothers. Dais conduct home-based deliveries. They rarely receive any formal training and learn their trade informally from other dais in the community or teach themselves through practice. Consequently, dais do not always follow standard safety protocols during home deliveries and may inadvertently promote harmful traditional practices.

While the public healthcare system provides monetary incentives to pregnant women to encourage institutional deliveries, many prefer home-based deliveries carried out by a dai. There are many reasons for this including, a high level of comfort with traditional methods of maternal care and childbirth, easy access to dais and a lack of trust in the public healthcare system. Despite high levels of acceptance by communities and a recognition of the critical role that they play in providing timely maternal and newborn care in remote areas, dais are rarely integrated into the public healthcare system.

Some non-profits, however, do recognize the value of working with dais to improve primary maternal and child healthcare provision. They train dais to promote positive practices and discard those that are harmful, as well as manage minor emergencies and refer patients when they do not have the necessary skills to manage complications and major emergencies.

CASE STUDY

Jan Swasthya Sahyog (JSS) works in the predominantly tribal district of Bilaspur in Chhattisgarh. It recognizes that communities inherently place high levels of trust in dais and integrates them into its three-tiered system of healthcare delivery. Skilled gynecologists and pediatricians have trained 101 dais from 54 remote villages where JSS works on an ongoing basis, to achieve the following objectives:

- Decrease maternal and neonatal mortality and morbidity.

- Encourage institutional deliveries.

- Ensure safe deliveries for those mothers who are unwilling or unable to go to health institutions.

- Recognize danger signs and promptly refer cases for institutional care when necessary.

Dais are trained in appropriate nutrition practices and safe delivery techniques. JSS provides them with a safe delivery kit that contains sterilized materials to aid home-based deliveries. They are also trained to manage certain emergencies, such as post-partum hemorrhage. JSS has found that unsafe practices—such as overuse of oxytocin and cutting of the umbilical cord by villagers (which can result in infections)—have reduced since it began the training program, resulting in an overall decline in maternal and neonatal mortality.

4.
Run Mobile Health Clinics

Many tribes live in very remote and inaccessible areas that are particularly difficult to reach. Non-profits working in such geographies will often provide health services through mobile outreach to ensure that those communities that cannot access health services at clinics and hospitals can still avail quality healthcare from trained healthcare professionals. Mobile outreach takes two forms:

- Permanently staffed vans travel to pre-defined locations and ensure that every village or hamlet in the program area receives periodic visits.

- Day-long health camps are set up at primary schools or community halls at regular frequencies, such that they are easily accessible to a cluster of villages.

Non-profits leverage other interventions, such as community mobilizers or community radio stations, to ensure that critical information about their mobile service provision, such as time and location, is well disseminated.
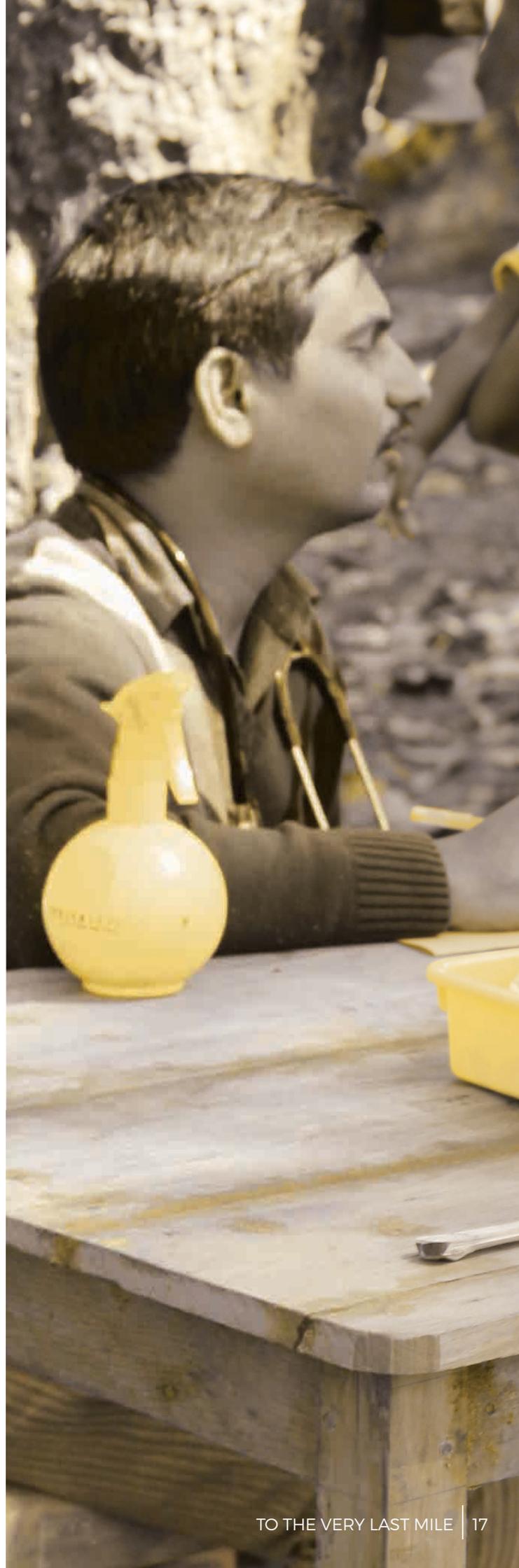
CASE STUDY

Swami Vivekananda Youth Movement (SVYM) operates Mobile Health Units (MHU) that service 70 tribal communities in Karnataka's Heggadadevana Kote taluk. A team comprising a medical officer, staff nurse, health facilitator and pharmacist visit each community, on a weekly basis. The objective of this initiative is for MHU teams to serve as the initial point of contact for a community's primary healthcare needs. It provides the following maternal and child health services:

- Identification and registration of pregnant women, as well as ensuring that they access antenatal care, institutional delivery and postnatal care.

- Screening children under five years for illnesses, immunizations and provision of referral and follow-up services to prevent nutritional deficiencies, pneumonia and diarrhea.

Information about the route, timing and location of the MHUs is disseminated to the public through boards that are prominently displayed in tribal colonies, and regular announcements through Janadhwani, a community radio station run by SVYM.

5.

Deliver Nutrition Programs for Children

Malnutrition among children under five years is one of the biggest determinants of neonatal and infant mortality, and addressing it is crucial to improving maternal and child health indicators among tribal communities. Non-profits have a variety of methods to address this issue, including nutrition counseling and home-based child care programs. These interventions include educating mothers and communities on the nutritional needs of young children, encouraging communities to adopt a diversified diet for their families, supplementing the public distribution system with necessary nutrients, and providing emergency treatment for dangerously malnourished children. These activities are most often carried out by frontline workers at the village level, but can also take the form of crèches that provide both childcare and meal supplements and through emergency care in hospitals.

CASE STUDY

The MAHAN Trust provides curative and preventive healthcare in Melghat, Maharashtra, one of the most inaccessible regions in India, with a predominantly tribal population. Its programs include the Severely Acute Malnourishment Management program, initiated in 2011, that focuses on the specialized treatment of malnutrition at the village level. MAHAN's Village Health Workers (VHWs) rehabilitate malnourished children by treating them with therapeutic foods. They are trained to recognize danger signals among children that necessitate more specialized intensive care. These cases are referred to the Nutrition Rehabilitation center at MAHAN's Mahatma Gandhi Tribal hospital. The VHWs also work to sensitize and train parents and children on healthy nutritive sources and the importance of nutrition for good health.

6.

Improve Nutrition at the Community Level

Malnutrition is widespread among tribal populations and impacts physical and intellectual development across these communities. The adverse effects of malnutrition are intergenerational and in order to sustainably improve health outcomes for tribal mothers and children, it is important to educate the entire community about the critical role that good nutrition plays.

Non-profits implement a range of interventions to improve nutrition and health outcomes for tribal communities. These include sustainable agricultural practices such as soil and water conservation, multi-cropping, integrated farming and the promotion of kitchen gardens to create access to a diverse and nutritious diet at the household level. Non-profits also engage community-based groups, focusing on adolescent girls and women, to promote good practices related to food preparation, nutrition, sanitation and hygiene.

CASE STUDY

Sambandh works with tribals in Odisha's Similipal Biosphere Reserve, where chronic malnutrition among women and children is an area of concern. It takes an integrated approach to improving nutrition outcomes and applies a nutrition lens to initiatives in multiple domains, as described below:

- Promotes organic farming and intercropping, wherein nutritious crops for consumption are grown alongside cash crops.

- Educates self-help groups, farmers' groups and groups of adolescent girls on a range of nutrition-related issues. These include the importance of safe drinking water, healthy sanitation practices and the benefits of a diverse diet. It promotes the development of kitchen gardens, where families grow indigenous fruit, vegetables and medicinal herbs and plants.

- Provides supplements and enriched foods to acutely malnourished children.

- Revives traditional health practices that are safe and effective, as well as promotes modern techniques such as supplementation and growth monitoring. It also engages and educates public healthcare workers and local healers, to enhance their knowledge of practices for improved nutrition, health and hygiene.

7.

Run Maternal and Child Health Awareness Programs

Ensuring that tribal communities display active health-seeking behavior, enabling them to understand determinants of good maternal and child health (MCH), and encouraging them to discard harmful traditional practices, have proven to be pivotal to improving MCH outcomes. Non-profit organizations, therefore, run awareness programs within communities on a variety of MCH-related issues. They conduct these awareness programs through volunteer-led community meetings, nukkad nataks (street plays) and communication material such as posters, audio and video clips. Tribal communities are given information on family planning methods, good maternal health practices like institutional deliveries, as well as good childcare practices, including immunizations and breastfeeding. Communities thus practice preventive care and are able to make informed decisions regarding their health.

Established in 1998, Network for Enterprise Enhancement and Development Support (NEEDS) runs awareness programs for different stakeholders among Jharkhand's tribal communities, to improve MCH outcomes. These programs include:

- Family-Planning Workshops for Women: These workshops are meant to educate women on family planning, menstrual hygiene, contraception, institutional delivery, safe and legal means of abortion, among others. Programs are led by trained community volunteers over six weeks.

- MenEngage Workshops: These workshops for men generate awareness on family planning, gender parity, and effective communication among couples. They aim to include men in conversations that traditionally don't take place due to cultural constraints. The program creates an environment within the community that includes women in key domestic decision-making such as family planning. For each cohort, this program typically lasts for six weeks and is led by trained community volunteers.

- Mobisodes: This is a program designed for adolescents (aged 15-19 years). It is an awareness generation program with modules on menstrual hygiene, sexually transmitted diseases, safe sex and gender equity. The chief modes of dissemination are audio and video clips.

CASE STUDY

8.

Build the Government's Capacity to Deliver Services

In tribal areas where the public healthcare system is functional, non-profits work with the government to improve the quality, efficiency and reach of service delivery. Government healthcare provision is often of poor quality due to a lack of trained and sensitised health workers. Non-profits improve service delivery by training health workers and equipping them with the knowledge, skills and resources necessary to provide primary healthcare effectively. They are also instrumental in strengthening institutional delivery mechanisms by working in public health centers to improve healthcare systems and processes.

CASE STUDY

SEWA Rural works with the government across three districts of Southern Gujarat, where it delivers a Community Health Program (CHP). The CHP leverages a mobile application to track and improve maternal and child health (MCH) outcomes. SEWA Rural trains government frontline health workers on an ongoing basis to increase their awareness about MCH-related issues. It also trains them to use a mobile application to track MCH outcomes across communities. Additionally, health supervisors are trained to monitor data collected by frontline workers as well as analyse and use this data to improve MCH outcomes. SEWA Rural clearly outlines an exit strategy, which involves transitioning the program to the government after providing hands-on support for three years.

9.

Improve Referral Care

Rural health centers lack the required human resources to provide quality care, especially in cases of complications during pregnancy or delivery. This means that primary and community health centers are often forced to refer patients to district hospitals. However, the government healthcare system does not have the required protocols or systems to ensure emergency transportation and communication between facilities, leading to several maternal deaths occurring in transit between hospitals. Receiving timely care at hospitals is especially problematic for tribal communities who aren't aware of their rights or hospital procedures.

Many organizations train their staff to make referrals and ensure transportation, either using their own ambulances or government services. Organizations also ensure that patients are accompanied by a health worker who supports them through the process and ensures timely care.

CASE STUDY

ARTH's Sampark program provides emergency referral services for maternal and newborn care in partnership with the government's 104 ambulance helpline. Every time the 104 helpline receives a maternal health-related call, the call is diverted to ARTH's helpline workers stationed at the district hospital. The helpline worker is responsible for:

- Communicating with family members and the ambulance worker to ensure that the woman arrives at the hospital on time and is provided with the required interim care.

- Receiving the patient at the hospital and helping her through the admission process and other formalities.

- Briefing hospital staff members about the condition of the patient, her previous history, and the treatment provided at the referring primary health centers (PHCs) and community health centers (CHCs)

- Tracking the daily progress of patients during their hospital stay and reviewing their clinical records.

ARTH also works with the CHCs, PHCs and District Hospitals to assess and improve their readiness for detecting complications, providing immediate care and referrals, as well as making transportation arrangements. Since June 2015, around 2,084 patients have received appropriate maternal care from ARTH's helpline workers.

10.

Audit Government Health Service Provision

Given the lack of data on government administration and service provision in tribal communities, it is difficult to ascertain the gaps in service delivery. Integrated as they are with tribal communities, non-profits are able to assess the quality of healthcare services in these areas and report back to the government. This can be done in a variety of ways. For example, non-profits sometimes work within the government healthcare system by appointing staff members to public health centers, to assess systems and processes and the quality of care provided, and then work with the government to plug any gaps found. Others conduct verbal autopsies every time a maternal or neonatal death is reported and contact the relevant health facility, the health worker as well as the family to ascertain the cause of death. In doing so, the organization highlights different points at which the system failed. These audits, therefore, have the potential to be extremely effective policy tools.

Amhi Amchya Arogyasathi works with tribal communities in Maharashtra's Gadchiroli district, where it implements a community-based monitoring program of the government's health and nutrition services. The objectives of this program include:

- Building the capacity of village institutions to monitor government health and nutrition services.

- Making government health and nutrition services accessible to the community.

It works with Village Health Water Nutrition and Sanitation Committees and the community at large to identify critical health issues in a village, prepare a plan to address them, plan awareness campaigns related to these issues, manage allocation of funds towards health and nutrition issues and monitor government frontline workers' performance. In order to improve the government's accountability to the community, the organization has facilitated the formation of Primary Health Centre Monitoring and Planning Committees, representing both community members and government officials—to discuss issues related to service delivery at healthcare centers.

CASE
STUDY

11.
Conduct Research for Advocacy

Non-profits working with tribal communities often have immense experience in making community-based healthcare programs work. This makes them extremely well placed to showcase successful pilot programs, which the government can scale. Specifically, organizations conduct research on strategies and interventions that create the most impact on the ground, in the form of improved maternal and child health outcomes. This enables them to advocate with local, state and national governments for the adoption of successful interventions in government health programs.

SEARCH (Society for Education, Action and Research in Community Health) has worked with 100 villages in Maharashtra's Gadchiroli district for over three decades, establishing a community health laboratory to identify priority health problems, collect evidence through field studies, develop people-centered solutions and test these through field trials.

In order to reduce neonatal mortality, SEARCH developed a package of home-based neonatal care and tested it through field trials in Gadchiroli. The neonatal mortality rate in the 39 intervention villages reduced from 62 per 1000 live births when the baseline was conducted (1993-1995) to 25 per 1000 live births in the third year of the intervention (1997-1998). In comparison, the neonatal mortality rate in the 47 control villages increased from 58 per 1000 live births at the time of the baseline to 60 per 1000 live births in the third year of the intervention.

Having demonstrated the impact of home-based neonatal care on reducing neonatal mortality in Gadchiroli, SEARCH initiated Project ANKUR in 1998, in partnership with seven non-profits to test if the model was replicable in other regions of Maharashtra. In 2003, the Ministry of Health and Family Welfare initiated a pilot across five states to replicate SEARCH's model through the existing public health system. SEARCH has also been instrumental in training over 800,000 public health workers across the country to provide home-based neonatal care.

CASE STUDY

CHAPTER 2

THE CHANGE MAKERS

During the course of this research, Dasra mapped over 200 organizations in the tribal health sector in India. Following a comprehensive due diligence process that evaluated the program, leadership and organizational strengths of these entities, eight non-profits have been shortlisted to profile in this report.

This chart maps these organizations to the interventions discussed in the preceding section.

INTERVENTIONS	ARTH	ASHWINI	Ekjut	JSS	SEARCH	SEWA Rural	SVYM	Swasthya Swaraj
Train Community-Based Health Workers	X	X	X	X	X	X		X
Fill Gaps in Government Service Provision	X	X	X	X	X	X	X	X
Train Traditional Birth Attendants	X			X	X	X		
Run Mobile Health Clinics					X	X	X	X
Deliver Nutrition Programs for Children			X	X		X		X
Improve Nutrition at the Community Level	X	X	X			X	X	X
Run Maternal and Child Health Awareness Programs	X	X	X	X	X	X	X	X
Build the Government's Capacity to Deliver Services	X		X	X	X	X	X	
Improve Referral Care	X		X			X		
Audit Government Health Service Provision								
Conduct Research for Advocacy	X		X	X			X	

Action Research and Training for Health (ARTH)

www.arth.in

ARTH
Action Research and Training for Health

ORGANIZATION OVERVIEW

☑ NON PROFIT ☑ 12 A ☑ 80 G ☑ FCRA

Founded: 1997 · **Head Office:** Udaipur · **Coverage:** Rajasthan · **Full-Time Staff:** 64 · **Budget (2015-16):** INR 3.06 crore (USD 457,000)

ARTH works in tribal districts across southern Rajasthan, to improve the health status of communities. It focuses on women's reproductive health, neonatal and child health, and nutrition through service provision and research. ARTH also supports and provides training to the National Health Mission, Rajasthan. Its mission is to help improve rather than replicate government healthcare provision.

HOW DID IT EVOLVE?

1997	2000	2007	2014	2015
Began its program and provided primary healthcare services through one health center, reaching 10 villages in Rajsamand district.	Used institutional support from Sir Ratan Tata Trust to open an additional health center and expand outreach to 28 villages.	Trained government healthcare providers and senior nurses across 33 districts in Rajasthan to improve the skills of traditional birth attendants.	Launched the Sampark program to enhance emergency referral services for maternal and newborn care through the government's 104 helpline.	Launched the Udai program to improve newborn survival in government facilities.

PROGRAM OVERVIEW

Coverage: Rajasthan • **Full-Time Program Staff:** 64 • **Budget (2015-16):** INR 3.06 Crore (USD 457,000)

▶ THE PROBLEM

Government systems often fail to provide quality care due to a lack of resources, insufficient training and inadequate systems. Tribal communities find it especially difficult to access public healthcare on account of isolation, social discrimination and poor levels of education, resulting in high rates of mortality and morbidity.

▶ ARTH'S RESPONSE

ARTH combines research, training and direct healthcare provision to improve health outcomes for tribal communities. It tests innovative ideas that make healthcare more accessible and relevant to the local population. ARTH then advocates for the use of these innovations and supports the government in integrating them into the public health system.

WHAT DOES IT DO?

ARTH's operating model works across five main pillars:

- **Research and Advocacy:** Conduct action research to test the effectiveness of new approaches and interventions, and subsequently advocate to scale successful interventions.
- **Program Support:** Provide technical assistance to the National Health Mission to effectively implement health programs. This involves developing more efficient systems and protocols, and providing support to government officials to improve the quality of healthcare provision.
- **Training:** Training government frontline health workers and NGOs using its residential training center. The courses use international and national curricula and standards that ARTH contextualizes.
- **Service Provision:** Provide primary healthcare, through health centers and house visits by nurse-midwives and village health workers. ARTH's health centers demonstrate that trained nurse-midwives are capable of providing a wide range of maternal-neonatal services in the absence of a doctor. ARTH also operates a referral system (counseling for decision making, arranging transport, accompanying patients and negotiating with hospital staff) to ensure patients receive timely care.
- **Community Action:** Recruit neighborhood volunteers that distribute pregnancy testing kits, contraceptives and sanitary napkins to help improve sexual and reproductive health.

KEY INTERVENTIONS

1. Train Community-Based Health Workers
2. Fill Gaps in Government Service Provision
3. Train Traditional Birth Attendants
4. Run Mobile Health Clinics
5. Deliver Nutrition Programs for Children
6. Improve Nutrition at the Community Level
7. Run Maternal and Child Health Awareness Programs
8. Build the Government's Capacity to Deliver Services
9. Improve Referral Care
10. Audit Government Health Service Provision
11. Conduct Research for Advocacy

■ Interventions undertaken   ■ Interventions not undertaken

- ARTH's centers serve over 22,000 mothers and children, annually. Until March 2016, ARTH's nurse-midwives had attended 9,877 deliveries, 92% of which were managed by nurses without the need for referral to doctors.
- A study conducted by ARTH revealed that its program reduced newborn mortality by 51% in just four years.
- In 1998, ARTH introduced contraceptives (Copper-T and 380A) as safer and cheaper alternatives to sterilization. In 2004, as a result of advocacy by ARTH and others, the government introduced these contraceptives throughout the country.
- In 2007, as a result of ARTH's advocacy, the Rajasthan Government directed all public health institutions to adopt the evidence-based best neonatal care and childbirth practices suggested by ARTH.

- Leverage its existing infrastructure and experience to become a major training organization. It plans to train women from tribal communities as nurses or skilled midwifery assistants. ARTH's first batch of trained nurses/midwifery assistants will graduate in 2016.
- Increase its focus on issues of newborn health and adolescent sexual and reproductive health, as ARTH believes that over the years, it has sufficiently built the government's capacity to address basic maternal health.
- Transform defunct government sub-centers into birthing centers over three to five years and then, hand these back to the government to run. ARTH has already received interest from the Rajasthan Government and is looking for funding to take this forward.

ARTH's staff members assisting a mother to wrap a kangaroo care jacket around her newborn to prevent hypothermia.

QUALITY INDICATORS

Leadership

Dr. Sharad and Dr. Kirti Iyengar, Co-Founders

- Dr. Sharad and Dr. Kirti Iyengar are medical doctors with advanced degrees in obstetrics, pediatrics and public health.
- Dr. Sharad worked with the United Nations Population Fund for eight years. He served on governance and technical committees of the WHO, Indian Council of Medical Research and Ministry of Health and Family Welfare, Government of India and Rajasthan.
- Both Dr. Sharad and Kirti Iyengar are Adjunct Professors at Duke University.

Partnerships

- Research Partners: WHO, University of Washington, UNICEF and Karolinska Institutet.
- Funders: MacArthur Foundation, WHO, Packard Foundation and GSK Pharmaceuticals.

Endorsements

- Creative and Effective Institutions award, MacArthur Foundation, 2011.

VOICES FROM THE GROUND

Basni Meghwal, a 20 year old girl living in the Kumbhalgarh block of Rajasthan, delivered her first baby at the ARTH health clinic. During her delivery, a potentially life-threatening complication arose that would normally have required the expertise of doctors at a tertiary hospital (situated almost 50 kilometers away). However, because of her training, ARTH's nurse was able to expertly and safely deliver the baby, without the presence of any doctors. Both the mother and the baby were healthy when they were discharged, two days later.

VOICES FROM THE TEAM

"ARTH's field programs function like a learning laboratory and enable us to continuously innovate in a scientific and ethical manner, and to then scale these innovations through the public healthcare system. The ultimate aim is to improve access to healthcare services and empower tribal communities, especially women, to use these services."
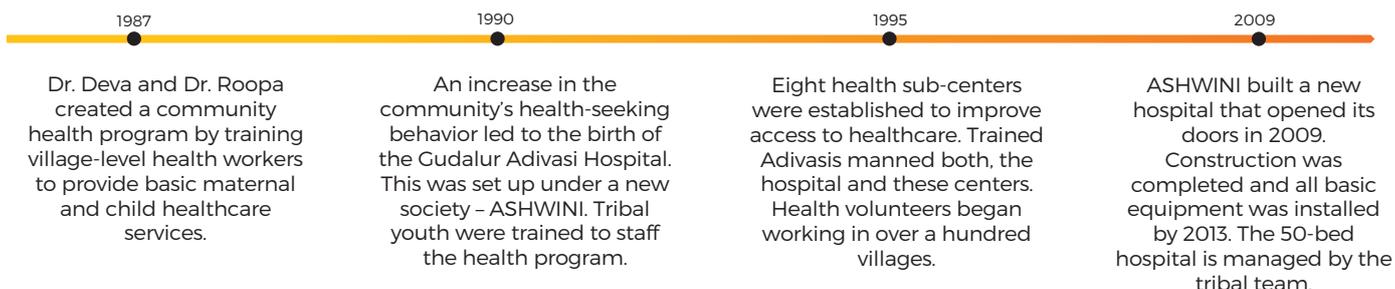
– **Dr. Sharad Iyengar, Co-Founder**

ASHWINI Gudalur

www.ashwini.org

ORGANIZATION OVERVIEW

Founded: 1990 · **Head Office:** Gudalur, Tamil Nadu · **Coverage:** Tamil Nadu · **Full-Time Staff:** 82
Budget (2015-16): INR 2.15 crore (USD 321,000)

Founded in 1990, ASHWINI (Association for Health Welfare in the Nilgiris) was spun out of ACCORD, a human rights organization that had been working for the land and housing rights of tribal communities in the Gudalur valley. ASHWINI meets the health needs of these communities and enhances their health-seeking behavior, while simultaneously training them to take over the organization's operations and administration.

HOW DID IT EVOLVE?

1987	1990	1995	2009
Dr. Deva and Dr. Roopa created a community health program by training village-level health workers to provide basic maternal and child healthcare services.	An increase in the community's health-seeking behavior led to the birth of the Gudalur Adivasi Hospital. This was set up under a new society – ASHWINI. Tribal youth were trained to staff the health program.	Eight health sub-centers were established to improve access to healthcare. Trained Adivasis manned both, the hospital and these centers. Health volunteers began working in over a hundred villages.	ASHWINI built a new hospital that opened its doors in 2009. Construction was completed and all basic equipment was installed by 2013. The 50-bed hospital is managed by the tribal team.

PROGRAM OVERVIEW

Coverage: Tamil Nadu • **Full-Time Program Staff:** 32 • **Budget (2014-15):** INR 1 Crore (USD 149,000)

▶ THE PROBLEM

Several barriers, including low levels of awareness, poverty, poor accessibility and discrimination, inhibit tribals in the Gudalur Valley from accessing public healthcare services.

▶ ASHWINI'S RESPONSE

ASHWINI provides holistic, community-based healthcare services for tribal groups, and enables them to take responsibility for their health. The organization also trains community members as medical and administrative staff, in order to empower the community to provide for its own healthcare needs.

WHAT DOES IT DO?

ASHWINI's maternal and child health program provides comprehensive healthcare to tribal communities in the area, and enhances their health-seeking behavior. This is done through:

- **Community Healthcare Program (CHP):** This operates through eight Area Centers that are managed by 15 health animators—men and women from the community who are trained as nurses. They work alongside health volunteers from each village. At village visits, the animators conduct antenatal and postnatal checks, monitor the nutritional status of children, provide counseling services and treat common illnesses. The Area Center provides primary curative care and maintains health records.

- **Gudalur Adivasi Hospital:** ASHWINI operates a hospital, staffed by the tribal community itself. The hospital has a blood bank, an operating theatre, a maternity ward, general inpatient and outpatient wards and a cancer-screening clinic. A majority of the hospital's services are provided for free or at a subsidized cost.

- **Training Program:** ASHWINI aims to transfer the ownership of the organization to the community it seeks to serve. To that end, it runs training courses for nurses, village health workers, office staff and other para-medical staff, in partnership with the Bharat Sevak Samaj, a vocational training organization.

KEY INTERVENTIONS

1. Train Community-Based Health Workers
2. Fill Gaps in Government Service Provision
3. Train Traditional Birth Attendants
4. Run Mobile Health Clinics
5. Deliver Nutrition Programs for Children
6. Improve Nutrition at the Community Level
7. Run Maternal and Child Health Awareness Programs
8. Build the Government's Capacity to Deliver Services
9. Improve Referral Care
10. Audit Government Health Service Provision
11. Conduct Research for Advocacy

■ Interventions undertaken ■ Interventions not undertaken

- ASHWINI serves 300 villages and hamlets in the Gudalur and Pandalur districts of Tamil Nadu, reaching a population of 20,000 tribals, of which 7,000 are women.

- When it began working in the region, less than 2% of pregnant women received antenatal check-ups (ANC), and 100% of women delivered at home. The infant mortality rate (IMR) was a staggering 250 deaths per 1,000 live births, until as late as 1998. In 2011, 90% of pregnant women received more than three ANCs, 80% of births were institutional deliveries, and the IMR rate was brought down to 24 deaths per 1,000 live births—less than half the national average. Maternal deaths rarely occur.

- Secure sustainable funding for maternal and child health services at the community and hospital level to facilitate well-planned and implemented programs.

- Improve the birth weight of newborns and address the heavy burden of malnutrition in children.

- Screen mothers for cancer, and decrease morbidity levels among mothers and children.

- Create a health training certificate course on topics of health and leadership for teenagers, to foster their leadership potential, and inculcate health-seeking behavior from a young age.

Health Animators on a field visit – conducting health check-ins at the village level.

QUALITY INDICATORS

Leadership
Dr. Shylaja Devi and Dr. Nandkumar Menon, Co-Founders

- Dr. Shyla has a MD in Obstetrics and Gynecology from the Trivandrum Medical College.

- Dr. Nandkumar is a Fellow of the American College of Surgeons, with medical training from Christian Medical College, Vellore and New York.

- Both have over 25 years of experience running community-based healthcare programs with marginalized communities.

Partnerships
- **Technical partners:** Bharat Sevak Samaj, ACCORD, Vidyodaya and Adivasi Munnetra Sangam (AMS).
- **Funders:** Tata Trusts, Poristes Stiftung, Cognizant Foundation and the Government of Tamil Nadu.

Awards & Endorsements
- Love for Service award, Tanker Foundation, 2016.
- Mother Theresa Memorial award for Social Justice, 2015.
- Humanitarian Services, Rotary, 2012.

VOICES FROM THE GROUND

"But for this work, the tribal community would probably not exist today. There was so much disease, death and discrimination - we could not sit next to or enter the home of a non-tribal. The challenge that 'we Adivasis can do it' has been my driving force. I joined ASHWINI after my tenth standard, and my work here has given me extensive knowledge. I am not a worker; I am a part of the whole movement and I have a sense of responsibility to keep this growing and to motivate the community to take ownership. Now I feel equal to anyone."

– **Patta, Finance Manager, ASHWINI**

VOICES FROM THE TEAM

"The community has completely taken responsibility for their own healthcare, showing that investing in people is the way forward for sustained development of a community. Our tribal staff and volunteers are instrumental in running the program, showing the true spirit of participation and ownership. Many preventable deaths have already been avoided, but efforts have to continue to improve the health status of the Adivasis, who have been exploited for generations."

– **Dr. Shylaja Devi, Co-Founder**

Ejkut

www.ekjutindia.org

NON PROFIT · 12 A · 80 G · FCRA

ORGANIZATION OVERVIEW

Founded: 2002 · **Head Office:** Chakradharpur, Jharkhand · **Coverage:** Bihar, Jharkhand, Madhya Pradesh, Odisha
Full-Time Staff: 80 · **Budget (2015-16):** INR 7.4 crore (USD 1.1 million)

Ekjut works with marginalized and tribal populations across Jharkhand, Madhya Pradesh, Bihar and Odisha, to improve maternal, newborn and child health and nutrition outcomes. It focuses on reducing maternal mortality, child mortality and malnutrition through interventions at the grassroots and policy level, including community mobilization, evidence building and strengthening of the public health system.

HOW DID IT EVOLVE?

2004	2008	2012	2013	2016
Ekjut undertook an experimental study and began working with 100,000 people in Jharkhand and Odisha, to reduce neonatal mortality.	Established proof of concept by demonstrating that its intervention reduced neonatal mortality by 45%.	Replicated its approach across two states working alongside the governments of Odisha and Madhya Pradesh.	Implemented the CARING Trial: an in-depth approach, to improve nutrition in two districts in Jharkhand & Odisha	Collaborated with the National Health Mission in Jharkhand to provide technical support to 40,000 Accredited Social Health Activists (ASHAs) and direct support to 1,300 women's groups on newborn care.

PROGRAM OVERVIEW

Coverage: Bihar, Jharkhand, Madhya Pradesh, Odisha • **Full-Time Program Staff:** 80 • **Budget (2015-16):** INR 7.4 Crore (USD 1.1 million)

▶ THE PROBLEM

Women and children in tribal and marginalized communities are susceptible to poor health outcomes due to ineffective governance, lack of access to healthcare and good health practices. These communities also face social discrimination and are viewed with suspicion by other communities.

▶ EKJUT'S RESPONSE

Ekjut adopts a community mobilization approach, driven by women and adolescent girls, to tackle issues on the ground and empowers them to develop sustainable solutions to address these issues. It uses a participatory approach to engage effectively with the community and thoroughly measures its impact.

WHAT DOES IT DO?

Ekjut operates in rural, remote geographies, with tribal and other marginalized communities and facilitates women's groups through its Participatory Learning and Action (PLA) methodology.

- Women's groups (approximately 25 women and girls) participate in monthly open group sessions, led by trained facilitators. These facilitators include women, adolescent girls and ASHAs, who are trained by Ekjut in the use of the PLA methodology.

- Women discuss community problems at these meetings and facilitators assist them in making decisions and solving problems. Ekjut is thus able to empower women to develop local approaches to tackle a host of issues, such as maternal and child morbidity and mortality, nutrition, adolescent health and gender-based violence.

- Participants are encouraged to identify and articulate the relation between the cause and effect of a problem, and analyze their actions and outcomes—so as to overcome a staunch traditional belief in destiny, among tribal communities.

- The PLA methodology is contextualized to suit low literacy levels and uses picture cards, physical demonstrations, games and plays - that are informative and fun for participants.

Ekjut uses robust and scientific impact evaluation systems, to assess the effectiveness of its programs. It publishes its research in reputed peer-reviewed journals, and thereby, advocates for the replication of its programs with key policy makers.

KEY INTERVENTIONS

1 Train Community-Based Health Workers

2 Fill Gaps in Government Service Provision

3 Train Traditional Birth Attendants

4 Run Mobile Health Clinics

5 Deliver Nutrition Programs for Children

6 Improve Nutrition at the Community Level

7 Run Maternal and Child Health Awareness Programs

8 Build the Government's Capacity to Deliver Services

9 Improve Referral Care

10 Audit Government Health Service Provision

11 Conduct Research for Advocacy

■ Interventions undertaken   ■ Interventions not undertaken

- Ekjut's PLA program has reduced neonatal mortality and maternal postnatal depression rates by 45% and 57%, respectively, between 2005 and 2008, with the most noteworthy impact recorded among extremely marginalized groups. Ekjut has replicated its program through partnerships in Odisha, Jharkhand, Bihar and Madhya Pradesh.

- PLAs, facilitated through ASHAs, reduced neonatal mortality by 32% in five districts in Jharkhand and Odisha.

- Ekjut engages over 30,000 women by directly facilitating women's groups. It also works through partner organizations in Madhya Pradesh and Bihar to reach 10,00,000 women.

- Ekjut plans to utilize the PLA methodology to tackle not just health issues, but the entire continuum of issues that plague its core constituents—tribal people and other marginalized communities.

- Ekjut will continue to conduct robust monitoring and evaluation to gauge the impact of its work and advocate for a systematic, community-driven approach to improve the life chances of women and children.

- The National Health Systems Resource Centre, New Delhi has invited Ekjut to serve as a technical advisor to public health and government officials, and address maternal and newborn health through PLAs in 10 states in India.

An open group PLA session facilitated through the use of easy-to-understand picture cards.

QUALITY INDICATORS

Leadership

Dr. Prasanta Tripathy and Dr. Nirmala Nair, Co-Founders

- Dr. Tripathy is a member of the Steering Committee for the National Health Mission, India.

- Dr. Nair has 38 years of experience in the medical and development sector.

Partnerships

- Funders: UNICEF, Sir Dorabjee Tata Trust, DFID, Wellcome Trust, USAID, Oak Foundation and Save the Children.

- Program Partners: Rural Livelihoods Mission (Madhya Pradesh, Governments of Jharkhand and Odisha.

- Nonprofit Partners: CINI, LEADS, PHFI and SNEHA.

- University College of London has been a strong research collaborator since 2004.

Endorsements

- WHO Global recommendation for Ekjut's PLA methodology of community engagement.

- impACT Trial of the Year award, 2011

VOICES FROM THE GROUND

"This process of learning together is a long-lasting, sustainable process which enables the community to identify its own health problems, discuss the root causes of challenges, find remedial solutions and use local expertize to ensure that it receives equitable healthcare. Through this process, the community chooses its own priorities, instead of being told what these are."

- Additional District Medical Officer, Keonjhar, Odisha

VOICES FROM THE TEAM

"Ekjut provides a systematic and supportive framework to harness the collective effort of women in different states in India. Our work gives voice to the otherwise voiceless, fosters inclusion, addresses inequities, enhances decision-making capacity and builds healthier communities."

- Dr. Prasanta Tripathy, Co-Founder
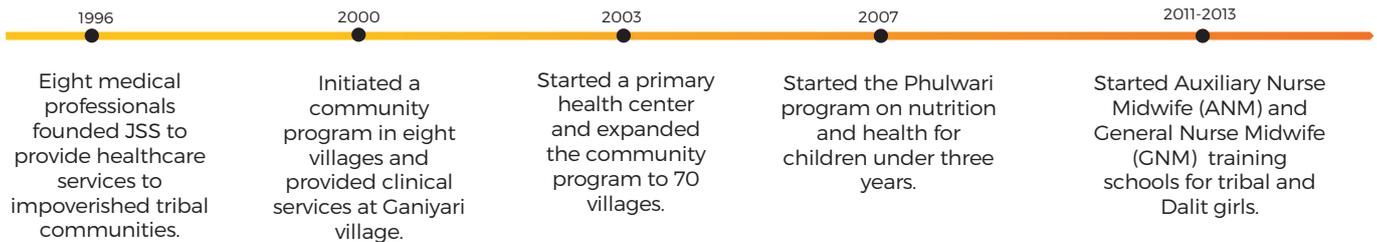
Jan Swasthya Sahyog (JSS)

www.jssbilaspur.org

ORGANIZATION OVERVIEW

Founded: 1996 · **Head Office:** Ganiyari, Chhattisgarh · **Coverage:** Chhattisgarh · **Full-Time Staff:** 222
Budget (2015-16): INR 7.8 crore (USD 1.1 million)

JSS caters to the healthcare needs of impoverished tribal communities by conducting research studies, implementing health programs, training local health workers and advocating with the government. It also runs three primary health centers and a hospital in Chhattisgarh.

HOW DID IT EVOLVE?

1996	2000	2003	2007	2011-2013
Eight medical professionals founded JSS to provide healthcare services to impoverished tribal communities.	Initiated a community program in eight villages and provided clinical services at Ganiyari village.	Started a primary health center and expanded the community program to 70 villages.	Started the Phulwari program on nutrition and health for children under three years.	Started Auxiliary Nurse Midwife (ANM) and General Nurse Midwife (GNM) training schools for tribal and Dalit girls.

PROGRAM OVERVIEW

Coverage: Chhattisgarh • **Full-Time Program Staff:** 55 • **Budget** (2015-16): INR 2 crore (USD 299,000)

▶ THE PROBLEM

Women and children in tribal areas lack access to quality healthcare services, given that they live in remote areas with limited government health facilities. The problem is compounded by rampant discrimination towards tribal communities, a lack of health awareness, poor nutrition levels and poverty.

▶ JSS'S RESPONSE

JSS works at both the community and institution level to provide healthcare services. It trains community and government health workers to improve the quality of care provided. JSS conducts research and collects evidence to advocate for policy change with the government.

WHAT DOES IT DO?

- **Community Care:** JSS trains community health workers in each village to monitor the health of pregnant tribal women and provide a minimum of four health checkups. These health workers also monitor the health of the mother and baby for six months, post-delivery. JSS conducts 11-12 clinical camps for tribal mothers and children, annually. It also runs a child nutrition program for children below three years at Phulwari (crèche) centers.

- **Institutional Care:** JSS runs a clinical program that includes inpatient and outpatient services. It operates an 82-bed hospital at Ganiyari village that offers maternal and child health services. This facility also offers tertiary care.

- **Stakeholder Training:** JSS trains health workers at its Ganyari facility. It runs several training programs for both government and community health workers, on a monthly basis.

- **Government Advocacy:** JSS works with the government to identify and address gaps in the existing care provider system through technical assistance and evidence-based research.

- **Technology Research:** JSS has a technology division that develops innovative healthcare products for health workers to monitor health conditions at the community level and improve delivery of care.

KEY INTERVENTIONS

1. Train Community-Based Health Workers
2. Fill Gaps in Government Service Provision
3. Train Traditional Birth Attendants
4. Run Mobile Health Clinics
5. Deliver Nutrition Programs for Children
6. Improve Nutrition at the Community Level
7. Run Maternal and Child Health Awareness Programs
8. Build the Government's Capacity to Deliver Services
9. Improve Referral Care
10. Audit Government Health Service Provision
11. Conduct Research for Advocacy

■ Interventions undertaken   ■ Interventions not undertaken

In 2014-15, JSS achieved the following:

- Provided medical services to over 3,500 tribal mothers and children, annually.

- Reached 1,200 children through the Phulwari program.

- Built the capacity of 110 Accredited Social Health Activists and 40 community health workers through training programs in reproductive and child health.

- Addressed the needs of 500 adolescent girls through sexual, reproductive and menstrual health awareness programs.

- JSS intends to improve the quality of its community healthcare program and expand it to two to three other villages. It is also keen to use an integrated healthcare approach that prioritizes non-communicable diseases.

- JSS plans to become a resource center for knowledge and training. It will use knowledge to advocate for policy change on issues such as tuberculosis, drug price control, sickle cell disease and hypertension.

Dr. Yogesh Jain demonstrating to community health workers how he screens a young child.

Leadership
Dr. Yogesh Jain, Co-founder and Director

- Dr. Yogesh Jain is a practicing public health physician with an MD in pediatrics from AIIMS, Delhi.

Partnerships
- **Partners:** AIIMS Delhi, Tata Institute of Social Sciences, Planning Commission, ASHA Mentoring Group, National Health Mission and Tribal Health Committee.

- **Funders:** Jamsetji Tata Trust, Sir Ratan Tata Trust, Oxfam India and Association for India's Development.

Awards & Endorsements
- Krishnadas Jaju award, for serving poor communities in Chhattisgarh, 2004.

- Governor's award, for serving rural-tribal communities, 2005.

VOICES FROM THE GROUND

"Jan Swasthya Sahyog provides consultations, medical investigations and surgery at their hospital. We were earlier told to run from one facility to another, but here everything happens in one place, and at an affordable price. These kinds of hospitals should be available in all districts."

– **Ramkali Baiga, Bahmani (Bilaspur District)**

VOICES FROM THE TEAM

"Over the years, we have learned that illnesses are a biological embodiment of deprivation. Thus, we use force multipliers of trainings (especially for middle-level health workers), action research and advocacy to address the health needs of the poor. All the work we do has an equity lens."

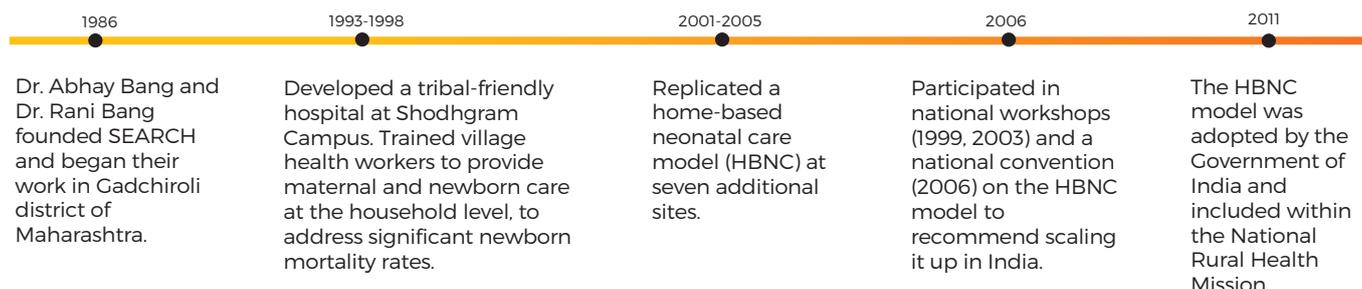– **Dr. Yogesh Jain, Co-Founder and Director, JSS**

Society for Education, Action and Research in Community Health (SEARCH)

www.searchgadchiroli.org

ORGANIZATION OVERVIEW

Founded: 1986 · **Head Office:** Gadchiroli, Maharashtra · **Coverage:** Maharashtra · **Full-Time Staff:** 97
Budget (2015-16): INR 4 crore (USD 597,000 million)

SEARCH primarily runs health programs in remote areas of Gadchiroli for tribal and rural communities. It conducts community-based research studies, facilitates training programs and runs a hospital. It uses research and evidence to drive policy change in tribal health, maternal and child health, as well as alcohol and tobacco abuse.

HOW DID IT EVOLVE?

1986	1993-1998	2001-2005	2006	2011
Dr. Abhay Bang and Dr. Rani Bang founded SEARCH and began their work in Gadchiroli district of Maharashtra.	Developed a tribal-friendly hospital at Shodhgram Campus. Trained village health workers to provide maternal and newborn care at the household level, to address significant newborn mortality rates.	Replicated a home-based neonatal care model (HBNC) at seven additional sites.	Participated in national workshops (1999, 2003) and a national convention (2006) on the HBNC model to recommend scaling it up in India.	The HBNC model was adopted by the Government of India and included within the National Rural Health Mission.

PROGRAM OVERVIEW

Coverage: Maharashtra • **Full-Time Program Staff:** 19 • **Budget (2015-16):** INR 29.3 lakh (USD 44,000)

▶ THE PROBLEM

Low levels of health awareness and a lack of access to quality health services severely impact the health of tribal women and children. Furthermore, government interventions in these areas are not closely monitored or evaluated, resulting in gaps in service delivery.

▶ SEARCH'S RESPONSE

SEARCH implements community-level interventions through community health workers, awareness programs and mobile clinics. It works closely with the community to understand their needs and designs interventions accordingly. SEARCH focuses strongly on evidence-based research to advocate for policy change.

WHAT DOES IT DO?

- **Community Care:** SEARCH-trained Arogyadoots (community health workers) screen pregnant women, as well as provide advice, referrals and one-on-one health education. Their services include managing birth asphyxia, identifying women-at-risk, as well as addressing issues such as hypothermia, breastfeeding problems, low-birth-weight babies and premature babies.

- **Institutional Care:** Arogyadoots refer omplex health issues that go beyond their skills to the SEARCH hospital. If required, cases are referred to the district hospital in Gadchiroli.

- **Stakeholder Training:** SEARCH operates a training facility for government agencies and non-profits that runs training-of-trainer programs to enhance the service delivery of health workers.

- **Policy Advocacy and Research:** SEARCH collects and evaluates the impact of newborn and child health services provided so as to identify new areas of research, in the field of maternal and child health. It draws the attention of decision makers by publishing research and delivering lectures.

KEY INTERVENTIONS

1. Train Community-Based Health Workers
2. Fill Gaps in Government Service Provision
3. Train Traditional Birth Attendants
4. Run Mobile Health Clinics
5. Deliver Nutrition Programs for Children
6. Improve Nutrition at the Community Level
7. Run Maternal and Child Health Awareness Programs
8. Build the Government's Capacity to Deliver Services
9. Improve Referral Care
10. Audit Government Health Service Provision
11. Conduct Research for Advocacy

■ Interventions undertaken   ■ Interventions not undertaken

- Developed an effective community-level model to manage childhood pneumonia and a home-based newborn care (HBNC) model to address high infant mortality rates in the region.

- A combination of these models has brought down the infant mortality rate in 39 SEARCH intervention villages from 120 (in 1988) to 30 (in 2003). The model was included within the National Rural Health Mission and replicated in over 20 Indian states, as well as by governments in six other countries.

- Provided maternal and child health services to 48 tribal villages and 131 non-tribal villages in Gadchiroli district, till date.

WHAT NEXT?

Key plans for SEARCH's tribal health program over the next three years include:

- Work with existing villages and increase the quality of care.

- Work with the government and use evidence-based research to influence policy change, at both the state and national level. It will also play a major role in scaling the HBNC model by supporting the government to train 800,000 Accredited Social Health Activists (ASHAs).

- Use an integrated community approach and work towards issues such as alcohol addiction, mental health and malaria. It plans to set up a tribal research center through which it can continue research on various tribal health issues.

Dr. Abhay Bang visits new mother Meena Dhit and her baby in her home in Bodli village, Maharashtra.

QUALITY INDICATORS

Leadership

Dr. Abhay Bang, Co-Founder and Director

- Dr. Abhay Bang is a public health researcher credited with developing the HBNC program.

- Served as a member of several committees, including the Scientist Advisory Board at Indian Council of Medical Research and the National Commission on Population

- Trained as a physician and completed a Master's degree in Public Health at John Hopkins.

Partnerships

- **Partners:** SEARCH is currently a member of several committees including Central Health Council, High Level Committee on Tribal People in India, Audit Advisory Board, National ASHA Mentoring Group, Tribal Advisory Council and the Government of Maharashtra.

- **Funders:** Tata Trust, MacArthur Foundation, Wipro Cares, Infosys Foundation and the National Rural Health Mission.

Endorsements

- Public Health Champion award for outstanding contribution to public health in the country, WHO India, 2016.

- Maharashtra Bhushan Puraskar, Government of Maharashtra, 2003.

VOICES FROM THE GROUND

"These women Arogyadoots have changed how things used to be in the past. Now I feel that there is support available for young mothers, that my mother did not have. There is someone to take care of me. I have more confidence now and less to worry about."

– **Beneficiary, HBNC program**

VOICES FROM THE TEAM

"If newborns and children cannot reach hospitals, we must go to where they are—their homes. No doctor can reach every home with a baby. Only the Arogyadoots, the angels of health, can do that."

- **Dr. Abhay Bang,
Co-Founder, Director, SEARCH**

Society for Education, Welfare and Action Rural (SEWA Rural)

www.sewarural.org

ORGANIZATION OVERVIEW

⬤ NON PROFIT ✓ 12 A ✓ 80 G ✓ FCRA

Founded: 1980 · **Head Office:** Jhagadia, Gujarat · **Coverage:** Gujarat · **Full-Time Staff:** 225
Budget (2015-16): INR 7.7 crore (USD 1.2 million)

SEWA Rural provides healthcare to tribal communities in Bharuch and Narmada districts of Gujarat. It works to improve the lives of tribal communities through a 150-bed tertiary care hospital, a comprehensive eye care program, a community-based healthcare project for mothers and children, a training center for frontline workers and activities focused on life skills development for men, women and adolescents.

HOW DID IT EVOLVE?

1980	1984-1999	2003-2011	2012 - Present
SEWA Rural was founded as a 30-bed hospital that provided curative care to the most vulnerable tribal populations of Jhagadia block in Gujarat.	Began working on preventive health by running a Primary Health Centre (PHC). Successfully transitioned PHC management to the government in 2000 (first such transition).	Began Safe Motherhood and Newborn Care project. In 2011, developed the Arogya Sakhi approach that engages the community through frontline workers.	Facilitated the transition of Arogya Sakhis to government frontline workers. Launched ImTeCHO, a mobile application, used to deliver continued community care across 45 villages in Gujarat.

PROGRAM OVERVIEW

Coverage: Narmada and Bharuch districts, Gujarat • **Full-Time Program Staff:** 225 • **Budget (2015-16):** INR 7.7 crore (USD 1.2 million)

▶ THE PROBLEM

Tribal mothers and children are particularly vulnerable to death and disease. In addition to limited healthcare access, availability and affordability, tribal communities are affected by poor health-seeking behavior, a trust deficit, superstitions and traditional beliefs that further contribute to poor health outcomes.

▶ SEWA RURAL'S RESPONSE

SEWA Rural bridges the gap between tribal communities and healthcare systems by bringing services to the community directly. It delivers timely and quality healthcare by establishing a strong community presence through frontline workers that are linked to a strong private and public referral system.

WHAT DOES IT DO?

SEWA Rural improves the lives of mothers and children through the following programs:

- **Kasturba Hospital** is a 150-bed tertiary-care hospital that offers affordable services to over 125,000 patients annually, across 5,000 villages. Its services include specialized care for women and children, clinics for diseases such as tuberculosis, diabetes, infertility and 24-hour emergency services that are supported by a well-equipped laboratory, X-ray and ultrasonography units.

- **Family-Centered Safe Motherhood and Newborn Care Project (FSMNCP)** is a community-based health project that aims to develop an evidence-based model to reduce maternal and newborn deaths. It achieves this by ensuring appropriate antenatal and postnatal care through community- and family-level interventions. It also focuses on sickle cell anemia, a highly prevalent disease in tribal populations. Programs are delivered through Arogya Sakhis and trained birth attendants that are supported by ImTeCHO–a mobile application, used to improve the performance of frontline workers, overcome bottlenecks and enhance service provision.

- **Health Training Center** provides on-going and refresher training to frontline workers from SEWA Rural, as well as other grassroots organizations, government staff workers and students. It trains approximately 1,000 trainees from over 50 organizations, annually.

KEY INTERVENTIONS

1	Train Community-Based Health Workers
2	Fill Gaps in Government Service Provision
3	Train Traditional Birth Attendants
4	Run Mobile Health Clinics
5	Deliver Nutrition Programs for Children
6	Improve Nutrition at the Community Level
7	Run Maternal and Child Health Awareness Programs
8	Build the Government's Capacity to Deliver Services
9	Improve Referral Care
10	Audit Government Health Service Provision
11	Conduct Research for Advocacy

■ Interventions undertaken   ■ Interventions not undertaken

- SEWA Rural has reached over 50,000,000 people till date.

- The FSMNCP intervention resulted in a 75% reduction of maternal deaths and a 38% reduction of newborn deaths over a period of seven years (2003-10). Additionally, it has influenced a significant increase in institutional delivery rates (from 29% to 65%) through community-based interventions.

- SEWA Rural uses technology to increase health worker coverage and improve health-seeking behavior amongst mothers. For example, in SEWA Rural adopted villages, 92% of mothers received at least three prenatal visits by the Accredited Social Health Activist (ASHA) in villages and 61% sought medical assistance from the ASHA for postnatal complications.

- Expand community health efforts in select primary healthcare centers (PHC). Having established its community presence through the FSMNCP intervention, SEWA Rural now aims to document and disseminate research and evaluation findings of this intervention. This will help to intensify advocacy efforts with the Government of Gujarat to expand SEWA Rural's reach in the state.

- Conduct a Randomized Control Trial (RCT) with a focus on building evidence for mHealth solutions. Examine effectiveness, efficiency and quality of care provided through the ImTeCHO mobile application.

- Expand mHealth coverage through ImTeCHO to an additional 300 villages (reaching a population of 300,000) within Bharuch and Narmada districts of Gujarat.

A frontline worker conducts a health information session with a pregnant woman and her family.

Leadership

- Medical doctors with an academic background in community medicine from leading universities such as Johns Hopkins and Emory.

- Specialists such as surgeons, gynecologists, ophthalmologists, pediatricians and public health experts.

Partnerships

- **Program Delivery Partners:** Government of Gujarat.

- **Technology Partners:** Argusoft India Ltd.

- **Funders:** Government of Gujarat, Jamsetji Tata Trust, MacArthur Foundation, WHO, and Indian Council of Medical Research.

Awards & Endorsements

- Best First Referral Unit in a tribal area, Government of Gujarat, 2011.

- Creative and Effective Institutions award, MacArthur Foundation (USA), 2007.

VOICES FROM THE GROUND

"SEWA Rural supports me to provide care for tribal mothers and children. Through on-going and refresher trainings, I am able to deliver healthcare that is reliable and timely. This is especially critical for high-risk pregnant women that would otherwise have limited access to healthcare."

– **Nayeedaben Vasava, ASHA from Timla, Gujarat**

VOICES FROM THE TEAM

"The SEWA Rural team has been working with and for the community over two decades at the grassroots level. We have been working closely with frontline workers and believe that most health workers want to do their best for their community. Through our community and technology interventions, we enable them to give their best through better support, motivation and supervision."

– **Dr. Pankaj Shah, Director, Community Health**
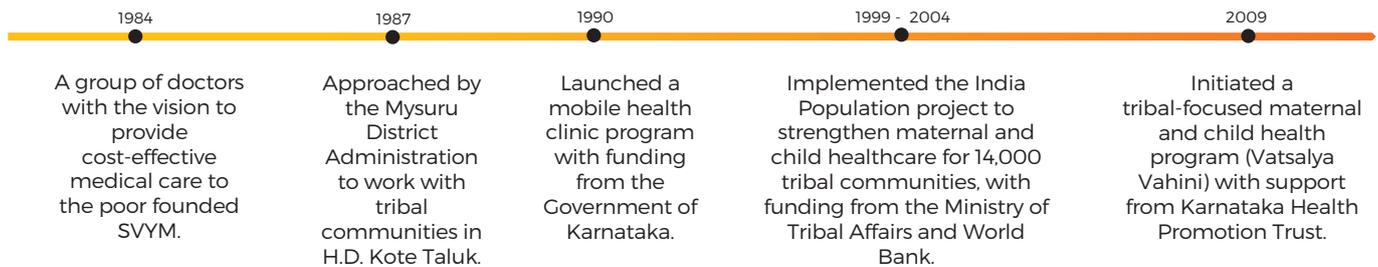
Swami Vivekananda Youth Movement (SVYM)

www.svym.org

ORGANIZATION OVERVIEW

⊘ NON PROFIT ⊘ 12 A ⊘ 80 G ⊘ FCRA

Founded: 1984 · **Head Office:** Saragur, Karnataka · **Coverage:** Karnataka · **Full-Time Staff:** 494
Budget (2015-16): INR 30 crore (USD 4.5 million)

SVYM runs eight institutions, including schools and hospitals, and has more than 50 programs in the areas of health, education, and socio-economic empowerment across Karnataka. It facilitates community efforts toward sustainability, self-reliance and empowerment through research, training local groups, and government advocacy.

HOW DID IT EVOLVE?

1984	1987	1990	1999 - 2004	2009
A group of doctors with the vision to provide cost-effective medical care to the poor founded SVYM.	Approached by the Mysuru District Administration to work with tribal communities in H.D. Kote Taluk.	Launched a mobile health clinic program with funding from the Government of Karnataka.	Implemented the India Population project to strengthen maternal and child healthcare for 14,000 tribal communities, with funding from the Ministry of Tribal Affairs and World Bank.	Initiated a tribal-focused maternal and child health program (Vatsalya Vahini) with support from Karnataka Health Promotion Trust.

PROGRAM OVERVIEW

Coverage: Karnataka • **Full-Time Program Staff:** 15 • **Budget (2015-16):** INR 14.2 lakh (USD 21,000)

▶ **THE PROBLEM**

Tribal mothers and children are especially susceptible to poor health outcomes, on account of a lack of availability and access to health services. This is compounded by poor awareness, mistrust of those outside the community, social discrimination and traditional beliefs.

▶ **SVYM'S RESPONSE**

SVYM collaborates with government health workers at both field and institution levels to create awareness about health conditions and improve systems and quality of care. It also builds the capacity of community members to serve as change agents and ensure sustainability of its programs.

WHAT DOES IT DO?

SVYM engages in the following interventions through its Mobile Health Unit and Vatsalya Vahini program:

- **Providing Care in Communities:** SVYM's Mobile Health Unit team visits communities six days a week to identify and register pregnant women, provide antenatal care, and offer treatment for diseases such as pneumonia, diarrhea, and tuberculosis. SVYM also conducts eight to ten clinical camps a year, for mothers and children.

- **Providing Institutional Care:** SVYM's 80-bed Vivekananda Memorial Hospital has safe motherhood clinics that offer services including antenatal, intrapartum and post-partum care and family planning. Pediatric services at the hospital include immunization, and treatment of anemia and common childhood diseases.

- **Training Stakeholders:** SVYM trains health workers twice a year on topics including reproductive, maternal and child health, as well as National Health Mission guidelines. It also trains leaders of self-help groups (SHGs) to serve as ambassadors of behavior change for institutional deliveries and child care.

- **Providing Program Support:** SVYM works with the government to help identify and tackle gaps in the existing care provider system through technical assistance, both at field and institution levels. It staffs two employees in each Primary Health Center (PHC) who help improve the quality of care and provide program support to government health workers.

- **Generating Awareness:** SVYM facilitates four to five awareness programs per month, on issues such as child marriage, immunization and nutrition, through focus group discussions, radio broadcasts and street plays.

KEY INTERVENTIONS

1	Train Community-Based Health Workers
2	Fill Gaps in Government Service Provision
3	Train Traditional Birth Attendants
4	Run Mobile Health Clinics
5	Deliver Nutrition Programs for Children
6	Improve Nutrition at the Community Level
7	Run Maternal and Child Health Awareness Programs
8	Build the Government's Capacity to Deliver Services
9	Improve Referral Care
10	Audit Government Health Service Provision
11	Conduct Research for Advocacy

■ Interventions undertaken ■ Interventions not undertaken

SVYM provides medical services to more than 7,500 tribal mothers and children annually.

In 2014-15:

- Reached about 20,000 tribals in both communities and hospitals through its Mobile Health Unit and Vatsalya Vahini programs.

- Built the capacity of 56 ASHAs, 48 ANMs and 31 Anganwadi workers by training them on reproductive and child health and delivery of care.

- Involved 10,793 community members in awareness activities such as street plays, health exhibitions and SHG meetings.

Key targets for SVYM's tribal health program over the next three years include:

- Expanding geographic coverage to the entire H.D. Kote taluk, reaching a total of 200,000 people and eight PHCs. Currently, the program covers 9,000 people in five PHCs.

- Strengthening collaboration with the Government of Karnataka, particularly through training an increased number of government personnel.

- Adopting a stronger focus on promoting institutional deliveries. Currently, the proportion of institutional deliveries in the community is about 85%, which the program aims to increase to 90-95% over the next three years.

A doctor in SVYM's mobile health unit screens the child of a tribal woman.

QUALITY INDICATORS

Leadership
Dr. M. A. Balasubramanya, Secretary and CEO
- Anesthesiologist by training and Founding Secretary of the Indian Medical Association, Saragur branch.
- Recipient of the Paul Harris Fellow award from Rotary International.
- Nominated by the town panchayat of Saragur as the Ambassador for Swacch Bharat Abhiyan.

Partnerships
- **Partners:** Ministry of Tribal Affairs, Government of India
- **Funders:** Bharat Petroleum Corporation Limited, Ministry of Tribal Affairs, Government of India, Government of Karnataka

Awards and Endorsements
- Best NGO India award, The Resource Alliance, 2015.
- Credibility Alliance India award for transparency and integrity in program reporting.
- Karnataka State Child Welfare award, 2008.

VOICES FROM THE GROUND

"The street play conducted by the SVYM team at our haadi (tribal colony) helped us learn about and understand mother and child health in a very simple way."

– **Mallesha, Basavanagiri Haadi**

VOICES FROM THE TEAM

"Putting tribal communities first is our motto. We strive to be inclusive of tribal culture and simultaneously nurture acceptance of modern scientific methods. In addition, complementing government resources and catalyzing government initiatives have been hallmarks of our interventions."

– **Dr. M.A.Balasubramanya, Secretary and CEO**

Swasthya Swaraj

www.swasthyaswaraj.org

ORGANIZATION OVERVIEW

⊘ NON PROFIT ⊘ 12 A ⊘ 80 G ⊘ FCRA

Founded: 2014 · **Head Office:** Bhawanipatna, Odisha · **Coverage:** Odisha · **Full Time Staff:** 31
Budget (2015-16): INR 1.93 Crore (USD 288,000)

Swasthya Swaraj aims to create a community-owned model of healthcare and education that empowers communities to take responsibility for their own health and well-being. It works in rural Odisha, where the public health system is almost non-existent, despite a critical need for healthcare services. Swasthya Swaraj implements a low-cost model of primary healthcare suited for tribal populations in the state.

HOW DID IT EVOLVE?

2013

Dr. Aquinas consulted various stakeholders in the Kalahandi district to identify areas in which to work. Based on these discussions, she decided to focus on the Thuamul Rampur block - an area most in need of healthcare provision.

2014

Organization was officially registered and received seed funding from Tata Steel, and a subsequent grant from the Tata Trusts, to establish its Comprehensive Community Health program.

2015

Expanded the health program to include TB and malaria control activities and converted weekly clinics into 24x7 health clinics.

PROGRAM OVERVIEW

Coverage: Odisha • **Full Time Program Staff:** 31 • **Budget (2015-16):** INR 1.93 crore (USD 288,000)

▶ THE PROBLEM

The Thuamul Rampur block is a predominantly tribal area where poverty, maternal and infant mortality rates are twice the national average. The area lacks government health systems, physical infrastructure and has abysmal literacy rates, with almost negligible female literacy.

▶ SWASTHYA SWARAJ'S RESPONSE

Swasthya Swaraj provides basic primary healthcare services to reduce mortality and morbidity among tribal populations. The program recruits and trains community members to take responsibility for their own health and well-being. The organization's goal is to create a sustainable program that the community eventually owns and operates.

WHAT DOES IT DO?

The Comprehensive Community Health program follows a three-tier structure of service delivery to ensure comprehensive primary care:

- **Primary Health Clinics** provide 24x7 healthcare and diagnostics facilities. Services are provided free of charge, but Swasthya Swaraj encourages its patients to pay a token amount so as to ensure that they value services provided. To secure community buy-in and keep infrastructure costs down, Swasthya Swaraj sets up clinics in buildings donated by the community.

- **Monthly Health Camps** are held in six fixed locations to serve populations in especially hard-to-reach areas. These camps are only for mothers and children and focus on improving maternal and child health, as well as reducing malnutrition and malaria, which are endemic in the region.

- **Village Health Workers** called Swasthya Sathis are selected from each of the 75 villages that Swasthya Swaraj works in and are trained to diagnose common diseases, provide essential treatment and disseminate health education.

A major focus of the program is to educate and empower communities in the region to take responsibility for their own health. Swasthya Swaraj has selected and trained a group of 20 literate boys, called Shikhya Sathis, to act as community mobilizers and educators. They focus on increasing demand for health services, improving health-seeking behavior and enhancing preventive healthcare practices.

KEY INTERVENTIONS

1 Train Community-Based Health Workers

2 Fill Gaps in Government Service Provision

3 Train Traditional Birth Attendants

4 Run Mobile Health Clinics

5 Deliver Nutrition Programs for Children

6 Improve Nutrition at the Community Level

7 Run Maternal and Child Health Awareness Programs

8 Build the Government's Capacity to Deliver Services

9 Improve Referral Care

10 Audit Government Health Service Provision

11 Conduct Research for Advocacy

■ Interventions undertaken ■ Interventions not undertaken

- Since 2013, over 9,000 patients have visited Swasthya Swaraj clinics. It reaches out to 75 villages through its community programs, covering a population of 15,000 people. Approximately 90% of its beneficiaries are tribal.

- While it usually takes organizations years to establish enough trust to get tribal communities to access their health services, Swasthya Swaraj was able to do so within a few months. Its clinics receive a large number of patients and on average, each clinic serves over 100 beneficiaries, every week.

- Approximately 90% of Swasthya Swaraj's staff members are recruited from the community itself. It trains community members to take over both clinical and management roles in the organization.

WHAT NEXT?

- Strengthen its program by adding technology components such as mobile tablets that will be used to communicate with beneficiaries and capture real-time data.

- Purchase equipment such as ambulances and X-ray machines to improve the quality of its clinical services.

- Pilot various non-formal education initiatives to provide essential life skills to adolescents, school-going and out-of-school children and nurture them as agents of change within their communities.

- Expand its health program to provide community-based care and prevent severe malnutrition among children under five.

Swasthya Swaraj staff conducting a community awareness meeting.

QUALITY INDICATORS

Leadership

Dr. Aquinas Edassery, Founder and Executive Director

- Medical doctor, former faculty member and board member of St. John's Medical College, Bangalore.

- Over 10 years of experience in community healthcare.

Partnerships

- Funders: Tata Steel (seed funding), Tata Trust, Department of Health and Family Welfare, Government of Odisha and SELCO Foundation.

- Program Partners: Jan Swasthya Sahyog (JSS), Christian Hospital, Bissamcuttack and Society for Community Health Action, Research and Advocacy (SOCHARA).

VOICES FROM THE GROUND

"When people ask me what reward I get in return for working as a Swasthya Sathi, I tell them that my greatest reward is the happiness and knowledge that I am able to bring to many families when I help them in their hour of need and teach them what I learned at Swasthya Swaraj."

– Mahadei Majhi, Swasthya Sathi

VOICES FROM THE TEAM

"In remote tribal areas, when we see victims of scandalous degrees of poverty that they can do nothing about, when children fall victim to tuberculosis, when so many children die of under nutrition or malaria—how can we as doctors and health professionals not be disturbed? We must commit ourselves to an ongoing fight against the injustice and inequalities that produce this situation. We are trying to make Swaraj (freedom) a reality for the poorest of the poor, something they are not even able to dream of now."

– Dr. Aquinas Edassery, Founder and Executive Director

APPENDICES

Dasra's expertise lies in recognizing and working with non-profits that have the potential to create impact at scale. Dasra strongly believes that the strength of an organization comes from its people, and has ingrained this philosophy in its due diligence process. Consequently, an organization is assessed not just on the basis of its program, but also on the potential of its leadership and management team. In order to identify such organizations, Dasra follows a comprehensive three stage due diligence process.

Phase I – Sector Mapping

· The process involves undertaking an exhaustive sector mapping and compiling a list of non-profit organizations working in the sector.

· Based on quantitative and qualitative secondary research, references from previous experience, and inputs from sector experts, the work carried out by the organizations is categorized under specific interventions.

· Organizations implementing programs with the most scalable and impactful interventions are screened from this universe against criteria such as – program focus, outreach, team, budget, scale, impact and growth plan.

Through sector mapping for this report, Dasra mapped over 200 non-profits across India.

The design for this report is inspired by Indian tribal motifs but is not meant to be representative of all tribal art.

Conversion Rate (used for this report): USD = INR 67 .

Phase II – Detailed Assessment of Organizations Based on Phone Calls and Site Visits

Dasra conducts a detailed assessment of the screened organizations by making a one-two day site visit to understand the work being done on the ground and spend time with the leadership and management team of the organization.

An organization profile is prepared to capture the current work and achievements of each organization and provide a sense of the future growth of the organization as a whole.

Organizations are evaluated using the Dasra Capacity Assessment Framework (DCAF), a tool that Dasra has developed to assess organizations against three key areas – leadership potential, organization strength and program effectiveness.

Dasra conducted phone calls with 40 non-profits that work to improve maternal and child health outcomes in tribal communities and identified 12 organizations on whom detailed diligence was conducted – either through site visits to these organizations or by building on Dasra's existing knowledge about these organizations.

Phase III – Final Shortlisting

• Dasra Capacity Assessment Framework (DCAF) and organization profiles are used to evaluate the program strength, organization potential and areas where Dasra can add value through its capacity building support.

• Members from Dasra's advisory research and diligence team, as well as senior management, participate in the shortlisting process to identify eight to ten high impact and scalable non-profits to be profiled in the report.

Eight non-profits were shortlisted to be profiled in this report, based on the strength of their programs to improve maternal and child health outcomes in tribal communities, the potential of their organization and the vision of their leadership.

Dasra re-engages with the final shortlisted organizations to create robust growth plans, and works with the organizations to explore funding opportunities. Dasra also offers peer-learning and capacity building opportunities to these organizations through two-three day, residential workshops.

APPENDIX - II

Acronyms

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
CHC	Community Health Center
ICDS	Integrated Child Development Services
IMR	Infant Mortality Rate
MMR	Maternal Mortality Rate
MCH	Maternal and Child Health
NRHM	National Rural Health Mission
PHC	Primary Health Center
PLA	Participatory Learning and Action
RDA	Recommended Daily Allowance
ST	Scheduled Tribes
UNICEF	The United Nations Children's Emergency Fund
WHO	World Health Organization

Glossary

Accredited Social Health Activists (ASHA) is a community health workers instituted by India's Ministry of Health and Family Welfare as part of its National Rural Health Mission.

Anganwadi Worker (AWW) is a health worker chosen from the community and given four months of training in health, nutrition and child-care. She is in-charge of an Aanganwadi or daycare centre for children.

Auxiliary Nurse Midwife (ANM) is a trained health care provider who conducts outreach and provides services to women and children in the community.

Community Health Center (CHC) is the third tier of the network of rural healthcare institutions, required to act primarily as a referral center for the neighboring primary health centers for patients requiring specialized health care services.

Integrated Child Development Services (ICDS) is an Indian government welfare program, which provides food, preschool education, and primary healthcare to children under six years and their mothers. These services are provided through Anganwadi centres established mainly in rural areas and staffed with frontline workers.

Primary Health Center (PHC) is the first point of contact between individuals and a qualified medical doctor. Each PHC is linked to approximately six sub centers (a population of approximately 30,000) and is typically a single-doctor clinic with about six inpatient beds as well as facilities for delivery, family planning (including sterilizations), minor surgeries and limited laboratory testing.

Stunting is a measure of height to age. A stunted person will be significantly shorter than is expected for their age. It is the long-term cumulative effect of malnutrition, and increases the likelihood of illness and poor health, reduces cognitive development, and lowers economic productivity.

Underweight is a measure of weight to age. This indicator is often used as a basic indicator of the health status of a population.

Wasting is a measure of weight to height. Because weight can change more quickly than height, wasting measures the current nutritional status of an individual, and can be an indicator of both acute short-term reduction of food intake and stunting.