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engaging communities to improve health and nutrition outcomes:
the role of community volunteers in inhp

care ®

Engaging Communities to Improve Health and Nutrition Outcomes: The Role of Community Volunteers in INHP

Abstract

Background and Interventions

INHP adopted a multiple volunteer per village model, with one volunteer serving the immediate neighborhood of about 20-30 households to rationalize volunteer workloads and to ensure cultural compatibility. Capacities of these volunteers, called Change Agents, were built through a mix of structured training events and on-the-job support by AWW of the ICDS program and ANM of the health programs. In about 10 percent of villages where INHP first started implementing interventions, called the demonstration sites, NGOs played a significant role by providing training and follow-up support to the Change Agents, while the AWW and ANM and their supervisors directly supported Change Agents in the later, replication sites, utilizing the experience from the demonstration sites. Change Agents were trained to communicate key information related to maternal and child care and feeding to families, and to mobilize them to utilize services provided on fixed-day, fixed-site Nutrition and Health Days (NHDs). This paper details the RACHNA's experience with Change Agents and discusses the relevance of the experience for other large-scale community volunteer programs, particularly within the context of Maternal and Child Health and Nutrition (MCHN).

Methods

Information about Change Agents was drawn from the baseline and endline surveys, the rapid assessments in one district each in the eight program states, evaluation research conducted in one program district each in Uttar Pradesh and Andhra Pradesh with non-CARE districts as controls, program monitoring information, and from the report of a study conducted after the final evaluation of INHP-II to assess the contribution Change Agents and program management tools and processes introduced by the project.

Results and Discussion

About 250,000 Change Agents and other community level were identified, trained and supported across about 50,000 *Anganwadi* centers by the end of the program. The actual pace of introduction of Change Agents varied from state to state. About 86 percent were women or girls, three quarters reported that they were less than 35 years old, 80 percent were currently married and three and about two thirds could read and write. About 16 percent of Change Agents met the basic criteria of ASHA, as laid down by the National Rural Health Mission.

When assessed at the endline, the Change Agents had reasonably good levels of knowledge on most of the key behaviors. They were effective in bringing those eligible for services; however, less than 20 percent mentioned talking to women about health and nutrition during the NHD which was one of their key envisaged roles. The data from the sample of replication sites in the second round of periodic rapid assessment surveys in late 2004, when the emphasis on Change Agents had reached its peak, showed that the contacts made by AWWs and ANMs were far greater than those made by Change Agents and most of the women who reported having been visited at home by Change Agents had also been visited at home by AWW or ANM during the same period. These findings were among the important reasons for reducing emphasis on Change Agents for home contacts in the remainder of the program life.

Background

The RACHNA program

The RACHNA program of CARE India included two USAID-supported projects: the second phase of Integrated Nutrition and Health Project (INHP-II), which focused on child health and nutrition, and the *Chayan* project, which supported interventions for promoting birth spacing and the prevention of transmission of HIV/AIDS among groups at high risk. INHP-II, built upon the lessons and experiences of the first phase, was implemented in 747 Integrated Child Development Services (ICDS) blocks[1] in 78 districts across nine states[2] from October 2001 to December 2006 to complement the maternal and child health and nutrition (MCHN) efforts of the ICDS and the Ministry of Health and Family Welfare (MoHFW) programs. To achieve its goal of "sustainable improvements in the nutrition and health status of seven million women and children", INHP-II adopted a two-track approach – supporting service providers to improve the quality and coverage of MCHN services and systems and engaging communities to support better infant feeding and caring practices and sustain activities for improved maternal and child health and survival. The implementation was facilitated by small program teams of CARE, located at the district, state and national levels, and working closely with the functionaries of the ICDS program and the programs of the MoHFW, and with a range of partners, including local NGOs and Community-Based Organizations (CBOs). The main strategies were strengthening of existing systems, behavior change communication and capacity building. A detailed description of the program can be found in the paper, *Program Description,* in this series.

Community health volunteers have been the central pillars of success in several, usually small, NGO programs across the world. They have often been established as alternatives to inefficient or ineffective or at times, non-existent government public health delivery systems and have played a crucial role in promoting community ownership and empowerment. Examples of community volunteer engagement in large-scale public health programs are less common and evidence around their effectiveness in such contexts is unclear and inconclusive. In India, recent large-scale efforts include the *Mitanin* program of the Government of Chhattisgarh, the National Rural Health Mission's (NRHM) Accredited Social Health Activist (ASHA) initiative across a large number of states and CARE's experience of Change Agents under the RACHNA program across nine states. RACHNA was an umbrella program of CARE India, supported by USAID, consisting of the INHP and the *Chayan* project. Across the paper, the term RACHNA is used where approaches and results pertain both to the Integrated Nutrition and Health Project and the *Chayan* projects whereas specific reference to either INHP or *Chayan* is made where approaches and results pertain to the specific project.

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[1] A block is an administrative sub-unit of a district, having a population of around 100,000, and often larger. An ICDS block is usually identical to the administrative block, and comprises about 100 *Anganwadi* Centers (AWC). Not all blocks in a district and not all villages and hamlets within a block may be served by the ICDS program. INHP-II was designed to be implemented only in ICDS-served blocks, but did not necessarily cover all ICDS blocks in the districts where it was implemented.

[2] These include Andhra Pradesh (AP), Bihar (BI), Chhattisgarh (CG), Jharkhand (JH), Madhya Pradesh (MP), Orissa (OR), Rajasthan (RA), Uttar Pradesh (UP) and West Bengal (WB). Since the program was implemented in Bihar only from late 2004 onwards, results presented are only from the other eight states.

INHP promoted a variety of approaches to engage communities around MCHN issues with the overall purpose of generating demand for services, creating an enabling environment to promote and sustain behavior change, and to hold service providers accountable for services, supplies and information and to help local problem solving. These included engaging CBOs, local governance bodies, the Panchayati Raj Institutions (PRIs) and a cadre of community volunteers called Change Agents. A set of processes were initiated and tools such as Social Maps and Community Based Monitoring were developed to help these community groups to both monitor and facilitate the reach of services and information, and to help families adopt positive maternal and childcare behaviors.

Although several community engagement approaches outlined above were used in INHP-II, this paper details the project's experience with Change Agents and discusses the relevance of the experience for other large-scale programs, especially the ASHA initiative under the NRHM. This paper examines the role and contributions of the Change Agents within the context of MCHN. While recognizing the possible contributions of community volunteers to longer-term social change and transformation, it does not delve into that domain.

The Change Agent Approach

INHP established Change Agents with the objective of having, at the community level, a cadre of volunteers to contribute to improving MCHN outcomes through better utilization of services by minimizing exclusion, and more importantly to promote and sustain the critical behavior change needed to affect MCHN outcomes. The name, Change Agent, reflects their envisioned role. A significant point that needs highlighting is that although local NGOs were contracted to recruit, train and support the Change Agents initially, all aspects of the Change Agent approach from recruitment to sustenance was transitioned to the ICDS, the Health systems and the PRIs when the program went to scale.

This section briefly describes the evolution of the Change Agent strategy and its scale-up, the expected roles of Change Agents, and INHP's approach to their selection and training.

Evolution and Scale-up

The strategy of using community level volunteers in the RACHNA Program evolved over a long period. The concept of recruiting and training Change Agents originated during INHP-I[3], the first five-year phase of INHP, as part of an intensive package implemented in selected *Anganwadi* Centers (AWCs)[4] in each of the INHP states to demonstrate behavior change. To rationalize volunteer workloads and to minimize "cultural mismatch", INHP adopted a 'multiple volunteers per village' model, with one volunteer serving her immediate neighborhood of about 15-20 households. The Change Agents were not paid.

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[3] INHP-I was implemented from October 1997 to September 2001.
[4] *Anganwadi*, literally a courtyard play center, is a childcare center, located within the village itself. A package of following six interventions is provided under ICDS scheme: supplementary nutrition, non-formal pre-education, immunization, health check-up, referral services and nutrition and health education.

The social recognition, satisfaction of "doing community good" and the sense of empowerment were considered important motivating factors to sustain their activities beyond the project life.

The concept, tested in multiple contexts, emerged as one of the several best practices identified by the external INHP-I final evaluation and recommended by the subsequent INHP-II design consultations for replication at scale during INHP-II. Each state, and sometimes different districts, gave the Change Agents a different name – *Sakhi* in Uttar Pradesh, *Mitanin* in Chhattisgarh, *Pragati mitrlu* in Andhra Pradesh, *Saarathi* in Orissa, *Paribartankari* in West Bengal, to list a few. This provided the necessary local flavor and ownership. A phased approach to scaling up Change Agents was adopted. During year 1, it was planned to establish Change Agents in all 'demonstration sites'[5] in each of the INHP's 747 blocks, i.e., in approximately 10 percent of villages in each block. During years 2 and 3, it was planned to expand the Change Agent model to about 30 percent of AWCs in the program universe and in years 4 and 5, i.e. by the end of the program, to about 50 percent of the AWCs. In terms of absolute numbers, this meant approximately 47,500 AWCs.

However, informed by internal reflections, evidence from periodic assessments and the mid-term review, INHP decided to make a greater level of effort to support the AWWs and Supervisors for behavior change than the Change Agents. All data, with the exception of Kanker district in Chhattisgarh, consistently highlighted that home contacts by *Anganwadi* Workers (AWWs) far exceeded those by the Change Agents. Given that the pace of building Change Agents was slow, the intensity of effort was high, and the urgent need to achieve change of a magnitude that would effect MCHN outcomes at scale, INHP made a conscious decision to focus its efforts on supporting the AWWs and the Supervisors with tools and messages to reach the right person, at the right time with the right MCHN messages. Change Agents were positioned as one of the several good practices that systems could develop and use to solve operational problems that come in the way of improving service uptake and household behaviors.

Roles of Change Agent

A Change Agent, under the guidance and support of the AWW and the Auxiliary Nurse Midwife (ANM), was expected to perform the following roles:

- Keep contact with the households having pregnant women or lactating mothers and children under two years, among the assigned households, and ensure their enrolment at the AWC

- Counsel for care during pregnancy and facilitate the planning for safe childbirth by the families of pregnant women

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[5] Demonstration sites are INHP-II AWCs that hold a Nutrition and Health Day (NHD) at least once a month, have a community group that manages nutrition and health activities, have at least three active Change Agents and have other need-based innovations.

- Preferably, be present at every child birth in the assigned households, to ensure clean and safe delivery practices, early and exclusive breast feeding and warmth. Make frequent visits to households with a newborn during the first week of birth and then weekly for one month, to identify the danger signs needing referral and to support the mother and other household members in adopting the positive behaviors, with a special focus on the weak newborn

- Facilitate exclusive breast feeding and complementary feeding and assist mothers and family members to overcome simple barriers in practicing these

- Track and counsel households with children below two years in their neighborhood for immunization, growth promotion as well as on the need and options for birth spacing and family planning with support from ANM (as described elsewhere, the role in family planning work was formally limited to *Chayan* states)

- Actively participate in the NHD activities, including ensuring that no one from their neighborhood misses out on the health and nutrition services

- Be depot holders for Iron-folate (IFA), Oral Rehydration Solution (ORS) and contraceptives, if appropriate and interested

- Actively participate in encouraging community-based monitoring of ICDS and Health programs.

By keeping expectations simple and clear, chances of success were sought to be maximized. Change Agents were not expected to maintain complicated registers or provide medical care services, like distribution of medicines, administering vaccines or undertaking health check-ups.

The Selection of Change Agents

Change Agents were identified and selected through a participatory approach, involving active opinion leaders in the communities (such as members of community organizations and teachers), as well as the AWW, ANM, and Panchayat members, as appropriate. In demonstration sites and at least part of the replication sites, social maps were used to ensure that Change Agents from hamlets and marginalized socio-economic groups were included. ICDS functionaries - AWW and Supervisors - led the selection process for Change Agents. In demonstration sites, NGOs provided close facilitation support in the selection process. Box 11.1 outlines the selection criteria for Change Agents as determined at the outset.

Given the role of Change Agents especially in influencing household behaviors, the importance of selecting individuals who were actual or potential *opinion* leaders in the community, such as members from Self-Help Groups (SHGs), women members of the PRIs, members of the *Mahila Mandals*, active youth members, adolescent girls and interested male members was recognized.

Box 11.1: Criteria for selection of community members to become Change Agents	
Essential	**Desirable**
• Accepted by the community • Having leadership qualities • Socially active and interested in volunteering • Residents of the hamlet/cluster that would be assigned to them • Sensitive to vulnerabilities of target population • Committed to the welfare of the neighborhood • A positive outlook	• Ability to communicate well with other community members • A good mix of male and female Change Agents in every village, including couples • Representation from various castes/tribes of the village • A mix of young, and elderly persons • Ability to read and write

Capacity Building and Support

Transforming lay community members into resource persons for communicating and counseling on health and nutrition behaviors with their fellow community members was a large and complex task. Capacities of Change Agents were built through a mix of structured training events and on-job support by the supervisors, AWWs and ANMs. These focused on:

- Enabling them to internalize the correct information and messages for promoting critical positive behaviors affecting MCHN

- Helping develop simple communication, problem solving and negotiation skills

- Helping them understand their role and the need to work closely with the AWW and the ANM

- Encouraging their voluntary spirit.

Structured training

Structured classroom training was relatively brief – a total of about six to nine days, divided into three rounds of two to three days each, and was delivered over a six month period. It was conducted for batches of 20 to 30 Change Agents each. Centrally produced generic training modules were adapted locally in every state and district to suit local dialects and customs, and different trainer backgrounds. Each round of training concluded with an "action planning session" with the AWWs, and at times also the ANMs, to plan out field-work and coordination. This ensured operationalization of their engagement immediately after the training.

The contents and modules followed a "life-cycle" approach. Typically, pregnancy and newborn care issues were covered in the first round, infant feeding and immunization in the second round and a review of these topics and family planning issues in the third round. The emphasis was two-fold, focusing on visiting homes to deal with each child and mother individually, and focusing on ensuring full utilization of services available from the AWW and ANM. The time in between the training rounds enabled the Change Agents to practice what they had learnt and come back with questions based on field experience. The training approach encouraged causal thinking and problem-seeking and solving,

rather than merely passing on information, and explicitly included approaches to sustain motivation as volunteers. The AWWs and ANMs in turn, were trained on the concept of a "Change Agent" and how to recruit, support and motivate them. By design, their training preceded the training of Change Agents. A visual job aid for counseling, adapted to local culture and locally field-tested, was also provided to each Change Agent.

In demonstration areas, the NGOs played a significant role in conducting the training and post-training follow-up for Change Agents along with the AWWs and the ICDS Supervisors, whereas in replication areas, the Change Agents were primarily supported by the government system, by the AWWs and the ICDS Supervisors. The existing training teams constituted at district and block levels by INHP, the District Training Team and the Block Training Team respectively,[6] were responsible for training the Change Agents from the replication areas, using resources provided by the RACHNA program. These training teams had a significant representation of the NGOs who were involved in developing Change Agents in the demonstration sites. The contents of training and the materials used were the same for demonstration areas as well as replication areas. However, the intensity of monitoring the quality of training was less when larger numbers were being trained from the replication areas.

Ongoing support mechanisms for skill upgradation and motivation

Two important elements recognized as critical to the Change Agent approach were the need to promote community ownership of this initiative, and to provide strong support systems for motivation and upgradation of the knowledge and skills of the Change Agents. It was envisaged that in demonstration sites, NGO field staff, the ICDS and health program staff would offer the needed support, whereas in replication sites, this responsibility would be entirely that of the ICDS and health system's program staff. The mechanisms identified included (illustrative):

- On the job support by the AWWs and ANMs to the Change Agents to improve their communication skills and ability to use communication aids. In the demonstration sites, NGOs appointed village level animators, one per 5-10 villages, and a block level coordinator to interface with Change Agents on a regular basis through field visits, village level meetings and get-togethers at block levels.

- A monthly half-day session or review meeting of Change Agents with the AWW and/or ANM to reinforce critical behaviors, discuss the problems faced, the frequently asked questions in the community, the barriers to behavior change, and solutions.

- Use of the monthly, quarterly block/sector meetings to monitor functioning, and refreshing knowledge.

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[6] The District Training Team (DTT) typically consisted of a group of people with recognized training skills and experience, nominated by the District Level Advisory Committee (DLAC) where the District Collector was the chairperson. The trainers were drawn from Health and ICDS training institutes in the same or neighboring district, senior program officials, and experienced external resources persons from academic bodies or NGOs. The role of these teams was to initiate the "cascade" by providing trainer's training to the Block Training Team (BTT). In turn, the BTT was constituted by experienced supervisors of ICDS and health programs, medical officers of Primary Health Centers, CDPOs and local NGO personnel, and they trained everyone at the block level and below, including Change Agents and other community members. At places, there was a further cadre of trainers below the BTT. In practice, CARE district team members, particularly the CBO (Capacity Building Officer) and DPO (Demonstration Partnership Officer) actively participated in both forums as the situation demanded.

- Recognition by PRIs, CBOs and AWW supervisors of the well performing Change Agents, during review meetings.

- Linking Change Agents to different government schemes meant for the poor, e.g., income generating and self-employment schemes, vocational training etc., as possible ways of recognizing their contributions. In some states (Chhattisgarh and Madhya Pradesh), Change Agents were encouraged to contest *Panchayat* elections, and substantial numbers also got selected as ASHAs.

Methods of Assessment

Evidence used in this paper comes mainly from program monitoring information systems and from a number of large sample surveys conducted over the life of the program for monitoring and evaluation purposes. This section describes the methodology of these surveys in brief.

Baseline and Endline Surveys

Baseline and endline surveys of INHP-II provided state-level estimates for selected indicators. The endline survey of INHP-I (early 2001) served as the baseline survey of INHP-II. The INHP-I endline for Bihar served as the baseline for Jharkhand and the Madhya Pradesh endline served as the baseline for both Madhya Pradesh and Chhattisgarh, since the new states of Chhattisgarh and Jharkhand were created from a division of the erstwhile Madhya Pradesh and Bihar respectively, just prior to the INHP endline survey.

INHP-I consisted of three kinds of program areas based on intensity of interventions and effort: the "High Impact" blocks, "Capacity Building blocks" and "Other blocks". The 2001 survey was designed to generate separate estimates of these three areas through a multi-stage sampling design: a fixed number of blocks and Primary Sampling Units (AWCs) were randomly picked from each of the three areas; 540, 540 and 832 respondents (mothers of children 0-23 months old) were selected from these arms, respectively using a pre-determined random selection process. The interview tool was common to all children 0-23 months, and covered all interventions supported by INHP – antenatal, natal and newborn care, infant feeding and immunization. State-level estimates, derived by applying population weights to the three areas, are used for all comparisons with the endline, without reference to the three kinds of program areas.

The endline survey of INHP-II (early 2006) used a multistage sampling design, but this differed in some respects from the baseline. The respondents (mothers of children 0-23 months old), were drawn from two groups. The mothers of children 0-5 months of age were asked questions related mainly to antenatal, natal and newborn care and breastfeeding, while mothers of children 6-23 months old were interviewed with questions mainly related to complementary feeding and immunization. This helped minimize recall bias and capture more recent events, likely to have been influenced by program interventions. The sample size for each group was sufficient to detect a 10 percentage points difference in an estimate with 95 percent confidence limits and 80 percent power, and an assumed

maximum design effect of 1.8. The numbers of Primary Sampling Units (PSUs) and blocks selected in each state varied according to the birth rates, being higher in states with lower birth rates. Blocks were selected in a manner that ensured proportionate representation of urban, rural and tribal blocks, and PSU selection within a block ensured the proportionate representation of demonstration sites (DS)[7], replication sites and other sites. Sampling frames were generated for children 0-5 months and 6-23 months old by prior house-listing and the target sample picked by circular systematic sampling, making allowance for a non-response rate of 15 percent. For each group, the target number to be completely interviewed was 733. Effectively, this resulted in a virtually self-weighted sample for each state.

Periodic Rapid Assessments (RAPs) in the Panel Districts

In order to monitor progress in outcomes to inform program strategies, a panel of one district from each of the eight states was established in 2003, where three rounds of periodic assessments were conducted between 2003 and 2005 at approximately annual intervals. The universe for these assessments was the first phase replication sites (the first batch of 25 percent AWCs in the district where at-scale implementation began).

Mothers of children 0-5 months of age were interviewed on antenatal, natal and newborn care and breastfeeding, while mothers of children 6-23 months old were interviewed on complementary feeding and immunization. Round 1 had a two-stage design, first randomly selecting five blocks from each district, and then five PSUs from each block, followed by selecting a fixed number of 0-23 months old from each PSU, whose mothers were respondents. The target sample size was 150 for children 0-5 months old and 450 for children 6-23 months old. Rounds 2 and 3 used a one-stage design, directly picking 90 PSUs from the universe, spread across all blocks in the district, and then randomly selecting the target sample (460 each for the two age groups: 0-5 and 6-23 months) from a sampling frame generated by house-listing after allowing for a 15 percent non-response. The latter samples were sufficient to detect a difference of 10 percentage points in estimates of two surveys with 95 percent significance and 80 percent power, assuming a small design effect. The estimates from the first round were therefore expected to be less precise than those for the subsequent rounds, particularly for the smaller sample of the 0-5 month group. The tools used in Round 1 were modified to add more questions and refine existing ones, while ensuring maximum comparability.

The Newborn Evaluation Research

A newborn evaluation research (NER) study was conducted by the Johns Hopkins Bloomberg School of Public Health, to assess the impact of the INHP intervention package when implemented at scale, on neonatal mortality, using a quasi-experimental design. The study covered one program district, Barabanki in Uttar Pradesh, using non-RACHNA ICDS sites in Unnao district for comparison, and

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[7] As described in the paper, *Program Description*, a Demonstration Site (DS) was an AWC that held an NHD every month, had a community group that managed nutrition and health activities, had at least three active Change Agents and had other need-based innovations. The DS were largely supported by local NGOs, and served to demonstrate how these "best practices" were to be implemented, thus facilitating their replication to the rest of the district. The AWCs beyond DS that were reached by end-2004 were termed Replication Sites (RS) and the rest as "Others", in order to provide a sense of the duration of RACHNA interventions in different AWC.

lasted about 30 months. The baseline survey was conducted in mid-2003 and the endline survey was contemporaneous with the RACHNA program endline survey in early 2006. Two smaller "adequacy" surveys were conducted at intervals between the baseline and endline surveys. This study was the only source of neonatal and infant mortality data in INHP.

More detail of these surveys and related information is available from the paper *Methods Used for Assessments in the RACHNA program*, in this series.

In all surveys, for all antenatal and newborn care practices assessed at the household level, data for mothers having a child up to six months of age has been used in order to minimize recall bias about perinatal events. This pattern was followed even for the evaluation research study, although data is available for a longer period of recall from these surveys. The use of a narrow age group also helps detect more recent change, which is helpful in understanding the effects of interventions that were rapidly scaled up over the last three years of program life, and hence were expected to produce greater effects later in the course of the intervention. Since the program interventions focused on home-based care for newborns, and since the program did not involve interventions for improving institutional care of the newborn, analysis is largely limited to those children born at home. Home births constitute the bulk of all births in most states, so the effect on sample size is small except in Andhra Pradesh and West Bengal, where larger proportions of births were institutional. For a few selected indicators, hospital births were separately analyzed, particularly in the Andhra Pradesh and West Bengal contexts.

With implementation and assessment experience, more refined and specific indicators were introduced. Thus the endline survey has far more detailed information on processes and outcomes than the baseline.

In tabulating and presenting results, estimates of indicators are presented separately for each district or state as the case may be, and in most cases, the average program-wide estimates are not emphasized. This pattern has been followed to retain the focus on individual states and districts, among which there is considerable variability.

Also, statistical significance tests are not presented for most primary results, such as when comparing estimates for indicators across baseline and endline surveys, or across rounds of periodic rapid assessments. Most of the surveys were large sample surveys, designed to detect differences of 10 percentage points or more between two comparable rounds. While confidence intervals or p-values could have been presented, this would have made the already large tables, each bearing results from eight states or districts, even less user-friendly. Instead, the authors have taken the view that it is safe to assume that a difference of 10 percentage points or more between rounds is likely to be statistically significant in most cases, and that showing statistical significance for differences of less than 10 percentage points may not be convincing from a program perspective. Thus, descriptions of results also generally distinguish between

differences of 10 percentage points or more (as being statistically significant and programmatically relevant in most cases), and lesser differences (as being not convincing in most cases). While this approach oversimplifies the presentation of results, it should help the general reader interpret results more easily. More experienced and interested readers will look deeper, in any case.

Coverage and Functionality

This paper draws from a number of different sources of information about Change Agents. The baseline and endline surveys,[8] the periodic rapid assessments[9] (RAPs) in one district each in the eight program states, evaluation research[10] conducted in one program district each in Uttar Pradesh and Andhra Pradesh, along with non-CARE districts as controls, the program monitoring system and an assessment of CARE India's INHP tools and Change Agents.

The endline survey and the second and third rounds of RAPs included Change Agent interviews[11] to obtain information about their levels of knowledge and functionality and AWW interviews[12] to understand the participation and support of Change Agents in health and nutrition activities. The program monitoring and information system provides information on the number of community members, including Change Agents trained and the number of AWCs with Change Agents. The assessment report provides qualitative information on the role and contributions of Change Agents, factors affecting these, and the lessons learnt. Put together and triangulated, these sources provide reliable information for drawing inferences and lessons learnt.

Coverage and the Pace of Scale Up

Program-wide, 63 percent of the AWWs reported at endline that they had Change Agents in their coverage areas to whom specific households had been assigned - ranging from 50 percent in Rajasthan to 83 percent in Chhattisgarh (Table 11.1); about 59 percent of them reported that they had at least three Change Agents. As per these estimates, about 250,000 Change Agents were identified, trained and supported across 50,000 AWCs by the end of the program. The actual pace of introduction of Change Agents varied from state to state. The monthly reporting system presents

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[8] The INHP and *Chayan* projects had separate baseline and Endline surveys. The Endline survey of INHP-I was conducted in 2001 and served as a baseline for INHP-II and the Endline for INHP-II was conducted in 2006.

[9] Three rounds of periodic rapid assessments were conducted in one district in each state, called the panel district, between 2003 and 2005 to monitor progress in outcomes to inform ongoing program strategies.

[10] Two Evaluation Research studies were conducted by Johns Hopkins Bloomberg School of Public Health to assess the impact of INHP intervention package using a quasi-experimental design.

[11] 1,238 Change Agents were interviewed.

[12] AWWs from across the program universe (about 150 per state, on an average) were interviewed.

Table 11.1: **Estimated number of Change Agents by state as per the Endline survey (2006)**

State	Total no. of AWCs**	Proportion of AWCs having Change Agents* (%)	Mean no. of Change Agents per AWC*	Total estimated no. of Change Agents
Andhra Pradesh	10,008	57.7	4.9	28,296
Chhattisgarh	12,833	94.2	2.94	35,541
Jharkhand	13,582	72.6	4.08	40,231
Madhya Pradesh	4,860	66.9	3.15	10,242
Orissa	10,556	73.1	4.37	33,721
Rajasthan	8,769	60.0	3.98	20,940
Uttar Pradesh	15,677	65.9	4.05	41,841
West Bengal	13,180	51.1	5.21	35,089
All India	**89,465**	**67.6**	**3.96**	**245,901**

*From interviews of a sample of AWW
**From program monitoring data. These figures do not include Bihar

a similar picture. It indicates that approximately 48,000 AWCs (51 percent of total areas) had at least three Change Agents in place by the end of the program, ranging from 21 percent of AWC in Rajasthan to 78 percent in Chhattisgarh.

While the program had met its target of having Change Agents in place in about 50 percent of the program areas, mid-course, INHP shifted the level of effort and focus from the universal establishment of Change Agents to utilizing other systems to promote behavior change. As explained earlier, the intensity of effort required to recruit and train Change Agents was tending to overshadow other program components, and making such levels of effort unsustainable in the face of the program commitment to reach a certain scale with improved nutrition and health outcomes by the endline. After considerable debate and dialogue with the state governments, with many in state leadership positions wanting a massive expansion of the Change Agents program, particularly in anticipation of the ASHA, eventually INHP state teams reduced emphasis on the Change Agents in the last year and hence, as expected, there were major reductions in number of community members trained during the last two years which is reflected in

Figure 11.1: **Year wise and cumulative distribution of number of trained community members, Program Monitoring Reports.**
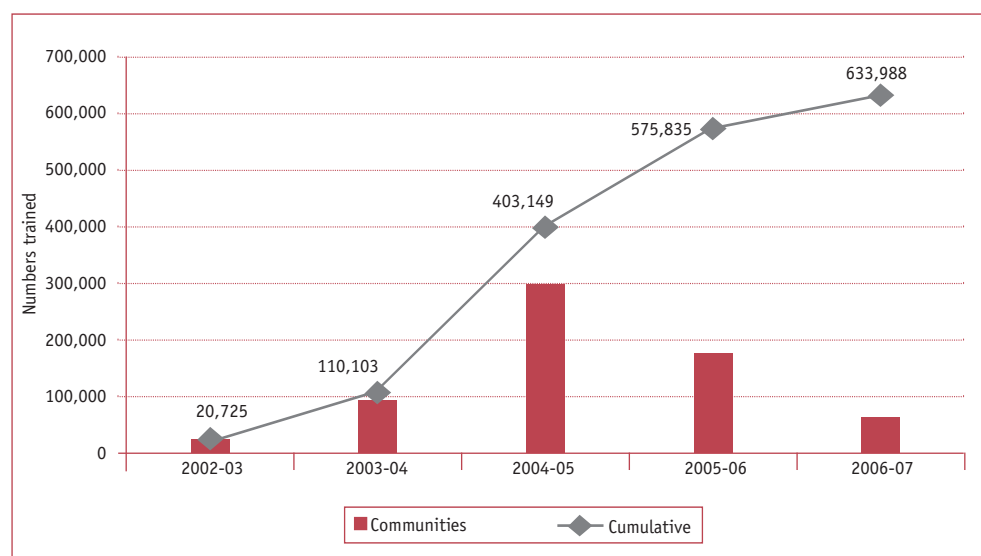
Figure 11.1. The numbers include Change Agents, and include total number of trainees across several rounds of training, counted as many times.

The Profile of Change Agents

Information from Change Agent interviews provides useful insights into some aspects of the socio-cultural profile of Change Agents. This is presented in Table 11.2.

Table 11.2: **Socio-cultural profile of Change Agents, Endline survey (2006)**

State	AP	CG	JH	MP	OR	RA	UP	WB	All India
Total no. of Change Agents interviewed	*202*	*101*	*103*	*187*	*207*	*72*	*96*	*270*	*1,238*
Sex									
Male	1.5	10.9	12.6	28.3	3.4	4.2	4.2	27.8	13.7
Female	98.5	89.1	87.4	71.7	96.6	95.8	95.8	72.2	86.3
Age in years									
"<18"	10.4	2.0	5.8	1.1	0.0	0.0	2.1	3.0	3.3
18-25	48.0	30.7	36.9	16.0	27.5	12.5	7.3	28.9	28.0
26-35	33.7	44.6	44.7	49.2	44.9	31.9	46.9	43.0	42.6
36-45	4.5	16.8	10.7	21.4	22.7	30.6	35.4	17.0	18.3
>45	3.5	5.9	1.9	12.3	4.8	25.0	8.3	8.1	7.8
Educational background									
No Schooling	38.1	23.8	27.2	21.9	39.6	51.4	46.9	16.7	30.6
0-4	12.9	8.9	23.3	11.8	19.3	8.3	6.3	16.7	14.4
5-9'	33.2	50.5	32.0	36.9	32.4	31.9	32.3	43.7	37.1
10+	15.8	16.8	17.5	29.4	8.7	8.3	14.6	23.0	17.9
Marital status									
Single	11.9	17.8	20.4	34.6	3.9	2.8	9.4	15.7	15.2
Currently Married	85.6	78.2	77.7	59.9	92.7	86.1	78.1	81.0	80.2
Others	2.5	4.0	1.9	5.5	3.4	11.1	12.5	3.4	4.6
% Change Agents as members of SHG	53.0	61.4	57.3	56.5	79.7	58.3	64.6	32.1	55.7
% Change Agents who were TBAs	9.4	14.9	3.9	10.1	11.2	15.3	13.5	3.4	9.2
% Change Agents who were Panchayat member	6.4	14.9	4.9	19.7	3.4	4.2	2.1	9.9	8.7
Working as Change Agents since									
4+ years	3.0	5.0	8.7	4.8	2.4	0.0	4.2	1.1	3.3
3+ years	7.9	6.9	1.0	13.9	15.0	11.1	4.2	6.7	9.0
2+ years	24.8	19.8	6.8	20.3	22.7	15.3	29.2	20.0	20.6
1+ years	23.8	37.6	36.9	28.9	26.6	38.9	29.2	31.9	30.3
< 1 year	35.1	21.8	42.7	19.8	29.5	30.6	30.2	33.7	30.5
Don't Know	5.4	8.9	3.9	12.3	3.9	4.2	3.1	6.7	6.4
No. of households assigned to Change Agents									
Mean	18.7	28.6	25.1	20.3	20.4	19.3	28.7	25.2	22.7
Median	12	24	25	20	18	20	25	22	20
Mode	10	20	20	20	20	20	25	20	20
% Change Agents who fit the basic selection criteria of ASHA[1]	5.0	19.8	14.6	23.0	15.0	12.5	26.0	18.5	16.4

[1] According to NRHM guidelines, the ASHA worker must be a woman between 25 and 45 years, educated at least until 8th class in school, and a resident of the same village. The educational limit may be relaxed when suitable candidates are not available

Overall, about 86 percent were women or girls, 80 percent were currently married and three quarters of them reported that they were less than 35 years old. About two thirds could read and write. Less than 10 percent were also Traditional Birth Attendants (TBAs) and a similar proportion were PRI members. More than half, including most of the TBAs and the *Panchayat* members were members of SHGs.

Change Agents were expected to come from all sections of the community so as to facilitate the tracking and inclusion of pregnant women and young children for services from their respective communities. As per the INHP tools and Change Agents assessment report "in some areas, the social maps were used to select Change Agents from each section of the community and ensure that everyone was covered." The report also mentioned "in that Uttar Pradesh (UP), respondents acknowledged that it was often difficult to recruit Change Agents from the Scheduled Caste community *because they have no time...*", suggesting that, at least in some instances, the most marginalized groups might not have had representation in the form of Change Agents.

Where Change Agents were selected, the allocation of households apparently followed the norms originally envisaged. The Change Agents interviewed at the endline reported that they covered a mean of about 23 households (and a median of 20), with a range of 19 in Andhra Pradesh to 29 in Chhattisgarh and Uttar Pradesh. The average number of Change Agents per AWC (Table 11.1), however, indicates that the typical AWC or village having Change Agents in place was able to cover about half the village (assuming that a typical AWC has about 150-200 households). Apparently, local factors such as training loads and budget constraints seem to have led to recruiting and training fewer Change Agents than actually required to cover entire villages at a norm of 20 households per Change Agent.

Training and Levels of Awareness

INHP invested huge efforts in building community capacity around MCHN. It trained about 634,000 community members on newborn care, nutrition and immunization essentials and their potential roles in the program. These included Change Agents, CBOs and the *Panchayat* members (Figure 11.1). The Management Information Systems (MIS) does not provide exact number of Change Agents recruited and trained, since reporting formats required reporting of number of Change Agents trained, but did not record the total number of Change Agents recruited. Given that Change Agents were trained in multiple rounds, it is not possible, at an aggregate level, to estimate the number of Change Agents who underwent all rounds of training. Similarly, it is equally difficult to determine the numbers who became inactive over time, since not being paid volunteers, there was no easy way to monitor how active each Change Agent was.

In the endline survey, among the Change Agents who were interviewed, 87 percent confirmed that they were trained in health and nutrition. Table 11.3 lists what the Change Agents spontaneously recalled regarding what was taught to them during training. This reflects the emphasis they perceive from both the training they

Table 11.3: **Training received as reported by Change Agents, Endline survey (2006)**

Training received by area of health and nutrition of children under two years of age	Percent of interviewed Change Agents
Advice and care during pregnancy	91.0
Advice for delivery and care of newborn	73.6
Breastfeeding and complementary feeding of child	42.8
Immunization	26.1
Others	6.2

received, in some cases 3-4 years earlier, and the issues currently emphasized by the AWWs, Supervisors and ANMs.

Change Agents were also asked a series of questions to test their understanding and awareness of desirable health and nutrition practices. Table 11.4 shows the proportion of Change Agents who demonstrated technically correct understanding of such practices. About 85 percent of them said nothing should be applied to the cord stump at birth, ranging from 75 percent in West Bengal to virtually all in Jharkhand. About 57 percent knew the right age for starting solids. However, this was found to be low in UP (25 percent). Around half of them said that breastfeeding should continue beyond two years, and a similar proportion knew the correct practices of giving more liquids during diarrhea and more solids when recovering from diarrhea. About 42 percent could tell the right age for administering the first mega dose of vitamin A, however, only 23 percent could tell the right age for the second dose. When asked what they would advise a pregnant woman about safe delivery at home, about two-thirds recalled each of the different "cleans" and half recalled immediate drying-wrapping. About 40 percent mentioned early and exclusive breastfeeding when asked how one might avoid infecting a newborn after birth. When asked about what time of pregnancy they were told to visit pregnant women at home, over two-thirds mentioned the third trimester. Over half of them said they had been told to visit a newborn on the day of birth. When asked about the appropriate time to visit a home to ensure complementary feeding is being given, over half mentioned 6-8 months of age. This data reflects reasonably good levels of knowledge on most of the key behaviors.

Table 11.4: **Proportion of Change Agents with correct knowledge of key childcare behaviors, Endline survey (2006)**

Indicator	AP	CG	JH	MP	OR	RA	UP	WB	All
Total no. of Change Agents interviewed	*202*	*101*	*103*	*181*	*207*	*72*	*96*	*259*	*1,221*
Vitamin A 1st dose at 9 months/with measles	43.1	59.4	68.0	40.9	37.7	38.9	54.2	23.6	*41.8*
Vitamin A 2nd dose at 15 months/18 months	5.0	48.5	51.5	23.5	16.4	27.8	45.8	13.6	*23.6*
Applying nothing to cord stump at birth	76.7	90.1	99.0	86.3	91.0	84.7	95.8	75.4	*85.2*
Applying nothing to umbilicus after drops cord	75.2	86.1	98.1	82.0	89.8	83.3	87.5	74.1	*82.7*
Starting water from 6 months	68.3	64.4	86.4	67.0	73.0	54.2	62.5	70.6	*69.3*
Starting liquids other than breast milk from 6 months	62.9	57.4	70.9	70.3	64.7	65.3	43.8	84.7	*67.9*
Starting semi-solids from 6 months	52.5	47.5	68.0	56.8	49.5	54.2	25.0	78.0	*57.0*
Continuing breastfeeding until 24 months	55.9	35.6	85.4	32.8	64.0	34.7	36.5	56.2	*52.0*
Advising more breastfeeds for diarrhea	69.3	78.2	55.3	58.6	31.8	51.4	39.6	36.3	*50.6*
Advising more semi-solids after recovery from diarrhea	58.4	60.4	60.2	55.9	31.7	41.7	40.6	23.5	*44.0*

Figure 11.2: **Mean hours spent per month on activities related to being a Change Agent, self reports, Endline (2006).**

Functionality

The key to Change Agents becoming functional was the level of their interaction with the AWW and ANM, particularly the former. At the endline interviews, Change Agents were asked how frequently they had meetings with the AWWs. From self-reports, this appears to have happened very frequently. In most states, over 60 percent reported to have interacted at least once a week while in the remaining states over 40 percent reported to have interacted once a week with AWWs. It is possible that this includes meeting the AWW at the NHD as well as informally, although the sense of question was a formal meeting.

The Change Agents were asked how much time they spend on the activities related to being a Change Agent. Overall, almost 60 percent reported that they perform Change Agent related work on less than five days a month, and 80 percent on less than 10 days. In terms of hours of work put in per month, the mean is around 15 hours, i.e., on an average, a Change Agent spends half-an-hour every day carrying out activities related to their roles, with little variation from state to state (Figure 11.2). This compares well with the estimated 13 hours a month expected from a Change Agent.[13] A point that needs recognition is that it is not the quantum of time but on what aspects they spend time that is important. Frontline workers can play a key role in guiding Change Agents on allocating more time to the critical tasks, e.g., visit to a newborn.

Contribution to Program Outcomes

While it is difficult to estimate directly the contribution of Change Agents to the program outcomes, a number of indirect measures serve as good indicators of the contribution of Change Agents to MCHN outcomes.

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[13] Assuming a catchment of about 25 families per Change Agent, it is estimated that a Change Agent would, on an average, every month spend about four hours on a typical NHD, about two hours prior to the NHD to remind families, another two hours on a take home ration day to distribute food supplements and about five hours to undertake house to house visits in the 10 prioritized homes, i.e., half-hour each. This amounts to about 13 hours.

Role in Service Delivery

One such indicator is their participation in NHDs. About 76 percent of Change Agents reported participating in the last NHD that happened in the village, which also shows a high level of continuing involvement. When asked what they did at this NHD that they attended, about two-thirds mentioned that they helped call women and children for services to the NHD and an equal proportion said they assisted the AWW in distributing food supplements. This indicates their contribution in bringing eligibles into the service fold. However, less than 20 percent mentioned talking to women about health and nutrition during the NHD which was one of the key envisaged roles. Field observations largely match the prioritization that this indicates. Most AWWs and ANMs are happy to have volunteers who help them call women and children to avail services, and counseling is not their priority on a busy NHD.

The above is substantiated with qualitative information from the INHP tools and Change Agents assessment which highlights "in all the areas visited, respondents reported that Change Agents made an important contribution by facilitating the early registration of pregnant women". It points out "another one of Change Agents' major contributions was to visit the homes of drop-outs and those due to be immunized around the time of the NHD and motivate them to come to the AWC. In many settings, the Change Agents would remind women a few days prior to the NHD to return for vaccination. The Change Agents were often vocal and articulate women who used all means to bring people to be immunized". It also highlighted that "many, perhaps most, of the messages given by Change Agents related to motivating people to use a service. This included tetanus toxoid, children's immunizations, iron tablets, or vitamin A."

Role in Behavior Change

Home contacts

Another indicator for measuring contributions to outcomes is the proportion of mothers reporting during household surveys that they were visited by or advised by Change Agents on some aspect of their own or their children's care. Respondents were asked in the RAPs, in the evaluation research as well as at the endline surveys, about whether AWW, ANM or anyone from the same neighborhood or village visited them at home during different periods of pregnancy and infancy to advise about caring or feeding.

The first indications of how Change Agents were contributing to home visits and counseling came from the second round of RAPs in late 2004, when the emphasis on Change Agents had reached its peak. The contacts made by AWWs and ANMs were found to be far greater than those made by Change Agents. For example, during the last trimester of pregnancy, contacts by Change Agents were in the range of 2.1 percent to 24.7 percent as compared to contacts made by AWW/ANM which were in the range of 12.6 percent to 47.6 percent (Figure 11.3); during the 6-11 month period, contacts by Change Agents were in the range of 0.7 percent to 21.5 percent compared to contacts made by AWW/ANM in the range of 11.8 percent to 59.2 percent. The pattern was similar for other critical life cycle periods such as the first postnatal week or in the month prior to interview

Figure 11.3: **Home contacts by Change Agents vs AWWs/ANMs in the last trimester of pregnancy, Periodic Assessments, Round 2 (2004).**
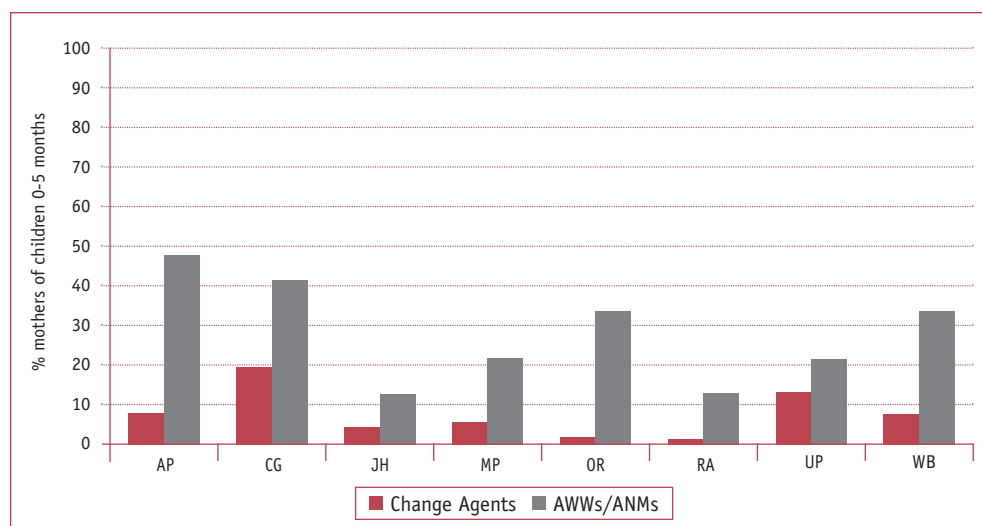
(not shown). All those women who reported having been visited at home by Change Agents had also been visited at home by AWW or ANM during the same period. These findings were among the important reasons for reducing emphasis on Change Agents in the remainder of the program life. The highest proportion of women reporting home visits by Change Agents was in Kanker, the panel district of Chhattisgarh, and here, virtually twice as many women reported that they had been visited by either the AWW or the ANM.

Similar patterns were seen again in all districts except Kanker (Chhattisgarh) in the third round of RAPs conducted in late 2005. In Kanker district, the contribution of Change Agents stood out, equaling or in some cases exceeding that of AWW and ANM. About 15 percent of the women who had never been visited at home by AWW or ANM reported being visited by Change Agents in Kanker. No other district came close. One obvious explanation was that the *Mitanin* program of the state government in Chhattisgarh had provided a strong motivating force for the volunteers. In addition, approaches such as 'Meets for Empowerment, Learning and Action' (MELA) promoted by INHP, provided a platform for volunteers to interface with families and service providers and this possibly lent to increase in their capacity and motivation levels. It was expected that similar findings would emerge at the endline survey, where Change Agents in all of Chhattisgarh state would be shown to have outperformed Change Agents elsewhere. When the results of the

Table 11.5: **Comparative performance of Change Agents vs AWW/ANM related to home contacts during pregnancy and 0-11 months of child's age, Endline survey (2006)**

Home contacts during	AP		CG		JH		MP		OR		RA		UP		WB	
	CA	AWW/ ANM	CA	AWW/ ANM	CA	AWW/ ANM	CA	AWW/ ANM	CA	AWW/ ANM	CA	AWW/ ANM	CA	AWW/ ANM	CA	AWW/ ANM
Last trimester pregnancy	10.9	75.8	8.0	56.7	5.0	53.8	9.0	45.7	10.0	53.1	3.6	29.7	11.7	55.0	5.3	43.8
Previous months (0-5 months)	9.5	77.9	15.6	57.1	4.9	54.5	9.4	37.2	6.4	47.2	5.4	23.8	16.9	68.3	7.3	49.6
Previous months (6-23 months)	3.5	73.7	2.3	52.2	3.4	65.6	4.0	41.1	2.5	44.4	2.2	26.0	9.0	67.2	4.5	51.8

Denomination not shown. Approximate range 650 to 700 for each state.

endline survey came in (Table 11.5), however, it became clear that, at least in terms of home visits, *Mitanins* were no more active in Chhattisgarh than Change Agents in most other states, and that the relative contribution of Change Agents was rather low compared to that of AWWs and ANMs across all the program state. However, this should be interpreted against the backdrop that this assessment was undertaken about a year after the decision to reduce emphasis on Change Agents, and only about 60 percent of the universe had Change Agents at the end of the program.

Additional channels for communication

While the data shows that the Change Agents visited the same homes visited by AWWs/ANMs, their contacts would have possibly contributed to reinforcement of optimal behaviors or to problem solving. According to the INHP Tools and Change Agents assessment, *"Change Agents reported that many of the messages they gave to women were supported by messages the women received from the AWW, the hospital and other sources. It is clear that the Change Agents serve as a way to reinforce messages from other channels. At the same time, the credibility and status of the Change Agent is enhanced when her messages are supported by medical staff."*

Another aspect, which emerges from qualitative information, is the fact that Change Agents were talking about key messages to secondary audience e.g. fathers, mother-in-laws as well. The report mentions that some Change Agents felt their role was not only to talk to the specific mother, but also her elders who may have more decision-making authority.

According to the Change Agent assessment report, Change Agents' perceived their main responsibility as being to call people for immunizations, especially during NHDs and not to make home visits or counsel women on specific behaviors. They also saw their key responsibility as "convincing people" of important messages.

The qualitative assessment points out that Change Agents' contacts might more frequently have been *ad hoc* conversations when collecting water or when they saw the women in the neighborhood, rather than more structured home visits, pointing to some possible under reporting. However, analysis of data related to "any contacts" made by Change Agents and specific home contacts, does not indicate much difference. Therefore, under-reporting if any, is likely to be small.

Some conclusions can be drawn with regard to their contributions. There is indirect evidence on their role in calling families to avail critical services. With respect to home contacts, their contributions appear to be small. However, they have a possible role in reinforcing of messages and not just with primary but also with secondary audience such as mothers-in-law. Hence they emerge more as mobilizers to improve service delivery and an additional communication channel for reinforcing key messages rather than doing door-to-door counseling to promote behavior change.

Lessons from the INHP Experience: Implications for other Large-scale Programs

Given that INHP implemented the Change Agents approach for about three years and the full program universe was not covered before the approach was de-emphasized, and the fact that this paper focuses only on the contributions of

Change Agents to MCHN outcomes, a number of questions arise. Are we judging their contributions too early? Given more time, would the results have been any different? Are there factors that could have been, or can be better managed? Are we judging the contributions of volunteers too narrowly? After all they could be playing more important roles in social transformation, or in sustaining MCHN behavior change by reinforcing critical messages within families and communities but undetected by the amendments used. How do we measure or assess such contributions? What is the contribution of their social mobilization efforts to MCHN outcomes achieved in INHP-II? If these measurements cannot be made in a reasonable timeframe, how do we justify the role of volunteers in large programs? What implications does this experience have for the ASHA initiative? Although INHP's experience and evidence might be insufficient to conclusively answer all these questions, they do provide important pointers with respect to recruitment, training and ongoing support, roles, motivation and effectiveness.

One of the biggest lessons learnt is that the intensity and level of effort required to build Change Agents was unsustainable for a large-scale program with a time-bound, outcome-oriented approach. Even with minimal support and the six to nine day training, it is very difficult and expensive to implement a community volunteer strategy at program scale. The pace of progress is slow and, in the short term, it may not be possible to see concrete results relative to the level of effort. In comparison, the system's adoption of a more results-oriented, problem-solving way of functioning possibly including the use of Change Agents as one of the ways of solving operational problems, brought about change at a faster pace and proved more critical in the achievement of results, especially behavior change aspects. A longer-term approach with adequate resources may be required for building and sustaining successful community volunteers.

Another significant learning has been that a more balanced level of effort dedicated to community engagement and strengthening systems is critical throughout the life cycle of a program. Although INHP was able to make mid-course corrections and strike a better balance, such major changes in focus might not be possible for public programs to make, at least not rapidly.

Conclusions and specific lessons may be summarized as follows:

1. Selection
- Despite the different ways of selection of Change Agents followed, from the profile of Change Agents gathered, it emerges that systems functionaries and communities have been able to select Change Agents that fit reasonably well with the expected profile.

- The quality of the Change Agents' work and their effectiveness depends greatly on the individual selected. Attributes such as being "active" in the community, having strong connections throughout the community and possessing good communication skills, are important, perhaps more so than higher education.

- Particular attention needs to be paid to ensuring representation from marginalized groups, especially since individuals from these groups may be unable to volunteer their time given even the negligible opportunity cost.

2. Training

- The length of the classroom training, the structure of three rounds of training with gaps between rounds to ensure that field practice informs further training appear suitable for the kind of time and work expected of Change Agents. The technical content has been simplified to make it commonsensical and the approach to training is one of dialogue, rather than discourse.

- The involvement of ICDS and Health program staff in the training ensures continuity after the structured training is complete. Assessment of their knowledge indicates that knowledge levels have been built up to a reasonable extent, although gaps do exist. Quality is a definite concern with cascade training happening at such a large scale and there is need for continually upgrading the skills of training teams.

- The kind and level of ongoing support and mentoring by AWW and the ANM was probably weak in many contexts. The gaps found in the knowledge and understanding of priorities among Change Agents were not addressed during the mentoring that followed structured training. The experience of Chhattisgarh is telling in this context. Even with the high level of government commitment for the *Mitanin* program, the Change Agents fared no better in their ability to maintain contact with mothers and children. This could serve as a point for caution that well-designed training with full state support is also not sufficient in itself. In order to ensure legitimacy and effective ongoing support, it is critical that systems see Change Agents as useful adjuncts to solving operational barriers and supporting implementation.

- INHP has demonstrated that better supportive supervision provided by Supervisors to AWWs using a set of tools helped the AWWs to focus on outcomes. In the case of Change Agents, while their mentoring was considered the explicit responsibility of AWWs and ANMs, neither were provided the tools and process guidelines such as those provided to the ICDS Supervisors. More detail on the tools and processes is provided in the paper of *Working with Existing Systems*.

3. Role

- The INHP experience found that Change Agents emerged more as community mobilizers than counselors. There is indirect evidence to suggest their role in calling families to avail critical services. With respect to home contacts, they have possibly played a supplemental role in reinforcement of messages during home visits and other points of engagement with the community. Thus, it is possible that they perceive their role as community mobilizers than as counselors and get more drawn to the more visible, public events such as NHDs. Given the level of training and the support levels planned, it was perhaps unrealistic to expect them to make regular home contacts. Defining catchment areas of their operation in a realistic manner for Change Agents probably helped them function better on the service delivery related elements, such as the NHD activities, mobilizing the 20-25 households for which each was responsible.

- Change Agents serve to facilitate the flow of information, act as additional communication channels that reinforce other channels and often focus on "secondary target audiences" such as mothers-in-law. The value of these factors in behavior change is well established and there is anecdotal evidence that by having several Change Agents and the AWW in a community, with them all giving consistent messages, social norms around MCHN behaviors are beginning to change.

- Change Agents have created a certain energy around AWC activities, especially the NHD, with their reminders about an upcoming NHD, calling and fetching people for service delivery and assisting the AWW during the NHD. So it is very likely that they have contributed to improving service coverage. Although there are visible signs of an 'AWW-Change Agents-ANM' team in operation at the village level, there is no hard evidence to conclusively infer the contributions of Change Agents in increasing program participation, expanding outreach and coverage, reducing drop-outs etc., just as it is not possible to attribute the *entire* success to the AWW.

4. Motivation

- Motivation is a key to sustaining the functioning of Change Agents. It is difficult to identify the minimum set of non-monetary incentives that would motivate and support Change Agents. There is anecdotal evidence that recognition at "public events" within their community or the block or higher levels or even the opportunity to speak at such events have contributed to their motivation levels. Thus, innovative means of locally suitable non-monetary benefits are important and program leaders and mentors of community volunteers must pay attention to this element.

- After some time in their volunteer role, many Change Agents expected to move into a paying position. Will monetary incentives alone make Change Agents more effective in terms of contributing to behavioral outcomes? The answer is "no". The experience with the AWW is also illustrative. It is clear that payment is a major attraction to continue to work as AWW – virtually a regular part-time worker than a mere volunteer. However, payment on its own has not made the AWW effective in terms of addressing important ICDS objectives such as reduction of malnutrition and mortality. Given the small demands on the time of Change Agents, the expectation of monetary compensation for time is unlikely to be a strong one and therefore non-monetary incentives such as rewards and recognition, and strong supervisory support are critical.

5. Monitoring

- Even in a program as closely and carefully tracked as INHP, tracking the recruitment and training of Change Agents at scale was a challenge. Three elements emerged as important:

  - A program promoting volunteer needs to institute good mechanisms for tracking the recruitment and training as well as have in place mechanisms to monitor how they are performing against the expected roles.

Figure 11.4: **Percent Change Agents who meet the selection criteria for ASHA, Endline survey, (2006).**
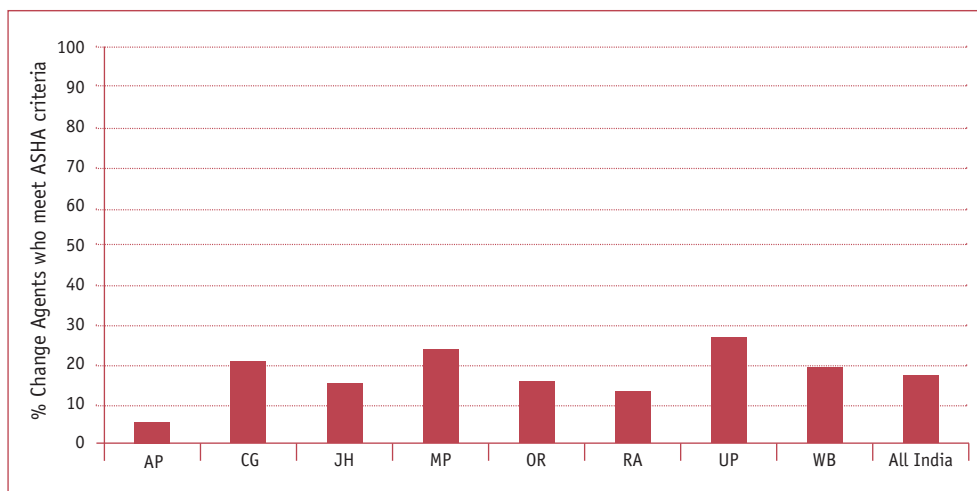
- Mechanisms for monitoring ongoing mentoring support are critical to be established, since "one gets what one inspects".

- Mechanisms for the mentors to periodically monitor what was accomplished by the volunteers need to be considered, not for upward reporting but for the mentor to use the information for effective mentoring.

What implications do these lessons have for the ASHAs of NRHM?

The lessons from the Change Agent experience could serve well to inform the NRHM's ASHA initiative. Some of them are:

- Under the NRHM, the basic criteria for qualifying to be trained as an ASHA are – being a woman, 25-45 years of age, having studied at least up to class VIII and being a resident of the village. In all, 16.4 percent of Change Agents interviewed met these basic criteria, ranging from five percent in Andhra Pradesh to 26 percent in Rajasthan (Figure 11.4). This proportion represents fairly large numbers and, across most states, it is hardly surprising that many of these Change Agents are now being recruited and trained as ASHAs. The qualitative assessment found that "being active and connected to communities" was more important than education in contributing to Change Agent effectiveness. If educational qualifications were to be relaxed (as envisaged in the NRHM for situations where suitable women who fulfill these requirements are not available in some communities), more Change Agents might qualify. This could contribute to better utilization of the already existing Change Agents as ASHAs under the NRHM.

- Mentoring - supportive supervision – is the most critical component likely to make or break such an initiative. It would be best if mentors can be helped to clearly understand how and through what critical processes the ASHA is likely to make a difference.

- Key indicators reflecting critical processes such as motivating families to avail services and informal and formal contacts including home contacts can then be evolved, as well as mechanisms for estimating and tracking them.

- These mechanisms would necessarily include processes and tools for supervisors, and for independent assessments to regularly understand how the volunteers/ASHAs are performing. Local resource persons, especially NGOs, can be effectively engaged to provide such mentoring support to volunteers.

- Selecting and training Change Agents carefully are critical to the success of Change Agents. Class-room training needs to be sufficiently supported by ongoing approaches to providing refreshers and problem-solving support in the field. Training methodologies should allow for adequate opportunities for field practice. The training content needs to be simple and the schedules flexible enough to suit local conditions.

- The facilitation of information flow and serving as additional channels for communication for reinforcement of messages are important contributions of Change Agents. The ASHA's role in maximizing these deserves special attention.

It is hoped that the above lessons from the Change Agent's experience will be considered seriously by the NRHM while taking the ASHA initiative forward. This assumes added significance given in early reports from the field that indicate gaps in some of the crucial points discussed above.

(Contd. from inside of the front cover)

The Change Agents emerged more as mobilizers to improve service delivery and an additional communication channel for reinforcing key messages rather than doing door-to-door counseling to promote behavior change. The need to promote community ownership of this initiative and to provide strong support systems for motivation and upgradation of the knowledge and skills of the Change Agents were recognized as key to sustaining the functioning of Change Agents. While it is difficult to estimate directly the contribution of Change Agents to the program outcomes, it was clear that the frontline workers played a key role in guiding Change Agents on allocating more time to the critical tasks. The intensity of monitoring the quality of training of Change Agents was less when larger numbers were being trained from the replication areas where the responsibility of trainings fell largely on the government systems.

The level of effort required to build Change Agents was unsustainable for a large-scale program with a time-bound, outcome-oriented approach. Even with minimal support and the six-nine day training, it was effort-intensive to implement a community volunteer strategy at program scale. These lessons from the Change Agents experience could serve well to inform the other large scale programs and initiatives like the ASHA.

About RACHNA

Two major projects of the Reproductive and Child Health, Nutrition and HIV/AIDS (RACHNA) program of CARE-India completed five years of work supported by funds from USAID in late 2006. The second phase of Integrated Nutrition and Health Project (INHP-II) was aimed at helping reduce child malnutrition and mortality. The rural component of the *Chayan* project primarily addressed the unmet need for spacing methods, while its urban component attempted to reduce HIV transmission among at-risk groups. Together, the projects covered 78 districts and 22 cities, spread over 10 states, and worked closely with key national programs and a spectrum of different partners. This series of working papers documents the results and lessons from these five years.

Other Papers in this Series