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COVID-Resilient Wash-Sensitive Panchayats and Communities in Maharashtra

PROCESS DOCUMENT

SSP
MARGIN TO MAINSTREAM
Swayam Shikshan Prayog

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July 2020–March 2021

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by Ms. Rajeshwari Chandrasekar,
Chief of Field Office, UNICEF

PREFACE

The "COVID-resilient Wash-sensitive Panchayats and Communities in Maharashtra" project was implemented from July 2020 to March 2021 as part of the collaboration between the Government of Maharashtra and UNICEF Maharashtra. The impact of COVID-19 and the lockdown related to it led to an unprecedented humanitarian disaster. The crisis affected the already poor and marginalized groups disproportionately and disturbingly brought down the resilience of many more, who had hitherto been able to sustain themselves. The influx of returning migrants into rural areas led to additional strain on people, causing the poorest communities continued distress. Migrant workers, the rural poor, women with children, people with disabilities, the elderly and socially excluded groups faced an extensive humanitarian and social crisis, in the form of food shortages, closure of basic services and large-scale unemployment.

Designed collaboratively with the district administrations of Osmanabad, Latur and Solapur at the peak of the lockdown, the project responded to the needs of a large number of vulnerable people who had lapsed into poverty and had no access to health and Social Protection services. It addressed multiple levels of challenges faced by the target groups and beneficiaries, across the intersectionality of social exclusion, poverty, gender and cultural biases. This 'Process Document' details and documents the approaches, results and challenges addressed through the project and celebrates the communities and frontline workers who demonstrated ways in which accountability and democratic participation were fundamental for good governance.

Opportunities to Rebuild Better Health and Social Protection Systems

The extensive impact of the COVID-19 disaster also provided new opportunities for reaching vulnerable rural communities. This has been demonstrated by women leaders mentored by Swayam Shikshan Prayog and who have been at the forefront of the response – generating awareness, caring for the needy, bridging the gaps in last mile connectivity and preparing alternate strategies for economic survival. The resilience of these women is a source of learning for the entire system; it not only enabled women in households to be recognized for their contributions, it also called for their active participation in decision-making since households needed to diversify sources of income, reduce dependencies, attain self-sufficiency and align with local networks and governance systems. As an outcome of this project, traditionally patriarchal households now have a scope for women to participate, collaborate and lead in public spaces.

This development has created new opportunities for civil society organizations to consolidate strategies for ensuring women's leadership in building disaster preparedness, community resilience and active participation in governance. The new national policy framework for self-reliance provides a more responsive institutional system to the aspirations of women for sustainable and inclusive change. Hence, there is an opportunity to develop more participatory and transparent systems, which ensure that each vulnerable person and household is adequately secured and cared for. The situation created by the COVID-19 pandemic, demonstrated the need for well managed Social Protection entitlements and recovery initiatives from the government. Once again, it has stressed upon the need to establish village-level internal coordination systems as well as common resource pools to take care of those at risk, like pregnant women, lactating mothers, children, the elderly and socially excluded groups. The project thus had an opportunity to leverage all stakeholders such as, the government,

community groups, the private sector and Panchayati Raj institutions, to improve access to services and build community resilience, within a sustainable development framework of participation and action.

Maintaining Continuity of Services

The frequent interactions at district and block levels between the nodal NGO, Swayam Shikshan Prayog (henceforth, SSP) directly led to an increase in sharing of risk management information and inclusion of most vulnerable households, through sustained communication with the Panchayat-led COVID-19 Sahayata Samitis. As a result, new ways of collective action, aimed at minimizing risks and improving the uptake of key services for health and Social Protection were demonstrated to all stakeholders. The implementation of the Disaster Management Act clearly demonstrated that convergence of government systems is essential within the districts to ensure that services reach each household. Such joint collaborative platforms must be widely scaled up.

I would like to thank the Office of the Principal Secretary, Relief and Rehabilitation, Government of Maharashtra and district-level administrations of Latur, Osmanabad and Solapur for offering Swayam Shikshan Prayog and UNICEF, the opportunity to partner with them in such critical times.

Empowering Women to Build Resilience in COVID-19 Affected Communities

Overview by Professor N. Vinod Chandra Menon Founder Member, National Disaster Management Authority, Government of India

This Process Document provides an overview of the women-led empowerment and resilience building process in 250 villages, selected from 29 blocks of Solapur, Osmanabad and Latur districts in the drought-prone Marathwada region of Maharashtra. The project, supported by UNICEF and district administrations, was carried out by village -level women leaders linked to Swayam Shikshan Prayog, who became part of the mandated COVID -19 Sahayata Samitis, mobilized women as well as community groups and joined hands with the government, to stem the spread of the infection through mass awareness campaigns and monitoring in these challenging times. The successful outcome of the project, despite the travel restrictions imposed during the various repeated versions of the lockdown, offers several insights and points regarding the need to recognize grass roots women as change makers, role models and visionaries, capable of initiating transformational and sustainable social change through a government-endorsed multi-stakeholder engagement process.

In January 2020, COVID-19 emerged as a rude shock, threatening lives, disrupting livelihoods, paralysing economies and challenging the health care delivery systems in 219 countries around the world. The fact that the pandemic continues to expose people to risk across India, even in March 2021, must compel governance institutions, humanitarian assistance agencies, multilateral and bilateral donors and civil society organizations to strengthen the preparedness for response to and recovery from such unforeseen crises, through lessons learned from the good practices highlighted in this Process Document. The impact of climate change along with the disasters it entails, the reduced access to jobs, income and food security as identified by Swayam

Shikshan Prayog and UNICEF provided an opportunity to work with the district administration and sub-district-level officials, of the three selected districts, to strengthen existing women's groups, by building recovery and resilience, through community engagement linked to local governance processes.

The Risk Informed Planning approach and Social Protection of vulnerable sections in the face of climate risks, economic shocks and disaster risks, pioneered by UNICEF, guided the humanitarian assistance programme of the SSP, in partnership with the Huairou Commission and women leaders at the village-level. The enabling provisions of the Disaster Management Act 2005, the directives from the Ministry of Panchayati Raj, Government of India to the Government of Maharashtra as well as the order of the Relief and Rehabilitation Department, Government of Maharashtra, designating Swayam Shikshan Prayog as the resource NGO for carrying out the capacity-building of stakeholder groups in the selected districts, all contributed to the partnership with the district administration in carrying out this innovative project. Swayam Shikshan Prayog's significant contributions in strengthening climate risk resilience were acknowledged and recognized by United Nations Framework Convention on Climate Change with the Momentum Award in 2016 and by the UNDP with the Equator Prize in 2017. The awards and recognition by the Government of India, Governments of Bihar and Maharashtra as well as the Schwab Foundation's Social Entrepreneurship Awards in 2018 and 2019, stand testimony to the effective social sector interventions, which Swayam Shikshan Prayog has been carrying out in the climate hit regions/states where it has been working in the last two decades.

A large number of critical activities carried out for the project in spite of the travel restrictions imposed during the lockdowns highlight the synergies created with the local officials in the districts – Heads of Departments, Block-level Officials, Gram Panchayats, village functionaries and others. The list of activities includes the preparation of 236 GP Preparedness Plans with 80

indicators, based on the Ministry of Panchayati Raj and Government of Maharashtra checklist, across the three selected districts; the creation of jobs for more than 15,000 women through Mahatma Gandhi National Rural Employment Guarantee Scheme in the 250 villages involved; the creation of joint monitoring platforms; data collection at the block, Gram Panchayats and primary health centre levels; embedding the trained Sakhis/leaders in the COVID-19 Sahayata Samitis and in the Gram Sabhas; creating multi-stakeholder alignments with frontline health workers like Accredited Social Health Activists, Auxiliary Nurse Midwives, Gram Sevaks, Rozgar Sevaks, teachers, Sarpanches; activating 20 Primary Health Centres; involving Self-help Groups, youth groups, community-based organizations and village health committees, nutrition committees, sanitation committees, school management committees, etc.

I am sure that the lessons learned from this short but intense six-month initiative will encourage the UNICEF India Country Office, NITI Aayog, the Ministry of Panchayati Raj and other ministries of the Government of India concerned, to replicate it in other states and union territories. I also hope that the UNICEF Maharashtra Field Office and the Government of Maharashtra will extend it to other districts of Maharashtra, where the hitherto excluded weaker and vulnerable sections can benefit from such a collaborative model of women-led community resilience building through multi-stakeholder engagement. I hope that the lessons will also inspire UNICEF and other United Nations agencies to institutionalize "gender inclusive disaster risk reduction" by making it an integral part of community-based disaster risk reduction in multi-hazard prone and climate risk prone districts in India. This approach would then hopefully get extended to countries in South Asia, South East Asia, the Asia-Pacific, Central America, Africa and also to intergovernmental platforms like the European Commission, Organisation for Economic Co-operation and Development, etc. If such an aspirational outcome becomes the logical conclusion of this Process Document, I hope it will bring quantum shifts in converting theory into praxis.

FOREWORD

by Prema Gopalan, Executive Director,
Swayam Shikshan Prayog (SSP)

The COVID-19 pandemic has led to long-term consequences for poor rural households. The two-decade-long experience of Swayam Shikshan Prayog (henceforth SSP) in building women's leadership in disasters and climate hit regions, was the inspiration behind turning the COVID recovery process into an opportunity to build long-term resilience by strengthening the existing women's groups to be part of locally led efforts.

SSP teams worked closely with the district-level administration to support vulnerable groups after the lockdown. Community level Sakhis and leaders trained by SSP, worked to assess the gaps in food security and to improve access to health services and awareness about the same, along with frontline workers. In the UNICEF supported, COVID-resilient WASH-sensitive project, women leaders were embedded in the mandated COVID Sahayata Samitis to spread awareness and to stop the spread of the infection. This Process Document details the insights, processes and good practices that led to the evolving of joint mechanisms and communication protocols for ensuring inclusion of socially and economically marginalized groups.

This intensive exercise taught us important lessons on the role of grassroots women leaders in leading social sector recovery as community facilitators and resulted in a huge increase in the access of vulnerable groups to real time benefits. It showed that collaboration at the grass roots, between local government, frontline workers and community leaders, produces big dividends for the poor. It also helped establish that resources can be leveraged and risks reduced on a significant scale, which is increasingly important for moving forward, to reduce the distress faced by the vulnerable groups.

ACKNOWLEDGEMENTS

The project was made possible with the support and active participation of the government and community representatives in the three districts and the UNICEF Maharashtra team.

State and District-level Governments:
Mr. G. Shrikant (ex-Collector, Latur), Ms. Deepa Vishwas Mudhol Munde (ex-Collector, Osmanabad) and Dr. Milind Shambharkar (District Collector, Solapur). From the Department of Health, Dr. Gangadhar Parge (DHO, Latur), Dr. Wadgave (DHO, Osmanabad) and Dr. Jamadar (DHO, Solapur), without whom the collaborative process would not have been effective. From the Rural Development Department, Mr. Pradip Kulkarni (HoD, Latur), Mr. Rajendra Khandave (HoD, Osmanabad) and Mr. Vijaysingh Deshmukh (HoD, Solapur).

UNICEF Maharashtra:
Ms. Rajeshwari Chandrashekar, Chief of Field Office; Mr. Yusuf Kabir, WASH Specialist and Emergency-DRR Focal Point; Ms. Aparna Kulkarni Gowande, State Consultant Communication for WASH; Mr. Jayant Deshpande, State Consultation, Sanitation; Mr. Balaji Varkath, State Consultant for Atal Bhujal Yojana and Water Resource Management; Mr. Omkar Khare, State Consultant, Disaster Risk Reduction and Climate Change.

Community Representatives:
250 women constituting the Sakhi Task Force worked voluntarily in their villages to implement the programmes, build new relationships with women FLWs and share critical feedback and data about the status of public services and vulnerable households, often at the risk of their own health and lives.

Project Team:
The project benefited from design and monitoring by Mr. Laxmikant Malwadkar, Mr. Upmanyu Patil and project leadership by Ms. Naseem Sheikh; with programme support, Ms. Sanjana Sen; and District Coordination Team – Ms. Devkanya Jagdale, Mr. Kaka Adsule, Mr. Rajabhau Jadhav and Mr. Vikas Kamble, who established strong relationships of trust with the district and block administrations and PRI members and also played a critical role in facilitation, data management, trainings and mentoring community leaders.

Process Documentation, Social Inclusion and Gender Consultant: Ms. Ratna Mathur, Development Support Group-India (DSG-I), New Delhi

Senior Medical Consultant: Dr. Rajendra Awate

EXECUTIVE SUMMARY

Context and Challenges:

The COVID-19 pandemic and the resulting humanitarian disaster and health crises followed by secondary impacts, called for a social sector recovery programme to reduce the distress that was being faced by rural communities and to ensure that the spread of the infection was restricted. In this context, three adversely affected districts were selected for the project: Sholapur, Osmanabad and Latur, which were in the high climate risk region of Marathwada (in the central part) of Maharashtra, with a large number of returned migrants. The key focus was on improving the effectiveness of national and state COVID-19 related protocols and implementing them in partnership with government systems at district, block and village levels and activating Panchayati Raj institutions, primary health services and local institutions to reach the affected marginalized groups.

Approach to Addressing Challenges:

The objectives of the project were to enhance the capacity of the village community groups and institutions for WASH and COVID preparedness; prevent and reduce infection through joint surveillance and establish as well as to activate effective village-level response mechanisms for dealing with COVID-19. To meet the acute distress being faced by specific groups, the project focused on improving access to safe food, drinking water, personal hygiene, health and nutrition services; and on Social Protection entitlements like ration cards, job cards and those under the Niradhar Yojana and Pradhan Mantri Kisan Pension schemes. The main groups addressed by the project were reverse migrants, vulnerable groups like children, women, the elderly; households with limited access to health and nutrition services and Social Protection programmes; and small marginal farmers and unskilled daily wage landless labour.

Activities and Outputs Achieved:

In the short duration from July 2020 to January 2021, the project benefited 250,000 people in 250 Gram Panchayats directly; it reached a population of one million in 29 blocks in the three districts indirectly. To operationalize the collaborative approach, 55 trainings on "COVID-19 Preparedness Planning and Disaster Response" were held for 3042 government, panchayat and community functionaries, covering all 29 blocks. Another training for 79 senior government district heads of departments was also conducted. Overall, 30 per cent more people accessed health services in more than 20 Primary Health Centres, where the project worked directly; linkages with Social Protection and welfare programmes like the public distribution system enabled 18,863 families without ration cards to access rations in the 250 villages, with data indicating a 63 per cent increase from the baseline. The project was implemented through 250 trained local women leaders who constituted the Women's Sakhi Task Force trained and supported by Swayam Shikshan Prayog teams. The Sakhis functioned as extra eyes, ears and hands of government frontline workers like ASHAs and ANMs, thereby overcoming restrictions on mobility due to the lockdown.

Key outputs and results demonstrate how a community and government coordination system through joint platforms for disaster risk reduction for vulnerable groups can lead to a supportive environment. The focus on women's roles as community facilitators improves participation of women and vulnerable groups in local governance significantly. The processes show the multiple ways in which climate change induced challenges worsen during disasters like the COVID-19 pandemic. Coordination between the government system at Gram Panchayat level with the Sahayata Samitis was enhanced by the use of tools like the preparedness checklist and joint household surveys. A Government Order of the recently formed Maharashtra State Disaster Management Authority mandating involvement of the NGO Swayam Shikshan Prayog as overall facilitator was

used in trainings to inform the community and FLWs. As the national Disaster Management Act was enforced, it was important to organize targeted awareness programmes to prevent obstruction of any duty bearers and to ensure dissemination of scientific information about the disease. Provisions of the Epidemic Diseases Act, 1897 were being used by authorities for enforcing containment measures and to improve infrastructure and services. The women members of the Sahayata Samitis played a critical role in rebuilding the trust of communities with respect to imbibing safety and health-seeking practices. The active role of health workers and women community leaders as volunteers has been an outstanding aspect of the project. All these efforts led to a more effective decentralized system for addressing the challenges posed by the pandemic.

Key Recommendations:

This short-duration project shows the significance of streamlined collaborative methodologies for scaling disaster response programmes and recovery resilient development, linked with Disaster Risk Reduction and climate change adaptation. The key strategy of scaling through system strengthening was successfully tested in the context of maintaining continuity of services and risk informed programming. In the course of the project, consolidation of local partnerships between Gram Panchayats and the community leadership was achieved through targeted planning for nutrition and livelihood security, activating the Public Distribution System network, improving access to primary healthcare services, WASH services in emergency and strengthening social welfare and protection services. The use of mobile-based technology created new learning and reporting pathways, for first-time community users and other stakeholders.

Summary of Project Scope and Results

COVID Sahayta Samitis are a coordination group comprising government functionaries and community representatives mandated to work on COVID-19 related activities at GP level.

As per the letter issued to Swayam Shikshan Prayog (Annexure 3.3)

https://www.firstpost.com/health/coronavirus-outbreak-disaster-management-act-provides-legal-backing-for-punitive-measures-allows-govt-to-access-emergency-funds-all-you-need-to-know-8190161.html>, accessed on 21 February 2021 ; The Disaster Management Act, 2005, https://legislative.gov.in/actsofparliamentfromtheyear/disaster-management-act-2005, accessed on 31 March 2021.

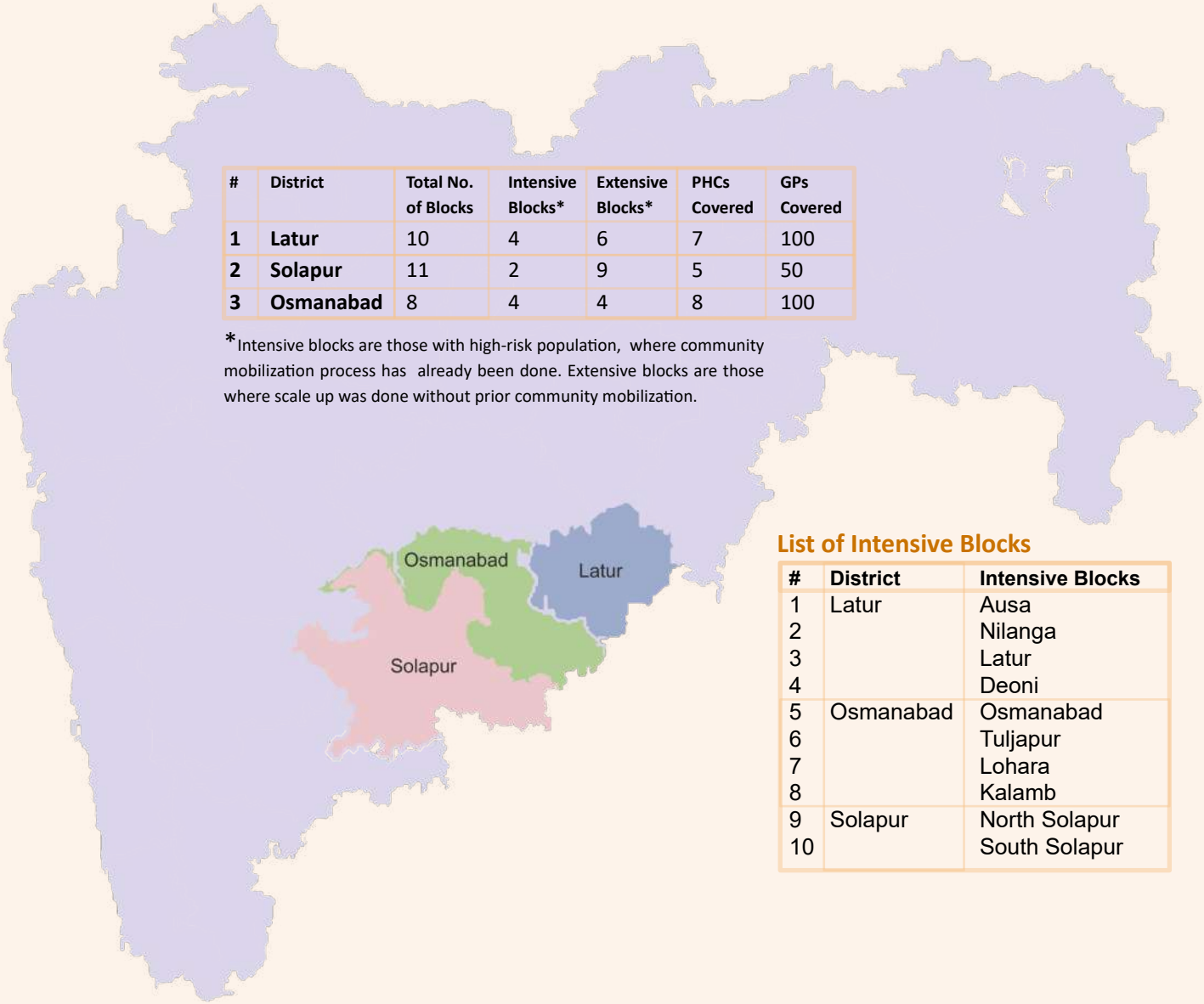
<www.thehindubusinessline.com/news/national/centre-invokes-epidemic-act-and-disaster-management-act-to-prevent-spread-of-coronavirus/article31049161.ece>, accessed on 21 February 2021.

Project Map – Districts of Maharashtra Covered

Project Coverage

#	District	Total No. of Blocks	Intensive Blocks*	Extensive Blocks*	PHCs Covered	GPs Covered
1	Latur	10	4	6	7	100
2	Solapur	11	2	9	5	50
3	Osmanabad	8	4	4	8	100

*Intensive blocks are those with high-risk population, where community mobilization process has already been done. Extensive blocks are those where scale up was done without prior community mobilization.



List of Intensive Blocks

#	District	Intensive Blocks
1	Latur	Ausa
2		Nilanga
3		Latur
4		Deoni
5	Osmanabad	Osmanabad
6		Tuljapur
7		Lohara
8		Kalamb
9	Solapur	North Solapur
10		South Solapur

Summary of Data Tracked for Key Government Flagship Schemes for Social Protection and Health in the Project, from July–December 2020

Indicators each month (2020)	July	August	September	October	November	December
Social Protection						
Families with ration cards receiving ration from PDS	1,27,286	1,00,980	1,13,501	1,62,704	1,17,536	1,74,086
Families without ration cards receiving ration from PDS	23,546	13,241	12,706	16,224	16,883	12,382
Children receiving Take Home Rations	28,778	19,188	23,766	32,854	26,754	31,114
People receiving MNREGS job cards	76,058	63,353	60,640	61,908	60,020	50,230
Women who have got work under MNREGS	26,120	17,891	17,226	22,820	16,113	18,083
Men who have got work under MNREGS	32,974	22,187	24,141	26,464	21,155	20,499
Health						
Screenings carried out by ASHAs	91,695	34,608	2,02,198	90,921	88,407	74,101
Access to outpatient department (OPD) services	36,801	5,420	20,380	14,022	23,883	14,096
Immunization	4,537	1,236	6,786	7,921	4,589	3,998
Women accessing antenatal (ANC) services	1,946	370	1,158	855	968	673
People accessing PHCs and health Sub-centres for basic health needs	942	101	565	957	340	245

Abbreviations, Acronyms and Glossary of Terms

Abbreviations

Term	Full form
ANM	Auxiliary Nurse cum Midwife are trained health workers of the National Health Mission placed in a cluster of villages under Department of Health
ASHA	Accredited Social Health Activist is a contractual worker of the National Health Mission placed in every village Gram Panchayat under the Department of Health
AWW under	Anganwadi Worker placed at Anganwadi centres to serve women and children the Integrated Child Development Scheme of the Ministry of Women & Child Development
BDO	Block Development Officer
CCA	Climate Change Adaptation
CHO	Community Health Officer placed at Primary Health Sub-centres under Department of Health
CMO	Chief Medical Officer heading Primary Health centres under Department of Health
DRR	Disaster Risk Reduction
FLW	Frontline Worker
GoM	Government of Maharashtra
GPs	Gram Panchayats – village council is the basic village governing institution as democratic structures as per the Constitution of India
JJM	Jal Jeevan Mission – flagship Government of India programme to provide safe and adequate drinking water through individual household tap connections by 2024 to all households in rural India
MIS	Management Information System
MNREGS	Mahatma Gandhi National Rural Employment Guarantee Scheme of the Ministry of Rural Development is the flagship rural employment scheme of the Government of India
MoPR	Ministry of Panchayati Raj
PDS	Public Distribution System
PHC	Primary Health Centre at cluster level under the Department of Health
PRIs	Panchayati Raj institutions
RDD	Rural Development Department of the Government of Maharashtra
RIP	Risk Informed Planning
SBM	Swachh Bharat Mission or Clean India Mission, flagship programme of the Government of India to eliminate open defecation and improve solid waste management
SMC	School Management Committee, mandated committees under the Right to E ducation Act in each government school with representation of teachers and parents as the basic unit of decentralized model of governance of the education system

Glossary of Terms

Term	Description
Arogya Sevika	Arogya Sevikas are trained health workers who assist doctors in Primary Health centres and do data-collection in Maharashtra
Arogya Vardhini Kendra	Government Primary Health Centres converted to Health and Wellness Centres for preventive health care, including under Ayurveda, Unani systems and nursing streams appointed as Community Health Officers
COVID Sahayata Samiti	Coordination group mandated at Gram Panchayat level for working on COVID-19 related activities comprising government functionaries and community representatives
Gram Sevak	Government Frontline Worker (FLW) at GP level employed to advise and assist villagers in matters of community welfare and development
High-risk frontline workers	Community facing government health and social welfare workers at GP, Cluster and Block levels;
High-risk essential workers	Community facing sanitation, retail and food supply daily wage workers who need to commute every day for carrying out their responsibilities
Krishi Sahayak	Krishi Sahayak serves farmers as a full-time employee of the Gram Panchayat along with Gram Sewak and Talathi in Maharashtra
MPW COVID	Multipurpose Worker attached to Primary Health Centres for assisting with COVID related programmes of the government
Non-presence areas	Blocks or Gram Panchayats where SSP did not have prior direct presence within the community
Police Patil	An official of the village in Maharashtra, with quasi-judicial and administrative duties, responsible for birth and death registrations and the care of unclaimed property
Rozgar Sewak	A contract employee in every GP with the primary duty to assist technical persons in MGNREGA schemes
Sakhi Task Force	Women's group at GP level formed by SSP comprising local women leaders drawn from across communities who jointly take initiative in public issues related to their communities
Sarpanch	Head of elected local government, duty bearer at village-level with financial powers
Swachagrahis	Community sanitation volunteers mandated under National Sanitation Mission
Tehsildar	Tax officer at subdistrict (block or tehsil) level responsible for collection of revenue and release of finances for government programmes

Talathi	Accountant – an official agent of the government; the term is used in rural western Indian states
Tanta Mukht Committee	As in COVID Sahayata Samiti – local name for disaster response coordination group comprising government functionaries and community representatives
Up-Sarpanch	Second level elected local government duty bearer at village-level with financial powers

Handwashing demonstrations to generate awareness in the community

Introduction: Purpose of the Document

Rationale and Use

Recognizing factors for an effective humanitarian response blended with community-led disaster risk reduction, climate change and development programmes– The Process Document of the project "COVID Resilient WASH-Sensitive Panchayats and Communities in Maharashtra" documents the strategies and approaches adopted, challenges faced and outputs attained by the project and also recognizes the factors that enabled communities and frontline workers to reach out and address the needs of the most vulnerable groups. It includes highlights of the results, key outputs and best practices, highlighting the connectivity from the district administration to the Gram Panchayat level and responses made to reach a dynamic recovery.

Documenting a collaborative model of community resilience– Overall, the Process Document presents an emerging model of a collaborative approach, developed in a short period, which spans a humanitarian response which includes disaster risk reduction as well as development programmes. It was made possible through the work of the COVID Sahayata Samitis and preparedness planning processes for scaling the collaborative approach in extended areas.

In view of the continuing crisis related to livelihoods and Social Protection needs of vulnerable groups affected by the pandemic and an increasing number of ongoing disasters, this document is designed as a peer learning guide for organizations working with governance systems, as well as to help them to understand effective strategies and result oriented approaches for rapid recovery and carrying out inclusive programmes with Gram Panchayats.
The document also highlights the ways in which communication technology was used to overcome the unique challenges of the lockdown and to develop information-sharing processes, through which gaps in public services could be overcome. In this context, this document serves as an important historic record of the agility of Frontline Workers and community leaders, their ability to adapt to mobility restrictions and to overcome personal risks.

Use of the document for evolving sustainable government-community partnerships– The document can thus be used as a model for evolving sustainable government-community partnerships during humanitarian disasters. The document serves as a reminder that accountability and democratic participation are fundamental for good governance. It shows the ways in which community leaders contributed to the effectiveness of programmes for ensuring access to entitlements, risk reduction and bringing last mile connectivity for excluded groups, by highlighting actual on ground challenges. A careful reading of the Best Practices will be helpful in finding out how oversight of the process was achieved, how information about Social Protection and public services got shared and ultimately built mutual trust.

Structure of the Process Document

The Process Document focuses on detailing the key steps at various phases of the short-duration project. It has six major sections and three sets of annexures containing key project documents and formats used.

The major sections are:

1

Project Approach and Scope

This includes a summary of the project, the steps for framing the priorities, details of the target groups and an outline of the cross-sectoral processes along with the coordination framework of the community and governance systems.

2

Operations, Management and Monitoring system

The details evolved for risk informed planning and project management are a part of this system. In this section the structured ways in which the monitoring and data management was done for the project with the assistance of government frontline workers and Gram Panchayat duty bearers are outlined.

3

Government-Community Coordination: Governance Activities in Districts

This section sets out the activities, framework for coordination, outputs and key results for outputs 1 to 4. Its focus is on establishment of the coordination processes between government departments, district administrations, local government representatives and community groups facilitated by Swayam Shikshan Prayog and UNICEF. The section documents two Best Practices in respect of the process for demonstration of Gram Panchayat plans and on the system in place for the functioning of village-level Sahayata Samitis for assessment, prevention and containment of COVID-19.

4

Improving Access to Health at Block and Cluster Levels and COVID-19 Prevention Programmes

The focus in this section is on access to health and COVID-19 prevention challenges addressed by the project. There are details of key activities and overall results. The section documents Best Practices on surveillance of COVID hotspots and adaptation of preventive practices in Primary Health Centres (PHCs) and Health Sub-centres and on PHCs where there was increased access to health services.

5

Strengthening Social Protection, Community Participation and Resilience at Gram Panchayat Level

This section documents the Social Protection challenges addressed, details of key activities and the overall results. It highlights processes carried out with major nodal government departments by GPs. The section also documents a Best Practice on increased access to Social Protection entitlements for all households from vulnerable groups.

6

Key Learnings and Recommendations

This includes a summary of findings on outputs and impact; learnings on programme management which are critical for this collaborative model; learnings from the Best Practices; major recommendations for scaling output and methodologies for maintaining continuity of services and risk informed programming.

Annexures

There are three categories of annexures with key project details and documents, namely details of trainings conducted (2); project reporting formats and activities (9); and key project documents (5). Together they are critical for understanding the cross-sectoral context and inter-sectionalities of vulnerabilities being responded to by the governance system.

Sakhi's attending Covid-19 Awareness Workshop with Social Distance over Zoom

1 Scope and Approach of the Project

1.1 Project Outline

Goal of the Project

Strengthen Gram Panchayat's preparedness for creating Wash-sensitive and COVID-resilient communities in three districts of Maharashtra.

Objectives

1 Enhance the capacity of the village community and institutions for WASH and COVID preparedness.

2 Prevent and reduce chances of infection, ensure effective surveillance and establish effective village-level response mechanisms for handling COVID-19 in cooperation with the government system.

3 Ensure safe food, drinking water, personal hygiene, health, nutrition, transport and logistics in Gram Panchayats.

4 Enhance access of communities to government Social Protection schemes and basic services.

5 Establish safe and secure livelihood opportunities for economically stressed households.

Time Period

July 2020 to March 2021

Location

Three climate-change affected districts in the Marathwada region of Maharashtra – Solapur, Osmanabad and Latur.

Target Groups

The main groups targeted by the project were reverse migrants, vulnerable groups like children, women, the elderly; households with limited access to health and nutrition services and Social Protection programmes; and small, marginal farmers as well as unskilled daily wage landless labourers.

The project directly benefited 250,000 people in 250 village Gram Panchayats of 10 Blocks; and indirectly reached a population of 10 lakhs, or one million, in 29 blocks of the three districts.

1.2 Framing Community Priorities and Linkages with Government

1.2.1 Defining the Approach to Framing Priorities

Given the rapidly changing context of the COVID-19 pandemic, the project sought to develop a rapid crisis recovery and resilience programme that was later scaled up across 2700 villages of the three districts.

The key approach of the project was to work in partnership with government systems, including Primary Health Care at district, block and village levels and activate the Panchayati Raj institutions (PRIs) to work with FLWs involving youth and women's groups towards a community level prevention of the spread of COVID-19, while also ensuring improved WASH, Basic Services and Social Protection entitlements like access to health, rations, jobs and other benefits through affirmative action.

The project was anchored on connecting community representatives with the government system in a structured and sustainable process and on activating the available government platforms, like COVID Sahayata Samitis and School Management Committees(SMCs), to connect in turn with the community. Swayam Shikshan Prayog developed the project on the basis of its experience of training, mentoring and empowering rural women as a task force for development work in their villages, with project support and recognition from the government system.

The project sought to address the challenges faced by the most vulnerable groups due to the high-risk of infection, food and livelihood insecurity and low levels of health and hygiene. Due to the unique nature of the crises arising from the COVID-19 pandemic, women who were at the front lines as *COVID carers* were supported in the project to become active members of village-level Sahayata Samitis. The idea was to enable them to better represent and highlight their own needs as well as those of the most vulnerable groups and empower them to take their recommendations to forums of governance.

According to the scale of the challenge and the intensive nature of the need, the short-duration project (six months) was built on a flexible *assess, act and review* approach with agile systems and means of communication.

1.2.2 Developing Key Strategies

The project facilitated an intensive approach to the work with 250 GPs in 10 blocks on a COVID Preparedness Plan and also to document the process and Best Practices. The project supported the government and PRIs in leading the implementation of the Preparedness Plans and monitoring them at scale. Overall SSP, UNICEF and local governments will take this project learning to embed it in state and national policies and programmes.

The key strategies of the project were intensive as well as extensive:

Intensive

1 Consolidation of community participation in COVID related initiatives in a structured process in 250 GPs of the three districts

2 Facilitation of improved access to Social Protection, basic services and COVID-linked entitlements for vulnerable groups in 250 GPs of the three districts

Extensive

3 Facilitating the establishment of institutionalized communication channels between communities and the government system in three districts

4 Initiation of joint review of the status of training, tracking of COVID prevention and community resilience preparedness in all GPs of 29 Blocks, functioning as a catalyst for change.

1.2.3 Processes for Operational Planning

- **Defining Roles**

SSP teams supported by UNICEF Maharashtra planned to work with the government PRI system including the Sahayata Samitis (with 50 per cent of the members being women) especially organized for the COVID-19 response under national guidelines and those mandated by the Disaster Management Unit, Government of Maharashtra (GoM). The SSP team facilitated the district-level COVID-intensive, WASH-sensitive community Preparedness Plan through a contextualized programme in the background of climate change, drought, flood and distress caused due to loss of livelihoods and food insecurity, being faced by people in the three districts.

- **Framing Priorities Amidst a Rapidly Changing Context**

The COVID-19 pandemic triggered a major disaster in rural areas and the government system responded. The project promoted community preparedness with GPs ensuring participation of women as elected members and community leaders. Accordingly, the project adapted and identified selected key outputs of the project which would be most essential for the communities.

- **Framework for Coordination With the Government System**

SSP teams coordinated with the district authorities and schemes (RDD, PDS, Public Health, ICDS, SBMJJM and MNREGS) to facilitate and ensure implementation of health, hygiene and Social Protection schemes so they could benefit socially vulnerable groups affected by the COVID-19 pandemic.

- **Strengthening Community-Government Joint Platforms**

SSP played a distinct role in facilitating dialogue between government officials, FLWs, GPs and the Sakhi Task Force, employing the existing mandated platforms as well as developing new mechanisms for responding to the pandemic.

- **Planning for Risks and Challenges**

The project operational plan was designed in a contextual manner for the situation during lockdown. Physical distancing had to be maintained, travel had to be minimal and personal contact was restricted to hyperlocal areas. Thus, the entire process of planning and conducting trainings, communicating with government functionaries, distributing essential supplies and tracking the disbursement of entitlements was mostly carried out remotely, using mobile phones and Zoom online platforms.

- **Phased Roll out**

Accordingly, the operational plan for the project was rolled out in three overlapping phases from the district up to the GP levels.

Mask Distribution at Hasegaon, (Dist. Latur) Primary Health Center.

Table 1 – Project Operational Phases

Operational phase	Major activities	Time	Key roles
Inception Phase:			
Planning and Coordination Systems	1.Acquiring mandatory approvals and agreement from district authorities 2.Establishing a framework within the government system and community platforms across levels 3.Conducting project inception workshops 4.Preparation of training modules 5.Establishment of formats and a management information system (MIS)	**frame** Month 1–2	SSP team Women Leaders, facilitators UNICEF team District authorities GP representatives .
Implementation Phase:			
Social Inclusion, Training, Mentoring and Participatory Tracking	1.Conducting district-level project inception workshops 2.Training and mentoring of Sahayata Samiti members in GPs 3.Facilitation of support for FLWs of key nodal departments in GPs by women leaders in Sahayata Samitis 4.Activation of COVID-19 protection supply chain and budget for safety kits 5.Strengthening of COVID-19 prevention surveillance and health care system 6.Data collection on status of entitlements by Sahayata Samiti members 7.Tracking of access and facilitation of documentation in respect of entitlements of excluded households by Sahayata Samiti members	Month 2–5	Government functionaries Women leaders Trainers and coordinators GP members and community group representatives . .
Consolidation Phase:			
System Activation and Continuity	1.Continuing campaigns for public awareness on protection and social welfare programmes and entitlements with respective departments 2.Reporting and following up with government system 3.Coordination meetings and dialogue workshops with officials and duty bearers across levels 4.Monitoring and reporting on the number of people accessing Social Protection schemes and health services 5.Assessment of all 250 GPs on Preparedness Plans	Month 4 – 6	Government functionaries Women leaders Trainers and coordinators GP members and community group representatives SSP team

The detailed activities carried out under each phase of operations are given in **Section 2**.

1.2.4 Project Outputs – Framing COVID and WASH Priorities

The project was focused on planning for COVID preparedness and access to social entitlements for building community resilience. The project built-in learnings from scaling women-led approaches through system strengthening.

Table 2 – Project Outputs and Indicators

District and Block Level

Output no.	Outputs	Performance indicator	Target	Overall outputs
1	All BDOs, Talathis and Extension Officers from three districts trained on village preparedness checklists and PRI modules issued by MoPR and UNICEF India	No. of block-level officials trained	110	A total of 3042 government officials and functionaries trained in three districts, including 79 BDOs, Talathis, Extension Officers; and other block-level officials like Heads of departments; GP functionaries and members; Sahayata Samiti members; and PHC staff
2	Preparation of block-level preparedness and recovery plans for all 10 blocks from three districts, with training calendar for all the GPs, facilitated	No. of block-level costed plans on village preparedness	10	Preparedness and recovery plans made for 250 villages in 10 intensive blocks in the three districts
3	Demonstration of plans at 250 GPs from 6 PHCs with one detailed process documentation	No. of village GP plans demonstrated and lessons learned shared	250	236 GP plans demonstrated and lessons learned shared
4	System in place for functioning of village-level Sahayata Samitis actively for assessment, prevention and containment of COVID in GPs in the three districts	No. of Sahayata Samitis activated to carry out containment strategy, screening, infection prevention and control (IPC), Risk Communication and Community Engagement (RCCE)	250	250 Sahayata Samitis activated in the three districts for containment strategy, screening, IPC, RCCE

Cluster and PHC Level

Output no.	Outputs	Performance indicator	Target	Overall outputs
4	System in place for functioning of village-level Sahayata Samitis actively for assessment, prevention and containment of COVID in GPs in the three districts	No. of Sahayata Samitis activated to carry out containment strategy, screening, infection prevention and control (IPC), Risk Communication and Community Engagement (RCCE)	250	250 Sahayata Samitis activated in the three districts for containment strategy, screening, IPC, RCCE
5	Surveillance of COVID hotspots and adaptation of preventive practices in 6 PHCs and 4 Sub-centres.	No. of PHCs and SCs strengthened for health surveillance and IPC	10	6 PHCs and 4 Sub-centres strengthened for health surveillance, IPC
6	Plan for strengthening of supply chain of hygiene and safety kits at district and block level as per PM-Care funding letter	No. of GPs receiving hygiene kits from block	250	250 GPs received 5–7 hygiene kits from respective blocks for 3 months totalling 4350
7	Awareness campaign to provide repeated information on prevention of COVID outbreak and encourage adaptation of health and hygiene seeking behaviour to reduce the stigma around COVID-19	No. of murals created for awareness No. of murals painted at selected 250 villages No. of information, education, communication (IEC) kits distributed	3 750 250	2 murals created for every selected village 500 murals painted for awareness in 250 villages 250 IEC kits distributed
8	No of PHCs with increased population accessing health services	Percentage increase in number of other cases treated at the end of the project by increased health-seeking behaviour	30 per cent	In six months, a total of 114,602 people accessed PHC OPDs, an approximately 30 per cent increase in the number of other cases treated at the end of the project, through increased health-seeking behaviour

GP Level

Output no.	Outputs	Performance indicator	Target	Overall outputs
9	Increased access to Social Protection entitlements for all households from vulnerable groups (families with children under 5, women-headed families, families of small and marginal farmers) in three districts, post block level planning compared to 2019-2020; entitlement education to identified vulnerable families	Percentage increase in access to Social Protection entitlement	30 per cent	Increase in access to Social Protection entitlements as per baseline (calculated as average of six months against the first month numbers): • 25 per cent increase in families with cards receiving ration from PDS • 40 per cent increase in families without ration cards, but receiving ration from PDS • 72 per cent increase in children receiving Take Home Rations • 57 per cent increase in the number of people who received job cards • 50 per cent increase in the number of women who got work under MNREGS 50 per cent increase in the number of men who have got work under NREGS
10	Awareness campaign with FLWs and functionaries on identifying gaps in Social Protection schemes (job cards, Gram Panchayat Development Plan (GPDP), ration cards, Jan Dhan, Niradhar, PM Kisan Pension, Education, etc.)	No. of vulnerable families identified during the campaign in 250 villages and details shared with block officials	10,000	15,727 vulnerable families identified from the campaign in 250 villages and details shared with block officials; of them, 6103 already linked with Social Protection schemes

GP Level

Output no.	Outputs	Performance indicator	Target	Overall outputs
11	Increased number of reverse migrants and vulnerable families with access to MNREGS work or other employment generated	No. of jobs generated for unskilled labour under MNREGS and other schemes in three districts at the end of 6 months	30,000 jobs	2,65,673 jobs generated for unskilled labour under MNREGS and other schemes in three districts at the end of 6 month
12	School and AWC readiness plan available for all 3 districts for WASH, use of community toilets and water points; maintaining physical distancing; and demonstrate to orient school teachers and AWC on readiness plan	No. of schools and Anganwadis with WASH readiness plan No. of schools and AWCs that implemented the readiness plan if and when schools reopen	500 Schools and AWCs 500 Schools and AWCs	Selected 250 schools and Anganwadis in intensive blocks assessed for WASH readiness plan Selected 250 Schools and AWCS in intensive blocks assessed on readiness plan for school reopening

1.2 Target Groups

The project was focused on ensuring community participation of women, youth group members and PRIs for COVID-19 prevention, preparedness and long-term recovery. These groups were the enablers that reached the vulnerable target groups through their collective initiatives in collaboration with government FLWs.

1.2.1 Identification of Target Groups

Categories of target groups were identified on the basis of the degree of vulnerability, level of access to services and entitlements and assessment of risks faced. In all, the project identified and benefited 16,000 households for providing improved access to Social Protection entitlements and basic services. Each of the key target groups covered were associated with nodal government departments.

Health Checkup Camp at Village

Table 3 – Project Target Groups

High-risk groups	Extremely vulnerable persons	Economically vulnerable groups
COVID-19 infected persons	Pregnant women and families with children under 5	Returned migrants without ration or job cards
High-risk frontline and essential workers	Women-headed families, widows, the elderly and people with disabilities	Unskilled labour
Migrants returned from other states and districts	Socially excluded households	Small and marginal farmers
	Children	

High-Risk Groups were identified on the basis of government protocols for COVID-19 prevention; those who may already have been infected and in need of health care, essential workers like sanitation workers or those involved with food supplies. The project also monitored migrants who had returned to their villages due to the lockdown and did not have food security or sources of regular income.

Extremely Vulnerable Persons comprised those persons who were in need of food security and basic services, for whom several entitlements may have been mandated, but were not accessible, or those without care and protection. Food and nutrition supplements, pensions, health care facilities, special support schemes and basic services were essential for their preparedness and protection. Children unable to attend school and access midday meals were also covered under this category.

Economically Vulnerable Groups included all those who were left without secure sources of income due to the lockdown, were unable to transact their income-generation activities and did not have the required documentation to access alternate schemes initiated by the government. It also included workers and small farmers who were unable to work or supplement their income due to the lockdown and the suspension of economic activities. The challenge of climate change affected a large number of small farming households and the pandemic placed even greater demands on critical inputs like water.

1.2.2 Enabling Community Groups and Forums

The project identified and leveraged the capacities of community representatives who provided the requisite energy and motivation for increasing awareness, behaviour change and sustainable practices within their communities.

Table 4 – Mandated Community Groups Interfacing with Government Systems

Mandated community groups	Women's and community groups	Economic platforms
COVID Sahayata Samitis	Sakhi Task Force	Farmer Producer Groups
Village Health Nutrition & Sanitation Committees	Self-help Groups	
School Management Committees	Youth Groups	
Youth Committees		

COVID Sahayata Samitis (SS) were the primary platforms for community participation. The Sahayata Samitis were created as per the guidelines of the MOPR and GoM in every GP. Each Samiti had a chairperson. At the GP level, the members of the SS include the Sarpanch, deputy Sarpanch, Gram Sevak, Talathi, Krushi Sahayak, Police Patil; government functionaries who were members were ASHAs, BDOs and CMOs (in villages with PHCs or sub-PHCs). There were several members from the village community across social groups. This included the Sakhi Task Force members trained by SSP.

The project played a key role in activating the Sahayata Samitis, with active participation of the Sakhi Task Force members to share responsibilities. These remain the empowered platforms for sustaining community engagement, particularly for essential basic services like PDS, health services and COVID management (details given in Sections 3 to 5).

School Management Committees and Village Health Nutrition & Sanitation Committees were mandated platforms that functioned with varying degrees of effectiveness in normal circumstances. During the crisis triggered by the pandemic, their role became critical in meeting the gaps in Preparedness Planning, ensuring that infrastructure was in place, supervising the functioning of health and education facilities and providing oversight over the budgetary allocations.

Masks and Soaps being handed over to the Solapur Municipal Corporation for the Frontline Workers

Sakhi Task Force consisted of 5–10 active women leaders working as a collective in response to the COVID crisis during the early phase of the pandemic; they became the core enabling group in the project's direct operational areas in 10 blocks. The learnings from their successes were used in all the other blocks of the three districts to ensure community participation. Together with the SHGs promoted under government programmes like SRLM, these women's groups were the prime movers up to the last mile; they worked to create awareness, interpret and adhere to the rapidly changing rules and procedural requirements.

Youth Committees were created by the Collectors across districts to channelize the energy of young people during the pandemic for distribution of relief material, surveillance and spreading awareness of safety rules. The groups played a stellar role in controlling the spread of the pandemic and providing aid to vulnerable families.

Farmer Producer Groups, comprising mostly women from small and marginal farmer households, had a presence in several of the project's operational villages. In order to ensure availability of nutritious food and access to special benefits provided to farmers by the government, these groups were activated to distribute benefits such as essential food supplies and wages to landless labourers, among others.

The community groups were coordinated and activated by the Sakhi Task Force, which led the processes related to government systems, while ensuring that all excluded persons and households were made aware, linked and able to access their entitlements. The framework of engagement is given below.

1.3 Cross-Sectoral Processes and Coordination Framework between Gram Panchayats and the Governance System

Through a participatory consultation with community representatives, the project identified five major project outputs from the overall 12, as requiring particular focus. These major outputs were related to the three nodal departments with which the project engaged, namely Panchayati Raj, Health and Social Welfare, in addition to their flagship schemes. The coverage also included key central government schemes especially implemented as part of the response to the pandemic.

Food Kit Distrubution to Needy Families

The project was designed to scale up community-led processes. As per the analysis of needs by communities as well as priorities identified by the government, the project engaged with the governance system within a defined framework.

Table 5 – Framework for Facilitating Connection between Communities and Governance System

Sectors/ Priorities	Nodal government department	Government functionary involved	Key schemes covered	Typology of major target groups–focus beneficiaries
COVID-19 Prevention and Awareness	Public Health Department	DHO CMO CHO MO ANM ASHA Tehsildar BDO	My Family, My Responsibility' Campaign Strengthening of PHC and Hygiene and Sanitation infrastructure from 14th Finance Commission funds Gram Panchayat Development Plan (GPDP)	1. COVID-infected persons 2.High-risk essential workers
Health Care	Public Health Department Women and Children Development Department	DHO MO CHO ANM ASHA AWW	ICDS VHSND	1. Pregnant women 2. Children
Food Security	PDS Women and Children Development Department	Tehsildar Deputy CEO Women & Child Welfare	Ration cards Antyodaya Scheme– free ration for vulnerable families ICDS food supplements	1. Reverse migrants without cards 2. Vulnerable families 3. Pregnant women and children
Social Protection	GPs (RDD) Social Welfare Revenue	Tehsildar BDO Sarpanch	Jan Dhan Yojana Niradhar Yojana PM Kisan Pension	1. Families with children under 5 2. Women-headed families 3. Widows 4. Elderly persons and people with disabilities
Livelihoods	Rural Development Department	Gram Sewak Rozgar Sewak	MNREGS job cards and work Rural Livelihood Mission	1. Returned migrants 2. Unskilled workers 3. Vulnerable families 4. Small and marginal farmers families
WASH	District Water & Sanitation GPs (RDD)	Gram Sewak Deputy CEO Extension Officer	Jal Jeevan Mission Swachh Bharat Mission	Excluded households

The project was able to establish a regular and sustainable collaborative mechanism between communities and the government system through a focused approach, empowered local teams and robust monitoring systems, which enabled the establishment and restoration of trust between government and communities during this phase of shock and disruption.

Role of Swayam Shikshan Prayog

Value Addition for Convergence Between Government programmes and the Community

Swayam Shikshan Prayog (SSP) has been increasingly engaged with pursuing convergence between various nodal departments of the district and local governments to ensure that the extraordinary circumstances of the pandemic created opportunities for improved coordination and access to services and entitlements.

Mask Distribution

SSP's major contribution to the process included:

- Training all BDOs, Talathis and Extension Officers from three districts on the village preparedness checklists and PRI modules issued by MoPR and UNICEF India
- Facilitating the preparation of block-level preparedness and recovery plans for all 29 Blocks of the three districts
- Supporting block officials in preparing training schedules for all GPs and conducting the trainings
- Demonstrating plans at 250 GPs with detailed process documentation
- Facilitating self-assessment by GPs of their Preparedness Plans and making action plans to improve the COVID 19 prevention and control
- Training of GP and Sahayata Samiti members on PRI modules and their roles
- Supporting PHC teams in carrying out self-assessment on PHC checklists, identifying the challenges and working to close the gaps
- Helping PHC staff to make plans and conduct village screening camps to identify high-risk patients and help them to access health services
- Supporting PHC staff to deliver other common health services at village and PHC levels, like immunization and delivery
- Reviewing progress made, along with ASHAs and ANMs, regarding access to health and sharing information collected by SSP teams from Sahayata Samitis to complete the assessment of the progress of blocks in relation to COVID risk reduction and improved WASH services.

Overall, SSP directly or collaboratively conducted 30 kinds of activities under 8 major heads. The planning and monitoring with the departments concerned and nodal persons tracked responsibilities and outputs, so that any gaps reported by the communities could be addressed by the block and district officials in a coordinated manner.

2 Operational Plan, Management and Monitoring System

This section outlines the process related to operationalization of the project, its key activities and management system. The section is structured as follows:

2.1 Risk Informed Planning (RIP)
- 2.1.1 Key Determinants of RIP
- 2.1.2 Project Planning Steps

2.2 Project Management System

2.3 Monitoring plan: Data and MIS leading to planning and community - led review system

2.1 Risk Informed Planning

The project based the key determinants of RIP on the checklist provided by the Ministry of Panchayati Raj (MoPR) for district-level implementation. The detailed checklist can be found in Annexure 3.

2.1.1 Key Determinants of RIP

The project operation plan was designed in a manner appropriate for the local situation during the COVID-19 pandemic and lockdown period.

- Physical distancing was maintained and travel was kept to a minimum; personal contact was restricted to hyper-local areas; all these factors made the process of scaling beyond the villages where SSP was already present highly challenging.
- The risk of exposure to the virus during the implementation process, created intense pressure on the teams, for which all the required protocols were maintained. The risks were also monitored on a regular basis.
- The entire process of planning and conducting trainings, communication with government functionaries at every level, distribution of essential supplies and safety kits and tracking of benefits to ensure that they were reaching the neediest households, were all conducted remotely, using mobile phones and the Zoom platform.
- Training on the use of ICT devices and apps for the collection of data and carrying out surveys was conducted remotely the SSP teams for the entire Sakhi Task Force in 250 GPs.

Meeting with Gram Panchayat on COVID-19 Risk Planning

2.1.2 Project Planning Steps

Prior to the commencement of the project, the SSP and UNICEF teams undertook a consultative exercise with senior district government functionaries and community representatives. This step became necessary, particularly because of rapid changes in guidelines and requirements for reporting about COVID-19 and the restrictions on mobility. With the initiation of the project, several steps were taken for planning the operation and scope of the project.

- **Step 1 – Ensuring Clarity of Roles**

to ensure a shared understanding at each level on the role of each group for attaining the project objectives and evolving collaborative approaches for working with GPs and the government system.

- **Step 2 – Framing Daily Activities**

to enable people at each level to optimize their energy and to focus effort during the lockdown, with weekly reviews of work done and support needed.

- **Step 3 – Ensuring Flexibility in the Reporting Plan**

in order to plan for monthly reports and for internal quality control, the MIS remained fluid during The Inception and Implementation Phases. The operational plans for each district had to remain agile due to rapidly changing rules, revised protocols and emerging priorities of the communities, all of which required intensive monitoring and course correction.

- **Step 4 – Listing the Information Required**

to be collected at each level, which would be fed into the GP and block plans (Plans were essentially steps for achieving the 12 outputs of the project and for SSP to track 60 activities being carried out at GP level).

- **Step 5 – Assessing Training Needs**

Trainings to be done at each level and in coordination with each department were listed so that they would lead to the achievement of the relevant outputs and help the GPs to conduct activities connected to their plans. The training details are in **Annexure 1.**

- **Step 6 – Revising Strategies for Non-presence GPs**

There were separate ways of working and conducting activities for the 250 directly affected GPs and the 2450 GPs remaining (where there was no prior SSP presence or leadership), or 10 blocks in which SSP had a prior presence plus 19 non-presence blocks. Accordingly, the project had to schedule systematic and distinct plans for the two kinds of GPs. Originally, it was planned that there would be partnerships with local groups and strategies for connecting with SHGs. However, as time is required to develop such mechanisms, an alternative system of connecting directly with the FLWs was devised during the initial phase of trainings of the government functionaries. This method served the purpose of supporting the GPs across all the blocks adequately so that they could develop their own Preparedness Plans to address the needs of vulnerable groups affected by the pandemic.

Specific planning tools, applications, guidelines and monitoring plans were developed for operationalizing the project for attaining the objective of GP Preparedness Plans for WASH-sensitive and COVID-resilient communities. As this was an intensive large-scale project, in which SSP would activate and mentor teams in 29 blocks, it was important to formalize the roles, responsibilities, information gathering process, PHC-GP-Block level tasks for planning and monitoring tools for verifying completion of the required steps. To activate COVID Sahayata Samitis in each GP, which were committees mandated by the governments of India and Maharashtra norms to coordinate oversight of the disaster response, five specific categories of operations based on the overall project strategy were focused on. Planned block-wise for block, GP and PHC levels in both intensive and extensive blocks, the five were:

- Team roles
- Main daily activities
- Main monthly activities
- Information to be collected and
- Trainings to be attended or conducted

Maintaining Links Between Disaster Response and Development Resilience Programmes in Routine Flagship programmes

The project identified the key FLWs from government departments concerned and worked with them in a collaborative process through the COVID Sahayata Samitis. A PHC and school may cover more than one GP; thus the planning for PHCs and schools required additional coordination. The key GP level FLWs were:

- Health– ASHA, ANM
- Rural Development – Gram Sewak and Rozgar Sewak
- Education– Teacher
- Social Protection– Sarpanch

Usually, these functionaries were engaged with long-term development programmes and services provided under different government departments. However, for this disaster resulting from the lockdown, they had to serve as the links between disaster response and development programmes, in order to ensure that the key strategy of the government's approach to the pandemic, could reach the population groups actually affected. Thus, the project remained aligned with these convergent approaches. However, as most of these institutions were closed due to COVID-19 or due to insufficiently functioning systems, it was important for the project teams to understand the risks and plan the activities accordingly, with the cooperation of the nodal government departments.

Hand Wash Demonstration at Villages

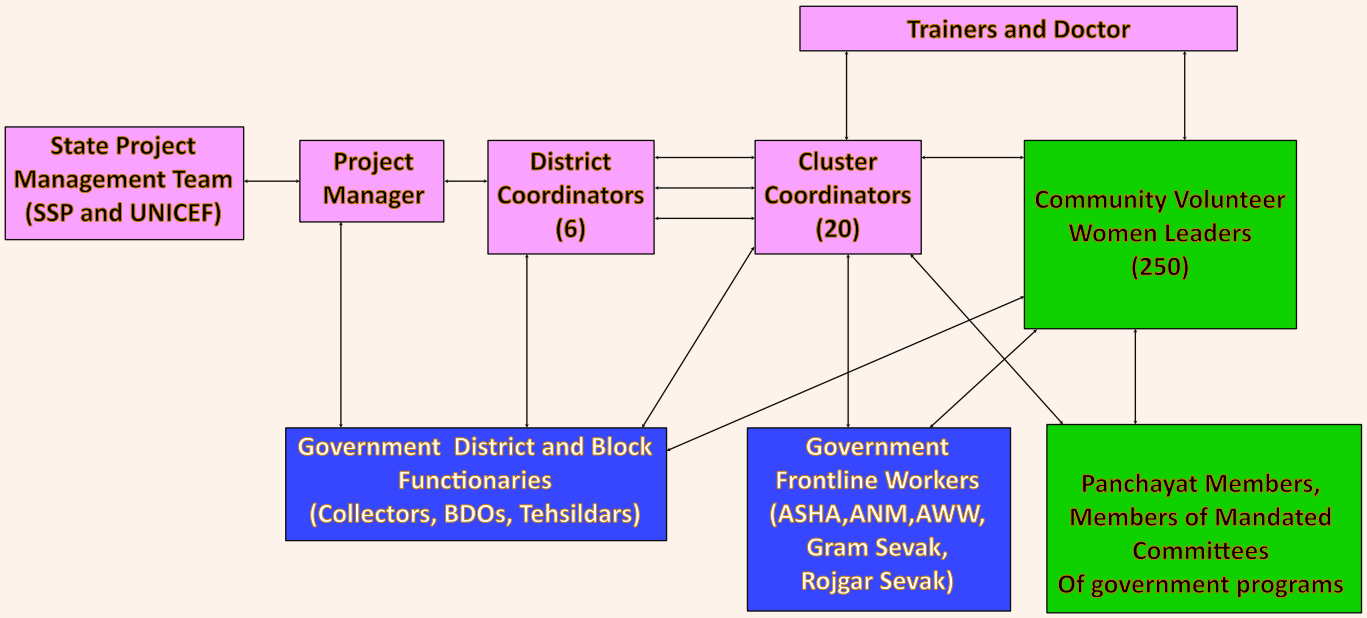
2.2 Project Management System

The project management system was devised according to the requirements of the intense, short-duration activities.

The project had a Project Coordination Committee comprising representatives from SSP, UNICEF and the Sakhi Task Force, who were community facilitators. Due to the nature of this disaster, close interaction and frequent review were essential in order to respond to changing government rules and the rapidly increasing needs of vulnerable groups.

Overall, the project manager was responsible for the strategy, quality, reporting and managing the team, as well as connecting with state and district officials.

Graphic 1 – Project Management and Community Coordination System



(Colour code: Green-Community, Blue-Government, Pink-Project team)

Eye Testing Camp at Village through Private-Public Partnership

District-level

District coordinators were responsible for overall management, oversight and coordination with district authorities across departments, ensuring timely implementation of the project activities and were instrumental in tracking progress at block level. They were responsible for collating and sharing district-wise data; identifying Best Practices; generating monthly and quarterly project reports; and mentoring the cluster teams particularly in relation to coordination with the government system.

Cluster level

There was no separate team at the block level, the mechanism for coordination with the government system was covered by the District Coordinators and the Cluster teams. The cluster level teams were aligned with their government counterparts. They were responsible for the implementation of the programme on a day-to-day basis. They coordinated with the PHC and Health Sub-centres under their purview. They were responsible for collecting PHC level data and monitoring health services through the PHCs with the Sahayata Samitis. They also scheduled Social Protection campaigns and awareness sessions at the village-level; and worked directly under the district coordinator to ensure timely implementation of planned activities. They served as the eyes and ears of the entire system, reporting any challenges, identifying Best Practices and highlighting issues and opportunities to the district coordinator as part of RIP.

Trainers

The project engaged two trainers to train the FLWs and block level officials on the Preparedness Plans and to assist in planning activities at the village-level. A doctor was engaged for trainings and for attending dialogue workshops with government functionaries at the district and block levels and also to visit and report on the status of the PHCs. The role of a doctor was critical for the Preparedness Plan for COVID-19 awareness and resilience.

Village leaders

Sakhi Task Force (250) members served as volunteers (not as paid staff) in their own villages for the project, coordinated the daily activities, collated household level data and supported the FLWs like ASHA, ANM and Anganwadi Workers (AWWs) to engage with vulnerable groups like pregnant women, the elderly or those unable to access Social Protection schemes. They tracked households and ensured that the documents were processed and any obstacles in the way of entitlements being received reported to the competent authorities.

Sakhi Task Force in Action to Support the Community

2.3 Project Monitoring Plan: Data and MIS Leading to Community-Led Planning and Review System

Monitoring Plan

The Preparedness Plan was planned and monitored at block and GP levels. Activities related to it were conducted at each level, as per tasks identified in the operational plan. Information collated by the Sakhi Task Force in collaboration with the COVID Sahayata Samiti would be filled for all three levels. Overall, there were 30 activities under 8 major heads. The planning and monitoring format included the departments concerned and nodal persons under each head and sub-head.

The Preparedness Plan format was developed according to the checklist provided by the GoM. The monitoring tool developed by the senior SSP data management team included internal tracking by SSP as part of the operations plan. For GP and PHC levels, it also included specific details of qualitative information to be added, for example, on challenges faced. This method proved important for course corrections to be addressed at block and district levels for ensuring their timely implementation.

A quality review system was also needed as the point of interface between the community and the government was being facilitated, which meant a high degree of accountability for field teams. The pandemic actually helped fast track many local solutions, like those for bringing excluded groups into Social Protection schemes, enabling improvement of water quality and distribution, as well as wastewater management.

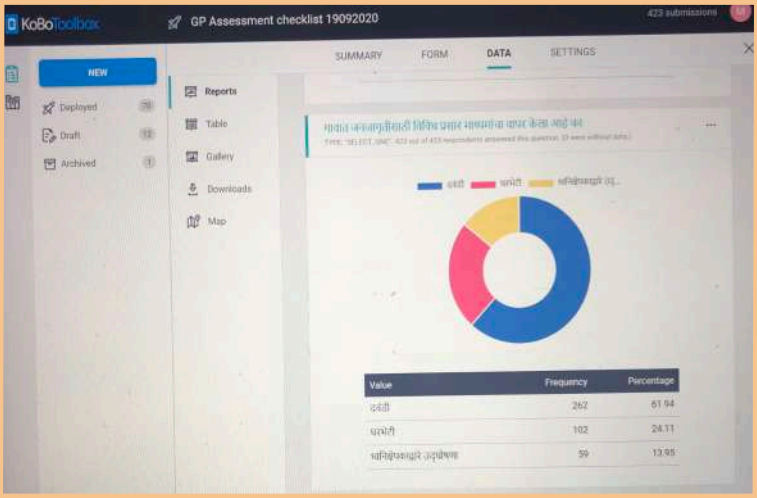
Mothers receiving Take Home Ration

These programmes were scaled up as part of the project's operational strategy. The household surveys showed the gaps in access faced by households and the assessment of facilities depicted the gaps in availability of water and solid waste management during the Inception Phase – these factors were collaboratively addressed by the GPs through requisite budgetary allocations. Further details are given in Section 3.

Communication and MIS Data Collection System

Communication protocols, monitoring systems and operational plans for each district were based on the use of communication technology. This enabled the operational system to remain agile despite rapidly updated Government Orders, revised protocols and emerging priorities of the communities – all of which meant that intensive monitoring and repeated course correction were required. As physical visits and monitoring were not possible due to the government restrictions on movement, the project developed a mobile-based communication system, for which specific communication protocols had to be developed to ensure quality and effectiveness on scale in intensive and extensive areas. The project required monitoring at different levels of the government system, hence a detailed MIS had to be set up with formats for the monthly monitoring of the activities carried out at all levels. The project MIS and reporting teams had formats based on checklists provided by GoM indicators:

Block – Social Protection data
PHC – Data of COVID-19 related and other health services
GP – Data on Social Protection and COVID-19 prevention and control activities undertaken



These formats were then linked to the KoBo App for the field team to collect and update on a monthly basis. Project reporting formats were developed and used for the following purposes:

1 Block level reporting
2 Cluster coordinator MIS Excel monthly reporting linked with KoBo app
3 PHC reporting
4 GP level reporting
5 Identification and tracking for Social Protection entitlements
6 Identification of vulnerable families

The details of the formats used in the project are given in **Annexure 2.**

My Familu
My Responsibility

'My Family, My Responsibility' Campaign: Convergence for Preventive Health Programmes

Role of SSP Trained Women Leaders Integrated Within Government Programmes

While carrying out activities related to Output 10, i.e. awareness campaigns with FLWs and functionaries, aimed at identifying gaps in COVID prevention and providing entitlement education to identified vulnerable families, the project facilitated several programmes for the 'My Family, My Responsibility' campaign of GoM. The Zilla Parishad Health Department was the nodal agency, which issued structured steps that GPs could use for identifying at-risk people aged above 50 years and those with co-morbidities (about 50 health conditions listed). An intensive process of targeted awareness interventions through the ASHA FLWs was used for ensuring that all households owned the responsibility for stopping the virus from entering their homes and improving their health-seeking behaviour. The campaign made vulnerable families aware of their health entitlements under government programmes. The campaign involved dissemination of scientific information on COVID-19 and prevention techniques like hand-washing. The campaign led to several initiatives in the GPs on sanitation, hygiene and prevented the spread of the disease due to the vigilance exercised by the collectives.

The 'My Family, My Responsibility' campaign was conducted in two phases – the first phase was from 15 September to 25 October 2020; and the second from 15 November to 14 December 2020. The first round included a survey of each household and the second phase covered any household which had not been contacted earlier. The focus of the survey was to reduce risks of spreading the infection. As fear of COVID was widespread, people were not willing to disclose their symptoms or to get tested and many were not willing to cooperate with the ASHAs for health check-ups even though they required them. After sustained efforts to improve the interactive experience, experience sharing and trainings, people started cooperating with the 'My Family, My Responsibility' campaign. FLWs and community leaders trained by SSP played a critical role in the campaign to ensure inclusion of vulnerable families and individuals. In all, the teams helped in identifying 15,727 persons, most of whom were pregnant or lactating women, elderly or poor and landless members of the SC and ST communities. Highlights of the identification efforts include:

Women collecting Household Information for the "My Family My Responsibility."

- Women leaders who became part of the Sahayata Samitis, doctors at blocks level, PHCs and Sub-centres were trained by the district health officers on how to carry out the screenings. The trained women leaders worked along with the ASHAs and AWWs for collecting community data as a part of the campaign. This process of joint monitoring and campaigning under the 'My Family, My Responsibility' with ASHA and AWWs by empowered women leaders included a survey to understand the health status of the people.
- In intensive blocks, with previous SSP presence, the villages were able to complete the campaign within eight days, owing to the support provided to government FLWs. This support included home visits to families unaware of their health entitlements. Through these interactions, awareness was spread and families and other vulnerable groups like the elderly, women and children were counselled about the process for getting health tests and entitlements. On a practical level, the vulnerable groups were supported in undertaking the process of completing their registration and other essential documentation.

In all, the SSP team supported 6013 people directly to gain access to various government services through linkages with health department FLWs and the public health system.

Sakhi's attending a Training Session on Covid Care

3 Project Outputs 1–4 – Governance System for Social Protection, Health, WASH And COVID-19 Prevention Based on Government-Community Coordination

This section outlines the key activities undertaken during the three phases of the project, the major outputs and Best Practices identified and documented during the period. The section is structured according to the major outputs at district, block or cluster and village levels. The specific sectoral outcomes related to COVID prevention, health, Social Protection and WASH are covered under each related output in Sections 4 and 5.

The overall Preparedness Plan for each GP, the challenges and achievements of the project and the details of the coordination between government, community and panchayats are documented accordingly. Best Practices, which illustrate the processes that can be replicated and scaled for implementing similar government-community-panchayat coordination projects for linking disaster response and development programmes through RIP, have been identified in respect of each output.

Hand-Washing Demonstrations to Generate Awareness in the Community

3.1 Establishing the Framework for a Government-Community Coordination Governance System at District and Block Levels – Outputs 1–4

With the onset of the COVID-19 pandemic, the GPs were faced with immense pressure from the government system and community representatives for ensuring that safety protocols were followed, care was taken of returning migrants and other vulnerable groups adversely affected by the pandemic and that Social Protection entitlements, particularly food security were available.

Challenges Addressed

The following challenges were addressed at district and block levels to improve coordination and establish processes:

1 Coordination with Government Functionaries

The project started during the lockdown phase, when senior government functionaries were under severe pressure to reduce the spread of the disease as well as to ensure that systems for essential supplies and health care were functioning properly. Some changes required in the administrative process for initiating project activities with the support of the district authorities were facilitated by UNICEF and the SSP teams. DM Control Rooms established at the district-level with key departments and the police, as well as relevant powers were devolved to the Tehsildar level. This coordination enabled the government functionaries to constantly assess and review measures, obtain feedback and establish better connectivity with the GPs and community groups.

2 Limitations of Online Training and Interactions at Initial Stages

Once coordination was established, the district authorities sought trainings for their functionaries across various levels. As very limited movement and physical meetings were possible, the project rapidly established remote meetings and trainings were conducted across locations using online Zoom and mobile-based applications. This posed several technical challenges such as, connectivity and uninterrupted interaction. Initially there was a low attendance of the government officials as well as a lack of responses during the training. This was primarily due to overload of online interactions and lack of proper devices for participation and thus required frequent facilitation.

3 Understanding Rapidly Changing Protocols for COVID-19 Prevention and Norms for Special Schemes

This issue was particularly challenging for those functionaries whose work was much more visible to higher officers and communities than earlier. They were now responsible for ensuring compliance and delivery of services, therefore, taking time to adapt to the new ways of COVID-19 prevention, would not be acceptable. This pressure led to greater cooperation from the HoDs and district officials, especially as the content of the trainings was considered to be useful and the experience sharing format constructive for coordination.

Scale of Coverage

More than 2,000 village GPs across three districts needed to be covered during the short-duration project. Lack of mobility and the need to cover several blocks and GPs where there was no prior experience, posed enormous challenges. These challenges were overcome through a threefold effort – intensive strategic operations, use of communication technology and a process of regular one-to-one mentoring by senior SSP team members.

3.2 Key Activities for Government-Community Coordination

Under the project, which was focused on building community-government coordination, a number of structured activities were conducted at district and block levels at the inception, implementation and Consolidation phases. They were:

1 Convergence planning with key district-level officials
2 Cross-sectoral trainings across levels
3 Awareness campaigns
4 Private sector partnerships to leverage resources for COVID-19 prevention
5 Improved processes and protocols to ease of access to services and entitlements

Inception Phase activities: Planning and Coordination Systems

Given the context of the project, the key activities during the Inception phase were:

a Establishing government system and community platforms across levels
b Acquiring mandatory letters and agreements with district and block authorities
c Conducting project inception workshops
d Preparing training modules
e Establishing formats and the MIS

Covid-19 Awareness on Wall Painting at Villages

The process involved coordination by UNICEF and the facilitation by the SSP teams of the coordination system with the district authorities. It also involved government functionaries at block level, GP representatives and the Sakhi Task Force.

Implementation Phase: Multi-sectoral RIP, Mentoring and Participatory Tracking

During the Implementation Phase spanning a period of four months, the key activities at district and block levels were:

a Cross-sectoral Trainings

As a major initiative under the project, a number of orientations and trainings were held with the district, block and GP level officials of Latur, Osmanabad and Solapur. The MoPR checklist and GoM guidelines formed the basis of the training. The trainings focused on:

a.i basic information on COVID-19;
a.ii measures urgently needed;
a.iii the role of community members in prevention of COVID-19;
a.iv role of GPs in COVID prevention and in prevention of stigma and discrimination around COVID-19.

Here, three orientation trainings were organized with the officials of three districts including the collectors, CEOs and deputy CEOs of the districts and HoDs of all the departments concerned. These trainings were also attended by the BDOs and Tehsildars. Trainings were also approved by the district authorities for block and GP level officials such as GP members, Sahayata Samiti members, Swachagrahis, Rozgar Sevaks, Gram Sevaks, Talathis, ASHA workers, AWWs and other FLWs. The details of the trainings are given in **Annexure 2**.

a COVID-19 Prevention Surveillance and Healthcare System Strengthening

In view of the district administration's mandate, the project was involved with facilitating the mass scale awareness campaigns, preventive surveillance and aid for infected or exposed persons. Critically, the follow-up spanned the entire public health system and services, about which there was a low-level of awareness among community members.

b Data Collection on Status of Entitlements

A regular system of data collection for identifying gaps in entitlements and facilitating last mile connectivity was established from the district to the GP level. This enabled the project to highlight at regular meetings, the issues that were being faced by the vulnerable target groups. The data was collected in two phases; initial phase for returning migrants and second one for continuous monthly updates, through community level leaders across 250 villages and district teams, on the status of services and entitlements related to the key nodal departments.

For implementation of these activities, key roles were played by senior government functionaries, trainers and coordinators and at the community level by GP members and representatives of community groups.

Consolidation Phase: System Accountability and Maintaining Continuity of Services

The key activities at district and block levels during the Consolidation Phase of the last two months of the project were:

a Campaigns for Public Awareness

Key government campaigns like 'My Family, My Responsibility' on awareness were conducted during the project. Most importantly, COVID-19 prevention and management were planned and coordinated with district authorities. At the same time, appropriate Government Orders were issued to ensure coordination with community groups up to GP level. The planning for the awareness campaigns was initiated at district-level. Planning for GP campaigns on protection and social welfare programmes and entitlements were also discussed and shared with respective nodal departments.

b Coordination Meetings

For reporting and following up with the government system, the project organized several dialogue workshops with officials and duty-bearers at district and block levels to ensure the functioning of Basic Services and access of vulnerable target groups to government schemes and entitlements.

c GP Preparedness Plans

The project developed a common format with 80 indicators based on the MoPR-GoM checklist. The plans were presented to the government authorities at district-level. The entire process at GP level was coordinated by cluster coordinators and the Sakhi Task Force. The process raised awareness on quality standards and rights on public services and facilities and was able to raise the aspirations of the community.

d Monitoring and Assessment

The project collated data and reported at the district-level about the number of people accessing Social Protection schemes and health services. In addition, the Shelter App for tracking migrants was also used in this phase. The Preparedness Plans with the GPDP plans of all 250 GPs being made at GP levels were tracked, reported on and presented to block and district authorities.

The key persons involved with the activities were senior government functionaries, trainers and coordinators and at the community level GP members and representatives of community groups.

Women sharing One Mobile to attend Training Workshops during the Lockdown

3.3 Overall Results of Government-Community Coordination in the Governance System

The district and block-level coordination and training activities with government officials were able to achieve the following:

- Training of 79 district-level officers was completed, which led to significant improvement in coordination between government FLWs and communities.

- 236 GP Preparedness Plans with 80 indicators based on the MOPR-GoM checklist were made during the short-duration project. This significant exercise of collating specific information on department-wise priorities of the communities was conducted under difficult circumstances. However, it proved to be important in raising awareness on rights, duties, quality standards and rights to public services and facilities. The process was a small start for the democratic accountability process, requiring further institutionalization through the PRI system.
- Sahayata Samiti meetings were regularized and activated. On an average, 40 per cent of the total 250 Sahayata Samitis in the three districts have been activated, which have conducted joint assessments and other activities to restrict the spread of COVID-19 in the districts.

- Women's participation post training was increased. Women have been at the forefront of ensuring universal access to Social Protection schemes; undertaking activities like awareness creation; conducting Samiti meetings; mobilizing communities to get tested under the 'My Family, My Responsibility' campaign; and participating and mobilizing the community for health-seeking behaviour or any awareness creation activities such as the Global Hand-washing Day.

- Participation and cooperation with GP level government FLWs was increased, particularly women workers, resulting in 95 per cent of the Sakhi Task Force becoming part of the Sahayata Samitis for community mobilization and awareness.

- Flagship government Social Protection and welfare schemes like Indira Awas Yojana brought under MNREGS, to ensure greater scope for work and to redefine jobs for women. In total, 1,18,253 jobs were created for women through MNREGS across 250 villages.

- Appointing nodal officers by all the three district offices to coordinate the project and to issue letters to all officials on behalf of the district administration.

Sakhi Task Force members visit a PHC to discuss on Community Health Problems and Solutions

Major Best Practices – I
Demonstration of plans at 250 GPs from 6 PHCs with 1 detailed process documentation (Output 3)

Haglur, North Solapur block, Solapur district

Objective of the Best Practice: Improved Social Protection access through GP Preparedness Planning and shared learnings

Major Challenges: Ignorance about the COVID-19 rules and lack of coordination regarding preparedness

Enablers: The GP joint team of FLWs and women leader members of the COVID Sahayata Samiti worked according to a systematic process, to develop the Preparedness Plan covering 80 indictors based on the MOPR-GoM checklist. There were separate meetings held to discuss the issues and responsibilities assigned.

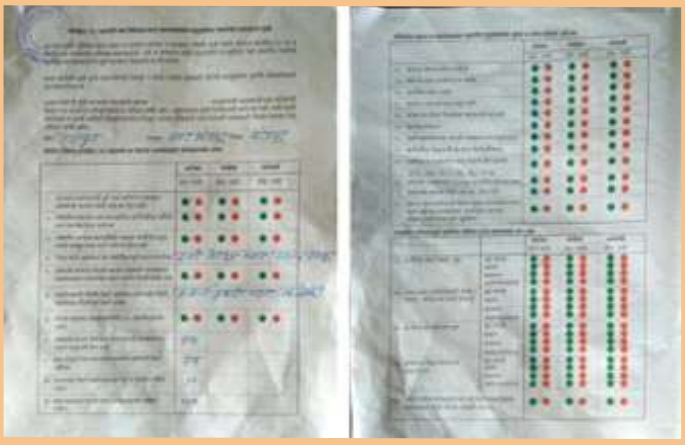
Coordination Processes and Key Activities

- **Home Visits for Vulnerable Groups**

The first COVID-19 case was identified in Haglur in July. After that the local women's group decided to look after the Social Protection needs of the elderly, the sick and children in order to protect the village from the spread of the disease. The community leader Mahananda Shinde personally went to every household and checked each member. She kept the Gram Sevak, Sarpanch and Health department updated on the status regularly. It was necessary to provide breastfeeding mothers, pregnant women, elderly people with high blood pressure, children with diabetes and infants, access to services. The group identified four diabetes patients and infants with minor ailments and then conducted home visits to constantly monitor their nutrition intake.

- **Ensuring Food Supplies**

The women's group was initially distributing rations to needy families. The food supplements from the Anganwadi centres were started again in January 2021, so efforts were shifted to food distribution through the system. Grocery store owners were instructed to adhere to physical distancing norms. Due to the pandemic and restrictions on movement, two grocery shops in



Covid-19 Action Preparedness Plan implemented by Local Gram Panchayats.

the village started charging very high prices for essential goods. In order to control the situation, the Sahayata Samiti stepped in and arranged loans for smaller grocery shops to open up for business, which regulated the prices. Milk is big business in Haglur and the village suffered a setback due to the lockdown. The GP appointed one person to carry out the milk collection and distribution in the village to avoid wastage. Through Swayam Shikshan Prayog, 10 poor, destitute and widowed women of the village were selected and 19 types of groceries were distributed to each of them.

- **Assistance to Jan Dhan Account Holders and Niradhar Pension Holders**

The people of the village had bank accounts, but the destitute ones were not able to access them. A service centre was set up to assist in the necessary process.

- **Key Changes and Potential Identified:**

The community accepted that the key role of the Sakhi Task Force was to find and facilitate solutions to shared problems. This new understanding marked a significant shift in perception.

Screening carried out under the "My Family, My Responsibility"Campaign

Major Best Practices – 2

System installed to facilitate the active functioning of village-level Sahayata Committees for assessment, prevention and containment of COVID in GPs for the three districts (Output 4)

Musti GP, South Solapur Block, Solapur District

The population of Musti is 6565, with 1200 households, of which 225 are Scheduled Castes. Ashwini Dudhbhat and Ashwini Vale are SSP leaders active in the GP.

Objective of the Best Practice

Activating the GP through coordination between FLWs and women community members to improve WASH services and habits in order to reduce the risk of the spread of COVID-19

Major Challenges

Public health was at risk due to lack of awareness on open dumping of garbage in residential areas, lack of drainage, open discharge of wastewater, low availability of water causing unhealthy living conditions and increased risk of waterborne diseases.

Enablers

While men were not interested in the issue of water and sanitation, the women were concerned about the risks to health and took the lead in their village.

Coordination Processes and Key Activities

- **Addressing Gaps in WASH**

Women addressed the issue of sewage water and unmanaged solid waste and unplanned drinking water supply. The local women SSP leaders, SHG group members and an ASHA collectively conducted an observation survey and, along with the Sarpanch and Gram Sevak, inspected seven garbage dumps, sewage lines and broken drinking water pipelines. The women members of the COVID SS passed a resolution which was then submitted as a complaint to the GP office and followed up continuously. These women members and ASHA conducted three meetings with the COVID SS about the ill effects of a poor water sewage system, inadequate drainage facilities and lack of a safe drinking water facility. Ultimately, with the support of the GP, a drinking water well damaged during the rainy season was repaired, a broken pipeline which was letting in contaminated drinking water was also repaired. As a result, there was an overall improvement in the village water supply.

- **COVID-19 Risk Reduction**

People were using a lot of single use items such as masks, sanitizers and plastic packages which could be harmful for the environment and health if not disposed of properly. With a view to protecting villagers and sanitation workers from getting infected, particular systems and processes were designed; people started putting garbage in one place and a garbage collection vehicle was organized to collect it thrice a week to avoid frequent visits and prevent the unintentional spread of the virus.

- **Open Defecation**

This registered an increase due to the water crisis, for which the women members worked to build awareness and encouraged families to adopt healthy habits. They supported access to government schemes for building toilets within private premises and took the initiative to build public toilets in the village.

- **Maintaining Hygiene**

To keep public places clean and organized, SHG members and villagers installed wet and dry waste collection bins at several locations. Representatives of the GP supported the initiative through strengthening the garbage collection and dumping system, along with its timely collection. Open drains were repaired and in addition to that, new covered drainage was built across the village. Water discharge from various sources was streamlined in a proper manner.

Covid Screenings at Doorstep

- **Joint Monitoring and Campaigning**

ASHAs, AWWs, SSP leaders and COVID SS members conducted a survey to understand the health status of the people and promoted the 'My Family, My Responsibility' campaign efficiently.

- **Key Changes**

The impact of the joint initiative encouraged people to follow the guidelines for cleanliness even after the lockdown was lifted. The transformation of women into confident village leaders was visible. Women without prior exposure to work outside of their houses, started taking the lead to access government schemes and learned to communicate with government officials and GP representatives. They participated in the GP meetings and spoke up. The impact on government functionaries has also been visible during the pandemic as they worked efficiently for the well-being of the villagers and started making decisions speedily.

4 Outputs 5–8 Improving Access to Health and COVID-19 Prevention Programmes in Blocks and Clusters

The activities regarding the access to health services and COVID-19 prevention and management programmes constituted the core of the project's rationale. At the onset of the COVID-19 pandemic, the highest responsibility of responding fell on the health and related departments. From managing the increasing cases to containment of the disease, every activity had to be carried out by the health workers, particularly ASHAs.

4.1 Health Access and COVID Prevention Challenges Addressed

Challenges addressed at block and cluster levels were as follows:

a Need to Increase Access to Quality Health Services

At the initial phase, PHCs were focused on only for tracking COVID positive patients, in setting up Quarantine Centres and making referrals directly to district hospitals from villages. Few initiatives were being taken to make the PHCs self-sufficient or to regularize other health services at the sub-health centres. This situation was affecting women and children the most. The PHC and Sub-centre functionaries were able to reach the unreached and revive the regular services for the most vulnerable groups like pregnant women and under-five (U5) children, through better coordination with SSP teams and women's groups.

b Lack of Clarity on Roles

The government constituted COVID-19 Sahayata Samitis in each village for creating awareness and ensuring adherence to norms. No formal training was given to the Samiti members, though they were formed according to government directives. The trainings conducted by UNICEF and SSP enabled the Samiti members to gain clarity on their roles in COVID-19 prevention at the village-level. The nodal departments, particularly the Health and PRI system involved SSP trained local leaders to help the ASHAs.

In order to overcome these challenges, the project undertook a systematic assessment and identified the following four categories of health activities to be carried out during the project:

1 Managing COVID patients and contact tracing;
2 Care of the elderly and patients with co-morbidities;
3 Infrastructure and supply of essentials;
4 Revival of regular health services.

These activities were conducted in a systematic manner under the aegis of the CMO and CHO and were spread across all the phases of the project.

4.2 Key Activities for Improving Health Access and COVID Prevention

Inception Phase Health Activities: Planning and Coordination Systems

Addressing the challenging context, the key activities during the Inception Phase were:

a Establishing Coordination

In order to identify gaps, assess resources, raise demands to the nearest PHC for testing services in the villages and plan for improvement of health services/ infrastructure to facilitate improved access to health awareness and services, the steps taken were to initiate and improve coordination between health FLWs and women members of the Sahayata Samitis. This process required intensive efforts as the functionaries were under pressure to fulfil COVID-19 related requirements.

b COVID-19 Prevention

As PHCs were responsible for surveillance, coordination with the community groups was introduced as a priority matter. This led to the strengthening of the overall health care system, which had long-term benefits for the village communities.

c Data Collection

The Sahayata Samiti members collected data from the PHCs and Sub-centres on the status of operations and functioning of the health system. This led to the conduct of a more formal survey in the next phase. The process improved the capabilities of community members to set up a continual cycle of COVID prevention planning to assess situations, identify gaps, initiate action and review the availability of health services.

The key persons involved with the activities were senior government functionaries, health functionaries at block and cluster levels, trainers and coordinators and at the community level, GP members and representatives of community groups.

Health Activities Implementation Phase: Training, Mentoring and Participatory Tracking

During the Implementation Phase spanning a period of four months, the key activities at block and cluster level were:

a Training and Coordination with PHC Functionaries

The trainings conducted by UNICEF and SSP were aimed at making the COVID-19 prevention efforts more community centric and increasing the involvement of the community in building resilience in relation to the disease.

b Participatory Assessment Survey at Six Health Centre Facilities

Several PHCs and Sub-centres did not have adequately functioning infrastructure to meet the needs of the COVID-19 pandemic. A survey indicated the urgent need for improved facilities. The centres lacked basic facilities and personal safety equipments to handle the high number of cases.

c Increased Testing and Healthcare Facilities

Specific interventions were done to ensure the functioning of the public health facilities and services. Key budgets were made available for developing better facilities at the PHCs and Sub-centres through coordinated efforts with the GPs. Significantly, the process was facilitated by block functionaries when the gaps were highlighted by the community groups.

Health System Coordination Consolidation Phase: System Accountability and Maintaining Continuity of Services

The key activities at block and cluster levels during the Consolidation Phase of the last two months of the project were:

a Awareness Campaigns and Surveillance

As there was extensive fear and stigma associated with the disease, a continuous awareness programme ofwas conducted during the project.

b Home Visits and Tracking Extremely Vulnerable Groups

At the initial phase, there was no access to regular health check-ups and as the private system was also inaccessible, this led to significant gaps in the care provided to vulnerable groups like pregnant and lactating women or children under the age of five years.

c Inclusive and Wider Coverage by PHCs

House-to-house visits were made by Sahayata Samiti members and FLWs to ensure that no one in need of care was missed. Once there was increased awareness on the availability of services at the PHCs, the footfall at OPDs significantly increased. The government ensured staff-placement and made available essential supplies of medicines to ASHAs, through the GPs, in a collaborative process.

d Activating COVID-19 Protection Supply Chain

Budget provisions linked to the PM-CARE fund were leveraged during the project for safety kits as well as WASH facilities, like water at the PHCs and Sub-centres. This was an important aspect of the COVID prevention activities. This initiative included the mass scale leveraging of resources for distribution of masks, soaps and protective gear at the centres and for the key functionaries. Overall, 100,000 N-95 masks were procured by SSP and distributed to health care workers. Similarly, over 300,000 households benefited from soap distribution. Masks were made by women's social enterprise groups and made available for distribution to the GPs for essential workers.

Launch of the IEC Material by the District Officials

4.3 Overall Results on Health Services and COVID-19 Prevention

The increased coordination between the community and the public health system led to several positive results:

- **Prevention of Spread of COVID-19**

Through the intense coordinated efforts of communities and government functionaries, the prevalence of the disease was highly restricted during the initial phase of the project. Even when it increased after the lifting of the lockdown, the improved awareness and health facilities ensured that it did not spread significantly.

- **Improved Quality of Services and Access to Health Facilities**

The prevalence of COVID-19 required improved testing and care facilities as had been observed during the participatory assessment survey conducted during the project. The activation of PHCs and Sub-centres Sub-centres increased awareness in the community about the availability of services. The footfall increased in significant numbers. Major services such as Antenatal Care (ANC), Postnatal Care (PNC), family planning and eye check-ups were restarted.

- **Activation of Sub-centres**

One of the outstanding changes brought about as a result of the project has been the activation of Health Sub-centres. This fact has been recognized by senior officials as well as by community representatives. Trust in the public health system was restored as the health department was strongly monitored and the support provided by women enabled them to collect data, improve infrastructure and increase the health- seeking behaviour of the community, particularly pregnant women.

- **Support for Women Health Functionaries**

One of the most significant factors for the success of the project was the consistent support of community women in the Sahayata Samitis for FLWs, a majority of whom were women. The health workers were able to improve the uptake of schemes like ICDS, Janani Suraksha Yojana and health services by those entitled to them at their own homes through this coordinated approach.

Sakhi Task Force Working together with ASHA and Health Team

Major Best Practices – 3
Surveillance of COVID hotspots and adaptation of preventive practices in 6 PHCs and 4 Sub-centres (Output 5)

Tendulwadi GP, South Solapur block, Solapur district

Population of Tendulwadi is 2936, of which 305 are members of the SCs.

Objective of the Best Practice:

COVID-19 prevention in high-risk village

Major Challenges

The village had a large number of truck drivers. It also had milk vendors who usually went to the city for distribution. The village families therefore, were at a high-risk, but were not following government guidelines. When media started telecasting updates on the impact of COVID-19 and cases began exploding, people became worried about their lives, families and businesses and even began panicking.

Enablers

GP and Sahayata Samiti members took early initiatives to share responsibility for COVID-19 prevention. The GP conducted a ward-wise survey of poor and needy families. The staff of the health department, the Sakhi Task Force and members of the GP went door-to-door and reached out to the extremely poor.

Coordination Processes and Key Activities

- **COVID Sahayata Samiti**

These Samitis were formed to execute preparedness and surveillance activities. They held weekly meetings. Awareness programmes were started on the use of masks and to observe physical distance from others. Local workers like ASHAs, AWWs and COVID Sahayata Samiti leaders demonstrated correct hand-washing methods and other healthful practices.

- **COVID-19 Prevention and Surveillance of Villages**

Twelve police tents were pitched on the Solapur border for three months and to support them, the GP involved a team of 10 youths on each road. As the police personnel were from outside that area, the Samiti encouraged them to stay in the nearest villages for the entire period of their postings and made arrangements for their boarding and lodging. The police and youthelected as “Police Mitra” (Friends of Police) were assigned the duty of patrolling the village every half hour to prevent people from collecting and causing the virus to spread further.

- **Management of High-risk Groups**

The village had 15 to 20 truck drivers. Observing regular visits to their families residing in the village, the COVID SS realized that there was a risk of infection spreading there. Consequently, a strategy was developed under which the drivers and their families were persuaded to let the truck drivers stay at the entrance of the village. The family would hand over their food and clothes to SS members. Similarly, as the village is near Solapur city, farmers used to earn through milk sales in the city. The restrictions resulting from the pandemic reduced their incomes, which pushed them into a financial crisis. The Sarpanch and Gram Sevak led the conversation with the dairy manager who agreed to help them sustain themselves financially in the critical period. As a result, the milk supplies were locally purchased and distributed so that farmers did not have to go every day to the city. Similar measures were taken for vegetable vendors who normally sold vegetables house-to-house and in local markets. To avoid the risk inherent in this system of selling, the COVID SS banned all such activities; instead it hired a vehicle to bring vegetables from the market and distribute them to every house in the village, to reduce the risk of an increase in COVID cases.

- **Ensuring WASH infrastructure**

To keep public places, schools, GP office and houses safe and hygienic, all common infrastructure was sanitized within the village. Residents were encouraged to keep the village clean. The school was set up as a Quarantine Centre, where isolation wards were also arranged. Distribution of various items was done by COVID SS members, for example, 500 masks, 500 sanitizers and 1600 soaps were distributed to all households, along with sanitary napkins for women and girls. Moreover, rice was distributed to school children through SMCs.

- **Health Care and Food Security**

To improve food security, people were encouraged to start kitchen gardens andcultivate vegetables for household use and sell the remainder to their neighbours, to increase healthy food consumption and avoid vegetables coming from outside.

- **Active Youth Committees**

Restrictions on movement meant that families in need of medicine faced problems going to medical stores. To avoid frequent visits to medical stores, the COVID SS found an alternative by assigning village Youth Committee members to collect medical prescriptions from families and purchase medicines from the stores, PHCs and GP office. Medicines for cough, cold, fever and other minor ailments were kept at the GP offices, so people could access and collect them easily in case of need.

- **COVID-19 Screening and Testing**

ASHAs, SSP leaders, AWWs and health representatives from the PHC conducted a house-to-house survey and screened everyone, especially concentrating on 520 members of the high-risk population, aged 60 plus. Along with that, women in need, children and people with sickness and people at risk were also screened frequently and monitored strictly during the lockdown. A total 178 Antigen tests were conducted. The 'My Family, My Responsibility' campaign was executed effectively, through which every household was encouraged to own the responsibility of stopping the virus from entering their premises.

- **Financial Support to Returned Migrants in Distress**

Migrant families who came from cities to be safe from COVID had exhausted their savings and were in dire need of financial support, which was duly provided. Also, the "ATM at the doorstep" initiative was implemented to help people access bank accounts and withdraw money. People who were facing shortage of cash could access the ATM and withdraw money at their convenience without assembling together.

This comprehensive set of initiatives significantly reduced the spread of COVID-19 in the village.

Key Changes

The experience of the new collaborative approach during the lockdown made people realize the potential of the GP and how it could effectively function in a participatory process. Women's confidence about working with the government increased as the initiative led to fostering contacts between government officials and Sakhi Task Force members, which changed their attitude about accessing government schemes. Most significantly, the bonding and peer learning process between health workers, ASHAs and Samiti leaders became strong.

Masks, Soap, Sanitizer,Food Kits and Financial Support to Migrants

Major Best Practices – 4

Number of PHCs with increased number of people accessing health services (Output 8)

Walsang PHC, South Solapur block, Solapur district

Objective of the Best Practice:

Improve community awareness and access to health services

Major Challenges

Overcoming Fear

COVID-19 created fear in the minds of people and the number of people coming to the PHCs decreased further. ANC, PNC and administration of vaccinations declined as a result. People did not report illnesses and in fact kept them a secret, also choosing not to attend PHC OPDs. Thy felt that health workers had to be avoided.

Limited Health Services and Facilities

The PHC was short of staff. Ambulances were not easily available for medical emergencies. The PHC did not have an adequate sewage system or drinking water facility to meet the safety norms.

Enablers

The PHC team reached out to the Sakhi Task Force for support and they jointly leveraged the facilities.

Coordination Processes and Key Activities

- **Health Awareness and Safety**

This work involved raising awareness constantly about COVID-19 through IEC material and encouraging people to maintain consistent personal hygiene and safety. The health workers and SS women leaders also tried to reduce the fear in the minds of people through home visits.

- **Using improved health infrastructure**

There was a 100 per cent success in keeping all the patients safe by giving priority to delivery cases and taking care of personal safety and that of the patient during the period. No case was refused. The PHC got a baby warmer facility and a new oxygen machine. Testing facilities became available, blood tests and routine immunization vaccine stock was also increased at the PHC.

- **Resumption of Services**

An ANC and PNC inspection camp for pregnant and lactating women was initiated; it has been continued and takes place every Tuesday. An eye check-up camp is held regularly on Wednesdays. Family planning surgeries were resumed in December. The doctors, ANM, ASHA and GP staff have been able to work well together in overcoming the enormous challenges they faced personally and have been recognized; Walsang Arogyavardhini Kendra is considered to be number one in Solapur.

- **Tracing and Testing High-risk People**

A notable joint effort was made by the SS, GP and the health workers to categorize people for monitoring and testing. People facing greater risk were categorized and checked daily. These categories were high-risk patients, essential workers like shop owners, medical shop employees and its owners. As a result of the efforts, only 64 out of 10,000 population became COVID +.

- **Reviving the PHCs**

The PHC had been dysfunctional for two years as it did not have a water connection. It was due to the close coordination and pressure from the GP, as highlighted by the SS members that funds were disbursed for a water tank and motor. The PHC's applications had not been approved by April and hence this intervention by the GP was beneficial for them. The health department had also been neglecting their request for extra staffing, to maintain cleanliness during the pandemic. The GP supported the PHC by appointing one person from the village to look after the hygiene of the PHC.

- **Coordination with COVID SS Established in the Village**

As staff members of the PHC were also members of the COVID Samiti, along with the ASHA, ANM, MPW, GP members and Sakhi Task Force, a regular coordination forum became institutionalized. Together they formed different teams according to different departments and did home visits in the village to spread awareness on personal hygiene and safety. A list of elderly people, pregnant women, lactating mothers, children and people with high blood sugar and hypertension was also prepared.

Key Changes and Potential Identified

Improvement in Facilities and Services

Drinking water became available and the sewage system was well managed. The premises remained clean and good hygiene was maintained. There is now a full testing facility for COVID-19 at the PHC. The complete system required for deliveries is functional. Family planning camps have been resumed. Overall, there has been an increase in the number of patients coming to the OPD.

Change in Attitude

Changes in behaviour of the staff and FLWs have come about after they were able to overcome major challenges through cooperative efforts and peer learning processes.

5 Strengthening Social Protection, Community Participation and Resilience for COVID Preparedness Planning at Gram Panchayat Level

The block and district administration worked consistently with the GPs and community representatives to address the challenges faced at the village-level. The COVID Sahayata Samitis were given the task of preparing villages on how to deal with COVID-19, maintain hygiene and ensure basic services and food security. Initially, the Samitis were inactive due to lack of clarity on the requirements and existed only on paper. The Sakhi Task Force trained by SSP approached the GPs to try to activate them. The Sakhi Task Force worked intensively at the forefront to meet the requirements and this led to their inclusion in the Samitis after August, in almost all the villages.

5.1 Social Protection Challenges Addressed

At the GP level, the challenges faced by the project were the following:

1 Lack of COVID-19 Preparedness and WASH

Lack of coordination mechanisms, information, as well as trust, initially led to lack of cooperation regarding safety protocols and the treatment of COVID-19. House-to-house visits by the Sakhi Task Force along with ASHAs helped to improve the situation and led to a better response when the first set of infections were reported. There were gaps in the availability of water, the use of toilets declined significantly and there were garbage dumps in the open, in several villages.

2 Ensuring Adherence to Safety Protocols and Activating Community Groups

Frequent movement of returned migrants, essential workers like sanitation staff, vegetable and milk vendors and retail shop owners would increase the risk of spreading the infection. The GPs had made committees of youths as required by Government Orders to help maintain a register of movements in the village. The SHGs and Sakhi Task Force groups earlier facilitated by SSP and UNICEF were also activated to support the process.

3 Ensuring Functioning of the Social Protection System

The most vulnerable groups had very limited access to basic services. They also lacked information about their rights, were apathetic about the gaps in relation to accessing Social Protection schemes like PDS, MNREGS, health insurance and other welfare programmes like pensions for widows and the elderly.

4 Reverse Migration

A large number of returning migrants came to their villages in distressed circumstances. Arranging for them to stay safely was a challenge for the GPs as resources like rations and space were limited at the initial stage. Sources of income and livelihoods had to be ensured for the migrants, but many of them did not have basic documentation like job cards or ration cards.

5.2 Key Activities for Social Protection

Inception Phase activities: Planning and Coordination Systems

Addressing the challenging context of the project, the key activities related to Social Protection during the Inception Phase at the GP level were:

a Establishing Communication with the Government system

At the GP level, there were multiple functionaries and mandated committees, which were at various stages of functioning or non-functioning. Even with the establishment of collaboration with the district authorities, it was sometimes a complex challenge to overcome the local dynamics and kinship systems through which the frontline functionaries operated. The project was able to establish relationships of trust because of its credibility which had been established earlier.

b Connecting with Community Groups

Meetings with GP members were conducted remotely during the Inception Phase to understand the scale and scope of the challenges being faced by the village communities, particularly by the extremely vulnerable groups affected by the pandemic in multiple ways. The plan for mentoring and follow-up support of COVID Sahayata Samiti representatives in extensive GPs was accordingly revised and implemented through the government system.

c Contacting COVID Sahayata Samitis

The government norms had mandated the establishment of COVID Sahayata Samitis. The project reviewed their status and made a plan for their revival in 250 villages. For the non-presence villages, the guidelines and support were provided through the first round of trainings conducted under the project.

Implementation Phase: Training, Mentoring and Participatory Tracking

During the Implementation Phase spanning a period of four months, some of the key activities at GP level were:

a Activating Sahayata Samitis

Active members of the community collectives worked continuously during the project. To coordinate their work with the government system and GPs, regular mentoring support was provided. Monthly meetings with Sahayata Samitis were held and records kept about actions taken.

b Follow-up on Preparedness Plans

Assessment of all 250 GPs on Preparedness Plans was done through monthly data collection on the progress of implementation of Preparedness Plans. Results were tracked and followed up.

c Holding Awareness Meetings

Continual meetings and regular telephonic communication were established in villages for COVID prevention and control, as well as for follow-up of Social Protection schemes.

d Organizing Campaigns in the Community

Organizing awareness campaigns for Social Protection schemes of various departments. 'My Family, My Responsibility' was a notable campaign conducted during the project. This involved dissemination of scientific information on COVID-19and prevention t echniques like hand-washing. The campaigns led to several initiatives in the GPs on sanitation and hygiene; they prevented the spread of the disease because of the vigilance exercised by the collectives.

e Enrolment of vulnerable people for Social Protection Schemes

This was a critical and continual activity conducted by the members of the Sahayata Samitis along with the government FLWs, to ensure that no one remained at risk due to lack of food or income. Members reported on the number of people accessing the Social Protection schemes and highlighted the gaps with the nodal departments.

f Working with Migrants

Intensive efforts were made regarding the welfare of migrant workers who had returned to their homes due to the lockdown. As many of them lacked documentation like PDS ration cards or MNREGS job cards, required to access essential services, the survey of migrants through the Shelter App and their enrolment in the schemes was a key activity.

Social Protection Consolidation Phase: System Accountability and Maintaining Continuity of Services

The key activities at GP level during the Consolidation Phase of the last two months of the project were:

a Working Towards School Safety

The project facilitated GPs and headmasters in making school safety plans and implementing and monitoring the GoM checklist. As the parents were unwilling to send their children to school, meetings were organized by the Sahayata Samitis and SMCs involving the parents to discuss the measures that had to be undertaken prior to the opening of the schools. Home visits were made by the Sahayata Samiti and SMC members in cases where the parents were unwilling to send their children to school.

b Assessing School Facilities

A survey was done in all the schools. For schools without adequate WASH facilities, meetings were conducted with the SMC, GP and Sahayata Samitis to discuss ways of addressing the gaps. Suitable accountability was fixed in respect of tasks to be carried out along with a timeline. Masks and sanitizers were distributed to the children attending school. Out of the 247 schools assessed, 224 had toilets for both boys and girls, while 226 had toilets for girls. This data however did not show whether the toilets were operational or adequate for the number of children enrolled.

c Continuing Awareness and Communication Campaigns

The project distributed IEC material in the GPs and highlighted prevention messages through wall paintings with key messages. The regular information updates on rules, maintaining hygiene and Social Protection and health services were shared by FLWs supported by women members of the Samitis.

d Documenting and Consolidating Processes

The short -intensive project was complex in terms of operations at several levels and involved a diverse group of people that had hitherto not worked together. The project's tactical focus on participatory processes and cooperating with government functionaries, FLWs, as well as members of the community Sahayata Samitis proved effective. It ensured that the broader environmental challenges were overcome and many informal methods/attempts at working evolved into regular processes. These experiences highlighted the importance of documenting and consolidating these community resilience building processes.

5.3 Social Protection – Overall Results

The activation of community groups and their coordination with government systems has yielded multiple outcomes at the early stage of this short-duration project, which may be summarized as follows:

- **Establishment of Relationships of Trust**

The close coordination between GPs and government functionaries with community groups in the Sahayata Samitis and other forums have become institutionalized and etched into the collective memory of the village communities through the leadership of women leaders trained by SSP. This result has been acknowledged by senior officers as well as community members who benefited from improved services during the disaster.

- **Social Protection and Welfare Programmes Made Accessible**

The impact of the pandemic led to many more households requiring support through various Social Protection programmes. The project brought in more than 15,000 vulnerable households into critical schemes like PDS, MNREGS and health insurances, by initiating their documentation with the government functionaries. Most significantly, persistent follow-ups resulted in benefits actually reaching the families.

- **Possibility of Continuity of Services**

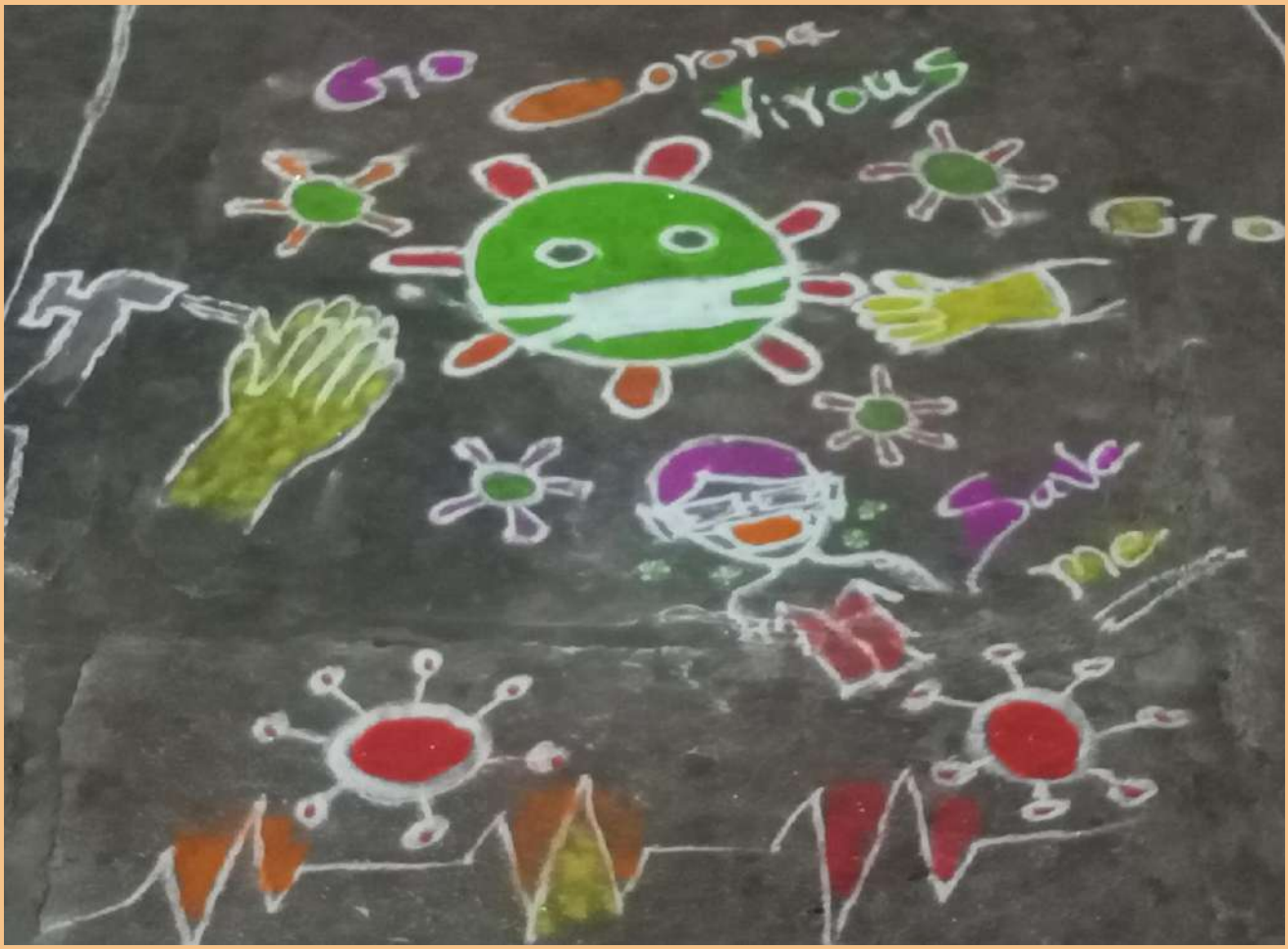
Water, sanitation, PDS, health and other critical basic services were improved during the pandemic due to better coordination between the government and communities. Services which got suspended, like those at the PHCs, were restarted. The higher level of awareness and the creation of a mechanism for coordination within the community and with the government system are showing promising results.

- **Higher Cleanliness in Villages**

Early assessment showed several villages had open garbage dumps, with people throwing garbage on the roadside or at market places.

- **Awareness Regarding Issue ofViolence Against Women**

The lockdown led to an increase in pressure on women. The activation of women's groups, the increased home visits by FLWs and the resulting empathy in women towards other women were observed and discussed in many villages. The women also became aware of social evils; they estimated that 5–10 early marriages were conducted post-COVID in each village. This issue was however reported only in FGDs and needs to be examined more closely in future.



Covid Awareness through Rangoli

Major Best Practices – 5

Increased access to Social Protection entitlements for all households from vulnerable groups post block level planning compared to 2019–2020; entitlement education to identified vulnerable families (Output 9)

(Vulnerable groups were defined as families with children under 5, women-headed families and families of small and marginal farmers)

Vadji, South Solapur block, Solapur district

Objective of the Best Practice:

100 per cent coverage of each household under Social Protection in COVID-19 free village

Major Challenges

Lack of awareness on norms and scientific facts about COVID-19

Enablers

A consensus about cooperation in the community ensured perfect compliance in the village. As awareness about COVID-19 was spread through door-to-door visits and meetings of 5 to 6 women leaders from the Sakhi Task Force, it created an atmosphere in favour of following every government rule regarding disaster preparedness and risk reduction. Every programme of the government was well implemented during the COVID-19 lockdown phase and also subsequently.

Coordination Processes and Key Activities

· **Coordinating with SHGs and Government Functionaries**

The SSP leaders, Sahayata Samiti members, in Vadji started communicating with the community through the 22 SHGs in the village. Awareness meetings with the SHGs were organized on COVID-19 prevention and preparedness and the processes for accessing various Social Protection schemes. The Gram Sevak, Police Patil and the Sarpanch worked closely with the SHGs to ensure that eligible people applied for benefits under the relevant schemes.

· **Addressing WASH Gaps**

Under the MNREGS scheme, some people got the work of closing open drains. There was an increase in the prevalence of Open Defecation during the pandemic, due to increased population and shortage of water. The SS tried to ensure that all new houses under construction had toilets.

· **Livelihood Linkages**

Alternative livelihood options were leveraged by the Samitis, for instance, the work of the construction of 150 houses sanctioned under the Gharkul Indira Awas Yojana and jobs under the MNREGS were given to construction workers.

· **Start-up Capital for Women Owned Enterprises**

To enable women to become self-reliant and financially empowered, 20 women from poor, SC and migrant families got bank loans of INR 500,000 to start businesses, which gave rise to 20 new women owned businesses.

Key Changes

The GP, Sahayata Samitis and government FLWs worked to make this a clean village, free of open drains and gutters. It has become a garbage free village. 100 per cent of the families in the village get ration under the PDS; and 100 women and 50 men got employment under MNREGS. Women participate in public meetings regularly.

In an important gesture, the Samiti and the village community collected three tons of wheat, sorghum and other grains from the people and donated them to the district tehsil office as food rations for distribution.

Awareness on WASH during Covid-19 by Sakhi Task Force

6 Key Learnings and Recommendations

Health and Social Protection Through Government-Community Convergence And RIP

This section provides an outline of the processes initiated and anchored by the Sakhi Task Force and community representatives, as well as the ways in which they were impacted by the pandemic. It also frames the preparedness of the processes for resilience. These aspects are detailed through the following sub-sections:

6.1 Key Outputs: Summary of Findings on Outputs and Impact
6.2 Learnings from Best Practices – Evolving a Process Methodology for Strengthening the Community, GPs, Block and District PRIs
6.3 Recommendations for Scaling Outputs and Methodologies for Continuity of Services and Risk informed programming.

The process for arriving at the learnings and implications for future programming are given below.

6.1 Key Outputs: Summary of Findings on Outputs and Impact

This sub-section aims to develop a better understanding of the role of community groups and women SHG leaders at the frontline of the COVID-19 preparedness and community resilience effort. Towards this, it relies substantially on a mid-phase survey on community engagement with the GPs and government FLWs, besides a series of structured interviews with field teams and government functionaries, conducted by SSP teams.

Community and Government System Level Coordination for Long-term DCCA Impact

1 Recurring Problems of Vulnerable Groups and Migrant Families

The influx of migrant families required that Preparedness Planning be focused on social inclusion, linked to building economic resilience, through access to MNREGS for poor households. The project has shown that the role of community facilitators is the key to improving the connect between marginalized vulnerable households and the government system as well as providing access to those who need it. Using the provisions of the Disaster Management Act and the Incident Response System (IRS) resulted in the ability to structure responses to cover humanitarian and risk informed climate and development issues. One of the key aspects of the response system was that powers were devolved fully to the Tehsildar, whose office had full control over the implementation of the COVID 19 response. Additionally, the blocks trained composite teams from nodal departments with proper documentation, as well as planning and data management skills to assess and manage response activities in dynamic shelter camps, Quarantine Centres and COVID centres at PHCs during the Response Phase.

See online at http://www.ndma.gov.in/Capacity_Building/Ops_Comm/IRS.

1 Joint Platforms for Building an Enabling Environment

Coordination through frequent meetings at the block level facilitated by the NGO, SSP, along with intensive follow-up by the Sahayata Samitis, resulted in higher enrolment of most vulnerable groups. It was thus demonstrated to government duty bearers as well as community representatives, that cooperation at multiple levels in identifying gaps and in planning jointly, greatly reduces risks and increases resilience. These findings can address emerging hazards and new forms of deprivation faced by vulnerable groups. The learnings from the operationalization of the Disaster Management Act shows the efficacy of convergence of government systems within districts. Such joint platforms must be mainstreamed and should have frequent meetings. They may be defined as Taluka level subcommittees for greater coordination, leading to more efficient responses.

2 Institutionalizing Women's Participation Improves Local Governance System

Collaborative functioning by GPs with local women's task forces improves the functioning of government FLWs significantly. GPs are able to be more responsive when supported by community leaders. During the project, such leaders functioned as extra hands that were much needed after the pandemic began and complex sets of frequently updated guidelines were required to be followed, together with widespread behaviour change to be adhered to.

3 Cross Learning Strengthens Local Communication

It is possible to institutionalize regular local systems of peer learning and sharing which are useful in improving governance despite challenges and limitations. Basic information, checklists and frequent communication on phone and through controlled meetings while adhering to COVID safety protocols need to be made available to the wider community in order to significantly improve its ability to initiate RIP.

4 Overcoming Climate- change Related Challenges During the COVID-19 Pandemic

The project was operationalized in the Marathwada region, which suffers from a chronic shortage of water. An increase in the use of water for hand-washing and sanitation for toilets and also open defecation were key challenges to be overcome during the project in each village. Maintaining basic hygiene in households and villages required greater use of water. Even public health facilities required a regular supply of safe water. The project worked intensively with the district authorities to provide budget allocations and infrastructure connected to availability of water.

5 Planning for Nutrition and Livelihood Security is the Core to Resilience Building

Key gaps in resilience of households resulted from the lack of local sources of income and of the ability to access public subsidies through such programmes as the Public Distribution System (PDS) and MNREGS, a job guarantee scheme. Enhancing coordination between the government system at the GP level with the Sahayata Samitis was critical; tools like the preparedness checklist and household survey proved to be extremely useful for providing essentials to vulnerable households.

6 Reviving the Public Health System Hit by the COVID Crisis Improves Health Outcomes

Public health services were badly hit due to overall fear and stigma and health centres suffered from neglect. Specific awareness campaigns and improving the infrastructure and services, especially of the health Sub-centre, as well as the active role of the field health workers and volunteers have been an outstanding aspect behind the successful functioning of the project.

7 Claiming Social Welfare and Protection Services Reduces Relapses into Poverty

Due to the lockdown, newly vulnerable or additionally at-risk groups like returned migrants or landless daily wage workers required a strongly enabling environment. For them, access to basic services and Social Protection prevented them lapsing into abject poverty. Beyond enrolment, it was proved that follow-up both at the GP and Block level is essential to ensure actual access to services and schemes.

Learnings On Programme Management

8 Overcoming Biases and Stigma Through Ensuring Participation

People in distress may be unwilling to articulate their needs and challenges as was the case with migrants and the additional households in villages. During the COVID pandemic, the reason was the stigma that became associated with families that had returned to their places of origin. Enumeration of these households by the Women's Task Force and bringing their issues to the notice of government functionaries significantly increased the last mile connectivity.

9 Establishing Relationships of Trust for Sustaining Basic Services

Access to basic services, especially WASH, both at the level of community institutions like schools, Anganwadis, PHCs and at water sources, became the key priority during the initial Implementation Phase. It was realized that an internal quality control system was needed at the point of interface between the community and government. The crisis brought on by the pandemic actually helped to fast track local solutions related to water quality, distribution and wastewater management, which were scaled up as part of the project's operational strategy. Communication protocols, the monitoring system and operational plans had to remain agile for each district due to Government Orders being rapidly updated, protocols being revised and the priorities of the communities evolving over time. In the given circumstances, both intensive monitoring and course correction were required. Many new milestones were reached during the brief period of the project and they need to be analysed and taken forward in a systematic process – some of them have been listed in Section 3.2.

10 System Strengthening Processes in Non-presence Areas

The project initiated an effective start for the process of scaling through a series of trainings and mentoring steps for government FLWs and GPs, in 19 blocks of the non-presence villages, aimed at strengthening the system. New communication protocols were explored, needs identified, trainings conducted and a regular system of mentoring established in non-presence areas. The process thus developed will be most critical for preparedness planning in a targeted manner for ensuring that no one is left behind and that the governance system is able to sustain the resulting improved connectivity with communities.

11 Technology Bridges Barriers in Uncertain Times

Remote-access communication technology helped overcome physical barriers resulting from the lockdown rather significantly. The Women's Task Force was able to facilitate entitlements to 30–100 households per village initially. Through the extensive use of mobile phones and the internet, as well as intensive follow-up online, task force leaders were able to expand this process to non-presence areas and provide hand-holding support to GP level government functionaries.

6.2 Learnings from Best Practices – Evolving a Process Methodology for Strengthening the Community, GP, Block and District PRIs

An Appreciative Enquiry Process including group discussions was carried out to identify human interest stories and Best Practices substantiated by evidence.

1 Rapid Analysis of Insights for Planning and Future Actions

The project identified the range of challenges faced by specific vulnerable groups and the insights gained thereby provide a basis for socially inclusive resilience building, strategy planning and monitoring in future. The process also helped to identify the diverse experiences, ideas and challenges faced by FLWs and the Sakhi Task Force whose members played the key roles in ensuring the outcomes.

2 Process of Sharing Human Interest Stories is Itself Key to the Learning Process

Structured interactions and exchanges between government functionaries and community groups, at various stages during the implementation of the project, highlighting Best Practices demonstrated the success of the SSP's participatory processes. The information was very useful for understanding local process innovations for community participation as these resulted in new approaches and behaviour becoming more acceptable to government authorities. Most importantly, these developments played a critical role in preventing the spread of COVID-19 in the GPs across the three districts.

3 Advancing Demonstration Sites and Peer learning

Peer learning is a critical part of reflection and institutionalization of learnings from community-driven efforts. The ways in which community members and the Sakhi Task Force perceived their engagement with the government system will bring learnings for scaling strategies as well as for fast-tracking them in rapidly changing situations like the COVID-19 pandemic and similar disasters.

6.3 Recommendations for Scaling Outputs and Methodologies for Continuity of Services and RIP

As identified in the learnings in Section 3.1, this short-duration project streamlined critical methodologies for scaling programmes which link disaster recovery, resilience and long-term development approaches. The key strategy of scaling through system strengthening was successfully tested during this project. The following are the recommendations for maintaining continuity of services and RIP.

1 Consolidation of Local Partnership Between GP and Community Leadership

The intensive processes for building capacities of GP level members and community leaders has a long-term impact on ensuring access to entitlements related to food, nutrition, health, WASH and economic resilience. The mandated Sahayata Samitis in GPs acted as platforms for defining needs and carrying out Preparedness Plans. These Samitis could be made the Village Disaster Management Committees (VDMCs) and there would also need to be a Taluka level body which would be called the Taluka Disaster Management Committee. These platforms can form the core for long-term disaster preparedness, resilience building and for addressing the challenges of recurring disasters and exclusions. The trainings would need to be structured, their outcomes tracked and the trainees provided mentoring and hand-holding support to take up the new challenges for vulnerable groups like pregnant women, children under five years, the elderly and people with disabilities. The SDMA, DDMA, TDMC and the VDMC would work as per the mandate of the Sendai Framework and the National Disaster Management Authority to minimize risks at the community levels.

2 Continuous Training and Assessment

The role of community collectives becomes critical as most of the programmes to be monitored are self-assessed to minimize physical contact risks. The project teams were trained to assess the training needs of community groups, FLWs and government functionaries. Its system of training and then monitoring the trainees became the major reason for SSP's ability to expand to GPs where it had no prior presence in the 29 blocks. The expansion helped to create a new set of local champions able to continue the critical processes.

3 Participatory Monitoring

The need for coordination and agility in responding to the recurring challenges, requires a high degree of autonomy being vested in the community level committees and local functionaries at every level. The force of circumstances related to COVID-19 restrictions created the opportunity for demonstration of leadership as well as mutual support. The Joint Local Action process included tracking of entitlements, awareness programmes for various stakeholders and community education on health practices and health-seeking behaviour. SSP teams and Sakhi Task Force members in the Sahayata Samitis were trained in remote mobile-based monitoring to ensure that no blockages were allowed to choke up the entire loop of outcomes for protection and entitlements in respect of vulnerable households.

4 Inclusive Social Protection and DRR Initiatives led by Community Collectives

Cultural biases and exclusions are hard to overcome and many of them are increased during disasters, when the powerful try to minimize their own risks. These biases were heightened during the pandemic as well and treated as fundamental to RIP. The project had to ensure that vulnerable households in distress were included in access to basic services, rations and living wages and this required committee members and leaders to monitor the status and listing of applications and legal compliance documentation for accessing entitlements.

Needy Families receiving Ration

5 Key Project Enablers

Some of the key enablers of the project have been SSP's time-tested community empowerment strategies, which navigated the risks and uncertainties caused among rural communities, by the COVID-19 pandemic and its aftermath. The extreme distress faced by vulnerable groups directly affected were balanced to an extent by the strong platforms of solidarity led by women. SSP's previous experience of association with key state and district government departments for Mission Jal Shakti, Swachh Bharat Mission, Mahila Kisan Sashaktikaran Pariyojana and SVEP were all leveraged effectively for increasing the impact of its interventions in supporting government programmes during the COVID-19 pandemic. The DRR strategies and protocols that Sakhi Task Force trained by SSP were able to bring into their work during the pandemic phases, enabled them to provide robust support to government FLWs at every level. Similarly, scaled programmes need local alliances and networks.

These learnings can be the basis of future programme initiatives for sustainability of processes and consolidation of resilience among communities. The inclusive and gender sensitive Social Protection programming approaches, significantly increased the reach, coverage and impact of the project to scale outcomes. While action was not directly taken on violence against women, awareness was created among women and FLWs.

The learning and recommendations related to scaling methodologies for projects with government-community collaboration for integrating humanitarian responses and development programmes for vulnerable at-risk groups, were presented to national and state policymakers and administrators by UNICEF and SSP during the Virtual Learning Workshop: Building COVID-19 Recovery with GO-NGO collaboration in March 2021.

My Family My Responsibility Rally

Project

Covid Resilient WASH Sensitive Panchayats and Communities

Annexures

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Annexure 1 - Trainings conducted

Trainings and orientation workshops were held for government functionaries at various levels to orient them about the technical requirements and community needs in 3 project operational districts.

Annexure 1.1 Type and levels of trainings

Annexure 1.2 Government functionaries at District, Block with PHC personnel training

Annexure 1.1 Type and levels of trainings

Level	Name of training	Participants	Trainers	# of trainings conducted	# participants	Training mode (physical/remote)	Module-Resource Material source
Project	Orientation Workshop	SSP team UNICEF team	Sector Experts Doctors UNICEF team SSP team	1	Project team	Remote	MoPR and GOM Guidelines
District	Training workshops with District HODs	Collector BDOs Department heads of Health, ICDS	Sector Experts Doctors UNICEF team SSP team	3	79	Remote	MoPR and GOM Guidelines
Block PHC-Cluster GP	Training with 29 Blocks across 3 districts on Covid-19 Preparedness Plan	Talathi CMO ANM ASHA AWW	Sector Experts Doctors SSP team	55	3042	Remote	MoPR and GOM Guidelines

Annexure 1.2 Training Module for Government functionaries at District, Block with PHC personnel training

The trainings focussed on basic information on Covid-19, measures to be undertaken for prevention at community and household levels, Gram Panchayats (GP) role in Covid prevention, importance and ways of community participation to create a conducive environment, GPs role in prevention of stigma and discrimination around Covid-19. The trainings were designed to overcome challenges faced in the project, like low attendance and response of government officials; longer time taken to adopt new ways of Covid-19 prevention being introduced; and large number of Gram Panchayats to be covered across three districts. The efforts of the team and cooperation of the HODs and district officials ensured that the trainings became an experience sharing platform in each GP and block.

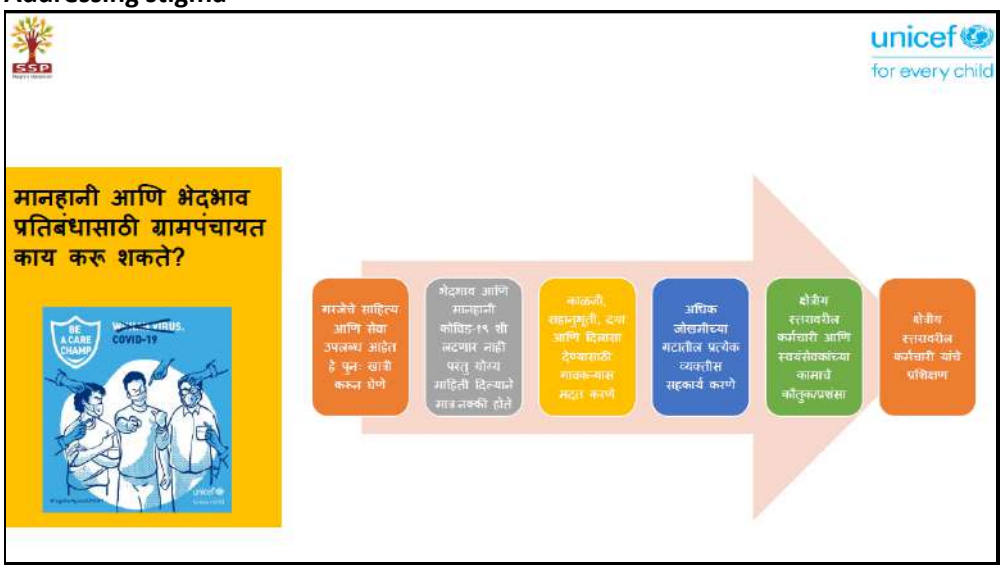
The following Training Module was used for training during the project, and is available for reference.

Training Content Outline

प्रशिक्षण विषय

सत्र क्र.	वेळ	सत्राचे नाव	साधन व्यक्ती
सत्र १	०५ मिनिटे	प्रकल्प व प्रशिक्षणाची ओळख	दिलीप धवण
सत्र २	२० मिनिटे	कोव्हीड -१९ ची ओळख व कोव्हीड -१९ उपाय आणि प्रतिबंध	डॉ. निलेश धवन
सत्र ३	२० मिनिटे	कोरोना प्रतिबंधासाठी वैयक्तिक, कौटुंबिक आणि सामाजिक स्तरावर घ्यावयाची काळजी	दिलीप धवण
सत्र ४	१५ मिनिटे	कोव्हीड -१९ काळातील प्रतिबंध आणि नियंत्रण संदर्भात ग्राम पंचायतीची भूमिका	प्रशांत सोनावणे
सत्र ५	१५ मिनिटे	कोव्हीड -१९ लोकसहभागातून प्रतिबंध नियंत्रण आणि परिस्थितीचे मुल्यांकन करण्यासाठी सक्षम वातावरण तयार करणे	माधव गोरकटे
सत्र ६	२० मिनिटे	कोविड-१९ संदर्भात कलंकीत व भेदभाव प्रतिबंध व्यवस्था निर्मिती व प्रतिसाद मिळवण्यात ग्रामपंचायतीची भूमिका	भाग्यश्री जवळगे-व्हरकट
सत्र ७	१५ मिनिटे	प्रश्नोतरे	सर्वांसाठी

Addressing stigma



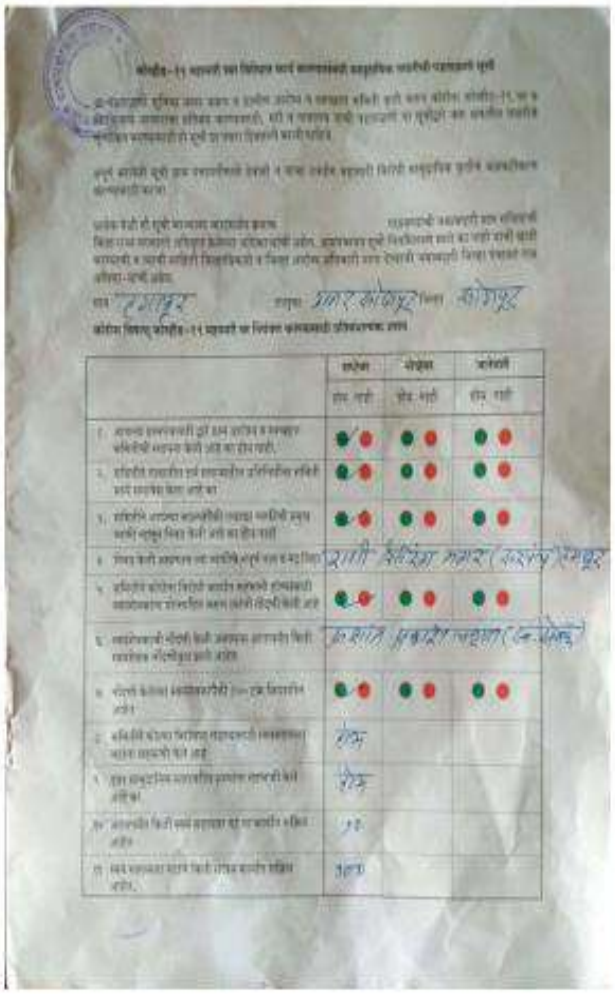
Maintaining hygiene

Annexure 2 – Project Reporting Formats and Activities

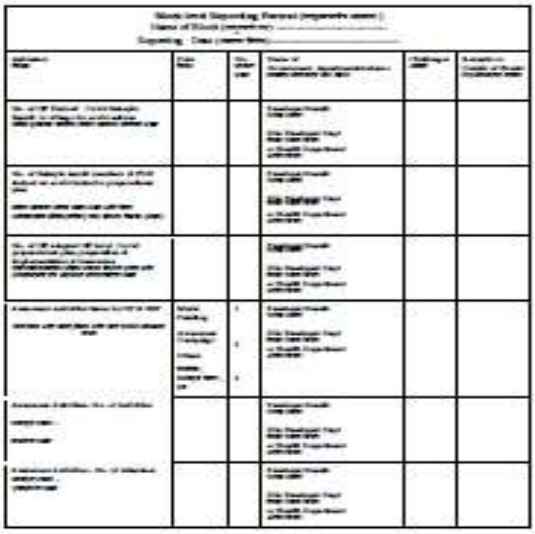
The following Project reporting formats were developed and used during the project.
Annexure 2.1 GP Preparedness Plan Format
Annexure 2.2 Block level Reporting Format
Annexure 2.3 Cluster Coordinator MIS Excel Monthly Reporting Format linked with KoBo app
Annexure 2.4 PHC Reporting Format
Annexure 2.5 GP level Reporting Format
Annexure 2.6 Social Protection Format for identification and tracking
Annexure 2.7 Format for identification of Vulnerable families
Annexure 2.8 Project team
Annexure 2.9 Detailed list of Key activities in phases and levels

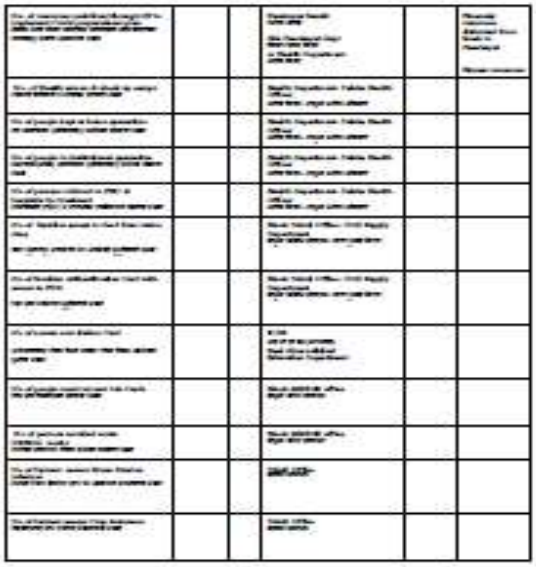
The documents are available separately for reference as pdf files.

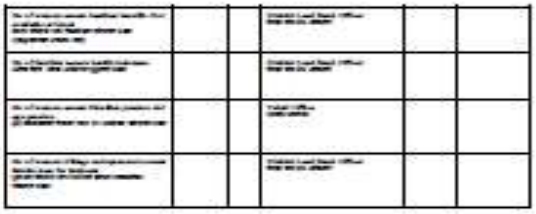
Annexure 2.1 Gram Panchayat Preparedness Format



Annexure 2.2 Block level Reporting format







Annexure 2.3 Cluster Coordinator MIS Excel Monthly Reporting Format linked with KoBo app

Project / Sector Activity MIS Sheet															
Sr.No	Project/Sector Name	Online/Physical	Type of activity	For whom	Activity Type/ description	Activity start Date(dd/mm/yyyy)	No of days	No of Participants	No of Villages	No of Blocks	No of District	Block Name	Photo uploaded or not Y/N	Activity Code	Remark if any
1															
2															
3															
4															
5															

The format was directly filled by the Cluster Coordinators on their mobile phones and was integrated online in the project MIS.

Annexure 2.4 PHC Reporting Format

PHC level Reporting (प्राथमिक आरोग्य केंद्र स्तर अहवाल) Name of PHC (प्राथमिक आरोग्य केंद्राचे नाव)---------- Cluster Coordinators Name (परिसर समन्वयकाचे नाव)---------- Reporting date (अहवाल दिनांक) ----------			
Indicators निर्देशक	No. लाभार्थी संख्या	Challenges आव्हाने	Support needed आवश्यक गरज
No of residentials doctors available on PHC प्राथमिक आरोग्य केंद्रावरील निवासी डॉक्टरांची संख्या			
No of total staff available उपलब्ध एकूण कर्मचारी संख्या			
No of patients screened through ASHA workers आशा कार्यकर्त्यांमार्फत तपासणी केलेल्या रुग्णांची संख्या			
No of people referred to hospital for covid testing कॉविड चाचणीसाठी हॉस्पिटल मध्ये पाठवलेल्या व्यक्तींची संख्या			
No of positive cases PHC has सकारात्मक (पॉझिटिव्ह) प्रकरणांची संख्या			
No of patients access the OPD services ओपीडी सेवा घेतलेल्या रुग्णांची संख्या			
No of children's access immunization लसीकरण घेतलेल्या लहान मुलांची संख्या			
No of pregnant women access ANC services एएनसी सेवा घेतलेल्या गरोदर महिलांची संख्या			
No of women delivered in PHC प्राथमिक आरोग्य केंद्रामध्ये प्रसूती झालेल्या महिलांची संख्या			
No of women referred to district hospital for delivery प्रसूतीसाठी जिल्हा रुग्णालयाकडे पाठविण्यात आलेल्या महिलांची संख्या			
No of patients admitted in PHC for other coman health needs इतर सामान्य आरोग्य गरजासाठी दाखल झालेल्या रुग्णांची संख्या			

Annexure 2.5 GP level Reporting Format

GP level Reporting Format (ग्रामपंचायतीय अहवाल)
Name of Gram Panchayat (ग्रामपंचायतीय नाव) ----------
Reporting Data (अहवाल दिनांक) ----------

Indicators निर्देशक	Date दिनांक	No. संख्या	Name of Government departments Authorities संबंधित कार्यालयांचे नाव/ पोस्ट	Challenges आव्हाने	Remarks or Details of Events टिप्पणी/ कार्यालय अभिप्राय
No. of Sahayta samiti members & FLW trained on covid intensive preparedness plan कोविड सुविधा तयारीच कोविड सहायता समितीचे सदस्य			GP ग्रामपंचायत		
Adopted GP level Covid preparedness plan preparation & implementation is happening ग्रामपंचायतीय कोविड तयारी योजनेचे तयारी आणि अंमलबजावणी होत आहेत ग्रामपंचायतीचे सदस्य					
Awareness Activities taken IwG GP & SSP ग्रामपंचायत आणि सामुदायिक आरोग्य केंद्रांचे कोविडबाबत जागरूकता			GP & ASHA ग्रामपंचायत आणि आशा		
Resources mobilized through GP to implement Covid preparedness plan कोविड तयारी योजना कार्यान्वित करण्यासाठी ग्रामपंचायतीच्या संसाधनांचे संकलन			GP & ASHA ग्रामपंचायत आणि आशा		
No. of Health screen & checkup camps आरोग्य तिकीटांचे व तपासणी शिबिरांचे संख्या			ASHA आशा		
No of people kept at home quarantine गृह अलगीकरण (कोविडबाबत) ठेवलेल्या लोकांचे संख्या			ASHA आशा		
No of people in institutional quarantine संस्थान(सदस्य) अलगीकरण (कोविडबाबत) ठेवलेल्या लोकांचे संख्या			ASHA आशा		
No of persons referred to PHC & hospitals for treatment उपचारासाठी PHC व रुग्णालयात पाठविलेल्या लोकांचे संख्या			ASHA आशा		
No of families access to food from ration shop रास्त धान्यदुकान अन्नपुरवठा ठेवलेल्या कुटुंबाचे संख्या			Ration Shop owner रास्त धान्यदुकान		
No of families without ration card with access to PDS रास्त धान्य दुकानांचे कुटुंबाचे संख्या			Ration Shop and GP रास्त धान्य दुकान आणि ग्रामपंचायत		
No of children access food from THR & midday meal अंगणवाडीत लेकर शिक्षा तसेच लेकर शिक्षा आहेत कुटुंबाचे संख्या			Angarwadi Worker अंगणवाडी कार्यकर्ता School Teacher		
No of people received job cards			Rojgaar Sevak or Gram Sevak रोजगार सेवक किंवा ग्रामसेवक		
No of persons enrolled under NRRGA works रोजगार कार्यालयात रोजगार कार्यालयाचे संख्या			Rojgaar Sevak or Gram Sevak रोजगार सेवक किंवा ग्रामसेवक		
No of farmers access kisan pension schemes शेतकरी शेतकरी लोकांचे सदस्य ठेवलेल्या लोकांचे संख्या			Talathi तलाठी		
No of farmers access crop insurance पीकविमाचे सदस्य ठेवलेल्या लोकांचे संख्या			Talathi तलाठी		
No of women access jandhan benefit जनता योजनेचे सदस्य ठेवलेल्या लोकांचे संख्या (सुरुवात जनता जनता सर्व)			CRP आरोग्य सर्व		
No of families access health insurance आरोग्य विमा सदस्य आरोग्य कुटुंबाचे संख्या			CRP आरोग्य सर्व		
No of women access sindhar pension old age pension वृद्ध योजनेचे विमाचे सदस्य ठेवलेल्या लोकांचे संख्या			Talathi तलाठी		
No of women /village entrepreneurs access mudra loan for business वृद्ध सर्व योजनेचे सदस्य ठेवलेल्या लोकांचे संख्या			CRP आरोग्य सर्व		

Annexure 2.6 Social Protection Format for identification and tracking

Sr. No.	District	Block	Village	Name	Mobile	Schemes applied for	Ration Card	Job Card	Niradhar Pension	Health Insurance
1										
2										
3										
4										
5										

The format was directly filled by the Cluster Coordinators on their mobile phones and was integrated online in the project MIS.

Annexure 2.7 Format for identification of Vulnerable families

Sr. No.	District	Block	Village	Name
1				
2				
3				
4				
5				

The format was directly filled by the Cluster Coordinators on their mobile phones and was integrated online in the project MIS.

Annexure 2.8 Project team

#	Team Members	Designation
1	Kaka Adsude	District coordinator
2	Devkanya Jagdale	District coordinator
3	Rajabhav Jadhav	District coordinator
4	Vikas Kamble	District coordinator
5	Dilshad Tamboli	Cluster coordinator
6	Sangita Raut	Cluster coordinator
7	Shaheda Mujawar	Cluster coordinator
8	Sumita Shiral	Cluster coordinator
9	Shital Rankhamb	Cluster coordinator
10	Shilpa Weldode	Cluster coordinator
11	Anjali Masalkar	Cluster coordinator
12	Sumitra Jadhav	Cluster coordinator
13	Priyanka Raje	Cluster coordinator
14	Ajit Dhanure	Cluster coordinator
15	Anjana Sable	Cluster coordinator
16	Josana Mane	Cluster coordinator
17	Mangal Waghamare	Cluster coordinator
18	Kaushaliya Mandale	Cluster coordinator
19	Mangal Dhumal	Cluster coordinator
20	Ashwini Korake	Cluster coordinator
21	Shamal Gurau	Cluster coordinator
22	Vaishali Wale	Cluster coordinator
23	Jayshri Kadam	Cluster coordinator
24	Archana Koli	Cluster coordinator

Annexure 2.9 - Detailed list of Key Activities

Inception phase across levels

1. Mandatory approvals and agreement with district authorities
2. Project Inception Workshop for team orientation on project management systems
3. Training modules preparation
4. Training of Trainers (TOT) team along with Unicef resources persons
5. Dialogue workshops with District officials
6. Formats and templates –
    - Preparedness Plan templates for Block and GP levels
    - MIS and Best Practices formats
    - Migrants status survey format
    - Vulnerable household identification format
7. Listing key Social Protection schemes
8. Establishing remote communication with government system across levels
9. Managing remote communication with women leaders in Sahayta Samitis in Intensive and Non-Intensive GPs

District level activities	**Block level activities**
1. Establishing communication with government system at District level 2. Documentation and Best Practices identification 3. District level project inception workshop 4. COVID-19 prevention supply chain (Masks and soaps) 5. Coordination meetings with Officials	1. Establishing communication with government system at Block level 2. Meeting with BDO /GP to ensure Supply Chain and budget for Safety Kit 3. Organizing campaign for Social Protection schemes with respective departments 4. Block data collection on Social Protection schemes 5. Documentation and Best Practices identification 6. Mask & soap distribution 7. Block officials training workshop on GP preparedness plan 8. Training workshop for all medical officers 9. Coordination meetings with Officials **10.** Dialogue workshops with Block officials
PHC – Cluster level activities	**Gram Panchayat level activities**
1. Establishing communication with government system at PHC-Cluster level 2. Assessment of PHC on Preparedness Checklist 3. Assessment at PHC level access to health services and preventive practices 4. Health Screening Camps at Health Sub-Center and GP levels 5. Distribution of IEC material 6. Wall painting of IEC messages 7. Monitoring and reporting on Health services access 8. Coordination meetings with Officials 9. Documentation and Best Practices identification 10. Hygiene kits Mask & soap distribution	1. Establishing communication with government system at GP level 2. Meetings with GP members 3. Establishment and revival of Covid Sahayta Samitis in 250 villages 4. Plan for mentoring and follow up support for Sahayta Samiti representatives in Non-Intensive GPs 5. Doing Assessment of all 250 GP on Preparedness Plan 6. Monthly meetings of with Sahayta Samiti, record keeping on actions taken 7. Monthly data collection on progress of Preparedness Plan implementation and results 8. Awareness meetings in villages for Covid prevention and control 9. Organizing awareness campaign for Social Protection schemes of various departments 10. Enrolment of vulnerable people for Social Protection schemes 11. Reporting on no. of people accessing Social Protection scheme 12. Survey of migrants in Unicef App 13. Enrolment of migrants and others for NREGS Job Card 14. Facilitate GP and Headmaster make School Safety Plan and implement and monitor the Checklist 15. Distribution of IEC material 16. Wall painting of IEC messages 17. Documentation and Best Practices identification **18.** Hygiene kits Mask and soap distribution

Annexure 3 - Key project documents

The following key documents formed the basis of the design of the project, which supported the government programs to address the challenges caused by the Covid-19 pandemic and the subsequent lockdown. The annexures include documents used by SSP and Unicef to operationalize the project as well as supplementary resource material developed during implementation phases.

Annexure 3.1 Government Order - Ministry of Panchayati Raj and Government of Maharashtra
Annexure 3.2 Community Preparedness Checklist for Action Against COVID-19 Pandemic
Annexure 3.3 Government Order for project by Disaster Management Unit Government of Maharashtra
Annexure 3.4 Government Order - District level Government Orders for Covid-19
Annexure 3.5 Government of Maharashtra order on My Family My Responsibility campaign

The documents are available separately as pdf files.

Annexure 3.1 Government Order - Ministry of Panchayati Raj and Government of Maharashtra

सुनील कुमार, भा.प्र.से.
SUNIL KUMAR, IAS

सचिव
भारत सरकार
पंचायती राज मंत्रालय
SECRETARY
GOVERNMENT OF INDIA
MINISTRY OF PANCHAYATI RAJ

D.O.No. M-11015/76/2020-CIS

May 15, 2020

Dear Shri Mehta,

As you are aware India's war against the COVID-19 pandemic is now entering a phase wherein we have to carefully resume economic activity even as we continue to maintain the vigil and adhere to strict guidelines laid down by the Health Authorities.

2. So far India has been able to successfully control the spread of COVID 19 and save human lives. The spread of COVID 19 has largely been confined to urban areas and certain pockets. It is a reflection of the effective steps taken in your State/UT for screening, quarantining and monitoring the people, including in rural areas. The exemplary work done by Gram Panchayats (GPs) in the fight against COVID 19 has also been noted and lauded by the Hon'ble Prime Minister in his interaction with PRI functionaries on the occasion of National Panchayati Raj Day – 24th April, 2020.

3. However, the threat of COVID 19 spreading to rural areas cannot be ruled out. With economic activities slowly resuming and ongoing return of migrants, both from abroad and other parts of the country, new challenges are emerging. These call for stepping up vigil and putting in place a robust system to continually monitor 'community preparedness' especially in rural areas so as to ensure that COVID 19 does not spread to rural areas. This would entail, inter alia, monitoring the following:

i. Preventive Measures for control of COVID 19 pandemic
ii. Solidarity at community level & steps to deal with issues related to 'social stigma'
iii. Help in surveillance activities
iv. Support quarantine/isolation
v. Identification of needy families & plan for providing help
vi. Ensure continued provision of essential health services at village level
vii. Prompt response in case COVID 19 positive cases are detected
viii. Ensure hygiene and sanitation in the Gram Panchayat

A Community Preparedness Checklist developed by Department of Community Medicine, Mahatma Gandhi Institute of Medical Sciences, Sewagram, Wardha and vetted by Union Health Ministry is enclosed. This will need to be distributed to all Gram Panchayats in local language and filled up every fortnight and system put in place by the Panchayati Raj Department and Health Department to take appropriate corrective measures.

4. Since Gram Panchayat is an institution that exists in all parts of the country, the elected representatives of GPs have a major role to play in the ongoing efforts of Union and State Governments to control the spread of COVID 19 pandemic. In Odisha the State Government has even gone to the extent of vesting powers of District Magistrate to the Gram Pradhans for dealing with this pandemic. All other States are also extensively using the GPs in tackling this situation in rural areas. This needs to be further strengthened. Special attention also needs to be paid to effectively deal with cases of 'social stigma' as and when they are reported. The message must be spread that death rate in India is among the lowest in the world and recovery rate is continually improving. Further, the special needs of old and infirm in rural areas must be suitably addressed.

कृषि भवन, डॉ. राजेंद्र प्रसाद रोड, नई दिल्ली-110001, KRISHI BHAWAN, DR. RAJENDRA PRASAD ROAD, NEW DELHI-110001
Tel.: 011-23389808, 23074309 • Fax: 011-23389826 • E-mail: secy-mopr@nic.in

5. Gram Panchayats should be directed to effectively coordinate the role and activities of frontline Health workers such as ANM, ASHA, Anganwadi worker and take help of volunteers of Nehru Yuva Kendra, NSS, Swacchagrahis, SHG workers in this massive exercise. Resumption of economic activity has to be associated with mandatory wearing of mask, maintaining physical distance of two metres at public places and compulsory hand washing using soap at frequent intervals among others. Several States and UTs have also prohibited spitting in public. This needs to be effectively enforced through GPs in rural areas. Strict vigil and adherence to guidelines issued by Health Authorities from time to time hold the key to success in this war against Corona.

6. In light of the above, you are requested to direct the Panchayati Raj and Health Department officials to take all necessary steps to strengthen community preparedness and ensure that an effective system is in place in the interior rural areas as per advisory issued by the Health Authorities to safeguard human lives. The Ministry will be seeking fortnightly reports in this regard.

With warm regards,

Yours sincerely,

Encl – as above

15.5.20
(Sunil Kumar)

Shri Ajoy Mehta,
Chief Secretary,
Government of Maharashtra,
Mantralya, 6th Floor,
Madam Cama Road,
Mumbai-400032.

Copy to: Additional Chief Secretary, Panchayati Raj & RD Department, Government of Maharashtra, 25, Marzban Marg, Bandham Bhawan, 7th Floor, Fort, Mumbai-400001

Annexure 3.2 Community Preparedness Checklist for Action Against COVID-19 Pandemic

COMMUNITY PREPAREDNESS CHECKLIST

FOR ACTION AGAINST COVID 19 PANDEMIC

This checklist has been developed for use by Gram Panchayat / Village Health & Sanitation Committee to assess the preparedness at village /GP level for timely action for prevention of COVID 19 and visitor borne diseases. This checklist should be filled by the Gram Panchayat every fortnight for assessing village preparedness. The filled in format should be retained at village/GP level and should be used for strengthening community action against the pandemic. It will be the responsibility of the Panchayat Secretary (or any official appointed by the State Government) to fill this Checklist and share a scanned copy of filled checklist on WhatsApp mobile number ..... each time it is filled. It will be the responsibility of the District Panchayati Raj Officer to ensure that this is regularly filled by each GP and action points shared with District Collector and/or District Health Officer.

Name of Gram Panchayat: **Block:** **District:**

Date of filling checklist:

No.	Assessment Item	Status	Remark
I.	***Preventive measures for control of COVID 19 Pandemic***		
1.	Is the Village Health & Sanitation Committee constituted in your Gram Panchayat ?	Yes/ No	
2.	Did the committee identify a nodal person among members?	Yes/ No	
3.	Did the committee motivate and enroll volunteers to participate in COVID19 activities?	Yes/ No	
4.	Did the committee ensure participation of Self-Help groups and other community-based organizations in COVID 19 activities?	Yes/ No	
5.	Do the committee members and volunteers have knowledge regarding the following: • Modes of transmission/spread of COVID 19 • Importance of using mask/ face cover • Maintaining physical distance • Thoroughly washing hands with soap and water • Cough etiquettes • Home quarantine • Cleaning & disinfecting of frequently used surfaces • Cleaning & disinfection of public places • Local and State level corona helpline numbers (1075, 011-23978046, 020-26127394)	Yes/ No	
6.	Did the Committee impart information about preventive and control measures against COVID19 to the villagers?	Yes/ No	
7.	Have the committee identified and used locally relevant modes of mass communication (e.g. Dawandi / announcement accompanied by beating of drums)?	Yes/ No	
8.	How good is compliance of villagers with the following? • Physical Distancing • Use of mask /handkerchief /face cover • Washing hands with soap and water	Very good/ Good/ Poor/ Very Poor Very good/ Good/ Poor/ Very Poor Very Poor Very good/ Good/ Poor/ Very Poor	
9.	Is there a system to check the compliance with the above?	Yes/ No	
10.	Did the committee identify places or events where the villagers gather in large numbers e.g. weekly market, festival etc.?	Yes/ No	
11.	Have measures been taken to control such gatherings? If yes, specify measures taken.	Yes/ No	
12.	Have you enlisted the elderly and person with Co-morbidities in your village?	Yes/ No	
13.	Do the committee have plan to ensure adequate care of elderly and persons with co-morbidities?	Yes/ No	
II.	***Solidarity at community level and address any stigma associated with the disease***		
14.	Does the committee have adequate representation of all sections of the society (including minority groups)?	Yes/ No	
15.	Did the committee make adequate efforts to reach out and address concerns of all sections of the society (including minority groups)?	Yes/ No	
16.	Do the committee members/ villagers understand the importance of supporting individuals and their families, in case they get the disease?	Yes/ No	
17.	Did the committee take any steps to address stigma associated with the disease?	Yes/ No	
III.	***Help in surveillance activities related to COVID 19 pandemic***		
18.	Did the committee prepare a list of following? • Elderly above 60 years of age • People with hypertension & diabetes • Pregnant women	Yes/ No Yes/ No Yes/ No	
19.	Does the committee have a plan to ensure adequate care of the above groups of people?	Yes/ No	
20.	Does the committee have a plan to keep a watch on the people suffering from cough, cold or fever?	Yes/ No	
21.	Do the committee members help the ASHA/ AWW in conducting the survey for cough, cold or fever?	Yes/ No	
22.	Does the committee keep vigilance on arrival of any outsider in the village and take measures for prevention of COVID 19 transmission?	Yes/ No	
IV.	***Support quarantine/ Isolation***		
23.	Do the committee members keep a watch on the people who have been quarantined in home apart from ASHA?	Yes/ No	
24.	Do the committee members advise and support the families having home quarantined persons to take necessary precautions?	Yes/ No	
25.	Has the committee made provision for doorstep delivery of essential items and services to the families with home quarantined person/s?	Yes/ No	
26.	Has any arrangement been made for village level quarantine facility wherever and whenever home quarantine is not possible?	Yes/ No	
27.	If yes, have they ensured the following arrangement at village-level quarantine facility?		
	• Enough space with adequate ventilation • Electricity and water arrangement • Toilet facility • Hand washing arrangement • Disinfectants (1% hypochlorite solution) • Arrangement for meals and drinking water	Yes/ No Yes/ No Yes/ No Yes/ No Yes/ No Yes /No	
V.	***Identify needy families and plan for providing them help***		
28.	Does the Committee have plans to deliver essential commodities to the needy people?	Yes/ No	
29.	If yes, have they identified resources to execute that plan?	Yes/ No	
30.	Does the village have a system of monitoring PDS?	Yes/ No	
31.	Other than PDS, does the village have plan to deliver essential commodities to the needy people?	Yes/ No	
32.	Has the committee made any arrangement for accommodation and other essential services for migrants?	Yes/ No	
33.	Has the committee made any plan to give work to the labourers under the schemes like MGNREGA?	Yes/ No	
34.	Has the committee ensured required support to frontline workers and their families?		
VI.	***Ensure continued provision of essential health services at village level***		
35.	Are routine health care services at village level (including Village Health and Nutrition Days) being conducted regularly?	Yes/ No	
36.	Are ASHA/ Anganwadi workers in regular contact with pregnant and lactating women to ensure continuity of care?	Yes/ No	
37.	Are ASHA/ Anganwadi workers in regular contact with all high-risk cases of communicable and non-communicable diseases to ensure continuity of care?	Yes/ No	
38.	Does the village committee ensure adequate stock of medicines for all individuals with hypertension and diabetes at village level?	Yes/ No	
39.	Is transport facility available in village for referral in case of emergency?	Yes/ No	
40.	Are the committee members aware about the Government ambulance services i.e. 108 for COVID19 patients and 102 and other ambulances for other essential health services as the case may be?	Yes/ No	
41.	Is the committee aware of the facilities wherein a suspected COVID patient can be referred ?		
42.	In case of any migrant workers returning to the village, having any notifiable disease like TB etc. or any other co-morbid conditions, has committee provided required support to them in consultation with Health officials?		
VII.	***Prompt response, in case COVID 19 positive case/s are detected*** *(This section needs to be filled , only if COVID 19 positive cases have been reported from this Gram Panchayat)*		
43.	Is there single entry/ exit for the village?	Yes/ No	
44.	If Yes, are adequate IEC materials displayed at the entry.	Yes/ No	
45.	Did the committee ensure mandatory registration at entry gate for all personnel (including police, health personnel and other volunteers)?	Yes/ No	
46.	Did the committee ensure near absolute interruption of movement of people to and from?	Yes/ No	
47.	Did the team ensure villagers are getting right information regarding risk?	Yes/ No	
48.	Are traditional cremation ground/ burial attendants trained and equipped for safety precautions during all deaths during this period?	Yes/ No	
49.	Does the Gram Panchayat have a plan to ensure the safety and well-being of everyone during the process of last rite?	Yes/ No	
50.	Has the committee ensured effective communication with the community for eliciting their support in ensuring required protocol management during containment?	Yes/ No	
51.	Has the committee ensured that required house to house active case search is conducted by the special teams formed for the purpose?	Yes/ No	
52.	Has the committee ensured that the relief measures provided by government are reaching to the most needy in the community?	Yes/ No	
53.	Has the committee helped the surveillance efforts through providing required volunteers from the community?	Yes/ No	
VIII.	**Ensure Hygiene and Sanitation in the Gram Panchayat**		
54.	Is there adequate facility for washing hands with water and soap in Primary School / Upper Primary School /Educational Institutions?	Yes/ No	
55.	Is regular fumigation of the village being undertaken by the Gram Panchayat? If yes, indicate periodicity and chemical	Yes /No	

Annexure 3.3 Government Order for project by Disaster Management Unit Government of Maharashtra

Government of Maharashtra

No: DMU -2018/CR 96 /DMU-1
Disaster Management Unit,
Relief and Rehabilitation Department,
Mantralaya, Mumbai
Date: 22/07/2020

To,
District Collector
(Osmanabad, Latur, Solapur)

Subject: Partnership with UNICEF Maharashtra and Swayam Shikshan Prayog (SSP) in Latur, Solapur and Osmanabad districts on WASH sensitive and COVID intensive GP preparedness and Community resilience.

Maharashtra is currently the most impacted state due to the COVID-19 pandemic. The Disaster Management, Relief and Rehabilitation Department jointly with United Nations Children's Funds (UNICEF) Maharashtra has proposed an innovative project in Latur, Osmanabad and Solapur on Water Sanitation and Hygiene (WASH) sensitive COVID intensive Gram Panchayat preparedness and Community resilience in Multi Hazard profile covering 3 districts of Maharashtra for next 6 months till mid January 2021. The detailed project proposal is enclosed for your reference.

Swayam Shikshan Prayog (SSP) will be functioning at District, block and village level (in pilot villages). This partnership plans to work with the Government PRI system to facilitate a district wide COVID intensive and personal hygiene in sensitive community preparedness initiative considering the instructions of MoPR and PM Care Fund planning and addressing planning issues on livelihood, social entitlement, sanitation and hygiene promotion, health surveillance and food security.

The project will aim to promote community preparedness with Panchayats including women sarpanchs and women leaders across Latur, Osmanabad and Solapur districts in Maharashtra with demonstration in 250 villages from 6 PHC villages (@ 2PHC per district). SSP teams will coordinate with the district authorities (RDD, WATSAN, MNREGA, PHD, PDS) to facilitate and ensure implementation of health, hygiene and social protection schemes to address needs of socially vulnerable groups impacted by COVID-19 Pandemic.

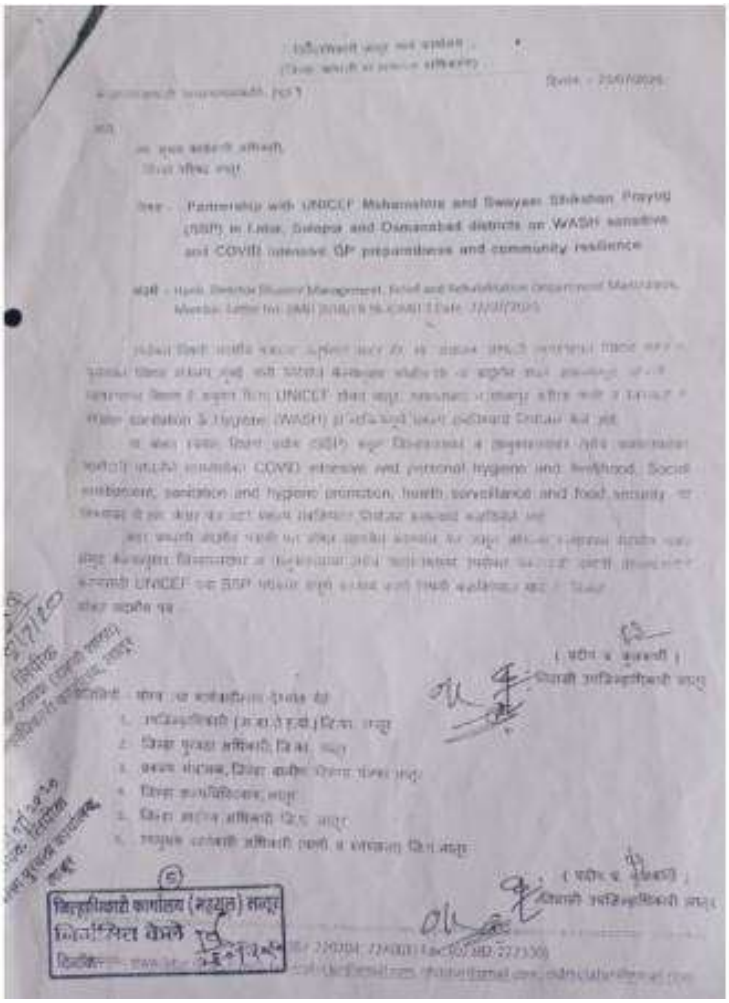
This is to request you to extend your support to district and the block level UNICEF – SSP team. This team will coordinate and extend technical support to the District and Block machineries. You may issue the necessary instruction to the appropriate authorities in this regard.

22/7/2020
(Abhay Yawalkar)
Director
Disaster Management,
Relief and Rehabilitation Department

CC Submitted to:
1. Additional Chief Secretary, Water Supply and Sanitation Department, Government of Maharashtra
2. Additional Chief Secretary, Rural Development Department, Government of Maharashtra
3. Principal Secretary, Public Health Department, Government of Maharashtra

CC to:
1. The Chief Executive Officer, Zilla Parishad, (Latur, Osmanabad and Solapur Districts)
2. Mr. Yusuf Kabir, WASH Specialist and Emergency Focal Point, UNICEF Maharashtra
3. Ms Prema Gopalan, Executive Director, Swayam Shikshan Prayog, Pune

Annexure 3.4 Government Order - District level Government Orders for COVID-19



Subject - Partnership with UNICEF Maharashtra and Swayam Shikshan Prayog (SSP) in Latur, Solapur and Osmanabad districts on WASH sensitive and COVID intensive GP preparedness and community resilience

Annexure 3.5 Government of Maharashtra order on My Family My Responsibility campaign

महाराष्ट्र शासन

अत्यंत तातडीचे

क्रमांक: कोरोना २०२०/प्र.क्र. ३९१/आरोग्य १
सार्वजनिक आरोग्य विभाग,
मोकुळदास तेजपाल रुग्णालय आवार,
कॉर्पोरेक्स बिल्डिंग, मलिन मंत्रालय,
मुंबई-४०० ००१
दिनांक- १९ सप्टेंबर, २०२०

प्रति,
विभागीय आयुक्त (सर्व),
जिल्हाधिकारी (सर्व),
मुख्य कार्यकारी अधिकारी (सर्व)
महानगर पालिका आयुक्त (सर्व)

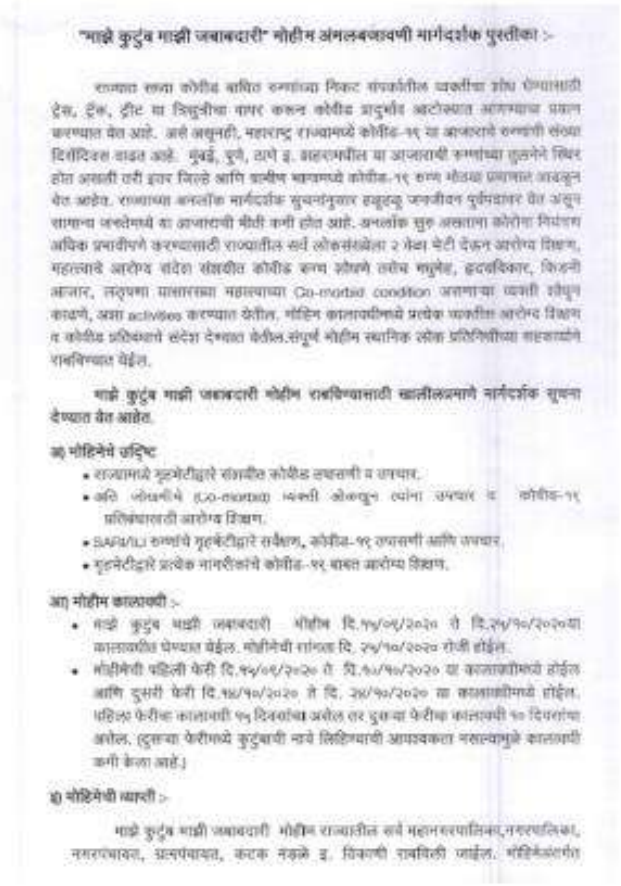
विषय - कोवीड-१९ नियंत्रणासाठी तसेच मृत्यु दर कमी करण्यासाठी "माझे कुटुंब - माझी जबाबदारी" कोवीड मुक्त महाराष्ट्र ही मोहीम राबविणे बाबत.

मागील २ आठवड्यामध्ये राज्यातील कोवीड-१९ रुग्णांमध्ये मृत्यूमध्ये लक्षणीयरित्या वर पडत आहे. यापुढे कोवीड-१९ नियंत्रण कार्यवाही जनतेच्या सहभागातून आवश्यक आहे. यासाठी राज्यभर "माझे कुटुंब - माझी जबाबदारी" ही मोहिम राबविण्याचा निर्णय शासनाने घेतला आहे.

"माझे कुटुंब -माझी जबाबदारी" मोहिमेअंतर्गत राज्यातील शहर/ गाव /पाडे-रुग्णवा/ तांडे यातील प्रत्येक नागरीकांची आरोग्य तपासणी, कोर्वीड आजार असल्यास उपचार आणि प्रत्येक नागरीकास व्यक्तीशः मेंटूर आरोग्य शिक्षण दयावयाचे आहे. वरील मोहीम दि.१५/०९/२०२० ते २५/१०/२०२० या कालावधीमध्ये घेण्याचे निश्चित करण्यात आले आहे.

दि.१५/०९/२०२० पासून मोहीम राबवावयाची असल्यामुळे लगेचच पूर्व तयारी सुरु करणे आवश्यक आहे. त्यासाठी प्रारुप मार्गदर्शक सुचना सोबत जोडल्या आहेत. त्यातील त्वरीत अंमलबजावणी करण्यासाठी आवश्यक बाबी आपणांस पुढील प्रमाणे कळविण्यात येत आहे:-

१. मोहीम कालावधीमध्ये गृहभेटी देण्यासाठी आरोग्य पथके तयार करावीत. प्रत्येक जिल्ह्यास आवश्यक आरोग्य पथकांची संख्या सोबत जोडली आहे. एक पथकामध्ये १ आरोग्य कर्मचारी आणि २ स्थानिक लोकप्रतिनिधींनी दिलेले स्वयंसेवक असतील.
२. एक पथक दररोज ५० घरांना भेटी देईल. भेटीदरम्यान घरातील सर्व सदस्यांचे तापमान SpO2 तपासणे तसेच Comorbid Condition आहे का याची माहिती घेण्यात येईल.



"माझे कुटुंब माझी जबाबदारी" मोहीम अंमलबजावणी मार्गदर्शक पुस्तीका :-

राज्यात सध्या कोवीड बाधित रुग्णांच्या निकट संपर्कातील व्यक्तींचा शोध घेण्यासाठी ट्रेस, ट्रॅक, ट्रीट या त्रिसूत्रीचा वापर करून कोवीड प्रादुर्भाव आटोक्यात आणण्याचा प्रयत्न करण्यात येत आहे. असे असूनही, महाराष्ट्र राज्यामध्ये कोवीड-१९ या आजाराचे रुग्णांची संख्या दिसेदिवस वाढत आहे. मुंबई, पुणे, ठाणे इ. शहरामधील या आजाराची रुग्णांच्या तुलनेने स्थिर होत असली तरी इतर जिल्हे आणि ग्रामीण भागामध्ये कोवीड-१९ रुग्ण मोठ्या प्रमाणात आढळून येत आहेत. राज्याच्या अनलॉक मार्गदर्शक सुचनांनुसार हळूहळू जनजीवन पूर्वपदावर येत असून सामान्य जनतेमध्ये या आजाराची भीती कमी होत आहे. अनलॉक सुरु असताना कोरोना नियंत्रण अधिक प्रभावीपणे करण्यासाठी राज्यातील सर्व लोकसंख्येला २ वेळा भेटी देऊन आरोग्य शिक्षण, महत्त्वाचे आरोग्य संदेश संशयीत कोवीड रुग्ण शोधणे तसेच मधुमेह, हृदयविकार, किडनी आजार, लठ्ठपणा यासारख्या महत्त्वाच्या Co-morbid condition असणाऱ्या व्यक्ती शोधून काढणे, अशा activities करण्यात येतील. मोहिम कालावधीमध्ये प्रत्येक व्यक्तीस आरोग्य शिक्षण व कोवीड प्रतिबंधाचे संदेश देण्यात येतील.संपूर्ण मोहीम स्थानिक लोक प्रतिनिधींच्या सहकार्याने राबविण्यात येईल.

माझे कुटुंब माझी जबाबदारी मोहीम राबविण्यासाठी खालीलप्रमाणे मार्गदर्शक सुचना देण्यात येत आहेत.

अ) मोहिमेचे उद्दिष्ट

- राज्यामध्ये गृहभेटीद्वारे संशयीत कोवीड तपासणी व उपचार.
- अति जोखमीचे (Co-morbid) व्यक्ती ओळखून त्यांना उपचार व कोवीड-१९ प्रतिबंधासाठी आरोग्य शिक्षण.
- SARI/ILI रुग्णांचे गृहभेटीद्वारे सर्वेक्षण, कोवीड-१९ तपासणी आणि उपचार.
- गृहभेटीद्वारे प्रत्येक नागरीकांचे कोवीड-१९ बाबत आरोग्य शिक्षण.

आ) मोहीम कालावधी :-

- माझे कुटुंब माझी जबाबदारी मोहीम दि.१५/०९/२०२० ते दि.२५/१०/२०२०या कालावधीत घेण्यात येईल. मोहीमेची सांगता दि. २५/१०/२०२० रोजी होईल.
- मोहीमेची पहिली फेरी दि.१५/०९/२०२० ते दि.१०/१०/२०२० या कालावधीमध्ये होईल आणि दुसरी फेरी दि.१४/१०/२०२० ते दि. २४/१०/२०२० या कालावधीमध्ये होईल. पहिला फेरीचा कालावधी १५ दिवसांचा असेल तर दुसऱ्या फेरीचा कालावधी १० दिवसांचा असेल. (दुसऱ्या फेरीमध्ये कुटुंबाची नावे लिहिण्याची आवश्यकता नसल्यामुळे कालावधी कमी केला आहे.)

इ) मोहिमेची व्याप्ती :-

माझे कुटुंब माझी जबाबदारी मोहीम राज्यातील सर्व महानगरपालिका,नगरपालिका, नगरपंचायत, ग्रामपंचायत, कटक मंडळे इ. ठिकाणी राबविली जाईल. मोहिमेअंतर्गत

Annexure 4 – Abbreviations and Glossary of Terms

Abbreviations

Term	Full form
ANM	Auxiliary Nurse cum Midwife are trained health workers of the National Health Mission placed in a cluster of villages under Department of Health
ASHA	ASHA are contractual workers of the National Health Mission placed in every village Gram Panchayat under Department of Health
AWW	Anganwadi Worker placed at Anganwadi Centres to serve women and children under the Integrated Child Development Scheme of the Ministry of Women & Child Development
BDO	Block Development Officer
CHO	Community Health Officer placed at Primary Health Sub-Centers under Department of Health
CMO	Chief Medical Officer heading Primary Health Centers under Department of Health
GOM	Government of Maharashtra
GPs	Gram Panchayats – village council is the basic village governing institution as democratic structures as per the Constitution of India.
JJM	Jal Jeevan Mission – flagship Government of India program to provide safe and adequate drinking water through individual household tap connections by 2024 to all households in rural India
MIS	Management Information System
MNREGS	Mahatma Gandhi National Rural Employment Guarantee Scheme of the Ministry of Rural Development is the flagship rural employment scheme of the Government of India.
PDS	Public Distribution System -
PHC	Primary Health Centre at cluster level under the Department of Health
PRIs	Panchayati Raj institutions
RDD	Rural Development Department of the Government of Maharashtra
SBM	Swachh Bharat Mission or Clean India Mission, flagship program of the Government of India to eliminate open defecation and improve solid waste management
SMC	School Management Committee, mandated committees under the Right to Education Act in each government school with representation of teachers and parents as the basic unit of decentralised model of governance of the education system

Glossary of Terms

Term	Description
Arogya Sevika	Arogya Sevikas are trained health workers who assist doctors in Primary Health Centres and do data collection in Maharashtra
Arogyavardhini Kendra	Government Primary Health Centers converted as Health Wellness Centers for taking preventive health care, including Ayurveda, Unani and nursing streams appointed as Community Health Officers
COVID Sahayta Samiti	Coordination group mandated at Gram Panchayat level for working on COVID-19 related activities comprising government functionaries and community representatives
Gram Sevak	Government frontline worker at GP level employed to advise and assist villagers in matters of community welfare and development
High risk Frontline workers	Community facing Government health and social welfare workers at GP, Cluster and Block levels
High risk Essential workers	Community facing sanitation, retail, and food supply daily wage workers who need to commute every day for doing their responsibilities
Krishi Sahayak	Krishi Sahayak serves farmers as a full time employee of the Gram Panchayat along with Gram Sewak and Talathi in Maharashtra
MPW COVID	Multi-Purpose Worker attached to Primary Health Centres for addressing COVID related programs of the government
Non-presence areas	Blocks or Gram Panchayats where SSP did not have prior direct presence within the community
Police Patil	An official of the village in Maharashtra, with quasi-judicial and administrative duties, responsible for birth and death registration and care of unclaimed property
Rozgar Sewak	A contract employee in every GP with primary duty to assist technical persons in MGNREGA scheme
Sakhi Task Force	Women's group at GP level formed by SSP comprising local women leaders drawn from across communities who jointly take initiative in public issues related to their communities
Sarpanch	Head of elected local government duty bearer at village level with financial powers
Swachagrahis	Community sanitation volunteers mandated under National Sanitation Mission
Tehsildar	Tax officer at sub-district (block or tehsil) level responsible for collection of revenue and release of finances for government programs
Talathi	Accountant - an official agent of the government, the term is used in rural western Indian states
Tanta Mukht Committee	As in COVID Sahayta Samiti – local name for disaster response coordination group comprising government functionaries and community representatives
Up-Sarpanch	Second level elected local government duty bearer at village level with financial powers

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MARGIN TO MAINSTREAM

Swayam Shikshan Prayog

102 First Floor, Gayatri Building, Orchid School Lane, Balewadi Phata, Baner, Pune-411 045, Maharashtra, India.

e sspindia1@gmail.com m +91 8605016700 / +91 9323557456 w www.swayamshikshanprayog.org