A report on
SOCIAL MOBILISATION CBM 2.0

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CENTRE FOR SOCIAL EQUITY AND INCLUSION
CSEI

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Background

The Covid-19 pandemic started in March 2020 and affected almost everyone, all families but the marginalised and vulnerable communities were affected the most, in a multi-dimensional way. Several studies worldwide have found that the lockdowns during the pandemic have led to the loss of employment opportunities in the form of job and business losses and a decline in the economic conditions of marginalised communities. This resulted in a decline in the income of the families and a rising debt burden. Due to the mass exodus, many of the population who came back to their hometowns or villages from towns and cities had no income for a very long period. The families, whose earning members were working in the informal sector were more severely affected. Similarly, the families who had individuals engaged in seasonal and casual employment, cross-border small trade and business, hawking, etc with no stable income source were also affected severely.

Several studies made it evident that those living in the informal settlements within the urban areas were hit hardest due to sudden and long periods of lockdown compared to the families living in rural areas. There was a cascading effect on health and nutrition, and notably on the education of children, in both rural and urban areas caused due to closure of schools. School-going children from poor and marginal families needed more requisite digital infrastructure to access online education from home. The disruption of health and nutritional services for children, added by mental stress compounded the multi-sectoral impact of the pandemic. However, the situation that started in March 2020 started easing out relatively by December 2020 and it appeared to many that the situation would normalize soon and the basic service would get back to a status close to that in the pre-pandemic period, including the economic activities. Unfortunately, that did not happen as, in fact, the pandemic situation aggravated due to the new Covid virus variant.

Rationale for CBM 2.0

In February 2021, the pandemic came back strongly in a few states like Maharashtra, Gujarat, and Madhya Pradesh and later, the pandemic engulfed almost all states and Union Territories with severe infection and high mortality. People had started easing the COVID coping mechanism and there was a lack of adequate hospital and medicine availability. The new emergence of the pandemic, which was named as 'second wave' turned out to be more infectious causing a hard effect on people. According to an estimate, more than 400,000 people died, and several million were affected, even though the recovery rate improved in July 2021. The pandemic continued, and, on average, more than 50,000 people were affected daily at all levels, though, the distribution of the cases varied across the states. The second wave severely affected the rural population. It brought a more stringent lockdown, and a close of transport, business, and people's movement. This compounded extension of further social and economic challenges, which were in recovery mode in December 2020. Changes were observed both at the macro as well as micro level and within the interconnecting sectors. Some of which included reduced income and expenditure, savings, changing consumption that affected children, problems related to accessing social, health and nutrition services, Covid Appropriate Behaviour (CAB), vaccine acceptance, child protection and Water Sanitation and Hygiene (WASH).

During the second wave, the government was not relatively quick to provide additional benefits on social protection, compared to those announced during the first wave of Covid. While some health and nutrition services that resumed their functioning in December 2020, got closed again and access to services was limited, enhancing challenges for poor people further. For example, Pregnant and lactating women could not access pregnancy and delivery care, including services from the Government's social service schemes (like ICDS). Limitations were also extended to access to Special Newborn Care Unit (SNCU) facilities which led to an increase in morbidities and mortality. Children continued to miss schools including preschool and supplementary nutrition services from Anganwadi Centres (AWCs) and Mid-day meals (MDMs). The alternative servicing mechanism was also not functional in a robust manner. From the evidence-gathering angle, the extent of the impact of the continued covid pandemic on the socio-economic conditions was not known. Therefore, there was a requirement to increase awareness about existing social protection measures to mitigate the deprivation on economic fronts.

CBM 2.0 with the added component of Social Mobilisation

Evidence gathering was a challenge during Covid but community-level monitoring was the need of the hour. Since the spread of the virus was more during the second wave, it was critical to not only measure the effect of Covid on marginalised communities but also capture the extent of Covid. Along with this, it was also imperative to know whether or not people are following Covid Appropriate Behaviour (CAB) and what are the reasons for the same. Such evidence was required for better management of the Covid-19 pandemic to safeguard people from the third wave of the pandemic. This led to Community-Based Monitoring (CBM) 2.0. There were several learnings from CBM that were included in CBM 2.0 which included the selection of habitations and respondents, capacity building and effectively managing community volunteers, and partnering with Community-level officers (CLOs). Overall, CBM 2.0 was more than just evidence gathering from the community. The new component included raising awareness of social measures and CAB at the community level. The idea of the 'plus component' was to engage with community volunteers through social mobilisation. Additionally, the following components were also included:

- Sharing Covid appropriate/ covid sensitive information through structured interpersonal communication with families in the community, utilising the existing engagement opportunities and platforms through the community volunteers
- Measuring knowledge on CAB and understanding the reasons behind the following or not following it
- Enhancing awareness about the selected set of social protection services

Strengthening communication on C-Vax and CABs and raising awareness about social protection measures through community volunteers was done, independent of the evidence-gathering set-up. For this, a separate set of community volunteers (with different skill sets) were trained by UNICEF and provided with effective Information, Education and Communication (IEC) materials. The social mobilisation component focused on the following:

- Training Needs Assessment (TNA) was conducted for 20 districts.

- Comprehensive capacity-building of 20 district anchors and 394 social mobilizers
- Social mobilization and communication activities were undertaken in 394 habitations with at least 2 rounds of home visits to families
- Periodic home visits, Community meetings, Stakeholder meetings, Vaccine drives, E-Shram registration drives, and Immunisation drives were conducted across 394 habitations[1]

Implementation

1. Identification of community volunteers: Based on the habitation template shared by UNICEF, the district organisations were asked to identify 2 volunteers in the given habitations (preferably female, having an individual android phone, with a minimum educational qualification of 10th pass, and having at least 2 years of experience working in that habitation). In habitations where the organization did not have a volunteer base, they were asked to propose an alternate habitation from the same or nearby block matching the original criteria of habitation selection. In case of habitations exceeding 200-250 families, organisations were asked to carve out a smaller habitation of 200-250 families. The district organisations were also given the discretion of proposing additional habitations where they had a strong volunteer base and which matched the original criteria of habitation selection. Based on the filled habitation templates shared by the anchors, UNICEF shortlisted a minimum of 20 habitations from each district. Key criteria for finalizing volunteers were gender (preference for female volunteers), age (ideally above 22 years of age for data enumeration, and above 25 years of age for social mobilization), vaccination status (all volunteers, but particularly social mobilizers had to be fully vaccinated),

[1] 6 habitations were dropped in the first round as community volunteers matching the criteria were not available

educational qualification (preference to those who were more educated) and work experience (minimum 2 years of experience working with the community).

2. Identification of Social Mobilisers: the criteria of selection were that the individuals were to be 20 -35 years of age and highly reliable and dependable; they were also required to have a strong community presence, knowledge of local issues and available institutions and networks; and also have completed schooling till 12th standard and essential commitment for 18 months; preferably a woman candidate from vulnerable groups and social identity. Preference was given to those who have been associated with COVID relief and support, and awareness generation activities in the community; should have an android phone; should be tech friendly and must possess basic knowledge of handling android phones and attending zoom, training sessions etc.

3. Training Needs Assessments (TNA): 2 TNAs were undertaken with the district anchors and 2-3 social mobilizers from each district. The TNA was conducted in 2 batches and helped EID (expert agency for training and capacity building of social mobilisers) assess the skills and capacities of the volunteers, as well as how to conduct the subsequent training sessions. A field exercise was undertaken with the social mobilizers to familiarize themselves with the habitation and social mobilization activities. Based on the house-listing data, the social mobilizers had to shortlist 50 families of which 30 families were required to be contacted. The criteria for shortlisting families included at least 15-17 families with children below 5 years, at least 15-17 families with school-going children; and 15-17 families who are BPL card holders. Each district was given 3 themes to discuss with the families and social mobilizers were expected to contact at least 10 families per the theme. The IEC material was shared with the anchors and volunteers on Whatsapp. Volunteers were trained by the anchors on the 3 thematic areas and a discussion guide was shared on how to go about the communication. Each volunteer contacted at least 30 families, the anchor was expected to submit a report on the number of families contacted by each volunteer, the number of families who refused to entertain the volunteers, the reason for refusal, common challenges/problems shared by families for not following the desired behaviours being discussed, and the challenges faced by volunteers in approaching/communicating with the families.

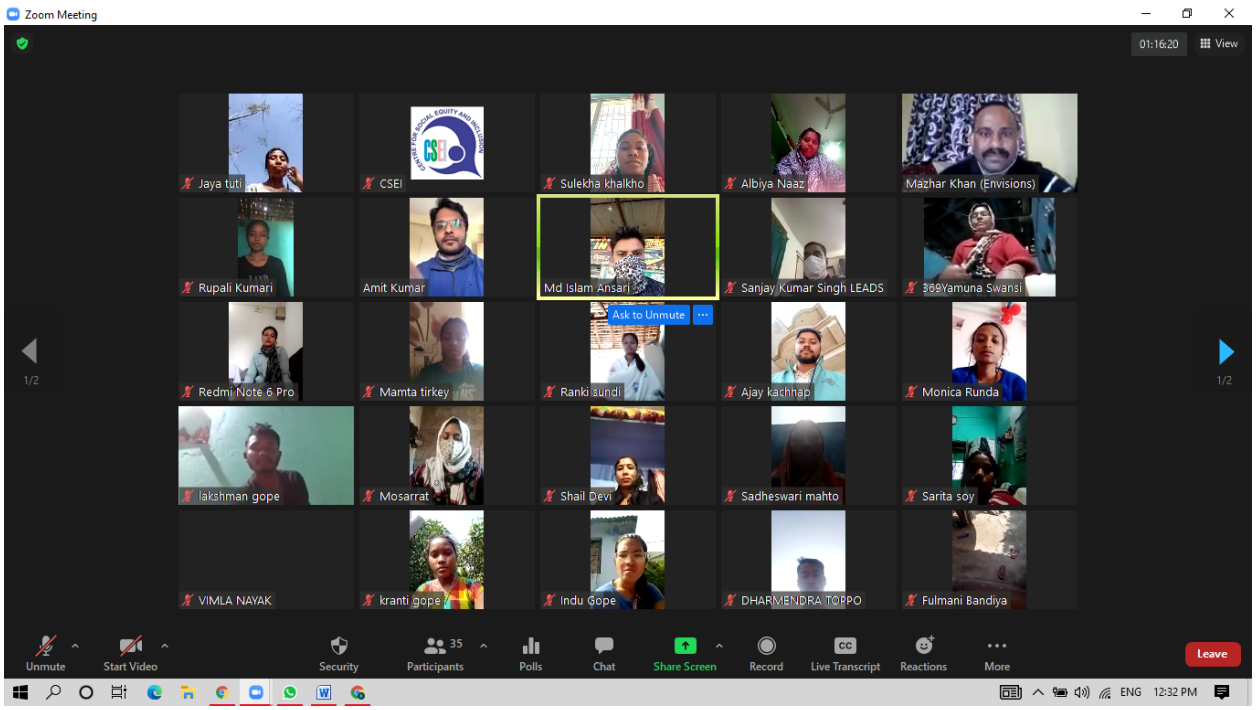
Following social mobilisers were assigned for the TNA field activity in districts[2]

- Andhra Pradesh – 2 from 1 district (Khamam)
- Assam – 4 from 2 districts (Baksa, Dibrugarh)
- Bihar – 2 from 1 district (Sitamarhi)
- Gujarat – 2 from 1 district (Ahmedabad)
- Telangana – 3 from 1 district (Hyderabad)
- Uttar Pradesh – 4 from 2 districts (Moradabad, Shravasti)
- Manipur – 4 from 2 districts (Chandel, Toubal)
- Mizoram – 4 from 2 districts (Aizawal, Mamit)
- Chhattisgarh – 2 from 1 district (Bastar)
- Jharkhand – 4 from 2 districts (Ranchi, West Singhbhum)
- Bihar – 2 from 1 district (Muzzafarpur)
- Madhya Pradesh – 4 from 2 districts (Bhopal, Shivpuri)
- Gujarat – 2 from 1 district (Banaskantha)

Additionally, their respective district anchors and cluster coordinators attended the training. Once the data enumeration was complete, skill-building and knowledge enhancement training was conducted for the volunteers to hone their networking, communication and social mobilization skills.

Training of the district anchors on Supportive Supervision was conducted and the anchors' role during the social mobilization process. In January 2022, a week-long training of social mobilizers took place. 7 sessions were conducted covering different aspects of Skill-Based Training and Knowledge-Based Training. The training was conducted in 5 languages- English, Hindi, Assamese, Gujarati and Telugu. Volunteers were given a pre and post-workshop test to assess their level of understanding before and after the training was done. The 7 sessions covered the following topics:

[2] in the first round a total of 20 districts were covered. In second round a total of 19 districts were covered as Bhopal was dropped from the final list of districts.



Online training session of social mobilisers

Skill-based Sessions-

1. Stakeholder Mapping and Micro-plan Development
2. Networking and Linkages with stakeholders
3. Communication Approaches
4. Communication Skills I
5. Communication Skills II

Knowledge-building Sessions:

1. Covid-19
2. Social Protection Schemes

The soft copies of the following materials were also provided to the social mobilisers:

• Microplan format

• Stakeholder mapping

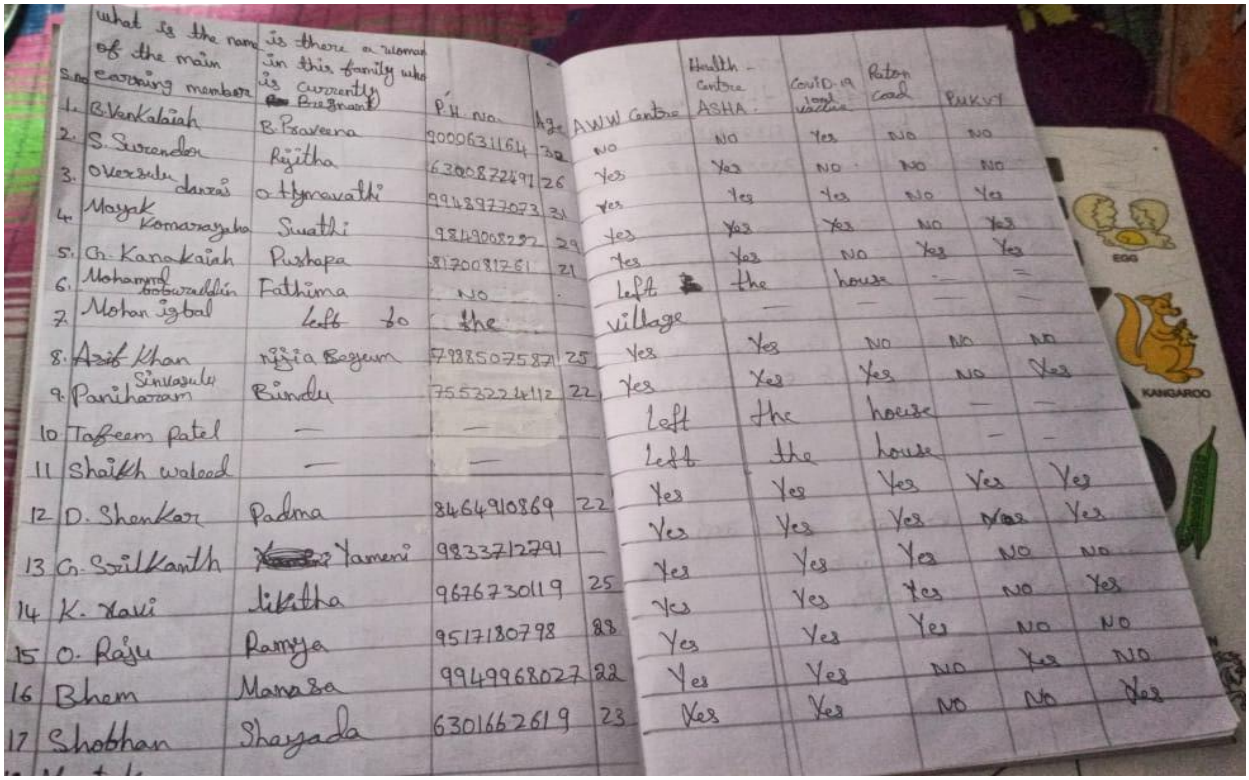
• Training content: PPT (language versions)

Post-training, an action plan for social mobilization was developed detailing the tasks and timelines for the social mobilization activities, as well as the monitoring processes in place.

- The first round of social mobilization was conducted in 394 habitations across 20 districts started in January 2022 and was concluded in the first week of March'2022.

- volunteers were asked to finalize their stakeholder mapping based on the format shared by EID. The anchors reviewed and shared their feedback for the stakeholder mapping that they received from the volunteers.

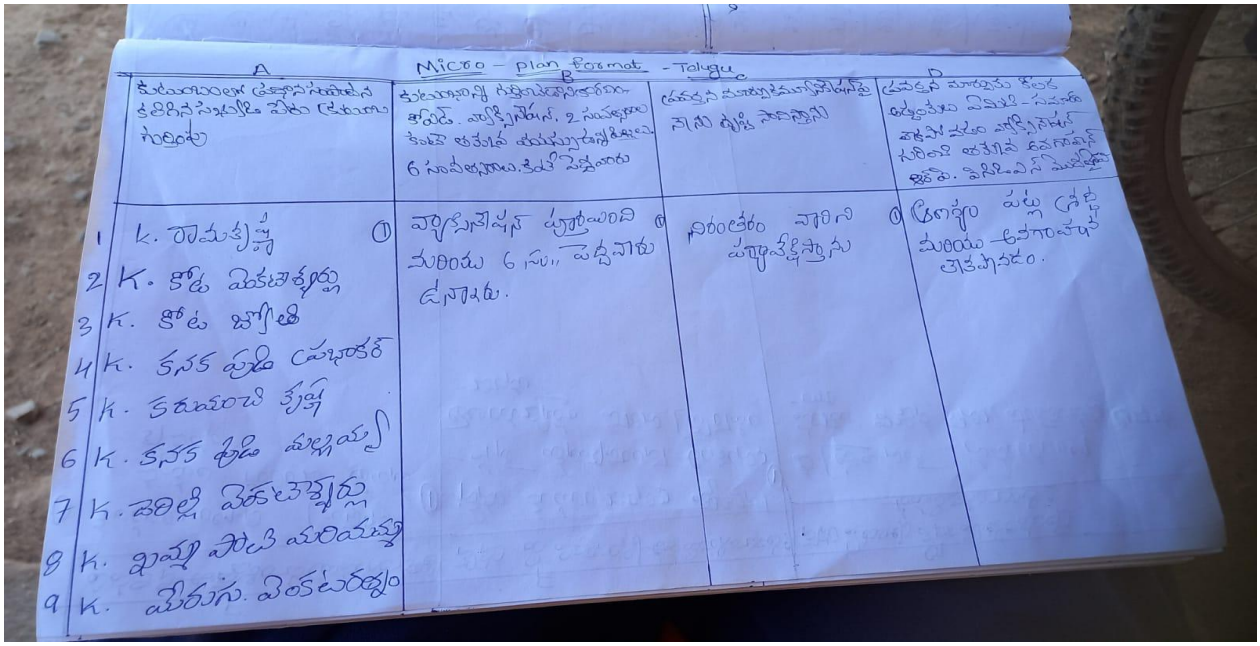
- Once the stakeholder mapping was complete, volunteers were asked to divide their habitation into roughly 3 segments (as they had done during the house-listing process) to initiate the micro-planning process. Every day, the volunteer(s) met at least 15 families (taking one segment each day to ensure that the entire habitation is covered). Based on their home visits, micro-plans were developed for families where immediate intervention was needed. At the end of a week, volunteers met at least 100 families and developed micro-plans for follow-up action where families required support/intervention.

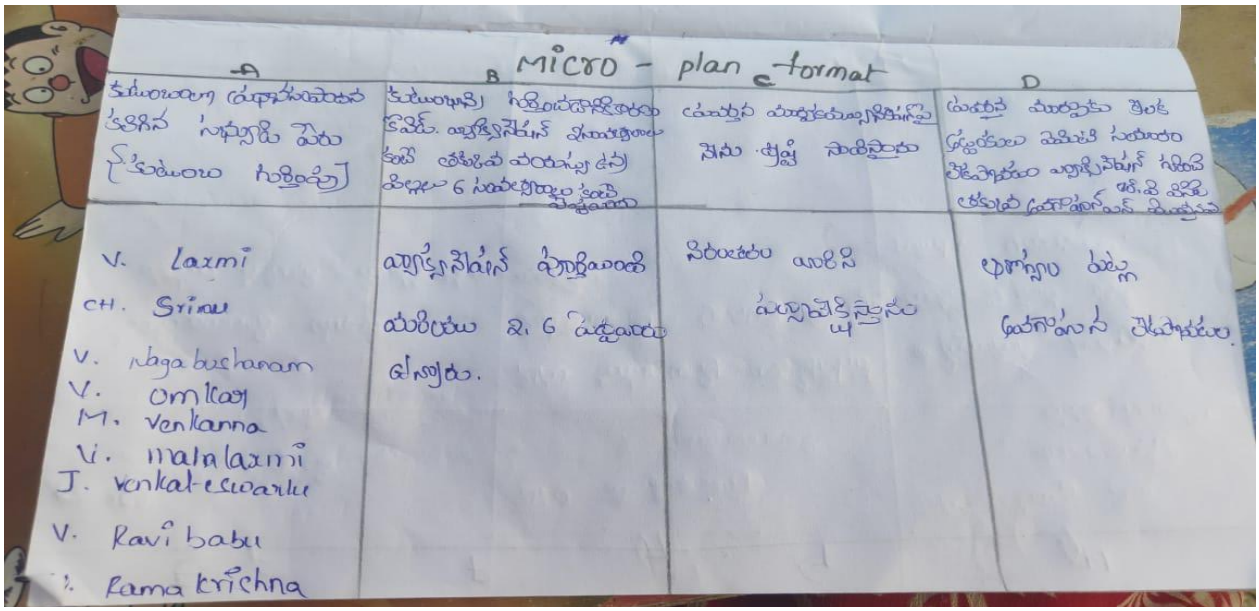


S.No	What is the name of the main earning member	Is there a woman in this family who is currently Pregnant	PH No.	Age	AWW Centre	Health - Centre ASHA	COVID-19 Land vaccine	Ration card	PMKVY
1.	B. Venkaiah	B. Praveena	9000631164	32	NO	NO	Yes	NO	NO
2.	S. Surendar	Rajitha	6300872497	26	Yes	Yes	NO	NO	NO
3.	Veerabadra dasari	Jyothi	9948977073	31	Yes	Yes	Yes	NO	Yes
4.	Mayuk Komarayya	Swathi	9849008292	29	Yes	Yes	Yes	NO	Yes
5.	Ch. Kanakaiah	Pushpa	8179008126	21	Yes	Yes	NO	Yes	Yes
6.	Mohammad Nabirulddin	Fathima	NO		Left	the	house	—	—
7.	Mohan Iqbal	Left to	the		village	—	—	—	—
8.	Azif Khan	Rijia Begum	7788507587	25	Yes	Yes	NO	NO	NO
9.	Panchakarla Srinivasulu	Bindu	7553224112	22	Yes	Yes	Yes	NO	Yes
10	Tasleem patel	—	—		Left	the	house	—	—
11	Shaikh waleed	—	—		Left	the	house	—	—
12	D. Shankar	Padma	8464910869	22	Yes	Yes	Yes	Yes	Yes
13	Ch. Sasikanth	Yamini	9833712791	—	Yes	Yes	Yes	Yes	Yes
14	K. Ravi	Likitha	9676730119	25	Yes	Yes	Yes	NO	NO
15	O. Raju	Ramya	9517180798	88	Yes	Yes	Yes	NO	Yes
16	Bhem	Manasa	9949968027	22	Yes	Yes	NO	Yes	NO
17	Shobhan	Shayada	6301662619	23	Yes	Yes	NO	NO	Yes

Sample of stakeholder mapping

- The first batch of micro-plans was simultaneously reviewed by the anchors, and they shared feedback where required. The national team shared sample micro-plans with UNICEF and EID for their feedback. Based on the feedback provided, volunteers refined their micro-plans and conducted follow-up actions based on the same.





Micro plans form Khammam & Hyderabad

- The next week was scheduled for micro-plan implementation where volunteers conducted home visits, community meetings, and stakeholder meetings to generate awareness, link families to service providers, and support families in accessing social protection schemes and services. Photos of the field activities were constantly shared on the Whatsapp groups for documentation purposes.

- Once the first round of follow-up was complete, volunteers conducted home visits for the remaining families of the habitation and developed micro-plans for families where immediate intervention was needed. For the second round of micro-planning, volunteers incorporated the feedback that was given to them initially. Based on their micro-plans, volunteers conducted home visits, community meetings, and stakeholder meetings to generate awareness, link families to service providers, and support families in accessing social protection schemes and services.

- The second round of social mobilization in 374 habitations started in August 2022 with Refresher in raining incorporating experiences and feedback from the first round. Updation of stakeholder mapping formats in each habitation. Follow-up home visits to families based on the first round of micro-planning. Updation of micro-plans as per the need. The second round of follow-up and home visits were conducted on the basis of the updated micro-plan developed for the first 100 families. Information dissemination, awareness generation, and linking of families to social protection schemes in 374 habitations. The same methodology used in round 1 was used for the second round of social mobilization in each habitation. The social mobilization was concluded in the first week of October 2022.

Our district team in Chandel, Manipur

Role of CSEI

- Selected CSOs and regional, district, and community volunteers as per the requirement of the study;
- Identification of social mobilization from each selected habitation matching the criteria and facilitating the registration of each social mobilizer
- Facilitating online capacity-building training programs
- Supported field monitoring set up in consultation with UNICEF
- Ensured that ethical considerations and protocols were adhered to
- Provided replacement for any CSO partner/ community volunteers dropping between rounds;

Coverage

- 20 CSOs and district anchors identified in 20 districts across 10 states
- Stakeholder mapping and micro-plan development across 394 habitations[3]
- Over **7000** families connected with relevant stakeholders
- Over **10,000** families demanded services from social mobilizers
- Over **5000** families accessed at least one service/scheme as a result of social mobilization
- Over **2500** refused families converted to a desired behavior as a result of social mobilization

[3] Due to challenges in Bhopal, the district was dropped for social mobilization. 1 habitation each in Ahmedabad and Khammam dropped due to challenges with existing volunteers and difficulty in finding replacements

Our district anchors shared their challenging experiences while approaching families during social mobilisation

1. Melody Lalrempuii (District Anchor) Mamit, Mizoram

As covid cases are high in the district, volunteers find it difficult to interact with families door-to-door as per our social mobilization action plan. There were many habitations which were in containment zones. We had challenges even in coordinating with our social mobilizers, internet connectivity was poor. There was a strong need to reach out to the families in these habitations, hence as an alternate approach it was decided that these families will be contacted over their mobile phones by their respective social mobilizers. These families were provided information on CAB, covid management, testing vaccine etc

2. Vinay Kumar, District Anchor Muzaffarpur, Bihar

There were so many prevailing myths in the communities about Covid vaccination. They are not sure whether it is beneficial for them or not. Our social mobilizers strategically busted each myth and with the help of vaccinated people, Anganwadi workers, and ASHA workers convinced the non-vaccinated members to take the vaccine. Some women members were not interested to know about the social protection schemes. However, with consistent follow-ups and visits from social mobilizers, they were made aware of schemes like Kanya Uthan Yojna, Sukanya Samriddhi Yojana etc. which they found very useful and later also registered for these schemes with the support of social mobilizers.

Experiences from field

1. Darshna Parmar, Social Mobilizer in Kevdawali Society area of CTM, Ahmedabad

Darshna visited every household in her habitation and shared information on all relevant social protection schemes. Most of the population in the settlement are migrants. About 300 households in the area mostly migrants from Uttar Pradesh and Bihar. During her home visit, she met Sarjuben Gaurishankar Nai whose family migrated from Uttar Pradesh a year ago in search of livelihood. Sarjuben lives with her husband and two children. Sarjuben was seven months pregnant and had her last two deliveries at home in her village. Sarjuben has not gone for any antenatal checkup yet and has not registered her pregnancy at the nearest Anganwadi centre. Sarjuben's house was visited four to five times by an Anganwadi worker, who registered her pregnancy in the Anganwadi and persuaded her to go for her antenatal check-up. During her check-up, it was found that Sarjuben had iron deficiency and was advised iron supplements, a nutrient-rich diet and follow-ups at the clinic.

The District Anchor was instrumental in creating the micro-plan, and the Anganwadi worker of the area and the ANM of the Urban Health Center were instrumental in changing the behaviour of Sarjuben.

Our Social mobiliser conducting home visits

2. Chayanika Deka, Barfulchaki, District: Baksa

Chayanika during her home visits found out that there were rumours in her habitations that after taking the COVID vaccine there will be serious side effects. Many families were afraid of taking COVID vaccines. The SM conducted regular home visits, and community meetings with ASHA workers and targeted the myths and misinformation regarding the vaccines among all community members. As of two months of continuous engagements and follow-ups, out of the 200 families around 80% of families took the vaccine.

Social mobiliser giving information about social protection schemes

3. Pushpa Kashyap, Shivnagar- Raipur

The area Pushpa covered, had around 255 families and all of them belonged to economically weaker backgrounds, mostly dependent on small entrepreneurship and daily wage tasks.

During the household visit, Pushpa met Rukmini Bai, a pregnant woman who was seven months pregnant. Her husband is a daily wage worker in private industry and she has a seven-year child, who is studying in a government school. She completed her ANC check-ups in a private hospital and every time she visited the hospital, it cost her a lot because their income level was not adequate. On enquiry, Rukmini Bai told that her family was tense because the doctor in the private hospital told them that they will have to arrange around 75,000 rupees for the delivery and family planning along with the ANC check-ups. Her family had already borrowed huge money for her treatment. The family was exploring support. She was not aware of the fixed-day services and other RCH services being offered free of cost at the government hospitals. Also, she had no knowledge about the JSY and JSSK benefits. The family did not have an Ayushman card.

Pushpa made three to four meetings with Rukmini and with her husband. She explained in detail about the various facilities available at the government hospitals and the support extended by the Mitanin and ANM for pregnant women. about JSY, JSSK and Matrutva Vandan Yojna. She told that the family should have an AYUSHMAN card which will help them save the medical expenses of the family. Pushpa then accompanied the husband to the Choice centre to get the Ayushman Card made. It was finally made in three days. Pushpa then brought Priyanka, the Mitanin didi to Rukmini`s house and explained that she is 7 months pregnant and is taking treatment at a private hospital. Priyanka then took Rukmini to Hamar Gaon Hamar Hospital, the urban PHC and registered Rukmini in her records, and facilitated the periodical testing. Rukmini got Iron and calcium tablets and was told to visit the hospital every week for a periodical check-up. Priyanka accompanied Rukmini to the hospital regularly. Rukmini and her husband were told that no expenses is required. All the treatment and medical care were made free of cost till her delivery as well as post-partum. Rukmini was enrolled under Matrutva Vandana Yojna by Mitanin and she got the first installment for this. Rukmini`s misery of arranging money was over and the family is happy now and undertaking health care regularly at the government hospital free of cost. They are happy with all the care and enjoyed the support of the Mitanin.

Our social mobiliser conducting periodic home visits

4. Hemin Sahu, Sarvodaya Nagar, Raipur

Hemin Sahu, the social mobiliser of the habitation covered around 267 households under the CBM programme and visited every household regularly to find out any issues with the family and make micro-plans for the family. Since she is also a member of Mahila Arogya Samiti, she enjoys very good proximity in the habitation. Sarvodaya nagar is dominated by persons whose earnings are from daily wages. Housewives face regular domestic violence from their husbands due to various reasons. Drunken males are unchecked and are not in a position to listen to anybody. Hemin did brainstorming with other Social Mobilizers Seema Chartri and Shradhha Rajput. The brainstorming revealed that the women sufferers are ill-informed about many things. Keeping the issue and its complexity into consideration the micro-plan making was supported by the following personnel:

- Co-Social Mobilisers from other areas, arranged in making combined efforts.

- The women police personnel joined the efforts in creating confidence amongst the women as well as creating fear among the culprits.

- The Ward Counsellor helped in making the team reach the police station and the making the team reach the Sakhi Center of the WCD department for counselling

- The district anchor helped in shaping the micro-plan and identifying the IEC and communication strategies for bringing the change.

After the demonstrations by the police and arresting some culprits, the male members in the habitation realized the legal complications, if they are responsible for domestic violence. The reporting of domestic violence cases has drastically reduced after the efforts.

Women have learnt the methods to deal with domestic violence and learnt the resistive approach for such instances. The women of the habitations are united in dealing with such cases in their habitations. The women started tracking such cases More than 12 such cases were identified and they were brought to the police station which is a good demonstration. People have gained lost confidence in police departments and their personnel. The strategy not only helped Sarvodaya Nagar but other habitations where domestic violence is a big problem. The Social mobilisers started replicating similar methods in their areas.

5. Saraswati Sahu, Ranchi.

She visited every household in her area and communicated with the families on various social welfare schemes of the government and encouraged COVID-appropriate behaviour amongst the people. During her daily visit to the household, she noticed that cleanliness has been a big issue in the habitation. The drainage lines are not being cleaned. She conducted a meeting of women and tried to understand the reasons. The major reason noted was the lack of efforts from the Municipal corporation.

The micro-plan was developed by Saraswati with the support of the Women members of the habitation, Mitanin and ANM of the area. The ward councillor responded immediately and

approached the zone commissioner's office to sort out the vendor problem. The zone commissioner put pressure on the vendor and threatened to terminate the contract if he does not fulfil the tasks. Women groups became more conscious of the regular cleaning of the area and supported the Mitanins and Mahila Arogya Samiti in monitoring the work periodically.

6. Ruchi Pandey, Khairaniya Veerpur- Shrawasti

Khairaniya Veerpur village in the Shrawasti District of Uttar Pradesh predominantly has residents belonging to the Scheduled Castes (SC) and Other Backward Classes (OBC) communities. The social mobilizer from Khairaniya Veerpur- Ruchi Pandey- previously worked as a school teacher and thus has a good connection with the mothers and children in the village.

During the micro-plan development, she initiated conversations with the villagers about their issues and concerns. One key problem that they faced was that the pregnant women and children were not getting adequate nutritious food from the Anganwadi. Even after delays of 2-3 months, they would receive a lesser quantity of their entitled food grains. The Anganwadi worker would either give them dariya or dal. Ruchi met with the Anganwadi worker who claimed that they get less ration than required for the enrolled pregnant women and children (for instance, if 30 women are enrolled, they receive ration only for 20). With the shortage in the ration, those who are left out get bitter and angry with the Anganwadi workers. She also informed Ruchi that the Anganwadi itself receives the ration very late, hence there is a delay in providing it to the beneficiaries.

Ruchi connected the Anganwadi worker to the district anchor, Gulshan Jahan, who spoke to her regarding the shortage of rations for the enrolled pregnant women and children. She asked her to file an application about this problem and ensure that whatever food is available at the Anganwadi is distributed among all the enrolled beneficiaries. Soon Ruchi realized that the Anganwadi centre was receiving sufficient ration, but the Anganwadi worker would not distribute the entire amount to the beneficiaries. She, along with Gulshan Jahan, persistently followed up with the Anganwadi worker who was worried about having a complaint registered against her.

Within 10 days, all the enrolled women and children had been given their due amount of ration by the Anganwadi worker and were extremely happy.

Community meeting facilitated by a District Anchor