Self-Help Groups can Deliver

A Study of Sure Start Project in Solapur

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One morning, Rasika Chandnshiwe, resident of the Habbu Wasti area of Solapur city, saw red water flowing down the bathroom-drain of her neighbour Savita's house. Rasika knew Savita was pregnant and was carrying on in the seventh month. Seeing the red water, Rasika got alarmed and immediately rushed to Savita's house. Savita was in great pain and was bleeding from the previous night. There was only her mother-in-law at home; her husband had gone to work early in the morning. Rasika knew this was not a good sign. She asked the mother-in-law to take Savita immediately to hospital. The mother-in-law rebuffed her, saying that in her experienced eye, this was not serious. Rasika was stunned but she was not just any other next door neighbour. She was a leader of the local women's self-help group and herself a trained community volunteer under a 'maternal and newborn health' (MNH) project run by the Halo Medical Foundation in Solapur. She left her domestic chores behind and rushed Savita immediately to the nearby hospital. Savita had an abortion but Rasika's timely intervention saved her life.[1]

Bahurupi Wasti is one of the extremely poor neighbourhoods of Solapur. The Bahurupis are traditional wandering entertainers. They used to roam around the villages and present their art through miming and masking. This traditional occupation is now weaning and they have resorted to selling picture-books and posters. However, traditional customs and rituals are still very strong. One young woman, Mangala (name changed) from this community was pregnant for the second time. Previously, she had a still-born baby and, hence, she was quite scared. She had a peculiar situation at home. Her husband was living with her but would not care for her at all. Worse, he would not speak a single word to her. Mangala had to support herself by selling books or seeking ritual alms. The husband would not give any money for domestic expenses but would come, eat, sit, sleep and carry out all the activities without speaking a word with her. This was quite traumatic to Mangala and she was on the verge of a nervous break-down. Fortunately, the Kartiki Bachat Gat (SHG) of the local women came to her rescue. Under the HMF project, the women's group adopted Mangala under their antenatal care activity. They not only briefed her about the various precautions during pregnancy and ensured necessary health check-ups but also provided her a strong emotional support. They also kept on interacting with her husband and broke the domestic tension between the two.

Lalita Chougule has been a community volunteer and a member of the Rupa Bhawani Bachat Gat from the Maddi Wasti

1. After HMF Sure Start Case Studies

area. Her married daughter was pregnant but had a difficult time due to incessant vomiting. Lalita brought her daughter home for rest for a while but in the fourth month when she went back, she started bleeding profusely. Lalita realized from her training that this was not a good sign. The in-laws had consulted a private doctor but Lalita took the daughter to the civil hospital in Solapur and requested for a ultrasound test. Her hunch came true. The daughter was detected with Hyadtitdiform mole (Draksha Garbha in Marathi) and the pregnancy had to be terminated. She lost a lot of blood and was admitted to the hospital for a month. However, Lalita's training and presence of mind saved her life.

Surekha Kadam has also been a community volunteer and a leader of the Mahalaxmi Bachat Gat of Hanuman Nagar. Their group was looking after one pregnant woman named Sheetal. They were systematically informing her through the behavioural change communications charts. When Sheetal delivered a baby, Surekha and other members were with her in the hospital. Surekha told Sheetal that she should immediately breast-feed the child. Sheetal did not listen and followed the age-old practice of giving sugared water. The child had convulsions after seven days and had to be readmitted. Surekha then forced Sheetal to start breast-feeding immediately. By this time clots were developed in her chest but Surekha personally helped her to feed the child. Later, the child's health improved.

These are some of the cases from the Sure Start Project being implemented by the Halo Medical Foundation in the city of Solapur. This is a maternal and neonatal health project supported by the International organization, PATH.

The high incidence of maternal and neonatal mortality in the developing countries has been a matter of serious concern not only from the health point of view but also from the social development point of view. Considering the importance of maternal and neonatal health, the General Assembly of United Nations in 2005 gave a high priority to these health indicators and set these as goals number 4 and 5 respectively (4- Reduce child mortality, 5 - improve maternal health) in the millennium development goals (MDG). While some progress has been made in reducing the under-five mortality rates worldwide, the situation with regard to maternal deaths has not improved. Among the developing countries, India has the dubious distinction of having 22% of global maternal mortality. Although the country makes much propaganda of becoming a 'super power' in the next 25 years, its basic health indicators are still pathetic compared not only to the developed countries but also to some of its poor peers. Further, despite various efforts the MMR in the country has remained stagnant over the past years (GoM, 2009:4).

The 'State of the World's Children 2009' report by UNICEF clearly mentions that "Most maternal and neonatal deaths can be averted through proven interventions - including adequate nutrition, improved hygiene practices, antenatal care, skilled health workers assisting at birth, emergency obstetric and newborn care, and post-natal visits for both mothers and newborns -

delivered through ***a continuum of care linking households and communities to health systems*** (emphasis added). Research indicates that around 80% of maternal deaths are preventable if women have access to essential maternity and basic health-care services." (UNICEF, 2008: iii). The emphasized words in this reference are important. While the government aims to extend basic health-care facilities to all the population, the need of the hour is to create innovative social arrangements which link the communities with the health-care system.

This is precisely being attempted by the project in Solapur. Halo Medical Foundation (HMF) is a non-governmental organization renowned for its work on creating a cadre of barefoot doctors in the remote rural area of Marathwada region of Maharashtra, and undertaking pioneering work in the area of community health and women's organization. The Sure Start Project by PATH is being implemented in seven cities of Maharashtra and it is an attempt to reduce maternal and neonatal mortality by creating innovative institutional arrangements. The distinguishing feature of the HMF project is that it makes use of women's self-help groups in developing the said 'continuum' of health care for women. Self-help groups have been known for facilitating social and economic empowerment of women through the mechanisms of savings and credit but their application for ensuring health care has been a novelty. Another distinguishing feature of the venture has been the consortium approach whereby voluntary energies of various civil society actors, especially that of educational institutions have been channelled for achieving the goal.

Dr. Shashikant Ahankari, President of HMF says:

"Maternal mortality is the worst form of death in human society. One life goes when another is borne. Hence, urgent efforts need to be made to eliminate this. With proper social support and medical care it is possible to reduce the maternal mortality rates. We have always looked at health in a holistic manner. Our experience of working in the remote rural areas has convinced us that common women can effectively shoulder the responsibility of preventive health."

The project in Solapur started from February 2007 and within the span of two and a half years has achieved some remarkable results. Considering the novelty of the approach and considering the need for documentation, HMF decided to commission a study. The basic aim of the study was to document the significance of the approach followed by HMF in reducing maternal and infant mortality, and disseminate the findings widely.

As this was a qualitative study aimed at elucidating important knowledge regarding the innovative approach, it made use of the techniques of focused group discussions, key informant interviews and analysis of secondary data. The list of SHGs studied and the key informants interviewed is given at Annexure I.

The City of Solapur

The city of Solapur has been known as the 'textile capital' of southern Maharashtra. The first textile mill was started in Solapur in 1870 soon after such mills were started in Mumbai. Subsequent expansion of the textile mills saw the growth of the city in early twentieth century. The region surrounding Solapur has been chronically drought prone and, hence, rural labourers and farmers flocked the city in search of employment. Solapur has also been situated at the confluence of three linguistic regions - Marathi, Telugu and Kannada. These people converged in Solapur from all directions. The Padmasali community which came from the Telangana region were traditional weavers. They brought the skills and techniques of handloom weaving which were later adapted to powerlooms. This community was also proficient in making *bidis* and following their habitation, the bidi making industry was also started in the first quarter of the last century.

While Solapur was in the erstwhile Bombay state, the region south and east of Solapur was under the dominion of the Nizam of Hyderabad. Rural people from this region, distressed due to droughts and atrocious rulers, found solace in the city. Solapur soon emerged as the city of labourers most of whom lived in the workers' quarters or in the poor neighbourhoods. The influx of different communities into Solapur gave the city a multi-lingual, multi-ethnic and multi-cultural character. A majority of these people belonged to the socially disadvantageous categories like scheduled castes, other backward classes, nomadic tribes and religious minorities. Being the city of mill-workers, socio-political consciousness and mobilization was high which was coupled with Dalit movements and other progressive social struggles.

No other city is Maharashtra could be as unique as Solapur as far as ethnic diversity is concerned. This is because the city is situated at the confluence of three linguistic regions, each having its own variety of communities – Maratha, Lingayat, Mahar (Nav-Bouddha), Matang, Chambhar, Dhor, Vaddar, Mehetar, Koli, Kashi Kapdi, Kumbhar, Bahurupi, Burud, Sali, Lodhi, Lohar, Ghisadi, Dhanagar, Fakir, Muslim, Christian and so on.

The textile industry in Solapur did very well in the first thirty years after Independence. The Jacquard looms fitted in the city produced a particularg Turkish towels made in Solapur were also in demand. Exports from Solapur were mainly targeted at the erstwhile USSR and Eastern Europe. In the 80s however the textile industry began to lose its lustre. This was mainly because of the forces of globalization. The old and archaic machinery in the mills could not compete with sophisticated machines fitted in countries like China, Indonesia and Thailand as well as in other parts of the country. The global recession in textile industry and the collapse of Soviet Union affected the exports adversely. The textile strike in Mumbai in the mid-80 had its echoes in Solapur too. Mill owners found it increasingly advantageous to outsource the work to powerlooms. All these factors led to the closure of Solapur mills one after another. By 1990 a majority of the mills in Solapur were closed. Attempts were made

to rejuvenate some of the mills but they did not succeed. At present, except one, all the mills are closed. Powerloom industry has survived and bed sheets and towels are still produced but it also needs considerable government subsidy and assistance from time to time.

The death of textile mills not only affected the economic well-being of the city but also devastated the livelihood options of thousands of workers. These organized workers were pushed into the unorganized sector. They tried to carve their existence as street vendors, itinerant buyers, rickshaw-drivers, construction labourers and casual workers. Many of them left the city in search of remunerative options. Women resorted to bidi making, waste-picking, domestic work, vegetable vending and other forms of unskilled labour. However, the lack of economic vitality in the city not only dampened the informal sector but also pauperized the labouring classes. Economic and demographic growth of the city was stagnated. The poor became poorer. The trends of globalization ushered in after 1990 further increased the inequities.

Project Strategies and Structure

The rationale for the project activities in Solapur rested on the realization that providing health related knowledge and skills to communities was a far better approach than establishing a cadre-based health delivery mechanism. HMF had found through its long-standing work in the district of Osmanabad that if people, especially those belonging to the disadvantaged sections, are motivated to become partners in health then a sustainable movement of health-care could be instituted. This was particularly true regarding maternal and newborn health (MNH) wherein women themselves could be made active participants rather than mere beneficiaries. In urban environment, they could be supported through a consortium of civil society actors who would join in with the spirit of solidarity and social responsibility.

Women and Bidi-making

Bidi-rolling is not just an important occupation for women in Solapur but has deep implications for their livelihoods. Although it is not conducive for good health, there is no other alternative for home-based, illiterate women. On the average a woman earns about Rs. 40 to 60 per day but at present there has been 15 to 20% reduction in the trade. Young girls are lured into the occupation because marriage prospects are increased if you have a 'bidi labour-card'. In marriage market, it is valued more than the SSC certificate.

The strategies of the project emanating from this rationale were as follows.

- dentification of target population in the city of Solapur. This consisted of the poor neighbourhood communities (slums) spread across the city.
- Identification of the eligible couples in the communities and gathering the socio-economic information through situational analysis.
- Organization of a consortium of civil society actors, particularly the educational institutions

- Organization of the project establishment consisting of staff and facilitators
- Identification/promotion of self-help groups of women as community based organizations.
- Training of college volunteers and community based volunteers for project activities
- Organization of core project activities - menstrual surveillance, tracking of antenatal and postnatal women, implementation of behavioural change communications (BCC) and organization and training of groups of adolescent girls
- Linkages with the existing health machinery
- Mass level awareness and sensitization programs
- Media and advocacy

Although these strategies were broadly pursued from the beginning, one major change was made as the project progressed. Initially, it was thought that the college volunteers would shoulder the responsibility of training and motivating the SHGs and also carry out the task of menstrual surveillance and tracking of ANC and PNC. However, after the first year it was realized that there were several limitations on the time and energies of the students and, hence, they could not effectively carry out this responsibility. Emphasis was therefore shifted to community based volunteers from among the SHGs. Enthusiastic, literate and articulate women from the SHGs were selected as community volunteers and the task of carrying out the core project activities was entrusted to them.

During the initial months of the project, the poor neighbourhoods in the city were surveyed and 73 communities (out of the total 256) were selected for intervention. The primary criterion for selection was that the community should be an authorized settlement. The population covered in these communities was around 180,000. The number of eligible couples identified in this population was about 9,000.[2] The proportion came to about 50 couples per 1000 population.

Opinion of a Consortium Partner:
Prof. Madhavi Rayate, Head, Dept. of Preventive Social Medicine,
V.M.V. Medical College, Solapur

"Maternity, although crucial in a woman's life, has always been a matter of gossiping. True knowledge about the whole fertility cycle has never been given to them. The whole subject area is governed not only by ignorance but also by superstitions and blind-faith. The dietary practices are not necessarily scientific and this adversely affects the health of a pregnant woman. In our country, the only way to change this is to undertake continuous educational and motivational drives."

The consortium approach was the distinguishing feature of the project in Solapur. This approach was envisaged right at the conception level of the project. The important civil society actors participating in the project were:

2 HMF, MIS Data Presentation, June 2009.

1. Preventive and Social Medicine Department of the Dr. Vaishmpayan Medical College,
2. Urban Community Development Department (UCD), Solapur Municipal Corporation
3. Walchand College of Social Sciences
4. National Social Service (NSS) Department of the University of Solapur.
5. L. B. Patil Mahila Mahavidyalaya
6. Burla Mahila Mahavidyalaya
7. Union Social Ladies College

The Medical College at Solapur, which is a Government run renowned institute of learning, provided technical inputs and expert medical services. The UCD provided the linkages with the SHGs in the communities. In the case of Walchand College, the students of the Master of Social Work program were involved in the project as part of their placement program and served as the volunteers. The NSS department of the University of Solapur wholeheartedly endorsed this initiative and provided university level administrative support. The last three colleges were involved in the project through their NSS wings whereby the girl-students were involved as volunteers in the project activities. The consortium members not only participated into the programs and activities but were also part of the management and coordination structure of the project. Besides these, other civil society actors like the Lions and Rotary Clubs and other voluntary organizations as well as local media were involved in project activities.

The key agencies for the project were of course the SHGs. The project had initially proposed to create SHGs especially for the project purpose. However, it was soon realized that owing to the popularity of the idea, virtually every locality had SHGs established. These were mainly by the Urban Community Development (UCD) project implemented by the Solapur Municipal Corporation. Hence, it was decided to make use of the existing entities and train them in the field of MNH. Only where such formations were non-existent, it was decided to promote either an SHG or other form of women's organization like a Mahila Mandal.

The Director of the project was Dr. Shashikant Ahankari, the President of the HMF. The day to day responsibility of the project was shouldered by the Project Coordinator, Dr. H.V. Wadgave who had done post-graduation in preventive and social medicine. He was assisted by Shri Upendra Tannu who acted as the Volunteers Coordinator. In order to cover the large and scattered population, the

Feedback from a male college volunteer (Walchand College):

"Before joining this project as NSS volunteer I did not know anything about this subject matter. I was also very shy and did not know how to talk with girls or women. But after participating in the project I realized how important this issue was. The exposure also changed my personality. I think, I have understood what gender difference is and what I have to do for reducing it."

project had appointed twenty facilitators. Each facilitator was to approximately cover 10,000 population and provide support to the community volunteers and the SHGs. An interesting feature of the facilitators was that all were women having professional, post-graduate qualifications in social work. The task of managing the facilitators was shouldered by two sub-coordinators namely Ms. Vasanti Mule and Ms. Vaishali Avad, both of whom were experienced social workers. The project had the necessary support staff at the office located in Solapur. The Consortium Committee provided the overall guidance and advisory inputs to the project.

Dr. Kranti Raimane of PATH:

"Although some experiments have been done in rural areas on Reproductive and Child Health, the need is dire in urban areas. Urban health infrastructure in India is quite inadequate. Nobody has definite answers as to how effectively the outreach of the existing system can be increased. That is why PATH has concentrated in urban areas. In Solapur we are exploring the model of peer pressure changing the behaviour of women. This is in contrast with the cadre-driven models."

The core activity of the project was to carry out menstrual surveillance of all the eligible couples in the project area and identify antenatal cases as early as possible. Initially, the college volunteers and later on the community volunteers were shouldering this task. Each community volunteer (CV) was monitoring approximately 1000 population. They would carry out menstrual surveillance every three months by undertaking a door to door visit in their area and identify the antenatal cases (ANC). Once the ANC was identified, then the volunteers' main task was to ensure that she was registered with the nearby MNH clinic, hospital or any other institutional facility. They were to also monitor whether she was making periodic visits to the clinics, whether all her health parameters were in order and whether she was taking the prescribed medication or not. They would also enrol her name in their registers and file her information with the respective facilitator. During the antenatal phase, they would brief and educate the women through a set of behavioural change communications (BCC) charts which were specially prepared under the Sure Start project. Their main role was to ensure that the pregnant woman remained healthy and happy, and a safe and sound delivery was conducted. They were to also ensure that delivery took place in the nearby institution and all the necessary care was extended to the newborn. However, their task would not end after delivery. They were to also ensure that the baby received the necessary lactation, nutrition, vaccination and familial and medical attention. Protecting the child in the first 28 days was the key task after delivery.

For raising general awareness and campaigning, the project undertook a series of activities across the city. This included a vast number of locality specific as well as city-based programs. The local media was involved systematically and meticulously. The local cable TV network was also extensively used.

The project did not envisage providing health care directly. Instead, the goal was to effectively utilize the existing infrastructure and make it accessible to the target groups. For this purpose close contact with the Municipal Corporation's health machinery as well as that of the district administration (civil hospital) was maintained. The anganwadis run under the Integrated Child Development Scheme (ICDS) have been also entrusted with the task of antenatal and postnatal care. The Auxiliary Nurse and Midwife (ANM) has also been an important link in the field of MNH. At each location, linkages were established with the anganwadis and the ANMs so that effective care could become available to women.

Another important activity of the project was formation of groups of adolescent girls across the localities. This was with the view of empowering the young girls with the knowledge about reproductive health and sexuality.

Besides these regular activities, some of the notable programs undertaken in the project were as follows.

- Janani Suraksha Abhiyan - A campaign across all the slums to inform the women about the Janani Suraksha Yojana (JSY) of the government meant for pregnant women below the poverty line.
- Organizing awareness programs on various themes and observing Nutrition Week, Breast-feeding Week, World Health Day, Anti-Domestic Violence Fortnight, Dr. Ambedkar Birth Anniversary as well as organizing NSS camps in project localities.

Training of the Auxiliary-Nurse-Midwives (ANMs) of the Solapur Municipal Corporations and orienting them to the project activities.

Organizing health check-up camps and women's gatherings in various localities.

Encouraging local SHGs to organize various community based programs.

Organizing special 'Arogya Samwad' (Health Communication) camps in collaboration with college volunteers.

The project rallied around the idea of voluntarism and it was expected that various sections of the communities and civil society would contribute its bit for the implementation of the project. In order to boost voluntarism certain tokens of appreciation were instituted in the project. The system worked at three levels. The community volunteers were rewarded by providing free-of-charge training, a family health insurance plan, annual gifts and a monetary incentive. The college volunteers were not remunerated individually but a sum of Rs. 500 per volunteer per year was granted to the college from which various welfare activities were conducted for students. The SHGs were awarded Rs. 100 per adopted ANC. This amount was given if the baby was delivered in an institution. Certain eligibility criteria were also stipulated before these grants were made.

Achievements

The project was however not just for its activities. A set of achievements has also been to its credit. The full significance of the project cannot be grasped unless the

Opinion of a Consortium Partner: Principal Swati Vadagbalkar of Burla College

"A majority of the girls who have enrolled as volunteers from our college belong to socio-economically lower classes of society. Many of them are first generation learners. About half of the parents are illiterate. We found that only one parent had post-graduate education. The burden of tradition is very strong. For these girls, the exposure to this project was awesome. They not only understood the problems and miseries of slum-women but the subject also opened up new vistas of understanding themselves."

achievements are noted. Some of the broad achievements from July 2008 to June 2009 are listed in the following.[3]

- The Project worked with 157 self-help groups covering 1884 women. These SHGs promoted 214 community volunteers who looked after the population of 180,000 in 73 localities. The Project also involved around 200 college volunteers
- The project catered to 3678 antenatal cases and 2155 postnatal cases during the year. Of these, 54% ANCs were registered before 12 weeks and the remaining after 12 weeks.
- As for utilization of antenatal services, awareness regarding tetanus injections was very high; 98.4% ANCs took these injections. However, only 40% took IFA tablets. The proportion of women undergoing ANC check-up was 78%.
- During this period, a total of 76 deliveries (3.65%) took place at home. However, over the year, the trend of home deliveries decreased from 8.13% in August 2008 to 1.8% in July 2009.
- The proportion of normal deliveries was 89% whereas caesarean operations were performed on 10.35% cases and forceps delivery on 0.6%.
- The proportion of live births was 93% whereas that of stillbirths was 2.51% and abortions 4.08%.
- On the average the first PNC check-up was carried out by 76.18% women within 48 hours of delivery. This trend improved from 39.74% in August 2008 to 90.5% in June 2009. However, only 56.77% women made the second check-up within seven to ten days.
- The time-gap between breast feeding immediately after delivery has come down significantly; 58% women breastfed the child within 30 minutes of delivery whereas 31% fed within 24 hours and remaining 11% fed after 24 hours. Traditionally breast feeding was delayed by a day or two. The proportion of women giving pre-lacteal feeds also came down to 18%. Previously it was in the range of 40-50%.
- Besides these, a number of changes in fertility related behaviours have been noted.
- In the first place, popular awareness regarding women's health, antenatal and postnatal care and care of the infants has increased substantially. The sensitization activities carried

3. MIS data presentation by the project.

out by the SHGs and the community volunteers through the BCC tools and through various campaigns have raised the level of understanding and knowledge on these issues.

- There was a positive impact on the age of marriage. The need for girls' education is being felt and subsequently the incidence of child marriage is getting reduced.
- Although the proportion of eligible women receiving benefits under the Janani Suraksha Yojana was 33%, the knowledge regarding this scheme and the Matrutva Anudan Yojana increased considerably. Previously women were unaware of these schemes and also did not have the wherewithal to access the same. Most importantly, there is now the understanding that JSY is the right of poor, disadvantaged women and they must acquire the benefit.
- The effect of carrying out the menstrual surveillance meticulously not only helped early detection of pregnancy but also sensitized the women regarding its importance. Now women have themselves begun to report missed periods to community volunteers. The information dissemination at the grassroots level has trained the women to look for danger signs and report them immediately.
- Similarly, BCC cards have become very popular as a means of information dissemination, and women from all the localities are asking for their presentation.
- Community volunteers have emerged as referral points in each given locality and are slowly assuming the status of community health workers. General illnesses and disorders are being reported to them and their consul is sought on health related matters, especially paediatrics. They are also rigorously implementing a scheme like Janani Suraksha Yojana.
- The awareness regarding health parameters has substantially improved. Not only women but also the adolescent girls organized in various groups have begun to check their haemoglobin levels. The term BP (blood pressure) has also become commonplace.

Some of the other distinguishing happenings include:

- NSS camps were organized in the slum communities. Conventionally, these camps were organized only in rural areas where the youth performed nominal labour-work. A new precedent was created by making due changes in the NSS framework at the University level so that the youthful energies were more meaningfully channelled.
- One of the consortium partners, the Burla Women's College has been so inspired by the project that besides involving the students as volunteers, the college started a counselling centre for the girls and is further desirous of implementing a project of the same type in a nearby slum-locality.
- Those college volunteers who have participated in the project have emerged as a strong and motivated cadre of youth heralding the flag of MNH care. A majority of these are girls who have awakened not only to the social issues but also to their

own, personal reproductive rights and sexuality.

The Idea of Self-help Groups

These gains and achievements invite our attention to the innovative organizational form used in this project i.e. the SHGs. Self-help groups or Bachat Gats as they are called in Marathi are neighbourhood groups promoted to facilitate savings and credit activity among the members. The principle has been simple i.e. what individuals cannot achieve the group can achieve. Although the idea of such groups was pioneered in Bangla Desh by the Grameen Bank, it has now caught the attention of all developing countries. In India, it has not only become a household name but also an omnipresent entity like the Gram Panchayat. Thrift or Bhishi funds preceded the SHGs. The SHGs in their current form are, however, geared for development ideals. They are promoted to overcome the indebtedness of poor families, break the hold of usurious moneylenders and usher in the process of capital formation through linkages with financial institutions. Although the cooperative credit movement had precisely aimed to do this at the turn of the previous century it could not meet its goal. This was because (1) it remained a masculine movement, subverted by unscrupulous and power-hungry politicians (2) it was entangled in the jumble of rules and regulations and (3) its spread and scope remained restricted. In contrast, the SHG movement was started as a women's movement, satisfying the credit needs of women and breaking down the traditional bastions of patriarchal, economic dominance of men. In the Grameen Bank model, however, the focus of the movement was primarily financial and the group was used mostly as peer-pressure mechanism for prompt recovery of the loans. The size of the group was also small; usually five persons. Those following the Grameen Bank model have developed SHGs mostly as financial intermediaries facilitating microfinance.

In Western and Southern India, where the movement has been greatly successful, the concept of savings and credit groups of women has been beautifully blended with the traditional formations like Mahila Mandals or Mahila Sangams. In states like Maharashtra and Gujarat, the SHGs have been thought not just as microfinance groups but as vehicles of socio-economic empowerment of women. This broader developmental orientation is important. It has come about due to the tradition of social reforms, especially the women's reforms movement in Western India. The Mahila Mandals were considered as the grassroots formations through which women could unite for strength and solve their problems collectively. The idea of savings and credit was merged with the idea of a 'mandal'. Particularly in the state of Maharashtra, the SHGs are thus conceived as the means for initiating a comprehensive process of empowerment of women covering all the three dimensions – social, economic and political.

With the empowerment orientation, a variety of goals and tasks have been pursued by the SHGs and the NGOs promoting them. Graduating from mere savings and credit functions, the SHGs have moved to livelihood aspects covering manufacturing, marketing, insurance and trading. On the social front, the SHGs have emerged as the strong proponents of women's rights. The

Saheli and Tamanna Groups from Shahpure Wasti

The Muslim women from this community have been tremendously benefited by the project interventions. Prior to the project, they did not know the idea of SHG but once they made the groups they have been wholeheartedly enjoying the warmth and strength of being united. The SHGs have given them a platform to come together and also to venture out which was not possible in their traditional setting. The birthday of the group was celebrated in the same manner as one does for a child. Their SHGs have been also helping them for livelihood ventures. The men in the community have now reconciled with fact that women are awakened. Now there is no opposition.

author's personal studies have indicated that SHGs can play a very effective role in stopping violence against women and reducing gender discrimination both at home and outside (Bokil, 2003 & 2005). There have been a number of examples where agencies have effectively used the medium of SHGs for tackling domestic violence and providing support to women. The Mahila Vikas Parishad in Vidarbha has demonstrated that SHGs can lead political enfranchisement of women and can emerge as an important political formation at the local level. In calamities like floods and accidents, SHGs have undertaken relief activities. Agricultural development, water issues, education (particularly of girl-child), campaigns against child-marriages and superstitions – the list of tasks pursued by SHGs is impressive.

Though some forays in the field of health have been made, examples of SHGs geared for health service have been few. This is where the present project merits attention. Conventional involvement of SHGs in the field of health has been limited to (1) providing credit for health needs of member women (2) undertaking health programs like medical check-ups, eye-camps and immunization-drives and (3) extending group support in case of illnesses. The Sure Start project in Solapur is perhaps the first major experiment where the SHGs have donned the mantle of accomplishing one of the most important MDG goals i.e. reducing the MMR and IMR.

SHGs at Work in Solapur

In order to fully grasp the significance of SHGs involvement into this activity it is essential to understand how the SHGs dealt with the whole issue of MNH.

The first step in any such project is the survey of all the eligible couples in the target population. Although in Solapur, this survey was carried out by the project staff before the involvement of the SHGs, the latter are ideally suited for this purpose. This is because they are the neighbourhood groups and have intimate knowledge of the local community. Conventionally, external investigators are employed for gathering information but the members of SHGs (many of whom are literates and school-educated) can easily shoulder this responsibility. The limitations of the external investigators can certainly be overcome by SHG involvement.

The second step was the identification or creation of SHGs for the project purpose.

In Solapur, the project had originally planned to promote the SHGs in the selected population. But once it was realized that SHGs already existed then duplication was avoided. Only where such groups did not exist, the project staff promoted new groups as in the case of Shahapure Wasti, Bagle Wasti, Maddi Wasti and so on. In some areas like Lodhi Pura, mahila mandals were promoted.

Once the SHGs were identified then the important task was to train the leaders or interested volunteers. Although it was advisable to involve each and every member of the SHG in MNH, in practice all the members could not and did not participate in this venture. This was for obvious reasons. Not all the members had aptitude for this kind of voluntary social work. Secondly, as these groups were composed of working-class women, most of them did not have the time or leisure. Thirdly, only a few had the drive and the willingness to learn new skills and knowledge. As a result, although the whole group was involved, only a couple of them could shoulder the task of community volunteering. Their training was important as they were the backbone of the whole program. This training was meticulously carried out in the project and refresher activities were also organized.

After identification and training, the first activity was menstrual surveillance. One of the major obstacles in MNH care is that pregnancy is not detected well in time. In the case of eligible women the first and clear sign of pregnancy is missing of the menses. However, women disclose this only to their closest relatives as this is a strict taboo. Conventionally the news of pregnancy is hidden until it is visibly apparent. Even then not all women consult the doctor. Medical check-ups are carried out in 5th or 6th month. Modern medicine advises that earlier the detection of pregnancy, greater are chances of safe delivery. The only way to detect pregnancy as early as possible is to undertake regular menstrual surveillance in the selected population. In the present project, each community volunteer handled 1000 population and undertook a door-to-door survey of all eligible couples every three months (or more frequently if the situation warranted). Menstrual surveillance is a sensitive matter. Outsiders do not have much scope to succeed. Only those health workers who have the confidence of local women can establish the required rapport. The involvement of SHGs has been path-breaking in this regard as only these women could reach the inner confines of fellow-women.

Once pregnancy was detected then the next task was registering with the nearest medical facility. As mentioned earlier, conventionally women would not do this until well beyond 5th or 6th month. Till recently, the dominant practice was to go to hospital only when the labour pains started. The SHG volunteers not only encouraged the ANCs to register as soon as possible but many of them personally accompanied them to the local facility. This measure encouraged 55% of all the ANCs to register before 12 weeks. Earlier, this proportion was very low. The ANCs which could not be registered before 12 weeks were mostly the daughters who came to these localities from outside for deliveries

The real function of the SHGs and CVs began when the ANC was identified. In

the present project a particular term - adoption - was used for this function. The SHGs adopted the ANC under their care. The idea of adoption is important although conventionally it is used in relation to children. The ANCs were not orphans or helpless women but adoption signified that they were not alone and a group of women cared for them. The CVs undertook mainly three activities during this phase: (1) Information and knowledge dissemination through the Behavioural Change Communication material (2) Monitoring the health of the ANC and (3) psychological and social support.

The BCC material for MNH care was specially prepared for the Sure Start Projects in Maharashtra, and in Solapur the CVs made use of the same. These charts were prepared in such a way that they could be useful at each stage of pregnancy and after delivery. They consisted of colourful illustrations and lucid information. Not only the ANCs but other women in the household and the community immensely liked the charts. The general feedback has been that these charts not only gave critical information but also opened up a whole new world of women's anatomy and physiology before them.

The SHGs and CVs also meticulously monitored the health of the ANC. The most important aspects were (1) proper food and nutrition (2) routine check-ups and medication and (3) watching for danger signs. Traditionally, it was known that pregnant women need to eat good food but in Indian society good food meant sweet and oily carbohydrates. The traditional notions needed to be modified with scientific, nutritional perspectives. The CVs informed the ANCs about proteins, vitamins, micro-nutrients, minerals and other essential ingredients through the BCC charts. Traditional diets have been deficient in proteins and minerals. Hence, the inclusion of *dal* and green leafy vegetables was emphasized. Conventional misgivings about what to eat and what to avoid were also removed. The CVs during their regular visits also tried to ensure whether the ANCs were actually following the advices. Poverty was a major impediment coupled with the high prices of pulses, vegetables, fruits and non-vegetarian products. Traditional cultural practices like women eating last also was an obstacle. To overcome these difficulties attempts were made to sensitize the family-members, especially the mother-in-laws who held the key to the nutrition of the daughter-in-laws.

The second important aspect was medical care. The ANCs were motivated to undergo stipulated medical check-ups and monitor the vital parameters like weight, haemoglobin, blood-pressure and others. Best gynaecological practices warrant that ANCs should make at least three visits to the doctor during pregnancy and more if needed. The SHGs ensured that this was undertaken and record of each visit was made on the card. The CVs noted down this information in their respective registers and handed it over to the project staff. Between July 2008 and June 2009, 79% ANCs underwent four or more visits. In terms of medication, the important elements were anti-tetanus injections and the Iron and Folic Acid (IFA) tablets. With regard to TT injections, awareness has been

good (98.4% ANCs took the injections) but the same was not true regarding IFA tablets.

It's common knowledge that Indian women are anaemic and the percentage is dangerously high in poor and marginalized communities. A sample study in the present project indicated that around 93% of the women from the target population were anaemic. This proportion was higher than the state or national average. Anaemia is a serious concern during pregnancy as it is the principal cause of maternal morbidity and mortality. While proper food and nutrition are the best means to overcome anaemia, the correctional measure is to take IFA tablets for 100 to 200 days. This is the most simple and cost-effective measure but not many ANCs follow this. Women have considerable resistance to taking IFA tablets. The major misgiving is that it would increase the size of the baby and would make delivery difficult. This is also the reason why pregnant women are denied nutritious food. This calls for motivational inputs. The CVs played a major role in clearing out this misgiving and ensuring that the ANCs took the stipulated dose of IFA tablets. There was however a limited response to this, mainly because although the CVs provided motivational inputs, the tablets were not available with the local functionaries like the ANM or the anganwadi worker. The project authorities had to make advocacy efforts at the state level to ensure smooth supply of the tablets in the city of Solapur.

In this regard, the third important aspect was watching for danger signs. High blood pressure, overall weakness, oedema on legs, pain in abdomen, blurred vision, PV bleeding and headaches are some of the prominent danger signs observed during pregnancy. The CVs made the ANCs aware about these signs and also made a record in the registers as and when these were reported. During the year July 2008-June 2009, 463 ANCs were detected with danger signs. Out of these, 87.3% availed the necessary treatment. The distribution of various danger signs in the year 08-09 was as follows.

No.	Distribution of Danger Signs	Number	Percentage
1	PV bleeding	32	6.91
2	Headache	23	4.97
3	Swelling over feet	28	6.05
4	Blurring of vision	27	5.83
5	Reduced fetal movements	6	1.30
6	PV watery discharge	5	1.08
7	Pain in abdomen	31	6.70
8	Convulsions	5	1.08
9	High fever	7	1.51
10	Weakness	66	14.25
11	Raised BP	59	12.74
12	Other (Non Specific)	174	37.58
Total		**463**	**100**

**From MIS Data of the project*

Alongside the medical support, the SHGs also provided a great deal of psychological support to the ANCs. As could be seen from some of the examples cited earlier, the SHG women and the CVs were senior and experienced women who had donned the mantle of helping the pregnant women. With their commitment and training they served as ideal pillars of support. Traditionally, mothers, elder sisters, sister-in-laws or mother-in-laws served this need but their scope and reach was limited. In today's difficult world, information and knowledge based support is required which could be provided only by trained, knowledgeable and friendly women.

The next step was the preparation for delivery. The CVs emphasized two aspects – a state of readiness and transport arrangements. It was clearly mentioned in the BCC charts that a bag packed with all the necessary utilities should be kept handy as the time approached. Traditional superstitions prevent the preparation of such a bag in advance but with constant motivation this misgiving was removed. Secondly, ANCs were advised to think of transport arrangements well in advance. The delay in transportation is one of the major causes of maternal mortality in India. Transportation was not an issue in Solapur as it was a big city but nevertheless the preparedness was necessary. Almost all the localities had auto-rickshaw drivers living there. The ANC families informed their closest one well in advance. *(In general auto-rickshaw drivers are found to be extremely sympathetic to this cause and never decline a pregnant passenger. In Solapur, the auto-rickshaw association has made a mandate to ferry patients from the civil hospital at a fixed charge of Rs. 25 to any destination in the city).*

The readiness in this regard was proved immensely beneficial and no delay in transporting any ANC was reported. The proportion of stillbirths was only 2.5% in the project.

Postnatal care was also a mandate of the CVs. Here also two aspects were emphasized – immediate breast feeding after delivery and mother's postnatal check-up. On both the counts the assistance by the CVs proved useful to the PNCs. Traditionally, the mothers did not breastfeed the infants immediately. Various pre-lacteal feeds were given; sugared water being the most preferred one. The SHGs and CVs made special efforts to change this practice and attained considerable success. As mentioned earlier, 58% mothers breastfed the child within 30 minutes of delivery whereas 31% fed subsequently. Though the practice of pre-lacteal feed was not completely abandoned (18%), a majority of the mothers gave breastfeeding to their children. The proportion of medical check-ups of PNCs and the newborns also increased substantially.

Besides adopting the ANCs in their vicinity, the SHGs also carried out a number of beneficial activities. The project had organized the groups of adolescent girls in various localities. The SHGs served as anchor points for these groups as mostly the daughters of the SHG members were enrolled in them. Similarly, they served as reference points for the college volunteers. But for the SHGs the college volunteers would not have established due rapport

Traditional Health Practices

Among the Bahurupis, the leaves of *Kadu Limb* (Azadirachta indica) are ground and boiled with turmeric. The paste is mixed in oil and thoroughly applied to a postnatal woman. She is then bathed in hot water. This is repeated for about a week. This is just not a strange and sporadic practice. In Marathi, Kadu Limb is also called '*Balant Limb*' and its medicinal properties for postnatal women have been known to both people and Ayurveda for long. It is believed that the juice of leaves taken during pregnancy not only keeps the woman healthy but also protects the child. The disinfectant properties of this tree are well known and it has emerged as the principal, organic alternative to insecticides and pesticides today. The Bahurupis and Vaddars also have a tradition that from every house in the community a pot of hot water is sent to bath the postnatal woman. Not sending a pot is considered an offence and not utilising it is also considered an insult. But there are some dangerous practices also. Among the Bahurupis from Karnataka, the infant is branded on stomach with a hot iron rod with the belief that it then never gets stomach ailments

with the communities. Some of the SHGs also undertook novel and innovative programs like those mentioned in the following.

- In Hanuman Nagar, the SHG organized a community program of 'Choli'. Traditionally, pregnancy is celebrated by the families and friends bygifting the pregnant woman with a saree, coconut, turmeric, vermillion and rice (together called as Otee). The SHG turned this into a social function and collectively celebrated all the ANCs on the day. The novelty was that instead of the traditional items, they put nutritious substances like nuts, dates, sprouted lentils, jaggery, etc.
- In Ratna Maruti Wasti, the group organized a program for the adolescent girls and included both the studying and working girls. They organized a Rangawali competition with the condition that the drawings should depict nutritious foods. Prizes were distributed to successful contestants.
- Saheli SHG from the Shahpure Wasti celebrated the group's first anniversary by cutting a cake and organizing a gala gathering of all the people in the locality. They played various games and competitions which was a 'first of its kind' opportunity for the Muslim member women.
- In Kongad Kumbhar Galli, a gathering of the newly-wedded women was organized. The newly weds were allowed to mingle freely with each other and vital information on marriage-life was shared with them.
- From Shastri Nagar locality, the SHG participated in a trade-fair organized by HMF at Andoor, in the neighbouring district and put up a stall selling various home-made products.
- In Shanti Nagar area, the Muslim women organized a 'Til-Gul' get-together on the occasion of Makar-Sankrant (14 January) for women from

all the cross-sections. Traditionally, the program is organized only by married, Hindu women.

These are some of the examples. A number of such activities were organized by the SHGs which created an environment of enthusiasm and joyfulness in the communities. The project did not remain restricted only to the issue of MNH but encompassed all the aspects of women's lives in the targeted areas.

One major activity facilitated by the SHGs has been the linkages with the existing health system and implementation of government schemes for pregnant women. The Sure Start project did not envisage provision of services but insisted that the existing services be optimally used. The present health system in an urban setting consists of the dispensaries and hospitals run by the metropolitan corporation, the extension service channelled through the Auxiliary-Nurse-Midwives, the supplementary services through the anganwadis and the district hospital run by the district council. The Solapur Metropolitan Council was part of the consortium of the project and, hence, their services were integral to the activities. Besides, the Medical College was also a part of the project and their services were also available. The project also had good linkages with the district hospital (called as civil hospital).

At the ground level, it was the anganwadi workers and ANMs who presented the interface with the communities. Anganwadi workers have also been given the mandate to care for the ANCs and PNCs. The work therefore overlapped. Initially, the anganwadi workers were hostile to project activities as they feared intervention into their work. Their city-unions had refused to cooperate. However, in the course of time, the local workers realized that the SHGs and CVs were actually making their task easier and the combined synergy was mutually useful. Thence, most of the anganwadi workers cooperated wholeheartedly. In most of the locations, the anganwadi sites were used by the SHGs and CVs as common meeting places. The situation with the ANMs however remained different. The ANMs were found deficient in fulfilling their duties. They would only sporadically visit the communities and cursorily carry out their activities. Their main focus was also restricted to immunization. Although qualified, they never emerged as sympathetic and efficient health workers. However, when the SHGs became active, the ANMs were compelled to dispense their job sincerely and also be accountable to the local communities.

The government scheme that is directly concerned with MNH is the *Janani Suraksha Yojana* (JSY). Under JSY, women above the age of 19, from the below poverty line (BPL) section or those belonging to SC/ST categories are granted Rs. 600

Chanchala Musalkhamb is an enthusiastic dalit girl from Awase Wasti. She has been both a member of the Kishori Gat as well as a community volunteer. She has been looking after 13 ANCs in her area and has been very successful in her undertaking. She is also studying first year law. She wants to follow the footsteps of Dr. Babasaheb Ambedkar and study hard so that she could play some useful role for the fellow women.

as a motherhood grant for the first two pregnancies provided they undergo at least three ANC check-ups and deliver at an institution. The grant is given post-delivery subject to making an application and attaching the necessary supporting documents. A special study of JSY was undertaken by the project team in 35 localities, which revealed that only 32.78% of the eligible mothers received the JSY benefit. The main reasons for not getting the benefit were (1) lack of knowledge of the scheme (2) difficulties in getting the documentary proofs and (3) delay in filling the form. It was also found that mostly those women who delivered at the government hospitals received the benefit as there they could get due information and could comply with the conditions. The project undertook a campaign in collaboration with the SHGs for popularizing the scheme and subsequently the facilitators and the CVs made personal efforts to extend the benefit to the eligible women. The emphasis was on informing the women that JSY was their right and they should exercise it.

There is also a parallel scheme by the central government called as *'Matrutva Anudan Yojana*' which is open to all the women but with similar requirements (above 19, three check-ups and institutional delivery). The scheme grants Rs. 800, half of which comes in kind (by way of medicines and supplements) and half is given after the delivery. This scheme has also been in vogue but the same has not been sufficiently availed of. The SHGs and CVs made efforts to extend this benefit as well.

While these health-related functions were effectively carried out by the SHGs, they were also involved in carrying out their basic function i.e. savings and credit. In most of the SHGs the savings ranged from Rs. 50 to 100 per month and they followed all the necessary procedures including maintaining a bank account. Almost all of these SHGs were lending internally and many of them had also established bank linkages. Some of the older SHGs had received loans ranging from Rs. 100,000 to 250,000 to undertake income generating programs. As mentioned earlier, the city of Solapur has been politically and socially vibrant and many political workers and city representatives have actively promoted SHGs in their respective localities. The additional motivational inputs provided by the project staff has added greater accountability to these SHGs and has increased the propensity to become more responsible and efficient.

The Significance of SHGs

The functioning of SHGs in the above manner brings out certain significant aspects and dimensions about their role and potential. This significance is not only the essence of the present project but

Feedback from a Facilitator

"I am married and I have a daughter. I have been working in this project for past one and a half years. As I had delivered a daughter I thought that I knew everything but when I worked in the project I realized that I did not know even 50% of the things. Had I known those things, my pregnancy would have been more enriching. I therefore strive to extend this knowledge to the women in communities. I feel great joy and satisfaction in doing it."

also the roadmap for replication in other situations.

Why are SHGs so well placed in tackling this issue?

In the first place, the SHGs are dealing with a very vital aspect of human life i.e. birth. This is a matter of core concern to human society. Birth is a natural process and a joyful event for all forms of life. The continuity of life is maintained by the process of birth and as such it is of utmost importance to all animates. There is no other process which is so basic and organic on earth.

The process of birth, although a common human process, has different implications for men and women. This is because women have to shoulder the responsibility of childbirth. Hence, although it is a common human process it affects women differently and intensely. In the present context, SHGs are primarily women's groups and, hence, they are concerned with a very vital aspect of their constituency. Savings, credit, livelihoods, social security and other issues are important but none of them is so intricately and organically related to women's life as conception and childbirth is. Individually and collectively women's life, bodies and wellbeing are comprehensively affected by this process.

Thirdly, childbirth is not just an individual issue or experience. It is a bisexual process and in human societies sexual relationships are governed by a number of social institutions like marriage, family, patriarchy and law. Thus childbirth becomes a social issue. It does not remain restricted to two individuals but becomes a concern of the whole society. In any case, the immediate community consisting of the kin-groups and the neighbouring families is directly concerned with it. SHGs being a community formation, particularly of women, thus have a clear linkage with this process. Traditionally the joint family, the kin-group, the caste or the village society facilitated this linkage but as these institutions are changing and losing their importance, other forms are required, especially those which are secular and compatible with the modern reality. A self-help group of women is a sound alternative.

Although the process of birth is a basic human process, in a society like India it is loaded with a number of social complexities. The joyful, primordial and familial process is burdened with a number of socio-political parameters like population explosion, ecological pressure, poverty and food insecurity, patriarchy, subjugation of women and social inequalities. For example, there is the consideration of population control which directly and indirectly affects individual's natural, biological choice of having children. Further, the skewed distribution of resources especially food also affects fertility patterns. The malnutrition of poor women and their children makes birth and child-rearing a risky process for them. The situation is further compounded with uneven distribution of health facilities. The advances of modern science and technology are for the betterment of health standards but the subversive use of ultrasonic techniques for sex-testing results into female foeticides. Traditional cultural practices and social preferences thus disrupt the natural process and the natural balance between males and females is distorted.

The additional dimension is the higher incidence of maternal and infant mortality rates in the country in general and among the disadvantaged sections in particular. There are also the issues of malnutrition and morbidity among these sections which adversely impact their life, livelihoods and development options. This is another social concern and needs to be addressed on priority. Special programs are therefore needed so that the full potential of human fertility and social development is realized by all. The best way to tackle these and related issues is to create social arrangements which (1) sensitize the society (2) change the attitudes and behaviours (3) and extend the benefits of existing health services for the needy sections. Among the social arrangements which have the best potential for fulfilling this need, SHGs would rank topmost.

In the present context, the role played by SHGs has two dimensions – social change and social service. The social change dimension includes dissemination of vital knowledge and information and demystifying the MNH, changing the attitude and behaviours of the stakeholders, initiating a process of empowerment of women and girls, changing gender relations at home and community and finally making the issue of reproductive rights a public discourse. The social service dimension comprises of extending social and psychological support to pregnant women and mothers, linking with the existing health systems, acting as civil society action groups and facilitating a socially inclusive process of development of the underprivileged sections.

We shall see these elements one by one.

As could be seen from the present experiment the first and foremost task performed by the SHGs and the CVs is the dissemination of vital knowledge and information on this issue. Reproduction has long been a mystery and because of its mysterious nature it has created a variety of inhibitions and hiatuses. The BCC charts created under the project not only aimed to demystify the whole process but also created strong knowledge tools in the hands of women. The knowledge did not remain restricted to the process of pregnancy alone but covered all the vital aspects including physiology and anatomy, menstruation and conception, food and nutrition, drugs and medicines, immunization and preventive health and child care and maternal well-being. As many of the ANCs reported they never had access to this information. The knowledge which was hidden in textbooks and was the monopoly of a select few was made open for all. This was a kind of knowledge explosion. The knowledge belonged to women but it was denied to them. Bringing it back to where it belonged was the most significant contribution of the project.

The knowledge and information was not just for learning or academic purposes. It was aimed at changing the attitudes and behaviours of all concerned – the pregnant women, the mothers and mother-in-laws, sisters and sisters-in-laws and above all the men of the families. Many of the problems and difficulties faced in MNH have been related to traditional attitudes and behavioural patterns. The SHGs and CVs applied their skills and knowledge for bringing about sustainable changes in the attitudes and behaviours; whether it was

related to pregnancy check-ups, IFA tablets consumption, institutional deliveries or pre-lacteal feeds. The changes in attitudes and behaviours held the key for better MNH and this was precisely being attempted by the SHGs.

The changed attitudes and behaviours initiated a process of empowerment for women and girls. As many of the women reported, the fear of pregnancy was removed and they were imbued with the confidence that they could handle the process competently. Knowledge is the most empowering tool and when it is backed with hand-holding and practical support, its strength is multiplied. The enlightenment received by the ANCs was exceptional because it pertained to their bodies and their beings. The practical results they saw by way of safe deliveries further increased their confidence. The empowerment did not remain limited to the ANCs. All the community women were benefited by it because this was an open, transparent and public process. The empowerment was quite marked in the case of adolescent girls and college volunteers who were better disposed for it. As many of the young girls described, they were not only enlightened but were also well-equipped to handle the prospective responsibilities. Schools, families or peer-groups had never bestowed this knowledge onto them. Their involvement in the project awakened them towards the choices they had in future and this made them more mature, courageous and competent.

The empowerment of women also initiated a process of changing gender relations in the family and the community. The changes brought about in attitudes and behaviours paved the way for changing the way gender roles, responsibilities and relations were patterned. The message given by the SHGs was that no woman was alone anymore and injustices could not be easily committed against her. Although men were only peripherally involved in these processes, the winds of change have wafted in their homes. At present, there is at least the understanding that both men and women are responsible to reproduction and the burden cannot be lifted by women alone.

There is also the dimension of reducing the superstitions and blind-faith. Social life of both men and women in India is dominated by a great deal of superstitions. In other walks of life they could be tolerated but

Experience of an adolescent girl:

Pooja Kamble from Maddi Wasti is studying in 9th standard and is a member of the Kishori Gat. She has been an accomplished sprinter who has won many trophies for her school. She is a devoted NCC cadet and also plays throw-ball and Kabaddi, She mentioned that after joining the Kishori Gat she got new knowledge and information. She said, "It was this information which the elders would have never told us. Now I know, how a child is conceived, how it grows, what precautions one has to take and how one has to care for oneself. Among my peers, I share this knowledge and they are astonished at how I know all this."

those relating to the process of birth could be decidedly dangerous. Many of the so called ethnic cultural practices have a lot of irrationality but they are practised due to tradition and precedence. One of the latent features of this project was that women were provided with a scientific perspective and factual information whereby they could see the fallacy of the superstitious practices and abandon them subsequently. Although this process was not direct, the eventual result was to bring in some rationality and objectivity.

Finally, the most significant aspect of social change was that the issue of reproduction became a matter of social discourse. Conventionally, the whole topic was a strict taboo and was dealt only in the dark and interior confines of households. Even women dealt with it in a suppressed manner. With the explosion of knowledge and the subsequent treatment it received, it became a matter of public discussion. Earlier, inhibitions and embarrassments were attached to it. Now it became a matter of participation and responsibility. Although, at present the discussion is limited to MNH care, it has the potential to discuss the advance issues of reproductive rights and sexuality.

As for the social service dimension, the first and foremost was that the SHGs extended the much needed social and psychological support to pregnant women and newly delivered mothers. The cycle of menstruation and the associated phases of puberty, pregnancy and menopause cause considerable strain and stress in the life of a woman. Although natural, the process of pregnancy becomes a tense and mysterious process. Substantial physiological changes are occurring in the body, not all of which are comprehensible. The social implications of pregnancy (expectation of a male child or an unwanted pregnancy) create different kinds of tension and trauma. A woman, especially the one in a patriarchal setting, therefore, needs great psychological support. Her mind is fraught with complex feelings - fear, anxiety, hope, reveries, vagueness, insecurity and so on. Although her family cares for her and the first delivery is often performed at her parents' place, she needs somebody to talk to, share her feelings, express her concerns and open her mind. She also needs a lot of counselling, confidential support and friendly advice. Nuclear families are deficient in this function and patriarchal joint families are not sensitive enough. In fact, the need is pronounced where husband's family is not caring and friendly. This function was ably performed by the SHG women, most of whom were senior and experienced ladies and who had donned this mandate through the project. Assuming the mandate was the most important thing as that brought out the much needed commitment in the field of MNH.

The second aspect of service was linking with the existing health systems. As mentioned earlier, the project did not provide any of the health services and insisted that the existing machinery and infrastructure provided by the municipal corporation or the Zilla Parishad be used. The deficiencies of the existing system are well known, the most troublesome being that it is unable to reach the desired population. This critical link was provided by the SHGs. They not only introduced the

ANCs with the health institutions but also compelled the institutions to be responsive to their clients. The fact that the municipal corporation and the medical college were part of the project was useful but more useful was the fact that agencies like the local SHGs were demanding proper service and were willing to extend the outreach. In that sense, they were actually performing the extension functions of the existing institutions. The additional dimension was that they were raising the awareness of clients and making the system more accountable.

Associated aspect of this was that the SHGs as civil society formations emerged as watchdogs to monitor the efficiency and efficacy of the existing health system. As mentioned earlier, they stayed in touch with the two grassroots level functionaries – anganwadi workers and ANMs - and ensured that they perform their tasks sincerely. With regard to anganwadis the role of SHGs was complimentary but their presence ensured that the anganwadis delivered the goods. Current mandate for anganwadis also prescribe the care of the ANCs and PNCs besides that of children. The women were reluctant to take food from anganwadis but other inputs were received. With regards to ANM, the situation has been complicated. The ANMs resented the role of the SHGs and CVs and, hence, the latter had to tread more carefully. But their involvement made the ANMs more responsive towards the women. It was noticed that among the various civil society formations the SHGs are best placed to serve as pressure groups within the local context. This is not only the democratization of health but also a step towards governance and people's control over services.

The other element of the service dimension was that this whole project has been oriented towards the betterment and development of the under-privileged sections of the society which not only consisted of the urban poor but also the socially subjugated communities and ethnic, religious and linguistic minorities. As mentioned earlier Solapur represents a complex mosaic of communities but most of them are socially deprived and economically poor. They have hand to mouth existence and have to struggle hard for livelihoods. The project not only included them in a developmental process but also paid attention to their identity and aspirations. Previously, the issues and concerns of these communities had not assumed the centre stage of discussion. The SHGs arose from within these communities and also acted as change agents for them.

Difficulties and Limitations

Although the present work made substantial progress in the field of MNH, it was not free from difficulties and limitations.

The Personality Changes in a Facilitator

- Learnt to speak confidently on a
- given topic
- Communication skills increased
- Became more patient and understanding
- Developed better time management
- Learnt to work in a team
- Knowledge increased
- Became fearless
- Increased ability to listen

- In the first place, it was difficult to build the trust and confidence of women. The CVs reported that initially the women did not believe them. As the CVs covered the whole communities, not all the women were members of the SHGs and many of them were not intimately known to them. Secondly, the SHGs were previously formed and this was not their original mandate. The women therefore found it hard to believe the volunteers and accept their advice. Only when positive results began to accrue the women started believing and respecting them.

SHGs and Local Politics

In recent years, local politicians have taken a fancy for SHGs. Virtually every corporator is involved in promoting SHGs or getting associated with them. Some young politicians are also building their clout out of this. A lot of groups are formed under the Urban Community Development project. The basic motivation is that they would get subsidies from the banks. The rackets operate systematically. The banks initially do not credit the subsidy. It is accrued only when the loan is repaid. Loans are not necessarily used for the specified purposes. Fortunately, the women are as yet sincere and have been repaying the loans punctually. That has been the saving grace. The manipulation of the concept of SHG for selfish and political ends undermines their potential. Women alone can rebel against this.

- The issue of *locus standi* or the rightful position of the CVs was sometimes raised by the family members of the ANCs, when the family was not part of the SHGs. They were suspicious as the CVs were intervening into a very personal and intimate matter.
- Another difficulty in this regard was that generally pregnancy is not disclosed unless and until it reaches 5th or 6th month. Attempts to inquire into this aspect were therefore looked with misgiving and resentment. The mother-in-laws were particularly doubtful in this regard.
- Even some of the ANCs were adamant and non-cooperative, especially when they did not understand the motive and purpose of the CVs. Illiteracy and ignorance was high and, hence, the idea did not go down easily.
- In cases where the ANCs appreciated the inputs, their socio-economic conditions came in the way of implementing the advice. Poverty and deprivation were the major impediments in taking nutritious diet, visiting the hospitals, taking medication or following the precautions. The ANCs could not stop working or undertaking domestic chores. PNCs also found it difficult to take complete rest.
- Although institutional deliveries were emphasized, the women were wary of government hospitals because they lacked the necessary warmth and homely feeling. Although doctors were good, the staff and infrastructure was not reportedly friendly and encouraging.
- In many families, the men i.e. husbands were addicted to drinking and this fact endangered the health of the ANCs and

Poverty, Labour and Diet

The women from Habbu Wasti reported that they very well understood the need for eating nutritious food during pregnancy but the price of gram was 100 Rs/kg, milk was Rs.25/litre. There were long queues at the ration shops. The do's and don'ts during pregnancy were known but a pregnant woman had to fetch water, which came once in two days, from a public source. She had to work to earn her daily bread. Worst was that she could not take rest after delivery. If she took rest, she starved.

PNCs. It was categorically reported that alcohol addiction of men was the most detrimental thing for family well-being.

- It was also reported that many men shunned the responsibility of caring for their wives. This happened due to a variety of reasons – patriarchal mindset, general apathy to women's health, ignorance, poverty, addictions and personal psychological factors.
- The living conditions in slums have not been conducive to health and hygiene, especially during pregnancy. As it is known, drainage and sanitation facilities are poor, water has to be struggled for, environment is dirty and unclean, gutters overflow, mosquitoes abound and people are permanently vulnerable to contiguous diseases and infections. In such conditions, merely advising ANCs and PNCs about IFA tablets or nutritious food is not sufficient.

Feedback from an NSS Coordinator

"The idea of involving college students is laudable but there are some practical difficulties. Students enrol into NSS only for a year or two. They cannot maintain continuity. After passing out, there is no contact. Many of the students are poor and cannot afford to involve in social work. They have to find jobs. The parents of the girl-students are reluctant to send their wards to slum areas. NSS is oriented towards *Shramdan* in rural areas. This bias needs to be removed and make NSS more intellectual so that students would find it more enriching."

Learning and Future Directions

The present experience also throws open a number of lessons and future directions. Some of these could be implemented in the remaining period of the project whereas others could be tried when similar projects are organized elsewhere.

- In the first place, there is a great need and opportunity to involve men in all the processes. It is noticed that at present the men are on the periphery. They have been aware of this program and some of them in their individual capacities have also extended a helping hand but there is a need to involve them systematically. The present issue is just not women's issue. This is a gender issue and, hence, men need to be made equally responsible and accountable. There is no reason why men can't be involved. The level of ignorance about

the whole process of reproduction and sexuality is alarmingly high among men. A lot of attitudinal problems and behavioural difficulties could be solved if men are involved in all the stages of reproductive care. It was noticed in the present project that men were curious about the BCC charts and some even requested to be educated on these issues. The BCC tools need to be administered to all the men in the family – husbands, brothers, fathers, father-in-laws and brother-in-laws and so on. This would not only increase their knowledge but would also ensure their due participation in achieving the targets of MNH. The corollary of this is the need for training young men alongwith adolescent girls.

- The project rallies around the SHGs but there is a need and scope to increase the responsibility of the groups. As mentioned earlier, due to various difficulties not all the members of the group actively participated in this venture and only those who had leadership qualities actually donned the mantle. This is inevitable to some extent but the whole group need to assume the responsibility of MNH care. This would warrant motivational inputs so that the idea is firmly ingrained in the minds of all. The project staff needs to be consciously oriented to this and should be encouraged to interact with the women as a group and not through a couple of individuals. Much of the promise of the present experiment lies in activating community-based groups and not the key individuals.
- It is also necessary to encompass as many women as possible under the purview of the SHGs. Ideally, all the women from the community should be members of the SHGs. Where groups are previously made, they could be loosely federated for undertaking this function. A member woman has better compliance to these ideals than a non-member.
- There is also the need to put in place clear and simple monitoring indicators so that project achievements can be effectively measured. This would not warrant a separate MIS, most of the information would be available through existing methods. Key indicators like ANC weight, Hb levels, BP readings, health signs can be monitored and recorded which would make the M & E functions easier. There is also a need to monitor the whole population effectively so that the rate of early detection of pregnancies is enhanced.
- In the present project only a beginning is made but the real next step is the true understanding by these women of their reproductive rights and sexuality. This is one area in which considerable awareness is required. Most of the programs relating to women's health (especially relating to reproductive health) take women for granted. Instead, it is necessary that women understand the significance of their productive and reproductive roles and have control over the same. This will lead to reducing the violence committed against women and help to bring about gender equity.
- The SHGs involved in this project have been carrying out their routine microfinance functions but it could be

Men and Maternity

The Taksila Yuvak Mandal in Mochi Galli has been a very active youth group. They have been imbued with the teachings of Lord Buddha and Dr. Babasaheb Ambedkar. They took active interest in organizing a health camp and other programs in the community and have been always extending a helping hand to the Project. They felt that maternity should not remain the affair of the women and men should be involved in this responsibility. Previously men have never been involved in either the discussion or in practice and hence they have been unaware of their responsibility. Men should be included and sensitised so that the goal of MNH is achieved. Men also need training in matters of sexuality and reproductive care.

Some Quotes by women

"It is the mother who cares the most for the pregnant woman".

"Men do not give company in pregnancy. They remain aloof, at times irresponsible".

"First pregnancy is cared for. Subsequently, the care dwindles".

"Illiterate women rely on experience".

"One of them should be strong and supportive: mother or the mother-in-law"

useful to set aside a certain quantum of money as women's health fund. A couple of SHGs have made grants to needy and deserving women (like Gurumata Wasti). Similar experiments have been reported from other Sure Start sites. This could be institutionalized.

- Post-project sustainability weighs heavily on the minds of the CVs. Their apprehensions are justified. Many of them could function as 'Arogya Mitra/Maitrin' under the new NHRM initiatives. This apprehension, however, need not worry the SHGs which are self-sustaining entities and have the capability of receiving external finance. They could always set aside due financial resources so that these functions could be carried out in future. In any case, these are knowledge-functions and do not warrant capital investment.

Conclusion

The present project in Solapur has shown how local women's groups organized around the idea of self-help can be effectively oriented towards the goal of MNH care. It unleashes community strength for its own development as well as for the wellbeing of the society at large. This is a path-breaking experiment not only in the field of community health but also in women's empowerment. Both of these are key elements in social development today. When coupled with the idea of voluntarism and participation by civil society, its transformation potential is increased manifold. It is time that cognizance of this model is taken and similar experiments are attempted in areas where they are urgently needed. The experiment is feasible

and replicable. The SHGs are known for satisfying savings and credit needs of poor women but this experience has shown that they can also deliver civilizational results.

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Annexure I

List of SHGs and other groups met during study

No	SHG/Other Focused Group	Old or Special	Locality	Representative
1	Muktai		Awase Vasti	Mangal Mane
2	Ahilyadevi			Asha Khedkar
3	Sadguru			Sangita Gadekar
4	Meerabai			Chanchala Musalkhamb
5	Dhamma Diksha			
6	Mahatma Phule		Habbu Vasti	Sharada Gade
7	Bhimai			Shakuntala Mane
8	Panchsheel			Hira Savant
9	Ramai			Alaka Prakshale
10	Aboli	special	Kongad Kumbhar Galli	Rizwana and five others
11	Saheli	special	Shahapure vasti	Various
12	Tamanna	special		Various
13	Siddheshwar		Gurumata vasti	Anita Patil
14	Gurumata			Meena Chaware
15	Laxmimata			Sanjeevani Pawar
16	Mahalaxmi	special	Lodhi Pura	Various
17	Kartiki	Special	Bahurupi Vasti	Various
18	Taxilla Yuvak Mandal		Mochi Galli	Various
19	Mahamaya		Bagle Vasti	Savita
20	Sidharth			Sandhya Dudhe
21	Mukta Sakhi			Mangal Santosh
22	Mata Ramai			Sadhana Survase
23	Mahesh		Maddi Vasti	Meera Bhujbal
24	Roopa Bhawani	Special	Vadar Vasti	Nagubai Chougale
25	Vishnu	Special		Surekha Pawar
26	Vadar Samaj Gat	Special		Kamal Itkar
27	Mahalaxmi		Hanuman Nagar	Surekha Kadam
28	Sidheshwar			Bhagyashri Bobde
29	Walchand College Volunteers			Twelve students (10 women + 2 men)
30	Adolscent Girls Group, Lodhipura		Lodhipura	Five girls
31	Adolscent Girls Group, Maddi Vasti		Maddi Vasti	Four girls
32	SSP Facilitators		SSP Office	Eighteen facilitators

List of Key Informants

1. Dr. Shashikant Ahankari, Director, Sure Start Project and President, HMF
2. Dr. H.V. Wadgave, Project Coordinator, Sure Start Project, Solapur
3. Shri Upendra Tannu, Volunteer Coordinator, Sure Start Project, Solapur
4. Smt. Vasanti Mule and Smt. Vaishali Avad, sub-coordinators, SSP, Solapur
5. Prof. Madhavi Rayate, Head, Department of Preventive Social Medicine, V. M. Vaishampayan Medical College, Solapur
6. Prof. Joshi, Walchand College of Social Work, Solapur
7. Shri Ravindra Mokashi, Parivartan Academy, Solapur
8. Prof. Uttan Hundekar, Vice-Principal, and Prof. Santosh Rajguru, NSS Coordinator, Bhaurao Patil College, Solapur
9. Prof. Swati Vadagbalkar, Principal, Burla Women's College, Solapur
10. Dr. Kranti Raimane, Gynecologist, Path, Mumbai