

ADB CoE Progress Report-3

Training and Capacity Building Workshops

(organised with external partners)



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List of Abbreviations

ADB: Asian Development Bank

ANM: Auxiliary Nurse Midwife

ASHA: Accredited Social Health Activist

BAIF: British Asia India Foundation

CAC: COVIDActionCollab

CB: Capacity Building

CBO: Community Based Organisation

CoE: Centre of Excellence

COVID-19: Coronavirus disease 2019

CSO: Civil Society Organisation

DST: Domain Specialist Team

FGD: Focussed Group Discussions

HD: Help Desk

HII: High Impact Intervention

HIS: High Impact Service

HR: Human Resources

i4We: Invest for Wellness

ISAP: The Indian Society of Agribusiness Professionals

LG: Local Government

NCD: Non-Communicable Diseases

NGO: Non-governmental Organisation

OP: Operational Planning

PHC: Primary Health Care

PRA: Partner Result Accelerators

PwD: Person with disabilities

TNA: Training Needs Assessment

ToTs: Training of Trainers

SC: Scheduled Castes

SP: Social Protection

ST: Scheduled Tribes

VDT: Value Delivery Team

VP: Vulnerable Population

1. Introduction

COVID-19 was a humanitarian crisis, the size and scale of which had never been experienced before. COVID-19 hit the whole country hard, but the vulnerable and marginalised communities were disproportionately impacted. These groups have experienced alienation on account of their marginalised status but they were further pushed to the periphery as they faced nuanced and intersectional barriers in accessing even essential services.

Organisations working on the well-being of the marginalised groups, whether in the public, private or social sector, struggled to mount a response that would reach and protect the most vulnerable during this crisis. Vulnerable communities had a spectrum of urgent and immediate needs, such as knowing how to protect themselves, ensuring income flows, food and nutrition, and taking care for COVID-19-positive people in their families/communities. **Hence a multi-disciplinary approach to providing vulnerable communities knowledge and services related to health, livelihoods and social protection was required.**

To respond to this, The COVIDActionCollaborative (CAC) was an initiative of the Catalyst Group. It recognised that (a) a single organisation, or a small group, would not be able to respond at the scale required and (b) an effective response would have to be multidisciplinary in nature. With a vision to empower vulnerable people, CAC built a collaborative of over 350 organisations of implementers (ex. non-governmental organisations, community-based organisations, private institutions, government, etc.) enablers (such as policymakers, academia, industry associations) and providers (of human resources, finance, technology, materials, knowledge, etc.) CAC provided a platform for partners to convene, learn, share, and channel resources, both monetary and non-monetary, towards a comprehensive COVID-19 response for vulnerable communities. It has been over two years that CAC has mounted its response, during which time it has surpassed its goals of reaching 10 million vulnerable people (VP) and has enabled 19.59 million services for them.

CAC's response has generated many learnings that can contribute to improved planning, execution and collaboration for future humanitarian crises. Being a programme aimed at vulnerable communities, its response also generates insights on the inclusion of those who face intersectional challenges in service access.

Swasti¹ and ADB have collaboratively established a Centre of Excellence (CoE) on COVID-19 to document and disseminate the learning of CAC during these two years especially on the response efforts for vulnerable women. CoE is a knowledge-management and learning platform for (1) connecting and collaborating with partners and (2) working to bridge the gap between communities and services to combat COVID-19. The CoE is focused on women due to the obstacles and inequities they face on account of biological and socio-economic factors and gender norms. It generates learnings from COVID-19 response efforts targeted towards vulnerable and marginalised women with the intent to share the education and glean pointers for improved community engagement and impact in the COVID-19 context, in other humanitarian crises.

In line with its objectives to 1) Generate and disseminate learnings for the COVID-19 response that address the specific vulnerabilities that marginalised women face and 2) Conduct knowledge management and dissemination to support key partners (as identified by the CoE and ADB), the CoE is publishing a series of learning products.

The CoE first set the stage by documenting learning by setting up a collaborative, working with government, partners and communities. Lessons from this report gave valuable insights and points for further inquiry from which progress report 2 was developed - contextual guidelines to ensure that the most vulnerable groups, including women, are not excluded from COVID-19 services. These two reports covered the importance of the capacity building of partners to reach VPs at speed and scale. Expanding on those impressions, this progress report 3 spotlights the 'how' of delivery of critical, often life-saving services that can be reached to VPs in a pandemic. Documenting the efforts and learning of CAC, ADB CoE looks at the components that make for a successful design and delivery of large-scale capacity building to on-ground, implementing partners and local government personnel.

CoE's first report drew lessons on how the collaborative was built, on working with the government, partners and the community. Since the government and CAC partners together were engaged in enabling services and distributing resources to the communities, **In the second report**, CoE then put together guidelines on inclusive COVID-19 sensitisation response services for women from marginalised communities. **This is the third learning product (report)**, detailing the training and capacity building

¹ Swasti is a health catalyst and co-founder of CAC

efforts which were required during the management of the crisis. This lays out a roadmap on how to build capacities to ensure that services reach the last mile.

This document is for the government and organisations providing and/or receiving training in pandemic-like volatile situations. It presents a blueprint of components and processes required for a capacity building (CB) response at scale and speed. It highlights considerations that need to be taken into account for effective reach.

The document provides, first, the background and rationale for the capacity-building work of CAC. It then presents the approach deployed in building capacities by outlining the interventions and the establishment of partners. Following this, it expands on training design by elaborating on each phase of the programmatic approach in detail. Finally, the document closes with the key takeaways of the training and capacity building conducted by CAC in collaboration with partners.

2. Rationale for Capacity Building as a Core Strategy

The governments everywhere in the world were the first to respond to these humanitarian crises, and local governments (LGs) played a pivotal role in formulating an effective response. They explore and implement solutions to hyper-local problems, identifying and connecting with organisations, communities and individuals to bring and deliver support as needed, make decisions to provide advisories to the general public and regulate these. NGOs and CBOs, with their direct connection to communities and through the trust that their interventions have built, are well placed to identify needs and channel support and services from governmental and nongovernmental quarters to the people who most need it.

All these organisations and personnel working with vulnerable communities to tide the COVID-19 pandemic did not have adequate knowledge, data and often the wherewithal to have an effective response at the required speed and scale.

For instance, there were *several myths and misconceptions* related to the virus and connected aspects such as vaccinations. While many general messages were being relayed by government authorities, there was not enough *communication to dispel fears of those with specific conditions*, ex., vaccination safety for people on Antiretroviral Therapy, Hormone Replacement Therapy, or pregnant women. The frontline personnel (ASHAs,

ANMs, panchayat officials, NGO personnel, etc.) themselves needed to have accurate information and communication material to share with communities.²

Capacity building was required, given the multi-dimensional nature of the pandemic. Communities had an urgent need for health, livelihoods and social protection and governments, NGOs and CBOs did not know how to provide these at the required scale and speed; for instance, while there were several existing social protection schemes and new ones were started related to COVID-19, local governments did not have mechanisms to reach large numbers - especially the vulnerable. Further, NGOs and CBOs working in the livelihoods space need to augment their capacities for providing health-related information and services to their communities.

CAC understood that a capacity-building strategy would be core to ensure that its partners were able to reach vulnerable communities with speed and it was a prominent aspect of its strategy.

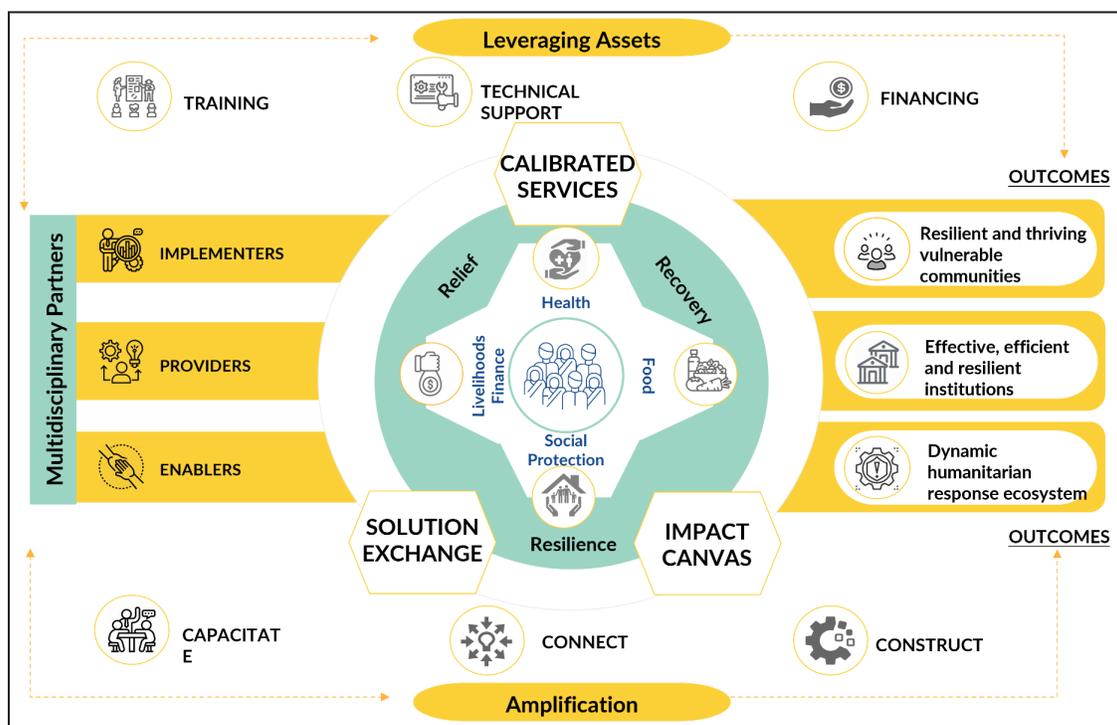


Figure 1: CAC Strategic Framework

² The CoE report on contextual guidelines gives pointers for effective awareness and information dissemination

The framework in Figure 1 illustrates the CAC collaborative approach with the people-centric at its core. In this strategy, a multi-disciplinary approach of partners was capacitated and connected with each other to leverage assets towards effective community interventions by receiving and/or providing training, technical support and financing. Services were calibrated to the needs of the communities, and collaborating partners offered solutions and learnings that improved the effectiveness of each others' interventions. Innovative solutions for more complex and intractable problems were designed, tested and then scaled through the partners. This system functions across the phases of relief, recovery and resilience. Together this collaborative machinery lends to better outcomes at the community, institutional and ecosystem levels that build resilience for the sustained well-being of the vulnerable communities during the COVID-19 pandemic and replicated to other such situations thereafter.

3. What we did - The Capacity Building Approach

Speed and scale in the delivery of health and SP services to VPs was critical and at the core of the CAC. CAC had a large number of partners, and its Training of Trainers (TOT) approach was the most feasible where the identified members of the partner's organisations were trained on service delivery, who, in turn, trained other frontline personnel who had the interface with the community for delivering of services.

In addition to scale, the TOT approach was also meant to strengthen the capacity and effectiveness of partners to subsequently train and empower vulnerable communities.

The partners were non-governmental organisations (NGOs), community-based organisations (CBOs) and private sector associations such as associations of health care providers, street vendors, and informal workers. In addition, CAC also trained local government officials, including panchayat members, ASHAs and ANMs.

CAC's capacity-building initiative trained 6,970 people (master trainers) from 156 partners from October 2020 to June 2022. This trained cadre trained other frontline workers such that relevant HIs reached over 1.2 Crore (12 million) VPs.

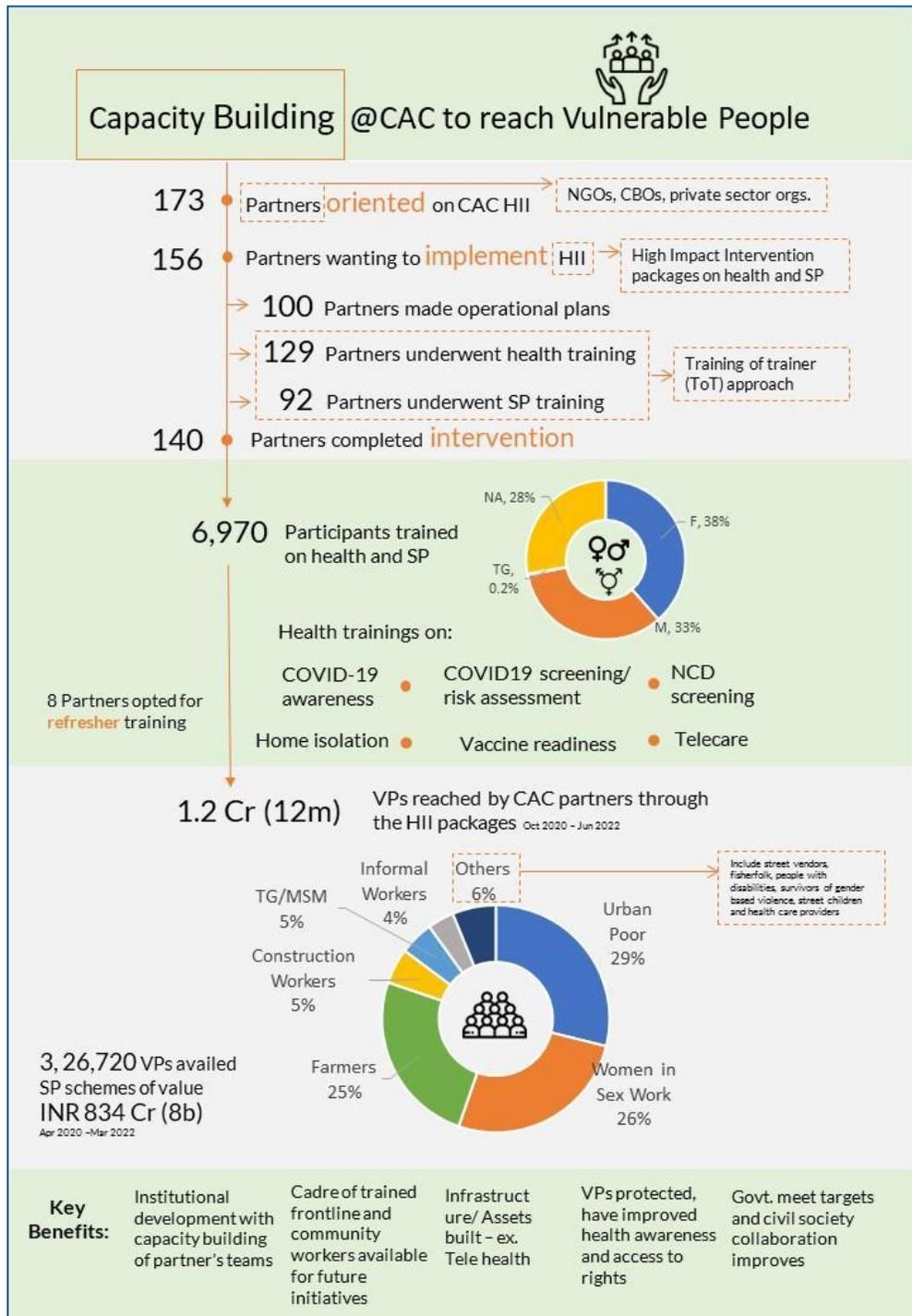


Figure 2: CAC capacity building process and reach

In addition to private and civil society organisations, CAC supported 12 states and 23 local governments on health and SP.

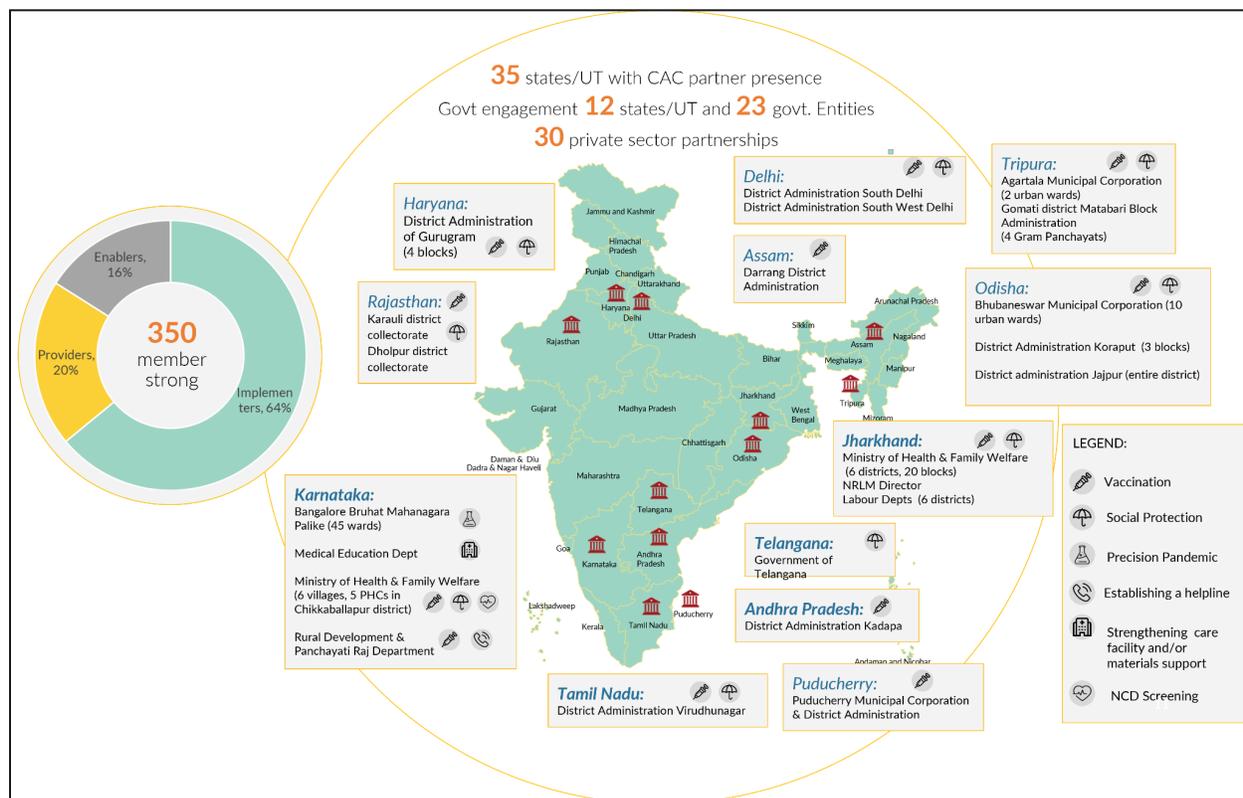


Figure 3: Geographic Spread of CAC Interventions (as of March 2022)

3.1 Capacity Building Interventions

The core needs of vulnerable populations that CAC identified in the strategic framework (Figure 1) were health, food, social protection and livelihoods/finance. Of these four, food was a part of the material distribution during relief phases across the pandemic waves and livelihoods support is a part of an impact canvas³ that is related to long-term resilience.

Health and social protection were the two areas where on-ground interventions would have a high impact on relief and recovery. The team at CAC, in partnership with Swasti, initially

³ CAC conceptualised the impact canvas as a mechanism to enable collective actions through innovative solutions to solve complex humanitarian challenges. The impact canvas, with its potential for achieving scale, creates a meaningful impact on vulnerable groups. As of June 2022 there were 11 active impact canvases, of which one on economic resilience is related to livelihoods.

developed a standard CB package that offered eight health training modules and two SP modules. The package was streamlined based on the ground needs and resource availability with the focus on prevention, mitigation and recovery response. CAC encouraged partners to avail at least two of the health offerings and facilitate at least one government scheme for their communities (see Box). However, over time, as the pandemic progressed and evolved, as CAC gained experience and understanding of the needs of the partners and communities, the offerings were streamlined towards High Impact Intervention (HII) packages. These packages were designed to ensure that the most vulnerable would be able to assess their risk of getting severe COVID-19 disease, manage their health and were vaccinated in a timely manner. HII also included access to social protection as a means to ensure access to their rights and provide a safety net to tide the difficult pandemic time.

The Initial Standard Training Packages

The Health Package: i) risk assessment for COVID-19; ii) awareness and health education; iii) linkages to testing; iv) isolation and quarantine services; v) counselling for infected or affected (Burnout), vi) addressing stigma and discrimination of infected persons and family members in facility, household and community settings; vii) protection against COVID-19 and other challenges, and viii) skill upgradation to handle COVID response.

The Social Protection Package: i) accessing different social protection programs of the government; ii) linkages to technical and financial resources, both government and private.

The 3 modified High Impact Interventions were:

i) **Driving vaccine uptake for the most vulnerable:** Intensified vaccine demand generation, counselling and supportive registration for COVID-19 vaccination and vaccination camps targeted at the most vulnerable.



Image 1: Training on vaccine uptake for marginalised communities

ii) **COVID-19 protection:** Providing awareness of COVID-19 and protection mechanisms, assessing the susceptibility of severe disease due to the infection through screening for comorbidities including anaemia, diabetes and hypertension, teaching people to manage home isolation, and using a telecare mechanism to enable them to manage their physical and mental health.

iii) **Social protection:** Awareness and facilitation of social protection to facilitate access to benefits from the government schemes

For more information on the training modules, find the [link in the annex](#).



Image 2: A community meeting on Social Protection and Awareness

The following section delves into the step-by-step process used to employ the capacity building approach and deploy the HII interventions. Starting with internal preparations of forming teams that engage directly with partners and subsequently identifying the appropriate partners. Once these connections were established, we outline the training design that was utilised in preparing the partners to engage with their target vulnerable communities. Partners were then able to effectively implement their chosen HIIs from the provided package.

4. How we did it

4.1 Team Set-up

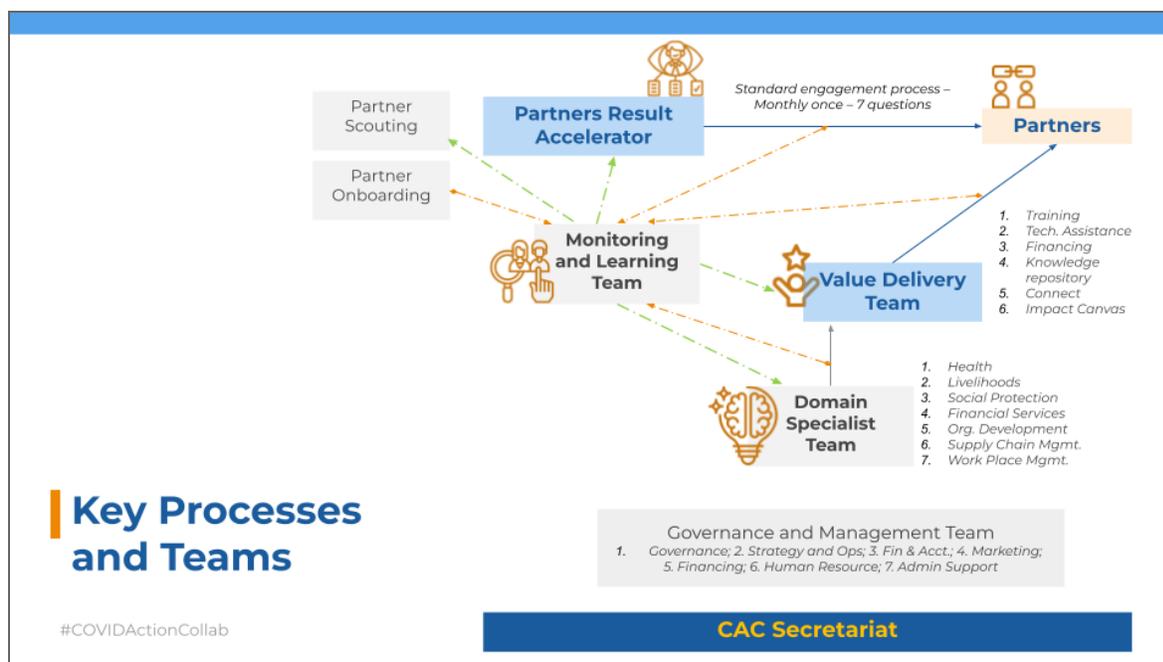


Figure 4: CAC Secretariat - Teams and engagement

The CAC secretariat set up a team in a manner to enable effective engagement with partners, who had an interface with VPs to deliver the HII services

The **first point of engagement of partners was with the Partner Result Accelerators (PRAs)**. Each partner was assigned a PRA who connected with them at least once a month, shared the work of CAC and understood the partner and their communities' needs and priorities and together generated the partner's offers to and asks from the collaborative.

The asks and offers were passed on to the Value Delivery Team (VDT), which was tasked with the responsibility of delivery to partners. When partners showed interest in understanding the HII, the VDT were at the forefront to connect with partners and kick start the process.

VDT was supported by the Domain Specialist Team (DST) and the Monitoring and Learning Team. The former, with their domain expertise, came in to help develop the models and deliver training wherever required. The latter helped develop and maintain the value delivery monitoring information systems (MIS).

Support was also provided by the government and management teams

Over two years of implementation the average number of members in each team was:

Team	Full-time	Part-time
Value Delivery Team	6	8
Domain Support team	14	13
Monitoring and learning team	3	9
Partner engagement team	8	6
Information communication and technology team	1	9
Governance and management	12	1

4.2 Partner Identification

In order to attain its goal of reaching 10 million VPs, CAC developed a strategic plan to **identify** and onboard a portfolio of multi-sectoral partners - particularly large-scale organisations (Private, Public, Civil Societies, Community-Based, etc.) that cover a wider range and number of vulnerable populations.

IDENTIFICATION: At the start, potential partners of different types were **identified**:

1. **Direct reach** by Catalyst Group organisations and its partner community organisations (Swasti, Vrutti, GREEN Foundation and CMS)

2. **Implementing partners in CAC** who are directly reaching VPs
3. **Other NGOs, CBOs, Faith Based organisations and Micro Finance Institutions** with large outreach (such as PHIA Foundation, SEWA, Bandhan, Ujjivan, APMAS, Pradan, Don Bosco).
4. **Cooperatives** of farmers, dairy farmers, etc. (AMUL, State Milk Federations, etc.)
5. **Large donors** to cover their partners (EdelGive Foundation, Azim Premji Philanthropic Initiatives, Ford Foundation, etc.)
6. **Local governments** and their programs (such as State Rural Livelihood Missions)
7. **Associations** of people or organisations based on occupations or geographies (labour associations, trade associations, industry associations, etc.)
8. **Networks and coalitions** (e.g. Change Alliance, Revitalising Rainfed Agriculture Network, Jan Sahas)
9. **Other Collaboratives** (e.g. Catalyst 2030, Migrant Resilient Collaborative), particularly on health issues.

Of this list of potential partner types, the first two categories of partners were ones with which the Catalyst Group had a strong relationship. Bringing them on board for HII was easy. A trust and mission alignment had already been established, as was an understanding of each other's work.

However, this group of partners did not have a reach that was adequately large enough to reach 10 million VPs or were not covering some of the priority VPS. CAC then actively approached civil society organisations with a large reach, cooperative institutions and private associations. This effort had its successes and its challenges. Many large organisations were tied up in their COVID-19-related interventions and could not make time to take on the HII. Associations, being collectives of VP groups themselves, often did not have a strong governance structure to make decisions to join the HII.

Governments that CAC worked with were identified by considering a set of criteria: (a) states with high COVID-19 cases, (b) states with highest aspirational districts, (c) states having CAC partner presence, preferably with a working relationship with government, (d) states where CAC Governing Council and senior advisors had a working relationship with

government bodies, (e) Governments open to external support (as identified by partners and advisors). Through these strategies, CAC worked with 12 states and 23 local governments (Figure 3).

Finally, CAC has been associated with other networks, coalitions and collaboratives, but with a very limited engagement of HII.

4.3 Training Design and Process

The HII TOT training approach was designed in three phases and this chapter details the phases, outlining the outcome, outputs and key considerations in each phase.

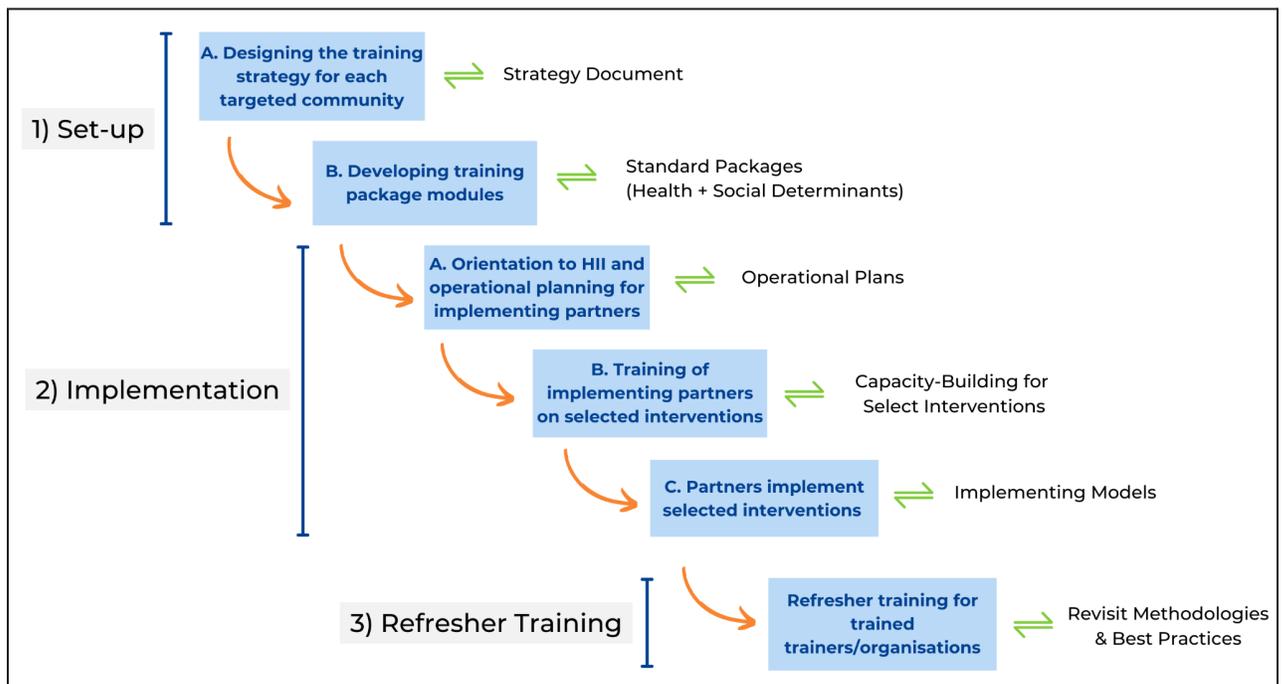


Figure 5: Programmatic Approach

4.3.1 Set-up

A. Designing the training strategy for each targeted community

Objective: To define a road map on the training component design for reaching 10 million VP with NGO and CBO partners and associations of private organisations; and how to reach out to and work with local governments. The strategies laid out the rationale for interventions, identification of partners and governments and themes.

Outcomes:

- A common understanding among the CAC Secretariat teams on the roadmap for achieving the goal of reaching 10 million VP and working with local governments.

Lessons Learnt:

1. Consult experts and reach out to community-based organisations for strategy development to understand the needs that would then define the training mandate.

B. Developing training package modules

Objective: To develop training modules having standard content. Please find the various training topics below:

Topic of Training
Orientation to Health and SP Packages
L1 orientation to VP Packages: 1. Purpose & Objectives of the VP package 2. Key outcomes for VP 3. Contents of the Package 4. Orientation Process and time
Re-orientation Session - 2+1 revised interventions and orientation on Operational Plan
Reorienting various artisans groups on (2+1) intervention under HII and understanding their struggle and demand.
Health-related trainings
Health Awareness: on preventive aspects of COVID 19 and SP - Orientation Session
Training on Health (Post-COVID Management)

Vaccine Readiness
Home Isolation and Personal Safety
Primary Healthcare at Factories
COVID 3rd wave preparedness and response
Social Protection (SP) trainings
SP Services by Central & State Governments & Help Desk Establishment
Social Protection: with emphasis on schemes for artisans
SP training for SMS Champions
SP training (Schemes Specific to Children including popular State and Central schemes applicable)
SP training for Karur factory cluster
Health and SP trainings
SP and COVID-19 Management Training for functionaries of PRI, frontline workers, SHGs, VOs, Community Volunteers:
1. Preventive aspects of COVID 19
2. Social Protection
3. Role & Responsibilities of Each Player(District Coordinator, Frontline Workers, PRI, SHG, Panchayats)
4. Designing Strategic Interventions
Telecare (Health/Counselling/SP)
Livelihood
Women in Factories: Foundational Life Skills Training
Women in Factories: Advanced Life Skills Training
Advanced Life Skills Training
Workplace Excellence Training
Other Topics
Communication and Negotiation
Basic training of digital app use
Gender and Gender-based Violence (GBV) Sensitisation Training
Training on Telephonic Triage for COVID Positive Persons at Gottigere Ward
Healthcare Providers Trainings
1. Personal Health and Hygiene during COVID times
2. Infection Prevention and Control
3. Self Management
4. Time and Stress Management
5. Effective Communication and Negotiation
6. Problem-Solving and Decision-Making
7. Financial Management

Outcomes:

- Quality and standard training being offered across partners

Lessons Learnt:

1. Consult experts and adapt materials from dependable sources such as the WHO and MoHFW to develop COVID-19 related training modules. Address myths and misconceptions in the material.
2. Design training modules with practical sessions. Keep theory light, but have it available in case some participants are interested to learn it.
3. Training programmes that go on through the day, especially if online, are very cumbersome. Spread long trainings across days and in a day, provide adequate resting time between sessions.
4. Focus on including topics needed by certain communities based on barriers they face on account of their specific vulnerabilities, ex. stigma faced by PLHIV, sex workers or TG, mobility difficulties of persons with disabilities, etc.
5. Keep abreast of the changing situation, i.e. new knowledge (on different variants) and solutions (vaccination) to quickly incorporate into training and messaging.

4.3.2 Levels of Training

A. Orientation to HII and operational planning for implementing partners (Level 1):

Objective: To build the perspective of implementing partners and inform them about HIS interventions to improve their outcomes in the key areas of Health, SP, livelihood, gender and empowerment. Orientation helps partners understand the value of the HII offering and an operational plan and the planning process.

Timeline: 173 orientation training sessions have been conducted from October 2020 to May 2022.

Outcomes:

- Partners – NGOs, the government and the private sector understand the specific high-impact interventions designed for VPs. They develop perspectives and decide on high-impact service interventions for the vulnerable communities they work with.
- Training needs of the partners are identified on the basis of which partners have the direction and ability to support their communities and meet their needs
- Partners effectively layer the packages as part of their current scope of work, based on the needs of the community.
- Through the development of the operational plan process partners learn to think through and leverage their existing resources, identify roles and responsibilities, and plan activities and timelines.

Lessons Learnt:

1. Onboarding government and new partners is a time and effort-intensive process involving senior leaders.
2. Involve decision makers from the partner organisations in the planning process to avoid frequent back-and-forth communication, which could delay the processes.
3. Draw operational plans in cooperation with field personnel as they have the best understanding of community needs.
4. Engage the government, even though the intervention is at the local level, as buy-in from the state level is necessary to ensure cooperation from local officials.
5. Pitch the packages from the perspective of “what’s in it for the partners” to raise their interest.
6. Identify and focus on the pain areas for partners and gap-fill in their interventions to develop partner interest in the HIIIs.
7. Being cognizant that organisations are likely to be hesitant to implement outside their focus area, i.e. livelihoods organisations implementing a health intervention or vice versa. Plan for greater intensity of engagement and support for these organisations.

8. Conduct an open dialogue about the support/resources partners require to deliver interventions to the community, and advise them on how existing resources can be leveraged and connect them to new sources as available.
9. Approach government officials with funding because rigorous processes will likely not allow them to provide budgets for the training and funding sources that need to be identified by the facilitating agencies.
10. Selection of TOTs is an important process. Work with partners to identify staff members who have a good working relationship with communities, who are keen to learn and will be able to invest time for the same.
11. During the development of operational plans consider multiple channels of resources to bring on board (personnel, financial, collaborators, other partners, etc.), and do not limit consideration to resources available by the partner.
12. Funding and manpower are the primary roadblocks for partners to take up HIIIs.
13. Build quality assurance into the process and plan through identification of experienced staff as TOT, review and learning meetings, data collection and analysis for decision making, etc.



Image 4: Training of Implementation Partners (VaxNow)

Below are a few case stories depicting CAC's capacity-building efforts and initiatives. These stories highlight the impact of improving capacities (strengthening partnerships and catalysing resource connections), and CAC's approach to capacity-building for high-impact by customising solutions to the needs of implementation partners.

Accommodating partner needs: The ARTIST engagement

The Asian Research & Training Institute for Skill Transfer (ARTIST) is a premier training institute for doctors and healthcare providers (HCPs) specialising in maternal health.

CAC was discussing the needs of HCPs on training on quality of care in the COVID-19 context with ARTIST leaders when a priority need of emotional support was identified. CAC designed specialised products as a part of its HII for HCPs, catering to the health and life skill needs of HCPs and addressing the gaps in the ecosystem exacerbated by the pandemic. These products - on effective communication and negotiation, problem-solving and decision making, self-management, infection prevention control and time and stress management - were developed keeping in mind the vulnerabilities of HCPs in COVID times and layered; and were layered over the quality of care training.

Appreciating the need for such training ARTIST rolled out the training to its member, the Bagalkot ObGyn Society. The Society reported positive results and outcomes among the HCPs, especially with respect to self-management and effective communication. This holds greater merit in the context of an increase in in-patients due to COVID.

HCPs who underwent the training reported improved ability to manage their personal and professional lives, thereby improving their satisfaction levels and overall wellbeing.

ARTIST shared that trained staff in their member organisations are training newly joined staff and also monitoring the adherence of the protocol taught to them. This awareness is also transferred among the patients who come to the hospitals. ARTIST further reported an increase in the demand for training on emotional support, which affords it more business opportunities, and a deeper connection formed with its members.

This case shows the need for flexibility in being able to pivot to accommodate the special needs of partners during the orientation training, where possible.



Building strong foundations: FXB India Suraksha's CAC engagement

FXB India Suraksha (FXBIS) is a non-governmental, non-profit organisation reaching over 300,000 fisherfolk. The CAC VDT team oriented FXBIS on HII and with the partner identified priority areas for training, namely, vaccine readiness, home isolation, and setting up an SP helpdesk in the community. It then supported FXBIS to prepare a one-year operational plan.

Resource connect was critically important support that FXBIS received. CAC's VaxNow initiative extended the honorarium for 10 volunteers from FXBIS to implement the initiative in collaboration with Govt. of Puducherry. This resulted in demand generation and aided community mobilisation for the vaccination drive. CAC supported FXBIS raising funds worth INR 3 lakhs (USD 3800) through Skoll Foundation for creating different IEC and BCC materials for vaccine preparedness intervention among community members in Puducherry. CAC also allocated INR 84,000 (USD 1,000) to FXBIS for the implementation of different HII services in their implementing geographies. Connects from the CAC ecosystem have provided opportunities to work with partners on other initiatives and engage with partners to facilitate an understanding of best practices that can be adopted while engaging with local government authorities.

FXBIS acknowledges the value-add from the CAC partnership. The CAC ecosystem and partnerships have helped them build leadership and have also taught them how to work with communities. The community is aware of their rights and schemes and has a certain amount of financial literacy. They can support themselves through alternative livelihood methods. Transparency and regular communication of implementation efforts through regular reporting has helped build trust among partners and establish long-term partnerships.

This case story shows how capacity-building initiatives result in partner growth - not only through improved capacities but also through resource and knowledge connections and partnership opportunities.

B. Training of implementing partners on selected interventions (Level 2):

Objective: To prepare the partners to implement the interventions effectively; provide detailed and specific information on a particular service intervention or building knowledge across a certain set of skills. Give some example from the experience

Timeline: 129 training sessions on the Health package and 92 training sessions on the SP package have been conducted from October 2020 to May 2022

Outcomes:

- Partners' capacities for specific HIS interventions are built
- Local government officials and implementing partners have information and value-added support for delivering HII

Lessons Learnt:

1. Employ experts to deliver the training, ensuring that they are conversationally fluent in the language of the participants.
2. Present information and tools effectively, for instance, explaining how to specifically roll out telecare programs or social protection schemes and benefits for a particular community or geo-location. Respond to participant questions, and lead activities that reinforce the messages from the HII interventions.
3. Make training modules dynamic so that experiences from the field, and solutions to challenges are generated and fed back to participants. For example, the vaccine readiness implementation drew considerable learnings on how to handle hesitancy related to local collaborations and messaging.
4. Account for more time for virtual training programmes. The medium makes training more difficult, and technical and network-related disruptions are common.
5. Adopt technology to enable scalability, yet prepare alternative solutions since many partners might have their technology solutions for data collection but might not have the capacity or infrastructure to adopt the technology solutions being provided.

"We are working with the fisher community for many years, but we are not aware of how many schemes are available to the vulnerable communities. Through CAC we have realised the value of it. We are incredibly happy to work and collaborate with CAC."

- Participant from United Artists' Association⁴

"The presentation, content and the interventions are quite insightful and useful. These interventions are quite necessary for the population belonging to the socio-economic backward class."

- Secretary, United Artists Association

C. Refresher Training for Trained Trainers/Organisations (Level 3):

Objective: To revisit the content, methodologies and best practices following the first round of implementation (give the actual timeline of trainings and how many modules/training sessions etc) towards strengthening the abilities and knowledge levels of participants. It also includes covering any additional content as need be.

The refresher training was designed as need-based training for partners who felt the need to go over the content once again and build on their first-round experiences.

Timeline: Only 8 partners have opted for the refresher training from October 2020 to June 2022

4.3.3 Implementation of HIIs by partners

Objective: To reach the HII services to VPs

Outcomes:

- Vulnerable populations benefit from the implementation of the interventions by having accurate information to protect themselves from COVID-19, ensure better health management, have improved access to diagnostic and medical facilities, and social protection schemes

⁴ United Artists' Association is an NGO formed in 1967 that primarily focuses on community empowerment, specifically women and children.

- The government and implementing partners have implementing models and cadres of trained frontline workers for scale and sustainability
- Government departments have improved target achievement

Lessons Learnt:

1. Stress the importance of data collection that is gender disaggregated as this gives indications of progress and also provides insights into coverage.
2. Factor in resource crunch at the planning stage as it is one of the main causes for delays or disruption of implementation and solutions.

The following case story demonstrates how training and capacity building has enabled partners to deploy High-Impact Interventions.

A new direction: Livelihoods organisation take on health

Vrutti works on transformative livelihoods for small producers. With COVID-19 Vrutti saw the need to build awareness of its communities on COVID-19 protection and care. As an organisation working on livelihoods, its field teams had no inkling on how to facilitate health promotion for its communities. But recognising the urgent need it identified the HII health package covering COVID prevention and management, home isolation and personal safety, vaccine readiness; telecare; and the SP package.

Implementing the health package did, of course, build the capacities of the Vrutti team; it also built internal mechanisms to deliver health interventions. Vrutti has been able to improve the referral network and refer community members to local PHCs, urban health centres, Government hospitals and Private Hospitals. One of its trained staff shared that he had stepped foot in a PHC for the first time in his life during the implementation. Meanwhile, a strong relationship has been built with local PHCs and district-level health departments in its operational areas.

Vrutti reports that community members to avail of medication, health screening for non-communicable diseases, treatment of identified health conditions and improved management of chronic health conditions. It has observed improved health-seeking behaviour and reduced hesitancy in visiting hospitals in the community.

Vrutti's case shows how civil society organisations, given the right training, can take on initiatives in new domains; and this provides them with a greater connection to their

communities, improved relationship with ecosystem players including the government, a deeper understanding of holistic needs and greater confidence to venture in new areas.

5. Key Takeaways and Conclusion

The COVID-19 pandemic hit the whole country hard but the vulnerable and marginalised communities were disproportionately impacted. These groups who face alienation on a regular basis on account of their marginalised status were further pushed to the periphery as they faced nuanced and intersectional barriers in access to essential services to tide over the detrimental effects of the pandemic. To address these barriers, ADB-CoE aimed to generate learnings from CAC, a successful collaborative.

Scale and speed of service delivery were important in the pandemic as VPs faced daily struggles with their health and wellbeing. A large collaborative is the only way to deliver critical services at a scale that can reach many vulnerable communities pan India.

However, a large collaborative also has very **diverse partners, and the design of the HII package was crucial** because it had capacity-building modules that found interest with these diverse stakeholders, including the local governments. **Incorporation of SP modules**, those where partners faced challenges such as vaccine readiness, and new initiatives like telehealth that were contextual to the pandemic situation was an anchor of partner interest. Incorporation of SP and optional Livelihood modules created a more well-rounded learning experience for partners working in the health promotion space and capacitated them to increase the COVID-19 resilience of VP's using a multidimensional approach that is not only limited to health-related solutions. Offering health, SP, and livelihood modules also enabled partners to move away from their primary domain of work (be it any of the aforementioned domains) to offer additional services and support to their VP's. Moreover, **a menu of options helped partners align their choices not only to community needs but also to resource availability. The targeted focus on urgent needs ensured uptake and scale.**

Fundraising was a challenge for partners, during the pandemic. Part of the capacity building planning process was seeing how we can layer HII packages in partners' existing programs such that they do not have to seek out additional funding to implement. Partners were thus supported to take on certain aspects and interventions from the HII packages, rather than all, depending on their funding/financial capacity. Funding for capacity building was obtained through innovative ways such as leveraging available funding within current projects.

Identification of partners also contributed to a sizable reach. While the partners onboarded initially had limited reach, the onboarding of partners with a large reach and private associations not only placed CAC on the way to its 10 million goals but enabled it to reach out to diverse VP groups.

The capacity-building approach, through TOTs, was an efficient way to extend the HII package across India. Yet, in the pandemic context, some of the traditional quality assurance measures like field observations and validations are not available. **Quality has to be assured** by frontloading the effort and time at the set-up stage **Detailed discussion on partner capacities**, resources, gaps in their knowledge and interventions direct decisions on specific packages required for communities. **The involvement of senior decision-makers** in these consultations makes for quick identification of the scope of work. Operational planning then provides a road map toward implementation.

Technology is an asset enabling scale but might also be a challenge in a large collaboration as different partners have their preferences for the **use of software applications** to record data and communicate. These requirements need to be allowed to prevent the risk of not getting information. The CAC CB initiatives give pointers on building sustainability. An important CAC strategy is **institutional resilience**, and the CB initiatives contribute to this by building institutional capacities on health and SP, planning, resource mobilisation, working with the government, etc. The HII package allows organisations, like Vrutti, to step beyond their comfort zones and implement initiatives in new domains, building their confidence and that of the communities they serve.

Sustainability is further enhanced as a cadre of trained frontline, and online personnel is built, who would be available to facilitate health and SP even in non-COVID times. Similarly, **inserting NDC screening, SP and telehealth into the HII ensures that the capacities gained by these workers remain relevant in the future**. In addition to personnel, the CB initiative also built infrastructure of telehealth and communication assets.

For associations, uptake of the HII strengthened their connection with members. For ARTIST sustainability also came in the form of increased demand for training on emotional health, translating into increased business. Finally, sustainability is strengthened through impacts that communities experience that strengthen their trust in the implementing organisations and the local governments. In the next report, the CoE will develop the best

practices from COVID-19 response services, particularly for vulnerable populations. The results will be further used to develop a working paper in consultation with ADB.

ANNEXURE/S:

Annex A: VaxNow

Box 1: [VaxNow](#) - A Big Shot

The VaxNow initiative, launched by Swasti in collaboration with the COVID Action Collab (CAC), is a response effort to the issue of vaccine inequity in India. The initiative is a solution to the last-mile delivery challenges that blocked vaccine access and equity for vulnerable communities through targeted domestic distribution and harnessing public, private and community partnerships.

Since its inception in October 2021 till the VaxNow initiative has enabled more than 6.5 million jabs across 24 states and union territories, for vulnerable communities including transgender persons, sex workers, migrant workers, people with disabilities, informal workers and street vendors, among others with the help of the partner network and in collaboration with local governments.

VaxNow continues to ensure that there is a continued focus on vaccinating vulnerable communities. The supply and demand barriers are many, including limited last-mile delivery capacity, physical access barriers due to infrastructure, distance or the timing of the centres, high opportunity costs for daily wage earners, vaccine hesitancy, and misinformation on vaccine redundancy with the pandemic ending, etc.

The initiative works on these demand and supply side constraints. CAC works with the local administration to spread information on the availability of vaccines and sets up camps for special groups as needed. Even though vaccines are given free of cost at government facilities, there is a cost associated with improving awareness, generating demand and mobilising and supporting communities to reach vaccine sites, or taking vaccination to the doorstep through mobile interventions. These costs are raised by private institutions. Hesitancy on account of myths and misconceptions, where possible, is addressed through awareness drives, community champions and influencers.

To reach the unreached population with vaccination and also to accelerate the vaccination process in the prioritised states and districts, **CAC proposed the following two approaches:**

A. Intense support via CAC members

To ensure vaccination for vulnerable and hard-to-reach individuals, this approach adopts a strategy that is agile, inclusive, and community-centric. It engages local community champions, leaders, and influencers (including faith-based organisations) to effectively facilitate end-to-end vaccination with empathy while tailoring interventions to suit communities' requirements. This was operationalized through multi-sectoral partnerships between government, private sector, civil society, and media. Under this approach, contextual tactics were deployed based on whether individuals are Vaccine Eager, Indifferent or Hesitant while leveraging technology. This approach includes the following 5 phases and steps.

B. Through technical support offered to district administration (Health) /govt.

Technical assistance aids in accelerating vaccine efforts across priority districts. It involves a partnership with the administration and health sector for planning or management support. This approach focuses on complementing the government's efforts and **strengthening its capacity** to accelerate the health and family welfare department to achieve its goal in improving vaccination statistics across the urban, rural, and semi-rural areas of the prioritised districts by reaching the unreached and focusing on the most vulnerable population.

Under this approach, the focus was on providing technical support and thus building the capacities of district-level authorities to achieve the set vaccination targets. **Technical assistance was provided in the following domains:**

- **Gap analysis and prioritisation** - Gaps related to institutional capacity and coordination include the need for central and local coordination, partnerships and governance. Identification of PHCs and vaccination blocks with the low turn-out for direct intervention and extending support.
- **Data analysis and reporting**- logistic support to the PHCs and health camps in the community.

- Efficient use of available resources by effective planning (**Micro Planning**) - accessing the social protection schemes by prompt registration assistance and helping community members to acquire required documents.
- Understanding **bottlenecks** and finding solutions in consultation with the concerned authorities- through community engagements, FGDs etc and identifying barriers.
- Sharing **best practices**

Learnings from VaxNow, obtained from a Vaccine-Hesitancy Study conducted:

- 1) The biggest driver of vaccine hesitancy is the apprehension of potential long-term side effects.
- 2) Vaccine-induced adverse effects are highly predictive of both past and future vaccination behaviour.
- 3) Vaccine-related peripheral issues, such as vaccines not being effective or lack of confidence in the government and/or media, were not significant in predicting future or past vaccination behaviour.
- 4) People from SC-ST backgrounds are less likely to get the third booster dose.
- 5) Primarily focusing on addressing the adverse effects and related misinformation and highlighting the benefits of vaccination is an effective method to increase vaccine uptake.

From the concurrent evaluation conducted for VaxNow 1.0, below are the key takeaways:

- 1) The local NGOs, CBOs and other stakeholders have a major role to play in the value delivery across different locations.
- 2) They are instrumental in forging the relationship with the local administration, working in close coordination with them and also establishing the connection with the communities.
- 3) Their role becomes even more important in case of mobilisation of the community and getting the support of the local leaders. The local leaders are an important player in mobilising the community and thus getting their support is of prime importance which can be secured with the support of these partners.

4) The CAC's efforts are thus amplified wherever there is the presence of strong partner organisations. This was evident both in Chikkaballapur as well as in Kadapa where the local partners were instrumental in amplifying the vaccination efforts.

5) The selection of new locations and villages should also depend upon the strength of the partner and its presence in the district or identify strong local partners in the targeted locations.

Scaling up 'VaxNow'

Reaching VaxNow's full potential and large-scale social impact can be achievable by:

- Expanding partner network across India; leveraging CAC's 350+ vetted partners, Catalyst 2030 & other networks
- Ensuring control, accountability & transparency through CAC's data capture system
- Increasing geographical coverage & community coverage to bridge inequities
- Collaborate, synergize and collectively save costs
- Leverage & build on CAC's syndicated fund

CAC has been adopting a strategic approach towards prioritising the locations for the subsequent phases of vaccine efforts. The location selection criteria follow a **four-step process**:

- States with relatively lower vaccine dose coverage (Especially the second dose)
- Districts within these selected states that are also not performing well in terms of the second dose coverage (<40-50%)
- Districts with a strong CAC partner presence and ongoing government engagement
- Priority population groups: Communities that have been somewhat neglected in the current vaccine efforts; **Children, PwD, Women, Tribal groups, Sex Workers, etc.**

Table A: A list of state-wise partner names and the expected coverage from each partner from VaxNow (GCPL Vaccination Project).

S.No.	State	S.No.	District	Partner Name	Target
1	Tamil Nadu	1	Madurai	Sri Lakshmi Pengal munnetra Sangam (SLPMS)	5,000
		2	Salem	SPNS	5,000
		3	Salem	STNS	5,000
		4	Theni	TPSPMS	5,000
		5	Pudukottai	ROSE	5,000
		6	Thanjavuru	ATMSM	5,000
2	Andhrapradesh	7	Vijayawada	Jeevana Rekha Mahila Sangham	5,000
		8	Vizianagaram	Kiranam Mahila Samakya Sangham	5,000
		9	Srikakulam	Swagathi Mahila Sangha	5,000
3	Telangana	10	Warangal	Navyashree Mahila Welfare Society	5,000
		11	Godavarikhani	Spandanashri Maitri Sri Public Welfare Society	5,000
4	Karnataka	12	Chikkaballapur a	SSS Chikkaballapur	5,000
		13	Chikkaballapur a	Nisarga Society	5,000
5	Puducherry	14	Karaikal	HOPE	20,000
		15	Puducherry	SCHOD	10,000
Total					95,000

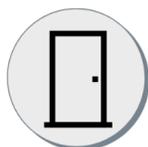
On-Ground Vaccine Outreach Process

During the project period **December 2021 - March 2022**, the following 4 approaches were adopted to reach VP's:



Mobilising Community members to access vaccination at PHCs: Under this approach, the project team provide navigation support to the members to reach the nearby PHCs to get vaccinated. This approach is adopted in the areas near the PHCs (within 1.5 to 2 km distance)

Organising Camps: These camps are organised at the community level in collaboration with the District Health Department. Project teams organised camps and provided all logistical support to the Health Department teams. The vaccinating team comes with the vaccine and vaccinates mobilised members



Door to Door visits: This approach is used for those members who are hesitant to come to the camps and PHCs. In this approach, project teams take the vaccination team to the doorsteps of the members

Vaccination at the workplace: This approach is adopted to reach the working population, who are willing to come to PHCs and are not available at their houses. In this approach, project teams take the vaccination team to the workplace and vaccinate the members



Figure A: On-Ground Vaccine Outreach Process (VaxNow)

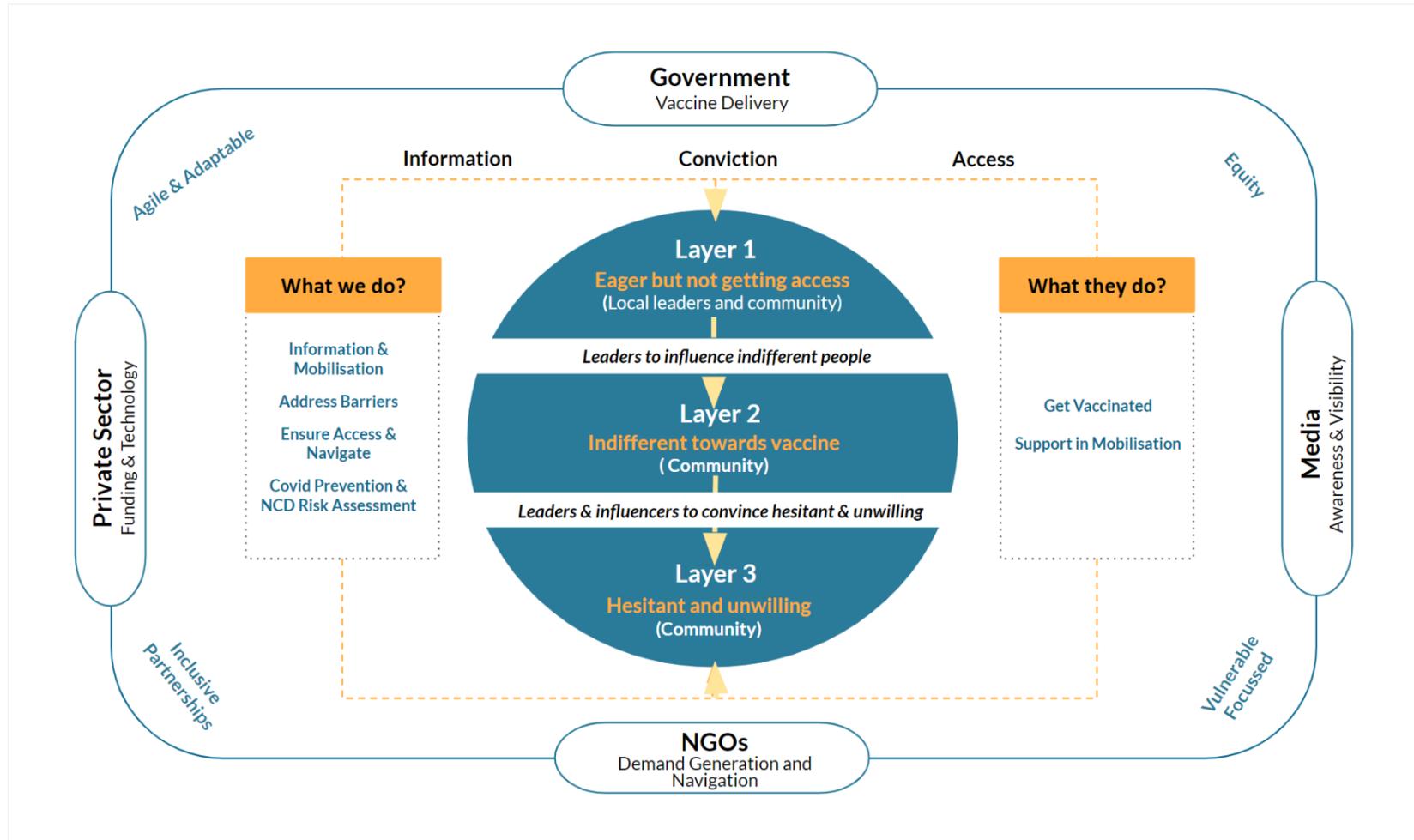


Figure B: Operational Framework of the Vaccination Drive (VaxNow)

1.	<h3 style="text-align: center;">Partner Identification</h3> <p>Partners were selected based on the following criteria:</p> <ol style="list-style-type: none"> a. Experience in working with vulnerable community members b. Engagement with the district-level stakeholders c. Successful implementation of projects with Swasti <p>These partners perform:</p> <ul style="list-style-type: none"> • Demand Generation for vaccination • Mobilization of Vulnerable members for Vaccination Camps • Navigation of members to access Vaccination
2.	<h3 style="text-align: center;">Planning Phase</h3> <ul style="list-style-type: none"> • Gap analysis and prioritisation • Prioritisation of locations (Blocks and Primary Health Centres) • Approval and Permissions from concerned authorities • Meeting with Block/PHC Level authorities: • Collaboration and Networking • Vaccine Delivery Preparedness.
3.	<h3 style="text-align: center;">Pre-Vaccination Phase</h3> <ol style="list-style-type: none"> 1. Recruitment and training of project team: <ul style="list-style-type: none"> • A total of 102 members from Swasti and partnering organisations were involved • After the recruitment of team members, a one-day in-person training for all the 15 partner teams was conducted. 2. Demand Generation 3. Logistic support for organising the camps
4.	<h3 style="text-align: center;">Vaccination Phase</h3> <ul style="list-style-type: none"> • Selection of vaccination sites • Organising of Vaccination Camps • Logistic arrangements in the camps (Space, Drinking Water, Chairs and tables, Refreshment) • Mobilisation of members to vaccination sites and camps • Navigation support to members to reach the Vaccine sites and camps. • Enrollment/registration assistance for community members
5.	<h3 style="text-align: center;">Post Vaccination Phase</h3> <ul style="list-style-type: none"> • Post-Vaccine Care and Support: Through teleconsultation services provide care and support to the community members as needed.

Figure C: Phase-Wise Implementation Process

Annex B: Training and capacity building approach

Link: [Value-added Service Report -Swasti](#)

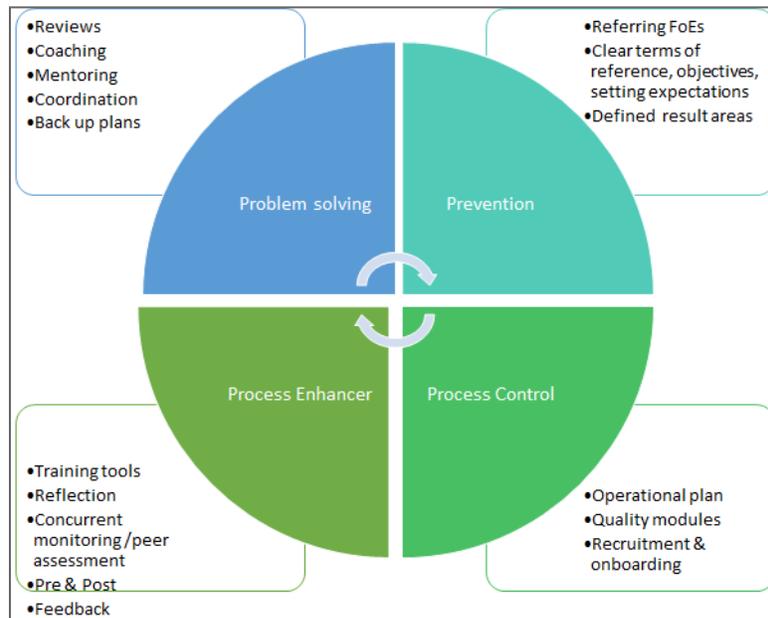


Figure D: QA Framework for CoE Trainings

CAC Capacity Building for Swasti Members

- The training aimed at introducing key offerings of COVID Action Collaborative (CAC) to the partner. The participating leaders of the partner organisation were oriented on CAC and its objectives, including how the training will benefit the community members, the kind of support and packages offered through the collaboration, and the outcomes it will have on the communities.
- The leaders of the partner organisations were oriented on the high impact packages – Health, Social Protection and Livelihoods on **15th March 2021**, one relevance and the benefits of these packages for the community members. The technical specialist team from CAC Secretariat provided training support to build the capacities of Swasti’s key staff in the following areas so that information, awareness, and support can be provided by the managers, TOTs and field facilitators. Some of the priority areas of focus have been the following:
 - A. Induction on CAC HII intervention for Managers, TOTs, Field facilitators:**

The CAC Secretariat conducted a Training of Trainers program for Leaders, Managers, Field officers, TOTs and federation members of Swasti on the High Impact Interventions – on Health, Social Protection and Livelihoods on 15th March 2021 with 3 participants which included 2 male and 1 female.
 - B. Vaccine Readiness:** A training and awareness session on vaccine readiness was conducted for Swasti with 50 participant members on May 14th, 2021, The one day training session addressed myths surrounding vaccination and provided information on vaccination and the supportive registration process. It improved awareness among the managers, TOTs and field facilitators who disseminated this information to community members. The capacity building led to the managers, TOTs, Field facilitators motivating and referring the community members for vaccination.
 - C. Home Isolation:** On the 6th of July 2021, training on Home Isolation and Personal safety with 75 participants was conducted in Tamil through partner organisation Noora Health. The training provided information on home isolation tips for treating COVID 19 patients at home as well as self-care and on personal safety such as usage of a thermometer, pulse oximeter, hand sanitization for prevention from COVID 19.

D. Social protection facilitation & Setting up of a Help desk in the community:

Capacities of Swasti leaders and managers were built on Social Protection on 8th July 2021. The training covered the strategy for Social Protection, establishing and managing a help desk, and providing information on relevant Social Protection schemes and services for the community. With improved Capacities the Managers realised that to avail schemes, the community members must first have basic documents. Their capacity was built to aid the process of application.

Table B: Summary Description of CLIN Reports

CLIN	Obj No	Deliverable
CLIN 1	1	Report on strategy to reach 10 million people developed and submitted
CLIN 2	1	Report on 10 packages for VPs developed and submitted
CLIN 3	1	Report submitted on 100 organisations trained on the standard packages
CLIN 4	1	Report on 100 organisations' operational plans to reach VPs developed and submitted
CLIN 5	1	Report on value-add services provided to 100 organisations submitted
CLIN 6	1	Progress reports of the 100 organisations prepared and submitted
CLIN 7	2	Report on strategy to reach 10 local governments developed and submitted
CLIN 8	2	5 packages for local governments developed and reports submitted
CLIN 9	2	Report on value added services provided to 10 local governments submitted
CLIN 10	2	Progress reports of the 10 local government prepared and submitted
CLIN 11	3	Strategy to reach 1,000 health care providers, 50,000 unorganised workers and 50,000 street vendors/ retailers developed and report submitted
CLIN 12	3	One package for health care providers developed and report submitted
CLIN 13	3	Report submitted on the training of 5 associations of health care providers on the packages
CLIN 14	3	Report on value added services provided to 5 associations of healthcare providers submitted
CLIN 15	3	Progress reports of the 5 associations of healthcare providers prepared and submitted
CLIN 16	3	One package for unorganised and informal workers developed and report submitted
CLIN 17	3	Report submitted on the training of 5 companies with unorganised and informal workers
CLIN 18	3	Report on value added services provided to 5 companies submitted
CLIN 19	3	Progress reports of the 5 companies prepared and submitted
CLIN 20	3	One package for street vendors/ retailers developed and report submitted
CLIN 21	3	Report on the training of 5 associations of retailers and small vendors prepared and submitted
CLIN 22	3	Report on value added services provided to 5 associations of retailers and small vendors submitted
CLIN 23	3	Progress reports of the 5 associations of retailers and small vendors prepared and submitted

Annex C: HII packages

Link to training modules: [Training and Capacity Building Workshops Conducted](#)

Links to IEC Materials that supported COVID-19 Management Trainings: [Swasti-Vihara IEC Materials](#)

Link: [i4We Health Packages - Operational Plan of Swasti](#)

Section 1: Vaccine Readiness

With assistance from the technical support team, CAC began building the capacities of the field team to implement the vaccine readiness and vaccination service as part of the HII package in the 6 districts of Rajasthan to contain the spread of the virus. The training helped the field team to not only create awareness amongst community members on the efficacies of vaccination but also encouraged them to get vaccinated. The team was also able to forge collaborations with the local health departments, ANMs and ASHA workers to discuss scope for scaling the impact of an intervention to different blocks and populations. The mutual value added by data sharing helped the health officials and the Swasti team acknowledge areas for immediate support and partnership.

The team developed strategies around concerns of COVID appropriate behaviours, care guidelines and vaccine awareness. Working closely with the frontline workers like ASHA, ANMs etc. helped in reaching maximum members of society and mobilising them for mass vaccination by effective communication. The team assisted in registration on online portals, informing details for vaccination sites and facilitating transportation/ facilitating mobile vaccine camps for individuals who are located in remote areas.

With approval for vaccination of the elderly, the team conducted home visits and phone calls and facilitated vaccination for the elderly through a pick and drop facility to aid their transport. With the approval for booster vaccine doses in April 2022, the team accelerated the vaccination for community members and also ensured that their eligible staff members had availed of booster doses.

Section 2: NCD Screening

NCD screening camps were conducted by partnering with local PHCs, and anyone who was identified to be at risk for any health condition like anaemia, diabetes and hypertension was encouraged to visit a healthcare provider and confirm the diagnosis. Those identified to be at risk for COVID were asked to follow COVID-appropriate behaviour starting immediately and were

guided and linked with the local COVID care centres. **The capacity-building sessions through CAC ensured that the implementation teams had good knowledge of follow-up mechanisms as well as closing the loop.** The excellent rapport that the implementation teams developed with the local health cadre like ASHA, ANMs, etc. ensured that the linkages, as well as follow-up of individuals at risk, happened systematically and periodically. **In addition to this, based on the training received from CAC, the partner teams also counselled these individuals to change their lifestyles and adopt healthy behaviours to maintain their wellbeing.**

Through the NCD screening program, the field team identified that women and the elderly were least likely to screen themselves for any health issues in comparison to men since they did not prioritise their health. To address this issue, the field team developed a due list of households with support from local health departments and local leaders to conduct targeted awareness sessions.

Regular home visits and phone calls were organised to build community members' insights into the importance of regular health screening and the advantages of free health camps through the provision of free medicines being made available for their illnesses. Since the ANMs and Anganwadi workers were in constant touch with a few members of several households, they were able to generate trust amongst the community members, especially for women and the elderly, which increased confidence amongst individuals and encouraged them to avail services.

Section 3: Social Protection

Due to a lack of awareness and hesitancy in enrolling in health-related schemes and the complexity in navigating the systemic processes, a larger chunk of the communities turned out to be reluctant in enrolling for schemes. The field teams trained by CAC conducted multiple awareness sessions and explained the entire enrollment process and claims of benefits process. This encouraged the majority of individuals to show interest in availing of social protection schemes, and through word of mouth a lot more community members approached the field team to connect them to social protection schemes. However, due to a lack of relevant documents, the enrollment process was delayed, which not only made the process time-consuming but also discouraged communities. **To mitigate this challenge, the field teams assisted individuals by setting up help desks in the administrative offices and deployed dedicated teams on the field to acquire valid documentation, complete the application on their behalf and submit them to the relevant government portals. Help-Desk Facilitators were trained by CAC to build the capacities of communities to access and effectively utilise SP entitlements and schemes.**

This helped to streamline the document verification process and link beneficiaries to the relevant social protection schemes. While the benefits of these services will reach them at different stages of the project period or even after that, Swasti was able to facilitate applications for 11,068 individuals, raising benefits worth INR 27.6 crores in the hands of the communities.

Section 4: Telecare

In keeping with the need of the hour, Swasti and partners of the CAC built an integrated digital platform - Call4Svasth - with hyper-localised, community-led, cost-effective helplines run by trained nurses, nurse-aide-callers, front-line counsellors, and social protection officers. It is, thus, a community-led integrated tele-triage and community care service to address physical, emotional, and social determinants of health, with provision for COVID-19 care. The program includes services such as awareness about COVID-19, risk assessment, counselling services, vaccination onboarding and registration support, facilitation of government social protection schemes along with the provision of care materials for safe home quarantine, COVID care management at home, and testing services to address the needs to vulnerable communities in a holistic manner. It differs from traditional telemedicine helplines by virtue of its hybrid nature - on-ground support for last-mile delivery - the range of services it offers and the depth of its intervention. It has successfully reached over 800,000 vulnerable people across the urban poor, rural poor and other unique settings. With over 100 community health workers (from partner organisations) supporting telecare services and a continuous follow-up model to identify changes in disease progression and thus, take appropriate preventive action for disease mitigation, the program delivers holistic care to the last mile making certain that no one gets left behind. The model is sustainable and easily scalable to ensure that accessible - green healthcare reaches the people who need it most.

Swasti, in partnership with Graamvani, has developed and deployed an IVR (Interactive Voice Recorder) based helplines that allows people to call and leave messages and also listen to responses to frequently asked questions on COVID-19.

IVRS (Interactive Voice Recorder Service) - In Partnership with [Graamvani](#)

In the wake of the outbreak of the COVID-19 pandemic, there has been an overwhelming availability of information on various platforms. However, given the panic around the outbreak, there is a need, particularly among the poor and marginalised

communities (including factory workers) to impart the right information and ensure that this group is able to easily access information. This would go a long way in protecting them and their families.

Workers in factory settings mostly hail from poor economic backgrounds, hence, it is important that they have access to the right information in the easiest way possible. Gramvaani, through its "[Mobile Vaani](#)" platform aims to promote social development by developing IVR (Interactive Voice Recorder) based helplines that allows people to call and leave messages and also listen to responses to frequently asked questions on COVID-19, thus ensuring that people have access to the right information and are not misled into panic.

Gramvaani has so far launched IVR based COVID-19 helplines in Karnataka, Bihar, Jharkhand, Uttar Pradesh and Tamil Nadu.

Objectives of the IVR based Mobile Vaani:

- Provide information and awareness, to ensure that workers get access to information
- Respond to needs through partner networks, Gramvaani's volunteer teams on the ground wherever present, and establishing a connection with relevant government departments.

How does this work?

The IVR system currently has FAQs which users can listen to, on COVID -19 related topics. Users can also take a self-assessment test. This will be activated only in states where there is regional support available to follow up on the cases. Using the inputs from users, information is collated at the regional level and central level (at the head office in Delhi). Useful information is then shared with Government, NGO partners and Social Enterprise partners in order to find solutions and provide support to the users.