Institutionalizing community participation processes in urban informal settlements: Lessons learnt from community volunteers in SNEHA's Child Health and Nutrition (Aahar) Program (2016-18)

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EXECUTIVE SUMMARY:

The Society for Nutrition, Education and Health Action (SNEHA) had implemented a community-based program against malnutrition between 2011-16 in Dharavi, an urban informal settlement in Mumbai, covering around 300,000 people, by name "Aahar". Despite the success of this program, there was concern about the sustainability of its efforts - for the program's partnerships with the public health sector (Municipal Corporation of Greater Mumbai) and nutrition sector (Integrated Child Development Services-ICDS) had been tokenistic; and the community had been a passive recipient of program services. To redress these shortcomings, a new model of Aahar is being implemented since 2016, in two informal settlements of Mumbai- Dharavi and Wadala. This model of the program operates in an "indirect" mode, with Aahar staff working to link ICDS and the community. In order to build capacity within the community "*to expect, demand and negotiate availability and improved quality services from ICDS*", and to undertake responsibility for its mothers and children, the Aahar program has recruited and trained a pool of community volunteers[i]. In this study, we examine the community volunteer strategy in the new model of Aahar, with respect to its salient features, strengths and challenges- and delineate mechanisms through which the volunteer strategy works.

As of February 2019, 698 volunteers (527 females and 171 males) have been recruited by the program. These large numbers have far exceeded the program's initial expectations. Staff persistence, innovative recruitment strategies, a culturally-sensitive program design and volunteer-perceived usefulness of Aahar's training sessions have contributed to building this volunteer pool. Aahar staff has worked hard to keep volunteers motivated through consistent public appreciation of their efforts- for volunteers have not been given any economic incentives. The volunteer program has been designed with cultural sensitivity and thus 1) implements the male and female volunteer's strategy separately and has different expectations from each category 2) moderates expectations from volunteers and ensures they can work at a pace that is convenient to them-on activities based on their interests, time and skills 3) appreciates all volunteer efforts and disregards inadequacies.

Aahar's volunteer strategy is based in a difficult urban social context- where migration rates are high and social networks are not as strong as rural ones. In addition, prevalent gender roles and identities hinder women from working outside their immediate neighbourhoods; these also prevent men from participating in what are considered as issues in the *"women's"* domain. To circumvent such contextual issues-and succeed in setting up a large pool of volunteers in a short program period, Aahar had to be flexible on certain aspects of the volunteer strategy (even while knowing these concessions could affect coverage/quality). To get female volunteers to participate in the program and retain them, the Aahar team had to give them a high degree of flexibility in their work and discount those who could not contribute. The social context also limits the scope of practice of female volunteers, in terms of both, the type of activities they could do and the time they could devote to volunteering. In many months, attending meetings/events/trainings organized by SNEHA - and to more limited extents, mobilize during weighing sessions. were the only activities female volunteers could contribute to. Female volunteers reported working about an hour a week (this time included that of participating in meetings/events) and within the confines of their immediate neighbourhood (10-20 houses in the lane). Since female volunteers rarely left their

immediate neighbourhood, there was little peer learning or support from one another. Male volunteers reported to work mainly on water and sanitation issues-by coordinating with the public sector department responsible for these issues. There has been little opportunity for collective action among volunteers. Thus, volunteers did not have the collective power to demand services from ICDS or enforce accountability. In addition, despite Aahar's intensive efforts at motivating ICDS frontline workers, the links between ICDS and volunteers remained weak. Aahar remained the main anchor and champion of volunteers through the course of the program.

One big achievement of Aahar's volunteer strategy has been in setting up a team of volunteers in the community, who report improvement in their technical knowledge on health and nutrition. Volunteers also report using this information to better related practices in their own families. Being a volunteer has been transformational for many women- for it has given them an identity beyond their households. Women who have rarely stepped out of their houses have gained confidence -during the course of the program-to speak in public forums. Women have revelled in the public acknowledgement of their efforts as volunteers. In their relationship with SNEHA, one can see that female volunteers feel safe to test their new identities as *"empowered"* women (by participating in discussions, arguments, by sharing new recipes and such); and are beginning to think about issues beyond their household. Male volunteers too are beginning to subvert existing gender norms and coming forward gradually to talk about women and child health. These are not easy achievements.

Thus, the volunteer strategy in Aahar can be thought of as a beginning of a transformative process in the community. However, since this can be considered as one of the pioneering attempts by Aahar to work with volunteers, there have been important learnings. One, we need to expand coverage of volunteers in the community. Each Anganwadi is reported to have around 300 households and about 3-5 volunteers who could take responsibility for 10-15 households each. With the present number of volunteers (though large), it was not possible to reach the entire community. Two, there is a need to improve volunteer-community interactions. While there are no standards that define the optimum numbers of volunteers or their reach, some successful community volunteer programs (unpaid, but through groups) against childhood malnutrition have reported community contact of volunteers to be 87% and more. Our endline study has shown that only 12% of community households knew about volunteers. We need to reflect on how we can incentivise volunteers to increase their work in the community, either through monetary or non-monetary mechanisms. Three, Aahar has so far played a major role in recruiting volunteers. There may be some benefits in involving the community closely in their recruitment (for example- 3-4 lanes can chose one representative)- so that volunteers become community representatives who interact with SNEHA- rather than SNEHA representatives who interact with communities. Fourth, the volunteer-ICDS linkage needs strengthening- and expectations of both parties need to be clarified and negotiated. We also need to put forth some mechanisms for peer-learning and collective action among volunteers. Fifth, we need to decide on the exact roles of male volunteers- pertaining to maternal and child health (while female volunteer roles have been clearly defined, the program is still struggling with what realistic expectations can be set from males). Lastly, the Aahar program has been the main anchor for volunteers. We need to reflect on who can take on this role in the absence of the program.

Those reading this report must note that the limitations in coverage or the constraints in the scope of work done by the volunteers were not due to lack of program effort. The extensive and committed efforts of the Aahar program was clearly visible in the field. Many limitations to the volunteer strategy were posed by the context- and there has been a genuine attempt in Aahar to work around these constraints. One must also note that transforming

hierarchical structures, prevalent social orders and attempting to realign relationships between the public system and community- is a challenging endeavour. Such transformations are likely to need tenacious higher-level advocacy support and funding periods longer than 2-3 years. Looking at the volunteer strategy from this angle, one can conclude that is has been a big journey for the community volunteers themselves and a courageous undertaking by Aahar. This attempt has resulted in much learning for SNEHA and hence deserves appreciation.

Key Messages

- Staff persistence, innovative recruitment strategies, a culturally-sensitive program design and volunteer-perceived usefulness of Aahar's training sessions have contributed to building a large volunteer pool in Aahar. The extensive and committed efforts of the Aahar program was clearly visible in the field.

- Volunteers report improvement in their technical knowledge on health and nutrition. Volunteers also report using this information to better health and nutrition practices in their own families. Being a volunteer has been transformational for many women- for it has given them an identity beyond their households. Male volunteers too are beginning to subvert existing gender norms and are coming forward gradually to talk about women and child health. These are important achievements of the Aahar program.

- The social context considerably limits the scope of practice of female and male volunteers- and thus the contributions of volunteers (beyond their families) presently is very little. In many months, attending meetings/events/trainings organized by Aahar- and to more limited extents, mobilize during weighing sessions. were the only activities volunteers could contribute to-given their practical constraints. There has been little opportunity for collective action among volunteers so far.

- To better the volunteer strategy, the following is needed. The reach/coverage and scope of work done by volunteers has to be more. Also, volunteer-ICDS interactions need to be strengthened. However, to improve the reach, scope of practice and relationships of volunteers- a wide range of contextual factors need to be dealt with. These factors include prevalent gender norms that limit social mobility of women, the lack of long-term social networks, and a deep-seated suspicion of the public sector. These factors are not easy to change. How much of these can be practically addressed by a program in a short funding cycle need to be considered- and the volunteer strategy re-assessed accordingly.

Institutionalizing community participation processes in urban informal settlements: Lessons learnt from community volunteers in the Aahar program (2016-18)

INTRODUCTION

The potential of community participation processes in moving forward the global maternal and child health agenda has been widely recognized (Kumar et al. 2018, Sharma et al. 2018, Prost et al. 2013). Many Non Government Organizations (NGOs) have tried to develop capacities within communities to actively participate in pertinent interventions on these issues. One way of developing community capacities is by recruiting and training volunteers from within the community. Community volunteers are intended to work as peer-educators to bring about behaviour change in communities (Kumar et al. 2018, Perry et al. 2015). They are also meant to be a springboard from which services can be launched in the community; and are intended to support existing social services in the public sector to deliver- as well as hold these services accountable to action (Kumar et al. 2018, Farmer et al 2018, George et al. 2015). In addition, community volunteers are expected to continue interventions in the community, even after the withdrawal of NGOs that originally anchored them, and thus lead to sustainable development. (Perry et al 2015, Bhiri et al 2014).

However, the recruitment, training and sustenance of community volunteers is not straightforward. For one, volunteers are not meant to be "paid" workers; and hence NGOs are often dependent on the moral commitments of volunteers to the cause they propagate. This leads to irregular working hours, piecemeal delivery of interventions, low-levels of responsibilities undertaken, and high drop-out rates among volunteers (Bhiri et al. 2014, Howard-Grabman et al. 2017). Such issues make it extremely challenging to understand and objectively evaluate volunteer contributions to a program. Thus, while there is much literature that touts community participation and its importance/potential, there are few reports of programmatic experiences and field-level evaluations of setting-up and sustaining community volunteers.

In this study, we share some experiences of one of the programs against childhood malnutrition, Aahar (2016-2018)- that has made focussed efforts to set up a pool of community volunteers in two urban informal settlements in Mumbai. The program Aahar has been implemented by the Society for Nutrition, Education and Health Action (SNEHA). In specific, we examine the community volunteer strategy in Aahar, with respect to its salient features, strengths and challenges. We also highlight mechanisms through which the volunteer strategy in Aahar worked.

This qualitative study was done across 5 beats in two urban informal settlements in Mumbai between March 2018-April 2019. Our data included 31 in-depth interviews with volunteers (23 female and 8 male), 4 in-depth interviews and 4 group discussions with program staff, interviews with 4 frontline workers of the Integrated Child Development Services, observations of trainings, and one discussion with the beneficiary community. We also used pre-existing documentation on the Aahar program, routine monitoring data, and results of the program's endline survey to support some of our findings. Based on an initial analysis of staff interviews and program documents, a hypothesized model of how the volunteer strategy was intended to work was constructed. We then compared this model with field realities (Paton 2002).

Section 1 of this report explains the origin of the volunteer strategy in Aahar. Section 2 delineates the nuances of the volunteer strategy- highlighting salient features and principle mechanisms through which the program is

intended to work. Sections 3, 4 and 5 compare the hypothesized strategy with the actual working of the program. Last, we discuss the implications of these findings for the Aahar program and other similar interventions.

SECTION 1: ORIGIN OF THE VOLUNTEER STRATEGY IN AAHAR

The Community-Based Management of Acute Malnutrition (CMAM) model of Aahar (2011-16): SNEHA implemented a modified version of CMAM in Dharavi, an urban informal settlement in Mumbai, between 2011-16, covering round 300,000 people, by name "Aahar". The program had focused on extensive screening of acutely malnourished children and their outpatient management, provision of ready-to-use therapeutic food, and inpatient treatment of medical complications. It worked through a broad base of field-level community health workers, recruited and trained by the NGO. Evaluations of the program had indicated good results; endline results for 0-3 years children showed an 18% reduction in wasting, 29% reduction of stunting among children less than 2 years, and a 33% increase in continued breastfeeding in children more than 6 months (Shah More et al. 2018). The program was appreciated for its intensive community-level messaging; persistence of its field staff in persuading reluctant families and its holistic approach to case-management.

Notions of "Sustainability" and consideration of an alternate program model: Despite its merits, during the exit phase of the above program, some of its shortcomings came to focus. There was concern that the intensive efforts of the program may be costly in the long run. While the program had partnered with government nutrition (Integrated Child Development Services-ICDS) and health services (Municipal Corporation of Greater Mumbai-MCGM); partnerships at field levels had been tokenistic, with Aahar providing direct services to the community. It was felt that ICDS had taken a step back in delivering services (since they knew this work would be done by the Aahar staff regardless of their inputs). In addition, it was felt that the program had considered the beneficiary community as a *"passive"* recipient of services; and had not actively involved them in the program. Program staff reported that the beneficiary community had become "habituated" to having Aahar staff around- and there were concerns that beneficiaries would find it difficult to obtain services post the program's exit.

Such thoughts reverberate with contemporary political thinking within SNEHA, that endorses a shift from direct service delivery to partnership models (partnerships with communities as well as different government departments). These models, termed as "indirect interventions" are intended to be more sustainable than direct service-delivery models. Before program exit, in some areas, a "supportive supervision" model of Aahar had been piloted. In the "supportive supervision" model, an attempt was made towards strengthening local partnerships- along with progressive reduction in direct intervention by Aahar. Drawing on some of the lessons of this attempt, a new Aahar model was proposed.

The new Aahar model: A new model of the Aahar program is being implemented since 2016, in two informal settlements in Dharavi (that overlap with the earlier Aahar program area- Beats 5,6 and 10) and Wadala (new program area- Beats 1 and 2). The program covers approximately 150 Anganwadi centers (90 in Dharavi and 60 in Wadala) and has worked with an average of 4376 children age 0-2 and 2271 pregnant and lactating women per month (year 2018-19).

This program operates in an "indirect" mode, with SNEHA working to link the frontline workers of ICDS-called as Anganwadi workers- and the community (see Table 1 for differences between the direct and indirect models of Aahar). To do this, SNEHA has undertaken to build the capacity of ICDS frontline workers (here after called

Anganwadi workers) as well as support them to deliver in the community. In addition, the need to build capacity within the community "to *expect, demand and negotiate availability and improved quality services from ICDS",* and to undertake responsibility for mothers and children has been recognized in this model. For this, SNEHA has recruited and trained a pool of community volunteers.

Table 1: Differences between the direct and indirect model

	The CMAM model of Aahar (2011-16)- Direct intervention	**New Model (2016-19)**
Goal	Improve child health and nutrition	Strengthen ICDS and the community to combat child nutrition
Indicators	Reduction in Severe Acute Malnutrition	Increase in access to and uptake of ICDS services, participation in meetings with ICDS, self-referral by mothers for self and children, self-monitoring by the community.
Approach/Strategy	Home visits and intensive counselling, extensive screening for Severe Acute Malnutrition through regular anthropometry, quick treatment, door-step delivery of therapeutic foods. All this was done by frontline workers of Aahar	Strengthen ICDS capacity, motivate Anganwadi workers to provide services to the community (through vision building, training, joint service provision) Frontline workers of Aahar to support the Anganwadi worker do Home visits, group meetings, monthly Anthropometric measurement planning, and follow up frequency of done referrals. Strengthen community ownership of maternal and child Health; and build capacity of the community to access and demand services.
Program structure	1 Community Organizer for 3 Anganwadis	1 Community Organizer for 5 Anganwadis

It was felt that by strengthening linkages between the ICDS and the beneficiary community, child and maternal health outcomes would continue to improve- even on the exit of the program. In such a model, the direct role of Aahar staff in providing services was intended to be low. This model of Aahar was intended to be a more sustainable, devolving greater responsibility on families and existing government structures, in comparison with the previous model.

Staff perspectives on transitioning to a new model: Unlearning and a perceived loss of control

Transitioning to a new model in Aahar had involved intensive "unlearning" on part of the program team. In the initial stages of the program, the Aahar team had felt that while the "indirect" partnership model had value, its practice would be challenging. The team reported having to get used to the "*loss of control"* over the intervention- for in the previous phase of the program, they could take active responsibility of the community and deliver quick results. To quote one of the senior staff in the program:

"In the direct intervention, the advantage was that that we all do the work, we are able to take quick action. We could identify quickly and do follow up…do whatever we have to do…all that was in our hands. The advantage was that whether the Anganwadi worker was there or not, we could approach beneficiaries directly."

Staff reported that during the initial phases of the new program, there was apprehension about the indirect way of working. The program staff were not convinced that Anganwadi workers would come forward to work. Staff also reported being apprehensive about their ability to recruit volunteers and sustain them in the absent of monetary

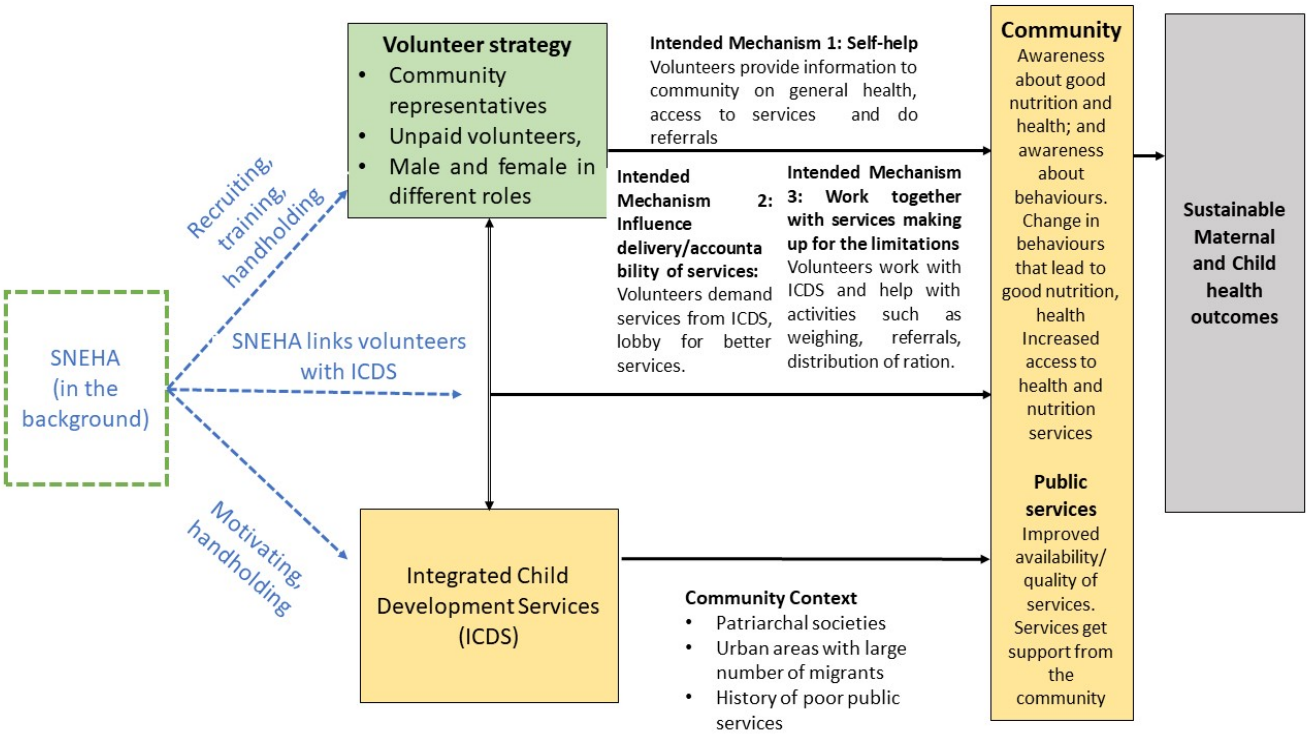
incentives. Also, the community in Dharavi, where the previous program model had run, had set expectations from Aahar based on the previous version of the model; and staff reported that explaining the rationale for this modified way of working to the community was challenging.

SECTION 2: THE VOLUNTEER STRATEGY IN AAHAR- SALIENT FEATURES AND INTENDED MECHANISMS OF WORKING

In the new model of Aahar, volunteers were intended to be unpaid community representatives who worked for its benefit. It was initially proposed that the program could start with recruiting a modest number of volunteers (100 volunteers); and then decide on the way forward-depending on response from the community. There were intentions within Aahar to build groups of volunteers-for collaborative action. As of December 2018, 150 groups have been formed (as told by the staff, not verified).

Figure 1 summarizes the key features and intended mechanisms of action of the volunteer strategy of Aahar. The figure has been derived from program proposal documents and discussions with Aahar staff.

Figure 1: The volunteer strategy in Aahar: Key features and hypothesized mechanisms of actions



Some of the important features of the proposed volunteer strategy have been described below:

Aahar's role as "behind the curtain" and temporary: In the new model of Aahar, the program was intended to work in the background ("*behind the curtain*" as one senior staff put it). Aahar was to act as a recruiter and hand-holder of volunteers (who were not to be paid by the program); and also work with ICDS to motivate and support frontline workers. In addition, it was intended that the program would link community volunteers with the frontline

workers in ICDS, and thus, enable both to work together towards the achievement of maternal and child health outcomes. These linkages were intended to sustain even after the program's exit. Thus, Aahar's role in the new model was hypothesized as a temporary motivating and linking agent.

Unpaid volunteers: It was a conscious decision of the program to recruit volunteers ready to work without monetary incentives-since their work was intended to continue even after the exit of the program.

Male and female volunteers had separate activities: Initially, only female volunteers were recruited by Aahar. The male volunteer component was included later on by the program. The inclusion of this component marks an important change in program strategy, which had so far targeted only women. The argument made in support of the male volunteer component was that decisions on health-such as where a woman's delivery would take place, or *financial* decisions on nutrition- were often taken by males- and hence, it was essential to involve them in the change process. However, given the patriarchal urban context, it was easier for the program to conduct most of the activities for male and female volunteers separately.

Conversations with staff highlight three mechanisms through which the volunteer strategy was originally intended to work:

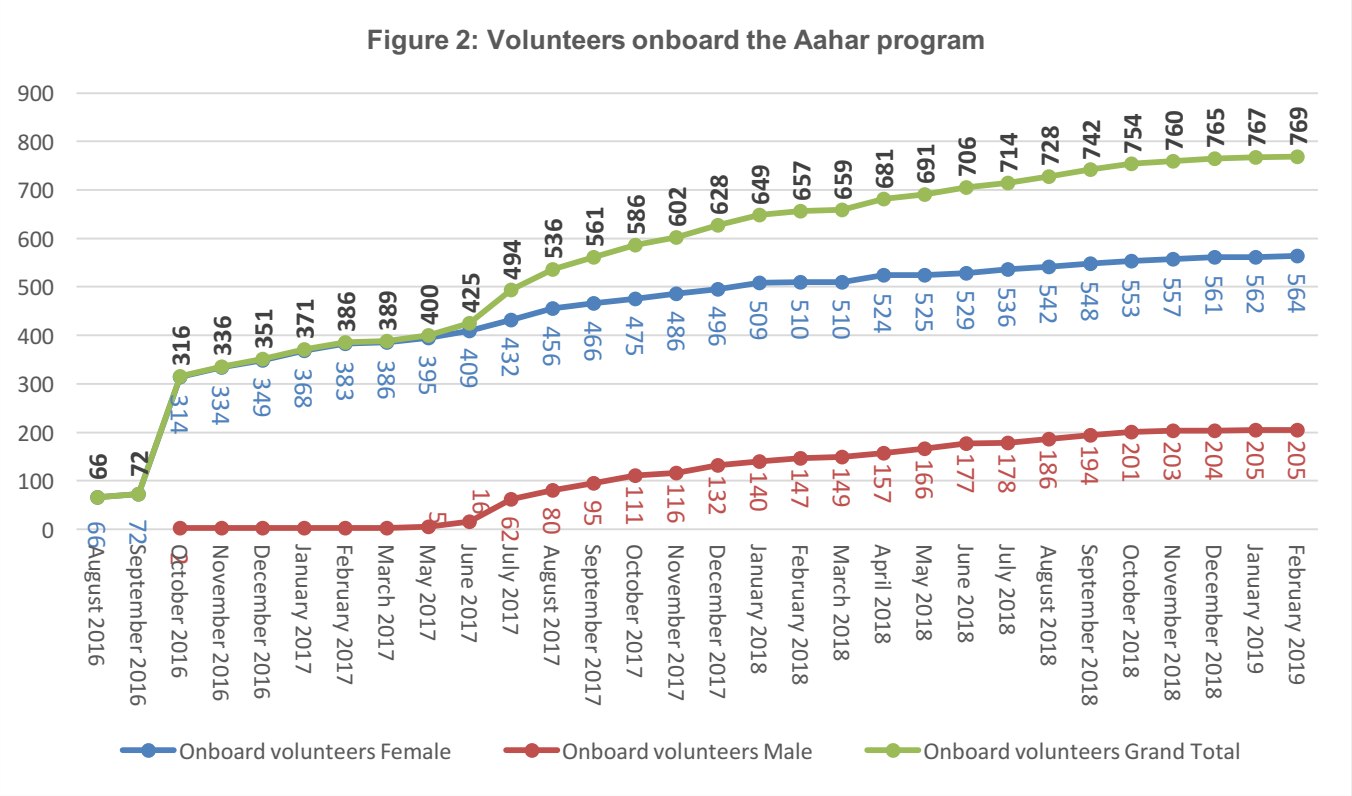
- ***Volunteers as peer-educators and a means to improve community capacity for self-help****:* Volunteers were intended to increase capacity within the community for "self-help". Through peer-to peer messaging, they were to create awareness in the community about mothers' and children's nutrition and health needs; counsel community members; refer people in need to the right places; and raise awareness about ICDS services in the community. The Aahar program would train volunteers and impart technical information on health and nutrition practices to volunteers; this information was, in turn, to be disseminated in the community.
- ***Volunteers to serve as "empowered" citizens who could demand services from ICDS and improve social accountability of services:*** Aahar's training and handholding of volunteers was to result in a pool of "empowered" citizens, who were not only aware of the government services available to them- but could also put pressure on these services to perform better.
- ***Volunteers as means to increase societal inputs into services, co-produce services and help government services perform better:*** Volunteers were to compensate, to some extent, for lacks in public sector services and resource limitations. They were to help the Anganwadi workers perform their tasks better, and in doing so, expand coverage of services in the community. In this role, volunteers were to mobilize children, help in weighing children, distribute Take Home Ration (THR) provided by ICDS, and refer people to public health services. In addition, volunteers were to persuade community members to uptake public sector interventions.

The new Aahar model was based on the assumptions that increased awareness about health and nutrition practices, and increased utilization of services would lead to better health outcomes; and that most activities of the program would continue through ICDS-Volunteer linkages even after the exit of the program. In lines with these assumptions, the key outcomes of the program included increase in the coverage of services in the mandate of ICDS (immunization, ANC, weighing, THR, Infant and Young Child Feeding), increase in appropriate referrals, and development of capacity of the community for self-help and demanding their rights (by improvements in the consumption of THR, demand for THR, and participation in group activities).

In the next three sections, we examine the field-level workings of this hypothesized model of volunteers in Aahar.

SECTION 3: VOLUNTEERS: WHO THEY ARE AND WHAT THEY DO

Numbers: As of February 2019, there are 698 volunteers in the program, of which 527 are female and 171 are males. These volunteers are distributed across 150 Anganwadi centers. Each frontline worker of SNEHA handles 20-25 volunteers approximately. Figure 2 depicts cumulative numbers of volunteers-male and female- recruited by the program since its inception. Table 2 shows demographic details of volunteers.



(Source: Monitoring data, Aahar, August 2016-Present)

Table 2: Volunteer Demographics

Demographics	n	%			N	%
	N=698					
Gender				**Religion**		
Female	527	**76**		Muslim	237	**34**
Male	171	**24**		Hindu	416	**60**
Age (in years)				**Others**	**45**	6
<20	37	**5**		**Marital status**		
20-30	248	**36**		Unmarried	57	**8**
30-40	236	**34**		Married	614	**88**
40-50	113	**16**		Separated	1	**-**
51+	64	**9**		Widowed	24	**3**
Educational Qualification				Divorced	**2**	**-**
No schooling	55	**8**		**Occupation**		
Primary	42	**6**		Employed	209	**30**
Secondary	436	**62**		Unemployed	469	**67**
Higher	165	**24**		Students	20	**3**

(*Source: Monitoring data, Aahar, February 2019)*

Activities:

Female volunteers reported participating in the following activities:

- *Events and trainings:* Events and trainings conducted by Aahar were reported to be of interest to many volunteers. Volunteers could not distinguish between meetings, trainings and events; and perceived all of these as Aahar's group activities. Volunteers felt that these activities helped them gain knowledge, confidence and provided them with opportunities to socialize. Of the different events, *Khana Khazana* appeared to be popular. As per self-reported data (see table 3), about half the volunteers participated in meetings or events held in a month.
- *Weighing:* Many volunteers reported that they mobilized mothers in the immediate neighborhood (15-20 households) to get their children for weighing to the Anganwadi (an activity that was conducted monthly). There have been instances when volunteers have convinced mothers who were reluctant to weigh their children to participate. It was reported by the Aahar staff that some volunteers could even weigh the children and keep records. A few volunteers also reported that they took the children for weighing and brought them back-if the mothers could not do so. A few volunteers also reported instances of assisting ICDS workers in the distribution of Take Home Ration (THR).
- *Informal dissemination of information:* Volunteers reported that they shared information gained from meetings and trainings with SNEHA- in their immediate neighborhoods. Most of this sharing happened informally during general discussions with neighbors, and not through formal home-visits. Volunteers reported that they shared information about healthy diets, importance of weighing, home-cooked foods for children and pregnant women, exclusive breastfeeding, immunization, early registration of pregnancy and family planning methods.
- *Referral/access to health services*: A few volunteers reported assisting mothers in their immediate neighborhood in getting their children immunized. Some also reported identifying mothers who might need

attention (for example-those who were pregnant) and directing them for health check-ups, though not always to public health facilities.

- *Others:* Volunteers reported being able to provide care and support to new mothers -by helping them to breastfeed or to manage their households. Instances of volunteers dealing with domestic violence in their neighborhood have been cited, one volunteer had identified a tuberculosis case. Instances of helping neighbors during emergencies have also been reported.

Table 3 summarizes activities of female volunteers from monitoring data of the program. This data reflects patterns observed from our qualitative interviews with volunteers. However, our sense from the qualitative data is that female volunteer participation in events and training could be slightly over-reported in the monitoring data- since volunteers we spoke to could not really distinguish these from routine trainings.

Also, the data table does not capture the following: In the interviews, most female volunteers reported to work about 1-2 hours in a week, including the time that they spent on meetings or trainings conducted by Aahar. Most female volunteers participated only in activities that happened in their immediate neighborhood. Each Anganwadi is reported to have around 300 households and about 3-4 volunteers who could take responsibility for 10-15 households each. Hence even with the large number of volunteers that Aahar recruited- and a large number of them being considered as *"actively"* participating in the program, the reach of female volunteers has remained low.

Table 3: Self -reported activities of female volunteers (compiled from monitoring data)

Month	Number of female volunteers	Reported doing Anthropometry %	Reported doing Home visits %	Reported identifying new cases %	Reported helping or attending meetings and events %	Reported doing referrals %	Reported assisting with THR %	% Active
Jan 2018	509	55.60	1.96	7.27	60.71	8.45	6.68	76.33
Feb 2018	510	57.06	2.55	4.51	64.51	6.67	7.25	76.45
Mar 2018	510	58.24	2.75	4.71	65.69	8.24	7.65	77.86
April 2018	524	47.14	3.05	2.86	55.15	6.49	5.92	65.52
May 2018	525	33.52	3.05	3.05	39.62	5.71	4.38	54.77
June 2018	529	35.35	3.21	3.78	51.23	6.43	3.02	67.19
July 2018	536	38.81	5.41	6.72	59.70	10.07	5.04	77.29
Aug 2018	542	42.25	5.17	4.06	65.68	10.70	5.54	77.71
Sept 2018	548	48.54	4.93	3.65	66.06	10.22	9.12	78.33
Oct 2018	553	45.57	10.67	9.95	61.48	14.65	12.48	81.30
Nov 2018	557	47.22	8.44	6.64	64.63	13.64	12.75	77.45
Dec 2018	561	59.89	10.52	11.41	68.81	25.13	18.54	81.90
Jan 2019	562	67.79	17.26	7.65	68.68	29.89	22.60	83.87
Feb 2019	564	59.04	18.97	7.27	63.48	24.82	19.68	81.55

Table 4: Self -reported activities of male volunteers (compiled from monitoring data)

Month	Number of male volunteers	Reported helping in Anthropometry %	Reported doing Home visits %	Reported identifying new cases %	Reported helping or attending meetings and events %	Reported doing referrals %	Reported assisting with THR %	% Active
Jan 2018	140	2.14	0.00	0.00	10.00	0.71	0.00	11.81
Feb 2018	147	2.72	0.00	0.00	10.20	0.00	0.00	11.94
Mar 2018	149	4.70	0.67	0.00	10.74	0.00	0.00	13.64
April 2018	157	4.46	0.00	0.00	10.19	0.00	0.00	13.67
May 2018	166	2.41	0.00	0.00	5.42	0.00	0.00	6.94
June 2018	177	3.95	0.00	0.00	16.95	1.13	0.00	24.18
July 2018	178	8.99	0.00	0.56	17.42	6.74	0.00	33.33
Aug 2018	186	13.98	0.00	0.00	24.73	5.38	0.00	42.68
Sept 2018	194	14.95	0.00	1.03	32.47	5.67	1.03	45.55
Oct 2018	201	13.43	0.00	0.50	30.35	5.97	1.49	45.16
Nov 2018	203	9.36	0.99	0.00	29.56	7.39	1.48	43.15
Dec 2018	204	16.18	0.00	0.49	33.82	14.71	2.94	56.16
Jan 2019	205	22.44	0.00	1.46	34.15	29.76	1.46	60.49
Feb 2019	205	15.12	0.00	0.98	28.78	21.46	3.41	55.33

(*Note for table 3 and 4:*
Tables have been compiled from the monitoring data of the program Jan 2018- present.
Some volunteers performed more than one activity; and some have not done any
Active volunteers have been defined as those who participated in at least one activity other than training.)

The involvement of male volunteers in program activities was even less than that of females. Men perceived themselves as having severe time constraints since they had to work and earn as a priority; and were not always present in the household. Men were considered as “busy” and “less free” in comparison to women-by both, the field staff and the volunteers themselves. Male volunteers reported that they worked mainly on water and sanitation issues in the community by connecting with the concerned municipal corporations. They reported having worked on public cleaning campaigns, garbage removal, electrical issues, sewage accumulation choking of gutters, de-addiction- and expressed interests in slum redevelopment. To a limited extent, male volunteers have worked on male health issues; by spotting and referring persons to the right places. These issues can be thought of as having an indirect effect on maternal and child health. Male volunteer’s direct work on maternal and child health activities has been limited- there have been instances reported of males helping women during emergencies or during circumstances when the male members of the household in concern were absent; engaging in male-to-male chats on maternal and child health topics; persuading families to weigh their children (we encountered only one instance); and doing general “*running around”* work.

Table 4 from the monitoring data reflects these trends as well. However, the monitoring data does not capture work done by male volunteers other than those connected to program processes directly (for instance, they seem to have contributed to water and sanitation improvement in the informal settlements).

Volunteer perspectives on what they gained from being volunteers:

Female volunteers reported that the experience of being volunteers helped them gain an identity, an opportunity to channelize their intentions towards social welfare, and gain knowledge and skills that benefitted their own families. Male volunteers reported that they used their status as SNEHA volunteers to do social work in a productive manner (like talk to the municipal corporation and solve issues pertaining to water and sanitation; or navigate a public hospital). It was reported that these were issues that male volunteers were often already trying to address but being a SNEHA volunteer gave legitimacy to their actions. These themes have been elaborated on below (also see quote box 1):

1. **Volunteering as a transformative experience: Many female volunteers felt that they had gained an identity and a chance to be a part of something "bigger"**

All female volunteers reported that volunteering helped them *"move forward*", "*become something*", "*get recognized*", "*be of value*", "*socialize with others*". gain "*an identity*", "*get respec*t" and "*be a part of something bigger*". Thus, in one sense, the very act of being volunteers helped women gain an identity beyond the house-hold; and gave them the confidence to step out of their households. Within their house-holds, these women were unused to being appreciated. Hence, SNEHA's public acknowledgement of volunteers' work (whatever little they could do) and the provision of a public forum for participation was highly prized by them. During interviews with volunteers, they often shared, with pride, photographs of them attending events and speaking in public forums (see quote box 2).

However, volunteers mostly operated within the boundaries of existing gender norms. Most female volunteers reported asking permissions from their husbands to participate in events (even the program staff ask permissions from spouses of female volunteers to ease the way for them). They juggled volunteer activities around household activities, so as to avoid other family members from pointing fingers at them for neglecting what is perceived as their "actual" work. They worked only in the immediate neighborhood where it was considered socially-acceptable for them to be seen. Also, there were very few volunteers who looked at issues in the neighborhood such as domestic violence as their concern (we had come across one exception). Thus, the volunteer program in Aahar mostly worked with established gender boundaries. However, in bringing women out of their households and giving them a new identity, one can say that there has been a gentle push at existing gender boundaries.

2. **For female volunteers, volunteering was a way to channelize intentions towards social welfare (make use of available time and look beyond personal problems)**

Many female volunteers selected by SNEHA already had inclinations to work towards social welfare, and volunteerism provided them with an opportunity to do so. Some of the volunteers had gone through bad experiences themselves- like having to abort a child or have had a difficult delivery or dealt with a special child with no support from family. These women wanted to avert such happenings in the community as well as provide emotional support to other women going through similar challenges. For others, volunteering became a means of forgetting their personal problems, overcoming negative feelings and getting involved in a larger cause. A few volunteers view their activities as "work" and expressed intentions to join a formal workforce at some point in time (but this was not common).

3. Female volunteers believed that information from SNEHA during training sessions helped them gain knowledge and skills to change practices that benefitted their own families (and the community to some extent)

Most volunteers acknowledged that the technical knowledge and skills they obtained from SNEHA's meetings/ trainings was interesting and of practical use. They reported applying this knowledge to better their own practices- for instance, they tried to cook nutritious and well-balanced meals for their families and got their children immunized and treated at the right time and place during ailments. They also reported trying to spread this knowledge informally in their neighborhood.

It was interesting to note that female volunteers often spoke of how attending training and events changed their perspectives on life. For instance, some talked of gaining confidence; one volunteer spoke about how women need to gain independence in society; another said that she realized even she could do something to help despite being *"only"* a housewife; and a few spoke of wanting to educate their girl children and giving them better opportunities that they themselves had.

Male volunteers and their perceived gains from volunteering:

The motives of male volunteers were very different from that of females. The male volunteers we interviewed were often socially well-connected; and already inclined towards doing community work. They reported that association with SNEHA gave their work legitimacy and support (see quote box 1). For instance, one male volunteer reported that the Aahar frontline workers had connected him with BMC (Brihanmumbai Municipal Corporation); which helped him solve drainage issues. Most male volunteers reported working on improving water and sanitation conditions in their neighborhood; and using their status as SNEHA volunteers to do this work. One male volunteer had used his status as a volunteer to navigate through a public hospital when his grandchild was not well; another when his daughter-in-law had to deliver.

A few male volunteers reported joining Aahar because their families had been previously benefited by its work. One male volunteer spoke of how the program staff had helped his son, who was malnourished, gain treatment and become better. This personal experience made him want to help Aahar in its efforts. Most male volunteers felt that the Aahar program had been beneficial in the community; and hence, they wanted to help the organization.

Quote box 1: Volunteers' perspectives on what they gain from being volunteers

Female volunteers: Having an identity and an opportunity to be a part of something

"I like it a lot. First, I never used to go out, I wasn't so daring. Since I have joined (as a volunteer) I have become more "daring" (a brave person) and I can go out and talk to everyone now. Before I wasn't able to talk to everyone now I can. Before I used to be scared of talking to people… now I can talk to them freely" (Female, 35 years, secondary education, homemaker)

"Now everyone in the street knows me. Like how when a Film Star comes, people say- yes, listen to what they say, like that, people listen to me. So, I feel happy. I feel very proud. Sometime back, -they called me-and I spoke in the mike. You know, first time in my life, I spoke on the mike. My daughter also came to the function and she saw this. Before SNEHA, all I knew was cooking and cleaning and taking care of children. Now I feel all women should become independent. It is good to go out and know your own value. I want my daughter to study and work." Female, 30 years, secondary education, homemaker)

"The opportunity of talking to other people like listening to each other's good or bad experiences, it instils a lot of hope. And also, when we see other successful women, we get inspired to be like them. My child will also think that my mother is going

out and doing such good work, she will also be then get inspired to become a good person. I will be able to give them (my children) a good life." (Female, 28 years, secondary education, homemaker)

"So, it felt nice listening to them (SNEHA/Teacher). We felt that we can also do something. So, we will have to do something. Here, it is said for women that a woman cannot do any work. How can a woman not do? Woman can also do a lot. One, we focus mostly on our children. If we would have been little educated, then we could have also done something. I also feel that if I would have studied, I could have done more (Female, 36 years, primary education, homemaker)

Female volunteers: Volunteering as a way to channelize intentions towards social welfare

"I like to learn about children and how to take care of them. There are many women who come from the villages who don't know what to do at what time. I like how we go to everyone and tell everyone everything on what they should do. It makes me feel good. It feels good to tell people "This is how you should do this" and "This is how you should do that". Those who don't know will at least find out. (Female, 19 years, secondary education, unmarried, unemployed)

"With what happened with me, I think it should not happen with anyone else (This volunteer has memories of having a sick child and she did not have the information then or the means to know what to do at that time. So, she wanted to help others.) (Female, 38 years, not literate, homemaker)

"I feel good in these meetings whenever I hear other people. I feel that my problems are lesser than them. So, I feel good in these meetings. And I feel like helping them so that their burden decreases. I also feel hopeful that I can also stand on my feet. (Female, 28 years, secondary education, homemaker- a mother with a 3 year old, who is separated with her husband and on medication for depression. She acknowledged not doing too many volunteer activities)

Female volunteers: Volunteering as a means to gain knowledge for one's family

"After joining, I learned the good and bad things, and even problems at my house that my kids face; I knew how to treat it better. Be it asthma or low weight, I knew what to give them." Female, 35 years, secondary education, home-based work)

"(My family) say if she goes, she brings knowledge with her especially about how to cook (like this or that), not too cook vegetables for too long. They are happy because those educated ladies are giving knowledge and that is helping us only." (Female, 19 years, unmarried, secondary education, unemployed)

Male volunteers: Legitimacy for their actions pertaining to social welfare through Aahar

My son was weak so because of him I got to know about SNEHA. He belonged to the SAM category and they suggested us to take him to Chota Sion Hospital for treatment. Like this I came to know about their work and from the beginning I use to do social work. (Male, 33 years, secondary education, currently unemployed)

"For our men is that in the neighborhood if there is any problem, about gutter, cleanliness... We can handle any gent's problem. There is no need to take help from anyone outside. Our work gets done. I also have contacts in BMC (Bombay Municipal Corporation) so work gets done. The gents have recognized me. (Male, 42 years, primary education, employed)

"*That when I called sister (CO of Aahar) and asked what to do, what to do. It was 8 pm and they called immediately. So, I felt that there was benefit because of becoming (volunteer). I showed the sisters the card of SNEHA and slip too.* (*Male, 61 years, secondary education, employed)*

SECTION 4: IMPLEMENTATION FEATURES OF THE VOLUNTEER STRATEGY

Volunteer relationships with SNEHA: "*Since they are there, so we exist"*

The hypothesized volunteer strategy in Aahar conceives volunteers as representatives of the community who provide "self-help" and peer-counseling; as well as link the community to ICDS. SNEHA was intended as a background entity, playing a temporary role in enabling the work of volunteers and ICDS.

However, in the field we found that

- Volunteers perceived themselves as "SNEHA volunteers" rather than community representatives. Much of volunteers' identity was rooted in their strong relationship with SNEHA. This was, to some extent, because it was Aahar that recruited, constantly motivated and trained these volunteers (volunteers were not elected by the community and hence, not their representatives strictly). Many of the volunteers' perceived gains from the experience- elaborated in the previous section- were linked to their connect with Aahar.
- Volunteers had mostly tried to function as a loose, extension arm of SNEHA in the community-rather than as community representatives. Female volunteers believed that they had certain advantages over the Aahar frontline team in performing these roles since they could address emergencies round the clock (whereas Aahar workers left at 6 pm); could make the community listen to them since they were "one of them" and thus increase their participation in Aahar's activities. Volunteers were also perceived as informants for Aahar, giving staff access to local knowledge (who is new, who is pregnant, how are the dynamics in a particular family- and best ways to tackle these). Male volunteers had used their status as "SNEHA volunteers" to perform roles they believed to be essential for the social welfare of the community. All this showed that the roles volunteers performed were clearly linked to their perceptions of themselves as "SNEHA volunteers"

For the Aahar program, there was no choice except to inculcate this strong relationship with volunteers-for volunteers, alteast during initial stages, clearly needed a strong anchoring system. In the absence of monetary incentives, it was only the appreciation and public recognition given by Aahar staff -and the "sense of belonging" to the larger cause that Aahar stood for- that kept volunteers motivated. The program has not yet found an alternate anchoring mechanism.

Volunteers had been told emphatically and repeatedly by Aahar that the program was temporary, and it was up to the volunteers to carry out volunteering activities-such as dissemination of information and provision of help to the Anganwadi workers during weighing- post the program's exit. While some volunteers felt this was possible, many felt that they would need Aahar's training, support and their "*being there*" to continue these activities. They indicated wanting more knowledge through repeated trainings. Volunteers also felt that in the absence of Aahar they did not have anyone to go to, when they needed help and guidance. Given these issues, it is important to recognize that the very identity of volunteers gets taken away in the organization's absence.

Quote box 2: Aahar-volunteer relationship: Motivation, support and legitimacy provided by Aahar

"*If they (SNEHA) will not be here, I think we will become weak because when they give us information is when we share it with the people. Since we are illiterate, we will not be able to do anything on our own. But when they give us information is only when we can impart information to other people. If they will not be here, we will not be able to do anything. Since they are there, so we exist." (Female, 38 years, illiterate, homemaker)*

"It's a combination of both, there are certain things that I got to know from SNEHA and some I figured out myself. I think to handle or address such issues in the community one needs support. I was able to combine my own will to do things and SNEHA's support. When I share things, people ask me for proof and if I am supported by an organization like SNEHA, I can give them proof." (Female, 26 years, secondary education, homemaker)

"Yes, we will do it, even normally we do it if they are not there. We do it anyway, what is there in that? The knowledge we have will stay, it is not going anywhere" (Female, 35 years, secondary education, homemaker)

"I won't be able to do it alone. I can give example of education that if teacher teaches than only children will learn, similarly, we do not have experience to work independently" (Female, 37 years, secondary education, home-based work)

"I'm not fully ready. I want more help and training from SNEHA… like malaria, typhoid… every year there's a new sickness or disease, and however much information we can get, the more beneficial it is for us, and the more we can convey to others."(Female, 35 years, secondary education, home-based work)

"I like when they call upon all the volunteers and shower them with appreciation. The volunteers are awarded medals, I really like as I get a sense that we are working and are going around, so these people are also recognizing our efforts and appreciating it." (Female, 32 years, secondary education, homemaker)

"When I have personal problems and I want to share them with someone, they're always there to listen and help. Like if something happened to me and I tell you about it, I feel better and lighter. So, whatever happens, there is always someone to share if we have problems. They treat you like family, and a part of your home. Even if there are any programs like Khaana Khazana or anything, we like attending" (This volunteer's children do not stay with her, and she feels volunteering as a part of Aahar helps her belong) Female, 51 years, secondary education, home-based work)

"For social work, sometimes if the gutter in our locality gets overfilled/gets damaged, we take the complaint to BMC. I had given the complaint just yesterday in fact but till now there has been no response. SNEHA people only told how to give online complaint; I had given the complaint number too but till now..." (Male, 40 years, secondary education, Self-employed)

She asked me to come and see the meeting once. Then I came and listened. I felt very good. Lot of information is given here which we don't know about. Information is told about health, diseases, children and mothers. This is especially for mother and children. They tell a lot about that. When they told, I was interested. She then said that I can become a volunteer. I said okay. ((Male, 35 years, graduate, not employed presently)

Below, we highlight some of the more specific implementation features of the volunteer strategy in AAHAR.

4.1. Committed and persistent efforts made by staff to recruit volunteers – through the adoption of several flexible, iterative and innovative mechanisms of recruitment.

The large number of 698 volunteers put in place by Aahar can be thought of as an important achievement of the program- and has involved intensive effort in finding, persuading (not only the volunteers, but also their families), formally recruiting and handholding volunteers in their journey. The Aahar team had initially proposed to recruit a conservative number of 100 volunteers, but over two years, had been able to put in place a much larger number.

The recruitment of volunteers in Aahar was not "random". There were formal criteria set for recruitment such as: volunteers should be above 18 years; hold good reputations in the community; be socially inclined; have time for social work; have no criminal record; have local knowledge of the area; and possess good interpersonal skills. In addition to the initial criteria for selection, others were added- as the program progressed- staff did not choose people who were perceived to have potential political agendas; abused drugs or alcohol; or were perceived as mentally challenged to an extent that work would be difficult. The program tried to bring about diversity in the pool of volunteers by selecting them across age-groups, religion and migration status. Selecting people who could migrate out (and thus lead to a loss in the pool of volunteers) was a conscious decision taken by the program. It was felt that involving migrants in the program helped to address the needs of the large migrant community in urban informal settlements better.

During the course of the program, the frontline team found several innovative ways of seeking out volunteers for recruitment, some of which included (also see box 4)

- People with whom Aahar had worked with earlier; hence, these people were familiar with the program's activities and could be persuaded to get involved
- People who had prior contacts with Anganwadi teachers (because their children were studying there; or because the Anganwadi ran in their house and such)
- People whom SNEHA found to be enthusiastic about helping out in the community-during informal discussions/survey.
- People who were looking for jobs; but were not eligible for these or had not found formal work
- Spouses of volunteers/family members.
- Through existing volunteer networks

While the program had a formal recruitment process- that included doing background checks, filling a recruitment form and submitting proofs of identity/residence- these must be looked at only the last steps of recruitment. Recruitment of volunteers, in practice, was reported to be a long and iterative process-that involved much persuasion on the part of Aahar's frontline workers. It involved having informal interactions and participatory meetings with potential candidates wherein health-related information was shared (many female volunteers reported that they got persuaded to join since this information was of value to them); organizing several sets of meetings rather than asking for decisions after only one meeting (for frontline workers found that people were hesitant to join after just one meeting); and roping in the Anganwadi teacher who was already known to the community and taking her help in persuading people to be volunteers. In addition, as the program progressed, existing volunteer networks were used to persuade others to join in.[1]
In summary, recruitment of volunteers is an active, innovative and iterative process in Aahar. Program staff was proud of their success in recruiting a large number of volunteers- and acknowledge that they had not expected results of this scale in the beginning of the program.

4.2. Intensive efforts to cultivate a role identity for unpaid volunteers- through appreciation and motivation

Aahar has adopted the policy of "unpaid" volunteerism. The intention behind this policy was to filter out candidates who were looking for formal job opportunities- and remove financial incentives to joining as volunteers. It was reasoned that only a pool of volunteers not paid by the program would continue to work after the program's exit. Initially, even the frontline workers of SNEHA found it difficult to accept that people might join as volunteers without pay ("*everyone works when paid*" was the thinking among them). But as number of volunteers gradually increased, staff conceded that unpaid strategies could work- at least where recruitment was concerned.

To retain volunteers in the system -without pay- the Aahar program has perfected several approaches to motivation. Volunteers were appreciated for every baby step they took. They were given badges, encouraged to speak in public; and honored during events and meetings. Even if volunteers were unable to contribute (and could do no work other than attend events/meetings); they were never disparaged. Volunteer families were invited to

[1] Program staff also reported facing issues of volunteers dropping out due to different reasons; one analysis by staff of 191 drop-out volunteers showed that more than half of them dropped out due to migration; and others mainly due to time and other pressures (jobs, families, health issues). We interviewed two drop-out volunteers but could not get substantial inputs from them.

several events hosted by Aahar- and this was source of special pride to them. Even during training sessions, volunteers were appreciated for taking out time to attend these; and made to feel comfortable.

Thus, in the absence of economic incentives, appreciation was the key to retaining volunteers- and the Aahar program has made serious efforts towards this. However, in the absence of pay, the identity of volunteers was not linked to performance in any way (you were a volunteer-whether you performed or not). In addition, staff often said that it would not be right to hold volunteers accountable for the work they did or did not do since they were not "paid". Hence, Aahar could not hold volunteers accountable for not working.

4.3. Efforts made by Aahar to work around contextual constraints in program design and implementation

We discuss below how the Aahar program has tried to work around contextual constraints -posed by the social and family context of volunteers as well as the lack of alternative anchors to the program in the public sector. We first discuss how the program worked around constraints posed by patriarchal social contexts- with respect to both, female and male volunteers. Then, we discuss how migration and urban topographies affected volunteer activities. Further, we touch upon why the ICDS-volunteer link remained weak during the course of the program; and some of the implications of this weak linkage.

4.3.1. *Patriarchal families and working with volunteers:* Compromises made by Aahar

We found that the patriarchal social system that surrounds volunteers inhibits their functioning in several ways.

Within such systems, female volunteers often needed permissions from male members/elders in the family to join as a volunteer. They reported that their families often did not mind them being volunteers since the meetings and events they attended were perceived as beneficial to their own families (reinforcing women's role as being limited to serving their own households). Female volunteers were often not allowed to venture out of their lanes alone. They reported that they could only attend meetings and events if these were held close to their homes- and even to attend these, they needed permission from their families. They also reported being busy with several household responsibilities, that limited the time they had for other activities. Due to all these issues, female volunteers often restricted their work -such as disseminating information or calling children for anthropometry) to their immediate neighborhood (10-20 households).

Existing social norms did not only restrict female volunteers in terms of geography and time, but also influenced the type of work they endeavored to do. In Aahar, the limited work that volunteers did revolved around mobilization for anthropometry; and dissemination of information on mother's and child health- in their lanes. These activities can be considered as those that were within the accepted social boundaries for women and were non-controversial. Most female volunteers did not interfere in issues of domestic violence in the community; some referred such issues to SNEHA.[ii]

The activities of male volunteers were also bound by existing social norms. Male volunteers genuinely believed that they ought to be doing "*running around*" work (work that involved going to different public sector offices or coordinating with these; work that women were not supposed to do) and the "*work of gents*" such as issues related to improvement of sanitation, electricity and general slum development. They also felt they could help other males with their health issues. Male volunteers we encountered were only beginning to understand that they might have a potential role in improving maternal and child health in their community. Men felt that the information that Aahar gave them on women and child health would definitely be useful for their own families; and to some extent, they could talk about these issues to other men folk. But they did not believe they could advice women from other households- since they would encroach upon the responsibility of other men[iii]. However, male volunteers were comfortable helping women in the neighborhood during emergencies when the males in their own families were absent or sought their help. Some also reported spreading messages about immunization drives.

The above social norms that restricted the activities of female as well as male volunteers also restricted the program design. Aahar has to keep male and female volunteers as separate strategies within the same program since a program design that brought male and female volunteers together would have been much more difficult to implement (for it was hypothesized that less women would have been given permission to attend mixed-group meetings; and may not have spoken in front of male members). While this compromised any collective action that could be taken by male and female volunteers together- as well as peer-learning, the program did not venture into the complexities of attempting mixed gender volunteer groups.

In order to circumvent contextual challenges-and set up a large pool of volunteers in such a short program period, Aahar had to be flexible about expectations from volunteers and have a culturally-sensitive approach (see table 5). To get female volunteers to participate in the program and retain them, the Aahar team had no option but to give them a high degree of flexibility in their work, accept that their reach would be low-and put more efforts into increasing the numbers of volunteers for better coverage. To get male volunteers, Aahar had to rope them in using topics of their interest- and gradually begin messaging on women and child health. This messaging was only beginning to take roots at the time of this study. Also, to avoid a breach of existing social norms (which would have unquestionably increased the complexity of implementation) Aahar had kept the male and female volunteer strategy completely separate. This resulted in little opportunity for collective action; and currently, the volunteer community did not have much collective power to demand services or hold public sector services accountable.

Table 5: Sensitivity of the Aahar program to the cultural context in urban informal settlements

Contextual constraints	**Cultural sensitivity of the volunteer strategy: How Aahar has tried to work around limitations**
Women need permissions to become volunteers	The program has recognized this; hence, the program staff not only talk to the women to convince them on volunteering, but also to the men and elders in the family to convince them to let women participate. This included explaining to them about how volunteering would benefit the family.
Women can work only in their immediate neighborhood and have time constraints	Aahar moderates its expectations from women volunteers- by keeping their tasks flexible. The program also constantly motivates them even when they are unable to perform any of the activities. Initially, the program had decided to work with individual volunteers rather than community group- so as to, facilitate quick recruitment of a minimal volunteer pool, and quickly train a mass of people who could work close to their homes, even if these people could not belong to a group and attend meetings

	that were far off.
Men feel their work in maternal and child health is limited.	Aahar roped in male volunteers allowing them to pursue activities of their interest (what they feel as "activities of males". It had to gradually begin messaging on women and child health.
Gender norms do not allow men and women to mix	Male and female volunteer strategies have been designed and implemented separate from each other. There is some intention within the program to make stronger community groups that can take collective action.

In summary, the Aahar program has been careful not to challenge too many pre-existing gender and family norms through the volunteer strategy. The thinking is that- if it had done so, it may not have been able to cross the initial barriers to recruiting volunteers.

4.3.2. Constraints to program implementation posed by the urban context: Migration and urban topographies

The Aahar program was based in an urban context- that had a huge migrant population; there was seasonal migration, movement of people across settlements and movement within the settlements. In addition, there was migration from different parts of the country into the settlements- resulting in the co-existence of different religions, languages and sub-cultures.

This context had several implications on the volunteer strategy. For one, it meant that loss of volunteers from the pool was inevitable. Second, studies have shown that the presence of strong social networks and cohesive populations-that had lived together for years together- make the building of participatory networks easier. But this was not the case with Aahar. There were few strong preexisting social networks that the program could bank upon- and it was recognized that such networks had to be built from scratch. There was little unity among the volunteers; they often did not know of one another; and hence, mutual learning and support was lacking. Lastly, volunteers reported that the surrounding community (which belonged to a different caste or language) did not always treat the volunteer as "*one of them"*- or trust their motives implicitly. In such cases, it was only Aahar's support that gave volunteers legitimacy.

4.3.3. Weak ICDS-volunteer linkages- and workarounds in the Aahar program

The hypothesized model of Aahar is based on building a strong volunteer-ICDS relationship. ICDS frontline workers were to hand-hold volunteers and work with them to achieve better coverage of their services in the community. In addition, volunteers were to act as "community representatives", demand services that the community had a right to through ICDS and also help ICDS perform its roles.

However, we found that these proposed relationships between ICDS and volunteers have not yet taken roots.

Despite efforts made by Aahar, Anganwadi workers could not be a part of training sessions held for volunteers since these happened during times convenient to the community (including on Sundays for men); which were inconvenient for the Anganwadi worker (so staff reported only sporadic instances of self-motivated Anganwadi teachers-who had taken an interest in the volunteer's work- participating in these). In general, it has been reported by staff that Anganwadi teachers have participated in community events (but not taken leading roles) and there have been instances cited where they have motivated volunteers. Instances have also been cited where

volunteers have gone to Anganwadi workers with their problems- but they have been redirected to Aahar. We spoke to a very small sample of Anganwadi workers in this evaluation- but these discussions revealed that they thought of volunteers mainly as "*SNEHA volunteers*" and were not always clear about the roles that volunteers were expected to play. From conversations with Anganwadi workers, it felt like they expected volunteers to put more concerted efforts into assisting them in their work, especially in the completion of anthropometry and mobilization for camps. In the absence of this assistance, they did not find much meaning in the volunteer strategy. Over all, program staff felt that ICDS was *"not yet ready"* to anchor volunteers or constantly motivate them, though some progress was being made in this direction.

Conversations with volunteers revealed that they did support ICDS in limited ways. Some volunteers-especially those who were recruited through links with Anganwadi, knew of its activities well, and had good relationships with the workers there. Some volunteers helped in mobilizing the community during anthropometry; and there have been instances reported of volunteers helping out in the weighing process. However, in this role of volunteers, there were two limitations- one, volunteers had low reach- and could mobilize people only in their immediate neighborhood (and usually when informed by Aahar to do so). Second, there was a deep-seated suspicion about public services being of poor quality- and many recent experiences (like finding stones or worms in the THR) had served to reinforce these perceptions. Hence, volunteers themselves sometimes hesitated to use ICDS rations- or convince others about these. Overall, we found that the kind of open and friendly relationships that volunteers shared with Aahar frontline staff was often missing in volunteer-ICDS interactions.

Volunteers were also meant to *"demand"* services from ICDS on behalf of the community. But they did not have the power to put pressure on ICDS. We encountered a few anecdotes where community volunteers had requested the Anganwadi workers to open the center on time (in an attempt to reduce worker absenteeism). But we felt that it was Aahar's very presence- and its relationships with ICDS supervisors- that posed bit of a threat to Anganwadi workers (Individual volunteer demands were not consequential).

In summary, it was challenging for the Aahar program to strengthen the volunteer-ICDS link. To anchor the volunteer strategy, Aahar had no option but to emerge as the main recruiter, trainer and motivator of volunteers.

4.4 **Routine training and handholding**

Training and handholding volunteers was an important feature of Aahar's volunteer strategy. From Oct 2017-March 2019, 115 trainings for female volunteers and 85 trainings for male volunteers have been held. During the initial phase of volunteer development, topics for the trainings were suggested by Aahar. As the program progressed, participants have also voiced requests for training on particular topics. We found that if the topics were beyond Aahar's area of expertise, and yet, linked in health and nutrition- even loosely- the program had brought in external expertise and tried to address the needs of the community.

Observation of the trainings revealed that

- The sessions were participatory, with questions being raised intermittently- though there were instances when trainers could not answer some of these.
- Efforts to make the session interesting were made by trainers. Trainers often used chits, messages on colored paper and other visual aids to assist them. Trainers tried to give examples from day-to-day lives

of people- during the sessions; and also provided practical information (like location of a hospital, phone numbers) to participants.

- Efforts were taken by the trainers to bring out conflicting opinions as well as existing myths in the community about a topic and resolve these.
- Trainers took efforts not to make the volunteers feel ignorant or ashamed while providing new information. (for instance, during one of the male volunteers' trainings directed at changing men's attitude towards maternal health, the trainer said *"I used to also think exactly like this- I used to think that my mother and father know everything about childbirth, and such- so they will take care of my wife. But we have to understand, my friends, girls come and live here for their husbands. They come here for us. We are more educated and have more sources of knowledge than our parents- so we must also take part in taking care of our wives")*
- The key messages of the sessions were repeated several times.

Trainers did face challenges in handling group dynamics- for volunteers came from different castes and religions- and had different beliefs. They also struggled with time-management- for they had to balance delivering the content of the session with participant concerns. Trainers with more experience handled the above issues better. Training sessions happened in public community spaces (like the Anganwadi/ Temples/Madrassa) close to the community.

Volunteers reported that the training sessions gave them knowledge and they often looked forward to attending these. Reasons for not attending were usually related to time and other work. Volunteers wanted sessions to begin and end on time and happen close to their houses. In summary, training for volunteers in Aahar was routinely done, using culturally appropriate materials and in local language; and was perceived as very useful by volunteers.

Quote box 4: Implementation features of the volunteer strategy

4.1. *Innovative recruitment of volunteers*

"When we were doing the survey for the first time in the community in the different lanes, the women who were taking the initiative to share information about different households…we caught hold of them (all laugh). We think- this woman is of use to us, since women don't generally talk." (Frontline worker of Aahar, Wadala 1 FGD 1)

"We got help from the teachers when we asked them if there were any ladies in their Anganwadi area, who speak nicely to everyone, with kindness, and those who wish to get information, and wish to give it to others" (Frontline worker of Aahar, Wadala 2, FGD 2)

"We had to identify what person had what skills. The person who shows some skill, we take that person. Then, there are always people in the slum who know about it- for example, there is a mother's survey group; from there, we chose 1-2 volunteers. Sometimes one person- example (name of a person)- if she says so, then 10 persons will turn up. We have to identify then-through meetings and home visits." (Frontline worker of Aahar, Beat 10, FGD 3)

4.2. Appreciation by SNEHA in lieu of payment

We cleared it at that time itself that we are not going to be paying anything; if you still want to stay you can stay... because this is not SNEHA's policy to pay in order to do something. So, we actually saw that change. So the confidence that we did not have in our community or the assumption that they won't do anything - turned out to be opposite. Sometimes we also feel surprised that they have really done so much; even now in the CO's meeting that happened, they also told us that they did not believe that they would be able to do this. (Senior Staff of the Aahar program # 3)

For example, their confidence level has increased. They speak on different issues with a lot of confidence. We have just given them a badge, of 'swayamsevaks'. Now the voluntary association forum that happened, they felt very good. They felt they have gotten an identity for themselves, which no one in their family recognized. "In the family, in the slum, we don't have an identity but because of SNEHA, we got one." (Senior Staff of the Aahar program # 2)

4.3 Working around contextual constraints

"Everyone's way of working is different. Some volunteers (women) cannot go beyond their GALLI. She may work with 10-12 houses in her GALLI and will not go to other places. BASTI is big one. Three- four volunteers are limited to their GALLIs only. In some of the meetings we introduce volunteers, but women say they could not reach to them. We have told volunteers to give time as per their convenience. We asked them only how much houses you can cover. If she takes 10-12 houses…. we give responsibility of those houses. We cannot force them that you have to cover this GALLI or something like that. Some people do not know volunteers. (Frontline worker of Aahar, Beat 5 and 6, FGD 4)

"And now also, we have male and females no, they don't work together. They do their work separately. Because we know if something goes wrong (laughs), what will the reaction be. So we have avoided it. So.... The males know how many females are there, where all they work; the females are also given an idea. (Senior Staff of the Aahar program # 2)

The Sevika (Anganwadi worker) comes at 11 and leaves by 1 or 1.30. If volunteers used to tell us take training at 2, then we have to take it at that time. But the sevika won't be able to be there at 2 (Frontline worker of Aahar, Beat 5 and 6, FGD 4)

One year was needed for making the sevika adjust working with us, and then only we started looking for volunteers. To make them want to join us takes time, right? No one was joining us readily. So somehow that one year went by. But now they have started helping us, not much but atleast a little in weighing and in events, these two things(Frontline worker of Aahar, Beat 10, FGD 3)

SECTION 5: CONCEPTUAL SUMMARY OF THE CURRENT WORKING OF THE VOLUNTEER STRATEGY

In the hypothesized model of Aahar (Figure 1 in Section 1 of the report), the program was intended to work in the background. Aahar was to act as a recruiter and hand-holder of volunteers; and also work with ICDS to motivate and support frontline workers. Volunteers were intended to be representatives of the community who would 1) improve the community's capacity for self-help by counselling community members and raising awareness about ICDS services in the community 2) support ICDS to deliver services and 3) serve as a social accountability mechanism for ICDS- and influence these services to perform better. The volunteer-ICDS linkages were intended to sustain even after the program's exit. Thus, Aahar's role in the new model was hypothesized as a temporary motivating and linking agent.

In this section, we present the field--level working of the volunteer strategy, constructed from programmatic experiences shared by different stakeholders.

Our study showed that the Aahar program has made a genuine attempt to remain in the background, and to work through ICDS and volunteers to bring about change- as intended in the hypothesized model. However, given several contextual limitations, the program has been unable to anchor the volunteer strategy to ICDS or build collective capacity within the volunteer program to self-sustain without external support. Hence, Aahar has

remained the key agent for training, motivating and supporting volunteers. Some of the key implementation features of the program include innovative recruitment strategies; a culturally-sensitive program design that separates males and females and accepts their work limitations; and regular training sessions perceived as useful by volunteers. In the previous section of the report, we have described in detail implementation features of the program- as well as the contextual constraints it faced.

Given the above program features and constraints posed by the context, what were the mechanisms through which the volunteer strategy has worked? In our data, we encountered three possible mechanisms.

Mechanism 1: Improved capacity in the community for self-help via a. confidence building of women/new identities b. Knowledge and skills applied to individual families and c. Knowledge and skills applied to the neighbourhood

In the hypothesized model of Aahar, volunteers were intended to improve community's capacity for self-help by counseling community members and raising awareness about ICDS services in the community. However, in practice, we found that female volunteers had several restrictions that limited their time and geographical reach. Hence, their counseling of other community members remained low key. Male volunteers did not believe they could advice women from other households; but said that they could talk about these issues to other men folk and reported helping men from other households with regard to their health issues-to limited extents. Due to these factors, the originally hypothesized mechanism of working -intended to improve community capacity for self-help was not strongly observed in the field.

However, the volunteer strategy can be thought of as contributing to the self-help capacity of the community in the following ways

1) Both male and female volunteers reported that the trainings they received were directly useful in their own family contexts
2) In case of female volunteers, being a volunteer was transformational - for it had given them confidence and an identity beyond their households. Female volunteers had felt safe to test their new identities during SNEHA forums. Male volunteers too were beginning to subvert existing gender norms and slowly coming forward to talk about women and child health issues.
3) In addition to counselling and dissemination, volunteers also reported providing emotional support to other women in their lanes- but here too, the female volunteers reach was restricted

Hence, while the hypothesized mechanism of self-help was weakly observed and did not pan out as intended, it did have some interesting spin-offs.

Mechanism 2: Working together with public services

In the hypothesized model of Aahar, volunteers were to support ICDS to deliver services as well as serve as a social accountability mechanism for ICDS- and influence these services to perform better. They were also supposed to refer women and children to public health services for immunization, ANC check ups and treatment of ailments.

We found that volunteers did not have the capacity to negotiate with ICDS and demand services; and these was little evidence of the existence of a social accountability mechanism through the volunteer strategy in the field.

However, the presence of Aahar and the connections the program had with ICDS supervisors- whom the Anganwadi workers report to- appeared to serve as a temporary supervisory mechanism.

We also found that female volunteers did support ICDS to limited extents- especially during the monthly Anthropometry sessions. Some volunteers reported helping out is the distribution of ration. A few female volunteers also reported doing referrals. However, as mentioned previously, the reach of these women was limited. Their activities were restricted to their immediate neighbourhood only.

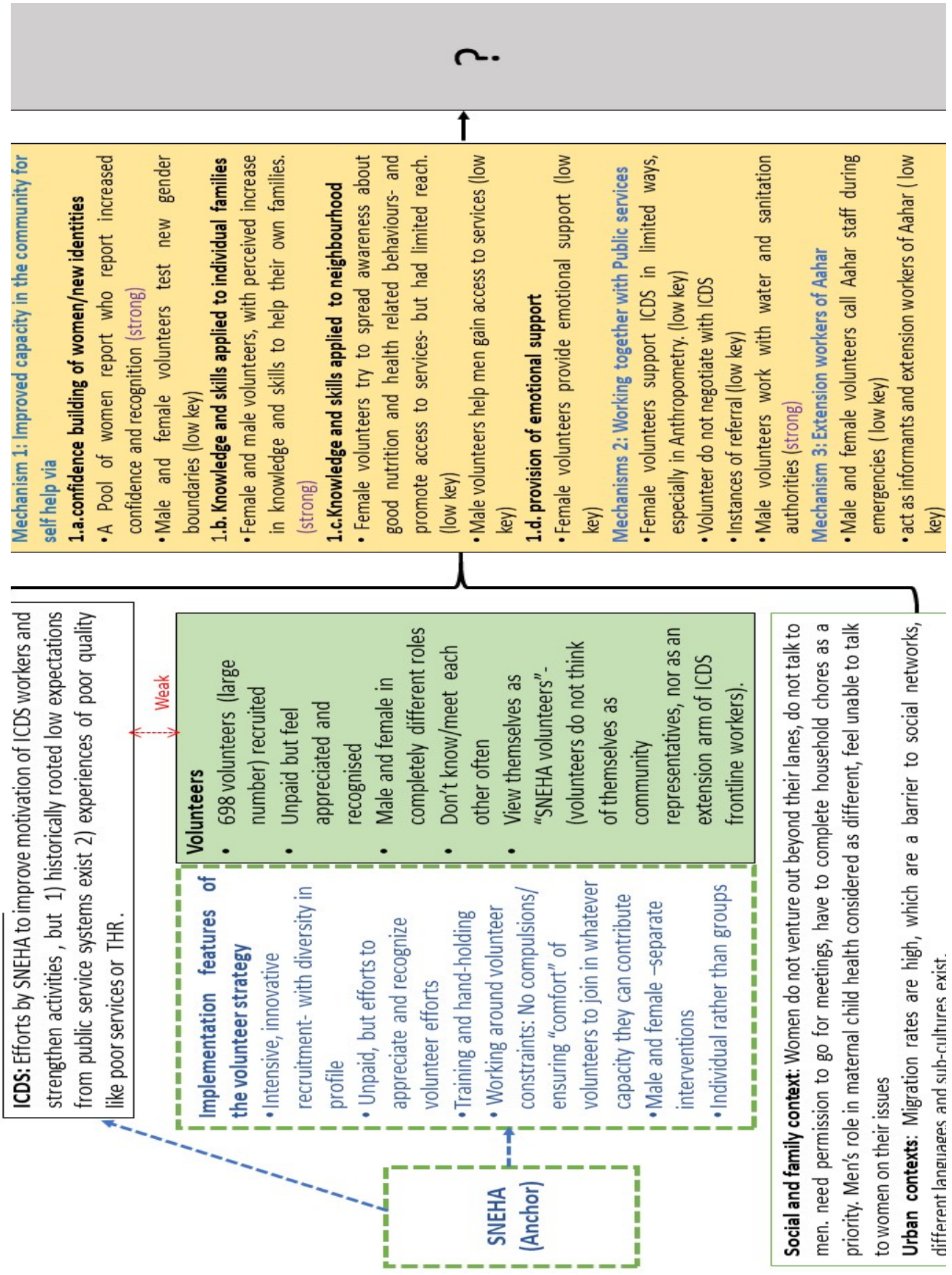
While a few male volunteers (especially those whose families had benefited from the Aahar program) helped during anthropometry, in general, this group did not involve themselves much with the activities of ICDS. However, male volunteers reported to work with other public services on issues related to improvement of sanitation, electricity and general slum development. Thus, one can say that the hypothesized mechanism of working with public services was weakly observed in the field.

Mechanism 3: Extension workers of Aahar

We found that volunteers were very closely linked to the Aahar program and were inclined to serve as an extension arm of the program. They have been a credible source of information about field-level happening to the program; and have also connected Aahar staff to the community during emergencies. While these mechanisms may not be sustainable post the program's exit, they have helped prevent mishaps in the community.

It is important to ask as to how the above mechanisms connect to maternal and child health outcomes in the community. An examination of the different program mechanisms reveals that many of these were low-key in the field. The main differences the program seems to have made is in the volunteers themselves and their families. This achievement must not be looked at as "small" - and in fact, seems realistic, considering that the program was a first-attempt, and has worked only for two years. We must, however, consider the possibility that maternal and child health outcomes achieved in the program area have stronger explanations elsewhere.

Figure 2: A conceptual summary of the workings of the volunteer strategy in Aahar.



The immense potential of community participation processes to contribute to maternal and child health outcomes has been recognized widely (Prost et al. 2013; Marston et al. 2013, Rosato et al. 2008). But, despite the appeal that community participation principles hold, experiences from other Indian contexts have shown that translating these to practice is not a straightforward task (Scott et al 2018; Feruglio et al. 2018). There is clearly a need for robust evaluations that document "real world" experiences of implementing such participatory strategies. In this study, we summarize some of the programmatic experiences of Aahar in attempting to set up a community volunteer strategy in two urban informal settlements in Mumbai.

The idea behind the community volunteer strategy in Aahar was to strengthen the community's role in addressing maternal and child health and nutrition issues in these informal settlements. Volunteers were conceptualized as unpaid community members, willing to serve the community. They were expected to 1) act as peer-educators and counsellors in the community; and hence increase its capacity for self-help 2) support public services such as ICDS to perform tasks and 3) demand services that the community was entitled to from the ICDS on its behalf. It was intended that Aahar would act as a temporary anchor for community volunteers, recruiting, training and handholding them- until the linkages between ICDS and the volunteers were strengthened. It was envisioned that building ICDS-volunteer linkages would ensure the continuity of health and nutrition related activities- such as screening for malnutrition, referrals, mobilization for immunization and such- even after the exit of the Aahar.

How did this idea translate in the field? As of February 2019, 698 volunteers (527 females and 171 males) have been recruited by Aahar. Persistent efforts have been made by Aahar's staff to recruit volunteers- through repeated discussions with potential volunteers (even their families at times), and constant assurances of work flexibility. In the absence of economic incentives, Aahar staff have worked very hard to keep volunteers motivated through public appreciation. Efforts have also been made consciously to recruit volunteers from diverse backgrounds- migrants, non-migrants and different religions/castes. Trainings have been conducted once a month, close to volunteer homes and usually host small groups of volunteers (around 10-15 volunteers per session). Volunteers reported that these trainings were useful to them in gaining knowledge and skills. The volunteer strategy in Aahar has been designed with cultural sensitivity and thus 1) keeps the male and female volunteers strategy separate in a patriarchal social context where it would have been challenging to work across genders 2) moderates expectations from volunteers and ensures they can work at a pace convenient to them 3) provides flexibility to volunteers to work on activities based on their interests, time and strengths and 4) appreciates all volunteer efforts and disregards inadequacies. In summary, staff persistence, innovative recruitment strategies, a culturally-sensitive program design and the perceived usefulness of Aahar's training sessions have resulted in a large pool of volunteers- whose numbers have exceeded all staff expectations!

But this pool of volunteers has not been able to function as hypothesized in the original Aahar model. For one, the program has been set in a difficult urban social context- where migration rates are high and social networks are not as strong as rural ones; posing challenges to prolonged community-engagement, peer-learning and potential collective action. In addition, prevalent gender roles and identities hinder women from working outside their immediate neighbourhoods; these also prevent men from participating in what were considered as issues in the *"women's"* domain. In order to set up a large pool of volunteers in the short program period, Aahar had to circumvent these contextual issues; and it did so by compromising on certain aspects of the volunteer strategy (even while knowing that these concessions could affect coverage/quality). To get female volunteers to participate in the program and retain them, the Aahar team had to give them a high degree of flexibility in their work and

discount non-contributors. The social context also limited the scope of practice of female volunteers, in terms of both, the type of activities they could do and the time they could devote to volunteering. In many months, the only activity that female volunteers had been able to do was attend meetings/events organized by SNEHA and to more limited extents, mobilize people in their immediate vicinity during weighing sessions. Female volunteers reported working about an hour a week (this time included that of attending meetings/events) and within the confines of their immediate neighborhood (10-15 houses in their vicinity). Since female volunteers rarely left their immediate neighbourhood, there was little peer learning or support. Male volunteers reported to work mainly on water and sanitation issues-by coordinating with the public sector department responsible for these issues. There has been little opportunity for collective action among volunteers. Thus, volunteers did not have the collective power to demand services from ICDS or enforce accountability. In addition, despite Aahar's intensive efforts at motivating ICDS frontline workers, the links between ICDS and volunteers remained weak. Aahar remained the main anchor and champion of volunteers through the course of the program.

The endline survey results also validate these qualitative findings. The participation of volunteers in mobilization for weighing, telling women to register for Ante Natal Care, in referring sick children and in calling people for meetings has been very less (see Appendix for process indicators).

One big achievement of Aahar's volunteer strategy has been in setting up a team of volunteers in the community, who reported improvement in their technical knowledge on health and nutrition. These volunteers also reported using this knowledge and skills to improve the lives of their families. Being a volunteer has been transformational for many women- for it has given them an identity beyond their households. Women who had rarely stepped out of their houses reported to have gained confidence -during the course of the program-to speak in public forums. Women have revelled in the public acknowledgement of their efforts as volunteers. In their relationship with SNEHA, one can see that female volunteers have felt safe to test their new identities as *"empowered"* women (by participating in discussions, arguments, by sharing new recipes and such); and are beginning to think about issues beyond their household. The empowerment of volunteers and changes in their attitudes/behaviour- as a spin-off result of community volunteer programs has been seen in other contexts as well (Davis et al. 2013). Male volunteers too were beginning to subvert existing gender norms and coming forward gradually to talk about women and child health. These were not easy achievements for the program. Thus, the volunteer strategy in Aahar can be thought of as a beginning of a transformative process in the community.

A relook at the volunteer strategy in Aahar: The volunteer strategy was a pioneering attempt by Aahar; and hence, has been rich in terms of learnings. Some of these learnings are presented below.

The need to expand coverage: Each Anganwadi is reported to have around 300 households and about 3-4 volunteers who could take responsibility only for 10-15 households each. Hence even with the large number of volunteers that Aahar had recruited, it was not possible to reach the entire community. Other studies have indicated that having one volunteer serving 10-20 households was ideal- and numbers higher than these were stressful for volunteers (Perry et al. 2005). Thus, we need to find alternate ways of improving coverage.

The need to develop better community engagement: One of the intended roles of volunteers was to engage with the rest of the community and serve as peer-educators. However, volunteers were able to perform this role only in a limited way. Most female volunteers reported to work about 1-2 hours in a week and only in their

immediate neighbourhood. Male volunteers reported even lesser time commitments to community engagement; and had few direct interactions with women. Our discussion with the community showed that many households did not know about the existence of volunteers and the endline survey confirms this. While there are no standards on what the optimum numbers of volunteers and their reach should be, one successful community volunteer program (unpaid, but through volunteer groups) against childhood malnutrition in Mozambique reported that their mothers had 90-94% contact with volunteers at different points of time in the program (Davis et al 2013). These volunteers spent 3-4 hours per week, worked only with 10-15 households in their neighbourhood, so that their workloads were not high; and spent around 3.3 hours per month with each beneficiary mother from these households. In another study in Burundi, volunteers did home visits to 10-12 households (at least one visit in a month)- and 87-94% of the households reported a visit from volunteers (Weiss 2015). Given what other successful international experiences show, we need to find ways to increase community-volunteer interactions. We also need to set up some informal community accountability mechanisms for the tasks that volunteers are given to perform.

Alternate ways of volunteer recruitment: It might be important to involve the community in recruitment of volunteers (for example- 3-4 lanes in a settlement can choose one representative). One study of a program in Mozambique against childhood malnutrition, where 44% of volunteers were recruited by the community; and 55% by a promotor/leader (akin to our COs), found that volunteers who were recruited by the community were 2.7 times more likely to serve for the entire period of time (Davis et al. 2013). One explanation given for this was that the community tried to choose women who were the "hub" in their social network as volunteers- and hence community-recruited volunteers became better community representatives.

Opportunities for peer-learning, support and collective action: We found few activities in the volunteer strategy that involved peer-learning from each other; and less opportunities for volunteers to mutually support each other. It has been shown that peer-support motivates volunteers as well as promotes learning (Perry et al. 2015). Aahar staff has reported that it was challenging for individuals to take action or demand services; and that volunteer groups would have more collective power.

Paid versus unpaid: Aahar has currently adopted an unpaid community health volunteer model. There has been much debate in literature on paid versus unpaid models. Paid models of volunteers were often not sustainable after program exit. Unpaid volunteer models had issues of accountability enforcement, ethical considerations (some groups believe that asking already overburdened women who work unpaid at home to do the same for their community also is unfair) (Maes 2012, Vareilles et al 2017, Tomlinson et al 2017). These debates have to be noted- and we need to think about different ways to incentivize volunteers, even if we cannot give financial incentives.

ICDS as an anchor: Despite efforts at involving the Anganwadi worker in the recruitment and training of volunteers, and despite Aahar's intensive efforts at motivating Anganwadi workers, volunteers did not have a strong relationship with ICDS. For one, there was a historically rooted suspicion of ICDS- confirmed by recurrent instances of getting poor quality ration from them. In addition, the timings of Anganwadi workers have limited their involvement with volunteers. Interactions between the Anganwadi worker and volunteers were limited to weighing sessions- so much so, that Anganwadi workers have started viewing the volunteers as intended mainly for "helping" them during the weighing process- and have far too many expectations of support in this regard from

volunteers[2]. The role of volunteers needs to be clarified to Anganwadi workers so that these workers have more realistic expectations from volunteers. We also need to re-assess the field-level practicalities of forging Anganwadi-Volunteer links, in the absence of supervisory mechanisms and higher-level commitment of ICDS.

On male volunteers: The male volunteer strategy in Aahar offers important lessons. The original intentions of the program behind having a male volunteer cadre was rooted in the idea that men took many important decisions - such as on anthropometry of their children, immunization, and place of delivery. The role of male volunteers was intended to be limited (for staff perceived men as "busy") to persuading reluctant cases, spreading some information on women and child health and helping out during emergencies. In the field, staff found it difficult to launch the male volunteer program- since meetings and trainings had to happen on holidays; and getting men to participate on what was perceived as issues in the women's domain was difficult. Staff had to conduct activities for males and females separately- even in the same neighborhood. In addition, male volunteers believed that they ought to be doing "*running around*" work (work that involved going to different public sector offices or coordinating with these; work that women were not supposed to do) and the "*work of gents*" such as issues related to improvement of sanitation, electricity and general slum development. They also felt they could help other males with their health issues. The male volunteers we encountered were just beginning to understand that they might have a potential role in improving maternal and child health in their community. There were instances of male volunteers helping women during emergencies, engaging in male-to-male chats on maternal and child health topics; and persuading families to weigh their children. But, in general, direct contributions of male volunteers to women and child health interventions-especially those measured in the program- were limited. Give these issues, we need to clarify what can be practically expected from male volunteers' and how programs can use their strengths. We might also want to use different indicators for evaluating their roles[iv].

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A note on sustainability of efforts: Currently, the Aahar program has been the main anchor for the volunteer strategy- and the main champion and motivators for volunteers. Volunteers perceive themselves as losing much of their identity and legitimacy for action- if and when support from SNEHA is withdrawn. Though they report that they would try and continue some of the activities, volunteers anchored to SNEHA do not feel confident of their ability to work after it exits. This attachment of community volunteers to Aahar is not unique- the strong role of NGOs in bringing about volunteer action in similar projects has been documented (Bhiri et al 2014, George et al 2018); and community participation processes tend to lose focus in the absence of strong anchors. Anganwadi workers could have been alternate anchors, but the study has shown that ICDS- volunteer linkages have remained weak despite much effort put in by Aahar. The program might want to think about how to anchor volunteers to ICDS better; or in lieu of ICDS, find some alternate mechanisms of anchoring the program. In addition, we found that many volunteers worked because they found the knowledge imparted by Aahar to have direct relevance to their family situations (women with young children who wanted to learn feeding practices). These women may not stay in the volunteer pool after exit of Aahar. This, along with migration, calls for recurrent efforts to set up volunteers, train and motivate them. Long term NGO-Public sector partnerships may be one way forward for sustainable action.

[2] This misinterpretation of the volunteer role could be because Aahar staff reported that they often tell the Anganwadi worker that volunteers are being set up for their benefit; and will be the ones helping them after SNEHA exits. Such a rationale is presented to the Anganwadi worker- so as to motivate them and participate In volunteer events, and to prevent Anganwadi workers from seeing volunteers in a negative role.

Conclusions: There has been much evidence in global circles that community participation contributes to improved maternal and child health outcomes. However, programmatic experiences and challenges in bringing about such participation in difficult contexts are less captured in studies. This study adds to literature on this topic.
It must be noted that many of the limitations of the volunteer strategy pointed out in this study are rooted in contextual constraints- such as migration, prevalent gender norms and practices, time constraints of volunteers in a busy urban lifestyle, lack of social networks, and historically poor functioning of health systems. The Aahar program has attempted to address some of these constraints-for example, it has tried to change people's views on services, and has begun to break some of the gender boundaries by bringing men into the program and getting women out of their houses. But mostly, in a short 3-year time, the program had to make a choice of working around contextual constraints rather than attempt to address these at scale.

It is a very important point for those reading this report to note that many of the limitations of the volunteer strategy were not due to lack of program effort- for the extensive efforts of the program were visible in the field. The constrained scope of practice by volunteers was mostly a contextual limitation- and the program's attempt to design a strategy around the contextual constraints that exist. Paradoxically, it is these difficult contexts that really need participatory interventions! Any genuine attempt to try and transform hierarchical structures, social orders and realign relationships between the system and community- is bound to be extremely challenging- and likely to need tenacious higher-level advocacy efforts and funding periods longer that 3-4 years. Looking at the volunteer strategy from this angle, one can conclude that is has been a big journey for the community volunteers and a courageous undertaking by Aahar- that deserves appreciation.

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APPENDIX 1: ENDLINE QUANITATIVE DATA FROM THE EVALUATION TEAM

1. Weighing process indicators

Who asked you to get your child weighed (N=1558)- Total sample	n	%	Wadala (N=697)		Dharavi (N=891)	
Aw Worker	496	32%	194	28%	302	35%
Aw Helper	293	19%	121	17%	172	20%
(AW Worker+CO)	397	25%	176	25%	221	26%
CHV	3	-	1	-	2	-
Family	21	1%	12	2%	9	1%
Self	115	7%	53	8%	62	7%
Neighbour	7	-	4	-	3	-
CO	223	14%	121	17%	102	12%
Volunteer	10	-	4	-	6	-
Other Person	24	-	14	2%	10	1%

Respondents who received service		
Who asked you to get your child weighed (N=1456)-	n	%
Aw Worker	496	40%
Aw Helper	293	24%
(AW Worker+CO)	397	32%
CHV	3	-
Family	21	2%
Self	115	9%
Neighbour	7	-
CO	223	18%
Volunteer	10	-
Other Person	24	2%

2. Home visits process indicators

Who visited you when you were pregnant with child aged 0-2 years (N=1558)	n	%	Wadala (N=697)		Dharavi (N=891)	
Aw Worker	238	15%	83	12%	155	18%
Aw Helper	11	-	7	1%	4	0%
(AW Worker+CO)	592	38%	248	36%	344	40%
CHV	159	10%	62	9%	97	11%
Sneha Co	82	-	33	5%	49	6%
Volunteer	4	-	1	0%	3	0%
No one	633	41%	339	49%	324	38%

This question was asked to all respondents

3. Antenatal care process indicators

Who advised to get registered for ANC(N=1558)	n	%	Wadala (N=697)		Dharavi (N=891)	
Aw Worker	112	**7%**	40	6%	72	8%
Aw Helper	2	**-**	2	0%	0	0%
(AW Worker+CO)	107	**7%**	36	5%	71	8%
CHV	37	**2%**	13	2%	24	3%
Doctor	27	**-**	11	2%	16	2%
Sneha Co	10	**-**	2	0%	8	1%
Realtives	770	**49%**	348	50%	422	49%
Self	900	**58%**	422	61%	478	56%
Dai	2	**-**	0	0%	2	0%
Volunteer	5	**-**	1	0%	4	0%
Others	2	**-**	0	0%	2	0%

Respondents who received service		
Who advised to get registered for ANC(N=1508)	n	**%**
Aw Worker	112	**7%**
Aw Helper	2	**-**
(AW Worker+CO)	107	**7%**
CHV	37	**2%**
Doctor	27	**-**
Sneha Co	10	**-**
Realtives	770	**51%**
Self	900	**60%**
Dai	2	**-**
Volunteer	5	**-**
Others	2	**-**

4. Child referral process indicators

Child referral(N=201)	n	%	Wadala(N=75)		Dharavi(N=126)	
Aw Worker	81	40	27	36%	54	43%
Aw Helper	7	3	4	5%	3	2%
(AW Worker+CO)	37	18	12	16%	25	20%
CHV	35	17	10	13%	25	20%
Family	0	0	0	0%	0	0%
Self	1	1	0	0%	1	1%
Neighbour	0	0	0	0%	0	0%

CO	36	18	19	25%	17	13%
Volunteer	3	1	3	4%	0	0%
Other Person	1	1	0	0%	1	1%
* N represent total no of responses made by mothers of the child who were referred						

5. Group meeting process indicators

Who asked you to attend group meetings(N=1558)	n	**%**	Wadala (N=697)		Dharavi (N=891)	
Aw Worker	216	14%	73	10%	143	17%
Aw Helper	67	4%	20	3%	47	5%
(AW Worker+CO)	163	10%	60	9%	103	12%
CHV	2	-	0	0%	2	0%
Family	2	-	2	0%	0	0%
Self	3	-	1	0%	2	0%
Neighbour	0	-	0	0%	0	0%
CO	201	13%	103	15%	98	11%
Volunteer	9	-	3	0%	6	1%
Other Person	0	-	0	0%	0	0%

Respondents who received service		
Who asked you to attend group meetings (N=321)	n	%
Aw Worker	116	36%
Aw Helper	36	11%
(AW Worker+ CO)	104	32%
CHV	1	-
Family	0	-
Self	3	-
Neighbour	0	-
CO	87	27%
Volunteer	7	-
Other Person	1	-

[i] Aahar Proposal Draft 2015

[ii] One volunteer reported an instance where she had stopped a man from beating his wife with a water-pipe; this case was interesting since the volunteer managed to stop the husband, but once he left the scene, she reported asking his wife "*why do you do such things that you get beaten up*" and that emphasized that the wife should "*not do anything according to her wishes*" and listen to her husband, in order to avoid getting beaten up again.

[iii] Interestingly Male COs did not seem to have this problem, since they were seen as external people doing their work.

[iv] Villa-Torres et al 2015 talk of challenges in engaging men. Men were not used to doing "unpaid" work- unlike women, men felt their job was to earn, not do free service. they felt women had more free time, had natural ability to talk to others, and could talk

to other women in the community. The same program also did the process evaluation. It talks about how men liked to work in more "holistic" areas of health- like housing, assistance to crime victims and criminal law-very similar to what we found in our study. Reference: Villa-Torres L, Fleming PJ, Barrington C. Engaging men as promotores de salud: perceptions of community health workers among Latino men in North Carolina. *J Community Health*. 2015;40(1):167–174.