# Chapter 12
# Sustainable Community-Based Health and Development Programs in Rural India

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## 12.1 Background

The 'Khoj' project is an initiative of Voluntary Health Association of India (VHAI), to bring about a holistic change in the lives of its beneficiaries by uplifting the socio-economic and health status of vulnerable communities. The Khoj project operates in the remote parts of the country and equitably involves the community members, organizational representatives, and other local bodies in all aspects of the project activities (see Table 12.1). The partners contribute unique strengths and shared responsibilities to enhance the health and development of the population. One of its objectives is to build on the inherent capacities of the community and create an enabling environment by incorporating the interrelated components of participation, networking and action. Khoj is based on the premise of developing healthy alliances with the community and creating conditions that allow people to improve their health and quality of life with a broad view of health encompassing social and environmental factors. Fundamental to the Khoj program's approach has been identifying important stakeholders for all health promotion initiatives and community involvement in each place and building on their strengths.

## 12.2 Introduction

Reaching out to the unreached is a global challenge and of a larger concern in India with one third of its population, constituting 250–300 million, living in remote, difficult and vulnerable areas and whose basic needs are not fulfilled. Despite

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**Table 12.1** Statistical profile of some of the Khoj Projects – Health Indicators

| | IMR (per 1000 live births) | | No. of maternal deaths | | % of women receiving complete ANC | | % of deliveries conducted by TBA | | Immunization coverage | |
|---|---|---|---|---|---|---|---|---|---|---|
| PROJECT | 2000 | 2006 | 2000 | 2006 | 2000 | 2006 | 2000 | 2006 | 2000 | 2006 |
| SHHC, Bihar | 62 | 25 | 10 | 4 | 64 | 86 | 63 | 95 | 74 | 92 |
| PANI, Uttar Pradesh | 44 | 34 | 5 | 1 | 78.8 | 83.1 | 72.8 | 96 | 78.7 | 94.1 |
| MSK Chandauli, Varanasi, Uttar Pradesh | 50 | 53 | 1 | 1 | 68 | 100 | 76 | 98 | 50 | 75 |
| ECAT Karauli, Rajasthan | 36.8 | 50.6 | 1 | NIL | 85 | 95 | 83 | 81 | 74 | 80 |
| Shramjivi Unnayan Chattisgarh | 52 | 30 | 5.2% | 2.3% | 53 | 94 | 61 | 98 | 53 | 98 |
| CREFTDA Orissa | 72 | 68.9 | NIL | NIL | 56 | 71 | 96.6 | 97 | 67.7 | 83 |
| SURE, Barmer, Rajasthan | 85.5 | 25.7 | - | 1 | 83.4 | 92 | 92.7 | 98 | 53.8 | 82.2 |
| Nagaland VHA | 46 | 32 | 2 | 1 | 56 | 85 | 20 | 50 | 52 | 80 |
| Arunachal VHA | 52 | 20 | 7 | 2 | 38 | 53 | 45 | 41 | 27 | 56 |

*ANC* antenatal care, *IMR* infant mortality rate, *TBA* traditional birth attendant

Source: The table is cited from VHAI Report (2007), "Khoj-A Search for Innovations and Sustainability in Community Health and Development, VHAI, New Delhi, pp. 25.

**Box 12.1** Jodhpur

In 1993, life for 50,000 inhabitants of twenty project villages spread over 12,000 km$^2$ in Osian block of Jodhpur district in the heart of the inhospitable Thar Desert, was undeniably very hard. In addition to harsh climatic conditions, the area lacks adequate infrastructure. Water shortage is a serious problem all the year round. Summers are very hot with temperatures going as high as 50 °C. Furthermore, the population is widely scattered and there are very few roads and little public transport, which makes people highly vulnerable to worsening health and socioeconomic situation. When the Khoj project began, health situation, especially women's health and social status was appalling in the twenty project villages. Poverty and unemployment were extensive and literacy level was dismal. Many villagers suffered from cholera, malaria, leucorrhoea, anemia, and other infectious diseases. Virtually no women used family planning or had any antenatal care. Serious pregnancy-related complications were common, and maternal death rates were high. This called for focused health intervention.

A decade later, the picture has changed dramatically. Antenatal care was introduced for the first time in the area. Morbidity has reduced considerably. In 2002–2003 itself, more than 4,500 patients were treated in OPDs[1] for a variety of ailments and special camps like malaria camps were also organized. Laboratory facility is available for pathological tests.

Much of the improvement is credited to the community centric approach of the Khoj Project "Gramin Vikas Vigyan Samity (GRAVIS)," the vision of Voluntary Health Association of India (VHAI) trying to improve the lives of the rural poor.

Khoj is a concept of community based health care being implemented by VHAI through partner organisations. The project related conceptual thinking as well as the mid course correction is done by VHAI through the empowerment of the local groups. GRAVIS who knows the pulse of the local community develops and upscales the programme keeping in context the local realities. The community-based health program that began in 20 villages in 1993 now concentrates on other villages, which were falling within a radius of 250–300 km in Jodhpur.

several achievements and efforts, the 50 years of development plan has not changed the lives of almost half of India's population. As per the United Nations Development Programme's (UNDP) Human Development Report 2001, India still ranks at 115th place (UNDP 2001). As far as women are concerned, the Gender-related Development Index (GDI) for India is 105, a rating classed by the United Nations as "medium human development."

[1]Out Patient Department (OPD) in hospitals provides health promotion diagnostic and therapeutic services to patients who need hospital services without; the need to be admitted. It includes references made from outside doctors, patients coming on their own, references from private clinics investigations recommendations and civil hospital references, etc.

The continuing poverty of the rural poor is mainly due to structural constraints in improving their livelihood and securing their well-being in terms of parameters of health, education and gender equity. Analysis of available qualitative and quantitative data clearly shows extremely uneven health and development progress in various parts of the country. Even within the states that are doing reasonably well, there remain regions where little has changed since independence. Much of this deprived population lives in remote, difficult and vulnerable areas. Findings of a district level survey by VHAI (Health For the Millions 2004 and ICDHI Monograph, VHAI 2004; 2007), to assess the extent of state variations in regard to health indicators based on the data generated by National Family Health Survey 2005–2006 (IIPS 2007), Census of India 2001 (Office of the Registrar General & Census Commissioner 2001), and Rapid Household Survey 1998–1999 (IIPS 2001), Government of India (GOI), further confirm the widespread impoverishment of the masses in terms of health care education, basic needs and income insecurity. *The survey suggested a three-sector model 'GOPIN' where 'GO' stands for Government departments, 'PI' for Panchayati Raj Institutions*[2] *and 'N' stands for non government groups (NGOs). Confluence of all these three bodies at the district /constituency level can bring about a tremendous improvement in the daily lives of masses* (VHAI 2004).

These vivid differences along with the wide variations in the health situation in various states, suggest that there is no simple, central solution for India's health challenge. Numerous programs, which oriented Government and other development agencies to take initiatives in these areas, have not been able to make any significant change. It has remained a challenge for serious minded organizations to evolve a strategy and process, addressing the various social determinants affecting the health of the population, to make a paradigm shift. NGOs are expected to perform a significant role including: mobilizing local initiative and resources; building self reliant sustainable social capital; moderating between government and people; transforming the attitude of people; facilitating development education; building on the assets of the individuals communities, etc. Hence it is important to study the functioning of NGOs and governmental organizations in using the asset model to address the health inequities. Asset model as particularly defined in the Ottawa Charter (WHO 1986) emphasizes the need to strengthen local communities – the model through asset mapping promotes the process of community empowerment to encourage their ownership and control of their own endeavors. It also supports the development of personal skills through its salutogenic approach to health development. This asset model promotes a multi method approach to evaluation using a set of salutogenic indicators to measure the effectiveness of programs and initiatives aiming to contribute to the reduction of health inequities.

[2]Panchayati Raj is a system of governance in which gram panchayats are the basic units of administration. It has 3 levels: village, block and district. At the village level, it is called a Panchayat. It is a local body working for the good of the village. The number of members usually ranges from 7 to 31; occasionally, groups are larger, but they never have fewer than seven members. The block-level institution is called the Panchayat Samiti. The district-level institution is called the Zilla Parishad. (http://en.wikipedia.org/wiki/Panchayati_Raj).

In this broader context of Indian state's commitment to achieve "health for all," this chapter attempts to study the cross cutting intervention of an NGO to bring about a holistic change in the lives of the communities by uplifting their socioeconomic and health status. The success story of Khoj, a VHAI project operational in the remote rural parts of the country is discussed. This chapter tries to establish the fact that *"we cannot achieve health for all without building on the strengths of the people."*[3] In the Khoj project there is no concept of recipients as the community is involved in managing the development efforts, as well as figuring out how to obtain the resources needed, (locally if possible). With a vision to create an enabling climate for an overall sociopolitical development of the community in the difficult terrains of the country, Khoj begins with developing an understanding of the social, economic, cultural and political dynamics of the community, and integrates the knowledge gained with action to improve the health and well-being of community members.

The chapter is divided into three parts. The first part of this chapter briefly outlines the Health Sector in India – status and trends with a focus on the health inequities in the country. The second part discusses in detail the community-centric sustainable strategy of Khoj in three difficult settings, and its impact on the overall well being of the population. The final part contains major findings and concluding remarks.

## 12.3 Health Inequities in India

Health is an important factor in development and is closely related to socioeconomic and other factors. India is undergoing a dramatic demographic, societal, and economic transformation. However, the health status of the residents of India still lags behind relative to other populations, and the health gains in each country have been uneven across subpopulations. Although they have achieved substantial advances in life expectancy and disease prevention since the middle of the 20th century, the Indian health systems provide little protection against financial risk, and most importantly there is widespread inequity in the health status of the population. It is now clearly indicated that the poor have much higher levels of mortality, malnutrition and fertility than the rich; the poor–rich risk ratio is 2.5 for infant mortality, 2.8 for under-five mortality, 1.7 for underweight children and 2 for total fertility rate (Peters et al. 2001). Childhood diseases like diarrhea, anemia, etc., are also more prevalent among low-income households compared to high income households (IIPS 2000). The health sector in India is still characterized by sharp socioeconomic, rural-urban and gender inequalities.

It is essential to thus understand that the all India health scenario disguises the most important feature of the population's health status – that there are significant

[3] Quote from: Baba Amte, Ramon Magsaysay Award Winner for Public Service during his meeting with Alok Mukhopadhyay in Hemalkasa project in Maharashtra.

differences in the patterns of morality, fertility and morbidity within regions and states. Progress has been uneven, and has been confined to advanced, approachable and progressive areas. Vulnerable areas which are hilly, tribal, arid, drought prone, flood prone, marshy and coastal continue to make a slower rate of progress. The more remote, sparsely populated and resource poor an area is, the greater the chances of its neglect in terms of availability and effectiveness of health services. The consequence of this has been neglected areas, forgotten populations and overlooked issues. For instance, the stretch of tribal areas extending from West Bengal to Maharashtra and Gujarat record high levels of morbidity, arising out of poor nutrition, forced displacement and changes in trade lifestyles. The population in the desert and arid zones of the Western frontier, sub-Himalayan hilly and Teri tracts in Bihar, Jammu & Kashmir and Uttar Pradesh – be they tribals, scheduled castes, displaced or migrant population in search of work, remained under-served, ignored and are forced to meekly accept a lower quality of life. These wide variations across the country further add to the task at policy level. It's clear that it is important to develop an appropriate strategy, which addresses these variations while achieving its objectives for the country per se. Prognosis for the health sector in India is thus a challenging task.

## 12.4 Policy Environment

During the last few decades, the country has failed in its effort to reach out to the people living in the vulnerable areas. This inequality greatly impairs successful outreach of social, economic and political benefits to a large sector of our citizens. It was realized that many facets of inequity need to be addressed, to successfully bring social, economic and political benefits to a large sector of India's vunrable population.

Inequity that affects the health sector in India could be broadly categorized as follows:

1. Economic – In spite of focused and priority steps to address the problems of the poor, the nation still has 32% of the population living below the poverty line.
2. Political – In spite of adult franchise, representation of the poor families in governance in India has been limited.
3. Social – Distorted cast system has put a very large section of our population in considerable disadvantage vis-à-vis their social and economic mobility.
4. Gender Issues – Like most developing countries, the gender inequity has been a considerable impediment towards the progress in health and development in India.
5. Locational Problems – Far flung, cut off areas and ecologically vulnerable areas where large section of the population live.

India realizes that a paradigm shift in the prevailing situation of inequity is only possible if there is a change in the fundamentals of legal, social and political rights

of the poor and under-privileged. The situation in India is also complicated by the fact that we are an extra-ordinarily heterogeneous nation with people from a variety of cultural and ethnic backgrounds. Being a democratic pluralistic nation, it is impossible to thrust a particular view of social transformation quickly and assertively. It is essential for the country to carry its people along in major decisions of social, economic, and political development, which means a long and sometimes frustrating consensus building process.

To address these issues of inequity in the recent times, some very radical measures have been taken by the GOI. These measures include: the 73rd Constitutional Amendment giving the responsibility of local level governance and development to the elected representatives of the people both in the rural as well as urban areas; special quota for employment for scheduled castes and scheduled tribes; active involvement of civil society in fulfilling the promises of health and development to the citizens. Despite such policy measures, the abysmal health and development indicators confirm the need for some innovative community based approach.

After many years of government under funding, India has committed to sizable increases in government investment in health. Although the public expenditure on health is still low – 0.85 of the Gross Domestic Product (GDP), there are now launches of ambitious programs like the National Rural Health Mission. It has been also recognized that the poor and rural populations are particularly disadvantaged in obtaining access to health care and face major financial risk in the event of illness. Thus, explicit policies are being developed to target the government's funding towards the poor and rural populations.

To date, however, the country doesn't have a systematic policy for reducing the inefficiencies in service provision and managing health spending inflation – a fundamental cause of unaffordable health care and heavy financial risk. It is still too early to know whether the additional government investment (channeled through insurance coverage and health facility infrastructure strengthening) will produce benefits for the people, in terms of increasing access to healthcare, reducing financial risk, improving health status, and reducing inequalities in health and healthcare. However, our view is that money alone will not be sufficient to deliver effective, high-quality care. Unless we make the health system community oriented by making the target group i.e., the community itself the subject of process. The existing policies still focus on the needs of the community whereas the conceptual framework gaining ground in rural development is "asset based" development (Allen 2007). In the asset based community development, as followed by Khoj projects in various rural settings, community members were purposively grouped together based on their needs and existing capabilities. The communities were found to be flexible and welcoming towards any support aimed at improving their basic situation. This has been identified as an important asset helping the projects like Khoj to work constructively on the existing skills in the community members and providing them new avenues to grow. With some initial support community members have the ability to organize amongst themselves to work towards common goals more proactively. Communities build personal and community capital through an efficient management of their traditional skills, improved farming

methods, and a natural resource base such as enhanced water use capacity, irrigation systems and forestry.

In India nearly 70% of the population lives in remote areas/villages, these people are often the most under privileged section of the society. The aim is to reach this segment of the population with a multi faceted approach aimed at an overall development of the individual and the community at grassroot level. Community involvement, self reliance and sustainability through efficient NGOs are the key factors.

The chapter focuses on the efficiency of Khoj, alternative strategies for health promotion and overall development, successfully practiced in villages/remote/difficult terrains of the country. Khoj strategies have been in implementation in more than 20 different locations of the country since 1993 and have helped create replicable examples that can be quickly adapted to a variety of contexts. The following section discusses in detail this community based health and development project in the unreached areas of India.

## 12.5 Community-Based Health and Development Programme – Khoj: An Innovation for Further Adoption

Against this backdrop, an innovative approach called Khoj, was developed to tackle health and development issues. The approach evolved from VHAI's deep concern to find the breakthrough to improve the health status of people living in remote and difficult areas and generally having extremely low economic status. Khoj is a Hindi word, which literally means 'search'. The philosophy of Khoj is to search for innovative methods and strategies to combat community health related problems. Khoj also aims to search for viable alternatives to the existing health care development model being followed by the government and also some voluntary organizations. Khoj puts this philosophy into practice by building upon the strengths of community and lending support to innovative projects by small voluntary organizations in neglected areas which can be replicated elsewhere without the recurring requirements of heavy infrastructure or investment which besiege some of the larger projects. This approach perhaps is an extension of the salutogenic model of health promotion based on the key premise of *involving community in improving health situation and an overall development.* The project helps the community to move towards better health as a facilitator.

Khoj is one of the long-term initiatives of VHAI, being implemented since 1993. The Khoj project is located in some of the most remote and difficult areas of our country. These areas have high mortality and morbidity rates and practically no semblance of health services. The overall concept and framework of Khoj – a community based health and development programme was carefully planned on the premise of having greater relative advantage, *compatibility*, potential for *replicability*, minimum or *no complexity* and *observability* (Tandon et al. 2007).

**Box 12.2** Definitions of Key Characteristics Ensuring Community Health and Development

- *Relative Advantage*: The degree to which an innovation is perceived as better than the idea it supersedes
- *Compatibility*: The degree to which an innovation is perceived as being consistent with existing values, past experiences, and needs of potential adopters
- *Complexity*: The degree to which an innovation is perceived as difficult to understand and use
- *Replicability*: The degree to which an innovation may be experimented elsewhere
- *Observability*: The degree to which the results of an innovation are visible to others

With these key characteristics Khoj has proven to be a successful example in the field of community health and development for improving the health status of the entire community through an integrated approach.

## 12.6 Khoj Initiative – Programme Approach and Outreach

Following various parameters outlined in Box 12.3, VHAI identified 21 pockets in the country to initiate the Khoj project. While identifying these locations, it was ensured that they sufficiently represent social, economic, political, geographical and ethnic varieties of the country. These locations are broadly in the physically hard areas like the remote mountains and desert areas, areas mainly inhabited by the indigenous people, and heartland India. In these areas, social, economic and gender status are highly polarized and the overall feudal infrastructure is still not dismantled. Our premise was that the experience of working in these diverse areas will give us enough experiential learning to upscale similar initiatives in most of the vulnerable pockets of the country.

### *12.6.1 Khoj Strategies*

At the conceptual level, the project emphasized development that was truly participatory and sustainable in nature. Direct health related activities were given primary importance during the initial years and gradually, with improvement in the health patterns, other developmental activities were focused upon. While finalizing the approach to our work for these pockets, we felt that (1) we should go with an open mind and develop the project depending on the local basic needs as expressed by the people; (2) utilize the existing government infrastructures as optimally as possible;

**Box 12.3** Khoj – A Vision for Progress in Community Health and Development Partnerships

1. *Khoj Initiative – Programme Approach and Outreach*
   - Partnership challenges and relationship to health and development
   - Khoj strategies
   - Experimental designs to assess Khoj impact
   - Outcomes
   - Sustainability
2. *Work-in-Progress and Lessons Learned*
   - Building community partnerships
   - Engaging community members in implementation
   - Training community partners
   - Challenges in working in difficult terrains
   - Sustainability, community ownership
   - Formative work
   - Sustainability
3. *Practical Tools*
   - Resources/tools to develop community partners' skills
   - Monitoring and Evaluation strategies
   - Systematic guidelines for project implementation and validating
   - Behavioral intervention to culturally diverse groups
   - The success/failure of community based approach
   - How to use local, state, and national data sources to help community partners with their service delivery and grant opportunities – sustainability
   - How to provide effective feedback and communication
4. *Systematic Review*
   - Reviews of Khoj methods
   - Review of Khoj effectiveness
   - Role of Khoj in empowering community and making the project sustainable
   - Community perspectives on role of Khoj projects

(3) identify and build local health and development skills and expertise; (4) use sustainable initiatives, from financial as well as human resources; and (5) ensure that on the whole it not only affects health and development status of the people, but ensures a permanent capacity building of the community. The initial phase involved mapping the existing services and potential of the community members. Another critical aspect was to identify local project partners in the voluntary sector, who may not have tremendous experience, but are motivated and are also rooted in the local community.

## 12.7 Work-in-Progress and Lessons Learned

VHAI in close collaboration with its state voluntary health associations (SVHAs) after the identification of the project area and the implementing agency performed the following key tasks:

Practical Tools to develop community Khoj partners' skills:

- Help in selecting of staff and their orientation
- Microplanning
- Assisting NGOs in the preparation of action plans based on the needs identified and also the narrative reports
- Providing support in setting up project management and financial management information systems
- Reporting format on the progress of the project
- Actively support the Khoj project in times of crisis or emergency
- Participating actively in monitoring and evaluation of the project in collaboration with VHAI
- Conducting relevant training programs for the project partners who in turn provide training to grassroots level workers
- Advising the project partners to comply with the project agreement particularly project related accounting and reporting based on the agreement between VHAI and the project partners
- Reminding the project partners of reporting in case of delays and ensuring that the request documents are submitted
- Visiting projects periodically for monitoring and evaluation and providing appropriate technical support to project partners
- Considering flexibility in the case of unforeseen deviation from the original action plan and implementing certain activities, which may not have been envisaged earlier, but have later became necessary

## 12.8 Khoj Thrust Areas of Work

The thrust areas of work of development initiative taken up under this programme can be classified as follows:

- Health
- Community development
- Gender rights – women empowerment
- Right based approach
- Environment

Over a period of time, a marked change has been seen in the previously mentioned areas in the Khoj project. However, all the project areas are at different stages of achievement due to differences in the time of their initiation and considerable variations in local geography, culture, political scenario, and law and order situation.

## 12.9 Health Interventions

Since the beginning, health interventions were used to develop rapport with the community so as to ensure their fullest participation in the overall development process for the area. Health interventions were mainly used as an entry point. From the baseline in most of the project areas, it was apparent that there was not any access to quality healthcare. In such projects, the emphasis in the initial phase was much more on provision of curative services. The curative services were provided by a team comprising of village health workers, a trained supervisor, and a medical doctor. To take care of emergencies and provide supervised care, a small Khoj health centre has been established in most of the projects for indoor admission and a small field laboratory managed by a qualified doctor and nurse. In most of the places, villagers or panchayats provide land either free or at a nominal cost. In addition, health camps and relief camps in epidemic like situations such as malaria, diarrhea, etc. are organized from time to time. Each project has developed linkages for proper referral of complicated cases. The projects have also developed rapport with some of the local doctors to provide specialized care on a regular basis.

### *12.9.1 Women and Health*

In the development of community health, priority has been placed on addressing the entire range of women's health needs; both for their own sake and for the effects that women's health has on community health. Women's health status has been given due consideration throughout their entire life span from young girls to reproductive age women, to menopausal and postmenopausal women. Khoj projects have adopted a holistic approach to reproductive health. This has enabled the projects to initiate an attitudinal change towards women's health not just in terms of their reproductive capacity but also in terms of their basic rights.

### *12.9.2 Specific Health Issues*

In almost all the areas, malaria, diarrhea and measles were extremely common. All three were the major cause of not only high morbidity, but also high mortality. Almost 40% of child deaths were due to these problems. Now each project has been able to control mortality and morbidity because of these diseases. In most of the areas, there were no epidemics in 1999. Similarly, most of the projects did not have deaths due to diarrhea or malaria.

### *12.9.3 Health Promotion*

In the Khoj projects, curative component is an important but small component. The major focus is on health promotion and prevention of diseases by improved communication through village health workers as well as Mahila Mandals and Youth Clubs members. Right from the beginning, the efforts were made to develop need based area specific communication strategy. Different tools more suitable for the particular area were used for government health services and health education.

## 12.10 Community Organization

With a focus on the existing assets of the community, all the projects have taken effective steps to organize people's groups at different levels in the project villages. The formation of these groups has ensured a comprehensive relationship between the project and the community. These groups are mainly in the form of:

Village health committees (VHC) – composed of representatives from different groups who come together and decide the future plans and strategies for health and development-related work to be undertaken in the villages. This process has also ensured that community has a say in the decision making process. This has also given a strong feeling of ownership to the community and has enhanced their involvement in all stages of the project.

These community groups have been women's groups (Mahila Mandals), youth groups and farmers groups, self help groups (SHGs), village development committees (VDCs); village education committees; village old people's associations (VOPAs). The people's organizations are democratic and engage people from all sections of the community to manage the development efforts, as well as figure out how to obtain the resources needed, locally if possible. The communities are thus endowed to carry on the development initiatives without further assistance from VHAI – and are able to attain self-reliance.

Each community has its own assets like traditional healing, local artisans and above all a desire to work together. Khoj projects looked at these assets and helped the communities in overcoming the initial hindrances and made the various groups which have been instrumental in sustaining the project and bringing about a holistic change in the socioeconomic situation of the masses.

The deficit model as mentioned in Chap. 1 focuses more on the needs of the community. Khoj, working with the asset mapping approach instead, calls them the key focus areas which need to be improved through the efforts of the community (see Box 12.4). This has been done in various settings like Kashmir/Orissa, where the untapped local skills of the artisans were promoted through the right channels and helped the community in generating self revenue and thus bringing an overall improvement in their health and living conditions.

**Box 12.4** Needs and asset based approaches to community development

Traditional Model: Need based Community Development:
Based on – Needs
Goal – Institutional Change
Conversation – Problems and Concerns
Change Agent – Power
View of Individual – Consumer/Client
Needs are based on Community Problems:
Broken families, child abuse, crime, gangs, housing, illiteracy, school drop outs, unemployment, etc.
Alternative Model: Asset Based Community Development:
Based on – Assets
Goal – Building Communities
Conversation – Gifts and Dreams
Change Agent – Relationship
View of Individual – Producer/Owner
Assets are based on Community Treasures:
Artistes, clubs, community groups, cultural groups, farms, hospitals, parks, youth, senior citizens, etc.

Source: Allen (2007)

### *12.10.1 Education*

Some of the Khoj projects have initiated non-formal education centres for school dropouts. It has helped not only in improving the literacy level but also developing rapport between the community and the project.

### *12.10.2 Community Development*

Khoj is a health initiative which tries from the beginning to address the conditions responsible for ill health. Major strategies adopted for community development are capacity building, income generation programmes and education.

### *12.10.3 Capacity Building*

The process of capacity building involved vocational training, training for other income generation activities, more effective utilization of locally available resources and entrepreneurship development.

### 12.10.4 Income Generation Programme

These include vocational trainings, promotion of local crafts (training/marketing support) and entrepreneurship development.

### 12.10.5 Formation of Self Help Groups

SHGs are usually groups of seven to ten women who are encouraged to make periodic savings, and are linked with banks. Women use this money either to initiate some income generation activity or to take a loan for the treatment of sickness or buying seeds, etc.

### 12.10.6 Livestock Improvement

Since most of the Khoj projects are in rural areas, artificial insemination was used to help communities improve livestock breeds. Projects also provide technical support on how to maintain the animals.

### 12.10.7 Environment

Improving the village environment, sanitation, and drinking water. Related project activities including proper care of drinking water sources and village drains by villagers themselves, aforestation, prevention of deforestation, preservation of natural resources, kitchen gardening and horticulture.

### 12.10.8 Collaboration with the Government

The trend towards collaboration with the government is increasing. The following activities are the mainstay:

- Health: Immunization programme, family planning programme, health camps, workshops (as resource persons from the government), referrals
- Sanitation and drinking water: linkages with government funding agencies, block offices and panchayats
- Direct benefits under various government schemes
- Training of panchayat members

- Recognition of the projects by state governments as seen by handing over of primary health centers (PHCs)[4] in Arunachal Pradesh, Orissa, etc., training of animators and direct financial support to projects for specific activities.

### *12.10.9 Sustainability*

Sustainability is an essential feature of the Khoj project. Right from the very beginning, conscious efforts were made to select sustainable interventions. Some of these efforts are in the direction of:

- Sustainable income generation programs
- Emphasis on human resources development
- Strengthening local panchayats
- Developing local leadership and linkages with government and other agencies

Ensuring sustainable impact requires consistent efforts over considerable time periods. In the case of Khoj initiatives in rural settings, this has meant concerted efforts at a grassroots level before the results and subsequent impact on the quality of life is visible.

### *12.10.10 Monitoring, Reporting and Evaluation*

Systematic guidelines for project implementation and validating have been developed. The evaluation strategy for the Khoj project is precisely based on asset mapping of the community. It is target free and carefully designed, comprising of both qualitative and quantitative aspects.

Systematic reviews of the Khoj methods; effectiveness of Khoj intervention and the role of Khoj in empowering community and making the project sustainable are undertaken on a regular basis. Monitoring of the Khoj projects is a participatory and ongoing process in which VHAI, state VHAs, project staff, and village committees are involved. Professionals from VHAI visit these projects on a regular basis. To assess the community perspectives on the role of Khoj projects, the process of project evaluation and impact assessment involves intensive interactions with the community, the village committees, people's groups, and the project staff. The project records and reports are also scrutinized.

Findings of the baseline survey act as the reference point to be checked after a considerable duration for the changes brought in various health and social indicators

[4]Primary Health Centers are the first contact pint between the village community and the medical officer. It is manned by a Medical Officer and 14 other staff. It acts as a referral point for six subcentres and has 4–6 beds for patients. It performs curative, preventive, promotive and family welfare services. Each PHC is targeted to cover a population of 30,000 in plain area and 20,000 in hilly/tribal area.

like infant mortality rate (IMR), maternal mortality rate, SHGs formed and savings of SHGs.

The village health workers maintain monthly records and vital statistics that are checked by the supervisor who reports to the programme coordinator. Doctors maintain clinical records and morbidity profile. Quarterly, half yearly and annual narrative and financial reports are sent to VHAI. A meeting of all the Khoj partners and VHAI is also held annually. This is followed by a mid-term evaluation in all the projects. This includes a scrutiny of the statistical figures and also focus group discussions, adding a qualitative dimension to our evaluation of the project.

### *12.10.11 Impact and Achievements*

The impact of the strategy tried out by the Khoj project should be assessed seriously. As discussed previously the Khoj project has successfully enhanced the knowledge, attitude and practice of community members on health, nutrition, water and sanitation. To bring in women empowerment, SHGs have been formed and linked with banks. Non-formal schools operated by projects have created an opportunity for the deprived children to achieve their right to primary education. Some of the current activities include capacity building of the state VHAs, local NGOs partners and the second line management staff through exposure visits to other development projects and training workshops on various health and development issues by VHAI. Some of the positive outcomes of initiatives towards community organisation are:

- Mobilization of village committees
- Formation of social action groups to optimize government resources
- Effective linkages with panchayats

The health impact of the Khoj project can be summarized as:

- Increased health awareness reflected by reduced time lag between onset of symptoms and reporting to health functionaries
- Increased utilization of available government health services
- Significant improvement in antenatal care, natal care and post natal care
- Reduction in mortality, especially due to communicable diseases like diarrhea, malaria, acute respiratory infections (ARI), as well as due to pregnancy and associated complications
- Effective diseases surveillance leading to prevention of epidemics from taking place
- Significant reduction in health expenditure as the quality health services including laboratory services are available within a reasonable distance and reasonable cost

In the annexure section we have discussed briefly the strategy, impact and learning gained in two areas of the Khoj project in different and difficult settings; in Shivpuri, a tribal belt of Madhya Pradesh and in the post disaster Orissa.

## 12.11 Key Learnings

The Khoj project focuses on asset building, and has been successful in achieving a holistic change in the lives of communities in some of the most remote and underserved rural areas of the country. This was possible only because of the following key factors:

- Strategic planning – Planning needs to be done from the onset with the local community
- Identification and building on the community's strengths
- Multidimensional approach – responding to various socio-economic determinants to bring about a change in the health and general condition of the population
- Creative partnering within the community and external environments need to be forged. Most importantly, communities need to control the process. The ultimate goal is for communities to have the confidence and competence to make informed choices from a range of appropriate options for sustainable and equitable development

Two key themes that emerged in this project were the importance of engaging community in positive activities, and providing opportunities for development. Positive activities ranged from: learning about their culture; forming village development committees and SHGs, especially of women; and networking with the local leaders, government, and organizations. The opportunities include: participation training and skill-development; promoting indigenous medicine; promoting community networking with the government and other agencies; and educational workshops on various schemes and programs.

In the early stages of the project's development it became apparent (mainly because of the team members comprised of local residents) that certain environmental realities had to be addressed. For example, the Khoj project in the Faizabad district of Uttar Pradesh state, known for the endemic caste conflict, intense gender stratification and political unrest, worked intensely to empower the community for its own development. A maternal and child health program was the core point of focus during project implementation with the vulnerable community. The source of the project's success was the formation of SHGs of women in this environment. Under the project, various activities were taken up and the nature, dimension and magnitude kept on changing as project progressed with time. For sake of simplicity, these activities were categorized in two major programme sectors: (1) community health promotion and (2) community development programme. In the first category, Khoj has initiated various activities like: activating and supplementing health facilities; maternal and child health programme; organization of a health camp; health education programme; training of traditional birth attendants (TBA); training of health monitors; preparation and distribution of information education and communication (IEC) material; school health programme; creating a cleaner health environment; promotion of personal hygiene; open well care; and hand pump maintenance. The community development programme also included school

health programme as well as: community based organizations[5]; income generation activities; promotion of self help groups; activating existing institutions like panchayati raj institutions (PRIs); capacity building activities; and linkages with other programmes.

The project has been able to achieve these objectives by strengthening and activating community health systems. The project innovated and adopted strategic approaches like taking low cost traditional agricultural practices among small and marginal farmers on one hand and emphasized new agricultural practices on the other. The project provides routine motivation for entrepreneurship development of a target community through a motivator. During 2005–2006, a total of 60 entrepreneurs were facilitated through Rs. 10,77,000 micro-finance mobilized through banks, which has led to an improved quality of life.

As a principle it has been important to shift ownership of projects to the community to ensure sustainability. The process was important and flexibility was essential to the overall outcome. It was also important to understand that circumstances within each community were dictated by its particular socio-economic and cultural issues.

For example, the problems of the communities in the Thar Deserts of Rajasthan were different from those of a cyclone affected community, or the tribals. A Khoj project in the valley of Kashmir with long standing armed conflicts, had a culturally sensitive approach while discussing issues of health, family planning and safe deliveries. The project area remains cut off due to snow for almost six months in a year, thus careful planning for health and medical services was required. Since the community has faced hardships for many years due to the armed conflicts in the state, an integrated health and development program was initiated by the Khoj project, gradually involving the local community and NGOs. It addressed the issue of chronic poverty and started appropriate income generation, literacy, women's empowerment and vocational training programs, thus building upon the capacities of the community for their overall development.

The feasibility of long-term partnerships with targeted local small scale organisations across the country needs to be scoped. This should take into account the fact that a significant number of these organizations have limited capacity to develop, implement and sustain reconciliation initiatives at the local level. To ensure sustainability, it is imperative that strategic alliances are identified at a national, state, regional and local level, and that community participation examples are explored. The Khoj projects creatively pooled the community's physical and financial resources, along with human and social capital. We focused earlier on building the capacity of the organiza-

[5]"Community Based Organizations (CBOs) are grassroots organisation, locally based membership organisations that work to develop their own communities. The most common types of CBOs are local development associations, such as village councils which represent an entire community and interest associations such as women clubs which represent a particular section of the community. Third group includes borrowers' groups, cooperatives which may make profit but are different from the private business due to their community development goals." (The challenge of slums: global report on human settlements, 2003, United Nations Human Settlements Programme (UN-Habitat), Nairobi, 2003, pp.151).

tions, and the local communities. That meant entering into relationships and partnerships being clear that Khoj was not going to run the projects forever, but build upon the capacities of the local organizations and the communities to do so.

Most importantly the value of women in the overall community development has been realized. Empowered women are able to contribute fully to the development process and should not be seen as a side issue, but central to and in the process. In all the different Khoj settings women's groups have been formed, trained, and involved in the income generation activities and health improvement efforts.

Another most important lesson learnt was need of perseverance in face of challenges. Challenges were not unexpected in the steps towards improving community health and an overall development: however, these challenges served to highlight the need for this project. In the beginning there were some difficulties experienced as a consequence of the community members reluctant to get involved or take any initiative. However, as time passed, the community and the Khoj project workers got to know each other and began working together. The need for consistency in all the programs is of utmost importance to bring about the desired impact. People are a part of the solution, not just the target. Their vulnerability needs to be reduced by building on their capacities and developing thier skills. Social mobilization can be a very effective tool of reaching and involving individuals, families, communities and government at various levels. This is only a part of the project, however; it does not show the background to the process of creating an empowered community in some of the most deprived, difficult terrains of the country. The project has been an innovative community based health and development tool in itself as it has facilitated and pioneered the development of good governance models based on community ownership in the country.

## 12.12 Conclusion

> "Development really is the process of expansion of individual freedom, which, in turn, is a function of people's capabilities and opportunities."

Amartya Sen, winner of the 1998 Nobel Prize for Economics. (Agarwal and Sarasua 2002)

In a large, complex yet vibrant country like India, promoting health is a challenging task, but given the size of the population of the country it also holds the key to dramatic change in global health situation. Happily, the solutions to these complex problems clearly exist in many innovative successful experiments within the country itself. It is a matter of concern that a large part of the existing health structure of the government within the country is operating in an unimaginative manner, which does not inspire confidence about their ability to cope effectively with the current problems and future challenges. Restructuring and revitalizing the sector is an urgent need.

In most parts of the country, the key to improving people's health lies in larger areas of social and economic development. Therefore, policy makers, health pro-

fessionals and activists need to take a more committed interest on these issues in every possible complex setting. Involvement of the larger civil society including the community, traditional healers, NGOs and private sector can make significant difference in all aspects of health and development. Until now, serious pro-active efforts have not been made towards their larger involvement.

In most of the rural communities of India, health and social infrastructure is inadequate and the governance has been poor, affecting the overall well being of communities. Thus proactive efforts are required to ensure that the benefits of various government policies and programmes reach the expected beneficiaries. It has been noted that the government approach has been insensitive and missing a creative dimension to address the developmental problems. Therefore our effort has been to provide an ingenious dimension by involving the community and helping them to build on their assets/capabilities in order to bring an overall improvement in their health, social and economic status. This approach makes the effort sustainable in the long term and provides an example for the government system to follow elsewhere.

Success has been shown over the years through an overall improvement in the various health and development indices of India's underserved communities living in difficult and remote parts of the country. Khoj exemplifies the need of identifying and building on the capabilities of the communities, unlike most other development projects based on the problems and needs of the community. The Khoj project is based on the following key premises:

1. Focusing and reinforcing the local capabilities, especially of the underprivileged sections, has been an integral component of the project.
2. Exploring the untapped potential of the smaller grassroots level projects that have been working towards the promotion of community health and development, but have been hindered from attaining excellence either due to paucity of resources or capabilities.
3. VHAI has taken up the "scaling up" of the beneficiary coverage, activity portfolio and the institutional sustainability as one of the core concerns in all its Khoj projects. In many ways scaling up has been a natural, almost organic, process for most of the Khoj projects. The motive remained to scale up the impact rather than making the organization larger.

We obviously need a new paradigm of healthcare, far removed from the current bio-medical model and closer to a sociopolitical and spiritual model. The "germ theory" needs to be replaced by a model where the human being is regarded as central and helped to regenerate a sense of well-being and fitness in his or her life situation. Interestingly, most of the traditional systems approach health from this holistic perspective. Human society must know how to deal with such biological occurrences as birth, death, pain, etc. Perhaps the solution to an enormously critical health and development problem lies in serious reflection on some of these issues.

The health of any nation is the sum total of the health of its citizens, communities and settlements in which they live. A healthy nation is, therefore feasible only if there is total participation of its citizens towards this goal.

## 12.13 Annex: Success Stories

### *12.13.1 Towards a Culture of Preparedness and Sustainability*

#### 12.13.1.1 Aparajita Orissa

The super cyclone struck coastal Orissa in the year 1999 and left the households, communities and the state exposed to the disastrous impact of the calamity. The loss of lives and property could have been reduced substantially if the system of disaster management and preparedness to face natural disaster were in place at both the household and community level. This realization brought out the idea of continuing an innovative long-term development initiative for an integrated development model.

To give this idea substance and meaning, the Khoj project is being implemented in the Kujanga Block of Jagatsinghpur district. The block consists of 27 gram panchayats (local government) and 169 revenue villages. Due to its coastal location, the area is highly disaster prone.

Currently no plans have been made to establish development linkages with the disenfranchised people. Unfortunately, the government and the policy makers have yet to establish a link between disaster preparedness and poverty alleviation. Furthermore, no initiative has so far been taken to integrate relief, disaster mitigation and preparedness into normal development plans. Normal development plans are poorly formulated, too loosely integrated with other programs and haphazardly implemented.

Aparajita's strategy, right from the onset is to strengthen the capacity of the affected community and minimize their vulnerability. Aparajita's program focuses on livelihood restoration, healthcare, capacity building of the community, self help, coordination and networking. The provision of livelihood focused inputs had a direct bearing on the earning opportunities of the beneficiaries and accelerated their journey to economic recovery. The healthcare package developed by Aparajita empowered the community in meeting their basic healthcare needs and promoting health status of the community. The coordination and networking have helped Aparajita to avoid duplication, unhealthy competition and conflict, and helped to use its resources, time and energy to reach out to a large number of people with significant inputs.

Aparajita is continuing its efforts to develop, manage and sustain disaster mitigation, preparedness and response planning. However there is a need for implementing more systematic survival strategy and effective coping mechanism to face the future emergencies. It is felt that the Khoj based community initiative will facilitate a long term planning for hazard mitigation, preparedness and capacity building of the community.

Agriculture and animal husbandry are the main occupations of the people. Since the arable land is single cropped, it does not provide sustenance to a family for more than three to four months in a year. Therefore the male population has to migrate to other areas to work as contract labor, road construction workers or to urban areas to undertake sundry activities. Due to the absence of male members in the family, the women have to look after the agricultural activities and animal husbandry. The women also look after the aged and young members of the family, collect wood and

drinking water and performing other household chores. This leaves them with little scope for taking care of their own health even during the advance stage of their pregnancy, leading to pregnancy related complications. The reach of health services is inadequate; which compel people to rely on traditional healers, quacks and diviners.

Women and child health is a major focus area of the project. The services are provided through project medical officers, auxiliary nurses, village health workers (VHWs) and trained traditional birth attendants (TBAs). During April 2005–August 2006, 176 antenatal cases were registered and 164 cases were provided complete antenatal care including tetanus immunization. Twenty-one high risk cases were identified and referred to district hospital. Total of 169 births were recorded out of which 162 were conducted by trained personnel, including trained TBAs.

To spread and disseminate the health and development messages to the community, the appropriate mode and suitable media is required. Through the information education and communication (IEC) activities, the project disseminates the development messages to the community. Street theatres and cultural groups are the major media that have been formed and trained to perform on different subjects. In all the five panchayats, these groups have performed on different issues such as mother and child health care, nutrition, sanitation, school health, environment, etc. The health awareness and education program has been attended by more than 15,000 people.

Several initiatives have been started with the SHGs to carry out and expand their livelihood program. One hundred sixty-five SHGs have been formed with a total membership of 2029. A holistic approach has been adopted to set up units of such activities where there is scope for the involvement of more number of women SHGs. Units of stitching and sewing, spices making and bamboo seasoning, and making of products have been supported through this initiative. The women SHGs are also involved in dry fish business, tent house management, agriculture, floriculture, etc.

The Khoj project essentially covers various population groups. There are specially designed program for schools as well as adolescents. The school health programme has different components to serve the health need of the school students of adolescent age group. Health promotion activities, safe drinking water, healthy sanitation conditions are maintained with the available facilities and infrastructure.

To address the specific issues of adolescents, regular monthly meetings amongst them are organized. Their need for education and awareness are very important as they are in the formative stage of their lives. Aparajita addresses these groups by dividing them into two parts, one is the school attending section through its school health program and the second one for the school drop outs. The school dropout adolescents are not only provided education and awareness on health issues; but are also provided with adequate and timely health services, vocational guidance and support to start their own group enterprises for earning livelihood. They have been formed into SHGs. There are 34 such SHGs consisting of 423 members. These groups maintain their group records and have opened banks accounts, so they have savings both in hand and in the bank.

All the initiatives under the Khoj program are regularly reviewed and assessed. Based on the feedback and suggestions of the field and core staff, the plan of action and priority area of intervention is decided.

The village level health workers have emerged as the most active health cadre in the villages of the Khoj operational area. Along with the health team of Aparajita, they are actively taking part in organizing the health activities in their respective areas. With adequate training, now they are well versed with different health issues which are commonly seen in their villages in different seasons. They are also trained to treat common diseases and provide first-aid.

Marginalised and vulnerable groups and individuals have been supported to initiate and sustain their livelihood activities. These marginalized families are identified after intensive interaction with the community, consultation with the panchayats, village leaders and community heads. After a through interaction with the family, their vulnerability is assessed. The support is extended, keeping in view the capacity of the person to take up and manage the activity. Appropriate follow up is done by the volunteers and supervisors.

A rescue equipment demonstration programme has been initiated in five panchayats of the operational areas of the Khoj programme, where five disaster shelters have been identified. These are the focal points of the gram panchayats for the purpose of disaster management and preparedness activities. Regular activities such as mock drills, meetings of disaster management team are organized in these shelters. In the previous year rescue equipments were procured and kept in these shelters.

Hema Manjari Behera, aged 45 years, belonged to a very poor family in the village Ameipala of Kendrapara district. Being part of the fisher folk community, she learnt about group cooperation from the beginning: the men would go fishing while the women would process and dry the fish for selling. When the boats and nets were damaged by the super-cyclone, the male population could not go fishing anymore and thereby women's work was also interrupted. It became difficult to meet the needs of the families. Hema Manjari and three of her friends went to Paradeep port where bigger boats and trawlers did the fishing, but they were disappointed as the fishermen would only sell in bulk. She realized that they would have to increase their investment capacity. Hema Manjari discussed the matter in a community meeting organised by Aparajita and learnt that women of the village could be formed into self help groups (SHGs) and thus make bigger. She managed to convince all the women and thus four SHGs were formed in the village. They collected money among themselves and went to Paradeep to purchase two truckloads of fish. There was a massive activity of dry fish processing and the women learnt the process of group enterprise. They underwent training for adding value to their products by processing them in a hygienic manner. They also went for an exposure visit to the Integrated Coastal Management Institute at Kakinada. With value-added production, they were able to increase their income and profit. Hema Manjari says "*our income was never enough to meet the basic needs of the family. We were not able to think about the education and health of our children. For a set of bangles and few yards of sari, we were dependent on our husbands. But today, we are earning, having our own savings. We care for our children and their future.*" Khoj builds on the potential of the community and makes them self sufficient.

Aparajita, Orissa: Impact Assessment

| Particulars | Base line year 2004 | Year 2000 | Year 2006 |
|---|---|---|---|
| No. of villages | 24 | 24 | 24 |
| Health Indicators | | | |
| (a) Morbidity | | | |
| Diarrhoea (%) | 12.5 | 14 | 5.6 |
| ARI (%) | 7.8 | 8.5 | 5.7 |
| Malaria (%) | 6 | 7 | 3.9 |
| TB (%) | 1.3 | 1.5 | 0.1 |
| Aneamia (%) | 61 | 68 | 38 |
| (b) Mortality | | | |
| IMR per 1000 live births | 62 | 68 | 43 |
| Maternal deaths (Total no. of cases) | 12 | 14 | 4 |
| (c) Maternal and Child Health | | | |
| Complete ANC Coverage (%) | 36 | 21 | 89 |
| TT immunization | 22 | 18 | 92 |
| Primary immunization | 46 | 41 | 86 |
| Births by TBAs | 32 | 25 | 76 |
| (d) Community Organization (No. of groups) | | | |
| SHGs | 11 | None | 96 |
| VHCs/VDCs | None | None | 24 (VDC) 24 (VHC) |
| Youth Groups | 8 | 4 | 21 |
| Any other type of organizations. (Male SHGs) | None | None | 19 |
| (e) Income Generation Programme (IGP) | | | |
| Total No. of programmes | 5 | 5 | 36 |
| Type of activities | Agriculture<br>Fishery<br>Goatery<br>Poultry<br>Petty trade | Agriculture<br>Fishery<br>Goatery<br>Poultry<br>Petty trade | Agriculture<br>Fishery, Goatery<br>Poultry, Handicraft<br>Activities – Agarbati making, Spices making, Food processing, Floriculture, Vegetable Cultivation, Dairy farm, Petty trade, |
| (f) Capacity Building | | | |
| No. of VHWs trained | None | None | 52 |
| No. of TBAs trained | 21 | 21 | 58 |
| No. of persons trained for IGPs | None | None | 52 |
| No. of participants in health education | No record | No record | 12,345 |

*ANC* antenatal care, *ARI* acute respiratory infection, *IGP* income generation programme, *IMR* infant mortality rate, *SHG* self help group, *TB* tuberculosis, *TBA* traditional birth attendant, *TT* Tetanus, *VDC* Village Development Committee, *VEC* Village Education Committee , *VHW* village health worker.

## 12.13.2 Long Term Development Through Community Participation

### *12.13.2.1 Sambhav Social Service Organisation, Shivpuri, Madhya Pradesh*

The Khoj project was initiated in 1993 in 20 villages in the Shivpuri block of Shivpuri district in Madhya Pradesh for the benefit of Saharia tribes, which belong to one of the most deprived communities in the state. The block is barely 125 km from the Gwalior city and 300 km from Delhi and yet it had remained resource poor and marginalized for years. Lack of appropriate health services and communication facilities were the major problems. Besides, there were a host of other problems including land alienation, exploitation, illiteracy, and lack of safe drinking water and sanitation. Saharias live under extreme poverty. There is rampant malnutrition especially among women and children, and alcohol was a serious social problem. The resultant effect was a self-perpetuating indebtedness. Khoj project in Shivpuri has been actively involved in the organizing Sahariya tribal communities to assert their rights of equality, health, food and secured livelihood and a respectful place in the society. Since health was a major concern, health services and health education was given top priority. Right from its inception, the project laid emphasis on a participatory approach. Various village based groups, VDCs, youth groups, SHGs, etc., were formed, duly trained and involved in the project. This gave the community a sense of ownership and confidence. While community capacity was thus being built, rapport was established with the district administration. This had a very desirable effect and the community began to demand proper health services from the government. Gradually, the ambit of health services was enlarged to include referrals, pathology tests, immunization, ante and postnatal clinics. A well developed planning and management system, with clearly defined parameters for monitoring, evaluation and a functional management information system[6] has seen to a very efficient implementation of project.

There has been a tremendous impact of the project on the health and overall development of the people. *Improvement in health care* has been significant and can be judged by a constantly declining trend in the Infant Mortality Rate (IMR), which from 124 in 1993 has declined to 50 in 2003. Better antenatal and postnatal care coverage (79% as against 16% in 1993), skill enhancement trainings of Dais and better immunization coverage have reduced maternal and infant mortality rates. Now, 100% deliveries are conducted by trained personnel.

There has been an *overall reduction in morbidity and mortality* due to increased awareness and knowledge about various diseases, their causes, prevention and management, for example, diarrhea related morbidity is well under control and there has

[6]Management Information System is a planned system of the collecting, processing, storing and disseminating data in the form of information needed to carry out the functions of management.

been a declining trend in mortality related to the same. No diarrhea deaths were reported during the previous year, against 30 in 1993. Furthermore, increased health awareness has encouraged people to come forward to seek treatment for tuberculosis (TB), which was very difficult for them earlier due to stigma attached.

*Local capacity building with a view of long-term sustainability* was a very important component. Thus, due emphasis was laid on local capacity building of village health workers (VHWs) and trained birth attendants (TBAs), etc. on regular basis. Village panchayats have been fully involved. Building linkages with the government departments has improved health services, encouraged peoples groups like SHGs, etc. to avail of various income generating schemes of the government. Beginning with nil in 1993 in 2003 there were 64 SHGs, 20 Mahila Mandals and 20 VDCs which helped in raising awareness about existing government schemes and facilities and raised voice for bridging the gaps. This is reflected in various memorandums submitted by people to the government. Promotional programs like education and school health, etc. have resulted in better attendance, increased health and environmental awareness.

Various *village development and income generating activities* like kitchen gardening; livestock farming, poultry, etc. are being implemented through the above people's organization. New technologies have been introduced in agriculture. Mahila Mandals have created a conducive atmosphere towards gender equity and overall empowerment of women. They also take care of programmes for adolescent girls. Women actively participate in advocacy campaigns through SHGs and Shabri Mukti Morcha, etc.

After the successful completion of 10 years, to make the programme financially sustainable in future, several funds like a health fund, TB fund, and education fund were set up. There has been an increased collaboration with the government and panchayats for future support to the development programs. There is full community support for TBAs, village meetings and cultural programs, and SHGs have already made rapid advancements towards self support.

One can say with confidence that the project has entered the phase of self-sustenance with due preparation. There is now a strong network of VHWs, Dais, animators and panchayat workers. Health workers are well versed to identify common ailments, their treatment and referrals as well as disease surveillance. It has also a functional training center at Shivpuri. With years of hard work, the project enjoys very good relationship with various government departments.

Sambhav

| Particulars | Baseline Year 1993 | Year 2000 | Year 2003 |
|---|---|---|---|
| No. of villages | 20 | 20 | 20 |
| Health | | | |
| (a) Morbidity % of total cases | | | |
| Diarrhea % | 10.8 | 6.5 | 4.6 |
| ARI % | 14.7 | 4.1 | 2.3 |
| Malaria % | 19.4 | 9.2 | 10.4 |
| TB % | 2.8 | 1.2 | 1.2 |

(continued)

(continued)

| Particulars | Baseline Year 1993 | Year 2000 | Year 2003 |
|---|---|---|---|
| (b) Mortality % of total deaths | | | |
| Deaths due to diarrhea | 30 | 7 | Nil |
| Deaths due to ARI | 25 | 6 | 8 |
| IMR per 1000 live births | 124 | 64 | 50 |
| Maternal deaths (Total no. of cases) | 15 | Nil | Nil |
| (c) Maternal & Child Health | | | |
| Complete ANC Coverage % | 16 | 81 | 79 |
| TT immunization % | 20 | 85 | 87 |
| Primary immunization coverage % | 4.9 | 68 | 78 |
| Registration in first trimester | 10 | 60 | 60 |
| Deliveries/births | 35–45% by untrained personnel | 100% by trained personnel | 100% by trained personnel |
| Community Organization | | | |
| SHGs | Nil | 14 | 64 |
| MMs | Nil | 20 | 20 |
| VDCs | Nil | 20 | 20 |
| Capacity building | | | |
| No. of VHWs trained | Nil | 15 | 15 |
| No. of TBAs trained | Nil | 21 | 21 |
| No. of people trained in health education | Nil | 3219 | 2907 |
| Income Generation Programs | | | |
| SHG Members | Nil | 267 | 674 |
| Agricultural program | Nil | 327 | 400 |
| Goat Breeding | Nil | 10 | 40 |
| Poultry | Nil | 95 | 100 |

*ARI* acute respiratory infection, *ANC* antenatal care, *MM* Mahila Mandal, *IMR* infant mortality rate, *SHG* self help group, *TB* tuberculosis, *TBA* traditional birth attendant, *TT* Tetanus, *VDC* Village Development Committee, *VHW* village health worker.

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