

A Project Proposal

for

**Block Level Programmes in Health,
Credit Co-operatives and Support to Women
in Bihar, Maharashtra and Tamilnadu**

For Funding from

**Association for India's Development
under the Hundred Block Plan Category**

Final Proposal being sent to AID after approval from the BGVS-HBP Committee. To be forwarded to AIDHBP Committee by Thomas Franco.

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This proposal is for a block level programme in health, credit co-operatives and women's support programmes like women's libraries, small scale enterprises and support shelters. The women's support programmes though part of the plan will happen as the need arises and may require a separate budget. The only components budgeted now are for the health and the credit co-operative programmes.

Overview of health status and existing approaches and the rationale for our approach

- 1) The health status of our people remains unacceptable. High maternal mortality and morbidity, high levels of child malnutrition, stagnating infant mortality rates and the resurgence of infectious diseases make necessary a review of our national strategy on health.
- 2) Inadequate development of the health infrastructure – particularly the PHC network – is only a part of the problem. In places like Tamilnadu infrastructure is well developed, but even here the impact on health status remains limited. Utilization of existing primary health care facilities is far below the optimal. This is much more pronounced in children and women's health. Thus, nutrition workers distribute nutrition mix in almost every village. But often the most malnourished either do not access them or even if they do, a corresponding amount is reduced in their daily quota at home due to their inadequate understanding of the problem. Iron and folic acid tablets are distributed but seldom consumed. Vitamin A syrup is not taken around and no one protests. Failure to identify all suspect tuberculosis cases in the villages serviced by a PHC despite adequate staff position and laboratory back up. Failure to conduct even a single delivery or admission in the PHC beds. And so on. Only in family planning services, especially in female sterilization operations, and in immunization services is the effectiveness at desired levels.

This sub-optimality is true for all three services – curative, preventive and promotive. Health programmes also suffer from a poor stress on preventive care – such measures being at best limited to immunization and some antenatal care. Problems like nutrition, sanitation and gender discrimination are seldom part of health programmes.

The above is the case in a relatively well-developed place. In places like Bihar, the situation is even worse, with even simple things like immunization not being done.

- 3) The poor utilization has been attributed to inadequate provisioning, poor staff morale and motivation, weak demand or lack of felt need for these services. Several training programmes have been held to address these issues but have not succeeded. The primary problem is the lack of community support for the staff. Local support ensures they are not teased when they visit the village and also ensures a place where they can take rest and someone with whom they can go on their house visits. This is at the micro level. At a macro scale, it is a reflection of the limitations of a centrally planned and administered health sector functioning within a market economy. Absence of community participation limits the effectiveness of health services. The lack of disease surveillance and local assessment of and planning for health priorities leads to wastage of scarce resources. This also results in fragmented and inadequate interventions. The alternative to this is to be found at one level by better financing & administration and greater community demand & awareness for these services. At another level, local planning for health and adopting processes that allow the

community to participate in its health care, as part of democratic governance, is the answer.

- 4) Attempts to solve the problem of poor utilization by contracting out PHCs to NGOs or to corporate agencies are not likely to solve the problem. Such coverage is likely to be limited and larger coverage by such strategies is likely to be affected by the same problems as affects the governmental structures today. Besides politically such moves will be interpreted as the state renegeing on its commitments to provide health care. Even the world bank which appeared to support such a rolling back in 1993 has in more recent position papers admitted the limitations of proposed alternatives like privatization and insurance and reiterated the government's central role in health care.
- 5) Utilization of existing sources means reducing wastage of scant public resources. At present the expenditure per PHC, including its sub centers, is about Rs 25 lakh non-recurring and about Rs 10 lakh per year recurrent. If we include investments in the anganwadi and balwadi programmes, it is still higher. Investing a further sum of Rs 1 lakh per year for two years per cluster of 30 villages (approx. 30,000 population) for fostering community initiatives and building Panchayat capabilities is a sound investment.
- 6) Even if state provided health services function optimally one needs collective action by the community for an adequate improvement in health status. Health education and awareness, women's education and gender equity and the organization of support activities to help women are essential for ensuring an acceptable health status. Ensuring adequate sanitation in the village and other steps to prevent disease outbreaks, first aid and symptomatic curative measures in those habitations that are too far away from any medical help, are examples of measures that a community needs to take to ensure adequate health care for itself. Moreover health is also a function of behaviour patterns and life styles and it is only a change in cultural awareness that can promote behaviour and life styles that are promotive of good health. Changing behaviour is a slow process and requires a number of negotiations with the villagers before it can take root. It is also a function of peer pressure and a larger change in the culture of the place. To a large extent, prevailing patriarchal norms contribute in a major way to the poor health of women and children. There is also insufficient appreciation of the contribution of nutrition, safe drinking water and sanitation, gender education, and working and living conditions of women in determining health.
- 7) Even if community participation and coordination with existing primary health sector is adequate one will need substantial changes in existing design and funding of certain health programmes and health facilities if sufficient impact needs to be made. This is all the more so when health problems beyond the focus of present health structures – like non-communicable diseases, are addressed. Whilst much of this is beyond the scope of this proposal, the central thrust of such changes is the same as that outlined in this proposal – namely the basing of health delivery on local (or area specific) planning, along with local capability building backed by adequate referral and information systems. The processes established during this programme can be built upon during future expansion to cover a more diverse range of health needs.

Where there is adequate confidence in this approach and where there is sufficient partnership between non-governmental and governmental structures a larger and more effective mandate for *district level planning for health* can be initiated in parallel with this proposal. Such a holistic district level approach would be ideal. But at present neither is there political will nor consensus on such a decentralized and participatory planning approach. Under such circumstances one has to settle for an iterative approach that begins with this proposal.

- 8) Changes of the sort that are sought to be introduced by this proposal will need sustained grass-roots pressure and work to build on. It is in our interests to organize a group that is capable of acting as a pressure group to carry out this function. Such a group needs an identity that is distinct from both government and panchayats. Amongst various possibilities it is the formation of a women's organization or network that is the most feasible and the most desirable. One of the root causes of ill health in our context is the patriarchal structure of our society and the values that it promotes. The building up of a women's network acts not only as a force that has a stake in ensuring an effective health care delivery system, but it also acts to counter and pose alternatives to patriarchal norms and values. While focusing on developing women's networks, the need is also to develop a culture amongst men (particularly youth) to co-operate and support the women's efforts.
- 9) This proposal builds on the rich experience that various NGOs have attained over five decades of work in community health. Programmes like Jamkhed in Maharashtra, SEWA-rural in Gujarat, RUHSA in Tamil Nadu, The FRCH programme at Mandwa, Vivekananda Girijana Kalyana Kendra at B.R. Hills, the SEARCH programme of Gadchiroli and the RAHA programme at Ambikapur are all successful community health programmes that have demonstrated beyond any reasonable doubt that community health workers can deliver substantial improvements in health status. This proposal also takes into account the sharp limitations of government run community health programmes in the late seventies and early eighties. Among the major reasons for the government's limited success with the CHW scheme were:
 - (a) CHWs were selected, trained and monitored by the government health system – they became the lowest rungs of the health bureaucracy rather than representatives of people.
 - (b) Their functions were insufficiently planned and there was no clear action programme for them.
 - (c) There is a need to build analytic and diagnostic skills of the CHW – to use scientific and technological inputs to analyze concrete situations and respond meaningfully to local needs. Only then is she seen as being effective. Not doing this was the greatest failure of the scheme.

Our own intervention addresses the above lacunae and also incorporates a new role for panchayats. For panchayats to become capable of effective community health interventions one needs to work out both a health programme design and an approach to developing the human resources that will make it possible. More than merely sensitizing panchayats, it is important to create health activists who are 'under' the panchayat and not the health department. The activist will inform and guide the

panchayat in making demands of the health structure. NGOs can train this force, but panchayats have to sustain it. The much higher level of capabilities needed to diagnose and intervene in community health justifies the creation of such a cadre, in contrast to merely a health educator or a sensitized panchayat member.

- 10) An important component of this programme is building inter-linkages with the existing departmental efforts. The CHW works closely with government functionaries while retaining an autonomous and voluntary character. Under no circumstance, should the community health worker become a poorly paid functionary of the existing health structure nor should the health department directly administer a community health worker programme. The health department needs to concentrate on the job of improving the quality (and where needed expansion) of its health facilities and personnel.
- 11) This proposal also builds on the experience of the total literacy campaigns and the nature of partnerships that could be built between government and non-governmental agencies. The critical role of the Bharat Gyan Vigyan Samithi and its various associate organizations in building people's network support in a large number of districts is one important lesson. This experience is important as it shows that it is possible to replicate voluntary action programmes in districts where there is no voluntary organization readily available if there is a planned and often patient process to build up such a voluntary network. The failure of the literacy programmes where they were hastily expanded before such people's network support could be built up is another important lesson from the total literacy campaigns. The literacy to health campaigns conducted in 20 districts of seven states and the pilot programmes on health interventions organized in over four districts have also shown that in many districts the network of literacy volunteers, largely made up of young women are available and receptive to such a health campaign. The pilot projects of Ramanathapuram, and Vellore in Tamilnadu and in Jehanabad and Madhepura in Bihar have helped the science movements to develop the tools (training materials, monitoring strategy, disease surveillance strategy and other programme design specifics) needed for this approach. A recent study of the Arogya Iyakkam programme in 7 blocks of Tamilnadu shows that this approach works well and is able to make a significant improvement – a 11% reduction in the overall number of malnourished children (from 66% to 55%) and more than 30% children showing a measurable improvement in their health status. The Jehanabad programme in Bihar even provided basic health facilities like immunization, since the public health system there was so poor.
- 12) This programme is also expected to form a part of the coordinated efforts of the People's Science Movements and other NGOs to promote panchayat level planning. The planning process in Kerala, in whose development the Kerala Shastra Sahitya Parishad had played a key role, has inspired both administrators and NGO's to look at panchayat level planning as a form of intervention in the developmental process. In states where neither the technical resources nor the political will for such decentralization is readily available such planning efforts are more in the nature of capability building and advocacy for change. Moreover, in many of these states, given the nature of domination by local vested interests, one needs to show how the

programme design ensures that the planning efforts serve the needs of weaker sections. This proposal moves towards panchayat level planning while addressing these concerns. In this approach panchayat planning in the health sector is the outcome of two years of activities. These two years of activities are planned to educate and equip the panchayats as well as to give some organizational strength to weaker sections (especially women) so that their needs are better represented in the planning process.

Objectives

- 1) **To improve the utilization of primary health care services:** To be achieved by organizing community initiatives and by building panchayats' capabilities through a number of planned activities. By such activities, to create the necessary processes at the village level essential for a better utilization of existing health care services.
- 2) **To make a measurable improvement in child health by training village women activists and by improving community awareness and organization:** Improved utilization of state provided health services must go hand in hand with community organized collective measures that are preventive and promotive of good health. Specifically the programme will bring about a measurable improvement in under one and under five malnutrition and therefore mortality.
- 3) **To organize and empower women around their health needs.** The initiation and strengthening of village level women's organization is not only a means for achieving programme ends but one of its most important goals as well. This requires intervention not only on health, but also related sectors like small savings, sanitation, information services, day care centers, etc.

Activities

Child Health

Outcome expected:

- Better child health as measured with child malnutrition as the index.
- Decrease in under five mortality
- Full utilization of immunization services, ORS, de-worming, iron and folic acid supplements, Vitamin A supplements, and supplementary feeding programmes

Approach:

- Children are weighed once in 6 months and level of malnutrition charted.
- Trained health activists visit families of children at risk regularly to ensure adequate feeding practices, utilization of services and optimal disease prevention and management strategies. Indeed the central activity in the entire programme is training the activists to be able to analyze the child's ill health in its social setting and be able

to enter into a dialogue with the mother to suggest optimal practices instead of merely prescribing as advice a standardized set of do's and don'ts.

Highlights:

- Individualized advice: The advice given is very specific and individualized to suit the child's needs and also the specific family situation, resource and time constraints. This ensures the advice is taken seriously and adopted by the family unlike advice given in large camps.
- Tracking child by child: Unlike most other preventive services, in this programme the main thrust is on following up each child and keeping track of its health condition. Children needing more attention are visited more often.
- Measurability: This is an integral component of the programme and approach. Child malnutrition status is used as an index for child health. Birth weight and anemia levels may also be used as indices for measuring women's health. Using these indices one is able to make on-line field level modifications in the programme to suit the specific circumstances.

Women's Health

Out come expected:

- Community awareness on all the necessary components of reproductive health – especially menstrual health and reproductive tract infections.
- Full utilization of peri-natal and family planning services especially spacing options.
- Improvement in women's health status reflected in reduced anemia & low birth weight babies
- Reduction in maternal mortality rate
- Counseling for women with low pre-pregnancy height and weight and support and help for them during pregnancies.
- Support activities for women's empowerment – credit cooperatives, library and information center and enterprise development.
- Viable local women's organization especially for weaker sections.
- Looking into factors that lead to female deaths in the 15-45 age group
- Awareness and confidence building for adolescent girls – particularly focused on women's health issues and gender issues.

Approach:

- Visits to families of all pregnant women
- Active support to Village Health Nurses and trained dais
- Initiating a women's health committee
- Initiating a self-help group/credit cooperative in each village and building up support activities around such an institution. This includes a village library and information center with preferential access to women, arrangements linked to the district to assist women who are victims of violence, guidance on employment and income enhancement options etc. While the credit cooperative and the library is an essential

feature of this programme, the others depend on the strength of the team and the nature of funding available.

- Educational and cultural campaigns around women's health issues.

Control of Chronic Communicable Diseases

Tuberculosis and Leprosy are the main two diseases in this category. The strategy of control in such conditions is essentially early diagnosis of all cases and complete treatment so as to reduce the sources of infection in the community.

Expected Outcome:

- Considerable decrease in prevalence of these diseases.

Approach:

- Intensive door-to-door survey of all households is organized to pick up all suspect cases of tuberculosis. These are graded for likelihood of TB using a history based grading system.
- Case detection camp is held after the survey and all suspected cases are brought for medical examination by doctors.
- Confirmed cases are initiated on treatment.
- After the camp all the suspect cases that need further investigation are assisted to get this done and are followed up till they are symptom free.
- All confirmed cases are met along with their families and if needed some respected members of the local community to impress upon them and arrange for complete treatment and this is followed up in subsequent months by the health activist.
- In the case of leprosy the process is similar to the above except that the case detection camp is held as a skin diseases camp. Here the majority of simple skin ailments are treated, while the cases of leprosy are picked up discreetly and followed up later.
- Key to this approach is community involvement in all the above steps. The health department staff is merely present at the camp to initiate investigation and drug treatment efficiently.

(These components will be introduced only at the appropriate time.)

First Level Curative Care

Expected Outcome:

- Better outreach of available preventive services that require regular provisioning (like ORS packets, de-worming tablets, iron and folic acid supplements, condom or oral contraceptive supplies) for primary care.
- Basic symptomatic treatment and first aid made universally accessible.
- Decreased reliance on unqualified and grossly irrational locally available medical help with pressures to rationalize such services.
- Building up of a referral system at the grassroots between community based health volunteers and the primary health care system.

Approach:

- Building upon the existing drug depot scheme by providing training to health volunteers to run this, as well as linking it to the other preventive and promotive aspects of health care. The drug depot is renamed the village medical kit.
- This Village Medical Kit is to provide three services
 - a) Symptomatic care in trivial illness with early recognition of serious complaints that need referral
 - b) First aid for simple cuts and bruises and for common health problems encountered
 - c) Help in some common gynecological problems
- Referral system is organized with the following components
 - ⇒ Referrals are sent only to those doctors who agree to participate voluntarily and are willing to use it to reinforce the health activist's role.
 - ⇒ Referrals are prioritized for some select disease conditions – like suspected tuberculosis, or malnutrition not responding to diet alone, cases of blindness etc.
 - ⇒ The doctor keeps referral cards sent with the patient and write his advice to the health activist on it. Subsequently these are collected by organizers and sent to the activists at the village.

It is important to note that the overall approach of the programme is one of working with and complementing the efforts of the PHC and VHN and replacing it or developing an independent health service system. The linkages with the PHC and the VHN through different components, especially for the referral, first aid and drug depot schemes, is therefore important for ensuring this complementarity and inter-dependence on the field.

Water Borne Disease Control

Expected Outcome

- Increased awareness of water borne diseases and measures needed to prevent it
- Greater demand for sanitary facilities
- Greater panchayat understanding and concern about unsafe drinking water sources and measures needed for ensuring safe water

Approach

- Intensive health education
- Surveillance for gastroenteritis outbreaks and promotion of safe water and sanitation in such situations.
- Eventual linkage with the sanitation mart approach for sanitation delivery

NOTE: Water and sanitation related vector borne diseases need a separate module. No work has been done by us in this area. These though part of an integrated package will not be done as part of this programme at the present time – a separate programme will have to be written up and implemented. They are put in here only to emphasize that the community health worker structure will be useful in implementing this component as well – though it will require a separate training and implementation programme.

Programme Monitoring

Expected outcome

- To install a functional community based health monitoring system which can be used for panchayat level planning as well as a constant feedback for programme improvement.

Approach

- A single register has been designed. The health activist needs to update only one page regularly — the page that records vital events of death, birth, marriage and pregnancy.
- Other information recorded is done, on occasion, collectively. This includes child immunization status and weight of children below 5 and suspected tuberculosis and leprosy cases etc. other than the basic demographic profile.
- The activist need not submit any written report, but once every month, the visiting facilitator transfers the data from her register.
- This register will guide in identifying the children at risk and their response to the programme.
- Basic statistics of birth and death rates also becomes available.
- Computerization of this data will cost relatively little. This will allow for easy analysis and display of data, which would be very useful for programme management as well as to inform and involve the community.

Disease Surveillance

(This is useful if carried out in partnership with government and/or a medical college etc. In the absence of such partnership this component will be deferred, as it needs a fair amount of administrative infrastructure and professional inputs to be fully operational.)

Expected Outcome

- Community based data and information feeds into the district level disease surveillance effort and local health planning process.
- Meaningful involvement of all health care providers in the public health effort with some upgrading of their understanding and skills.

Approach

- All private health care providers who agree to participate and all government doctors and village health nurses and all health activists are provided with printed post cards. When the participant encounters a disease outbreak that conforms to the case definition provided s/he fills up the card and posts it. The district office then initiates the intervention measures needed and acknowledges the information received. The list of reportable diseases is kept very limited.
- The health care providers receive a regular bulletin summarizing the data received along with written material that updates their understanding and skills.
- Computerization of this service along with the computerization of the programme monitoring will be relatively of low cost but very effective.

Mobilization and Panchayat Capability Building

Expected outcome

- Panchayats get the database, motivation, skills and confidence needed for planning for health in their area.
- Community is adequately informed of existing health programmes and participates in their implementation.
- Community understands the need to support measures to safeguard its health interests.
- Weaker sections of the people get better access to health facilities.

Approach

- Formation of a village health committee made up largely by women.
- Sensitization and training programmes for elected panchayat members.
- Cultural programmes using local folk and street theater forms.
- Events where the village is physically mobilized – these may be cultural programmes, but even programme features like organizing TB and leprosy case detection camps and child weighing or surveys can be used to create such an event.
- Frequent village meetings and individual contacts with key players to inform them about health status and measures being undertaken.
- Periodic presentation of health status and programme response reports to the key persons, so as to inform and involve them.

Organization and Sequencing

The programme needs a wide range of activities to be carried out within the short space of two years and with a limited force of community-based volunteers. The key to this is diligent organization, giving great attention to detail, and a very carefully planned sequence of programme events.

Organization structure:

At the block there is a health committee made of three to four part time resource persons and two to three full time trainers (facilitators). One recommends one full-time trainer for 10 health activists. A full-time coordinator coordinates the health committee. The part time resource persons qualify by their past involvement in the science movements' activities and their readiness to understand this new area of work. They have an important role in sustaining the programme after the project period. It is this full time team along with the coordinator who does the bulk of the work and who will form the strength of the emerging women's network. After two years the organization must find ways support them without depending on the govt. It is preferable to find women who will remain in that area indefinitely so that they can sustain the programme after the project period.

At the village level the key person is the health activist. Invariably a woman, preferably a young woman of at least 8th class education, likely to permanently reside in that village (married), this health activist acts as the coordinator of the village health committee that is formed later in the programme. Her functioning is critical to the success of this programme and is achieved by good training and a very good quality of support that is

provided to her by the block team. The village health committee should be made of similar women, each chosen from a different cluster of houses. Each such unit should have about 150 to 200 houses for optimal functioning. In case of small, scattered habitations one could increase this number. The health activist who is expected to give three hours per day for about three days per week, other than attending training camps is not paid even a token honorarium – especially during the first two years.

Training

Training is constrained by the fact that even the best volunteers cannot leave their homes and work for considerable periods. Paying a stipend would seriously jeopardize the dynamics of selection of these volunteers. Therefore training adopts two strategies. The first is to hold a series of monthly training camps, beginning with a four or five day residential camp and then following it up with two or three day or even one day camps held at regular intervals. The training content is organized into 8 modules. In each camp one module is initiated and a module covered earlier is reiterated. Over a period of one and half years about thirty days of training should be achieved. The second strategy which is the more important one is for a persistent “on -the- job” training imparted by the full time trainers. At least once a week the activist should be accompanied by the trainer/facilitator on her rounds and be actively coached on the job. For the trainers to be effective they themselves are provided with over 30 days of training in the first year all of which is residential and with a number of supervised field visits so that their skills are adequate. The single major skill repeatedly emphasized in the training process is that of assisting a mother to improve her child’s health based on an analytic understanding of each child’s situation and needs.

There are 3 kinds of training:

1. At the state level for block level full-timers
2. At the Block Level for the village level activists
3. On the field training to the activists and the health committees

The training is on the various aspects mentioned above. Each component of training is followed by actual implementation and only after the activist is clear about the programme component, do we move on to the next aspect. A lot of details on this is given in the Arogya Iyakkam Report on the 7 block programme that has been done in Tamilnadu and is available with AID. The training course material is also prepared in the form of books. One set is for the block full-timers – a set of books called “Health Campaign Guidebook, Women and Child Health and Village Medical Kit”. Another set is 15 short easy reading books for the village activists and the health committees which deal with water borne diseases, diarrhoea, pregnancy care, child care, etc. The former set is available with AID and has details on the training course that is proposed.

Sequencing

Each component is introduced sequentially and once internalized and made part of a regular process the next component is introduced. Assuming the funding for the programme will come by May, we have the following schedule:

1st Year:

- a) 1st month: 4 day training camp of state resource persons and trainers. Basic survey in the programme areas for analyzing the specific problems of each area and establish contacts with the government PHC system. Starting of Self-Help Groups.
- b) 2nd month: Preparing the register (a survey where basic demographic profile and details of each child below 5 years of age are gathered.)
- c) 3rd month: After the first round of training is completed, all the children below five are weighed and the high risk children identified and house visits to these houses are initiated
- d) 4th month: One round of meetings with health employees and panchayat members is organized. A round of kalajatha (cultural programmes by a traveling group) builds up a favorable environment. Expanding the SHG network.
- e) 5th month: Second round of training strengthens child health programme and introduces women's health components relating to care in pregnancy.
- f) 6th month: Third round of training strengthens both above components.
- g) 7th and 8th months: Another round of panchayat sensitization and village meetings, followed by the anti tuberculosis camps. A one-day training on tuberculosis precedes the first camp, the camp itself acting as the second day of training. Introduction of referrals along with the tuberculosis camp. The TB camps also act as a way to garner village support for the programme.
- h) 9th-10th months: Introduction of the village medical kit (first level curative care) following a 3 or 4 day training camp. Second round of weighing children. Analysis of the data obtained to study effectiveness and to correct programme direction in places where some points have been missed.
- i) 11th-12th months: Strengthening all the four above elements through repeated one or two day trainings and field level follow up. Starting more SHGs and using these for communicating health messages.

2nd Year:

- a) 13th-14th months: Introducing remaining elements of women's health and consolidation of support activities like credit cooperatives, village libraries with specific focus on organizing and building awareness in adolescent girls. Training on issues relating to adolescent girls. Programmes and group discussions with adolescent girls in schools and villages.
- b) 15th month: All components should be introduced. Building sustainability – strengthening women's credit co-operatives. Strengthening the women's health committees and libraries for adolescent girls.
- c) 16th month: Re-training new activists who replace the ones who drop out in the middle of the programme. Improving overall effectiveness of all components of the programme. 3rd round of weighing of children.
- d) 17th month: Analysis of data generated by the weighing. Display of the data at panchayat meeting and encouraging local level planning on health. Raising local funds for running the programme the next year. Third round of training strengthens both above components.
- e) 18th-24th months: Focus on continuous re-training and improving effectiveness and strengthening women's credit co-operatives and networks and generation of

local funds to sustain the programme. The need is to develop the confidence, the will and the ability to both raise funds for sustaining the programme and at the same time not reduce the intensity of it. Negotiating with panchayats to support the health activist and to review and monitor her work and include her inputs in local level health planning is one important component.

It may be noted that all activities once initiated are continuing activities but initiating them in sequence not only allows us to structure training and support but also allows for ensuring that field conditions are adequate for such introduction. Thus, a medical kit is introduced only in a village where the health activist is well trained and effective. By the 16th month all the proposed components must be introduced. After this the stress of the programme is on improving effectiveness and building up for sustainability.

Sustainability Strategies

Funding for the programme cannot continue indefinitely, especially at this scale. That would only add another structure that over time would bureaucratize and fall into the same problems as the present structures. In that sense this is only a two-year campaign that is being proposed. But then the questions that arise are how to sustain the programme after the initial two-year phase. Without an independent network to support the village health activists and the panchayat level planning efforts, these cannot be expected to continue on their own. Also as programme needs change the government would need mechanisms to equip the health activists and the panchayats.

This programme hopes to be sustainable using one or more of the following options:

- c) Health activists may continue their work voluntarily, as theirs is only a part time task. A good grass-roots women's movement identity, as are associated with credit cooperative movements, would foster such voluntarism. Alternatively the panchayat could pay a small encouragement fee to the activist for a given set of services—like presenting the health status report, maintaining a drug kit, identifying and following up malnutrition and TB cases etc. (Panchayats already pay for overhead tank operator, TV-in-charge, and similar part time staff). Panchayats where the health activists are more effective and where the health team has considerable influence are more likely to offer such support. Such support is less likely where the weaker sections amongst whom the programme is focused do not have much influence on the panchayat leadership. Improving the economic status of the individual volunteer by arranging for access to relevant development schemes—like the milch cow scheme, or a TRYSEM programme or a DWCRA group loan would be useful. Whatever the option exercised, the key to sustaining the health activist's work is maintaining a good quality of support.
- b) Full-time trainers/facilitators would continue only if there is adequate will in the science movement to do so. Such continuation may be based on the group raising the necessary fund by public contribution, raised in the spirit of sustaining their women's network. Credit cooperative based support in the lines of the MALAR model is another viable and attractive option. Another, more hypothetical option is their being able to undertake economically productive activity that supports them and may be

possibly related to their work (like a sanitary mart or food products like weaning foods/nutritious mix production). The part time resource persons who have been contributing voluntarily play an important role in "forcing through" this transition. Such a transition should have occurred before the project period is completed.

- c) Sustenance of the programme also means a continued link with the government. Without funding it is difficult to sustain such a relationship. However a NGO (people's movement) structure fully dependent in perpetuity on government funding would completely alter its NGO (people's movement) character. It is suggested therefore that the government can commit to supporting a small resource group of four or five at the district level in those districts where over five blocks (over 300 villages) were taken up for the campaign. Where only one block (60 villages) was in the campaign a small fund to support one person along with some training and materials cost could be provided.
- d) One possibility is that the government funds this small honorarium to the health activist through the panchayat. However this is paid only with the concurrence of the NGO resource group, which is responsible for providing training and support to them. This would be a form of institutionalizing the relationship between government, panchayat and the NGO at terms where the spirit of such partnership has maximal chance for constant renewal. The caution is that such an arrangement must be entered into only after the two-year campaign has achieved its objectives, at least to a significant degree. If this caution is ignored in the hope of covering a much wider area in a much shorter time, one is likely to end up as similar community health worker programmes in the government sector have done in the past (village health guide, link volunteer scheme, Jan Swasthya Rakshak scheme etc).

Budgetary Implications

Given below is the unit cost of undertaking this programme in one block. It is proposed that in the average block not more than 60 villages (i.e. 12000 households, or about 60000 population) need be taken up. This is only two-thirds to half the population of a block. The understanding is that it is more cost and effort effective to concentrate on habitations of weaker sections and those that have greater problems of access – than on all habitations equally. However one insists on taking up the campaign in one or two villages under every panchayat so that the capability building does occur in every panchayat.

Unit cost for 60 villages (one block) - Spent at the block Level

Item	Unit Cost (Rs.)	No.	Per Month	Per Year
Stationary, Xerox, etc	500	1	500	6000
Travel Costs	250 (FT) and 400 (BRG)	7	2150	25800
Training Activists (Camp)	30	60*20 (days)	3000	36000
Salaries for Full-timers	1000/month	7	7000	84000
Total			12650	151800
Administrative overheads			1265	15180
Total (for one year)			13915	166980

FT=Full-timers, BRG=Block Resource Group (part-timers not paid)

The above is only budgeting what is needed from outside, not counting the local support raised. Block and district level support, review and monitoring is not budgeted and will be sponsored by the local organization. Also, a part of the expense for camp training will be raised locally. If that happens, the money budgeted for the training will be kept at the block to be used at the non-funded phase for sustaining the programme. The money generated from the Small savings groups will also likewise be used for sustaining the programme. The amount comes to Rs. 2783/year/village – which is quite small.

But this small expense at the block level is possible only with a corresponding expense at the state level – for training of block level full-timers and for materials. The budget for this is given below:

This is the per block state level expense:

Item	Unit Cost (Rs.)	No.	Per Month	Per Year
Stationary, Xerox, etc	500	1	500	6000
Travel Costs to Training Camps and Review Meetings	400	9*6 times/year		21600
State Training Camps and Review Meetings for Block FT and BRG	50	9*20 (days)		9000
Materials for training (books, notepads, files, papers, survey forms, registers, etc, a book set for each village committee)	350	60 activists +7 FT+ 3 BRG		24500
Preliminary support for printing of passbooks, account books, etc (only provided if needed by the district)				5000
Medical Kit	100	60		6000
Monitoring, Photos, Documenting, etc				6000
Total				78100
Administrative overheads				7810
Total (for one year)				85910

(Training camps are State Level Camps and 4 day residential activities. We expect to hold 4 such camps in a year – once every 3 months. In between, we will hold 3-4 monitoring and review meetings – sometimes with all the FTs, sometimes only with the Block coordinators and 1-2 FTs. If a 10-day environment building through Kalajathas is planned that will be an extra Rs. 15000/Block + a state training camp of Rs. 30,000– but this is not budgeted now. It may be latter added in as part of a different proposal.)

Apart from the above each State needs a state level support team. The budget for this is given below:

Item	Unit Cost	No.	Per Month	Per Year
Typing, Xerox, Stationary			3000	36000
Phone, letters, etc			2000	24000
Salaries for State FT	3000 pm 2000 pm 2000 pm	1 coordinator 4 field level 1 office asst	13000	156000
TA for State FT	1500	6	9000	108000
Total (for one year)				324000

If a computer is needed by the state to document the programme details and use the health software, this can be arranged for by the state or with some help from the Computer Assembling unit in Chennai – support for which already comes from AID.

Based on interest expressed by the State Teams (which in turn have finalized this based on discussions with the district teams), the following places will take up the programme:

- **Bihar – 13 Blocks in 13 districts.** Implemented by the Bihar Gyan Vigyan Samithi – the exact blocks and districts to be confirmed by the Bihar GVS State Coordinator and BGVS National Secretary. The money for this can be accepted by the BGVS National office at Delhi and the accounts and coordination done from there.
- **Maharashtra – 3 Blocks – These are Beed (40 villages), Nasik (30 villages) and Pune (25 villages).** It is expected that the funds will be routed through Tathapi (coordinator – Audrey Fernandes) which will also be the training organization. The programme will be implemented by the BGVS-Maharashtra with Dutta Desai as the overall programme coordinator.
- **Tamilnadu – 20 Blocks.** After a lot of discussions with the districts, the following list of blocks has been prepared.

Tiruvallur district – Tirutani, Gummidipoondi, Kadambattur Blocks – 3 blocks
 Madurai district – T. Kallupatti, Sedapatti, Tirumangalam – 3 blocks
 Virudunagar district – Vembukottai, Virudunagar, Sivakasi, Srivilliputhur, - 4 blocks
 Cuddalore district – Keerapalayam, Parangipettai, Kurinjipadi – 3 blocks
 Theni district – Periyakulam, Chinnamanur, Kadamalamailee – 3 blocks
 Pondicherry – Bahoor commune – 1 block
 Villupuram – Kandamangalam – 1 block
 Thanjavur, Nagapattinam, Tiruvarur, Pudukottai, Dharmapuri – 5 blocks
 Chennai – 1 Urban Slum

These together come to 24 blocks. The full-scale programme will not be launched in all the blocks. We will have a state training workshop and ask the blocks to form savings groups and start a health programme with no funding for a few months. Based on the response, the best blocks alone would be chosen for the funded phase. The others would continue without funding at the level they are able to manage till they pick up. Apart from these, Kanyakumari has asked for a minimal health programme in all the 10 blocks

which will be built around their savings group network with a minimal funding of Rs. 1000/month/block for training costs.

The cost of the per block programme in Tamilnadu will be less than the other states since a team committed to health is already built up here. (In Bihar also there is such a team, but the scale of the current programme is much smaller, though they have been working in all the districts in literacy and other areas). Maharashtra's villages/block is also lower and the cost of the programme will also be correspondingly lower. Since the situation is each state is different, the budget for each state is given below separately.

Within the HBP committee in BGVS a discussion was held on what level of funding would be required. One of the options is to ask for funds for all three - the state level coordination, state level block expenses and block level expenses. The other is to just ask for the state level coordination and state level block expenses and try to manage the block level expenses locally. The latter though ideal may not be feasible everywhere. After some discussions it was decided that since Tamilnadu already has more experience in implementing the programme, TN will manage with just the state and state level block expenses and will not ask for block level expenses. On the other hand Maharashtra and Bihar will need the entire support.

Budget for Bihar (13 Blocks) for 1 year

Entire Funding Requested

Block Level Expenses	= 13 x 166980	= 2170740
State Level Expense for the Blocks	= 13 x 85910	= 1116830
Overall State Coordination Expense	=	324000
Total	=	Rs. 36,11,570

This total amount maybe sent in 4 installments to BGVS Delhi. The actual expense for the first quarter will be slightly less – the state coordination team and the block teams will have to be selected in phases. Therefore the first quarter expense will be used for a slightly longer period.

If the block team is asked to raise the block support component of the programme, the budget comes down by a large amount (Though we know it is possible after 2 years of the programme, it is yet to be seen if this is possible right from the start.) The overall budget for Bihar then becomes:

Case II with only State Training, coordination, materials and State Full-timer expenses requested is not an option at the current time. Possibly one could go for this lower funding option (works out to only Rs. 14.4 Lakhs) at the next phase when we have a larger strength and a bigger team in Bihar.

Budget for Maharashtra (3 Blocks) for 1 year

Maharashtra is taking up 40, 30 and 25 villages in 3 blocks. This means 5, 4 and 4 FTs in each of these blocks. The number of State Level Fulltimers will also be correspondingly less – 2 people will be enough. If more State Resource Persons are available, then the number of blocks can be increased – this can be done in the second phase. This is a proposal for expansion to 2 more blocks – but which needs confirmation and the extra State RPs needed can be proposed then. CEHAT also wanted to take up a five blocks in Maharashtra – the state full-timers for that can also be used for helping the BGVS blocks. The Maharashtra expenses for the 3 blocks therefore comes to the following:

Block Level Expenses	= 316140
(40 Village Block = 120780	
30 Village Block = 97680	
25 Village Block = 97680)	
State Level Expense for the Blocks	= 153780
(40 Village Block = 61710	
30 village Block = 46035	
25 village Block = 46035)	
Overall State Coordination Expense	= 198000
Total	= Rs. 6,67,920

This total amount maybe sent in 4 installments to Tathapi (to be confirmed by Duttaji). The actual expense for the first quarter will be slightly less – the state coordination team and the block teams will have to be selected in phases. Therefore the first quarter expense will be used for a slightly longer period.

If the block support amount could be raised locally, then the budget would come down to Rs. 3,51,780. But given the current strength in Maharashtra, it does not seem as if the block support component of the programme could be raised locally. Therefore the budget requested remains the same as the above.

There are two funding options:

- The entire amount (either Rs. 6.67 Lakhs) is sent to Tathapi in 4 installments or
- A part of the funds is sent to the coordinators (the salary plus travel components) directly as fellowship and the rest sent to Tathapi. The fellowship component comes to Rs. 1,38,000 paid to 3 people at the state level – again as installments

Budget for Tamilnadu (24 + 10 Blocks) for 1 year

Tamilnadu is taking up the programme in 24 Blocks + 10 Blocks of Kanyakumari. But the full-programme will be initiated only in 18 Blocks + 10 blocks of Kanyakumari.

Though the state training will be given to all the blocks. The requirements for this programme varies and the break up is given below:

For each block which will be part of the funded phase, only Rs. 6000/month will be provided. The rest of the funds required will be raised locally. Kanyakumari will only be provided Rs. 1000/month. The number of full-time coordinators is also correspondingly lower and so will the components introduced. The 10 blocks will therefore require the kind of funding that 2 blocks need. Therefore the whole programme can be seen as a 20 block programme (as far as funding goes). The state expenses for the 20 blocks has to be borne entirely.

Case I

Block Level Expenses	= 20 x 6000 x 12 = 14,40,000
State Level Expense for the Blocks	= 20 x 85910 = 17,18,200
Overall State Coordination Expense	= 324000
Total	= Rs. 34,82,200

There will be an attempt to raise the block support amount locally. If it is not possible, a requested for funding can be made separately. Therefore the amount requested is only:

Case II

State Level Expense for the Blocks	= 20 x 85910 = 17,18,200
Overall State Coordination Expense	= 324000
Total	= Rs. 20,42,200

This amount should be sent in the following ways:

- Rs. 2,64,000 – fellowships (salaries+TA) to the state fulltimers directly. The exact names will be sent after the proposal is approved.
- The expense for materials and books, medical kits etc should be sent to: **Science Publications** (publications wing of TNSF). A letter saying this amount is for printing and purchase of books for a health programme being supported by AID would be needed. That is in our records we will show that AID has purchased the books, registers, etc from Science Publications and donated it to the health programme. The amount to be sent to Science Publications is: Rs. 8,30,000.
- The rest of the amount (training camps and travel to camps, monitoring etc) should be sent to the NGO (with FCRA) that we will send after confirmation. The amount for this is Rs. 9,48,200. If possible, AID can even send this money as a cash advance through some volunteers just before the camp – and take back the vouchers and expense bills for it and settle it with the AID accounts directly. The camp would then be seen as a directly sponsored event. But this is not possible, then we will identify an NGO who can receive the amount for providing us training through camps.

All of the above can be sent in quarterly installments.

Budget Summary

The Total Budget Requested by this proposal is:

Bihar (13 Blocks)	= Rs. 36,11,570
Maharashtra (3 Blocks)	= Rs. 6,67,920
Tamilnadu (18 + 10 KK Blocks)	= Rs. 20,42,200
Total	= Rs. 63,21,690

Cost per village estimates:

The total number of villages covered by this programme will be = 2075
The cost per village per year (with Rs. 77,61,690) = Rs. 3740
With Rs. 63,21,690, the cost per village per year works out to = Rs. 3046

Both of the above costs are quite reasonable.

In the next round (by November) we will be submitting proposals for Karnataka, Madhya Pradesh, Assam and Rajasthan. The ground work in these places has been started and the states are getting committed to such a block level programme. UP and Orissa are already overburdened with programmes and cannot take up more right now. Himachal, Haryana and Andhra will come in once the programme starts up in the other places and the fund handling situation has been established. This will happen possibly by next May.

STRENGTHENING AID PARTICIPATION in HBP

The request from BGVS to AID is to support the block programmes above. Monetary support only a part of the request. A more complex, but in the long term more fruitful support will be non-monetary. In particular, we see the following options:

- Visit by one (or more) volunteers for at least a week to a block (district) and a detailed study of the evolution of the PSM in the district and the various programmes that they have been involved in. This should be followed up by the volunteer writing a report and getting it corrected by the district/state team. Once ready (with pictures) it can form a documentation of the district's activities and can be put up on the web and used by the district. Every month, the volunteer can call up the district and update the report. Apart from giving the volunteer (and the chapter) a much better understanding of the process, this will help in monitoring the programme and provide the national & state coordination teams with detailed documentation which can be very useful in understanding, modifying and expanding the programme or using it to try for policy changes.

- Helping create a volunteer team in nearby cities who can visit the block regularly and provide support is another useful though difficult contribution.
- Helping procure materials – books, slides, videos, computers, software, camera, etc – for the block team is yet another way to support the programme. Some of this will require more work though – particularly in the selection of good progressive books for a block level library, collection of slides and software, modifying them for the programme, etc will take some doing. For example if the block volunteers are meeting adolescent girls and taking health classes for them, some educational softwares, posters, slides may be very helpful. But finding things appropriate will require someone to really understand the programme requirements well.
- Help with analyzing the data generated by the programme and generating reports is another very important contribution.
- Building up linkages with government officials and international agencies, arranging to present the work done in the blocks and using the programme to fight for larger policy changes. Contacts with government (both by visiting the block and meeting doctors and by talking with officials at the state level) to ensure support for the programme. Building up the image of the village volunteers and the block teams within the local area by meeting different influential sections in the block/district and convincing them about the need and usefulness of a programme such as this.

Almost for all of the above, AID volunteers will have to spend a fair amount of time learning about the programme, reading up the literature (which is already available with AID in terms of reports and books), and thinking about how they can contribute creatively. Understanding the process by which the programme happens, the actual local dynamics that motivates the volunteer and the actual change making process is far more complex than anything that can be written on paper. Only by actively joining the movement for catalyzing change can one learn about the process. And by participating in the details, the volunteer will understand the process much better and therefore participate even more effectively.

To help AID in this process of understanding the HBP programme on the ground better, one could have a state full-timer with the main responsibility of documenting the programme and coordination with the national center and with AID. This is anyway a necessary for the programme as we will need to track the progress in various places and rush support where the programme is weak. But it can also serve to help AID be informed. Ideally if some AID volunteers would like to come and take up this aspect for one or two years, and are being supported by a fellowship, it would be great. But in case this does not happen, one can identify someone here who can take up this task.

We also suggest that 3 chapters link up with the Bihar programme and try to follow up, review, visit and support the programme. Similarly three chapters can link up with the Tamilnadu programme and one chapter can link up with the Maharastra programme.

A NOTE TO AID

We wish to clarify to AID that the above money is the budgeted amount. The programme speed may follow what we expect in which case the money will be spent within the time frame specified. But if the programme proceeds more slowly, the expenditure will be correspondingly less. The exact account of how the money was used will be sent to AID and any extra money left over will be used for the next phase (so the funds released for the second phase can be correspondingly lowered). This way the question of whether the money sent is indeed being used need not arise, even if the programme pace is slower. It is usually understood that the sanction of the proposal from AID means the money is available – under the condition that the previous advance (every quarter) has been spent and accounts for it submitted. If the quarter becomes 4-5 months, then the next release will only be from the 6th month or 5.5th month.