Effective social determinants of health approach in India through community mobilization

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Executive Summary

The unsatisfactory health condition of the economically and socially deprived sections of the communities is caused by unequal distribution of income, goods, and services. Their vulnerability makes it difficult for them to achieve satisfactory health status since they are continuously affected by poor social policies and programmes, unfair economic arrangements and decades of economic and social deprivation. Their health condition can be substantially altered only by a social determinants approach, which improves their daily living conditions, help to tackle inequitable distribution of power and resources, and adequate State Policies to address their multiple development challenges adequately.

It is heartening that now in all health forums, the social determinants dimension of health is well recognized. Millennium Development Goals are very important moves in that direction, but unfortunately “we have only 7 and a half years left and one billion people still live in extreme poverty. More than one billion people lack access to safe drinking water. About 2 billion people have no regular access to reliable energy services. 750 million adults cannot read. And one of the most striking statistics is that the odds that a woman will die from complications in pregnancy in sub-Saharan Africa are 1 in 16 over the course of her lifetime, compared to 1 in 3800 in the developed world”. Until we have made significant progress on these critical areas, health will remain a distant dream for millions of people all over the world.

The Voluntary Health Association of India (VHAI) is the world’s largest association of voluntary organizations formed by the federation of State level Voluntary Health Associations linking over 4000 health and development organizations in India. At present, 27 State Voluntary Health Associations are in operation all over the country. VHAI has also taken significant initiatives in development work at the grass roots level in the remotest parts of India through comprehensive health and development projects, known as ‘KHOJ’ (meaning search).

The KHOJ Project is an initiative of VHAI to bring about a holistic change in the lives of its beneficiaries by uplifting the socio-economic and health status of vulnerable communities. Its primary objective is to develop an enduring partnership between VHAI and the implementing organization, thereby
strengthening the latter to effectively implement innovative, self-sustaining community health and development programmes.

**Problem Statement**

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 several achievements and efforts, the 50 years of development plan has not changed the lives of almost on third of India’s population.

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 and vulnerable areas. Findings of a district level survey by VHAI (Health For the Millions 2004 and ICDHI Monograph, VHAI, 2007), to assess the extent of state variations in regard to health indicators based on the data generated by National Family Health Survey, India (NFHS) 2005-06, Census 2001 and Rapid Household Survey (RHS) 1998-99, Government of India (GOI), further confirm the widespread impoverishment of the people in terms of health care education, basic needs and income insecurity.

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 citizens of India still lags behind and the health gains in the country have been uneven. Although there has been 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 (World Bank, 2001). Childhood diseases like diarrhea, anemia etc are also more prevalent among low-income households compared to high income households (IIPS,
The health sector in India is still characterized by sharp socioeconomic, rural-urban and gender inequalities.

**Table 1 A: Some Important Health Service Indicators**

<table>
<thead>
<tr>
<th>Indicators (service)</th>
<th>Year 1951</th>
<th>Year 1986</th>
<th>Year 2000</th>
<th>Year 2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Allopathic Doctors per 100000 Population</td>
<td>17.11</td>
<td>42.75</td>
<td>56</td>
<td>60</td>
</tr>
<tr>
<td>No. of Nurses per 100000 Population</td>
<td>5</td>
<td>27</td>
<td>78</td>
<td>80</td>
</tr>
</tbody>
</table>


**Table 1 B: Some Important Health Status Indicators**

<table>
<thead>
<tr>
<th>Indicators (Health Status)</th>
<th>Year 1951</th>
<th>Year 1986</th>
<th>Year 2000</th>
<th>Target HFA</th>
<th>Year 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth: men</td>
<td>32.45</td>
<td>58.10</td>
<td>60.4</td>
<td>64</td>
<td>61</td>
</tr>
<tr>
<td>Life expectancy at birth: women</td>
<td>31.66</td>
<td>59.10</td>
<td>61.8</td>
<td>64</td>
<td>63</td>
</tr>
<tr>
<td>Infant Mortality per 1000 live births</td>
<td>146</td>
<td>96</td>
<td>68</td>
<td>&lt; 60</td>
<td>58</td>
</tr>
</tbody>
</table>


These gains notwithstanding, survival standards in our country are still comparable to some of the poorest nations of Sub-Saharan Africa. Furthermore, the achievement seen in various frontiers of
health care might be generalised, keeping in view the dramatic differences between the health status of the poorest and the richest states. This is evident from Table 2.

Table 2. Crucial indicators of Social and Health Differences in Major Indian States

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Punjab</td>
<td>6.16</td>
<td>69.95</td>
<td>45</td>
<td>69.8 Male 72 Female</td>
</tr>
<tr>
<td>H.P.</td>
<td>7.63</td>
<td>77.13</td>
<td>51</td>
<td>N.A Male N.A Female</td>
</tr>
<tr>
<td>Haryana</td>
<td>8.74</td>
<td>68.54</td>
<td>61</td>
<td>64.6 Male 69.3 Female</td>
</tr>
<tr>
<td>Kerala</td>
<td>12.72</td>
<td>90.92</td>
<td>12</td>
<td>71.7 Male 75 Female</td>
</tr>
<tr>
<td>M.P.</td>
<td>37.43</td>
<td>64.11</td>
<td>79</td>
<td>59.2 Male 58 Female</td>
</tr>
<tr>
<td>Orissa</td>
<td>47.15</td>
<td>63.61</td>
<td>77</td>
<td>60.1 Male 59.7 Female</td>
</tr>
<tr>
<td>Bihar</td>
<td>42.60</td>
<td>47.53</td>
<td>61</td>
<td>65.7 Male 64.8 Female</td>
</tr>
</tbody>
</table>


Table 2 presents the literacy, infant mortality, and life expectancy figures of the three larger Indian states with the lowest rate of people living below the poverty line (Punjab, Haryana and HP), the three
states with the highest rate of people in poverty (Madhya Pradesh, Orissa and Bihar), and (in the middle) the state of Kerala. These figures point out that the health status of the people is intricately linked with their social and economic status on the one hand and social and political reforms taking place in the society on the other. This is shown in Table 2 by the example of Kerala. Although economically, this state is not as advanced as some other states, it is doing extremely well in terms of its health status due to its long tradition of socio-political reforms, better education, better status of women and egalitarian movements. It is also important to mention here that even within the richer states there are areas of darkness, such as the drought-prone districts.

Similarly, there are clear indications that critical indicators as the infant mortality rate, maternal mortality rate, and fertility rate, are directly related to the literacy rate of Indian women, which in turn, is directly related to their social and economic status.

**Table 3: Estimated Death Rate 0-4 Years in India**

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>11.3</td>
<td>11.7</td>
<td>11.5</td>
</tr>
<tr>
<td>Rural</td>
<td>20.6</td>
<td>23.0</td>
<td>21.7</td>
</tr>
<tr>
<td>Combined</td>
<td>18.6</td>
<td>20.6</td>
<td>19.5</td>
</tr>
</tbody>
</table>

*Source: Health Information of India 2002 (Ministry of Health & Family Welfare)*

Table 3 shows that among children, the chances of survival are nearly twice as high in urban areas compared with rural areas. It also shows that both in urban and in rural areas, the chances of survival are better for boys than for girls. The main cause of this is that in India, generally speaking, boys are more wanted and therefore better cared for than girls, as a result of the dowry system. Although this system is officially prohibited, in practice it still prevails. In early adolescence the mortality of men and
women is at par, but at the child-bearing age (15 to 34 years), female mortality is again higher. Particularly during the peak years (20 to 24), maternal mortality takes a heavy toll. Interestingly, after the age of 35, the death rate among females is lower than among males. Improvement in these areas has been marginal and slow. As a result, a declining sex ratio has persisted in India throughout the century, as shown in Table 4.

Table 4: Sex Ratio (Number of Women per 1000 Men) India, 1901-2001

<table>
<thead>
<tr>
<th>Year</th>
<th>1901</th>
<th>1931</th>
<th>1961</th>
<th>1991</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex Ratio</td>
<td>972</td>
<td>950</td>
<td>941</td>
<td>927</td>
<td>933</td>
</tr>
</tbody>
</table>

Source: Census of India Reports

Context

Given this overall backdrop and the Voluntary Health Association of India’s deep concern about making a breakthrough in the health status of the people, particularly those living in remote and inaccessible areas and generally of extremely low economic status, an innovative approach of tackling health and development issues, called KHOJ, was evolved.

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 in remote areas. 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 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. The objective of KHOJ is to explore the untapped potential of the community to promote community health.

To ensure that health and development programmes have a lasting impact, VHAI emphasizes sustainability as an essential feature of such projects. To ensure sustainability, inputs are provided in
the initial stages itself. The proposed budget is aimed at supporting community health or development interventions of grass roots level organizations by drawing upon the achievements of successful projects. Support of the government machinery is sought to arrive at a holistic programme of community health. Focusing on the local needs, especially of the underprivileged sections, is an integral component of the project.

In its endeavour to support, develop, and sustain voluntary action in the area of health, VHAI had gradually come to realize that community health is a crucial component in the development of a broad base of human capital that can reinforce economic growth. It also came to recognize areas of light and darkness in the implementation of community health programmes. VHAI, therefore, made concerted and conscious effort to do away with the “areas of darkness”.

We were greatly encouraged to launch this initiative due to the prevailing climate of partnership being created by the government in view of their own concern regarding the extremely uneven health and development status of the country. The Ninth Five-Year Plan of the Government of India states, “Keeping in view the potentiality of panchayat raj, it is proposed that the health infrastructure in the rural areas, is gradually but surely, made accountable to village panchayats, panchayat samitis and zila parishads”.

The focus has been on the strengths of Village Councils. Their multi-faceted approach, individuality and problem-solving capabilities have been encouraged. The functions envisaged and performed by the Councils in the field of health and development are:

- Preparing area plans and allocating resources.
- Making the government health infrastructure accountable to panchayats.
- Empowering zila parishads to appoint (and dismiss) doctors.
- Involving and mobilizing the community and encouraging community participation, in order to meet the health and development needs of the area.

If the first three above stated functions of the Councils are facilitated at the earliest, many of the health problems in the rural areas can be tackled at the primary level itself.
This situation permeated right to the grass roots where district officials were looking for effective partnerships between the government health and development infrastructure, NGOs and the private sector to optimize the health infrastructure and improve the health and development status of the people.

This opened up an enormous potential for involving people and elected village leaders, many of whom were women, in a process of transformation of the village development scenario. The other major factor, which helped us to realize this goal was present either in nascent or developed form from among some motivated local NGOs, who were willing to work hard with communities with a considerable degree of commitment to experiment with this innovative approach to development.

While taking up this important step, we realized that in a sub-continent as diverse as India, centralized planning for health, does not make sense - socially, economically, politically, culturally, demographically and topographically. Given the uneven terrain, it is hopeless to do centralized planning and implementation for the whole country. Besides this wide spectrum of situations, it is naive to expect people to participate in a programme in which does not involve them in its conceptualization, planning and implementation. Far off Central Ministry or State Secretariats are as alien to an ordinary villager as is the UN Headquarters to a commuter in Delhi. On the other hand, if we opt for decentralized planning and implementation, we open up enormous possibilities.

In VHAI’s work at the grass roots level throughout the country, we have also realized that decentralization opens up a range of possibilities such as school teachers becoming motivators and health educators, local healers and TBAs becoming an additional work-force to strengthen our human resources, local festivals giving us ready-made fora to plan, discuss and implement the programmes as well as to educate the people and local panchayats and youth clubs becoming active partners in our effort. We have often been surprised by the incredible potential of these partnerships. Perhaps we should not be, since for centuries the communities of people have been organizing massive events around their aspirations and needs. We need to get our health and population programmes linked to this energetic normal day-to-day life of our communities all over the country. This will mean initiating a process of give and take; by joining their momentum and not the other way around. We need to be bold, energetic and creative in meeting this challenge of
implanting on existing local health traditions, not uprooting them and transplanting our “hybrid” ideas, but implanting them with some marriageable solutions.

Convergence of services was the essence of the community development model that India had adopted in the early fifties. Somehow, this got displaced by target-oriented selective models due to the pressure and influence from multiple external funding agencies, despite the earlier model having paid rich dividends towards self-sufficiency in food grains as well as in creating an early infrastructure in health, education and other social sectors. A selective approach has created a situation where holistic public health and family welfare have been left with very little space, with no additional resources and with a large unmotivated defunct infrastructure, in many parts of the country. Currently we are in a situation where the people are being offered DOTS while they cry out for treatment of Malaria; kids are dying of diarrhoea due to unsafe drinking water and we say our mandate ends at Polio. We are working on the health and population front to help people lead a happy and healthy life and not just wage a battle against one particular disease. It is cynical to talk about micro nutrients, while not bothering about minimum wages or unequal wages between men and women.

Our experience of several years in many parts of the country has taught us that critical aspects like infant mortality, maternal mortality and fertility are directly linked to the socio-economic status of women; their literacy, age of marriage and gainful employment. It is, therefore, clear that there will be very little impact on the health and population front if we do not ensure gradual but comprehensive development of other related sectors. The unparalleled opportunity that has been given to us to empower more than four million elected panchayat leaders, almost half of whom are women, so that they can turn around decades of underdevelopment, must be availed of in full measure.

**Policy Environment**

Given the fact that during the last few decades, the country has failed in its effort to reach out to the people living in vulnerable areas, it was realized that unless many facets of inequity among its population are addressed, which greatly impairs successful outreach of social, economic and political benefit to a large sector of our citizens, this may not be possible.

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 problem 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 poor families in governance in India has been limited.

3. Social: A distorted caste system has put a very large section of our population at 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 progress in health and development in India.

5. Locational Problems: Far flung, cut off areas and ecologically vulnerably areas where the large section of the population lives.

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 extraordinarily 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 upon the population. 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. In this overall background, we need to look at the issues of equity and health in India.

To address these issues of inequity in recent times, some very radical measures have been taken by the Government of India, which could be described as follows:

**1. Panchayati Raj and Nagar Palikas (73rd Constitutional Amendment)**

Under this almost revolutionary constitutional change, efforts are being made to give the responsibility of local level governance and development to elected representatives of the people both in rural as well as urban areas. Although it might take a long while before representatives of the poor can effectively handle their new found political and economic power. However this measure has ensured that slowly but gradually effective decentralization of political and economic development takes place.
The other important aspect of this constitutional amendment is that one third of the seats of elected representatives are reserved for women. Consequently, more than a million women have found an important place in the political and development arena of their villages. Even if one tenth of them are able to assert themselves, there will be a dramatic change in women’s economic, social and political status in large parts of the country.

2. Special quota for employment for Scheduled Castes and Scheduled Tribes

Keeping in view the need to give a say to Scheduled Castes and Scheduled Tribes within the political system, a very radical measure was taken to reserve one-third of government employment for people from these categories. Since a vast section of the poor in India comes from these castes and tribes, this will make a great difference to their economic and social status within a short time. The direct outcome of these reservations is already felt in most parts of the country.

3. Active anti-poverty programmes launched throughout the country

In India, a large measure of government resources are allocated for poverty eradication programmes per year. These include very considerable commercial bank loans, which are available to the poor and needy for various income generation and self-employment activities. But the fact remains that there has not been a proportionate dent in poverty in spite of this large resource allocation due to sometimes ineffective governance and pilferage. Perhaps with the gradual allocation of these financial resources to the local level, the situation will improve dramatically.

4. Decentralized planning of health services as initiated in Kerala

With many years of experience of the hazards of top down planning in the health sector, initiative has been taken to gradually decentralize health planning at the district level. This is a relatively new initiative where a very good beginning has been made in the state of Kerala.

5. Handing over management of health infrastructure to elected representatives of the people at the district level

It is proposed that gradually the management of health infrastructure will be handed over to elected representatives of the people at the district and block level, ensuring better accountability. We have seen considerable progress on this front as well as associated results in a few States already.
6. **Active involvement of civil society in fulfilling the promises of health and development to the citizens**

Keeping in view the continuity of the Gandhian tradition of social service as well as emergence of a large number of active NGOs in the field of health and development, the Government of India has taken several steps to involve as well as support them, both politically as well as financially so as to address many aspects of the health care, including provision of health services in remote and difficult areas as well as reproductive and child health programmes and emerging problems like HIV/AIDS and STDs. In the coming years, there is a proposal for even greater involvement of civil society in health and development programmes.

7. **Addressal of locational problems**

Since the people living in far flung and ecologically vulnerable areas face special problems in terms of equity in health care, there efforts have been made to give special consideration for these areas, e.g. the states of northeastern Region get 100% central assistance for their programmes compared with 50% to the rest of the States.

8. **National Rural Health Mission**

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of citizens, Government of India launched the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care.

9. **Right to Information Act**

One way of participating in governance is by exercising the right to access information from bodies which spend public money or perform public services, including Health Care. Following the enactment of the Right to Information Act in May 2005, all citizens of India now have the right to access information. The RTI Act recognizes that in a democracy like Indi, all information held by the government ultimately belongs to the public.
Planning and Implementation

Following the various parameters outlined above, VHAI identified 14 pockets in the country in which to initiate the KHOJ Project. While identifying these locations, it was ensured that they sufficiently represented the social, economic, political, geographical, and ethnic diversity of the country. Broadly, these locations are in the physically challenging areas like the remote mountains and deserts. Areas mainly inhabited by the indigenous peoples and heartland India, where social, economic and gender status are polarized and the feudal infrastructure has still not been dismantled. Our premise was that the experience of working in these diverse areas would give us enough experiential learning to upscale similar initiatives in most of the country’s vulnerable pockets.

While finalizing the approach to our work in these pockets, we felt that we should (1) go in 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 to the optimum level; (3) build local health and development skills and expertise; (4) launch sustainable initiatives, in terms of financial as well as human resources; (5) ensure that on the whole it not only affects the health and development status of the people, but ensures permanent capacity building in the community.

One of the critical elements of the project was to identify local partners in the voluntary sector, who may not have tremendous experience, but are motivated and are also rooted in the local community. State VHAs played an instrumental role in this process.

Thrust Areas

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

- Health
- Community Development
- Community Organization
- Environment
- Women’s Empowerment

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

Health Interventions

Since the beginning, health interventions were used to develop a 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 area, it was apparent that those areas did not have any access to quality health care. In such projects, the main emphasis during the initial phase was on provision of curative services. Curative services were provided by a team comprising 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, diarrhoea, 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.

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 women’s health has on community health.

Women’s health status has been given due consideration throughout their entire life span from the girl child to women of reproductive age, to menopausal and post menopausal women.

At their initiation, maternal and child related health services were in poor shape in all of the KHOJ projects. Complete antenatal care was being received only by 15-20 per cent of women. TT immunization coverage was hardly more than 25 per cent. Untrained birth attendants and relatives were conducting 60 to 90 per cent of the deliveries. Everywhere there were maternal deaths ranging from low of 3-4 per year to high of 10-12 per year. Now in each project area, trained birth attendants provide these services. Most of the projects did not report a single maternal death in the year 1999.
In addition to maternity related problems specialist care has also been provided to tackle gynaecological problems. 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 in terms of their basic rights.

Specific Health Issues

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

Health Promotion

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

Thus, the health impact of the KHOJ Project can be summarized as under:

- Increased health awareness reflected by the reduced time lag between the 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 from communicable diseases like diarrhoea, malaria, and ARI as well as due to pregnancy and associated complications
- Effective disease surveillance leading to prevention of epidemics
- Significant reduction in health expenditure as quality health services, including laboratory services, are available within reasonable distance and at reasonable cost
Community Organization

All the projects have taken effective steps to organize people’s groups at different levels in the project villages. These groups are mainly in the form of women’s groups (Mahila Mandals), youth groups and farmers groups. The formation of these groups has ensured a comprehensive relationship between the project and the community. In most of the projects apart from these groups there are also village health committees where representatives from different groups 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 the community has a say in the decision making process. This has also given the community a strong feeling of ownership and has enhanced their involvement in all stages of the project. Some of the positive outcomes of these processes are:

Mobilization of Village Committees: Village communities have been mobilized at various levels i.e. villages, blocks, panchayats, etc. and are aware of and making efforts for improving their conditions.

Formation of Social Action Groups to Optimize Government Resources

In most of these areas, it was found that the existing large government health infrastructure was not operating optimally. Subsequently, over time the local communities had lost faith in it and the facilities were being hardly utilized, except for dire emergency and occasional preventive health work. Keeping in view the large amount of government expenditure that is incurred on maintaining these facilities, it was necessary to ensure that they were operating at an acceptable level of performance. They needed sometimes to bridge critical gaps that exist in the government systems, organizing events for them to complete their preventive activities like immunization or re-orienting the government functionaries, so that they can effectively meet the local needs.

Effective Linkages with Panchayats: The projects have been able to establish good working relationships with local panchayats with the result that health has become an important aspect of panchayat activities. The micro plans being developed by local panchayats are more relevant and available to the local needs. Panchayat members are also functioning as effective change agents.

Education: In many of the KHOJ projects literacy levels are extremely low and no other NGO is working for education in those areas. Some of the KHOJ projects have initiated non-formal education centres
for school dropouts. This has proven to be a very successful programme. It has helped not only in improving literacy levels but also developing rapport between the community and the project.

Community Development

Though KHOJ is a health initiative, it has from the beginning tried to address the conditions responsible for ill health. KHOJ has never looked at health with a narrow vision of presence or absence of disease. KHOJ has tried to address the health issues as a part of the overall development process. Therefore, in every KHOJ project, community development is an extremely important area. Major strategies adopted for community development are capacity building, income generation programmes and education.

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. To make relevant information available to local villages many projects have set up Village Information Centres to meet information needs of remote difficult areas.

Income Generation: These include,

Vocational Training: There is a wide variety of training opportunities in this programme. However those with a traditional base, like handloom, crafts, etc. are taken up mainly for skill enhancement as well as providing marketing outlets.

Promotion of Local Crafts (training/marketing support): This activity has been taken up in view of limited marketing outlets and the capacity of the artisans to negotiate prices. The idea is to provide all necessary support, including skill upgradation to artisans.

Entrepreneurship Development: This training assumes special significance in view of numerous government schemes available to the rural unemployed, especially the educated unemployed.

Formation of Self-Help Groups: A self-help group is usually a group of 7 to 10 women, who are encouraged to make periodic savings. Each project has initiated such groups. The group’s saving are deposited in a nationalized bank and the women members manage the money themselves. Many places, projects have also contributed a matching grant to the women’s savings. These self-help
groups have been linked with banks. The women use this money to either initiate some income generation activity or as loans for medical treatment or buying seeds etc.

**Livestock Improvement:** Since most of the KHOJ projects are in rural areas where livestock, particularly cows, goats and sheep are some of the most valuable resources available, the projects have tried to help the community to improve the breed through artificial insemination. Projects also provide technical support on maintenance of animals.

**Environment:** Village environment, sanitation and drinking water related activities, including proper care of drinking water sources and village drains by the villagers themselves, aforestation, prevention of deforestation, preservation of natural resources, kitchen gardens and horticulture are some of the areas covered by the projects.

**Water and Sanitation:** During the baseline survey and identification of the projects, lack of water resources and sanitation problems were found in almost all the project areas. The problems varied in specific areas, ranging from lack of water sources, scarcity of water, distance of water sources from the houses and poor quality water, etc. At most places poor communities are from accessing drinking water sources.

**Collaboration with Government**

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

1. Health: Immunization programmes, family planning programmes, health camps, workshops (as government resource persons), referrals.

2. Sanitation and drinking water: Linkages with CAPART, DRDA, and Block Offices and Panchayats.

3. Direct benefits under various government schemes: e.g. maternity, Ayushmati, Vatsalya, old age pension, adolescent girls, Rashtriya Parivar Yojana, Indira Awas Yojna, Jawahar Rozgar Yojna, etc.

5. Recognition of the projects by State governments: As seen by handing over of PHCs (Arunachal, ORISSA, etc.), training of animators (NLM) and direct financial support to projects for specific activities.

**Sustainability**

Sustainability is an essential feature of KHOJ Projects. From the very beginning, conscious efforts were made to select sustainable interventions. Some of these efforts are in the direction of:

- Sustainable income generation programmes
- Emphasis on human resource development
- Strengthening local panchayats
- Developing linkages with government and other agencies.
**Statistical Profile of KHOJ Projects**

<table>
<thead>
<tr>
<th>Health Indicators</th>
<th>IMR</th>
<th>No. of Maternal Deaths</th>
<th>% women receiving complete antenatal care</th>
<th>% deliveries conducted by TBA</th>
<th>Immunization coverage</th>
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<tr>
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<tr>
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<td>10 4</td>
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<td>1 1</td>
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<td>76 98</td>
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<tr>
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<td>50.6</td>
<td>1 NIL</td>
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<tr>
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<td>30</td>
<td>5.2% 2.3%</td>
<td>53 94</td>
<td>61 98</td>
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<tr>
<td><strong>SURE, Barmer</strong></td>
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<td>68.9</td>
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<td>32</td>
<td>7 2</td>
<td>56 85</td>
<td>20 50</td>
</tr>
</tbody>
</table>
Evaluation of results and impacts, including on social determinants and health inequities

The impact of the strategy tried out by Khoj project has been assessed seriously. As discussed previously the Khoj projects have 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

The Khoj projects focus 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:
- Draft Background Paper 9 -

- 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 socioeconomic 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

Follow-up and lessons learned

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.

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 who 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.

**Challenges**

Poverty along with limited employment opportunities has been a hurdle for overall development, in the project areas. Various sustainability approaches have been advocated during the Khoj partner meetings and their implementation after withdrawal of the project has been envisaged.

- Induction of VHWs as the Multi Purpose Health Workers in the National Rural Health Mission Project in some of the project areas. Induction of TBAs as ASHA in the government primary health care system.
- Creation of various schemes of the Planning Commission under social sectors for the community benefit.
- Capacity building of the state/district level NGOs for induction of community development activities.
- Introduction of handicraft and other locally manufactured products to the state/national level manufacturers, for better benefits of the rural individuals that are engaged in income generation programmes.
- School health promotion activities to be carried on by the group of School Teachers that have been our associates during the school health promotion activities.

VHAI has made a landmark journey with the Khoj project and this journey has been acknowledged and applauded at state, central and institutional level. This endeavour has significantly influenced various aspects of National Rural Health Mission, including the concept of appointing ASHA (Accredited Social Health Activist) in every village, setting-up of Village Health & Sanitation Committees and introducing the concept of Community Monitoring. An active effort has been made to implement the concept of Public, Non-profit Partnership to revamp the defunct government health infrastructure in the remote pockets of the country. Strengthening inter-sectoral coordination for an improved social determinants of health approach on the ground.