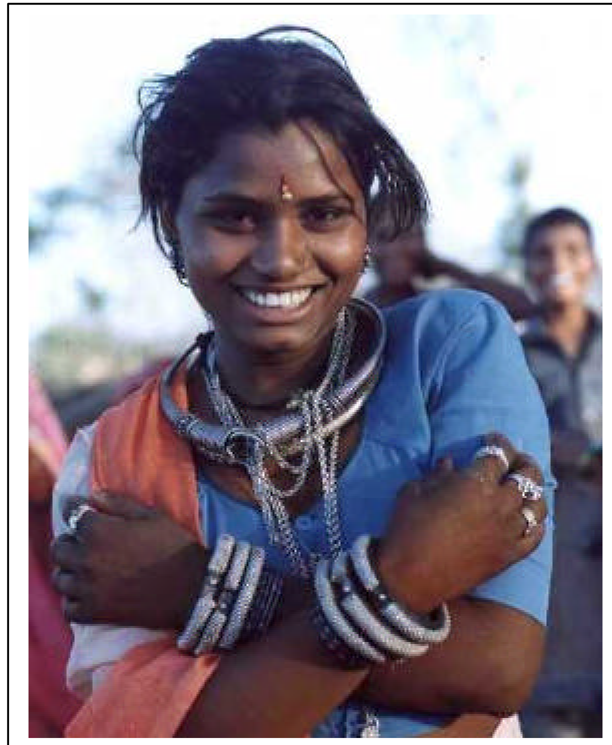
BUILDING ON HEALTH AND NUTRITION PROJECT

(BHNP – II)



WFP, CARE and Government of Rajasthan

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BUILDING ON HEALTH AND NUTRITION PROJECT (BHNP II)

Final Report

1. Background

Building on Health & Nutrition Project (BHNP - II), a collaborative program of Government of Rajasthan, United Nations World Food Program (WFP) and CARE India was initiated in five blocks of two districts in Southern Rajasthan from 1st September, 2000 for a period of two years. Prior to this, CARE had implemented Better Health and Nutrition Project (BHNP – I) with financial support from WFP. The experiences indicated that enhancing community capacity and access to the available health and nutrition services is as important as strengthening the delivery systems. The BHNP-II focused not only on improving the systems that deliver health and nutrition services, but also improving access to capital and the use of natural and land resources which are the primary cause of low-level of health and nutrition status. Therefore, this multi-sectoral project had Health and Nutrition as the primary intervention supported by micro-finance and ANR to address the cycle of poor health, nutrition and ineffective use of capital and natural resources.

2. Goals and Objectives

The goal of BHNP II is to bring 'A sustainable improvement of health and nutrition status with special emphasis on children up to 2 years and pregnant and nursing mothers'.

The project purposed to improve the household food security as well as intensification of ICDS activities in the project area with the following objectives:

- Reinforcement and intensification of the government system provision of health and nutrition services
- Improvement of women's capacity to access capital resources
- Improvement of the communities' capacity to increased crop productivity and effective management of natural resources
- Involvement of Community Based Organisations in the programme management

3. Project Area

BHNP II was implemented in the same five blocks of BHNP I. It continued to work in Mavli, Salumber and Kotda blocks in Udaipur district and Abu Road and Reodar blocks in Sirohi district. WFP provides supplementary nutrition in Udaipur district, while the blocks in Sirohi district was covered by the supplementary nutrition from CARE. A total of 642 Anganwadis were covered of which nearly 70% were in WFP food area and 30% in CARE's food area.

4. The rigors of the Drought:

By September 2000, the monsoon had failed to reach Mewar, (the project area) for the third consecutive year. The rigors of the drought had resulted in large-scale migration of local populations along with their livestock and the villages were practically empty of population. The remaining people were struggling for their very survival and were unwilling to listen to health-related messages. The NGOs were engaged in relief work in the crisis situation. The BHNP II Log-frame had mention of creation of additional water points as a part of agriculture and natural resource interventions. In light of the severe drought conditions, the

project activities were prioritized and a more pro-active approach was adopted to ensure the success of the project.

Since 'water harvesting' formed a part of the Log-frame, it was decided to undertake the deepening of wells on a priority basis, as a first step to meet the challenges of the drought. Ten new water points were proposed as a part of the project interventions. An extensive assessment of the status of provisioning of water in the area was undertaken which included guidelines and activities of the government and other agencies. Most bore wells in the area were dry. Digging new open wells would require seven or eight months in view of the rocky nature of the terrain, the scarcity of technical skills and the inaccessibility of the regions to heavy drilling and boring equipment. Hence, it was decided to deepen the existing dry wells. The services of a senior geologist from Jodhpur were hired as a consultant for technical analysis to determine the success in finding a high level of ground water. NGO partners were involved to mobilize the community for participation in labor contribution. In the end, 33 wells were successfully deepened as contrasted to the originally determined figure of 10. The migratory populace had started returning to their villages by the winter season. Since then BHNP II started picking up its activities rigorously.

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5. Key Strategies

The overall implementation strategy of the project was through partnership with Government, NGOs, Professional bodies and other agencies. The project has also strategized its main health and nutrition interventions in the villages of the project areas, while micro-finance and ANR interventions were implemented in selected villages in collaboration with local NGOs. The key strategies of the project were –

5.1 Partnerships:

In order to build strong and responsive people's institutions, in the form of SHGs, Seed Banks, and Grain Banks in selected villages, a collaborative approach was adopted. To facilitate the formation of these institutions and their functioning, particularly supporting health and nutrition activities, a need was felt to forge partnership with local NGOs. This was also undertaken for optimal utilization of local level resources for better project outcomes. Some of these local level partners were actively involved in undertaking micro-finance and ANR activities.

5.2 Co-ordination and collaboration:

BHNP II continued to implement project activities in close co-ordination and networking with the Government departments, especially the ICDS and the Health. At field level close coordination was maintained with the government functionaries for better service delivery, while monitoring and review processes had been institutionalized at higher level to address key issues related to convergence and supply logistics.

5.3 Capacity building:

Orientation on BHNP II interventions and capacity building of the government functionaries from ICDS and Health Departments and partner NGOs were taken up. Different types of CB events were organized on various themes pertinent to BHNP II project. As a part of capacity building, cross visits have also been undertaken particularly in the areas of SEAD interventions and establishment of 'Grain Banks', which initiated change in the perspective of the functionaries of the partner NGOs.

5.4 Human resource structure of the project:

The requirements of communication with the partner agencies without duplication and with authentic technical know-how created a need to have different human-resource mix in BHNP II than that of its earlier phase. For implementing multi-sectoral interventions of BHNP II, a team of professionals was deployed with a strategic mix of generalists and specialists. A Project Coordinator leads this team, with supports from State Director of CARE Rajasthan; Health Sector Director and technical specialists of CARE-India Headquarters. The organogram of the project is provided in annex-I. At the field level the project team included three generalist Field Officers for supported Health and nutrition activities. They are involved in co-ordination and liaison with the partners on all aspects. These field officers formed main monitoring agents of the project progress and they work to ensure convergence of sectoral interventions at the community level. In addition to these three FOs, there were two Field Officers specializing, in Micro-finance and ANR related activities respectively. They contributed to the project activities across all the five blocks. They are placed at the project office and were mainly involved in Capacity Building of partners for operationalizing the sectoral interventions.

6. Key Accomplishment

6.1 Constitution of District Level Advisory Committee

For coordination with the government department a forum was created at the district level in the form of "District Level Advisory Committee" (DLAC), in both the districts. The co-ordination forum at the block level was the 'Core-team' of heads at the block level ICDS and Health departments and the partner NGOs of the area along with the concerned CARE field officer. Both these forums scheduled to meet quarterly, however, it also met in between depending upon the need.

The core teams were constituted in all the five blocks and their meetings held regularly. The review process at these meetings contributed to further refining the implementation of monthly Nutrition and Health Days (NHDs) based on the changing situations. These forums had helped in resolving many issues related to convergence and effective service delivery at the village level.

6.2 Identification of local NGO partners

As per the project proposal, the intensified activities were to be implemented with compatible partners to ensure long lasting impact with a better and wider out-reach at the community level. In order to meet this objective, efforts were initiated to identify compatible NGOs who are closer to the community and enjoy good reputation with the communities and local Govt. administration.

A thorough assessment of the local NGOs was undertaken using the CARE-India's tool for NGO assessment. In order to keep the Partner's proposals more specific to the context, the short-listed NGOs were given the project objective and broad sectors of interventions and they were requested to formulate the proposals specific to their area of operation. An NGO-Mela was organized during 23rd to 25th January, 2001 at Udaipur to discuss their proposals and provide them necessary feedback to modify the proposal. This face to face discussion with local NGOs helped in formulation of final partnership agreement. Gujarat earthquake happening the very next day of this event and involvement of BHNP staff in relief operations caused some delay in follow-up partnership development process.

Currently there are seven implementing partners for BHNP. Depending upon the capabilities and expertise available with the local NGOs, they are involved in carrying out mix of the project activities. The coverage of geographical area by these partnering NGOs also varies. The specific activities carried out by each of the partners and their geographical spread is outlined in table 1.

NGO Partner Details (Table 1)

NGO	No. of villages covered	No. of AWCs	Key Activities
Jagaran Jana Vikas Samithi (JJVS), Salumber	15	17	1. Health and ICDS coordination. 2. Health Awareness Campaigns 3. Seed and grain Banks formation. 4. Kitchen Gardening 5. SHGs for micro-finance interventions. 6. Promoting Sustainable agriculture 7. Well deepening for creating drinking water points.
Society for All Round Development (SARD), Reodar	31	43	1. Formation of Mahila Mandals 2. ICDS and Health co-ordination. 3. Involving of PRIs in program implementation
Jan Chethna Sansthan (JCS), Abu Road	53	72	1. Formation of SHGs and Mahila Mandals 2. Seed Bank and grain bank formation 3. Sustainable agriculture training 4. Kitchen gardening 5. Well deepening
Manav Kalyan society (MKS), Kotra	16	19	1. Health Awareness camp 2. Creation of a band of health Motivators 3. Vitamin A and IFA camp 4. Campaign for complementary feeding 5. Sustainable agriculture training 6. Creation of drinking Water points for cattle 7. Kheda village development for demonstration.
Kotra Adivasi Sansthan, (KAS), Kotra	22	22	1. Formation of core groups of community members in each village to manage AWCs activities and to bring convergence. 2. Training Of Swasthya Sewika to act as change agents. 3. Kitchen Gardens promotion 4. SHGs formation and maturation 5. Wells Deepening 6. Seed banks formation
Uthhan Shodh Sansthan, (USS), Mavli	26	32	1. Institutionalizing Meetings with PRI representatives for reviewing AWC's functioning. 2. Promotion of sustainable agriculture 3. Launching Awareness campaigns on optimal utilization of water 4. Kitchen gardening 5. Formation of grain banks.
Prayathna Samithi (PS), Salumber	18	20	1. Formation of cluster level advisory groups of ICDS and Health departments. 2. Health Awareness Campaign 3. Establishment of Seed banks and Grain Banks 4. Kitchen Gardening 5. SHGs formation.
Total	**181**	**225**	

In addition to these implementing partners, the partnership with **Bharatiya Lok Kala Mandal** was also forged. The awareness Campaigns component of the project needed developing of folk-media based content and training of artists in performing the shows. This has been accomplished through collaborating

with an organization well known for folk-theater and related art forms. Bharatiya Lok Kala Mandal served as a resource partner for BHNP II, for the awareness campaign component.

6.3 Creation of water points

Due to sever drought conditions in the first year of the project, the interventions listed in the log-frame were prioritized. Following the approach adopted by the government, deepening of existing open wells were taken up on priority in BHNP II. A total of 35 wells were deepened in most affected villages, out of which water level considerably increased in 31 locations.

6.4 Capacity building

6.4.1 Health and nutrition: An intensive efforts for capacity building of AWWs and ANMs had already been undertaken in BHNP I, hence, refresher CB on relevant aspects like preparing and updating of *social maps* is undertaken in each of the block. The ICDS supervisors were also trained in basic counseling techniques for breastfeeding and complementary feeding. The capacity building sessions were also organized for PRI members for their support in the formation of mothers' committee to promote health and nutrition activities at the village level.

In the earlier phase of the project, the village volunteers called ***change agents*** were identified and trained in each of the village. It was found that some of these change agents were not active or have migrated to other places. In order to create an active band of change agents in each village, especially belonging to the secondary target groups viz. mothers-in-law, traditional birth attendant etc, some of the new change agents were identified with support of the SHG and AWWc. All the change agents were given knowledge regarding Maternal and child health practices and on the referral centers nearer to their villages. These capacity building events were jointly organized for change agents as well as for the leaders of the SHGs and PRI members. They were also oriented on the procedures and practices in referral hospitals as they have to act as first points of promoting timely referral of sick new-born to appropriate centers.

Awareness campaigns using local folk art forms are used as mass media for community mobilization. The staff from partner NGOs were provided with capacity building on the use of local folk media for awareness generation programmes. Bhartiya Lok Kala Mandal as a resource agency undertook such capacity building session. As a result of such training, a total of seven troupes carried out these puppet shows in the villages. Five partner-NGOs were involved in coordination of this activity with the resource agency.
There was an overwhelming response to these shows in all the villages. There was an immediate increase in the attendance at the NHD and in the AWC. The interest of the community members in the activities of the AWC greatly increased after the shows.

6.4.2 SEAD and ANR: A series of ToTs were undertaken for facilitating SHG formation and maturation aspects. The government officials and NGO functionaries gained a systematized understanding of the processes required to form well-functioning thrift and credit groups. The capacity building efforts at the facilitator levels culminated into formation of self help groups at the community level. Later, the members of the SHGs were also trained in account keeping and other aspects of a functional SHGs.

6.5 Monitoring system

A detailed monitoring system to capture the process level indicators was designed for BHNP II in consultation with the HMIS unit of CARE-India HQ. Four different formats were developed through the participatory approach and they were put to field test for a month. The purpose was to have a system of monthly reporting on the project activities from Partner NGOs, ICDS Supervisors and the CARE Field Officers. During field testing, it was found that the ICDS supervisors were over-worked in terms of existing reporting requirements and without uniformity across the district, it was difficult to implement monitoring format for ICDS supervisors in the five blocks. Thus the format was discontinued while two columns for the

required information were added to their already existing reporting format which they have to report to the CDPO on monthly basis. This additional information from the ICDS supervisors helped in tracking the progress of NHDs and Social Mapping in the project blocks. Modified Monthly Progress Reports (MPRs) for CARE's Field Officers and for the partner NGOs have been implemented and this generated information about the achievements of the project activities on a regular basis.

7. Achievements of the project interventions

7.1 Health and Nutrition

7.1.1 Social map: For complete enumeration of all the eligible beneficiaries for ICDS and Health services, social maps were prepared in most of the AWCs during BHNP I. However, these AWCs could not update the maps regularly after the completion of the 1st phase of the project mainly due to the reasons such as difficulty felt by anganwadi workers in replacing Bindi's / sticker form the social maps for updating every quarter, inadequate capacity of the anganwadi workers in mobilizing the community for preparation and updating and inadequate support provided by the supervisory staff to maintain the maps. In BHNP II social map preparation and updating was undertaken through the involvement of NGO partners and the ICDS functionaries. These maps were developed in all the 642 AWCs of the project area. Regular updating, every quarter, was reported form all the NGO partnership areas, while the updating was not so regular in the non-partner areas, due to competing priorities of the ICDS functionaries. The following table brings out the progress on regular updating of the social maps by the end of the project period.

Regular Updating of Social maps	Progress		
	Till August, 2001	Till December, 2001	Till August 2002
	208	442	552

7.1.2 Nutrition and Health Days: Institutionalization of monthly Nutrition and Health Days in the project area has been a major activity promoted in the project. This ensures regular service delivery at the village level by convergence of health and nutrition services at the Anganwadi Centres. On this day ICDS and health functionaries provide the following services:

- Distribution of Supplementary nutrition
- Immunization to children and pregnant women
- ANC check up to pregnant women
- Health and Nutrition Education
- Treatment of minor ailments

Based on the secondary data collected from the blocks at the initiation of BHNP II, it was observed that only about 40% of the Anganwadi Cenrtres were observing NHDs on regular basis due to other priorities of the government functionaries. Efforts were undertaken to scale up the NH days to all the AWCs with the necessary support from the district administration. A monthly schedule has been worked out for all the AWCs of Sirohi district giving the details of the ANM and specific date. In Udaipur district, the THR and Health Day are occurring on different days of the month. The local health department has de-linked the visit of ANMs on the day of THR due to irregular supply of food. However, the ANMs are visiting as per their schedule of monthly visits to the village. The district health officials of Udaipur have strong logical argument against having the health and nutrition day together. In order to investigate the coverage of immunization and other health services without clubbing with THR in Udaipur district as compared to Sirohi district, a case control study was conducted in BHNP II project areas. The findings of the study indicated slightly better

health coverage in Udaipur as compared to Sirohi district after controlling for social and programmatic variables.

7.1.3 Awareness Camps*:* The awareness generation campaigns were undertaken in each of the AWC village in the project area. The project proposed to have one such show per year in each of the AWC village. With the support of seven trained teams of folk-artists, who were trained by Bharatiya Lok Kala Mandal, first round of awareness campaign on health and nutrition were completed by January 2002 across the project area. The second round of the campaign shows were completed by June 2002. In the second round, an innovation of having daylong mela on health and nutrition as well as sustainable agricultural practices on the same day of the awareness campaign using folk-art forms has been attempted in the NGO-partner areas. For this component, local volunteers were identified and trained on the technical aspects. These bands of volunteers and the folk-artists are a valuable resource that BHNP II has created in the area. SHG related themes were incorporated in the shows of one artist's troupe on an experimental basis. The response to the innovative mela-model of awareness show was encouraging and the retention of the messages was found higher than the folk-art shows alone. The progress on the number of shows by the end of the project is indicated in the table below -

Awareness campaigns	Progress	
	Till August, 2001	Till August, 2002
Number of shows	152	868
Number of villages	152	550

7.1.4 Mothers' committees: The Government of Rajasthan had issued notification for the formation of Mother's Committee through ICDS system. The project initiated the formation of this mother's committee with the involvement of PRI and to evolve a system of community managed health and nutrition service delivery.

In consultation with some select Panchayat representatives and NGO partners, the modalities were worked out about the shape and process for formation of these committees. It was decided that five women, who are either direct beneficiaries of health and nutrition services and women who have beneficiaries from their household, would be members of the mothers' committee. The women of the community would make the selection with facilitation by the NGO partner and the Panchayat representative of the village would be part of the selection process.

As there was no departmental approval for the status of such committees, it was decided that, drawing from the Panchayati Raj Act, this body could be given a status of a sub-committee of the gram-panchayat. It was further decided that the panchayat body would pass a resolution in the next gram sabha meeting and ratify the formation of the committee. This was to make the body responsible to the general council of the village through the governing council of gram panchayat. This was a clear innovative departure from the usual manner in which mothers' committees have been formed in different states. Either in case of watershed committees of Rajasthan or mothers' committees of Andhra Pradesh, the state government official machinery at block level was responsible for formation of these committees. The participation of the people in such bodies has been nominal and the panchayat was not kept in the loop formally. In the BHNP's innovation, the panchayat has been given a role of an umbrella CBO, having role of co-ordination and broad guidance. The day-to-day affairs of the AWC and the health service delivery are made the responsibilities of the mothers' committees. The project was able to form 29 mother's committees in 23 partner villages.

7.1.5 Malnutrition assessment campaign: The ICDS is responsible for growth monitoring of all the children till six years of age. Due to several reasons like, lack of numerical skills among the AWWs, faulty weighing scales, lack of proper supportive supervisory monitoring, limited number of beneficiaries being covered by the AWCs. Some of these reasons have led to extremely low reporting of severely malnourished children form all the AWCs. There are great numbers of children who have never been weighed even once. Such situation of prevalence of severe malnutrition was observed in almost every AWC that was visited by the BHNP team members. Hence it was decided that a massive campaign to weigh and check the nutritional status of all the children below three years of age be taken up.

Local volunteers were identified through NGO partners and they were trained on weighing of children, marking on the growth charts and determining the nutritional status of the children. *Weight for age* was used as the parameter for malnutrition assessment among children. Considering the pros and cons as well as operational feasibility of all other indices e.g. weight for height, weight for age and mid-arm-circumference, finally one index of weight for age has been selected for measurement through this campaign. This indicator was finally selected in consultation with the resource persons from ARTH, Technical specialist at CIHQ and program officer of WFP in Rajasthan. The same parameter is used by the AWWs in their regular monthly growth monitoring, therefore, it was felt that it would be easy for the ICDS system to follow it up regularly.

The trained volunteers visited each of the AWC villages in a team of two and conduct the survey of all the children under three and identify the grade three and four malnourished. The list of all the children weighed along with details for identification are recorded and shared with the AWW at the village level itself and AWW is being requested to follow up the children who are severely malnourished.

The mothers of children in grade three and four malnourished categories were advised on rehabilitating the child to normal. The volunteers also discuss possible recipes out of locally used food commodities and the way to make the daily food more nutritious. The findings of these surveys were compiled and shared with the district and block ICDS officials. The teams of trained volunteers are available with the NGOs and they could be utilised by ICDS or other departments for similar activities at the community level. This is in a way creating a more sensitive civil society responsive to the nutrition and health issues.

7.2 Small Economic Activity Development (SEAD)

7.2.1 Self Help Group (SHG) formation:

A total of 142 SHGs have been formed as part of BHNP II. The formation of SHGs was completed by the beginning of January 2002. There were 2556 women were the members of these SHGs. The project focused on strengthening of their operational systems and management systems. Groups having more than Rs. 1000/- of saving were facilitated to initiate small consumption loans, with half the group fund, especially to meet the requirement of grains and for treatment of illnesses. This was intended to promote credit and repayment behavior with small amounts, to reduce the idle balance of each group and most importantly, to build trust and confidence of financial transactions among group members, starting with small amounts.

Self Help Groups (SHGs)	Progress		
	Till August, 2001	Till December, 2001	Till August 2002
Operational SHGs	**99**	**130**	**142**[*]

In order to ensure systematic recording of transactions, individual passbooks and group wise ledgers have been provided to all the SHGs.

[*] These SHGs were formed by January 2002 and thereafter the process of strengthening of the SHGs was carried out to ensure sustainability.

To promote practicing and propagating of positive health behaviors related to mother and child health, SHG members are being used to create a critical minimum number at the community. This need was felt as the change agents were facing difficulty in promoting positive health behaviors. Community level capacity building of the SHG members during their monthly meetings was taken up through resource persons specializing in maternal and child health. With the increase in the number of women having knowledge of positive health behaviors, from two to nearly twenty-two in each village having SHG, is expected to pace up the adoption of the positive behaviors.

7.3 Agriculture and Natural Resource interventions (ANR)

7.3.1 Well Deepening:

33 sites of Well-deepening for creating drinking water points have been successfully completed during the summer of 2001. After one year, in the peak summer of 2002, community members expressed satisfaction with the water levels in these wells. The efforts of the BHNP II team and the partner NGOs were highly commended by the community members.

7.3.2 Grain Banks:

Formation of grain banks has been one of the most successful interventions of BHNP II. The intensive efforts in designing the model and the facilitation by the NGO partners have resulted in very high acceptance of this concept among the community members. With in a short span of four months, the number of grain banks formed has exceeded the target due to demand form the community members. *Against a target of 50 grain banks, 92 grain banks have been formed in the project area.* The norms for transaction have been developed in a complete participatory way and BHNP team members and the partner NGOs. A total of 1270 women were the members of these Grain Banks.

Borrowing of grains from the grain banks by some of the members was reported since March 2002. Complete transparency in transactions has been promoted through normative process, the books for accounting the loans and repayments have been provided to each group. Preference of the group members for storage method has been taken into consideration and thus there is no uniform storage pattern across the project area. In places with more forest cover, community has preferred to build traditional storage bins of bamboo and in others, members have procured metal bins for storing the grains.

> ***Sisterhood in Jamalpura village***
>
> *In Jamalpura village, Reodar block, the son of a Grain Bank member died. She had already availed of her component of the GB loan. She needed more grains to meet the family get-together as a part of the rituals related to her son's death. Another female member of the GB took the loan in her own name and passed it on to the woman whose son had died. Thus, the women were able to tide over the need without loss of self-respect and without falling into a debt trap.*

7.3.3 Kitchen Gardens:

During the Kharif season of 2001, vegetable cultivation was promoted with nearly 280 households in BHNP II project area. Follow up with the community members having irrigation facility for promoting Rabi vegetables yielded good results, and nearly 55 households with irrigation facility were promoted to grow vegetables for the winter season. Collective nurseries were raised and the saplings were distributed to all those interested to grow the vegetables. The community members with out any external facilitation did this collective effort in vegetable cultivation. As the water level for cultivating summer crop was very low in the project area, no vegetables were cultivated after the Rabi crop. The NGO partner field functionaries reported that the households who had saved the seeds of the last years, Kharif Vegetables are intending to use the same for the Kharif season of 2002 as well. This would be an encouraging achievement of BHNP II, in promoting cultivation and consumption of vegetables among the tribal population of the project area.

8. Project Outcomes

8.1 Chage in behaviours/ practices by the target groups

The impact level indicators related to behavioural change and practice by the target population have been captured by baseline and final evaluation studies conducted by the external agencies. India Institute of Health Management Research (IIHMR) based at Jaipur, conducted the baseline survey and submitted the report in August, 2000. The final evaluation survey has been conducted by Centre for Operation Research and Training (CORT) based at Vadodara. The results on the key indicators of project outcome has been presented in the following table –

Change in behaviors/ practices	Log-frame indicators	Baseline August, 2000	Final Evaluation, September, 2002
Improve nutrition and health behavior among pregnant, lactating women and children under 2 years of age	10 percentage points increase in three ANC* check-ups during index pregnancy		
	▪ 90 or more IFA received	19.7	45.8
	▪ 90 or more IFA consumed	13.0	36.4
	▪ Received TT2 by delivery	77.8	72.8
	▪ At least three ANC	19.3	14.2
	▪ Weight taken during index pregnancy	14.6	21.8
	10 percentage points increase in the number of children 0-4 months exclusively breast fed in the last 24 hours	14.0	27.0
	20 percentage points increase in the number of children 6 to 12 months who received semi-solid food in addition to breast milk in the last 24 hours	56.0	77.6
	10 percentage points increase in the number of children from 12-24 months fully immunized by the age of 12 months	22.7	33.0
	15 percentage points increase in the receipt of supplementary nutrition form AWCs by the target beneficiaries		
	▪ During index pregnancy	31.8	39.2
	▪ During lactation	29.6	27.2
Improvement in household food security	40 percentage points increase in the number of households/women who are saving either money or grains		
	▪ Saving money	9.6	35.3
	▪ Saving grains	39.0	36.7
	10 percentage points increase in the number of women directly engaged in nutritional food (fruits and vegetables) production for self consumption Kitchen garden	40.0	11.0

* ANC – 3 check-ups, 2 TT and receipt of IFA

8.2 Chage in Organization / systems

The project aimed at institutional building at the community level by establishing strategic partnerships with local NGOs, functional self help groups and by involving Panchyati Raj Insititutions. The progress made in this direction is captured through the project monitoring system, which is described below -

Change in Organization / System	Log-frame Indicators	Information from MIS (August, 2001)	Information from MIS (August 2002)
Strengthening of Government's health and nutrition services' provision	Sustain quality NHDs in all 642 AWCs	55% of NHDs have ANMs presence	85% of planned health days have ANMs presence
Involve Panchyati Raj Institutions (PRIs) in the project	25% of Gram Panchayats involved in the project	No Gram Panchayats involvement	27% of Mothers Committees with PRI's involvement
Establish strategic partnership with local NGOs	Partnership with 5 local NGOs (one in each of the project block)	7 NGO partnerships	8 NGO Partnerships (across five blocks)

8.3 Expected Outputs

The output of the project activities has been presented in the table below which is based on the information generated through project monitoring system –

Expected Outputs	Process Indicators	Information from MIS (August, 2001)	Information from MIS (August 2002)
Enhancing food security options through Grain Banks	Establish 50 Grain Banks (10 in each block)	No Grain Banks	92 Grain Banks (80% members have accessed grain loans)
Drinking Water points to be created	Minimum 10 water resources points in needy villages	33 water points activated	32 water points activated
Generate support of secondary target group from change in heath practices	Awareness generation in 532 villages (twice in each villages during project life through folk media)	152 vilalges covered	550 villages covered (868 shows were conducted)
Generate community support for behaviour change by the target group	2 active change agents in each of the 642 AWC	156 AWC have active Change Agents	642 AWCs have active change Agents
Complete enumeration of target population through social mapping	100% AWCs have updated social maps	32% AWCs have social maps	100% AWCs have updated social maps (85% AWCs reported regular updating)

9. Lessons Learned

In two years of project implementation, some lessons learned are related to operationalization of the project interventions, realities at the community level, partnering with government and NGOs, monitoring and evaluation of the project progress and impact and challenges in co-ordination of team efforts. Some of the lesson learned are as below –

9.1 Drought, Saving Groups and Feeding Program

The severe drought for three consecutive years in the project area, when this phase of the project was launched in September 2000, was a real challenge, as the project envisaged operationalizing interventions of saving groups for money and grains. With absolutely no stock of food grains and meager amounts of money generated through wage labor, most of the households were just surviving a hand-to-mouth existence. It seemed to be an impracticable proposition to talk of saving when people had nothing to consume even. At this juncture, the initial thoughts were of suspending the project. The issues in the challenging situation were discussed among all the stakeholders. Taking a pragmatic opinion to intervene in the most harsh conditions, the project activities with in the log-frame were prioritized in such a way that the most needy and suitable interventions were taken up early, with out pushing for initiation of all activities simultaneously. With taking up of well deepening n most needy places, the interest of the community members and the NGO partners could be generated for the future activities. *It is essential to have the flexibility to make suitable modifications in the project log-frame depending on the changing conditions. A dynamic log-frame with fixed impact and outcomes would be a suitable tool for the project management team.*

Prioritizing and planning of the sequencing of the activities was a crucial aspect that contributed to timely accomplishment of all the activities in the direction of the progress indicators. The project team, identified that with the drought situation, the capacity building activities for the functionaries of NGOs and Government, involved in facilitating the community mobilization efforts, could be taken up initially with out much impact of the drought. Thus the CB of facilitators on formation and norms development processes was undertaken first. This had immediate impact at the community, the women started to get organized to form into groups, though the actual saving could start only after two or three months of initial group formation.

9.2 NGO partnerships

It was a challenge to identify NGOs, having a focus beyond the devastating drought situation. All the NGO proposals were talking in terms of relief and no one was interested to look at the developmental priorities. It was the efforts of the project direction team of CARE Head quarters at Delhi and Jaipur, which could bring the importance of developmental needs to the forefront in the drought situation. With the facilitation of the process by the senior managers of CARE, the local NGOs could see beyond the drought situation and were able to plan activities in line with the project objectives.

The NGO partners had very little experience of facilitating micro-finance groups and no experience at all of grain bank formation. The BHNP team developed its own approach to the SHGs, with an attempt to link the micro-finance efforts to the health and nutrition behaviour change. The forum of SHG was used to discuss and disseminate the positive health behaviors.

The grain bank approach was developed based on community needs assessment, cross visits to other grain bank sites, participation in national seminar on Food Banks and discussions with the partner NGO functionaries. These detailed deliberations to arrive at the design have contributed to better internalization of the concept and approach by the facilitators and the community members also. Thus despite just one agricultural cycle for the functioning of grain banks, all NGO partners are confident of continuation of the effort beyond the project life.

9.3 Awareness Campaigns in Epidemic Situation

With outbreak of Gastro-enteritis, in some of the villages of Kotra Block, the health department launches intensive epidemic control exercise. With limited options to support the effort, the project team identified the Awareness Campaign component as useful support for the government's efforts. The folk-art teams, which were involved in the campaigns elsewhere, were immediately re-deployed to the affected areas to generate awareness on water-borne diseases, treatment of Diarrhea and to disseminate the information on schedule of the epidemic control camps in remotest villages of Kotra Block. This was very useful in mobilizing the communities to participate and make use of the services offered.

9.4 Mix of Specialists and Generalists in the project team

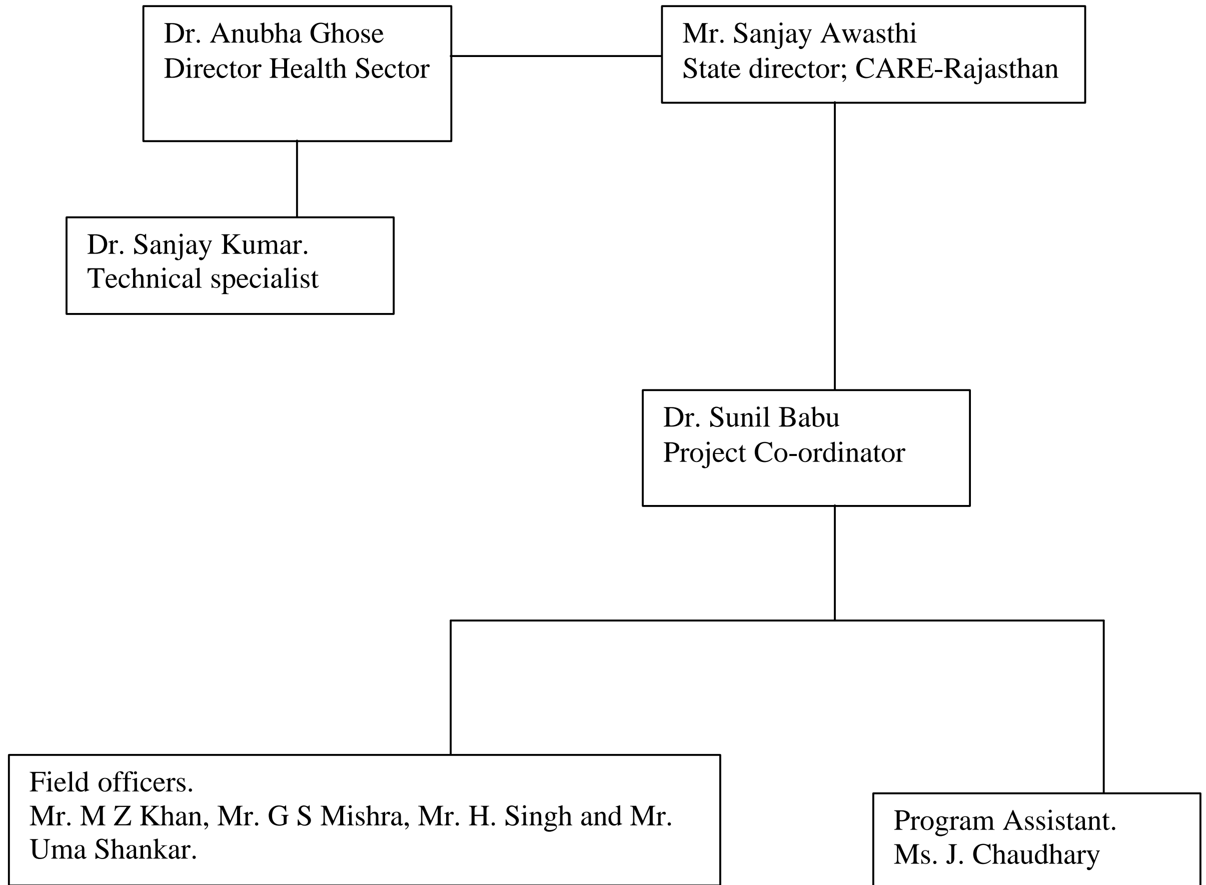
One of the interesting innovations of the project is the Human Resource structure of the team. There were two specialist field officers, one supporting ANR and the other Micro-Finance interventions across the five Blocks. There were three other field officers, supporting all the activities in the assigned Blocks. The former were recognized as specialists in their field and the latter three were generalists, who had ability to support all the interventions and the NGO and GO partnership management. All these five were co-ordinated by one project co-ordinator. The internal and external communication with this complicated structure was the most challenging aspect of the team. With such small distances and overlapping roles and responsibilities among the field officers, it was great team spirit of the individuals, which kept the flow of information in all directions with out many problems.

9.5 Nature of activities, desired impact and Duration of the Project

The project had an ambitious objective of gaining the impact of food security and economic security related interventions on the health status. Considering the recurrent drought situation and the agricultural practices of the project area, the nature of ANR and SEAD activities that were chosen definitely needed more agricultural production seasons than two that were envisioned in the project and just one that was available actually. The impact of ANR and SEAD interventions on health status could probably be seen only in longer run and definitely not at the end of one agricultural season. Thus the incorporation of these activities in this phase of the project might not yield the desired results with in the project duration, except creation of people's institutions around SEAD and ANR activities.

Annex – I

BHNP II Project - Ornogram



Annex-2

Building on Health and Nutrition Project (BHNP-II) in Rajasthan

- Final Evaluation Report

Submitted to

CARE-INDIA, NEW DELHI

cort

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402, Woodland Apartment, Race Course

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September 2002

Preface

CARE-India implemented a project, Building on Health and Nutrition (BHNP-II) in two districts of Rajasthan to improve the nutrition and health status of women and children in the project area. Building on its earlier experience in Better Health and Nutrition Project (BHNP-I), CARE incorporated a holistic community development approach in BHNP-II, wherein interventions related to agriculture and natural resource management including water resource, micro financing and horticulture were added. The BHNP-II was implemented in five blocks of Udaipur and Sirohi districts. This report presents the final evaluation of the project.

We take this opportunity to thank Dr. V. S. Gurumani, Acting Country Director, CARE-India for entrusting CORT with the task of carrying out this study. We would like to thank Dr. Sanjay Kumar, Technical Specialist, CARE-India, for his constant interest and support throughout the study.

Thanks are due to Ms. Geeta S. Kumar, Secretary, Health, Nutrition and Population Programme, and Mr. K. Agnihotri, Assistant Manager, Finance, for their timely help and cooperation. We are also grateful to Dr. Sunil Babu (Project Coordinator, Udaipur) and field officers Mr. Gaurishankar Mishra, Rajender Singh, Mr. Uma Shankar and Mr. Zulfikar Khan, for all the support and cooperation extended to our team to complete the fieldwork on time.

Above all we would like to thank all our respondents, without whose cooperation it would not have been possible to complete the study successfully. Thanks are also extended to the CORT field and support staff for their contribution in the timely completion of the study. We acknowledge the efforts put in by all the team members in the various stages of the report preparation.

Prof. M. M. Gandotra
Director

September 2002

Centre for Operations Research and Training (CORT), Vadodara

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Executive Summary

CARE-India implemented a health and nutrition project, Building on Health and Nutrition Project (BHNP-II), in five blocks of Udaipur and Sirohi districts. The project aimed to achieve a sustainable improvement of health and nutrition status with special emphasis on children upto two years and pregnant and nursing mothers. To achieve this end a holistic approach was adopted, in which interventions like horticulture, savings, and grain banks were implemented.

The present study is the final evaluation of the project interventions. A sample of 1014 households was selected from 60 anganwadi centres (40 in Udaipur and 20 in Sirohi) in the project area. The criterion for selection of households was women having children below two years of age. A structured questionnaire was administered to the women. In addition to this, structured interviews were conducted with anganwadi workers and ANMs of the project areas. The major performance indicators for the health and nutrition interventions assessed by the study were antenatal care (for women with children under two years), safe delivery, infant feeding practices, immunization of children and supplemental nutrition. In addition to this, the study assessed the participation and utilization of the other economic and agricultural activities. NGOs were active in some of the villages in the project area. Therefore a comparison was made between villages covered by NGOs and those that were not. The following presents the major findings that emerged from the study.

ANTENATAL CARE

- According to the data collected, only 36 percent of the women had received any antenatal care services. There was no significant difference in the percentage of women receiving antenatal care services in the NGO and non-NGO villages. But compared with the baseline survey, the percentage of women who received antenatal care services was 62 percent. Utilization of such services therefore appears to have declined over a period of time.
- For ANC services that require women to go to health providers there was little improvement between the baseline and the end line data. However for services which they receive at home like IFA and TT injection and weight monitoring, there has been significant improvement from the baseline to the end line. A higher percentage of women in the endline (21 percent) as compared to the baseline data (6 percent) realised the importance of getting their weight measured during pregnancy. This means there has been 15 percent point increase after the intervention programme. Looking into such services provided in two different types of villages, the data showed no significant difference in the practice of weight monitoring, an almost equal percentage of women in NGO (26 percent) and the non-NGO village (27 percent) had their weight taken during pregnancy. Similarly, as compared to the baseline data there has been 10 or more percentage point increase in the number of women receiving IFA tablets (20 percent baseline and 69 percent endline) and two TT injections (78 percent baseline and 80 percent endline) during their index pregnancy. Even consumption of IFA tablets showed a substantial improvement, from 13 percent of the women in the baseline to 25 percent of the

women in the end line having received IFA tablets and also consumed them, this means within two years there had been a 12 percentage point increase in the number of women consuming the IFA tablets. Again, if we see the receipt of IFA tablets and TT injection and consumption of IFA tablets in the two project areas, the data showed a marginal difference in the use of IFA tablets and the administration of two TT injections in the NGO and non-NGO areas.

SAFE DELIVERY

- The data shows that home delivery continued to be preferred by women. Almost 80 percent of women had delivered at home and this practice remained almost same in both the project areas, NGO and non-NGO areas. Over the last two years there has been some improvement in deliveries attended by a trained person. This is obvious from the fact that while during the baseline survey 16 percent of all the deliveries were attended by a trained person, this percentage increased to 21 in the endline survey. This practice remained more or less the same in both the NGO and non-NGO villages. This shows that though there had been some impact of the project, there is still a need to make women realise the necessity of institutional delivery or having the delivery conducted by a trained person. Women should be informed about the common health problems that can turn fatal if attended by an untrained person this might influence women to go for institutional delivery or calling a trained health professional.

INFANT FEEDING PRACTICES

- In both the project areas it was found that there was a practice of feeding the newborn with some traditional syrup called *janam ghutti* which they either prepared at home before the birth of the child or they bought the preparation widely available in the market, manufactured by reputed companies like Dabur. They continue giving the child *janam ghutti* till the age of 4-5 months. This practice was found to be almost the same in the two-project areas.
- Due to the practice of feeding *janam ghutti,* initiation of breastfeeding was delayed; the child was put to the mother's breast only after six hours of its birth in both the NGO and non-NGO areas. But when compared with the baseline, the data indicate that there has not been much impact of the project intervention; in the baseline 34 percent of the women initiated breastfeeding within first six hours of birth which declined to 27 percent in the endline.
- The custom of giving *janam ghutti* showed a further impact on the practice of exclusive breastfeeding too. Though the child is reported to be only on mother's milk, the child is also given the said traditional syrup till the age of 4-5 months, after which, liquids like water, animal milk, tea and other such things are given. Eighty-two percent of the children were given liquids besides breast milk during the first six months. This was 81 percent in the NGO and 83 percent in the non-NGO villages. Besides, this complementary feeds were also initiated to the child before the age of six months.
- Looking into the percent of women with children below six months who had exclusively breast fed their child in the last 24 hours, the data shows that there has been an increase in the awareness among the women on importance of exclusive breastfeeding. Twenty-seven percent of the women in the end line had exclusively breastfed their child (below 6 months) in the last 24 hours which was only 12 percent

in the baseline line. The practice of exclusive breastfeeding remained almost same in both the NGO and non-NGO villages. This means, overall, there has been an improvement in infant feeding practices in both the project areas.

IMMUNIZATION OF CHILDREN

- The immunization status of children aged 12-24 months shows that 33 percent of the children were fully immunized, 47 percent were partially immunized and 20 percent were never immunized in the end line survey. This, when compared with the baseline shows that only 7 percent of the children were fully immunized. It is encouraging to note that irrespective of whether it was NGO or non-NGO village there has been an impact on the immunization status of the children due to the NHDs.
- Increase in the immunization status has also brought about improvement in children being immunized against DPT (3rd dose) (baseline 42 percent and end line 44 percent), polio (3rd dose) (baseline 40 percent and end line 56 percent) and measles (baseline 27 percent and end line 35 percent). However, there was a decline in BCG coverage of children. Compared with the coverage of BCG immunization in the end line data (74 percent), the coverage of BCG immunization in the baseline survey was (92 percent).

SUPPLEMENTAL NUTRITION

- Utilization of supplementary food provided at the anganwadi centre as take home ration (THR) was very low, but it was better in the NGO than in the non-NGO villages. Forty-one percent of the women ever received THR for their children above six months of age, this was 32 percent in the baseline survey.
- There has not been much impact on supplementary nutrition (SN) for nursing mothers (having children below 6 months of age). Thirty percent of the women in the baseline survey reported having received SN during lactation period; the same in the end line was found to be 27 percent. This indicates that not all had received the THR regularly. In the end line it was found that the food distributed at the AWC was generally shared with their family members; some did not like it, as a result they either threw it away or gave it to their pets or stray animals.

AWARENESS AND PARTICIPATION IN NUTRITION AND HEALTH DAYS

- Only 30 percent women were aware of Nutrition and Health Days (NHD). This was higher in the NGO villages, where 37 percent women knew about NHD as against 25 percent in the non-NGO villages. Over the years, women seemed to show less interest in these NHDs. As a result, compared to the baseline line where 38 percent of the women mentioned about NHDs, in the end line there was a decline by 8 percentage points in the number of women who were aware about NHDs.
- Of those who reported being aware of NHDs, 80 percent said NHDs were held at the anganwadi centres. Half of the women did not know when the last NHD was held in their village. Given such low level of awareness among women, it cannot be expected that women would regularly participate in NHDs.

- When the ANM and AWW were asked about the services provided during these NHDs ANM reported providing immunisation and antenatal care services to pregnant

women, while AWW reported providing only THRs during the monthly NHDs. Under the project the NHD has been envisaged as a convergence of nutrition and health services, however, the impact of this activity is not visible in the outcome indicators of supplementary food and immunisation services.

Small Economic Activities

- Over the past two years of this project intervention, there has been a substantial increase in the awareness about the saving schemes. Compared with the baseline where 10 percent of the women saved money regularly for future use, in the end line survey 35 percent women reported the same.
- Utilization of the loan facility at the time of need also increased. In the baseline data a very negligible percentage (0.4 percent) of women had taken loan at the time of need, while in the end line survey a higher percentage (54 percent) of the women reported having availed of loan facility in emergencies like sickness and socio-religious events. The money saved by these women was enough only to meet their small day-to-day expenses, and not for incidences like sickness, death, marriages, births etc. The money in such cases was borrowed not from savings groups rather from relatives and friends.
- Thirty seven percent women reported saving grains for future requirements and of these 21 percent said that the amount saved was enough to meet their requirements. A negligible proportion of women were a member of grain banks.

Agriculture and Natural Resources (ANR) Activities

- The project had prioritised utilisation of drinking water, micro irrigation and kitchen garden activities to grow vegetables rich in micronutrients as its ANR activities. The data, however, showed low participation of women in these activities. Only 17 percent of the women in the NGO village and 7 percent in the non-NGO village mentioned having a kitchen garden, where they mainly cultivate vegetables. In the absence of data on micro irrigation and drinking water activities, it may only be speculated that the reason for low participation in the kitchen garden activities could be due to scarcity of water.

It seems that the intervention have made an impact as far as the antenatal care services like IFA, TT injection and weight measurement and immunization of children it has not made much dent in improving the nutritional status of the children, pregnant and lactating mothers. There thus appears to be a great need to put additional efforts to improve such services if the infant mortality is to be reduced expeditiously in these areas.

CHAPTER 1

INTRODUCTION

To improve the nutrition and health status of women and children, CARE-India in support of WFP implemented a project on Building on Health and Nutrition (BHNP-II) in five blocks of Udaipur and Sirohi districts of Rajasthan namely Abu Road, Reodar, Mavli, Kotra and Salumbar blocks. This project was built on an earlier project named Better Health and Nutrition Project (BHNP-I) to incorporate a holistic community development approach by adding interventions related to agriculture and natural resource management including water resource, and livelihood security over and above the health and nutrition interventions. The project focuses not only on improving the systems that deliver health and nutrition services, but also improving access to capital and the use of natural and land resources. To establish benchmark indicators related to health, nutrition, micro financing and horticulture, a baseline survey was conducted in 2000. Based on the findings of the survey following interventions were framed.

SPECIFIC INTERVENTION AND ACTIVITIES

A. Health and Nutrition Activities

BHNP-II continued to promote the key interventions of its earlier phase related to health and nutrition activities. The key activities were:

Strengthening Service Delivery Related to Health and Nutrition

The project aimed to strengthen government health and nutrition services at the village level. The project team worked in close collaboration with district health and ICDS department. To strengthen these services, the project institutionalized monthly Nutrition and Health Days (NHDs) to build the capacity of the Anganwadi workers to prepare and update Social Maps for complete enumeration of the target population.

Complete enumeration of target group: To ensure complete enumeration of the target population the project worked through NGO partners and trained Anganwadi workers (AWW) in preparing and updating Social Maps. The aim was that 100 percent Anganwadi Centres (AWCs) would update social maps by the end of the project.

Institutionalizing NHDs: A NHD is a fixed place (usually the AWC) and day of a month when supplementary food is provided to the beneficiaries along with basic heath services and counseling. The project attempted the convergence of nutrition and health services at the village level by advocacy with the local health and ICDS department and institutionalized NHDs in the project blocks. The Auxiliary Nurse Midwife (ANM) provided the health services and visited the village on the pre-specified days in the villages which coincide with the NHD. For the service provider this becomes a convenient gathering of target population and for the community it became a convenient sources of both nutrition and health services.

B. Small Economic Activity Development (SEAD) Interventions
The saving and credit activities were a critical part of enhancing health and nutrition status in the longer term. The micro finance activities were introduced in such a way that they are viewed as intertwined with the pursuit of optimal health and nutrition status. BHNP-II addresses the issue of increasing access to credit by undertaking savings and credit activities in the project area. CARE and partner NGOs facilitate the community themselves to develop appropriate savings & credit designs, keeping in view their own needs and expectations. The Self-help Groups (SHGs) are informed about various options and obstacles, but has ensured that the communities, themselves, make the decisions. The key project activities are:

Formation of Self-Help Groups (SHGs): The project has established and strengthened SHGs with the help of partner NGOs at the local levels. These groups were encouraged to ensure monthly NHDs in their villages and utilize funds for the health need of its members.

Training the SHG members: Project has organized training programmes to the partner NGOs as well as of the members of the groups on administration, management, sustainability and related topics.

C. Agriculture and Natural Resources (ANR) Activities
The project undertook agricultural and natural resource management activities. Depending upon the need of the community, CARE prioritized ANR interventions. The key ANR activities were:

Assist in utilization of water for drinking and micro irrigation: The project has suffered severe drought conditions. CARE had prioritized this intervention and had provided drinking water points in the identified villages. The water has been further used for promoting kitchen garden activities.

Promotion of kitchen gardens: BHNP-II has promoted kitchen garden activities and has involved many families to grow vegetables rich in micro-nutrients. This activity has been accomplished through the help of partner NGOs.

Introduction of the concept of micro level planning and resource mapping with partner NGOs and CBOs: CARE has provided training to the NGO partners for undertaking resource mapping and its use for micro level planning.

Assistance in establishing grain and seeds bank: To address the food security issue in drought prone area, the project initiated grain banks with the help of the SHGs. The project built the capacity of the partner NGOs to facilitate the formation of grain banks and its smooth functioning.

BHNP-II was initiated on 1st September 2000 for a period of two years in approximately 642 sanctioned anganwadi centres representing 804,120 population with the goal to achieve “a sustainable improvement of health and nutrition status with special emphasis on children up to 2 years and pregnant and nursing mothers”. Thus, to improve the household food security as well as intensification of ICDS activities in the project area the objectives was to:

- Reinforce and intensify the government system of providing health and nutrition services
- Improve women's capacity to access capital resources
- Improve the communities' capacity to increased crop productivity and effective management of natural resources
- Involve Community Based Organisations in the programme management

Based on the quantitative assessment of the performance indicators related to health, nutrition, micro finance and ANR activities this report is prepared by Centre for Operations Research and Training (CORT), a multi disciplinary social, sciences research organization based at Vadodara.

OBJECTIVES OF THE STUDY

The objective of the study was to:

- Compare the process and performance indicators as stipulated in the project logical framework overtime with the baseline. (To assess achievement of outcomes/coverage rates since the baseline)
- Analyze the project implementation strategies adopted by the project to reach its objectives

STUDY AREA

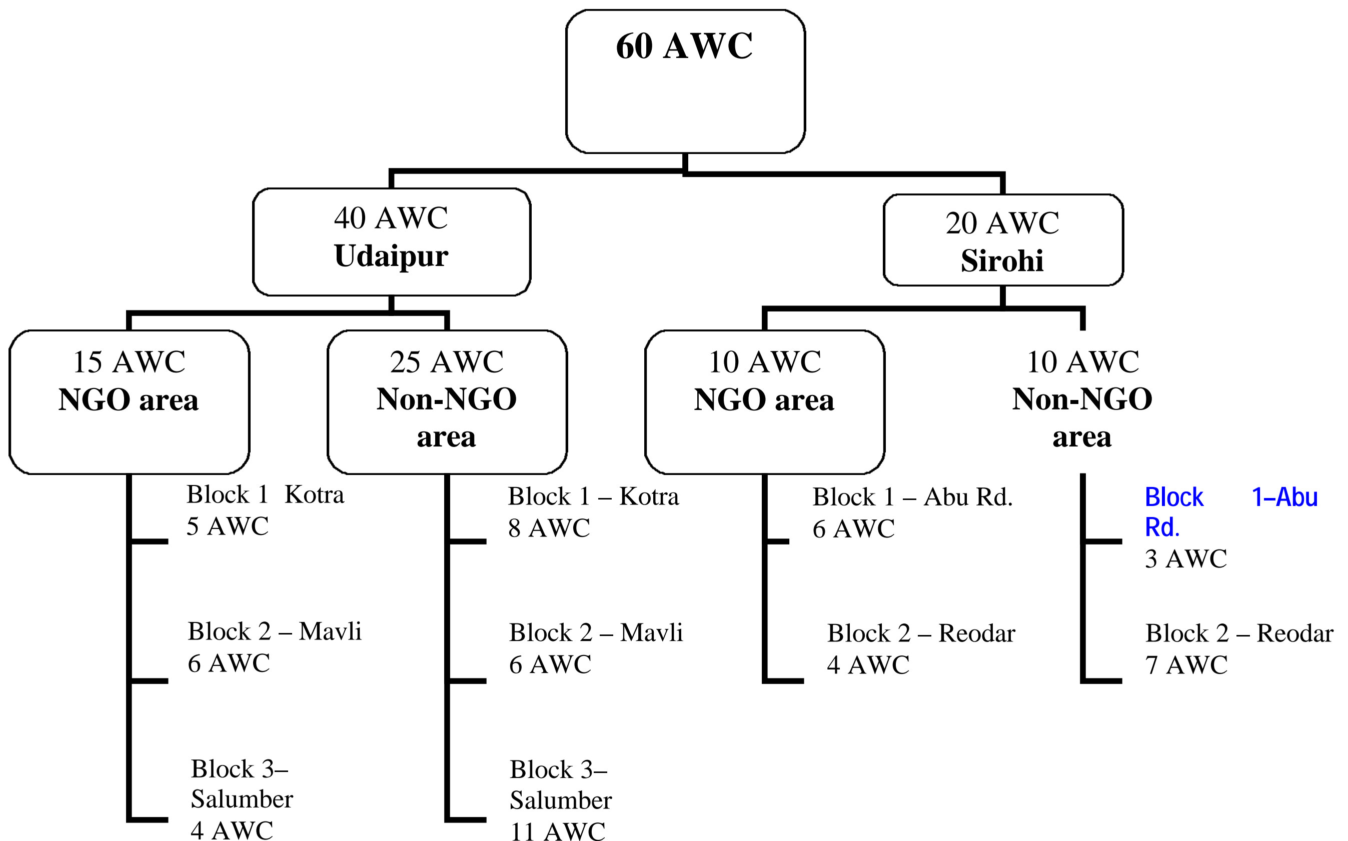
The study was carried out in the five blocks of Udaipur and Sirohi districts of Rajasthan. The blocks visited were Abu Road, Reodar, Mavli, Kotra and Salumbar.

Sample design and size: Anganwadi was considered as the primary sampling unit (PSU) for the study as all CARE activities related to health and nutrition were disseminated from the AWC. It was proposed to cover 60 AWCs, that is, around 10 percent of the total AWCs were covered for the study.

Another major component of the project was the involvement of NGOs as partners to train Anganwadi workers in preparing and updating social maps and identifying the target groups. From the information provided by CARE officials, it was learnt that there was a difference in the coverage of the villages in the study districts. In Udaipur district, NGOs covered almost 35 to 40 percent of the villages, while this was 75 percent in Sirohi district. Based on this, in each of the two study districts, the AWCs were further stratified as those covered by partner NGOs and those not covered by NGOs.

A schematic representation of the distribution of the AWC across the study area is as under

DISTRIBUTION OF ANGANWADI CENTRES
SCHEMATIC DIAGRAM



The above distribution would give a fair representation of the AWC across the project area.

Selection of the target population: Since the target group for the study were women with atleast one child below the age of 2 years and pregnant women, households meeting these criteria were included in the sample. From each AWC or the primary sampling unit 17 women falling in the target group were interviewed. Thus, in all 1014 women were contacted for the interview.

For the selection of the women the AWC area was divided into four equal clusters geographically. From each cluster a minimum of 4 target women were randomly

selected for the interview. For identification of the target women in each cluster, investigators selected the first household by random sampling method and then proceeded in clockwise direction contacting the next nearest household to cover the requisite sample size in the cluster.

Selection of Anganwadi Worker, ANM and Partners NGO: In each of the selected Anganwadi center, anganwadi worker, ANM were also contacted for the interview. In all we had to cover 60 anganwadi workers and all ANMs covering the selected AWW villages. At the time of survey 29 AWWs and 17 ANMs could be contacted. The required number of AWW and ANM could not be covered because some of the AWW were outstation for training and some were on leave. Similarly two ANMs could not be contacted because they were on leave.

STUDY TOOLS

As per the study objective and TOR questionnaires were prepared for the women (with children under two) and Anganwadi workers and ANMs. Questionnaires were prepared based on the indicators provided in the TOR.

Women's Schedule

- Background information of the women
- Utilization of antenatal and postnatal care services
- Breast feeding practices
- Immunization Status of the children
- Supplementary feeding for children above 6 months
- Supplementary feeding for pregnant women
- Supplementary feeding for nursing mothers (0-6 months child)
- Saving made by women
- Horticulture production
- CBO efforts/gram panchyat/mahila mandals

Anganwadi Schedule

- General information about the anganwadi worker
- Accessibility of the services
- Drug supply
- Availability of equipments
- Knowledge of AWW about the project and convergence with the ANM

ANM schedule

- General information about the ANM
- NHD camps
- Knowledge of ANM about the project and convergence with the AWW

STUDY PERIOD

The duration of the study was from July 2002 – September 2002.

ORGANIZATION OF THE REPORT

Based on the objective of the study, the report has separate section for respondents. Chapter 1 namely Introduction briefly describes project, objective and methodology used to carry out the study. In Chapter 2 utilization of health and nutritional services by women having children less than two years of age. Chapter 3 gives anganwadi worker's knowledge and perception about the integration of nutrition and health services. Chapter

4 presents knowledge and perception of ANM about the integration of nutrition and health services.

CHAPTER 2

NUTRITION AND HEALTH STATUS OF WOMEN AND CHILDREN

This chapter presents the attitudes and perceptions of women regarding various interventions framed under the CARE-project aimed at improving the nutrition and health status of women and children. Women were asked whether they had received the relevant health services during the antenatal, natal and post-natal period, and about immunisation services and supplementary feeding received by children, pregnant and lactating mothers. Other than this, information was also collected on the benefits gained from the savings and credit activity. In addition, information on the household characteristics of the women was collected to understand the background of the beneficiaries of the project.

Household Characteristics

Table 2.1 presents the household characteristics of the women interviewed. As can be seen from the table relatively more NGO villagers (69 percent) were found to live in kachcha houses as compared to villagers in non-NGO villagers (56 percent). Further, the major source of earning in the NGO villages was relatively more from agricultural jobs (55 percent) like agricultural labour or agriculturist as compared to the non-NGO villages (45 percent). This illustrates that the NGO villages are relatively poorer than the non-NGO villages. However, the difference in the other characteristics like type of family, family size and even land ownership was not found between the NGO and non-NGO villages. This is obvious from the fact that around 59 percent of the women in both types of villages belonged to nuclear family with an average family size of around 7 members. Further, there were equal number of male and female members in the family; on an average, there were three male and three female members. Majority of the families (87 percent) had, on an average, five bighas of irrigated land and this had been their major source of livelihood. Half of the families earned their living from agricultural work (49 percent) and others earned livelihood from labour work (27 percent) self employed work (12 percent) or other related work.

Table 2.1: Household characteristics (Percentage)

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
Type of family			
Nuclear	59.7	58.8	59.2
Joint	40.3	41.2	40.8
Family size			
Small up to 4 members	19.0	16.4	17.5
Medium 5 to 9	58.8	63.7	61.6
Large 9+	22.0	19.9	20.8
No response	0.2	-	0.1
Average family size	6.8	6.8	6.8
Average male members in family	3.3	3.4	3.4
Average female members in family	3.5	3.5	3.5
Type of house			
Kachcha	69.2	56.4	61.7
Semi-*pucca*	19.0	24.2	22.0
Pucca	11.8	19.4	16.3
Major source of earning			
Agricultural labour	17.3	14.0	15.4
Urban labour	20.4	21.6	21.1
Skilled labour	6.6	6.1	6.3
Agriculturist	37.9	30.6	33.6
Government services	2.1	4.1	3.3
Self employed	7.8	14.5	11.7
Other	6.6	7.6	7.2
Do not know	0.5	0.5	0.5
Unemployed	0.7	1.0	0.9
Land ownership			
Av. Land (Bighas)	5.9	5.8	5.8
Av. Irrigated land (Bighas)	5.3	4.8	5.0
Total women interviewed	422	592	1014

With regard to availability of basic amenities such as light and drinking water, majority of the households in the NGO village used kerosene (60 percent), while in non-NGO villages households had electricity connection in majority (51 percent). Hand pump/bore well was the major source of drinking water facility in both types of (NGO and non-NGO) villages. However, while 21 percent of non-NGO villages had the facility of tap (shared/public or their own), this facility was available to only 9 percent of NGO villages. This again speaks about relatively poor socio-economic status of the NGO villages as compared to non-NGO villages.

Table 2.2: Basic amenities available at household (Percentage)

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
Main source of drinking			
water	2.6	10.8	7.4
Tap (inside	6.2	10.0	8.4
residence/yard/plot)	59.7	56.8	58.0
Tap (shared/public)	2.6	2.2	2.4
Hand pump/bore well/pipe	23.0	17.6	19.8
Well (covered)	2.4	1.5	1.9
Well (uncovered)	3.6	1.2	2.2
River/pond			
Other			
Main source of lighting			
Electricity	37.9	51.0	45.6
Kerosene	60.4	46.1	52.1
Other	1.7	2.9	2.4
Total women interviewed	422	592	1014

BACKGROUND CHARACTERISTICS OF INDEX WOMEN

Analysis of the information collected on the background characteristics of the women including their present age, age at marriage and gauna, their educational and fertility status, is presented in Table 2.3. On an average, women interviewed from both types of villages were 25 years of age. About 10 percent were adolescents. This percentage was slightly higher in the NGO villages (12 percent) than in the non-NGO villages (9 percent). Further, women were married when they were 14.7 years of age, on an average, and they started living with their husbands after one and half years (16.1 years on an average). Age at consummation of marriage suggests that roughly 7 out of 10 girls consumed marriage before even reaching the age 18 the prescribed legal age at marriage.

Table 2.3: Background characteristics of index women (Percentage)

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
Age (in years)			
Upto 19	11.6	8.8	10.0
20-24	36.7	39.2	38.2
25-29	34.4	29.6	31.6
30-34	11.1	16.6	14.3
35-39	5.2	4.6	4.8
40-44	0.2	0.7	0.6
45-49	0.2	0.3	0.3
50+	-	0.2	0.1
Don't know	0.5	-	0.2
Average age	25.0	25.5	25.3
Age at marriage			
Below 15	42.9	36.8	39.3
15-17	36.0	38.3	37.4
18	9.2	11.8	10.7
19+	11.6	13.0	12.4
Don't know	0.2	-	0.1
Average	14.5	14.9	14.7
Age at Gauna			
Below 15	24.2	18.2	20.7
15-17	48.1	48.3	48.2
18	13.0	16.2	14.9
19+	14.2	17.1	15.9
Don't know	0.5	0.2	0.3
Average	15.9	16.3	16.1
Educational status			
Illiterate	88.6	81.1	84.2
Below primary	2.8	5.9	4.6
Higher secondary &	6.7	8.8	7.9
above	-	0.2	0.1
Undergraduate	0.5	0.5	0.5
Graduate	1.4	3.7	2.8
Do not know			
Total women	422	592	1014

The educational status of the women was very poor. Majority (84 percent) of the women interviewed were illiterate. Only five percent had studied upto primary level and eight percent up to higher secondary and above level. A very negligible percent had completed graduation.

Table 2.4: Total number of pregnancies and living children among respondents (women with child less than 2 years) (Percentage)

Total living children	*Project Area*		
	NGO	*Non-NGO*	*Total*
No. of pregnancies			
Upto 3	63.5	62.3	62.8
4-6	30.8	31.4	31.2
7+	5.7	6.3	6.0
Average	3.2	3.2	3.2
Parity			
One child	22.5	22.0	22.2
Two children	24.4	22.8	23.5
Three children	19.4	24.0	22.1
Four children	17.1	15.0	15.9
Five children or more	16.6	16.2	16.3
Average living children	2.9	2.9	2.9
Total women interviewed	422	592	1014

As is evident from Table 2.4, on an average a woman had experienced 3.2 pregnancies during her present reproductive span. However, about 31 percent of them had 4-6 pregnancies and another six percent of the women had seven or more pregnancies. The distribution of pregnancies remained more or less the same in both types of villages. Further, with regard to parity, women had, on an average, 2.9 living children. More specifically, 22 percent of the women had one child and almost an equal percent each had two and three living children. About 16 percent each had four and five (or more) children. This means around one-third (32 percent) of the women had relatively large families consisting of four or more children.

Looking into the sex composition of the living children, the data shows that women tend to have high parity when they have no or only one male child. To have at least one male child, women tend to continue having children upto three or higher parity (Table 2.5).

Table 2.5: Sex combination of living children

Sex composition	*Percentage*
One parity	22.2
One male no female	11.7
No male one female	10.4
Two parity	23.5
Two males no female	6.4
One male one female	5.6
No male two females	11.4
Three parity	22.0
Three males no female	2.0
Two males one female	1.7
One male two females	9.2
No male three females	9.3
Four parity	15.9
Four males no female	0.9
Three males one female	0.5
Two males two females	3.9
One male three females	5.4
No male four females	5.1
Five and more children	16.3
Total women interviewed	1014

Information on the youngest index child was also collected and is presented in Table 2.6. As can be seen from the table, the youngest child was on an average 10.8 months of age. Age specific data shows that 67 percent of the children were aged one year or less and the rest 33 percent were 13-24 months old. There was no significant difference in the age cohort of children in both project areas. Further, in both types of villages there were more males (54 percent) than females (46 percent).

Table 2.6: Percentage distribution of age and sex of the youngest child

(Percentage)

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
Age of youngest child (in months)	16.1	15.9	16.0
1-3	14.0	15.5	14.9
4-6	14.0	14.5	14.3
7-9	23.9	20.6	22.0
10-12	19.4	17.8	18.4
13-18	12.6	15.7	14.4
19-24	10.7	10.9	10.8
Average			
Sex of youngest child			
Male	56.2	53.0	54.3
Female	43.8	47.0	45.7
Total women interviewed	422	592	1014

AVAILABILITY OF HEALTH AND NUTRITIONAL SERVICES

Table 2.7 presents accessibility to health services and anganwadi centre (AWC). Of the total women, 13 percent reported that the health facility was located within their village. A higher percentage of women in non-NGO villages (17 percent) than NGO villages (7 percent) reported availability of a health facility at a walking distance. Majority of the respondents reported that the distance of health facility was located within the radius of 4 kms (46 percent), while for others the distance of nearest health facility varied from 5 to more than 21 kilo meters. The average distance of health and nutritional services was found to be relatively more in the NGO area (6.2 kms) as compared to non-NGO area (4.6 kms). About 8 percent of the women, though aware of the availability of health facility, found it difficult to state the distance.

Table 2.7: Accessibility to health and anganwadi centre

(Percentage)

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
Distance of nearest health facility (in km)			
Within 4	42.4	48.1	45.8
5-10	32.0	21.1	25.6
11-15	5.2	3.4	4.1
16-20	3.8	0.2	1.7
21+	3.3	2.0	2.6
Walking distance	6.6	16.7	12.6
Don't know	6.5	8.4	7.6
Average	6.2	4.6	5.3
Percent aware of an anganwadi center in village	92.7	80.9	85.8
Total women interviewed	422	592	1014
Distance of AWC from home			
Walking distance	96.2	95.0	95.5
Within 5 k.m	3.8	4.2	4.0
5-10 k.m.	-	0.8	0.5
Average time to reach the AWC	9.8	10.7	10.3
Women aware of anganwadi center	391	479	870

In the same way, when asked about the availability of the AWC in the village, 14 percent of the women were unaware about the existence of anganwadi centre in their village, the rest (86 percent) knew about the centre. Majority of those who were aware stated that it was located within the village, at a walking distance. And when asked about the time taken for them to reach the centre, almost all stated that, on an average, it takes about 10 minutes to reach the centre.

To understand the utilization of the anganwadi centre, information was collected on the frequency and purpose of visits of the respondents to the centre. The data analysed is presented in Table 2.8. As seen earlier, majority of women were aware about the anganwadi centre, however only 36 percent had visited the centre to avail any of its services during the last one month. In the last one-month, women visited the anganwadi centre, on an average, 3.8 times, mainly to take the ration. Such visits, on an average, were more in the NGO (4.5) villages as compared to non-NGO villages (3.2). It can be seen from the table that the anganwadi centre was mostly utilized for the food that they distribute (THR). However, about 28 percent of the women had visited the centre for immunization of their children or for health check-ups. A very small percent (5 percent) of women also stated that they visited the anganwadi to attend the self-help group meetings.

Table 2.8: Utilization of the anganwadi centre (Percentage)

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
Number of times visited AWC in the last one month			
Not visited in last one month	62.1	65.1	63.8
Daily	1.5	0.4	0.9
10-25 times	1.2	0.4	0.6
2-9 times	15.0	13.7	14.2
Once a month	9.2	9.0	9.1
Don't know	11.0	11.3	11.1
Average	4.5	3.2	3.8
Total women interviewed	422	592	1014
Purpose of the visit to AWC			
Take home ration	70.3	75.4	73.0
For health check-up/immunization	27.0	28.1	27.6
Self help group/meetings	5.4	5.4	5.4
Others	10.1	13.2	11.7
Women who visited AWC	148	167	315

ANTENATAL CARE SERVICES

Since pregnant women are one of the target groups for providing nutritional and health services, information was also collected on the extent to which they were being covered in the programme. Table 2.9 presents the type of antenatal care (ANC) services received by the pregnant women during their pregnancy. As can be seen from the table, only 36 percent of the women received any antenatal care services during their last pregnancy; the difference between NGO and non-NGO village in terms of receipt of antenatal care was not very much marked. Timing of the initial antenatal check-up among the women who received antenatal check-ups shows that an equal percentage of women had received their first check-up in the first trimester (12 percent) or second trimester (12 percent) of pregnancy. The mean timing of the first antenatal check-up was after 4.8 months. However, about one-tenth of the women had received their first check-up during the third trimester of pregnancy. This shows that women are either unaware about the benefits of early registration of their pregnancy or unable to do so. Among those who visited the health facility for ANC check-up, they made, on an average, three visits.

Table 2.9: Percentage women received antenatal care services
(Percentage)

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
% received ANC	35.5	36.3	36.0
Month of 1st check-up			
1st trimester	10.7	12.3	11.6
2nd trimester	11.6	12.3	12.0
3rd trimester	10.0	9.3	9.6
DK	3.2	2.4	2.8
Average	4.9	4.7	4.8
No. of visits to health facility*			
1-2	21.1	20.4	20.7
3	5.2	4.1	4.5
4-8	6.4	9.1	8.0
9	1.2	2.0	1.7
Don't know	1.6	0.7	1.1
Average	2.8	3.2	3.0
% received IFA tablet/syrup during pregnancy	72.0	67.6	69.4
% received TT injection	76.3	70.3	72.8
Total women interviewed	422	592	1014
No. of times taken TT			
1	17.4	20.0	18.8
2	61.5	56.7	58.8
3+	18.9	22.4	20.9
Do not remember/DK	2.2	0.9	1.5
Percent received booster dose*	4.3	11.8	8.5
Women received TT injection	322	416	738

Supplements received during pregnancy shows that 69 percent of the women had received IFA tablets and almost an equal percent (73 percent) had also received TT injection. Among these, 59 percent of them had received two doses of TT injection and about 9 percent reported having received the booster doses of TT. A higher percentage of women in NGO villages reported having received IFA tablets (72 percent) as compared to non-NGO villages (68 percent). Similarly, TT injection was reported to have been received maximum by NGO villages (76 percent) as compared to non-NGO villages (70 percent). Compared with the baseline data there has been an increase by more than 10 percentage points in the women receiving the IFA tablet (50 percent in the baseline) and TT injection during pregnancy (60 percent in the baseline).

Components of Antenatal Check-ups

Among all the mothers whose child was less than 2 years, about one-fourth of the women had an abdominal examination done (27 percent), and one-fifths or more had their weight (22 percent) and blood pressure measured (21 percent) and pathological test of blood and urine done as part of the ante-natal check-ups. A small percentage of women had a breast examination (10 percent) and internal examination (8 percent) done (See Table 2.10). Prior to the intervention very low percentage of women (6 percent) had reported having had their weight taken during pregnancy; this increased to 22 percent after the intervention period.

Table 2.10: Type of checkups done during pregnancy

(Percentage)

Type of Checkups done	*Project Area*		
	NGO	*Non-NGO*	*Total*
Abdomen examined	26.3	27.0	26.7
Blood test	21.3	24.3	23.1
Weight	20.9	22.5	21.8
Blood pressure	19.4	21.8	20.8
Urine test	18.7	21.3	20.2
Height	8.3	11.1	10.0
Breast examined	9.2	9.8	9.6
Internal examination	7.3	8.8	8.2
Other	3.1	4.2	3.7
Total women interviewed	422	592	1014

Further, all women who reported having had their weight taken during pregnancy, were also asked about the number of times their weight was measured and the person who measured their weight. The data collected is presented in Table 2.11. As can be seen from the table, majority of women (65 percent) were weighed once or twice during their entire pregnancy period. Only 11 percent of the women were weighed more than five times. This percentage, though less, was reported more by women in non-NGO villages (14 percent) than by those in the NGO villages (8 percent). Mostly the women were weighed by a govt. doctor or an ANM. About 23 percent of women also reported being weighed by a private doctor. It can be said that women in the non-NGO villages avail themselves of antenatal care services more from private doctors and this could have been the reason for receiving slightly better antenatal care as compared with their counterparts from NGO villages.

Table 2.11: Frequency and place of weight measurement

(Percentage)

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
Number of times weighed during the index pregnancy			
Once	33.0	32.3	32.6
Twice	35.2	30.1	32.1
3-4 times	20.5	16.5	18.1
5 times or more	8.3	13.5	11.3
DK	2.3	7.5	5.4
Average	2.5	2.9	2.8
Person who weighed you			
Govt. doctor	33.0	39.4	36.8
ANM/LHV	38.6	25.0	30.5
Private doctor	12.5	30.3	23.2
Anganwadi worker	9.1	2.3	5.0
Others	6.8	3.0	4.5
Women weighed during pregnancy	88	133	221

Iron and Folic Acid Supplementation

It is recommended that pregnant women should consume 100 tablets of iron and folic acid (IFA) during pregnancy to prevent or treat nutritional anaemia during pregnancy. For easy accessibility and for complete supplementation, under the project, AWWs have been given the additional task of distributing IFA to pregnant women. The data collected on the place, type and number of IFA received and consumed is presented in Table 2.12. As mentioned earlier, around 70 percent of the women in both the project areas had received IFA tablets during pregnancy, mainly from the ANM (54 percent). About one-fifth reportedly procured it from the anganwadi worker. Percentage of women reported having received IFA tablets from anganwadi worker was more in NGO villages (23 percent) than in non-NGO villages (16 percent). With regard to type of tablets, majority had received large IFA tablets (78 percent). However, about 20 percent reported having received small and about two percent, could not recollect the size. There had even been some substantial improvement in the consumption of IFA tablets. In the baseline 13 percent of the women had consumed the IFA tablets which they had received and this increased to 25 percent after the intervention, which means within two years time there had been a 12 percentage point increase in the number of women consuming the IFA tablets. Overall, it can be said that the ANC services has improved after the intervention of CARE.

Table 2.12: Place, type and consumption pattern of IFA tablets

(Percentage)

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
% received IFA tablet/syrup during pregnancy	72.0	67.6	69.4
Place of IFA receipt			
ANM/LHV	54.3	53.8	54.0
Anganwadi worker	23.0	15.8	18.9
Govt. doctor	11.8	13.3	12.6
Medical shop	6.6	11.8	9.5
Private doctor	2.6	4.5	3.7
Others	1.6	1.0	1.3
Type of IFA received			
Big	74.7	80.3	77.8
Small	23.0	18.3	20.4
Do not know	2.3	1.4	1.8
No. IFA received			
<50	19.1	20.0	19.6
50-89	29.6	33.3	31.7
90-100	26.6	20.5	23.2
101+	23.4	22.0	22.6
Don't know	1.3	4.3	3.0
Average	89.5	89.9	89.7
No. IFA consumed			
<50	33.2	35.3	34.4
50-89	24.7	25.3	25.0
90-100	20.4	16.0	17.9
101+	19.4	17.8	18.5
Don't know	2.3	5.8	4.3
Average	76.3	74.1	75.0
Women received IFA tablets	304	400	704

As is evident from the table, not all women had received the required course of tablets. Half of them had received less than 90 IFA tablets and among the rest, 23 percent had received 90-100 tablets and another 23 percent received more than 100 tablets. On an average, women had received 90 IFA tablets. The consumption pattern shows that not all women who received IFA had consumed the full course. Nearly 60 percent of the women had consumed less than 90 tablets only, similarly 72 percent had consumed all 90 to 100 tablets received and only 49 percent of the women who had received more than 100 tablets had consumed all. Thus, on an average, women had consumed 75 IFA tablets during pregnancy.

An attempt was also made to know the reasons for not consuming the complete course of the IFA supplementation. Analysis of their response is presented in Table 2.13. Women discontinued taking IFA tablets mainly due to side effects like vomiting or because of the taste. A slightly higher percentage of women in NGO villages stated vomiting as the reason for discontinuing IFA tablets (66 percent). On the other hand, though a lesser percentage of women reported taste as the reason for not completing this course, this was reported more by women in non-NGO villages (14 percent) than by those in NGO villages (8 percent). Some of the women also stated that they forgot to take pills, experienced health problems or believed that the tablets were of poor quality.

Table 2.13: Reasons for not consuming the full course of IFA tablets (Percentages)*

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
Due to vomiting	66.3	61.3	63.2
Not like the taste	7.9	14.1	11.7
Forget to take	7.9	7.7	7.8
Cause health problem	6.6	3.5	4.7
Poor quality tablets	2.2	2.1	2.2
Family members ask not to take	2.2	0.7	1.3
Felt better stopped taking it	2.2	0.7	1.3
Threw it away	1.1	1.4	1.3
Hospital person did not give full	1.1	-	1.3
course	-	0.7	0.4
Did not feel the need	-	0.7	0.4
Did not get same tablets	9.0	9.1	9.1
Others			
Total women not consumed full course of IFA	89	142	231

* Percentages add up to more than 100 because of multiple response

DELIVERY CARE

Place of Delivery – Information was collected to know how far deliveries were conducted under safe and hygienic conditions and under the supervision of trained health professionals. Table 2.14 shows that only one-fifth of births took place in health facilities, and the rest (79 percent) at home. Seven percent of births took place in a private health facility, and 14 percent took place in public institutions. Institutional deliveries were reported to be almost same in both project areas.

Table 2.14: Place and person attended delivery (Percentage)			
Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
Place of delivery			
At home	81.5	77.5	79.2
Government/ municipal hospital	11.6	10.7	10.7
Private hospital/ clinic	3.1	7.3	5.5
Private ISM hospital/clinic	0.5	2.2	1.5
Govt. ISM hospital/clinic	1.7	0.7	1.1
Government dispensary	0.7	1.2	1.0
PHC/Sub-center	0.2	0.6	0.5
UHC/UHP/UFWC/CHC/ rural hospital	0.2	0.2	0.2
Others	0.5	0.3	0.4
Total women interviewed	422	592	1014
Person who conducted the delivery			
Doctor	2.6	4.6	3.7
ANM/nurse/LHV	10.0	14.2	12.4
Trained dai	12.8	9.5	10.8
Untrained dai	27.0	24.0	25.2
Relatives/friends	24.9	21.3	22.8
None	4.7	4.4	4.5
Number delivered at home	346	461	807

Women who reported home deliveries were further probed on the person who attended the delivery. Twenty-five percent of the home deliveries in the NGO area and 28 percent in the non-NGO area were conducted by a trained professional and the rest were attended either by untrained dais or by family members.

BREAST-FEEDING PRACTICES

Breast feeding practices have significant effects on both mother and child. Breast-feeding improves the nutritional status of infants and reduces morbidity and mortality. Breast milk not only provides important nutrients but also protects the child against infection. The timing and type of supplementary foods introduced in an infant's diet also have significant effects on the child's nutritional status.

Initiation of breastfeeding immediately after childbirth is important for both the mother and the child. It is also recommended that the first breast milk (colostrum) should be given to the child rather than being squeezed from the breast and discarded, because it provides natural immunity to the child. Information collected on the same shows that only 27 percent of the women had breastfed their child within six hours of birth; for a majority of the others initiation was delayed (73 percent). The practice remained more or less the same in both types of villages. Compared to the baseline data (IIHMR 2000) there has been 7 percentage point decline in the number of children who were breastfed within first six hours after their birth.

Further, women who reported delayed breastfeeding were asked the reasons for the same. Majority among them reported "did not have enough milk" (60 percent), as one of the major reasons for initiating it late. About one-fifth of the other women mentioned that delayed feeding was a practice followed by all the women in their village. Other than this, reasons like health related problem, or influence of family members were also mentioned by the women.

Table 2.15 also gives the percentage of children whose mothers had squeezed out the first milk before breastfeeding, which is not the recommended practice. It was interesting to note that majority of the women (77 percent) did not squeeze out the first milk. Among those who squeezed out

Table 2.15: Initiation of breast-feeding (Percentage)

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
Time when started BF to child			
Immediately, within two hours of birth	20.6	19.6	20.0
Same day between 2 to 6 hours of birth	4.5	8.4	6.8
Same day after 6 hours of birth	1.7	1.0	1.3
1-3 days	25.4	28.7	27.3
After 3 days	47.3	41.6	44.0
Never breastfed	0.5	0.7	0.6
Total Women interviewed	422	592	1014
Reasons for delay in breast-feeding*			
Did not have enough milk	62.1	57.8	59.6
Everyone in the village does this	22.3	20.6	21.3
Nipple were sore, engorged or inverted	5.7	9.5	7.9
Mother/mother-in-law/someone advised	5.5	3.6	4.4
Child was ill/weak/child refused	2.5	1.6	1.2
I was ill/weak or tired	0.6	1.7	1.2
None told me to do it	0.3	0.7	0.5
Did not want to give colostrums	-	0.2	0.1
Others	2.2	3.3	2.9
Do not know	1.0	2.1	1.6
Number reported delay of more than 6 hours in initiating breast-feeding	316	426	742
Percentage squeezed out first milk before feeding the child	21.4	24.1	23.0
Total Women interviewed	422	592	1014
Reasons for squeezed out first milk*			
Customary	31.2	48.6	41.8
Thick milk not easy to digest	23.3	21.1	22.0
Mother advice	10.0	7.7	8.6
Doctor advised	1.1	2.1	1.7
Health reason	1.1	1.4	1.3
Not safe for child	1.1	0.7	0.9
Other	18.9	16.9	17.6
Don't know	14.4	2.1	6.9
Number of women reported having squeezed out first milk	90	143	233

the first milk, forty-two percent of the women squeezed out the first milk mainly because it was a custom. Some women (22 percent) did not feed the first milk because they felt first milk was too thick for the child to digest. Another 9 percent women squeezed the first milk on their mother's advice.

Besides the practice of colostrum feeding, information was collected also to know the prevalence of the practice of pre-lactal feeding. It is generally found that after birth the child is first given some traditional liquids, which again is not the recommended practice when exclusive breast-feeding is concerned. For this, mothers were asked if the child was given any fluids before putting the child to breast for the first time. In response to this, 76 percent of mothers reported in the affirmative, this percentage was 78 in NGO villages and 74 in non-NGO villages. Immediately after birth it was a practice to give the child mainly janam ghutti (57 percent) or animal milk (42 percent). Some of the women also reported tea, jaggery/sugar/gripe/glucose water or ghee as a pre-lactal feeds to the child. From informal discussions it was learnt that children were given janam ghutti or animal milk for the first two or three days. One of the women, explaining this said–

> "In our village after a child is born, as a tradition, the child is given janam ghutti, which we either prepare at home or get it from a general shop. We mix this ghutti in water and feed the child because it works as a cleanser of the bowels. This we continue giving to the child even when breast-feeding. If not this, some women also give honey water or other such solution made of jaggery or sugar (pattasa)."

Due to this it was difficult to understand practice of exclusive breast-feeding in the project areas. When explained the meaning of exclusive breast-feeding, around half (48 percent) of the women reported having exclusively breast-fed their children for 3 months, 24 percent for six months and five percent mentioned having breast-fed for seven or more months. However, 22 percent of the women found it difficult to recollect the duration of exclusive breast-feeding. No significant difference was observed in the breast-feeding practices in the two study areas.

Table 2.16: Practice of pre-lactal feeding (Percentage)

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
Percentage child given any pre-lactal feed	77.6	74.0	75.5
Total women interviewed	422	592	1014
Type of pre-lactal feed			
Janam ghutti	57.6	56.0	56.9
Animal milk	43.2	40.7	41.8
Tea	1.5	0.7	1.0
Jaggery/sugar/ghee/gripe/glucos	3.7	4.0	3.9
e water	3.7	6.2	5.6
Other	0.3	0.2	0.3
Don't know			
Number of women reported giving pre-lactal feed	327	438	765
Number of months child breastfed exclusively (in months)			
Upto 3 months	48.3	48.5	48.4
4-6	28.6	20.7	24.0
7+	6.2	4.6	5.3
Don't know/No response	16.9	26.2	22.2
Average	3.5	3.2	3.2
Total women interviewed	422	592	1014

Further, the data shows that almost all the children below the age of one were on breast-feeding, but the percent exclusively breast-fed in the first six months was very low (Table 2.16). Less than half of infants below four months of age were exclusively breast-fed for the recommended period of time and only 13 percent

aged 4-6 months were exclusively breast-fed (Table 2.17). Not only is the practice of feeding pre-lactals widespread, in the first six months, mothers continue to feed their children other liquids, mainly water (98 percent), animal milk (56 percent), and tea (26 percent), which explains the low percentage of children being exclusively breast-fed (refer Table 2.18).

Table 2.17: Age wise breast-feeding practices of children
(Percentage)

Age (in months)	*NGO*		*Non-NGO*		*Total*		*All*
	Currently BF	*Exclusive BF in 1st 6 mths*	*Currently BF*	*Exclusive BF in 1st 6 mths*	*Currently BF*	*Exclusive BF in 1st 6 mths*	
< 4 months	98.8	51.1	100.0	45.5	99.5	47.8	209
4-6 months	100.0	12.2	100.0	12.7	100.0	12.5	104
7-12 months	97.5	9.4	99.0	9.2	98.4	9.3	365
13-24 months	80.6	11.9	74.5	7.6	77.0	9.4	330

The practice of giving other liquids besides breast milk starts as early as one month age of the child. There is a common perception among women that water should be fed to the child to quench its thirst and animal milk is given, as the mother perceives the quantity of milk secreted to be inadequate to satiate the child. Efforts should be made to educate mothers that mother's milk is enough to meet the nutritional requirements of the child, including water. Therefore, exclusive breastfeeding would be enough to satisfy the child's thirst and hunger.

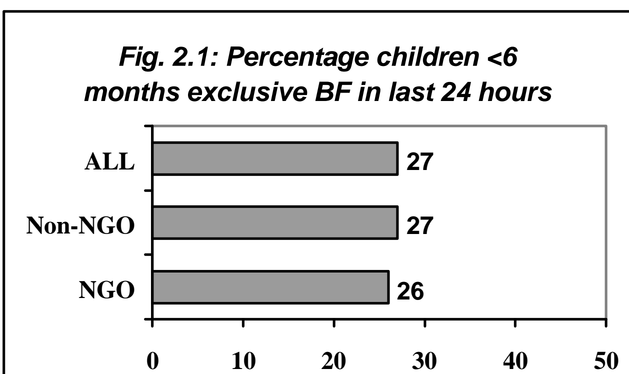
Table 2.18: Type of liquids given to the child within first 6 months
(Percentage)

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
% of child given liquid besides BF during 1st 6 months	81.0	83.3	82.3
Total women interviewed	422	592	1014
Type of liquid/food given during 1st six months			
Water	97.6	97.6	97.6
Buffalo/goat/cow milk	54.1	57.3	56.0
Tea	28.5	24.1	25.9
Ghutti/janam ghutti	20.9	17.8	19.0
Honey/jaggery/sugar water	9.1	12.0	10.8
Semi solid/other solid food	9.1	10.6	10.0
Fruit juice	3.5	3.5	3.5
Baby formula (lactogen, etc.)	2.9	3.3	3.1
Jeera, podina and other brew	0.9	3.1	2.2
Others	2.4	1.6	1.9

Age of the child when started giving liquids			
Less than 1	15.9	26.7	22.3
1-3	46.2	44.7	45.3
4-6	28.2	22.2	24.7
7-9	2.4	2.7	2.5
10+	1.8	0.8	1.2
Don't know	5.6	2.9	4.0
Average	3.4	3.2	3.3
Number of women initiation of pre-lactal food	340	490	830

Again women with children under six months of age were asked whether they had exclusively breast-fed their child in last 24 hours. In response to this 27 percent of the women in both project areas reported in the affirmative. Considering figure 2.1, 27 percent of the children less than six months of age were exclusively breastfed in the last 24 hours (see figure 2.1). Considering the base-line data (IIHMR 2000), only 12 percent of the children aged 0-6 months were exclusively breastfed in the past 24 hours. In other words it can be said that there has been improvement in the exclusively breastfeeding practices among the children below six months of age by 15 percent percentage points.

Fig. 2.1: Percentage children <6 months exclusive BF in last 24 hours



Breast-feeding Practice for Children above six months of age

From about six months of age, the introduction of complementary food is critical for meeting protein, energy, and micronutrient needs of children. However, in the project area majority of the children (78 percent) were given semi-solid or solid food within stipulated period of time. As can be seen from Table 2.19, 12 percent of the children were given supplementary food within the age of six months. This proportion rises to 40 percent for children aged of 7-9 months and 43 percent for children aged 10+ months. On an average, children were given supplementary food by the age of 9.8 months. The type of supplementary food given shows that two percent of the children were on liquids, 15 percent on semi-solid diets and majority of the children were given solid food like biscuit or roti.

Table 2.19: Breast-feeding practices for child above 6 months
(Percentage)

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
Percentage given solid/semi solid food (for more than 6 months child)	79.5	76.1	77.6
Women with children above 6 months	293	402	695

Age of the child when started given semi solid or solid food	2.1	1.6	1.9
Within 4 month	11.2	9.8	10.4
5-6	38.6	40.2	39.5
7-9	41.2	44.8	43.2
10+	6.9	3.6	5.0
Don't know			
	9.6	9.9	9.8
Average			
Fluid/semi-solid/solid started to given child**			
Liquid			
Animal milk	1.3	1.0	1.1
Tea	-	1.3	0.7
Janam Ghutti	0.4	-	0.2
Semi-solid			
Rubri/rab	3.4	4.9	4.3
Daliya	3.0	4.6	3.9
Dal juice	3.4	2.0	2.6
Khichadi	1.7	2.3	2.0
Cerelac/farex	0.9	1.3	1.1
Potato paste	0.9	-	0.4
Halwa	0.4	-	0.2
Rice flakes	0.4	-	0.2
Solid			
Biscuits	61.8	61.1	61.4
Roti	59.2	62.4	61.0
Rice	9.9	18.3	14.7
Bread	13.7	6.9	9.8
Vegetable	3.0	2.9	3.0
Khana/meal	2.6	1.3	1.9
Baati	2.6	1.3	1.9
Fruits	1.3	2.0	1.7
Sev/namkin	0.9	1.0	0.9
Women reported giving solid/semi solid to child above 6 months	233	306	539

IMMUNIZATION

The vaccination of children against six serious but preventable diseases has been a cornerstone of the child health care. Table 2.20 presents the immunization coverage of children 12-24 months of age according to whether a vaccination card was shown to the interviewer or the mother was the source of all vaccination information. Immunization coverage shows that 74 percent of the children were given BCG, the first dose of DPT was received by 69 percent of children and the third dose by 44 percent of children, the first does of Polio was received by 76 percent, the second dose by 71 percent and the third dose by 56 percent of the children respectively. Although DPT and polio vaccinations are given at the same time as part of the routine immunization programme, the coverage is much higher for polio than DPT. Not all children who begin the DPT and polio vaccination series go on to complete them. The difference of about 25 percentage points between the percentage of children receiving the first and the third dose of DPT and a difference of 20 percentage points for polio was observed. Thirty-five percent of children were reported to have been vaccinated against measles. Looking into the baseline data (IIHMR 2000) the percentage of children who received BCG decreased from 92 to 78 percent. The coverage for DPT-3, OPV-3, and measles increased in the end line by 2, 16, and 8 percentage points respectively. The relatively low coverage of the measles vaccine and the third dose of DPT have lowered the percentage of children fully immunised.

Table 2.20: Immunization coverage of children 12-24 months
(Percentage)

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
BCG	76.5	71.8	73.8
DPT-1	73.0	65.9	68.9
DPT-2	59.2	50.5	54.2
DPT-3	46.4	41.8	43.7
OPV-1	76.5	75.1	75.7
OPV-2	73.0	68.9	70.6
OPV-3	57.1	55.7	56.3
Measles	37.2	34.1	35.4
Vitamin –A1	22.4	20.9	21.5
Vitamin –A2	5.6	4.0	4.7
Vitamin –A3	5.1	2.6	3.6
Total Children 12-24 months	196	273	469
Children 12-24 months			
Fully immunized	33.7	32.6	33.0
Partially immunized	50.0	45.4	47.3
Not immunized	16.3	22.0	19.6
Children above 12 months of age	196	273	469

Children who received BCG, measles and three doses each of DPT as well as polio (excluding Polio 0) vaccine are considered to be fully immunized. Based on the information obtained from either sources (immunisation card and mothers) 33 percent of the children aged 12-24 months were found to be fully immunised, 19 percent did not receive vaccination against any disease while 47 percent of the children were found to be partially immunized in the area under study. The percentage of children

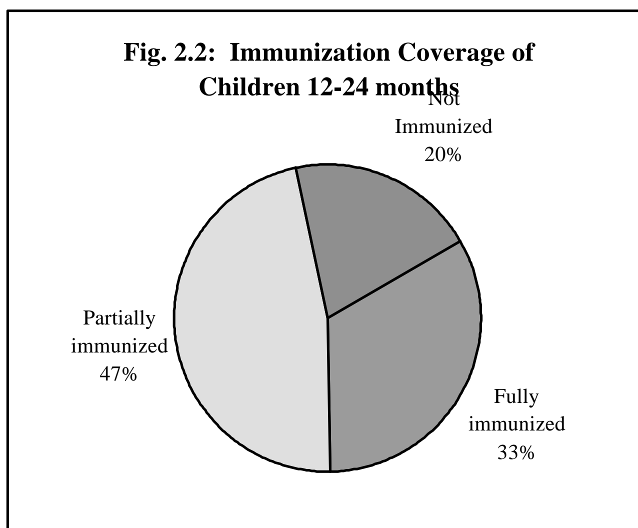


Fig. 2.2: Immunization Coverage of Children 12-24 months

fully immunised increased by 26 percent from the baseline (7 percent).

While providing the reasons for not immunizing the children (12-24 months), nearly half (47 percent) reported that the ANM/vaccinator did not visit them and as a result their children could not be immunised. Some of them (19 percent) said they were not aware of the need for getting their children immunised; a few mentioned that they did not know the day or time of immunization (5 percent), or that the place of immunisation was not within reach (3 percent) or they considered their child too young to be immunised (2 percent).

Table 2.21: Reasons for not immunizing the children (12-24 months) (Percentage)

Reasons	*Project Area*		
	NGO	*Non-NGO*	*Total*
ANM absent/vaccinator has not made a visit	53.1	41.7	46.6
Unaware of need for immunization	17.2	20.2	18.9
Mother too busy or ill	6.3	4.8	5.4
Time of immunization unknown	3.1	6.0	4.7
Place of immunization too far to go	3.1	2.4	2.7
Child too young for immunization	1.6	2.4	2.0
Time of immunization inconvenient	3.1	1.2	2.0
Others	12.5	21.5	17.6
Children above 12 months not fully immunized	64	84	148

The place of immunization shows that children were mainly immunized at home by the ANM (50 percent). About 29 percent of the children were immunized at the anganwadi centres. Percent children immunized at anganwadi centres were higher in NGO villages (32 percent) than those in non-NGO village (26 percent).

SUPPLEMENTARY FEEDING FOR CHILDREN ABOVE 6 MONTHS

Attempt was made to assess whether women with children above six months of age avail nutritional supplements – Take Home Ration (THR) - from the anganwadi centre. As presented in Table 2.22, only 41 percent of the women ever received THR for their children. The proportion receiving THR for children aged 6-24 months in NGO and non-NGO areas was 51 and 35 percent respectively. Of these only 18 percent had received THR for their children during the last two weeks. Again when the duration was further narrowed down to the previous day, only 15 percent women mentioned that they had taken/fed their children the AWC food the previous day. The same for the reference period of last 7 days was 35 percent in the base-line survey (IIHMR 2000). No comparison between the baseline and the end-line survey is possible due to the difference in the reference period. It is, thus, clearly evident from this table that relatively higher proportion of children above 6 months of age have received supplementary nutrition, through AWW, in the NGO villages as compared to non-NGO villages. Further, when asked the reasons for not having fed their children the THR they had received the previous day, majority of the women reported that they shared the food with their other family members (30 percent). A small percentage of them also mentioned that they either threw it away or gave it to the animals.

Table 2.22: Supplementary feeding for children above 6 months of age (Percentage)

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
% mothers ever received food/THR from the AWC for children	50.8	34.5	41.4
% mothers received food/THR from the AWC for child in the last two weeks	22.7	14.5	18.0
% of child ate AWC food yesterday	18.0	13.1	15.1
Total children above 6 months of age	295	406	701
Ways handled the food received from the AWC, when not consumed			
Shared with other family members	26.8	33.3	29.9
Threw it away	4.1	3.4	3.8
Gave it to animals	3.1	4.6	3.8
Others	50.5	48.3	49.5
Do not know/No response	15.5	10.3	13.0
Total women reported child not eating supplementary food yesterday but usually received	97	87	184

The above analysis clearly illustrates that the variation was observed in the two project areas with regard to supplementary feeding of children. Utilization of supplementary feeding or THR, though low, was relatively better among the children in the NGO villages than among those in non-NGO villages. However, looking into the percentage of children benefiting from THR, it can be said that women have not been regular in taking the supplementary food for their children. There is a need to understand the reasons for taking THR irregularly, and to find out additional ways of promoting the supplementation of nutrition to larger proportion of children in the community.

SUPPLEMENTARY FEEDING FOR PREGNANT WOMEN

All the women were further asked about the receipt of supplementary feeding during their index pregnancy. Analysis of their responses is presented in Table 2.23. Around two-fifths of the women mentioned that they had received food either at AWC or as THR during their last pregnancy. A higher percentage of women in NGO villages (49 percent) than those in non-NGO village (32 percent) mentioned the same. After the intervention, there has been some impact in number of women having received the supplementary food. During the base line (IIHMR 2000), 32 percent of women reported to have received THR during their index pregnancy and in the end-line 7 percentage point more reported the same. The duration for which they received food shows that more than half of the women (53 percent) had received supplementary food for their full pregnancy period and 19 percent each had received either for first trimester and/or second trimesters. However, about nine percent of the women could not recollect the period for which they had received the supplementary food from the AWC. Here again it is apparent that relatively higher proportion of pregnant women, especially during the first two trimesters, in the NGO villages did receive supplementary food as compared to the pregnant women in the non-NGO villages.

Table 2.23: Supplementary feeding for pregnant women
(Percentage)

Particulars	Project Area		
	NGO	Non-NGO	Total
Percentage of pregnant women received food either at the AWC or as a take home food	49.1	32.3	39.2
Total women interviewed	422	592	1014
Number of month received supplementary food			
1-3	22.2	14.7	18.6
4-6	19.8	18.3	19.1
7-9	45.4	60.7	52.8
Do not know	12.6	6.3	9.5
Average	6.0	6.8	6.4
Women received THR	207	191	398
During the index pregnancy, did you eat less, more, or the same amount of food as before	32.2	28.7	30.2
More amount	37.2	37.5	37.4
Less amount	20.6	26.2	23.9
Same as before	7.8	5.9	6.7
Can't say	2.1	1.7	1.9
Do not know			
Total women interviewed	422	592	1014

An attempt was further, made to understand the food intake of women during their pregnancy. Women were asked whether their food intake during the pregnancy had remained the same or had increased or decreased. Based on the information collected, it can be said that most women did not see any reason for increasing their diet during pregnancy, as a result only 30 percent of the total women mentioned that they had increased their diet during pregnancy; in fact 37 percent had reduced the quantity of food and 24 percent did not alter their diet pattern. This calls for enormous efforts, through the promotion of IEC activities, to improve the knowledge of pregnant women per se and the community at large that the pregnant mothers do require additional supplementation of food during their pregnancy.

The same information was collected also for women who were currently pregnant. Of the total women, twenty-eight were currently pregnant. Four out of six in the NGO village and only five out of 22 in non-NGO village reported having consumed anganwadi food the previous day.

SUPPLEMENTARY FEEDING FOR NURSING MOTHERS

Breast-feeding mothers also receive supplementary food from the anganwadi centre. Data collected is presented in Table 2.24. Of the total 313 women who were breast-feeding a child below six months of age, 27 percent had received the THR from the AWC. This was 30 percent in the base-line survey (IIHMR 2000). This mean over the years slightly less percentage of nursing mother receive the take home ration. Again slightly higher percentage of women in NGO villages (32 percent) had received the THR than those in the non-NGO villages (24 percent). Further, duration of receipt of supplementary food shows that, 12 percent of the women had received for a shorter period of time i.e., for three months, and the rest 11 percent had received till their child was six months of age.

Table 2.24: Supplementary feeding for nursing women having a child below 6 months of age (Percentage)

Particulars	*Project Area*		
	NGO	*Non-NGO*	*Total*
Percentage nursing women received food or THR at AWC after last delivery	31.5	24.2	27.2
Duration received supplementary food			
Upto 3 months	11.0	12.9	12.1
4-6	13.4	9.2	10.9
Do not know/No response	7.1	2.2	4.2
Average	3.6	3.3	3.4
Food intake increase/decrease/ remain the same as normal intake			
Increased	45.7	36.0	39.9
Decreased	16.5	15.6	16.0
Same	30.7	41.9	37.4
Can't say	5.5	5.4	5.4
Do not know	1.6	1.1	1.3
Total nursing women with child less than 6 months	127	186	313

Food intake after delivery shows that two-fifths of the women had increased the quantity of food, saying that, *"we have to eat more because we also have to feed our child"*. Thirty-seven percent of the women did not change their eating habits; it remained more or less the same, and 16 percent of the women had reduced their food intake. This shows that there is a need to educate mothers about the importance of increasing the food intake during breast-feeding.

Table 2.25: Saving of money and arrangements of borrowing

(Percentage)

Particulars	Project Area		
	NGO	*Non-NGO*	*Total*
% save money regularly for future needs	38.9	32.8	35.3
Total women interviewed	422	529	1014
% mentioned money saved is enough for their needs	40.9	42.8	41.9
% avail loan facility in case need arise	54.2	54.1	54.2
% do not avail loan facility even if need arise	4.9	3.1	3.9
Women reported money saved	164	194	358
Source of money borrowed			
Friends/relatives	58.4	71.4	65.5
Bank	2.2	5.7	4.1
Money lenders	19.1	12.4	15.5
SHG	14.6	8.6	11.3
Others	5.6	1.9	3.6
Purpose of taking loan			
Socio-religious	9.0	17.1	13.4
Marriage	7.9	8.6	8.2
Delivery	9.0	3.8	6.2
Sickness	36.0	31.4	33.5
Purchase of food	11.2	6.7	8.8
Others	26.9	32.4	29.9
No. availed loan facility in case need arise	89	105	194

SAVING MADE BY THE WOMEN

CARE interventions also incorporated community development activities apart from basic nutrition programme. The following paragraph gives a brief review regarding the utilization of these interventions. Table 2.25 presents data on saving habits of women and the utilisation of saving banks by them. As compared to only 10 percent in the baseline survey, 35 percent of the women reported that they save money regularly for their future needs. Among those who saved money in banks, for 42 percent the money saved was enough to meet their needs. However, 54 percent had to borrow when they needed it and 4 percent did not borrow even when they were in need of it. Women borrowed money mostly from their friends or relatives (66 percent). Other sources were money lenders (16 percent) and SHG (11 percent). Borrowing money from SHG was reported more by women in NGO villages than non-NGO villages. It was also found that money is borrowed mainly in case of sickness or for socio-religious purpose.

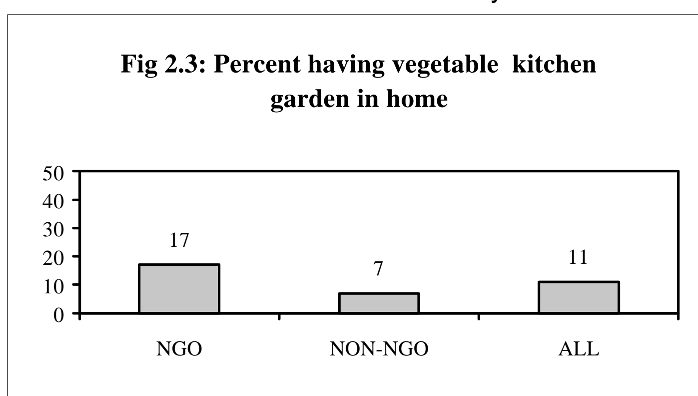
Not all women save grain to meet their future needs. Only 37 percent of the total women mentioned that their families save the grain regularly (Table 2.26), and 21 percent reported that it is enough to meet their future needs. Further, a very negligible proportion of the women were reported to be members of grain banks (3 percent) and hardly one percent took benefit of it. This shows that utilisation of such facilities was very low.

Table 2.26: Percent saving of grains and arrangements of borrowing (Percentage)

Particulars	Project Area		
	NGO	Non-NGO	Total
% save grain regularly	43.1	32.1	36.7
% having grain saved enough for future needs	23.7	19.9	21.5
% member of grain bank	3.8	2.9	3.3
% take grain loan from loan bank	1.4	1.0	1.2
Total women interviewed	422	592	1014

Horticulture Production

Few people were engaged in horticulture production. As can be seen from figure 2.3, only 17 percent of the women in NGO villages and 7 percent in non-NGO villages mentioned having a kitchen garden, where they cultivated mainly vegetables (98 percent). Only 4 percent mentioned cultivating fruits in their kitchen garden.



CBO EFFORTS/ GRAM PANCHAYAT/ MAHILA MANDALS

Awareness of women about the existence of CBOs in their villages shows that only 23 percent (30 percent in NGO and 17 percent in non-NGO villages) knew that CBO did exist in their villages (Table 2.27). Further, according to the women the type of CBOs that exist in the villages were mainly Self Help Groups (49 percent) and mahila mandals (20 percent). Some women were aware also of CBOs like mothers' committees and grain banks.

Table 2.27: Awareness of CBO in the village (Percentage)

Particulars	Project Area		
	NGO	Non-NGO	Total
Percentage aware availability of CBO in the village	29.9	17.4	22.6
Total women interviewed	422	592	1014
Type of CBOs available			
Mahila Mandal	19.8	20.4	20.1
Self help group	50.0	48.5	49.3
Mother's committee	0.8	-	0.4
Grain bank	3.2	1.9	2.6
Others	23.0	20.4	21.8
Do not know	3.2	8.7	5.7
Number aware of CBO in the village.	126	103	229

AWARENESS AND PARTICIPATION IN NUTRITION AND HEALTH DAYS

Under the CARE BHNP project, nutrition and health days are regularly organised in the village by AWWs and ANMs. It is also expected that village leaders would participate in the NHD programme. Women were asked about the nutritional and health days organized in their villages. As compared to 38 percent in the baseline survey only 30 percent of the total women were aware about the NHD being organised in the anganwadi centre (See Table 2.28). Awareness about such camps was slightly more among the women in the NGO villages (37 percent) than those in the non-NGO villages (25 percent). These women were asked the time when the last NHD was held. About half of them could not recollect or did not know, and among the rest, 27 percent said it was in the previous month. These camps were mainly organised at the anganwadi centre (80 percent). The other places mentioned were temple, market place, school, and community place. Half of the women also stated that gram panchayat members also actively participated in these NHDs. The above analysis indicates that the awareness about the NHD instead of improving overtime infact has reduced illustrating thereby the motivation of generation of such awareness has weekend overtime which calls for a need for additional efforts to boost the motivation of the functionaries and in turn that of the beneficiaries.

Table 2.28: Awareness and participation of NHD by women (Percentage)

Particulars	Project Area		
	NGO	Non-NGO	Total
% aware NHD organized in the AWC	36.7	25.3	30.1
Total women interviewed	422	592	1014
Time when last NHD was held in the village			
Weekly	14.2	2.7	8.5
Fortnightly	6.5	2.0	4.3
Within a month	25.8	28.0	26.9
Within two months	4.5	4.7	4.6
Two or more months	3.2	8.7	5.9
Don't know	45.8	54.0	49.8
% participate in NHD	73.5	73.3	73.4
Place where NHD held			
AWC	82.6	73.2	80.0
Temple	2.5	2.7	2.7
Market place	1.9	2.7	2.3
School	3.1	6.0	4.9
Common community place	1.9	2.7	2.1
Don't know/No response	9.0	8.6	7.8
% mentioned involvement of gram panchayat members in NHD	52.9	47.3	50.2
Number aware of NHD organized in the AWC	155	150	305

The above information shows that implementation of the CARE project activities in the NGO villages was slightly better than in the non-NGO villages. For example, the participation and utilization of women in the activities such as supplementary feeding for children above six, pregnant and lactating mothers, saving of money and utilization of grain banks, horticulture and nutrition and health days was better in NGO villages. It can be said that the strategy of working through the local partner NGOs has contributed to increased coverage and utilization of services to some extent. It also helps in strengthening the NGO partners and for long term sustainability of the project activities. These efforts, however, need to be further promoted with greater vigour and enthusiasm, as the impact of interventions is still very small.

CHAPTER 3

Anganwadi Worker

To promote the key intervention related to health and nutritional activities, anganwadi workers (AWW) under the Building on Health and Nutrition Project (BHNP-II) were assigned additional responsibilities like preparing and updating social maps for complete enumeration of the target population, maintain close liaison with self help groups (SHG) to promote economic and ANR activities. To assess the extent to which AWW were able to fulfil their roles, sixty AWWs were to be interviewed but during survey 33 (12 from NGO villages and 21 from non-NGO villages) were interviewed other could not be contacted as they had gone to Udaipur to receive some training. In one of the village named Jar Kha Khadra, there never existed any AWC in the village so the AWW could not be covered. Requisite information collected from these AWWs is described in this chapter.

GENERAL INFORMATION ABOUT AWW

This section provides information about the coverage of the target population by the AWW. Most of the AWWs (23 out of 29 AWW) were from the same village where their anganwadi centre was located and the remaining six functioned from nearby villages.

Table 3.1: Number of Households Covered by AWW

Particulars	*NGO village*	*Non-NGO village*
No. of HHs		
Upto 100	9	5
101-200	3	8
200-500	-	1
500 above	-	2
Average	82	246
Children 2 enrolled**		
Upto 50	10	13
51 – 60	1	1
61 – 80	-	2
Average	27	36
Av. Preg. women enrolled@	8	7
Av. Lact. Women enrolled@	9	9
Total AWW	13*	16

*One AWW did not provide any information
** Two not registered
@ One each in NGO and Non-NGO not registered

With regard to the coverage of households, data analysed shows that, on an average, an AWW covered 179 households. AWW from non-NGO villages covered more households (average 246 HHs) compared to their counterparts in NGO villages (average 82 HHs). Enrolment of children under two shows that, on an average, 33 children (18 males and 15 females) were registered at the AWC. The number of children registered was more in non-NGO villages (36 children) than in NGO villages (27 children). This could probably be due to higher coverage of households in non-NGO village. Further, as can be seen from the Table 1, though there was significant difference in the coverage of HHs in different types of villages, the average number of pregnant and lactating women enrolled in both NGO and non-NGO villages remained more or less the same. On an average, 7 to 8 pregnant and 9

lactating women were registered at each of these AWC. According to the AWW, new cases of pregnant women are registered by the survey procedure.

PERCEIVED OPINION ABOUT SOCIAL MAPPING

Under the project one of the major responsibilities of the AWW was to prepare social maps of their work area. For this, information was collected to know whether they had received any training for it and their opinion about its usefulness in identifying children under two. Nineteen out of 29 AWWs reported having received the training and among them four found the training very useful and the rest could not say anything about it. According to the four AWWs the most useful part of the training was the different techniques taught for identifying children under two. These techniques are

- 'marking houses' with pregnant and lactating mother with a standard symbol for identification
- calculating or analysing children under two from birth and death registers and lastly
- by doing a household survey asking mother about the number of children under two they have.

Though the techniques taught for mapping out the target population was simple, not all AWWs were comfortable with it. This could have been one of the factor due to which the coverage of the target population was less at the AWC. It can be said that mapping being a very new concept for AWW, they lacked in practical aspect of preparing the maps.

Since the focus of the project was to provide better nutrition and health by proper identification of the target population through social mapping, it was found that only 19 AWWs who had received the training had social maps with them. Eight among them had prepared these maps independently based on their training, 11 others had prepared by taking the help of a school teacher or village members or CARE officials. Of the 19 AWWs who had prepared the maps not all had updated them. Data collected shows that four AWWs had updated them 15 days prior to the date of survey and the rest had all updated it three or four months prior to the survey i.e. in the month of March-April, 2002. Thus, it can be said that the training was not sufficient to enable/equip AWWs to prepare the maps independently.

TAKE HOME RATION (THR) AND NUTRITION HEALTH DAYS (NHD)

To combat malnutrition among the target population, one of the major activities of the AWW is to provide take-home ration along with the health services. Information was collected to know when and how Nutritional health days and take home ration (THR) were scheduled. For this AWW were asked how frequently they distributed the THR; and during the last three months, how many NHDs had they organised. As discussed earlier, a

Table 3.2: Number of NHDs organised at AWW

No. of NHDs	*NGO village*	*Non-NGO village*
2-3	5	8
4-6	4	1
7-9	-	1
10+	2	5
Total AWW	13*	16*

* two AWW in NGO and one Non-NGO could not provide information

day is fixed for conducting the NHDs and this particular day coincides with one of the days of THR. The AWW along with the ANM set the date for NHD. The ANM fixes the day as per the convenience and gets it approved by the AWW with the idea that both are available on that particular day. However, seven AWWs (five in NGO village and two in non-NGO village) reported that they had organized NHD every week. During the discussion it was also found that AWWs took assistance from influential members of the community like sarpanch, teacher or member of mahila mandal in organizing the NHD in their respective areas. On the other hand, THR was distributed every week, whereas NHD was conducted once every month.

Accessibility to Health Services and Availability of Equipment and Drug Supply

As regards accessibility to health services it was observed that, mostly the health services were available within the radius of 5 km. Only one AWW reported that one had to travel 13 km to reach a facility. And the ANM always visited the AWC during her field visit.

To monitor the health of children and pregnant and lactating women AWWs should have the infant and adult weighing machines and a growth monitoring register to record the weight of the children. Other than this, as a preventive measure, the AWWs are also supposed to have a stock/supply of some essential drugs like iron folic tablets for children and women, ORS packets for children suffering from diarrhoea, Vit. A syrup, paracetamol tablets for fever and deworming tablets. According to the data, almost all the AWWs had infant weighing scale and growth monitoring registers at their centres. On the other hand, only nine AWWs had an adult weighing machine with them, the rest reported that these were not provided to them. This means the AWW does not meet the needs of all the target population.

Further, with regard to the availability of the drugs only half of them reported that they had all the mentioned drugs at their centre, the rest mentioned that they keep the supply based on the requirements.

One of the AWWs could not provide this information, when asked for the reason she said –

> *"I have my son who looks after everything, in other word, I can say that at present he is in charge of the centre."*

Overall, it can be said that to a large extent the AWCs were equipped as regards drugs were concerned to carry out their responsibilities, however majority of them were not having adult weighing machine to check the weight of pregnant and lactating mothers which calls for a need to improve the situation in case the implementation of the project activities are to be successful.

AWWs Knowledge about the Project and Convergence with ANM

The AWWs being part of the major programme, an attempt was made to know the extent to which they were aware about the project. For this, AWWs were asked whether they were aware about the CARE BHNP-II project and its activities. Of the total (N=29), majority (n=21) anganwadi reported to have heard about the project. And according to them one of the most frequently reported activities mentioned by them were small economic activity of saving money and taking loan from the grain bank, and

social mapping. Social mapping was mainly reported by AWW who had received the training for it. None of the AWWs mentioned the agricultural and natural resources activities, this could probably be due to the reason that these activities were not emphasised, on or the community was disinterested due to the problem of water shortage.

Further, all the AWW reported that they were visited by the ANM whenever she visited the village. Every month she is also visited by her supervisor, who check their work performance and also assist them in case they have any problem.

As the AWW has to provide nutritional supplements to all the pregnant women in their work area information was collected to know the procedure adopted for the registration of the new cases (pregnant women). In response to this almost all (n=25) the AWW mentioned that they identify the cases by carrying out the survey in the village. Three AWWs mentioned that the pregnant women themselves come to register them.

To organise the NHD in the village, the AWWs are supported by the community leader or sarpanch or the teacher. However, about nine AWW reported otherwise. It was also learnt that almost all the AWWs (n=20) had participated in the awareness campaign organised in the village.

AWW were aware about the SHG as a change agent. For formation of such groups in the village, the AWW help them to get the required women for the group or if they want to organise a meeting with village women, they help by gathering the women at one place.

Overall, it can be said that AWW were not adequately trained to prepare the social maps and this might have affected their coverage. As mentioned earlier, it can be said that more efforts need to be made to enhance the ability of AWWs from time-to-time through guidance and support. On the other hand, the community was very supportive in organising the NHDs in their respective areas.

CHAPTER 4

AUXILIARY NURSE MIDWIFE (ANM)

To promote the key intervention related to health, ANM under the BHNP-II project have to provide the basic health services and counselling. To assess the extent to which ANMs were able to fulfil their role at the time of survey 17 ANMs (5 from NGO village and 12 from non-NGO village) were interviewed. Two ANMs could not be contacted as they were on leave. Information collected is described in this chapter.

GENERAL INFORMATION ABOUT ANM

This section provides information about the place of residence, interaction of ANM with the anganwadi worker, coverage of target population, children under two and pregnant women. To provide better services place of residence plays a very major role. Usually, every ANM is provided with the residence facility but not all take advantage of such services due to their personal problems. On interviewing ANM it was found that most of them (10 out of 17 ANM) lived in the same village where their SC was located and remaining seven were staying in the nearby village.

On an average, an ANM covered three villages in their work area. Each of the villages covered by the ANM had anganwadi centres (AWC). Thus, the number of anganwadi centres that fell in their work area were two or three on an average. Almost all the ANMs (n=15) interacted with the anganwadi worker once every month mainly for immunisation of children or educating women about importance of health and hygiene or check food distributed at the centre. Sometimes they also promote family planning methods or assist anganwadi worker in taking weight of children.

In their work area ANMs, on an average, covered 57 children of age less than two years (26 male children and 27 female children). However three of the ANMs could not provide this information, on inquiry, it was found that they had not maintained any register so it was difficult for them to give the requisite data. Similarly, they covered 17-60 pregnant women in their work area.

NUTRITIONAL AND HEALTH DAYS (NHDS)

To strengthen the health services, the project has institutionalised monthly Nutritional and Health Days (NHDs). Usually NHDs are fixed at anganwadi centre. During this time the ANM provides the health services. As per the schedule, ANM organise the NHDs every month at the anganwadi centre. During the last three months prior to the date of survey eleven ANM had conducted three NHDs (monthly one) all the others had conducted more than three NHDs. During the NHDs, ANM mainly immunized the children and also provided the ante-natal care services to pregnant women. Further, with regard to the coverage, on an average, an ANM provided services to 21 children below two years of age, 15 pregnant and nine lactating mothers.

ANMs Knowledge about the Project and Convergence with AWW

An attempt was made to know the extent to which ANM were aware about the project. For this, ANMs were asked whether they were aware about the CARE BHNP-II project and its activities. Of the total (N=17), seven ANMs reported to have heard about the project. But when asked about the activities carried out under the project they mainly reported about the health related activities and about small economic activity of saving money and taking loan from the grain bank. This shows that ANM knew their work related activities and that they were not aware about the other activities which were undertaken to meet the financial and health needs of the people.

Further, all the ANMs mentioned that they were supported by the AWW in their work mainly by gathering the children and pregnant and lactating mothers for providing health services to them. At time when women could not come to immunize their children, under such circumstance AWW accompany ANM in locating the child. The AWW also assist ANM by distributing IFA tablets to pregnant women in her absence and carry out similar other work. This means ANM get all the required support from the AWW.

During their visit to the anganwadi centre, all the ANM carry out the physical examination of all the pregnant women who ever visit the centre and also visit the post-natal women. On an average, in a month an ANM conduct 4-5 deliveries.

Overall, it has been observed that ANMs carried out their work effectively. But their knowledge about the project was limited to providing the health services. They were unaware about the other activities that were framed to fulfil nutritional needs of the people.

Annexsure-3

Process Documentation

of

Building on Health and Nutrition Project (BHNP II)

by

Jayati Chaturvedi

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LIST OF ABBREVIATIONS

ANM	Auxiliary Nurse Midwife.
ANR	Agriculture and Natural Resource Management.
AWC	*Aanganwadi* Center.
AWW	*Aanganwadi* Worker.
BDO	Block Development Officer.
BEO	Block Education Officer.
BHNP I	Better Health and Nutrition Project.
BHNP II	Building on Health and Nutrition Program.
CARE	Cooperation for Assistance and Relief Everywhere.
CBO	Community Based Organization.
CDPO	Child Development Project Officer.
CGB	Community Grain Banks.
DLAC	District Level Advisory Committees.
FO	Field Officer
GOI	Government of India.
HVVS	*Hanuman Van Vikas Samiti* (an NGO).
GoR	Government of Rajasthan.
ICDS	Integrated Childhood Development Services.
IFA	Iron and Folic Acid.
JJVS	*Jagran Jan Vikas Sansthan* (an NGO).
JCS	*Jan Chetna Sansthan* (an NGO).
KAS	Kotra Adivasi Sansthan (an NGO)
LS	Lady Supervisor.
MKS	*Manav Kalyan Society* (an NGO).
NGO	Non-Government Organization.
NHD	Nutrition and Health Day.
PA	Program Assistant.
PDS	Public Distribution System.
PS	*Prayatna Samiti* (an NGO).
PRI	Panchayati Raj Institutions.
RDD	Regional Deputy Director.
SARD	Society for All Round Development (an NGO).
SEAD	Small Economic Activity Development.
SHG	Self-Help Groups.
SS	Sector Supervisor.
THR	Take Home Rations.
TT2	Tetanus Toxoid (two doses).
USS	*Utthan Shoudh Sansthan* (an NGO).
VDF	Village Development Funds.
WFP	World Food Program.

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ACKNOWLEDGEMENTS

This report is a sequence of my long-standing interest in the socio-economic consolidation and welfare of marginal groups and vulnerable communities. It is the result of my attempt to gather into the pages of my notebook, the myriad voices I heard in the field, to organize and analyze them and cull coherence out of them.

Being an academic, and an empirical social scientist at that, the above exercise was not a new one. Nevertheless, one never fails to be moved by the experience of sharing, which the field provides. Self-evolution is inherent in field studies and I am grateful to the local communities, who without reservation, opened up their homes and hearts, to me, and offered me this very rewarding opportunity. For them, the rigors of the droughts will continue to occur as they go about their lives with dignity and fortitude in extremely adverse conditions. For them, I was just one more visitor, an educated one, clutching a notebook and writing feverishly. It is to them, that I want to dedicate this report.

I wish to thank the project team, who helped me find my way around, giving freely of their time, energy and experience. I could see them tiring as they zestfully drove their vehicles around in the scorching heat of the desert summer, often in extremely difficult terrain. Their dedication to the cause and their commitment to the local communities are laudable.

I wish to hank the partner NGOs for the help and information provided and the occasional hospitality for the night, at their centers.

Licy George, at the CARE office in Jaipur, supported me with her unfailing efficiency and dependability.

Above all, I wish to thank Sanjay Awasthi, State Director, CARE India (Rajasthan), for offering me this self-enriching experience and for showing patience in the face of my occasional lapses.

In the end, I wish to thank my husband, Dr. Gyaneshwar Chaturvedi, for patiently “holding the fort” as I made my numerous sorties into the field, and my children, Sumati and Ujjwal, as their e-mail mother, ceased to be even that.

Jayati Chaturvedi.

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PREFACE

This report was written towards the end of July 2002, on the eve of CARE's withdrawal from the Project area. It is based on a number of field trips to the project area between May and July 2002. It hopes to document the process and bring before the discerning reader, the fine aspects of social intervention in a developing society.

The analysis is complicated by the fact that while some of the communities encompassed by the above project are rural poor with pastoral lifestyles, mostly agriculturists, (the residents of Mavli and partly Salumber), the rest are tribal, with a part-migratory lifestyle (the residents of Kotra and largely Salumber). Clearly, the initiatives of making the benefits of development accessible to them, has followed a different pace and path in each community and the levels of success achieved too have been different.

For the purpose of authoring this report, the consultant first participated in an **Orientation Meeting** with the BHNP II Project Coordinator at the CARE office in Jaipur, Rajasthan, India, on 14th. May 2002. Subsequently, many trips were undertaken to the villages in Udaipur and Sirohi Districts of Rajasthan, covered by the project, between 3rd. June and 26th. July 2002. In the course of these visits, **there were many interactions with the various stakeholders** – the BNHP II team members, particularly the Field Officers, members of the partner NGOs, community members organized in Self-Help Groups (SHGs) as well as members of Mother's Committees, local level government functionaries such as the Auxiliary Nurse Midwives (ANMs), *Aanganwadi* Workers (AWW), in some instances the BDO, the BEO etc., tribal respondents and secondary target groups consisting of men folk and elderly women. Health and Nutrition *melas* (fairs) were attended on the Health and Nutrition Days (NHDs).

The specific villages visited were Dabok, Udakhera, Bidghas, Vasni Kalan, Navikheti *phalan* of Nara Magra and Ladhani in Mavli Block, Ghaati and Isherwas in Salumber Block, Kotra city, Matasula, Keltara, Kheda, Beyana, Bilwan, Nichli Subri and Kalakheter in Kotra Block, Dhaan and Jirawal in Reodar Block, Dhamsara, Kalora *phalan* of Bosa village and Aamthala in Abu Road Block, for interactions with community members. Some of these villages were approachable by bitumen-layered roads; some were approachable by dirt tracks while some were approachable by foot alone. **A Sector Meeting, which was a convergence meeting** of *Aanganwadi* workers and Sector Supervisors, presided over by the CDPO and attended by representatives of the local NGO, **was attended** at the Primary Health Center in Abu Road.

A video cassette depicting the proceedings of the *Mahila Sangam,* organized by JCS in Abu Road in December 2001 **was analytically viewed**.

Partner NGO headquarters visited included the *Jan Chetna Sansthan* headquarters in Abu Road, the *Aastha* Center in Kotra, which is the headquarter of the *Kotra Adivasi Sansthan*, the headquarters of SARD in Reodar, the *Manav Kalyan Society* headquarters in Oogna, the headquarters of *Hanuman Van Vikas Samiti* in Sakroda, Mavli, for interactions with NGO partners.

Continuous exchange of ideas took place with CARE FOs in the course of the field visits. Detailed exchanges were had with them in the CARE office in Udaipur.

Numerous *Aanganwadi* Centers were visited and interactions were held with AWWs and community members. **ANMs were interviewed** as also the **response of the local community to the ANM were recorded.** On three occasions, **puppet shows involving the use of the folk media for the dissemination of health related messages were attended.** Many **wells deepened under the BHNP II project were visited,** their water levels were observed and the responses of community members were recorded.

At the time of writing this report, following the two year term assigned for BHNP II, extensive preparations were underway for CARE's withdrawal from the area. This impending withdrawal by CARE lent a special poignancy to the fieldwork and this is likely to be reflected in the report.

It is hoped that this report captures the flavor of the project, which it seeks to document – its activities, the inputs of those responsible for its implementation, the community response so crucial to its success and sustainability and the lessons learnt. If it achieves the above, and makes even a small contribution to the understanding of the complex dynamics witnessed in the field, the writer would feel sufficiently rewarded for her labors.

Jayati Chaturvedi.

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Project Area Map

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BHNP - II LOGICAL FRAMEWORK (For Two Years)

Narrative Summary	Performance Indicators	Means of Verification	
Project Goals			**Goal to Supergoal**
1. Sustainable improvement of health and nutrition status with special emphasis on children up to 2 years, pregnant and nursing women	1.1 Reduction in the number of severely malnourished children up to 2 years*	1.1.1 These are long term goals and may not demonstrate significant reductions during the 2 year project period*	1. Lower IMR*
Project Purpose			**Purpose to Goal**
1. Strengthen ICDS activities to improve nutritional and health status 2. Improvement in food security	1.1 Increase in the number of women who had atleast three ANC contacts during their last pregnancy 1.2 Increase in the number of children (under 12 months) breastfed within 4 hours of birth 1.3 Increase in the number of children 0-4 months exclusively breastfed in the last 24 hours 1.4 Increase in the number of children 6-12 months who received semi-solid food in addition to breast milk in the last 24 hours 1.5 Increase in the number of children 12-24 months fully immunized by the age of 12 months 1.6 Increase in the number of households/ women who are saving regularly either money, grain or seeds and accessing the same in times of need 1.7 Increase in the number of households with new or increased horticulture production 1.8 Increase in the number of CBOs actively supporting health and nutrition related activities (eg. the Nutrition and Health Days)	1.1.1 Baseline study compared with evaluation study	1. Increase access ' health a: nutritional services 2. Increase in t: nutritional intake of t: target population 3. Increase income and fo security target population
Project Outputs			
1. Strengthening and intensification of the Govt.'s provision of health and nutrition services 2. Improvement of women's capacity to access capital resources 3. Improvement of communities' capacity to produce or access more food 4. Involvement of community based organizations in program	Process indicators for monitoring	Monitoring system	1. Target grou get t: supplementary food 2. Community participation

MANAGEMENT			

******THESE ARE LONG TERM GOALS AND MAY NOT DEMONSTRATE SIGNIFICANT REDUCTIONS DURING THE PROJECT.*
THE PROJECT PURPOSE INDICATORS WILL FORM THE EVALUATION INDICATORS.

PROJECT ACTIVITIES	INPUTS		
1. STRENGTHENING SERVICE DELIVERY RELATED TO HEALTH AND NUTRITION			
1.1 ESTABLISHMENT AND STRENGTHENING OF CBOS	FOUR FIELD OFFICERS, SUPERVISOR, PROGRAM MANAGER, PROGRAM ASSISTANT AND A DRIVER, HQ SUPPORT		
1.2 INSTITUTIONALIZATION OF NUTRITION & HEALTH DAYS (NHDS)	BRIDGE FUNDS FOR CREDIT, SEEDS AND GRAINS AT INITIAL STAGES		
1.3 PROMOTION OF HEALTHY BEHAVIOURS AMONG TARGET BENEFICIARIES	CAPACITY BUILDING		
1.4 TESTING OF HOME BASED HEALTH RECORDS (HBHR)	NGO SUB-CONTRACTS		
2. INTRODUCE SAVINGS & CREDIT ACTIVITIES	MONITORING AND EVALUATION SYSTEM		
2.1 FORMATION OF SMALL SAVING & CREDIT GROUPS FOR HEALTH AND MICRO-ECONOMIC ACTIVITIES	ADMINISTRATIVE SUPPORT		
2. TRAINING MEMBERS OF SAVINGS GROUPS ON ADMINISTRATION, MANAGEMENT, SUSTAINABILITY AND RELATED TOPICS			
3. INTRODUCING AGRICULTURE/ HORTICULTURE & NATURAL RESOURCE MANAGEMENT ACTIVITIES			
3.1 PROMOTION OF VILLAGE NURSERIES MANAGED BY WOMEN			
3.2 PROMOTION OF KITCHEN GARDENS WITH VEGETABLES RICH IN MICRO-NUTRIENTS			
3.3 ASSISTANCE TO WOMEN AND GROUPS TO GROW FRUIT TREES			
3.4 INTRODUCTION OF THE CONCEPT OF MICRO LEVEL PLANNING AND WATER HARVESTING TO THE VILLAGE WOMEN AND COMMUNITY GROUPS			
3. ASSISTANCE IN ESTABLISHING GRAIN AND SEED BANKS (INCLUDING TRAINING REGARDING STORAGE)			
4. FORMING SUSTAINABLE PARTNERSHIPS			
4.1 SENSITIZATION OF THE GRAM PANCHAYAT AND ENLIST THEIR SUPPORT IN THE PROJECT			
4.2 ESTABLISHING PARTNERSHIPS WITH LOCAL NGOS AND CBOS			

EXECUTIVE SUMMARY

(1) BHNP II, which was an extension of BHNP I, was primarily envisioned as a health related intervention of CARE Rajasthan. However, it was led by circumstances and ground realities to metamorphose itself into a multi-sectoral project with strong and effective inter-sectoral linkages. This adaptability and far-sighted vision, has earned the project and the team members extensive support, implicit trust and boundless affection of local communities, specially its women members, enthusiastic participation and collaboration of partner NGOs and the grudging recognition of the government machinery.

(2) Some sections of the project area constitute the most deprived and endemically poverty-ridden regions of the country and are home to some of the most vulnerable groups of populations, largely overlooked and by-passed by government sponsored development schemes. The tribal complexion of large demographical segments only complicates matters. Ensnared in a time warp, clinging to age-old traditions and practices, a large number of which are clearly unscientific, the target communities stand in great need of development interventions, which are flexible enough to incorporate acceptable traditions in modern approaches. This enmeshing of tradition and modernity has been one of the biggest triumphs of the project.

(3) The capacity-building initiatives, an integral part of the project, have been very successful initiatives and have gone a long way in making possible the achievement of target deliverables. CARE FOs have undertaken the enhancement of their own comprehension of concepts meant to be implemented through participation in national level workshops and cross visits, partner NGOs have transited through reorientations to development modes of functioning and introduction to novel concepts which were enmeshed with traditional approaches, the capacities of AWWs, Change Agents, traditional midwives, the local populace and above all, PRI representatives, familiar only with structured and hide-bound processes of functioning, have been upgraded and sensitized through workshops and exposure. This valuable input, a permanent asset in the project area, is likely to ensure the sustainability of the project, even after the withdrawal of CARE.

(4) Strong and detailed institutional mechanisms, and in some instances, statutory mechanisms have been structured to endow the beneficiaries with a sense of empowerment and this will surely ensure the future sustainability of the project. This is especially evident in the new self-perception of the AWWs, the moral and societal pressures exerted by Change Agents, members of the Mother's Committees and SHGs, the determination of basic rules for the operation of Grain Banks, the linking of the SEAD activities to local lead banks and the statutory linkages forged between Mother's Committees and PRI.

(5) The convergence, collaboration and partnerships forged between partner NGOs, CBOs and PRI has been a very productive and rewarding experience of the project. This activity has emerged as a very successful anchoring strategy for the continuance and sustenance of project based interventions.

(6) The health-related interventions of the project, specially the awareness generation campaigns, indicate perceptibly heightened levels of success. Employing the local folk media to achieve the above objective has been a masterstroke of the project. Rajasthan has been, since times immemorial, the land of story-telling through music, pageantry and puppetry and rural populations were seen to respond very well to the CARE-NGO sponsored puppet shows and the messages of health awareness and positive behavioral changes, which were sought to be transmitted through these shows.

(7) The health-related interventions of the project have been successfully institutionalized through the Nutrition and Health Days (NHDs) and the Referral System. The collaboration of partner NGO workers with the AWW and the ANM to ensure the success of the immunization drives, the active collaboration of Mother's Committees to identify the most vulnerable members of the community and potential beneficiaries, through the use of updated social maps and drawing them out to participate in the NHDs, has been a quantifiable success area of the project.

(8) Convergence of CARE sponsored NHDs with the government sponsored health program services and ICDS has been another successful institutionalization activity of the project. This activity has yielded two major benefits for local communities –
(a) The discrepancies between the day-wise and date-wise visits of the ANMs to their respective villages has been ironed out in Sirohi District through the drawing up of a calendar for NHDs with the collaboration of the government machinery, despite their reservations to do so in Udaipur District.
(b) The ostrich policy of the ICDS in growth monitoring of infants below 2 years of age, today stands exposed, when contrasted with the CARE initiative in the matter. While the government figures for 642 AWCs in the five Blocks covering 540 villages reported two or three malnourished children at every center, CARE survey figures indicated 5 to 7 malnourished children in every AWC.
Initially the government refused to accept these figures, but in the end, these figures were accepted and more stringent regulatory and rectifying mechanisms were ordered by the government.

(9) Many SHGs continue to function with dynamism and effectiveness in the project area. Several of these SHGs have the potential to demand for the effective delivery of services. Clearly, this has been possible through a lot of capacity and vision building at the community level by CARE and partner NGOs.

(10) The AWCs and the AWWs represent the proverbial 'storm in the tea cup'. Local communities, today, have a heightened awareness of the service deliverables through the AWCs and effectively demand the same. Many negligent, recalcitrant and inflexible AWWs have been pressurized to resign while others with a duty-conscience have gained better visibility and acceptance among the beneficiary groups. In some places, AWWs have even gone beyond their normal extent of duties to play a facilitative role in account keeping for the SEAD component of SHG activity. This has resulted in building community owned processes and better delivery of welfare services.

(11) In the non-partner areas of BHNP II the responsibility of sustainability lies completely at the doorsteps of government functionaries, more specifically the AWW. The levels of community empowerment achieved in these areas will ultimately determine the sustainability prospects.

(12) Setting up of the District Level Advisory Committees (DLACs) have served to effectively link up CARE initiatives with parallel but sluggish government sponsored welfare measures.

(13) Micro savings were envisaged as one of the central activities of the SHGs along with health awareness. The SHGs with comfortable fund pools are being encouraged to initiate small consumption loans with half the group fund, to meet exigencies such as illness, marriages, buying of seeds, to meet the requirement of grains and fodder, to meet delivery expenses, etc. This is intended to encourage credit and repayment behavior and to foster feelings of trust and confidence in financial transactions amongst the group members. Internal loaning has begun in many of the groups. This financial security has contributed considerably to the empowerment of local women organized in SHGs.

(14) Establishment and maintenance of Community Grain Banks (CGBs) has been one intervention, which has been greatly appreciated and supported by both partner NGOs as well as the local communities. Initially a relatively new concept, it encountered some apprehension and resentment, but once it took off, there was no looking back! Today, the CGBs, promising food security, glow as bright beacons of success in the general glow of the successful project.

(15) The deepening of wells has contributed to the successful creation of drinking water points and this has made a perceptible difference in the quality of life of local communities. Even so, this success can only be termed as the proverbial 'tip of the iceberg' in terms of needs fulfilled.

(16) Community kitchen gardens, a fall out of the well deepening activity, have added variety to the *thalis* (plates) of the local communities, partially contributed to the enhancement of nutritional intakes of pregnant and lactating women and the creative activity has filled the women members of the community with a new sense of self worth.

(17) The Village Development Funds (VDFs), (locally termed as *graam kosh*) the creation of which was assisted by CARE, have financially empowered local communities to undertake independent and self-supported development activities. It has served to boost their morale and undermined their sense of helplessness in the face of natural calamities.

(18) Mother's Committees, comprising of the representatives of immediate beneficiaries, representatives of secondary target groups and representatives of PRI are monitoring service deliverables in a supervisory mode.

(19) Deliberate and well thought out steps to link community based institutions to PRI have yielded very positive results. It has not only empowered the local communities so that they are no longer at the mercy and goodwill of the government functionaries, but has also made the government sit up to try to emulate such efforts in their own areas of work. Mother's Committees, SHGs and SEAD are pioneering interventions, which are now being emulated by the government.

(20) Last, but not the least, personal enthusiasm, group motivation and dedication, collective hard work, unity of vision and professional competence of the BHNP team has not only ensured the success of the project deliverables, but has also earned them the affection and trust of all the stakeholders.

Chapter 1
INTRODUCTION

BNHP is **a pilot project** under the **collaborative efforts of CARE, WFP and the Government of Rajasthan** with CARE, on the one hand, providing the mediating structure between WFP and the Government of Rajasthan, and on the other, between selected local NGOs and the Government of Rajasthan. Finally, CARE provides the mediating structures between the local communities, the local NGOs and the Government of Rajasthan. It focuses on the link between the health and nutritional betterment of the vulnerable and the enhancement of nutritional and economic security of the household. **The areas of intervention were health and nutrition, micro-finance and agriculture and natural resource management**. The objective was to attain a sustainable improvement in the health and nutritional status of women in the reproductive phase of life as well as children less than two years old.

The project was started in 1997, initially for a two-year term. In its first phase, the project focused only on Food and Nutrition and was titled 'Better Health and Nutrition I' (BNHP I). It was completed in the year 2000.

The second phase, titled 'Building on Health and Nutrition II' (BNHP II), was initiated in September 2000 and is scheduled for completion in August 2002. While **Health and Nutrition** continued to remain the main concern of the project, the ambit of the second phase was extended to include **Agriculture and Natural Resource management** (cultivation and consumption of vegetables through **kitchen gardens**, formation of **grain banks** as a measure of food security and as a bulwark against crop failure due to frequent droughts, the creation of **seed banks**, **optimal utilization of water resources** through the **deepening of existing wells**, building of check-dams with a view to **preventing soil erosion** as also the **recharging of wells** through the creation of artificial ponds etc.). It also included **micro-level finance** management by Self Help Groups as a security against distress and illness, health related awareness generation amongst **secondary target groups**, such as elderly women and men folk, the **training of voluntary community based counselors** and the involvement of the *panchayati raj* system (local level self-government system) sponsored by the Government of Rajasthan. The **Mothers Committees** were created and these women were made accountable to the *panchayats* (local self-government bodies), thereby granting them a semi-legal, constitutional justification and role for effective functioning. **The effectiveness and success of the Grain Banks as well as the Mother's Committee schemes are borne out by the fact that these two measures are now being adopted by the state government in other parts of the state.**[1]

The operational area of the project:

The operational area of the project are three blocks of Udaipur District (Mavli, Salumber and Kotra) and two blocks of Sirohi District (Abu Road and Reodar). While WFP food is supplied to the three blocks of Udaipur district, CARE food was supplied to the two blocks of Sirohi district. Since the distribution of food is through the institutionalized government structures at the village level called *Aanganwadi* Centers (AWCs), the exercise requires close coordination with the government and the energizing of the dormant *Aanganwadi* Centers, partly through the initiatives of and the pressures exerted by the SHGs and local NGO workers, and partly through the moral awakening of the *Aanganwadi* Worker, a government appointee, secure in her post, often totally oblivious to her call of duty and frequently at loggerheads with the local community women. In BHNP II a total of 642 AWCs were being covered of which nearly 70% were in the WFP area and 30% in the CARE food area. Subsequently, as part of the withdrawal strategy and geographical consolidation of INHP, CARE commodity supply to the AWCs of Abu Road and Reodar of Sirohi district was withdrawn in April 2002 and the Government of Rajasthan food supply has been initiated in the above blocks.

Partnerships & Mediating Structures:

[1] Most of the above information has been gleaned from Progress Reports and other reports prepared by CARE – BNHP team.

The implementation strategy adopted in the project is a complicated one. CARE teams up with counterpart departments of state and a host of partner NGOs (different ones in different blocks, eight in all)[2], to implement the project targets. The counterpart government departments of Health and Integrated Child Development Services (ICDS) provide services at the community level. The partner NGOs facilitate community mobilization for better implementation by the government machinery and better utilization of the services already available. They also facilitate the micro-level finance as well as the Agriculture and Natural Resources Management interventions. A few of them also employ the services of indigenous artists trained in indigenous entertainment forms by the prestigious and well known *Bharatiya Lok Kala Mandal*,[3] Udaipur, to send home the health related messages in an enjoyable and culturally acceptable milieu. CARE provides the crucial capacity-building element to the partner NGOs and promotes the building of cordial relations between the community and the government service delivery functionaries. The partner NGOs, the corresponding departments and members of the local community organized in Self Help Groups are brought together to iron out bottlenecks in the Core Groups formed at the Block level. Both districts covered by the project, Udaipur and Sirohi, have District Level Advisory Committees (DLACs) for the project, in which the District Magistrate, the district Health officials and the ICDS officials are included. Thus, a review and planning forum at the district level is provided.

This partnership has worked very well for all concerned.

The Background:

Two years ago, when BHNP I graduated to BHNP II, the effects of the drought were still widespread in Mavli, Salumber and Kotra blocks of Udaipur District as well as Abu Road and Reodar blocks of Sirohi District.

Located in the shadow of the Aravalli Ranges, this region, almost invariably misses the salubrious effects of the Arabian Sea branch of the South-West monsoon, which is the life-sustaining force on the Indian sub-continent. If only, by another twist of Fate, the Aravallis had been located at a right angle to the monsoon currents, rather than parallel to it, the region would have received almost as much precipitation as the coastal regions of Maharashtra; but alas! this is not the case. Consequently, the monsoon clouds skim over the denuded Aravallis, so that failure of monsoons and famine conditions have become endemic to the region. The local communities scan the stark skies for rain-bearing clouds, pray for rain and in distress consult the *khairvi*, the Wise Ones amongst the tribal communities, who predict rains through observation of natural phenomena.[4] Hence, living and coping with drought conditions, though not new to the residents of the area, nevertheless imposes a tremendous strain on their slim resources, very basic lifestyles, the tending of cattle-heads, in short, the very business of living.

The rigors of the Drought:

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[2]The eight partner NGOs of CARE for the implementation of BNHP II are –

(1) JVVS – *Jagran Jan Vikas Samiti*, Salumber.
(2) USS – *Utthan Shodh Sansthan*, Mavli.
(3) HVVS – *Hanuman Van Vikas Samiti*, Mavli.
(4) PS – *Prayatna Samiti*, Salumber.
(5) KAS – *Kotra Adivasi Sansthan*, Kotra.
(6) MKS – *Manav Kalyan Society*, Kotra
(7) SARD – Society for All Round Development, Reodar
(8) JCS – *Jan Chetna Sanasthan*, Abu Road..

In addition, the folk artists trained by *Bharatiya Lok Kala Mandal*, Udaipur are engaged for the folk shows.

[3] Established in 1952, this institution works for the preservation, development and popularization of the unique popular culture of this region. It has a Research Center, has published 54 books and reference tracts. It also publishes a quarterly magazine titled "*Rangayan*" in Hindi. It is a well known institution in the world in the area of puppetry.

[4] The institution of the *khairvi* and his methods of prediction of rain are very interesting. This consultant was told that, if the breeze stops blowing and an eerie calmness prevails, if the temperature and humidity levels rise to unbearable levels, if colonies of ants are seen carrying their eggs in their mouths to alternate nests on higher grounds, if a snake is seen climbing a tree, if one or all of these indications are present, then one can be sure of imminent rainfall. There are other indications, which are secrets, zealously guarded, and so, they were not revealed to this consultant. One can see, most of these explanations can be scientifically explained. The locals swear by the accuracy of the *khairvi's* predictions.

The fickle and unpredictable monsoons have taught the residents not to be wholly dependent on agriculture, so that, over the centuries, they have learnt to maintain their cattle-heads as processing units for food – the cattle (mostly goats, cows in somewhat better-off families and camels kept by the *Rabbari* castes) eat the sparse grass and fodder and process it into milk and other by-products such as curds, *ghee* (clarified butter), *chanch* (butter-milk) etc. Most of the poor households tend some hens, which potter around and pick their own food even in extremely adverse conditions, yet supply some eggs and in extreme drought conditions, themselves become a tasty morsel for the households! The staple diet of the families vulnerable to food shortage consists of a gruel called *raab* or *rabri*. It consists of a combination of '*chanch*' (buttermilk) and maize flour and is boiled for a prolonged period over wood fire. (Incidentally, the use of wood for fire and the widespread practice of tending goats has largely resulted in the deforestation of the Aravalis and led to large scale siol erosion and other related ecological imbalances.)

As the food shortage deepens and the crisis grows, the amount of maize flour, generally used for a family meal, gradually decreases and the gruel grows thinner, so that the maize flour stock of the family can be made to last longer. As the cattle-heads become emaciated in drought situations, the *chanch* becomes scarce. This leads to a further liquefication of the *raabri*, through addition of water, until in the end, the family begins to border on starvation. The prospect of nutrition decreases and finally reaches non-existent levels.

Families, which can afford it, would also keep a couple of donkeys for carrying loads, generally turning them loose to forage and find their own grass. Hence the drought conditions, specially the recurrent long-drawn ones, which occur for a couple of years in succession, not only put a heavy strain on the food resources of the household, making them subject to food insecurity, but also put a tremendous strain on the maintenance of livestock due to fodder shortage.

Consequently, when BHNP II, with its predominant health related message and other subsidiary messages, was initiated two years ago, there were hardly any takers. The local communities, fighting for their very survival, had more serious preoccupations to cope with. Food shortage and insecurity had prompted huge migrations into the neighboring states of Gujarat, Madhya Pradesh and Uttar Pradesh. As the situation was not much better in these neighboring states, the migrants were unable to find work and were returning empty-handed, thereby making the grim situation even more desperate.

Difficulties in forging partnerships:

Since the functioning policy of CARE is to forge partnerships with local NGOs, even the task of selecting suitable partner NGOs was made extremely difficult by the prevailing drought conditions.

Most NGOs in the area were involved in providing relief to communities in their area of work. They also tended to view the corruption and mismanagement of the crisis by the government machinery as a prime cause of aggravation of drought related rigors. As a result, CARE's tri-partite partnership proposal, to act as a facilitator between local NGOs and the government, was not particularly palatable to most of them.

Besides, prior to their partnership with CARE, most NGOs in the region had been engaged in activism (confrontations with the government over the *tendu* leaves issue, fighting the equivocal terms of the Money-Lending Act which was being manipulated by local money-lenders to the detriment of the local populace, rights of forest-dwellers in the face of claims by the Forest Department, lapses and rampant corruption in the Public Distribution System (PDS), lapses and corruption in the Ministry of Women and Child Development etc.) rather than developmental work. This meant that they would have to be willing to reorient themselves and their workers to work in partnership with the government machinery as per CARE's policies. They would also need, to be able to explain to their constituencies (the local communities), how and why they chose to view the government as a cooperator rather than an adversary. Even so, after collaborating with CARE and undergoing orientation training, the partner NGOs, in testing

situations, consciously and unconsciously reverted to their activist mode, thereby causing some embarrassment to CARE FOs.[5]

Under such situations, it soon became clear that "Health" was low on the priority of local NGOs and the local communities.

Teething problems which the project encountered:

BHNP II, since its inception, passed through serious teething problems. Initially, it faced the serious problem of just not getting off the ground. Besides, its budget utilization was very low. The project commenced in September 2000. Seven months after its inception, it was almost exactly where it had started.

At that time, it was part of CARE's INHP project. The resolve to kick-start the project in an effort to aid it towards success led to deliberations and changes at the administrative level. The then Project Coordinator, was Jaipur based. Since he was primarily responsible for the INHP, it was understood that BHNP II was an additional responsibility for him. This highlighted the need for some degree of devolution of responsibility if the project was to succeed. Seven months after its inception, a new Project Coordinator, the present one, responsible exclusively for BHNP II was inducted in April 2001. The new Project Coordinator underwent an Orientation Session at the CARE office in New Delhi before being posted out to Udaipur, from where he was expected to report to the INHP Project Coordinator, who had initially been charge of BHNP II.

The dynamic new Project Coordinator, self professedly, was given a relatively free had in the administration work, in decision-making, in forging partnerships etc. A month after the new Project Coordinator joined in, the new State Director joined CARE. The new State Director too, pursued an open policy of devolution of responsibility, gave extensive rights of decision-making, followed a flexible approach suited to the need of the hour and afforded full support to the BHNP II team. In this melieu of freedom, led by an euridite youthful Project Coordinator and supported by a band of youthful FOs, BHNP II, which had been resisting all attempts at resuscitation, finally got off the ground. Thereafter, it soared to success and there was no looking back.

However, the problems were not really over. The project was just about beginning to turn the corner.

By September 2002, the monsoon had failed to reach Mewar, (the project area) for the third consecutive year. It was the third consecutive year of drought. The rigors of the drought had resulted in large scale migration of local populations along with their livestock and the villages were practically empty of population. The remaining people were struggling for their very survival and were unwilling to listen to health-related messages. The NGOs were engaged in relief work in the crisis situation. Tardy succor afforded by the government was fueling resentment amongst the NGOs and the people. The idea of a partnership with the state government was itself abhorrent to all concerned. The NGOs, in view of the cultural nicety and the practical irony involved in asking starving people to save in SEAD or collect food grains in CGBs, were, naturally unwilling to do so. The BHNP II Log. Frame. drawn up in October 2000, had failed to take into account the endemic droughts which plagued this area. There was no component of drought-relief in-built into the project. It had no budgetary allocations for the same. The State Director, in consultation with the Sector Director, had begun to feel that the project could not be implemented due to the drought conditions. The funds allocated for the project were about to be returned to the donor. After discussions with the donor officials, it was decided that one more chance should be given to the success of the project and some more efforts should be made to make it succeed. The project activities were somewhat

[5] During BHNP II, CARE had a working relationship with *Aastha*, a reputed Udaipur based NGO and a partnership with one of its allied NGO, *Kotra Adivasi Sansthan*. During this period, there was a sudden sequence of child mortality due to starvation or infection in a village called Mewaron ka Math. National media attention brought the Chief Minister to the site. The Ministry of Women & Child Development and the District Magistrate were hauled up. *Aastha* and *Kotra Adivasi Sansthan* added fuel to the fire through their activism. The state administration, embarrassed by their activities, frowned upon CARE's partnership with them and the FOs went into low profile till the clouds blew over.

modified, the initiative areas mentioned in the Log. Frame. were prioritized and a more pro-active approach was adopted to ensure the success of the project.

Since 'water harvesting' formed a part of the Log. Frame. it was decided to undertake the deepening of wells on a priority basis, as a first step to meet the challenges of the drought. Ten new water points were sought to be created through the deepening of wells. Most bore wells in the area were dry. Digging new open wells would require seven or eight months in view of the rocky nature of the terrain, the scarcity of technical skills and the inaccessibility of the regions to heavy drilling and boring equipment. Hence, it was decided to deepen the existing dry wells. The services of a senior geologist from Jodhpur were hired as a consultant for technical analysis to determine the success in finding a high level of ground water. NGO partners were involved to mobilize the community for participation in labor contribution. In the end, 33 wells were successfully deepened as contrasted to the originally determined figure of 10.

However, the mismatch between the ideals of partner NGOs and CARE continued. There were three new partners – PS, JJVS and SARD. They had to be engaged in the coordination of mutual targets, their personnel were subjected to training sessions and workshops and sometimes, their activity plans had to be pruned to tally with BHNPII targets.

By April – May 2001, the migratory populace had started returning to the villages in anticipation of the monsoon. In 2001, the monsoon did not belie the hopes of the people and by the month of June there were heavy beneficial rains so essential for the survival of agricultural communities. From then on, BHNP II activities picked up seriously.

At the time of writing this report (July 2001), there has been a widespread failure of monsoons yet again. Sixteen states in India have been declared as 'drought affected' and needless to say, Udaipur and Sirohi Districts, which form the project area, are seriously affected.

Adaptations in strategy and priorities of the project to meet ground realities:

Within months of onset of the project, a joint meeting of CARE Rajasthan, CARE India and UNWFP was held to discuss a contingent plan of action. It was decided that the initiatives of BHNP II will be prioritized and the creation of additional water resources will be taken up first to provide immediate relief to the local populace. The other interventions would be introduced gradually, whenever feasible. Since the policies of CARE also included "Relief", a conscious broadening was undertaken in the policy of BHNP II to accommodate "relief measures" in the original plans. Other **ANR activities** such as the **deepening of wells** and the creation of additional water points were also undertaken. **Community kitchen gardens** were to be popularized to supplement the nutritional aspects of the communities while at the same time supplementing their dependence on grains. This was initially a by-product and a sequel to the well deepening activity as subsequent to one round of blasting, the waste-water needed to be drained out before the next round and this water was used for fostering nurseries for kitchen gardens in the immediate proximity to the wells deepened.

The methodological tools employed for process documentation:

The methodology employed for the survey, culminating in this report, were multidimensional. The dominant method was the questionnaire method in which pre-determined questions were taken up for answering in a discussion format. Sometimes, for the purpose of ice breaking before the questionnaire, the consultant and the CARE Field Officer would introduce themselves, we would enumerate our food preferences ("I like *bhindi* (okra) / *daal* (lentils) /*dahi* (yogurt) etc. How about you?.....and you?.......and you?"). This was done in order to ascertain if the women had gathered an idea about what foods were

nutritious and therefore preferable to others.[6] Sometimes they were requested to sing a song or two, and they sat in a tight-knit circle, facing each other and obliged immediately. The trouble was, once they started singing, they never wanted to stop!![7]

Sometimes, the consultant would generate a discussion on pregnancy or childbirth related themes amongst the women present and then sit back to observe and take notes about the group dynamics, their faith in and equations with the Auxiliary Nurse Midwife (ANM) or the *Aanganwadi* worker (AWW) and the limits of sustainability of the work accomplished (this would generally happen when the CARE Field Officer, a male, would take off temporarily to supervise some incomplete activity in the area, as the women, almost always felt inhibited to talk on such intimate issues before men).[8]

In places where the Self Help Groups (SHGs) were engaged in collecting money for the Community Fund through Small Savings, the consultant would ask them to show their account books and ask them to read out the balance figure to ascertain their levels of literacy. In many cases, they were unable to do so and this highlights the continuing role of the local NGO partners and their activists in the future plans of sustainability.[9]

At the health *melas*, the operational dynamics of the Referral System was observed.[10]

In the entertainment sessions, consisting of song, dance and puppet shows, the observational method was employed to ascertain audience response and thereby hopefully, the message assimilation.[11] Copious notes were taken on the occasion as it is a novel method of rural mobilization, observed by the consultant only once before.[12]

This consultant, wishes to place on record the fact that while Mavli Block comprises largely of agricultural settlers, Salumber has approximately 70% tribal population), while the communities covered by BHNP II in Kotra and Abu Road are almost completely tribal. Reodar on the other hand, producing three crops a year, presents a far more prosperous picture, yet continues to be extremely feudal in outlook. Not only the demographical complexion, but the social problems, issues involved in development, the initiatives involved in capacity building, the deliverable targets – all fall into different parameters in the different demographical tracts. In view of the above, it is extremely difficult to formulate generalist and simplistic documentation of the BHNP processes in the various habitation tracts.

A testing time of transition:

At the time of writing this report, pending CARE's withdrawal from the project area, every office, every unit, every person, every small organization, which had until now been actively and emotionally involved

[6] This method was adopted and was very successful in the interactions with the SHGs in Ghaati village in Salumber Block visited on 6/6/02. The meeting was held at the *Aanganwadi* Center. The SHG at Ghaati calls itself *Gatodji Mahila Swayam Sahayog Samiti* and the local NGO is *Jagaran Jan Vikas Samiti*, Jaisamand.

[7] This happened in Dabok, Mavli Block, visited on 4/6/02, Ghaati, Salumber Block, visited on 6/6/02 and Isherwas, Salumber Block, also visited on 6/6/02 .

[8] There was long and animated discussion in village Bilwan, Block Kotra, on this theme. The promptings and initiatives of Shantiben, an irrepressible and dynamic worker of the local NGO, *Aastha*, added an edge to the discussions.

[9] This happened in Dabok, Ghaati and Kheda villages.

[10] The referral system was observed in Udakhera where a woman brought in two twin babies for weighing to ascertain their nutrition level and one of the two twins was very sick.

[11] Dissemination of health related messages through folk media was witnessed in Udakheda, Keltara and Bayana.

[12] This was in a *tamasha* show in Hadshi village, Mulshi Taluka, Poona district in Maharashtra, where the present consultant was taken as a participant in an international conference on "Popular Cultures and Social Cultural Action", organized by the Center for Cooperative Research in Social Sciences in collaboration with The Charles Leopold Mayer Foundation for the Progress of Mankind, Paris, 2-8 January, 1998.

in the project, were in a sense, engaged in "clearing the table". This included the CARE office in Udaipur, CARE Field Officers, local partner NGOs and their field staff, the *Aanganwadi* workers, as well as the enthusiastic women members and some men of the SHGs formed at the village levels.

CARE Field Officers appeared somewhat distraught. Some of them were in the process of being absorbed in a new intervention concerning AIDS control, being introduced by CARE in the neighboring areas, some were in the process of being absorbed in concurrent projects elsewhere, while some were looking anew for fresh placements and dreading the inevitable resultant upheaval. Alongside, they were troubled by the certitude of having to sever their relationship with the areas, persons and groups, whose well-being they had nurtured with so much concern, giving them the best of their physical and emotional reserves, never counting the costs. To complicate their emotional turmoil, was the lingering suspicion that CARE's withdrawal might lead to a lapse and consequent undoing of some of the good work which was beginning to manifest itself after the grueling process of implementation of BHNP II.

The partner NGOs were in an ambivalent state of mind. All of them could clearly see that the withdrawal by CARE would pave the way for their greater and more intense continued support to the beneficiary communities. Many SHGs lacked a single literate member. Hence, their account keeping, writing of applications to government functionaries and the consequent follow-up of project deliverables etc. would have to remain under the supervision and guidance of the partner NGOs. Yet, some of them were being required to shift their area and focus of functioning to coincide with CARE's new intervention in the offing. They had thus, decided to leave behind a skeletal staff of experienced field-workers in the BHNP area. Most of them said that they knew well in advance about CARE's intended withdrawal. Only one partner NGO seemed rather resentful of the withdrawal and some of his resentful anger transferred to the present consultant, whom he mistook to be a representative and a spokesperson of CARE!

The representative of one partner NGO told this consultant that she knew for sure that the local community had fully grasped the theoretical aspects of the BHNP message. How far they were actually practicing these expected behavioral changes was something, which could not be stated with certainty.

Another NGO worker told this consultant that when they hear of an impending delivery, they (a few NGO workers) camp before that house and occasionally go in for a peep to ensure that the local *dai* (midwife) is actually following the training she received and is using the *Mamta kit*.[13]

The *Aanganwadi* workers (AWW), in the light of CARE's withdrawal, were also an ambivalent lot. Some of them appreciated the introduction of a new, dynamic and pro-active style of functioning introduced by CARE under the BHNP II. These ones had come to realize their crucial role as the link between the local communities and the government. They had been provided technical, administrative and community support, to enhance their efficiency, accountability and acceptance. They had developed camaraderie with the SHGs at the community level. As part of the capacity building of the AWW, they had been trained in the preparation of tasty recipes with the food provided at the AWCs, under a joint program of the government and the BHNP II. Other AWWs, who did not have a satisfactory relationships with the SHGs of local communities, were, somewhat resentfully and grudgingly, beginning to accept the pressures of local demands for service deliverables through the newly capacitated SHGs .

Members of the SHGs in the villages were all aware of CARE's withdrawal. They had been made to understand that other people, battling against greater odds in more diverse conditions, needed the support of CARE, just as they had needed it four years ago. This explanation they accepted with stoic resignation. All of them confirmed their resolve to carry on with the SHGs, grain banks, kitchen gardens and positive health behaviors even after the withdrawal of CARE. The BHNP messages of nutrition, health, vaccinations, hygiene, pre-natal and antenatal care of women and infants, food security and economic security had gone home, deep and permanent. This consultant asked the members of many SHGs how they would accomplish the account keeping of the SHG funds after the withdrawal by CARE and the partner NGOs as there were no literate persons in that SHG. They answered that a federation of villages intended to employ a person capable of maintaining their accounts and pay him though the SHG funds. This consultant asked if they

[13] In conversation with Shantiben at the *Aastha* Center in Kotra on 10/6/02.

apprehended the embezzlement of their SHG funds. They explained that since the person employed for the maintenance of accounts did not have withdrawal powers, there was no fear of embezzlement from that quarter. They said that until now, they had kept faith in the partner NGOs and their faith had been upheld. They presented a shining example of sustainability, yet were saddened by the prospect of losing contact with people whom they had come to trust.

Water is still the most scarce commodity:

All the respondents incessantly complained about the scarcity of water resources and the total absence of veterinary support for their cattle, though some of the villages were only marginally better off than the others. In the circumstances, where acquiring the basic and elementary necessities of life was such a struggle, this consultant, could not but wonder, if interventionist activities and messages concerning health and hygiene seemed a little farcical to the ears of the villagers. Of course, when questioned on the issue, the boundless enthusiasm of the rural womenfolk coupled with their desire to be viewed by the outside world as enlightened beneficiaries of the fruits of development, led them to affirm the BHNP II message. One can only hope that the BNHP II message has, however, gone home to last.

The future chapters are a recording of the processes through which the project has transited. Health Awareness Campaigns, the formation and consolidation of SHGs, the ANR components of the project, the formation of Mother's Committees as well as forging their linkages with PRI, the difficulties encountered on the ground and the transcendence of those difficulties have been dealt with in separate chapters. The feedbacks received from the team members has also been included in a separate chapter.

It ends with a hope and confidence that the BHNP II intervention will make a lasting impact on the lives of the vulnerable communities it chose to assist in the last two years.

Chapter 3
SITUATING THE PROJECT

This chapter will try to locate the project in its natural setting, in terms of time and the socio-cultural settings of the five blocks in which it was implemented. The purpose is to give to the reader an idea of the exclusive character of the time and the area of the project, to enhance a comprehension of the uphill task achieved by the BHNP team; as also to give to the reader an idea of the need for development activity in the project area and its sustainability.

SITUATING THE PROJECT IN TIME:

Four years ago, when BHNP I was launched the area was experiencing a severe and prolonged drought due to the failure of the monsoon rains in the preceding five years. Lacking in alternative income generation possibilities, the people of the project area were entirely dependent on agriculture. For them, the failure of the monsoon meant no crop cycle, starvation, inability to attend to the illness of family members, specially the children, forced migration, dipping of groundwater levels and the drying up of wells in the already harsh arid area of their inhabitation, inability to feed their cattle-heads or lead them to water, loss of cattle-heads due to death through starvation and extreme distress. Other engagements of life, such as the solemnizing of marriages etc., were best forgotten. Inevitably, these conditions led them to the local moneylenders (locally known as *modi*, *vanya* and *soni*), to pawn their silver jewellery for a pittance at extremely high interest rates, fixed at will by the local moneylenders. These moneylenders operated, often without licenses and in total contravention of the Indian Money Lending Act. The interest rate fixed by them, at will, ranged between 25% and 50% payable monthly.

A local NGO field worker told this consultant that on his field trips in those days, he witnessed the spectacle that, many cows and buffaloes, which sat down in the shades of scrubs, found they had no strength to get up. From a sitting position they passed to a prostrate position and thence to eternal slumber.[14] A CARE Field Officer told this consultant that, in those days, on his way to the field, he would see a cow, a buffalo or a goat sitting pathetically under a scrub; on his return, he would find the animal dead.[15] So many cattle-heads died that in the end, their remains were no longer cleared. Their carcasses were just left to rot. The partner NGO in Abu Road, fearing the outbreak of an epidemic due to putrid and rotting carcasses of animals, took up the matter of the removal of carcasses with the man who was the contractor for the collection and sale of animal skins and bones in the area. The contractor belonged to the so-called low caste and was a *bhangi*. The contractor responded that he had collected and sold enough animal skins and bones for the next seven generations of his offsprings to live in adequate comfort; so he was not interested in collecting anymore.[16]

The severity of the drought was graphically narrated by a FO who told this consultant that in the first year of the BHNP II intervention, he was on his way to a place called Baansphali, a *phalan* in Uplagarh village in the Abu Road block of Sirohi district. He had to abandon his vehicle a few kilometers from his destination and cover the remaining distance on foot, as the scattered hutments were not accessible by any road. He was thirsty and decided that he would ask for some water on reaching the huts. When he reached the huts, he found that sixty families of the *phalan* were drinking water from a stagnant, fetid pool located in a depression in the ground. As if that wasn't enough, the stagnant pool was shared by the sixty families with their surviving cattle.[17] Thereafter, CARE undertook the deepening of wells in the area. In all, ten wells were to be deepened. In the end, nine wells were deepened while the tenth well could not be deepened due to technical reasons. The villagers of Baansphali cooperated in deepening a nearby well through the contribution of their labor. Today, the well is functioning and women who leave their homes for the forest, to collect *tendu* leaves, early in the morning as the first cock crows, quench their thirst, late afternoon, at that very same well.

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[14] In conversation with Yogesh Bhai, NGO worker in *Jan Chetna Sanasthan*, in Abu Road on 21/6/02.
[15] In conversation with Umashankar, CARE FO in Abu Road.
[16] Story narrated by Yogesh Bhai.
[17] Incident narrated by Umashankar, FO.

Such was the vicissitude of the *akaal* (famine) in which the BHNP I intervention began. Under the circumstances, when the BHNP catalysts, went into the field with their messages of health and nutrition, small savings, self-help groups and committees, there were absolutely no takers. The standard and anticipated answers of the villagers were "Do something to alleviate our miseries. We have no food and no drinking water. We do not want to talk to you about anything else. We are dying, our children are dying, what to talk of savings?"

Consequently, plans for the first year of the project had to be changed in order to address the severe water crisis and the famine conditions arising from drought in the project areas.

One partner NGO field worker told this consultant that in their four years partnership with CARE, the first year was devoted to emergency action to alleviate the rigours of the drought conditions. The second year was spent in the co-ordination of perspectives and policies (a number of these partner NGOs, specially in the Kotra area were originally action oriented and had to shift to a development oriented mode in order to work successfully in partnership with CARE). The third year saw an improvement of their relationship with the government organization, under prodding from CARE and some good work, beneficial to the local community, was accomplished.[18] The bulk of the project work was done in the fourth year and by then it was time for CARE to withdraw.

Another Partner NGO representative, was also highly appreciative of the guidance and capacity building offered by CARE, especially through the Field Officer, in helping the NGO move from its past activist mode to a new development oriented mode expected and required by CARE.[19] The latter part of the fourth year has also been devoted to winding up and clearing the table as the partner NGO prepared to leave behind a residual staff for the BHNP II area and move into a fresh collaboration for AIDS control activities with CARE.

SITUATING THE PROJECT IN ITS SOCIO-CULTURAL CONTEXT:

THE URBAN BLOCK CALLED MAVLI:

The township of Mavli is located some forty kilometers or so from Udaipur. It is the most "urban" of the five blocks of BHNP II intervention. In many ways, it kept reminding the writer of this report, of the Punjab countryside, though its level of affluence is far less. Even scattered villages are constantly in touch with "civilization", ie. Udaipur. Many of the houses in the villages are large permanent structures with dish antennas located on roof-tops.

The local communities are mostly engaged in agriculture and the landless earn their living through wage labor. Due to its proximity with Udaipur, it is usually possible for the landless to find employment and thus, sustaining a livelihood is not very difficult.

The entire Block, nevertheless, like all the other Blocks, suffers from water scarcity.

The rural areas of the block are dotted with small factories and industrial units, of which, the most prominent, a zinc smelter factory, owned by the GoI had been shut down, probably pending disinvestment.

For those desirous of upward mobility, there were primary schools, secondary schools and degree colleges, AWCs, PHCs, often located not very far from their residences. Communication links existed and the people spoke a dialect which is easily comprehensible. Cable channels of TV programs, beamed into their homes, cemented their links with the so called developed world.

The local communities look considerably self-assured.

[18] In conversation with Nanalal Meena in Kotra on 23/6/02.
[19] In conversation with Richa Audichya, *Jan Chetna Sansthan*, Abu Road, 21/6/02.

CARE's partner NGOs in Mavli are *Utthan Shoudh Sansthan* (USS) and *Hanuman Van Vikas Samiti* (HVVS).

THE TRIBAL BLOCK CALLED SALUMBER:

Salumber Block, consists approximately 70% tribal population. Nestled in the nook and cranny of the Aravallis, it is farther removed from "civilization" and "development" than Mavli. Nevertheless, most villages are approachable either by the trunk routes or subsidiary roads. PRI exist and function, in greater and lesser degrees in all villages.

The partner institution of CARE in this Block are *Prayatna Samiti* (PS) and *Jagaran Jan Vikas Samiti* (JJVS). Both these NGOs have very interesting though diverse approaches.

In respect of the "bottoms up" approach, PS believes in complete submission to community wishes, to the extent of allowing them to make mistakes and learn from them. It believes in a minimum of initiatives or interventions, and rather prefers working 'with' the community rather than 'for' them. Project targets are therefore not followed up aggressively by PS as it runs counter to their approach. For this reason, PS frequently requires to be nudged and coaxed by the concerned FO. For this reason too, sometimes PS's budget allocations from CARE lie underutilized.

JJVS on the other hand, has unique philosophy and approach. It has a deep commitment to the use, determining the efficacy and recording the effects of traditional indigenous herbal medicines. They joined CARE as a new partner in BHNP II. After entering into a partnership with CARE, there was an internal change in their leadership and the new leader, a woman, was even more committed to the cause of rejuvenation of the traditional indigenous healing system. They import these herbs from the forests of Jharkhand, employ traditional herbal practitioners locally known as *guni*, send them to the homes of patients with the herbs, where the *gunis* then make the medicines before the family. Volunteers of the NGO then supervise the long term administration and keep objective records of the benefits of the medicines. Other volunteers record the components, method of preparation etc.

JJVS had originally entered into a partnership with CARE because both emphasized community health. However, due to a mismatch in vision and objectives, midway through BHNP II, JJVS reached a stage where it wanted to sever its relationship with CARE. CARE did not wish to lose the benefits of partnership by changing horses mid-stream. It required a lot of pursuation and cajoling by the BHNP II team to keep the partnership going. In the end, it was agreed that it would include the administration of herbal medicines in pre-natal and ante-natal care and in the growth monitoring of babies in coping with malnutrition.

THE DIFFICULT BLOCK CALLED "KOTRA"

A previous report, titled "Graduation Strategy Document of BHNP II", submitted in February 2002,[20] quotes the Director, RCH Program, Udaipur, as saying "Kotra is the most difficult block to work in Rajasthan. No doctor or ANM wants to work there". Apart from its underdeveloped status, the block is riddled with many problems. Most of these problems arise from an encounter between tribal traditions and the demands of development and this will be dealt at length in the section titled "The Dark Clouds of Superstition and Cultural Conditioning".

[20] Document prepared by Vandana Mahajan, dated 26/2/02, procured by the consultant from the CARE office, Udaipur.

THE DIFFICULT BLOCK CALLED "KOTRA"

The tribals do not make things easier either. Following the hunter-gatherer's lifestyle, they scourge the forests all day and often at night and in some parts of the block, as for example in Mandwa, they are, for all practical purposes, a law unto themselves. In certain parts of the block, the state police are powerless. When things escalate beyond a point, the army has to be called in. There have been countless incidents of roadblocks, lootings and killings of travelers, forest guards, teachers of village schools etc. The last State Roadways bus crosses these stretches no later than 7:00 or 7:30PM. The Field Officers of CARE are advised to restrict their travels through these areas in the daylight hours.

Sprawling and forested (though most of the forests are now disappearing due to overgrazing, land erosion through deforestation and seasonal rivers in spate as well as uncontrolled exploitation of the forests for the collection of firewood), it has a low density of population scattered in isolated huts, often without any road leading up to it. This makes it extremely difficult to make the benefits of development accessible to the tribals. Here, the government can build schools but cannot motivate the teacher to go and teach; it can set up AWCs but cannot motivate the AWW to attend it regularly. The sparse rains bring some respite, but in the rainy season, the seasonal rivers come into spate, inundating the tenuous road links and completely cutting off access, thus making it impossible to sustain the food supply chain or to sustain medical help to the needy.

One Field Officer told this consultant that on one of his return trips through one such area in the late evening, he saw two tribal women asking him for a lift in his vehicle. Just as he began braking, he saw a couple of male forms, covered in brown blankets to merge into the thicket, bestirring themselves and groping for their long handled iron tipped spears. Needless to say, that, he stepped on the accelerator for all he was worth! [21]

This consultant, driving through a forested area of the Kotra block with a CARE Field Officer, came upon a roadblock. Tribal youth with naked upper torsos, armed with bows and iron tipped spears came to peep inside the vehicle. Clearly, they were looking for somebody. Not finding their quarry in our vehicle, they were kind enough to let us go by removing the roadblock, which they promptly replaced. Though unable to read or write, they probably also recognized the CARE vehicle, which often does the rounds in these parts. [22]

Though these tribes have a reputation for criminality, the responses of the non-tribals concerning their reputation is an ambivalent one. One NGO representative told this consultant that they are not criminally inclined *per se* though they sometimes do resort to criminal activity as a short-cut to economic betterment in crisis situations.

The Block Education Officer (BEO), Mahendra Kumar Jain, told this consultant that Kotra block suffered from extensive poverty, there were no industries to offer alternate income generating options and the tribals themselves were largely uneducated. The government had set up a number of Rajiv Gandhi Model Schools, in which teachers were appointed from outside Kotra as there were not sufficient applicants from amongst the locals. On joining their duties, these teachers found the bogey of "sons-of-the-soil" (*bhumiputra*) demand raised against them. Some of them were beaten up and they fled. Others were stoned. Some who fought back were even murdered. In his own words, approximately 50% of the teachers in the state run schools do not go to teach. He wanted to bring them to book and stop their salaries, but for that action, he needed a certification from the *Sarpanch*s of the villages that the teachers did not go to the schools to teach. This magic piece of paper was impossible to secure because the *sarpanchs* would ask for and settle with bribes from the errant teachers for the favor of not issuing the certificates concerning their negligence of duties.

[21] Incident narrated by Gaurishankar, CARE FO.
[22] This incident occurred on the afternoon of 23/6/02 while driving down from Abu Road to Kotra with Umashankar, CARE FO.

The BEO pointed out that sometime ago, there was a proposal to set up a cement factory in Khajuria, and this would offer employment opportunities to the tribals, but the plans was subverted due to an agitation by the tribals. The agitation rested on arguments that the ground on which the cement factory residential colony was planned was fertile agricultural land, the plant would contaminate the water sources in the area, etc.

The Block Development Officer (BDO), one Mr. Pandey, told this consultant that in Kotra, the entire *panchayati raj* system (local self-government system) has become so faulty that it is difficult to count the faults. He said that poverty was so extensive that it had let led to a strange and distorted mindset. Though the tribals might not have anything to eat, yet they did not want to work. The men prefer to lie around in an intoxicated daze while the women do all the work – in the homes as well as in the fields. He said the writ of the government does not run in these parts (*yahan CRPC ya IPC nahin chalti hai*). Altercations are settled by their tribal *panchs* (mediators) who work on a commission basis for favoring one party or the other through their decisions. Sometime ago the tribals had killed a policeman and they let his corpse rot in the sun, demanding from the government an amount of rupees two lakhs as a compromise to let the government remove the body and hand it over to the family. The incident had so demoralized the police force in the area, that it was difficult to get any policeman to do his duty in Kotra. The government in a bid to promote the use of non-conventional energy resources had solar electricity kits installed in select villages at subsidized rates. These solar kits, worth rupees 25,000 were made available in Kotra for rupees 350. Soon thereafter, the tribals broke up the contraptions and threw it away. He told the present consultant tongue-in-cheek "*jo yahan sudhar karne aata hai, khud hi sudhar ke chala jata hai*" (he who comes here to make changes, changes himself and goes away).[23]

A representative of a partner NGO told this consultant that the tribals were bound by their own social customs and these were inhibiting development. When the manufacture of disposable plates made of *palash* leaves locally available in abundance (*donae-pattal*) was suggested to them as an alternate income generating activities, they agreed, but as soon as the back of the NGO representative was turned, they conferred amongst themselves and said, "this is the work of low caste people like *kaalbeli* and *jogi*. We are not low caste. Why should we do this work?" The NGO representative maintained that the tribals are not bad people but they are incited by vested interest groups whose interests would suffer if the tribals had access to development. He opined that interest for development and awareness was growing amongst women ward *panchs,* they had started attending meetings without husbands in tow and had begun to demand the allowance granted to them to attend these meetings. Some attempts to install *Lok Adalats* had been undertaken, but these were now defunct.[24]

Kotra, for these reasons is known in local parlance as "*kala paani*" (externed area) and is believed to be a dangerous area. Government servants are sent to Kotra on "punishment postings" and such hard-boiled cynics are, ironically, exhorted to work selflessly and with dedication!

The notion of *vair* :

Central to the tribal existence, is the notion of *vair*. The word *vair*, literally translated, means "revenge"; yet to the tribal, the meaning of the word *vair* goes far beyond its literal translation.

[23] These conversations with the BEO and the BDO were held on the evening of 23/6/02 in Kotra.
[24] In conversation with Nanalal Meena in Kotra.

REVENGE INSTITUTIONALISED:

The concept of '*vair*' not only holds that the aggrieved has the right to punish the offender as per his own conscience based on equity (equity here is construed very subjectively), but it also institutionalizes this system of justice by specifically allocating a "season of revenge". A month long period in the Spring Equinox, around the time of the Hindu festival of *Holi*, is culturally designated as the time for *vair*. Drunk and in a rumbustious mood, it is the time for the tribal to settle old scores with his enemy. A large number of criminal and anti-social incidents take place in the season of *vair* while the law-enforcement machinery looks the other way.

Historically, never well integrated in the state structure, they have always remained somewhat anti-state in their attitudes. Their expectations from and experiences of the state have never been that from a friendly, welfare-oriented, development promoting organization. Leading the lives of hunter-gatherers and traditionally following a migrant lifestyle (though some of them are moving toward settled lifestyles now), they have a close affinity with the forests and have always considered the forests as their habitat. They know the hills and valleys as also the forest pathways like the back of their hands. They gather their food and herbal medicines from the forests for sustenance. Hence, they cannot comprehend, nor appreciate, the reasons for state intervention in their lives, as for example, intervention by the Forest Department or the Health Department or the Women and Child Development Department etc.

Even the British colonialists, with a flair for reorganizing and ushering in a uniform administrative system failed to impose upon them the desired uniformity and declared the tribal area as different and distinct administrative units. It was in the colonial era that they gained the disrepute of being included in the government list of "Criminal Tribes". The tribals on the other hand could never fully grasp the intricacies of the British administrative system. Being illiterate, poor and nomadic in their lifestyles, their inherent response, in any crisis, is to avenge and flee. In the colonial past, whenever a criminal incident occurred in a village, the village policeman would head for the nearby tribal encampment, pick up a few of the men folk for questioning and brand a couple of them as criminals apprehended. This was the local policeman's shortcut to the completion of target records, maintained in the *thanas* (police stations) in registers under headings such as 'Crimes Committed' and 'Criminals Apprehended'. Being poor, illiterate and completely at sea *vis-à-vis* the government's administrative and judicial structures, the tribals quickly succumbed to the "interrogation" (read "strong-armed tactics") of the police, pleaded guilty of the charges and went on to serve sentences.[25] This trauma concerning the state remains a part of their collective memory to this day and explains the stoning of government appointed teachers, medical and para-medical personnel even today.

A few years ago, a voluntary religious organization named *Dhan Dhan Sat Guru* with headquarters in Hissar, Haryana, set up an *ashram* (retreat) for its own disciples in village Jhadol in Kotra in the BHNP intervention area. The disciples, comprising of both men and women, came in a cyclic rotation to voluntarily serve the poor people in the extreme drought conditions. They went to the huts, clipped the nails of the children, washed their hair, taught them hygiene, propagated polite behavior like doing *namaste*, distributed food and sweets as *prasad* demonstrated the cultivation of wheat, tomatoes, papayas on their retreat grounds, preached the basic unity of all religions, distributed blankets, taught the tribals carpet-making as an alternate income generating activity and the doctors amongst the volunteers treated the sick. Despite these welfare activities, one night, the retreat was surrounded by arrow and spear wielding tribals, intent on murdering them. This incident serves to demonstrate the extreme distrust and resentment of the tribals to any welfare organization – voluntary or state sponsored.

Resentful and suspicious of the state, they do not accept the state-sponsored judicial system and follow their own tribal norms of justice (refer to BDO Pandey's statement that the writ of the government does not

[25] See for instance, a novel in Hindi tiled *Kab Tak Pukaroon* (Till When Shall I Call) by Hindi litterateur Rangeya Raghav.

run in Kotra). Like all primitive tribes, they follow the retributive theory of justice and believe that the aggrieved person has the right to "punish" the offender. To bolster this "eye-for-an-eye and tooth-for-a-tooth" justice system, as a reference group, they have their group of tribal elders called *panch*.

VAIR Vs. DEVELOPMENT

Kheda was a model village; a triumphant and resplendent example of a successful BHNP intervention, a shining star in the firmament of CARE Rajasthan, until tragedy struck!

In a tribal marriage, one participant, under the intoxication of liquor, in a reckless mood, knifed another participant and then all hell broke loose as the community resorted to the application of the principle of *vair*. The knifed man died and the stage was set for an avenging murder of one member of the opposite party. A successful grain bank was functioning in the tribal quarter of the village and the women members of the SHG collectively carried the grain storage bins of considerable weight and hid them in the houses of the Rajput quarter. Fortunately, they were portable bins and so they could be transported and hidden. Had they been made of bamboo and mud in indigenous style (as they are sometimes made), it would have been impossible to transport them. They would have been subject to loot or they would have been burned down. As tribal violence and revenge escalated, the government machinery looked the other way. The FOs of CARE and the partner NGO looked on helplessly as the tribals caught in the crossfire of *vair* took to the hills and the forests, sleeping away from their homes at nigh to avoid becoming victims of *vair*. There was no question of reasoning things out with them. There were just no takers. The notion of *vair* had to run its full gamut. There just had to be an avenging murder. This consultant visited Kheda village on 9th. May 2002. The model village lay in shambles. The only hope was a tribal *panchayat* (tribunal) for which everyone was waiting. It could only be called when both parties would have run the full length of violence and when they were mutually agreeable for the tribunal.

At the time of writing this report, the monsoon had set in. The villagers wait for the rains the year through, but this year, in Kheda, the fields had not been prepared. They had not been ploughed, there was no sowing and consequently there would be no harvest. The village, so lovingly and proudly nursed by the BHNP would once again face food insecurity.

Occasionally, in serious matters, tribal culture enjoins that one need not wait for the designated season of *vair*. One such incident took place in Kheda village in Kotra block in the BHNP intervention area. The village consisted of two sections – a Rajput section and a tribal section. These inhabitation tracts were not contiguous, but were separated by a small distance from each other. The tribal section had approximately fifty houses. The Drought Relief program of CARE had been instrumental in constructing some ninety check dams and anicuts in the area along with two hundred *gullies* and *nalas*. As the groundwater recharged, the wells in the village filled with water. In the previous season, the village devoted five thousand hectares to the growing of fodder for the cattle. Each fodder-growing farmer reaped in an income of rupees one thousand to fifteen hundred. Forty farmers in the village were given seeds for the cultivation of pulses. For every three quintals of seeds sown, the farmers recovered eighteen quintals at harvest time. Thirty families were given gram seeds to grow. Six wells in the area were deepened and a structure was constructed for the animals to drink from (*nari nirmaan*). Twenty-five farmers were encouraged to grow ginger and together they produced a total of fifty tons of ginger – two tons per farmer on the average! There is no electricity in the village and the farmers ran water pumps in the wells on diesel on a contributory basis. Nor was the village linked by road, the nearest road terminal being Vaas, a four kilometers away. The SHG in the tribal sector, a year old, had collected a capital amount of rupees 28,000/ and loaning and recovery of small amounts to members was well underway.

Kheda was a model village; a triumphant and resplendent example of a successful BHNP intervention, a shining star in the firmament of CARE Rajasthan, until tragedy struck![26]

[26] Kheda Village was visited by this consultant on 9/6/02.

In a tribal marriage, one participant, under the intoxication of liquor, in a reckless mood, knifed another participant and then all hell broke loose as the community resorted to the application of the principle of *vair*. The aggrieved party brought out its arms, looted the houses of the offending party and set fire to the houses. The offending party responded likewise. The knifed man died and the stage was set for an avenging murder of any member of the opposite party. A successful grain bank was functioning in the tribal quarter of the village and the women members of the SHG collectively carried the grain storage bins of considerable weight and hid them in the houses of the Rajput quarter. Fortunately, they were portable bins and so they could be transported and hidden. Had they been made of bamboo and mud in indigenous style (as they are sometimes made), it would have been impossible to transport them. They would have been subject to loot or they would have been burned down. As tribal violence and revenge escalated, the government machinery looked the other way. The FOs of CARE and the partner NGO looked on helplessly as the tribals caught in the crossfire of *vair* took to the hills and the forests, sleeping away from their homes at nigh to avoid becoming victims of *vair*. There was no question of reasoning things out with them. There were just no takers. The notion of *vair* had to run its full gamut. There just had to be an avenging murder. This consultant visited Kheda village on 9th. May 2002. The model village lay in shambles. The moral authority of the partner NGO ran high enough for a few fearful women to emerge from their hiding to interact with the consultant. The only hope was a tribal *panchayat* (tribunal) for which everyone was waiting. It could only be called when both parties would have run the full length of violence and when they were mutually agreeable for the tribunal.

At the time of writing this report, the monsoon was about to set in. The villagers wait for the rains the year through, but this year, in Kheda, the fields had not been prepared. They had not been ploughed, there was no sowing and consequently there would be no harvest. The village, so lovingly and proudly nursed by the BHNP would once again face food insecurity.

So much for money invested in Kheda, so much for the democratic functioning of the SHGs, so much for the empathy and labor of CARE FOs and the partner NGOs.

A FEUDAL BLOCK CALLED REODAR:

Reodar block in Sirohi district, is very different in social composition, economic prosperity and development requirement as compared to the Kotra and Salumber blocks, which are predominantly tribal or Mavli block, which is semi-urban and part agriculturalist or Abu Road block, which is a combination of semi-urban and tribal settlers.

It is, therefore, a matter of surprise, that, the commonly agreed program of BHNP II could be implemented with equal success and facility in such disparate blocks. The idealism of the BHNP II team, their untiring efforts, their minute and constant supervision, their attitude of empathy towards to welfare of the local communities and above all, their patience, stands to be commended that an inter-sectoral project like BHNP II with myriad components could be implemented in such disparate geographical segments.

Resting in the shadows of the highest ranges and peaks of the Aravallis, just 90km. or so from the international border, stands the Reodar block. Reodar is frozen in time, in feudal India, where time has stood still.

CAPTIVATING THE “RAIN GODS”.

These entire districts of Udaipur and Sirohi are frequently plagued by the failure of rains. Apart from the tribals, the area houses a large number of Jain shrines, monasteries and temples. During one such period of drought, the grapevine amongst the tribals had it that the Jain monks had captured and kept captive the 'rain gods' in their temple and hence there was no rainfall. A group of tribals approached a Jain temple, accused the monks of keeping the 'rain gods' captive and demanded to have a look inside their temple. The monks refused to let them in, saying that this would violate the sanctity of their temple. This convinced the tribals even more that their accusation was justified. Just to get rid of them, the monks told them 'Go home. Tomorrow it will rain'. As luck would have it, it rained the next day!! The tribals are now convinced more than ever that the Jain monks keep the rain gods captive and can precipitate rainfall at will by releasing them. The years in which the drought sets in, are also the years of escalating tension between the tribals and the Jains in the area.

Agriculturally, Reodar is far more prosperous than the other BHNP II blocks. It boasts of three crops a year while in contrast Kotra and Salumber could be considered fortunate if they were able to produce even one good crop a year. It is a predominant area for the farming of tomatoes, which is exported, through contractors, largely to Bombay. It is home to a large number of religious minded Jain industrialists who have shifted their base of operations and financial inputs, to Bombay. Yet these industrialists like to retain minimal links with their ancestral place of origin. They retain their ancestral homes, maintain the old structures, and sometimes build spanky new homes which lie vacant for the major part of the year, in the charge of caretakers. True to the customs of Indian feudal notables, they return to these ancestral homes to solemnize the marriages of their offspring's and for other socio-cultural events. Consequently, Reodar is dotted with impressive structures, farm houses, *gaushalas* (homes for destitute cows) built over acres and acres of property and any number of temple structures. These rich Jain business houses believe in philanthropy, not development. They will happily open their coffers for temple-building activity, creation of water points, alms giving, supporting vassals and retainers through pay rolls while at the same time financially contributing towards marriages of their children etc. Yet they will have nothing to do with formation of SHGs or CGBs. The extent of their prosperity can be gauged by the fact that the area is dotted with boards and hoardings announcing *piaus* (drinking water points), *dharamshalas* (free or minimal cost residences for travelers), temples or *gaushalas* (homes for destitute cows) built by this or that "Sanghvi".[27] Names of industrialists like Bharat Shah, K.P.Sanghvi and Bhairmal Hakmaji (of Montex pens fame, the advertisements of which appear regularly on various TV channels), are household names. Reodar is the general area where "Sanghvis" come wholesale!

The local population consists largely of caste groups who have traditionally served as the retainers and vassals of the above-mentioned feudal lords. They include *Rajputs*, *Purohits*, Muslim artisans of the *Silawat* sect specializing in the carving of stone idols for temples etc. The vulnerable communities consist of the indigenous people *Bhils, Kolis, Meghwals, Tooris* (the *dholak* players), *Mehthars* etc. Most of the vulnerable segments of the population are landless and work as agricultural labors, earning their livelihood through share-cropping, getting 1/6th. part of the cropped grains as their share. The social structure is heavily caste laden and so stratified that it is difficult to organize the local populace for common economic or developmental ends. To them, maintaining the caste structures is more important than economic betterment or development.

[27] A 'Sanghvi', is a title bestowed to a rich but religious minded Jain businessman who has conducted a Sangh. A Sangh consists of a large group of devout Jains, consisting of an average five hundred members or so, who are packed into buses and taken on a pilgrimage of one hundred and one Jain pilgrimage spots, all at the expense of the Sanghvi, who thereafter shuns active economic life to live the life of a kind of *sanyasi*.

Working in the above-mentioned situation can pose a challenge even to the most highly motivated or experienced NGO. The partner NGO of CARE in Reodar is SARD (Society for All Round Development), a three year old NGO with 11 paid workers and 11 voluntary workers. CARE's search in the area for more NGOs yielded a blank. While the scope for NGO work in the area is abundant, the expected achievements can only be slim, under the enumerated set of circumstances. SARD is no exception to the rule. Nevertheless, the organization has been instrumental in forming strong SHGs and Mother's Committees, as in Sonela and a few CGBs.

The theory of Social Capital, as propounded by the French cultural theorist Pierre Bourdieu,[28] American sociologist James Coleman[29] and more recently the High Priest of the theory Robert Putnam,[30] finds its practical application in Reodar. The theory of Social Capital, is today proclaimed by the World Bank as "the missing link in development"[31] and has become the subject of a flurry of books and research papers, including some on India.[32] Simply put, this discourse on development holds that, social relationships constitute resources. It refers to the 'trusts, norms and networks, that can improve the efficiency of society by facilitating coordinated actions.' It is this reasoning which has resonated strongly amongst World Bank specialists, who have by now, devoted a good deal of energy to demonstrating that, 'membership in groups' is 'good for people.' Trans-national development agencies, like CARE too function on similar principles, and this accounts for the emphasis on group formation activities like SHGs, CGBs and VDFs. It also accounts for the emphasis on training and exposure as instruments for group cohesion.

The theory of Social Capital would explain why Reodar, located in the proximity of some of the most underdeveloped blocks like Kotra, is nevertheless, comparatively better off than them in terms of economic development. Industrialists and businessmen, who originated from Reodar, have left the region, but continue to return to it for family regions, sentimental reasons and cultural reasons and religious reasons. They continue to invest some money in the block, though not for developmental reasons. They constitute the 'linkages' and 'networks' which empower the local community, which does not feel an urgent need to democratize or revolt against the traditional power structure. The social structure of the block might be feudal, it might not be very democratic, but there is no great dearth of alternate income generating possibilities. Reodar, thus, is a block which is rich in Social Capital and this is apparent even to the most casual observer.

In these difficult blocks, in these difficult times, ran the BHNP II project, buoyed by the zest and enthusiasm of its youthful and flexible team, the idealism and motivation of its partner NGOs and the hope which ran high in the hearts of the village women who formed the numerous SHGs -- all running in the face of government cynicism.

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[28] See P. Bourdieu 'The Forms of Capital' in J. Richardson (ed.) , *Handbook of Theoryand Research for the Sociology of Education,* Greenwood Press, New York, 1986.

[29] J. Coleman, 'Social Capital and the Creation of Human Capital' in *American Journal of Sociology*, 94, Supplement, 1988, pp. S95 – S120. .

[30] R. Putnam, 'The Prosperous Community: Social Capital and Public Life', *The American Prospect*, 13, 1993,pp.35-42.

[31] See World Bank Social Capital Homepage.

[32] See H. Blomkvist and A. Swain 'Investigating Social Capital and Democracy in India', Economic and Political Weekly, XXXVI, 8 (February 24,2001). Also, series of articles by columnist Swaminathan S. Anklesaria Aiyar in The *Sunday Times of India*, May-June 2000.

Chapter 4

HEALTH AWARENESS GENERATION CAMPAIGN

Though the scope of the 'Building on Health and Nutrition Project II' (BNHP II) is wide and encompasses at least four broad constituents, this chapter will specifically focus upon the awareness generation campaign relating to the practicing and propagating of positive health behavior amongst the local communities. The other three components (the formation and effective functioning of *Self-Help Groups* (SHGs) as the watchdogs of community interests, the creation operationalization and successful functioning of *Grain Banks*, and the formation and effective functioning of *Mother's Committees*) will be taken up for specific and detailed treatment in subsequent chapters. However, references to the other three components will crop up occasionally as all the components together, form the cohesive project.

Since this chapter chooses to focus primarily upon the health related interventions, it is necessary to mention that the **first round of health related awareness generation campaign** promoting the practice and propagation of positive health behavior was completed by January 2002 across the entire project area. The second round of the campaign had also been completed in the villages of Reodar, Abu Road, Mavli and parts of Salumber and Kotra. The remaining campaigns were planned in June 2002 and the present consultant was witness to and participated in some of these activities.

DETAILS OF THE AWARENESS GENERATION CAMPAIGN:

As mentioned earlier, the 'Awareness Generation Campaign' centered on health and nutrition.

It's components included immunization drives against polio, smallpox, administration of tetanus vaccines to expectant mothers, raising of nutritional levels as the first step towards better health, encouragement to pregnant and lactating mothers to avail of the nutritional food being supplied under the WFP and by CARE, which is distributed through the local *Aanganwadi* centers, encouraging the breast-feeding of babies up to 6 months of age and thereafter the gradual inclusion of cereals in their diets, combating local breast-feeding practices which included the squeezing out and rejection of the initial drops of breast milk containing immunizing agents and feeding the baby goat milk instead, encouraging mothers to breast-feed the new born babies one hour after birth, encouraging the community members to take ailing women and children first to the ANM and thereafter through a referral system to a doctor and not patronize the local witch doctor (*Bhopaji*), encouraging pregnant women to consume vegetables in large quantities as against the staple local diet of maize flour cooked into bread, or boiled with buttermilk into a thin gruel, maintaining cleanliness and hygienic conditions around their huts and in the village etc.

MOBILIZATION & AWARENESS GENERATION THROUGH FOLK MEDIA:

It was observed by the consultant that the song and dance and the puppet shows in local dialect by folk artists generated unprecedented group interest, so much so, that many children were literally gawking open mouthed at the proceedings. Even the village dogs joined in curiously in all the excitement!

As mentioned elsewhere in this report, Rajasthan has traditionally been the land of pageantry and grandeur which has, since times immemorial, been reflected in its puppetry, performed after sunset under starry skies. The local communities, class no bar, relate very intimately with these shows.

The troupes of folk artists commissioned, consisted of five to seven men. They were commissioned under the directives of CARE by the partner NGOs and consisted of local artists who practiced puppetry. After

being commissioned, they had received training at the *Bharatiya Lok Kala Mandal*, Udaipur,[33] and were specifically trained to create and send home health related messages in an enjoyable and culturally welcome manner, sometimes, even a rustic manner. There also existed a payment rate for every performance.

The messages transmitted in these shows appealed to different audience segments at different times, in the course of the performance though their overwhelming message centered on health and nutrition. The audience remained transfixed and watched with total participation. The success of these shows can be judged by the fact that, in the past, as the villagers turned out in full strength to watch these shows, their houses had been burgled in the darkness of the night!

Of particular interest, was the fact that slogans like *Bharat Mata ki Jai* (Hail to Mother India) were joined by slogans like *uttam swasthya dev ki jai* (Hail to the god of perfect health!) and *uttam poshan dev ki jai* (Hail to the god of perfect nutrition!) It was the first time that this consultant was hearing such incantations![34]

The shows performed by folk artists ran along the following lines:

In the evening, after the people had returned from the fields, after the evening meals were over, the folk artists would locate themselves in the AWC or the village school or simply in a village clearing and begin a loud drumming with their traditional drums – the *dholak*. This was a kind of prelude to indicate that a show was in the offing. The first to contribute towards the formation of an audience would be the children. While one member of the performing troupe would beat a rhythmic beat from the *dholak* and start a *bhajan* (a religious hymn), two others would busy themselves in the erection of an impromptu stage, while another two of them would get busy dressing – one of them as a man and the other as a woman with garish make up, brocade clothes etc. Fleeting glimpses of these dressed up artists, in the light from gas lanterns, would create a sense of anticipation and excitement, bordering on tension, amongst the audience gathered for the show.

The hymns would be followed by secular singing on traditional themes and the songs would begin with a " hara…ra…..ra….ra…..ra…..ra….ra …..rah!" in the traditional rumbustious Rajasthani manner. Then the singing would imperceptibly move to health related messages like –

Teekakaran khusi ka mole; usmein karma kabhi na bhool
(Vaccinations ought to be taken happily, never forget the schedules),

Garbhwati mahila nee chave; leeli bhaji khoob khave
(A pregnant woman ought to eat a lot of green vegetables).

Sometimes, to prevent the men from feeling left out of the entire hullaballoo, there would be a modified version -

Garbhwati mahila ne chave; leeli bhaji khoob kavave
(One ought to feed a pregnant woman lots of vegetables),

Aanganwadi jaano hai; poshahaar khano hai
(Have to go to the *Aanganwadi* center; got to eat the supplementary nutrients),

Joonhi hove paanv bhari; tetanus ka teeka lagvave
(As soon as a woman gets pregnant, the tetanus vaccine ought to be administered),

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[33] As mentioned in the chapter titled "Introduction", *Bharatiya Lok Kala Mandal*, established in 1952, is an institution which works for the preservation and popularization of the unique popular culture of the region. It has a Research Center, has published 54 books and reference tracts related to the subject. It is a well known institution in the world in the field of puppetry and allows the affiliation and training of students involved in the study and practice of puppetry.
[34] These Folk Shows were witnessed in Udakhera, Keltara and Bayana.

Pehla doodh jo baccha peeta; voh nirogi ho kar jeeta
(The baby which has the first drop's of its mothers milk lives to be a healthy individual) etc.

This singing is a time filler for gathering the audience and as the singing progresses, a sizeable audience collects.

Next, the artists dressed as a man and a woman, perform a couple dance in which they resolve through the songs to go to the AWC and eat the supplementary food.

This is followed by a skit, in which the couple talks of maintaining hygiene, cleaning up the area around the house and the man scolds the woman for being lazy and unmindful of cleanliness. Together, they pick a little boy from the audience, pull him up on the stage and go through the motions of giving him a bath. **By now, the audience identification with the themes and the cause is complete.**

The man goes to work in the field and after a while, the woman carries his lunch to the field. Finding some moments of privacy, she informs him that she isn't well and feels nauseated. She goes through a few very convincing retching and vomiting noises and the husband goes to call the *Bhopaji* (the witch doctor). A lot of rustic shouting and conversation follow. The *Bhopaji* takes his time to hike up his price but nevertheless arrives in the end with iron chains for exorcism, to examine and announce that he is ready to treat her. With bloodshot eyes, he goes through the exorcism ritual but after he leaves, the woman doesn't feel any better.

In some performances, the *Bhopaji* advises the husband to take her to the ANM
In other performances, the obscurantist *Bhopaji* is replaced with an elderly village woman who has lost her buffalo. Amidst lots of rustic shouting in calling the buffalo and conversing with the visiting husband, she advises the husband to take the wife to the ANM. All ends happily thereafter

Next, a deep baritone voice comes over the public address system and announces 'When I say three, you must clap'. He proceeds to say 'One…..Two…..Three' and everyone claps. Innocent jokes are shared; by now almost the entire village has joined in and audience participation is complete. They are watching with smiles on their faces. The village children are transfixed, clapping and in complete identification, though there is a somewhat free flow of audience – people coming and going, new ones joining in etc.

Next, a stick puppet (with a long flexible neck), appears over the curtain. He asks the audience 'Will you like to have *gur* (jaggery)?' Everyone says 'Yes' in unison. 'Will you have *batasha* (white puffed balls of sugar)? 'Ye-e-e-s'. Will you have *laddoos* (an Indian sweet)? 'Ye-e-e-s'. 'Will you like to have stones?' Half the audience, lulled into a routine response says 'Ye-e-e-s', while the other half says 'No-o-o' and there is good natured laughter all round.

The stick puppet disappears and a small moppet (puppets worn on the hand as gloves and manipulated through the moving of fingers), dressed as a small schoolboy, called Gobla, appears over the curtain. He calls to another friend to say that the school is closed, he is bored, so can they play together? The friend, joins him, they play for a while and then there is a squabble between the two boys in which Gobla gives his friend a few resounding slaps. The audience roars with laughter and the friend sets up a loud wail. The friend's mother (another moppet dressed as a woman) appears and thrashes Gobla. More laughter all around and now Gobla sets up a whimper. Gobla's mother Gangu Bai arrives, there is a quarrel between the two women and Gangu Bai demands why the other woman beat up Gobla. More cacophonous quarreling ensues and the AWW intervenes to separate the two women. In the end, the friend's mother asks Gangu Bai how come Gobla is so strong that he beats up other boys. Gangu Bai says that when she was expecting Gobla, she regularly visited the AWC, had supplementary food, took the vaccines etc.

By now, Gangu Bai is being addressed by various names to denote the other women of the village. Gangu Bai advises all the women present there to practice and propagate positive health behavior and the *natak* ends, happily for all.

HEALTH MELAS:

To achieve the project objectives, health *melas* (fairs), are organized and Nutrition and Health Days (NHDs) are held at least once a month. The present consultant attended both the health *mela* as well as the Nutrition and Health Day (NHD) in different places. While the NHDs highlighted the immunization drive and proceeded with the weighing of children below two years of age to identify malnutrition cases, they also followed a referral system, in which severely sick children were advised to be taken to a doctor in a nearby but bigger village or township.

THE REFERRAL SYSTEM AT WORK.

This consultant was witness to a poignant incident in which a tribal woman approached the group of NGO workers, CARE representative and the crowd of local women and children gathered in the primary school campus where the NHD was being held. She complained that she had to go twice a day to fetch water for the household requirements and did not see how she could do it in view of the fact that she had two tiny twin babies whom she could not leave alone while she went to fetch water. She said that God had given her these tiny babies and they had to be reared somehow, but fetching water was a big problem for her. The babies might be bitten by a field rat or a dog inside her open hut in her absence.

The crowd collected there explained to her that we weren't exactly the 'water people' (though CARE has undertaken the deepening of some wells to alleviate the water problem, there are other NGOs, working specifically towards the alleviation of the water problem in the area, such as 'Wells For India, UK'), but that we were the 'health people'.

The women gathered there enquired if she had got her babies weighed to ascertain their health and nutrition levels. When she answered in the negative, they motivated her to bring the babies there. She disappeared and reappeared in a short while with two tiny bundles wrapped in filthy rags. We asked her how old they were and she said they were 7 months old. When they emerged from the bundle, they did not look a day more than 3 months. The first of the babies was, of course, underweight, but nevertheless, in reasonable health. The second of the babies was covered with boils, some of which had made the skin raw. The entire head was covered with raw skin, there were big abscesses behind the ear on the neck and the baby looked positively sick. The crowd collected there was moved by the suffering of the baby and I could not help but wonder if it was a somewhat advanced stage of primary complex. This meant that the baby would not survive without quick and sustained medical assistance. Worse still, it would infect the healthier baby before long. The NGO workers weighed the babies, recorded their weights and referred the sick one to a doctor in a nearby bigger village, but the mother looked so confused and dazed that it was a foregone conclusion that she wouldn't go. Probably she did not have the wherewithal to follow up the referral system either.[35]

Local childbirth practices include the severing of the umbilical chord with a household knife or the scythe (locally known as *daantna*) used for cutting grass in the fields or the axe, which is used to chop firewood. The baby's umbilical chord is then tied up with a piece of rag or a ribbon taken from the midwives plait. Some modern studies on childbirth practices in Rajasthan have claimed that the dry desert climate coupled with the searing sun sterilizes everything that comes in contact with it. The scythes used for cutting grass are generally left on the thatched roof of the hut and are thus automatically sterilized, minimizing the possibility of infections. Nevertheless, it is clear that the local practices leave much to be desired by way of hygiene. In view of this, the Government of Rajasthan has provided to the ANMs and the village midwives a simplified delivery kit called the *'Mamta Kit'* (translated as 'the kit of love'). This kit contains sterilized blades and synthetic sutures. In the Awareness Generation Camps, pregnant women are advised not to have their deliveries at home, to call in the trained ANM or the midwife and insist on the use of the Mamta Kit.

There are some more bizarre practices related to pregnancy and childbirth in this area. A pregnant woman is advised to stop eating everything nutritious. Milk, curds, clarified butter (*ghee*), peanuts, buttermilk,

[35] This incident took place in Udakheda, visited on 5/6/02.

coconut, are all taboo. The reasoning offered is that these foods contained high levels of fat, this fat accumulates on the developing fetus and the baby dies while still in the womb (*baccha jam jata hai*). Only bread and chilies are allowed and that too, not too much of it. This low nutrition diet is to be coupled with a regimen of hard work like grinding flour on grinding stones, chopping firewood etc. to facilitate the movement of the fetus. After delivery, the woman is kept on a special diet of bread made from seeds of grass. No herbal medicines are administered. There are many more barbaric practices, a countdown of which would be both gory and disgusting. Not a single tradition relating to antenatal or postnatal care is scientific or right in the modern context. It is a wonder how the women stay alive after childbirth.[36]

Besides the NHDs, health *melas* were organized for giving a boost to the local level interests and awareness on health and nutrition related matters. The mothers of undernourished children were recommended the use of nourishment-enhancing nutrients distributed by the Government of Rajasthan under the World Food Program (WFP), information was given to them about the distribution of such food through the *Aanganwadi* Centers and they were encouraged to bring back the children to future pre-scheduled Nutrition and Health Days (NHDs) to monitor their progress. Nursing and lactating mothers were given similar information and advice. Information concerning future immunization days was imparted.

Another activity of these *melas* was the slogan writing on the walls of village huts and at vantage points such as primary schools, local shops and the village well, so that these health-related messages may serve as a reminder to the local community about the need to practice and propagate positive health behavior.

In the evenings, a Health Procession consisting of slogan-shouting village children, led by visiting folk artists did the round of the village and after nightfall, this consultant was audience to the dissemination of these health-related messages through indigenous communication methods involving troupes of local folk-artists, using the local dialects and local musical instruments such as a harmonium, *dholak, majira*, etc., drawing upon local forms of entertainment such as puppet and moppet shows on hastily improvised stages and performing in the light of gas lanterns in villages without electricity supply, using a 35kg. battery-operated sound amplifying system, which they sometimes carried on their heads and walked for four or five kilometers into the villages bereft of any communication lines, all in searing 45 to 48 degrees centigrade desert temperature. These interactions have thrown up a wealth of insights, which will be shared in this report.

BENEFITS OF THE FOLK MEDIA SHOWS CONFIRMED.

Apart from the entertainment aspect, in many villages women spoke of the efficacy of the folk methods of communication. In Matasula village I was specifically told that the dissemination of health related information through these folk shows has had a very positive effect on the men folk of the village and that it was through these shows (*natak*) that the women of the village came to know about the supply and distribution of food through the *Aanganwadi* centers. The Aanganwadi worker was indifferent to her official duties and did not distribute the food to the villagers. Armed with this information gained from the folk show, the village women complained to the *Gram Sabha* to dismiss the errant *Aanganwadi* worker. This pressure worked and now the *Aanganwadi* Center runs well. This is one shining example of the maturation and culmination of the Rural Participatory Action.

A REVIEW OF THE SOCIAL REALITY:

1. Initial resistance by secondary target groups.

[36] Most of this information was gathered in a one-to-one conversation with women in village Bilwan in Kotra Block, thanks to the forthcoming initiatives of Shantaben, a local NGO worker and Gallo Bai, the local health worker. Some of it was also collected in conversation with women in Matasula and Kheda.

Without fail, all the NGO workers, ANMs and Aanganwadi workers complained that they had met with tough resistance from secondary groups consisting of older women and the men folk in the initial days of implementing the project.[37] Old social customs die hard and the propagation of new norms concerning health practices generated a wave of resistance amongst the secondary target groups. The new norms concerning health were seen as a rejection of age-old customs incorporating the wisdom of the ages. Consequently, these new practices were viewed as undermining the authority and control of the older women and men over the younger women. As the movement progressed, there was a gradual attrition of this psychological resistance and this made possible a greater degree of success of the project

THE JOGIWARAH STORY.

In Jogiwarah village of Kotra Block, I was told, the husband of an active and trained woman worker, in a drunken fit, egged on by his fellow male colleagues, beat up his wife and threw her out of the house on the charge of disobeying him and undermining his authority through her active participation in the BNHP II. Upon this, fifteen women members of the Self Help Group marched to his house and in an unprecedented show of solidarity, insisted that he take her back. When he stuck to his guns and refused to do so, the fifteen women threatened to leave their respective husbands *en mass.* Upon this the husbands of the fifteen women interceded with the errant husband and thus the matter was amicably sorted out.

Another resplendent example of Active Rural Participation and Solidarity.

Traditionally, women in Rajasthan have been viewed as 'Mothers' – the *raison de etre* of their existence is the begetting of children for the furthering of the race. In such a milieu, the concept of a woman's control on her body as well as on her reproductive abilities just did not exist. In this socio-cultural backdrop, the propagation of the birth control pill, available with the Nurse *behenji* did not go down too well with the men folk. They viewed these birth control initiatives adopted by their women as a rejection of their Rajput sense of masculinity and ability to beget children.

2. Occasional need for an "out-of-town-specialist-with-a-briefcase".

2.1 In many of our interactions with the stakeholders, we would ask the community if they understood well the message, which CARE had been propagating, and if they agreed with it. Most respondents, both from the community and from the partner NGOs agreed that things had improved vastly in the last 4 years, which had been marked by the CARE intervention. In view of the end of the project and CARE's intended withdrawal in the near future, we would ask the respondents if, in the context of the training and capacity building by CARE, they felt sufficiently strengthened to carry the good work forward on their own. Almost all the respondents felt that would be able to carry on, on their own, yet the need for an occasional "out-of-town-specialist-with-a-briefcase" was widely felt, both by the community and by the partner NGOs.[38] Most Field Officers of CARE were of the same opinion. It was widely felt that the first phase, BHNP I was devoted to preparing the ground for the successful intervention by wearing down the local socio-cultural resistance levels through attrition and devising and putting into place effective institutional structures such as the Self Help Groups, Mother's Committees, building responsive attitudes in the *Aanganwadi* workers

[37] The local NGO worker Mini, in Matasula, another representative of the NGO *Manav Kalyan Society*, Mr. Madan Nagda in Matasula and Shantaben in Kotra, all complained of tough resistance by secondary targets in the initial stages of the project.

[38] Mr. Madan Nagda, in his conversation with this consultant in Matasula on 8/6/02 was very confident of carrying on the good work after the withdrawal by CARE. In fact, his confidence was tinged with a slight dose of arrogance, probably because he mistakenly viewed the consultant as a representative of CARE and therefore responsible in an unexplained and illogical way for CARE's withdrawal strategy!
In another meeting of SHG members in Dabok, a woman told me "Of course we will continue to work but occasionally we need people from outside, like you, to come and tell the villagers how to develop positive health behavior. We stay in their midst, they are familiar with us and so sometimes they don't take us seriously". This I thought was a poignant plea for an "out-of-town-specialist-with-a-briefcase", a need which until now was being fulfilled by the CARE Field Officers.

and the ANMs etc. Just when all this had been successfully accomplished, it was time for CARE to withdraw.[39]

2.2 In the course of the last four years that the project had been running, many of the community members, the NGO workers and the Field Officers had developed a comfortable working equation and camaraderie amongst themselves. This consultant found the group dynamics at the grassroots somewhat disturbed as the community bemoaned the severance of the relationship, the Field Officers engaged themselves in clearing their tables and starting a new job hunt and the NGO partners, brave in their resolve to carry the good work forward were nevertheless somewhat apprehensive of the future scenario.

2.3. In view of the above, it was felt by this consultant that CARE should, perhaps, knit into its withdrawal strategy a gradual withdrawal in phases rather than a sudden withdrawal. This would not disturb the community dynamics and contribute towards sustainability.

3. The successful role of local catalysts in the local communities:
Everywhere, the community women, organized in Self Help Groups and as Change Agents, were doing an excellent job of motivating the other women in the community to adopt positive health behavior, micro-economic management, optimize the use of water resources etc. This, to the observant eye of the present consultant, was one area where the capacity building workshops conducted by CARE have been successful. In fact Shantiben of the *Aastha* Center, herself a Change Agent told this consultant that when she hears of an impending delivery, she plants herself firmly in front of the concerned hut, peeps in occasionally to ensure that the health related injunctions are being followed and leaves only after everything is over.

4. Residual efforts to minimize the role of the witch doctor (*Bhopaji*) necessary:
Superstitions relating to health and the role of the witch doctor continue to hold its sway over the minds of the communities. Herein lies the danger of the positive interventionist work done by CARE being partly undone. In a five thousand year old culture, which has always revered the unexplained in mystical terms, in communities where the impact of modern education is minimal, where economic sustainability is sometimes not even sufficient to allow a follow up of the referral system, this is only to be expected.

When the witch doctor (*Bhopaji*) is consulted for medical problems, he first negotiates a price for his services. Then he has a ritual bath for self-purification. Thereafter he calls upon the spirits to possess his body so that he may begin the ritual of exorcising the evil spirits in the patients causing the illness. His body shudders in a trance-like condition and his bloodshot eyes glaze over. In the exorcism ritual, he indulges in self-flagellation with some iron chains, which he carries with himself as part of the ritual. Sometimes he indulges in flagellation of the patient with the iron chains as well. Then he comes out of the trance as the villagers look on reverentially, only to announce that the evil spirits have been chased away.

One of the folk theatres enacted the above scene, but in a progressive act showed the witch doctor advising the husband of a young pregnant woman to take her to the ANM and the *Aaanganwadi* Centre. Since the sustenance of a band of faithful adherents, is an issue linked to the livelihood of the *Bhopaji*, it is a foregone conclusion that no *Bhopaji* in real life will refer his patients to an ANM.

In addition, in some villages, the community was found to be at loggerheads with the ANM and there was a total lack of faith both in the competence of the ANM as well as her motives. This situation is likely to push the local community members to the *Bhopaji*

In the CARE contact villages as well as in the NGO contact villages located on the highways and even on feeder roads, the message concerning positive health behavior has gone home and is likely to last, but in the

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[39] In conversations with Mr. Gaurishankar and Mr. Ajinder Singh, both CARE Field Officers in Kotra and Mavli-Salumber respectively.

villages located in the interior hinterlands, specially in the tribal tracts of Salumber and Kotra, the Bhopaji is and will continue to remain the Ruling Lord of the health scenario.

5. Hesitation in getting the children weighed for fear of the evil eye:
Some of the village women showed a hesitation in bringing their children to be weighed to determine their nutritional levels. The suspicion of the present consultant was confirmed by the NGO worker that the hesitation stemmed from the fear of the evil eye.[40] There is a belief prevalent in the area and indeed large parts of India that if a healthy baby is weighed, then the evil eye falls on him/her and the baby lapses into illness (*nazar lagna*). Such age-old beliefs need to be countered for further consolidation of BNHP II.

6. Ambivalent responses of the community to the ANM and the *Aanganwadi* worker:
The Auxiliary Nurse Midwife (ANM), appointed by the state government, is the kingpin of the health enhancement efforts, by CARE, the local NGO partners as well as the Government of Rajasthan. Different communities had different equations with their ANMs. Some villagers complained bitterly about the incompetence and negligence of the ANM. They said that every injection she administers transforms into an abscess. Further, that she had administered to them iron tablets which had crossed the expiry date and this had precipitated a skin reaction and made them sick. Neither did she ever transmit any health-related information to them. In any case, she lived in another village, which was four or five kms. away. When the consultant suggested that the women take up the matter with the local self-government body (the *panchayat*) the women said that the head (*Sarpanch*) was a loose character debauch and it wasn't safe to approach him. The consultant enquired if there was any woman in the *panchayat*, so that they could approach the *Sarpanch* as a group under the leadership of the woman member of the *panchayat*. The consultant was told that though there was actually a woman member in the *panchayat*, she was no good and that all her official duties were discharged by her husband, who was sound of character. In the end, it was agreed that the community women, led by the woman member of the *panchayat* and accompanied by the partner NGO representative would approach the *Sarpanch* to find a solution to the problem.[41]

Likewise the case of the *Aanganwadi* workers. Some villagers complained that she did not come to the *Aanganwadi* Center, did not distribute the food and perhaps sold it or ate it herself. There have been many incidents of clashes between the local community and the *Aanganwadi* workers and both CARE and the partner NGOs have been called upon to intervene to iron out issues.

At many other centers, the villagers were all praise for their ANMs as well as *Aanganwadi* workers.[42]

HINDU METAPHYSICAL APPEAL FOR AN ERRANT AWW !

A very interesting solution to the above confrontational problem has been found by one of the CARE Field Officers.

In his conversation with an errant *Aanganwadi* worker, Kesarbai, in Kheda village of Vaas Sector, which has a Rajput *phalan* and a tribal *phalan*, following the Indian metaphysical tradition, the Field Officer explained that she must count herself lucky that God had chosen her for the beneficial work of distribution of food to so many needy children and women. This was an act of Divine beneficence (*punya*) in which she was the medium. She was already 40 or so and

[40] In conversation wit the local NGO representative in Udakhera.
[41] This incident took place in Udakheda village on 5/6/02.

[42] In Udakhera the villagers complained against the negligent attitude of the *Aanganwadi* worker, but in Isherwas and Keltara, the *Aanganwadi* worker was taking an active and leading part in all the proceedings and the women were all praises for them.

would one day leave this world and be answerable before the Almighty. It was better that she did not enter into a conflict with the community, but rather tried to serve it. That conversation changed the *Aanganwadi* worker forever and today she is both a faithful worker and a reporter.[43]

7. Need for a greater effort in the area of water management:

Though CARE has successfully worked towards the deepening of wells, propagated the effective management of natural resources and undertaken the building of small check dams for recharging the ground water, the drought conditions and the failure of rains in the past few years has resulted in a dipping of the water table. This has led to an acute water crisis and women are forced to carry every drop of water for household needs in pots on their heads for 3 to 5kms. often up gradient over hillsides. Every community visited, without fail, complained of water shortage making their lives more difficult. However, in exceptional situations, where water is available through deep boring, the ground is very fertile, abundant cultivation of vegetables is possible and even community kitchen gardens can be sustained, as in Kheda, Matasula and Bilwan.[44] Clearly, a lot of work remains to be accomplished on that quarter.

8. Acute need for veterinary doctors felt:

In the absolute absence of alternate income generating possibilities, farming and livestock are the only two livelihood options available to the local communities. While drought conditions have made both these livelihood options extremely precarious, complete absence of veterinary support has only made the situation worse. A buffalo can be bought for Rs. 10,000 to Rs.15, 000 depending on its health and milk yielding ability. Therefore, when a cattle head dies in the absence of veterinary support, that is the amount an impoverished family loses. In addition, it is bereft of nutrition through milk.

It is suggested by this consultant that if CARE could enter into an agreement with veterinary hospitals in India as well as in western countries, then some of the interns could offer to do their internships in these communities. Alternately, the framework of “Voluntary Service Overseas Programs” in European and American Universities and a CARE partnership could bring skilled veterinary doctors for service to this much-needed part of the world.

9. The problem of illiteracy:

This consultant noticed the women at some of the SHG meetings affixing their thumb impression on the Attendance Register. Discussions with the NGO workers revealed that even the marginally educated prefer to leave the villages and head for the cities in the vicinity in the absence of income generating and livelihood options. This precluded total sustainability in the area of micro-finance as it involved some account keeping. Clearly, now and for sometime in the future, the NGO partners will have to do the accounting on their behalf.

10. The ingenious and cost-effective use of indigenous nutrients and herbal tonics:

This consultant was pleasantly surprised to find that workers of one partner NGO were distributing supplementary indigenous nutrients manufactured by a well-known Indian company (Dabur) to those children identified as undernourished after being weighed.

EFFICACY OF INDIGENOUS HERBAL NUTRIENTS

[43] This incident was narrated to me by CARE Field Officer Mr. Gaurishankar. Today the *Aanganwadi* worker is not only regular in her official duties, but runs up to Mr. Gaurishankar whenever he is on a round of the village, to report that all is well. Again, in Bilwan, Andubai, the AWW, who stayed far away and could not be regular, was morally persuaded to resign and Jhumli Bai was persuaded to take on the responsibilities of the AWW.

[44] This has been the case in Matasula and Bilwan villages.

There were 10 children suffering from malnutrition in a village visited and the CARE Field Officer explained that since this NGO also dealt in herbal medicines, in consultation with and with the consent of CARE, they were administering indigenous herbal nutrients like *Chyawanprash, Liv 52* and *Isabgol* to the children and *Batisa* (a medicine containing the extract of 32 herbs) for post natal care of selected women.[45]

The Project Coordinator, in conversation with the consultant confirmed that in the JJVS area of work, a little girl in Grade IV malnourishment category was treated with indigenous herbal medicines. Today, the girl is two years old, though she looks like a one year old. Nevertheless she walks and is progressing.

CONCLUSION.

It did occur to this consultant, that, the pattern of scattered inhabitation was the biggest obstacle to development in these parts. This was the underlying cause why the ANMs and the *Aanganwadi* workers, functioning at low levels of motivation, played truant in the face of official duty. It imposed on the government, the objective responsibility of building roads to these clusters of, sometimes as few as one or two huts, extend rural electrification to cover these settlements, provide water resources and build an elementary educational infra-structure through the building of a primary school and the appointment of teachers (who due to the security of service tenures are once again infamous for their negligence and low motivational levels). Carrying forward the torch of development also made it incumbent upon the government to establish *Aanganwadi* centers in these inhabitation clusters, appointing the *Aanganwadi* workers, monitoring their performance, and finally building a sustained structure for the distribution of food through these centers. Only after the above structures fall in place, interventions in areas of food and nutrition, propagation of positive health behavior, provision of alternate livelihood options, improvements in the areas of reproductive health etc. can culminate in effective and sustainable interventions. In the absence of the above structure, all interventionist efforts, even those with the highest motivational levels, like those of CARE and the partner NGOs, run the risk of being reduced to a flash in the pan.

It did seem to the present consultant that a permanent change in the inhabitation pattern, introduced at the behest of the government, could offer one solution out of the quagmire. The Collective Farms established in the then USSR after the Bolshevik Revolution, the communes of Maoist China and the “kibbutz” in Israel, suggested themselves as alternate optional models of development. However, the biggest socio-psychological challenge, in any such reorganization, would be visited upon the tribals of Kotra and Salumber, who follow a semi-migrant lifestyle and would therefore necessarily be subjected to the trauma of relocation and rehabilitation. We now know that, all anthropological and ethnological studies frown upon attempts to tamper with the lifestyles of indigenous communities. The American experience of attempting to alter the migratory/nomadic lifestyles of indigenous Americans (the so called Red Indians), through the Daw’s Allotment Act and transform them into sedentary American “gentlemen” today stands discredited. Consequently, the American government is now playing a lead role in initiating the restoration of specific indigenous lifestyles and cultures through incentives in the organization of pow-wows etc.

Finding a balance between governability and cultural autonomy of local communities while at the same time making the benefits of development accessible to the underprivileged, has remained the perennial challenge of administrators, voluntary donors and non-governmental organizations. Until the final fine balance is achieved, we may say with Robert Frost:

“The woods are lovely, dark and deep,
But I have promises to keep
And miles to go before I sleep
And miles to go before I sleep”

[45] This is being done by the partner NGO Jagran Jan Vikas Samiti, Jaisamand and was witnessed by the consultant in Ghaati on 6/6/02. For more details, see chapter titled “Feedbacks of Team Members and Partner NGOs”.

Chapter 5

FORMATION, SUSTENANCE & SUCCESS OF SHGs.

The formation, promotion and sustenance of SHGs are the 'in thing' in all government and non-government programs today. Forming SHGs is an important mechanism for the advocacy, mobilization and pressure building to demand better delivery of services. For an effective functioning of the government sponsored health and nutrition programs, linking of SHGs with PRIs is an important strategy. This was also a project objective of the BHNP II.

Today, the SHGs formed in the BHNP II area, boast of fancy and poetic names for themselves, often reflecting the local culture, such as – *Durga, Lakshmi, Lalita Samuha* (names of goddesses) in Nichli Subri in Kotra, *Jagruti* (Awakening)and *Ekta* (Unity) in Kalora Phalan, *Madhvaji* and *Paintali Mata* (names of local gods and goddesses) in Dhamsara, *Sonar Mata Mahila Mandal* and *Sheetala Mata Mahila Mandal* (names after local goddesses) in Isherwas, *Gatodji Mahila Swayam Sahyog Samiti* (named after a local god) in Ghaati etc. This consultant asked the SHG members the reason for preference of religious names and was informed that when the groups were being formed, the women were deeply aware that they were beginning an auspicious endeavor. What could be a better way to invoke Divine Blessings than naming the groups after the gods and goddesses? Besides, the names would continue to remind them constantly of Divine Beneficence.

SHGs aware of CARE's impending withdrawal:

When the fieldwork for this project was underway, the SHGs in the villages were all aware of CARE's withdrawal. It had been explained to them that other communities, battling against greater adversities in more trying conditions, needed the support of CARE, just as they had needed it four years ago. This explanation they accepted with dignity and courage.

This consultant interacted with many SHGs and all the groups confirmed their resolve to carry on with the SHG activities, kitchen gardens, grain banks, and practice positive health behaviors even after the withdrawal of CARE. Clearly, the BHNP messages of better nutrition, health, food security, pre-natal and antenatal care of women and infants, vaccinations, hygiene, and economic security was going to last.

This consultant asked the members of many SHGs how they would undertake the account keeping of the SHG funds after the withdrawal by CARE and the partner NGOs, since, in some villages there was not even one literate persons in that SHG. They answered that a federation of villages intended to employ a person capable of maintaining their accounts and pay him though the SHG funds.

This consultant asked if they feared the embezzlement of their dearly collected SHG funds. They explained that since the person employed for the maintenance of accounts did not have withdrawal powers, there was no fear of embezzlement from that quarter. They said that until now, they had reposed faith in the partner NGOs and their faith had been upheld. They presented a shining example of sustainability, yet were saddened by the prospect of losing contact with people whom they had come to trust.

A previous report speaks of the formation of 142 SHGs as part of the BHNP II by the beginning of January 2002. Throughout the remaining calendar year, focus was shifted to strengthening their operational and management systems, rather than the formation of further new units.[46]

[46] Report titled "Building on Health and Nutrition Project (BHNP II), A Short Report on Project Progress till May 2002" procured from the office of CARE Udaipur.

Micro-savings were envisaged as one of the central activities of the SHGs along with health awareness. SHG groups, whose fund pool of small savings exceeded rupees 1000/ were being encouraged to initiate small consumption loans with half the group fund, to meet exigencies such as illness, marriages, buying of seeds, to meet the requirement of grains and fodder, to meet delivery expenses, etc. This was intended to encourage credit and repayment behavior with small amounts amongst the group members, fruitfully engage the idle balance of each group and last but not least to foster a feeling of trust and confidence in financial transactions amongst the group members. In order to ensure a systematic recording of transactions, individual passbooks have been issued and group wise ledgers are maintained. Internal loaning has begun in many of the groups. While the local money-lenders charge anything between 12% to 25% interst on money loaned, depending upon their whims and the severity of the drought in the concerning year, loans from the fund pool of the SHGs can be availed by the members at 2% interest rate. This financial security has contributed considerably to the empowerment of local women organized in SHGs. This consultant met many women who had secured loans from their SHGs and were either in the process of repayment or had already repaid the loan.

Progress in the Formation of SHGs

Self Help Groups (SHGs)	Till August 2001	Till December 2001	Till May 2002
Operational SHGs	99	130	142

Since many of the SHGs lack members educated enough to maintain their own accounts, it is clear that this support will have to be provided on a continued basis by the field workers of the partner NGOs. Many NGO representatives seemed alive to this need of the SHG groups. In the event of the withdrawal by the partner NGOs, plans were being floated that a federation of villages would employ a person capable of maintaining their accounts on behalf of the group. Possibilities of embezzlement of funds by the employee were precluded by the fact that withdrawal powers rested in a committee of three women - President (*adhyaksh*), Secretary (*sachiv*) and the Treasurer (*koshadhyaksh*) – and the signatures or thumb impression of at least two of them was necessary for a withdrawal.

Plans to link up the SHG groups with lead banks and NABARD have been accomplished in some places. This is being done with a view to raising their collateral and starting income generating activities. Banks also have a mandate to link up and promote saving and credit groups at the community level. Both the NGOs as well as the SHG members themselves are likely to sustain the activity for thrift and credit activities, for reasons of empowerment of the village women and for reasons of self-dignity of the members.

In Abu Road, SHGs of women were complemented by SHGs of men. In our visit to Kalora Phalan, the present consultant and the FO were joined by both men and women, organized in different groups under separate SHGs. A board in the partner NGO office in Abu Road, (the *Jan Chetna Sansthan* office), gave an update on the SHGs in the area, as in May 2002, as follows-

Micro-finance position in SHGs under JCS area

All-women SHGs	Rs. 1,30,148
All-men SHGs	Rs. 28,400
Total till May 2002	Rs. 1.58,548

The NGO representative mentioned that initially joint SHGs comprising of both sex were started. In the course of time, it was discovered that many intimate issues, which the women wished to discuss, could not be discussed in a SHG meeting comprising of both sexes as the women felt inhibited by the presence of the

men. Thereafter, different SHGs were organized for men and women. However, in the tribal areas, this problem did not exist as the tribal culture was more liberated in such matters. In these areas, as in Kalora Phalan, **joint SHGs continued to exist**.

Another project objective sought to be promoted through the SHGs was the **propagation and promotion of positive health behavior** related to mother and child health in the community. This was done to strengthen the role of the Change Agents in the communities and included encouragement to the practice of breast-feeding. Community level capacity building of the SHG members in monthly meetings was taken up through Resource Persons specializing in maternal and childcare. NHDs (Nutrition and Health Days) were institutionalized with the support of the SHGs, the weighing of infants, children under three years of age, to asses malnutrition levels are conducted, and records of improvements are maintained. Vaccination drives of both expectant mothers and children are undertaken and safe delivery practices are propagated with the support of the SHGs. Complete enumeration of the communities has been achieved through **Social Mapping**. At the initiatives of the SHGs, often organized in smaller units as **Mothers Committees**, the AWW and the ANMs have been made accountable for their responsibilities.

Fighting the dark clouds of superstition and cultural conditioning:

Some of the tribal traditions and customs, prevalent in the project area, having their roots in superstition, make it extremely difficult to convey to the tribals and to SHG members, logically, the health and development related messages of BHNP II. Since the merging of development related initiatives with local cultural beliefs, as far as possible, is now a well-accepted theory of development, it seems in the fitness of things that a mention of some such beliefs, circulating in the project area and detracting to some extent from the success of the project, should be made here. This however, should not be construed as a plea for obscurantism, but rather as a plea to devise mechanisms for the diffusion of social tensions, the mechanisms themselves being largely drawn from social traditions, such as the organization and encouragement of *Lok Adalats,*[47] presently lying defunct in the area.

VESTED INTERESTS STRIKE BACK:
RUPI BAI'S LEADERSHIP

Rupi Bai, a dynamic tribal woman in her late forties, though well maintained enough to look much younger, lives in Aambaveri Phalan of Chandela village in Abu Road block of Sirohi district. She is an active member of the SHG. The local moneylender of Aambaveri detested the SHGs and the Mothers Committees because these organizations empowered the village women and decreased their dependence on him and his whimsical interest rates. In March, during the festival of Holi, the village women went to him, urging him either to allow them to throw color on him or give them *gur* or money in lieu of *gur* to signify mutual goodwill. The moneylender, who detested these women, however, had a nasty plan up his sleeve. He precipitated a brawl and called in the local policeman to beat up the women! The women retaliated violently and the policeman filed an FIR in the nearest police station. The money-lender and the constable got the *Sarpanch* to certify that there had actually been a brawl in the village on Holi. They got an illiterate local to affix his thumb impression on a paper which said the women had started the brawl. The poor illiterate was tricked and did not know what he was saying through the paper on which his thumb impression was taken! The policemen, through the *Sarpanch* asked for Rs. 5000/ to settle the matter out of courts. Rupi Bai and five other women of the SHG, accompanied by a partner NGO worker, marched to the police station, confronted the Circle Officer, wagged their index finger at him and accused him of asking for a bribe to settle a framed-up case out of courts. At the time of writing this report, the matter rests in court. The SHG has hired a woman lawyer, who is fighting the case on their behalf at minimal cost. Rupi Bai's husband is supportive of her actions. Her eldest son is handicapped and receives a government pension. Rupi Bai declared to this consultant that she would get her daughter-in-law sterilized after she had two children.

SHGs combat superstitions related to vaccination:

[47] The concept of *Lok Adalats* (literally translated as People's Courts), was propagated and adopted by Shri Hari Vallabh Parikh, a Gandhian, through his organization *Anand Niketan Ashram*, located in village Rangpur, block Chota Udaipur, district Vadodra. The organization is more than fifty years old and is held in high esteem by both the local people and the government. It takes into account the possibility of biased decisions at the panchayat level and functions based on moral power. Shri Parikh functions as a *panch*. A Secretary notes cases, fixes dates and defendants are notified through letters. These letters are always respected by the villagers. Mutual reconciliation and token punishments are attempted. There are no judges.

At every SHG meeting attended by this consultant, the SHG members, the local *dais* (midwives), the Change Agents, elsewhere the AWWs and the ANMs affirmed that they were practicing positive health behavior patterns advocated by CARE. This message had very forcefully gone home through the use of the folk media in local dialect. Some women even stated that after the folk media performances, there had been a positive change in the attitudes of the men folk of the community. This signified a degree of success with secondary target groups. Nevertheless, in some places, AWWs as well as SHG members reported to this consultant that older women in the village were against the idea of administering tetanus vaccination to expectant mothers. The dominant superstition was that vaccination of the expectant mother would precipitate a miscarriage. The foreign body, injected into the expectant mother's body, would weaken the fetus and cause it to abort. The elder women would tell the younger women, "Look, in our times there were no such things, I've born eight children in my life; I'm alive, hale and hearty. We needed no such vaccinations, so why should you?"

ACTIVE SHGs IN MAVLI BLOCK.

This consultant was repeatedly told by many SHGs that initially, when BHNP II started, the village women were afraid of the idea of inoculations.

They were incited by older women, not to go in for inoculations, because the local communities believed that inoculations would lead to the death of the unborn babies in the womb and even new born babies. When some young mothers did break out of the cordon of superstition to get their babies inoculated, the babies promptly got fever, as is inevitable after inoculations. At this, the older women could not refrain from saying "we told you so".

There also exists the common belief that if an expectant mother gets herself inoculated (the Tetanus Toxide vaccine), then she is sure to have a miscarriage.

The most regressive incident came from Bajaj Nagar, a village in Mavli Block in Udaipur District. There, the men of the local community, comprising mostly of Bhil tribals, in a drunken fit of resentment, beat up the ANM when she visited the village for vaccinations. Now, a team of women, comprising of SHG members accompany the ANM whenever she visits Bajaj Nagar.

The weighing of babies and the evil eye :

Though the ICDS is primarily responsible for monitoring the growth of children up to six years of age, the data supplied by them can hardly be depended upon. The malnutrition assessment drive of BHNP II included weighing of the children, recording their growth progress and determining their growth status. Thus, 'weight for age' was employed as the index of assessment.

In the course of the field trip and conversation with SHG members, this consultant gathered that in some villages, there was a hesitation, even an aversion to getting the children weighed for fear of the evil eye. It was believed that if a healthy baby was weighed before outsiders, he would soon fall sick, perhaps even die.

Clearly, these are some of the superstitions, born of cultural conditioning which have been detracting from the possibility of a greater success of BHNP II.

The witch doctor (*Bhopaji*) still reigns supreme in the hinterlands :

Many of the villages visited, for consultations with local SHGs were not connected by road and were a few kilometers from the nearest road. These villages were often neglected by the ANMs, who did not particularly cherish the idea of walking long distances in the scorching sun. Transporting the severely ill patients to hospitals was a real problem in these villages. One such village was Kalora Phalan, which,

unconnected by road until very recently, has now built a connecting road for itself through the voluntary efforts (*shram daan*) of the residents. Being connected by a road link has brought many blessings for the village and the residents were highly appreciative of the motivation imparted by the FO and the partner NGO for the purpose.

The villagers of Kalora Phalan told this consultant that in the past, sometimes even now (because transportation by a jeep was expensive), when a fellow villager fell severely ill, they would make an improvised hammock with a tough sheet, place the patient in it, four men would hold the four ends of the sheet and carry him/her over the hills to the nearest point from where a jeep could be hired.

On a visit to the village, this consultant, while sitting in the AWC along with the FO and attending a joint SHG meeting of both the men and women of the village, heard strange singing noises (not musical) accompanied with the beating of a metal gong emanating from one of the huts. On enquiry, we were told that somebody was sick. We walked over to the hut and enquired if someone was ill. A young man emerged to confirm that his wife was ill. We enquired after the problem and ventured a few steps inside the hut. It was the peak of the summer season and in the stifling heat inside the hut, a young woman was lying prostrate on the ground, face down. Adding to the stifling heat was an earthen burner (*chulla*) on which bread was being cooked. The young woman was hauled up by one arm by her husband and brought to a sitting position to be presented to us. Her arm was jerking continually. We were informed that she was expectant and was near the due date, though she did not look so. The jerky tremors were racking her entire body – arms, leg, body – all. The trouble had started that morning and the witch doctor had been called. The family was waiting for him to arrive. This consultant touched her body but she did not seem to have much fever. We asked her to lie down comfortably. The FO informed the family that he had a jeep and would be returning to town soon. If the family wished, they could accompany the young woman in the jeep to town and to a hospital. Before leaving the village, we enquired after the sick woman. We were told that her parents had been informed, they had arrived, they had expressed greater faith in their own *Bhopaji* as compared to theirs and had taken her home. The family seemed much relieved that the young woman had not died in their house for then it would become a case for *vair* – 'you were instrumental in our daughter's death through your neglect of her ailment and so now we must avenge her death'.

The villagers informed us that while the ANM would come and go away if called, the *Bhopaji* would go through the exorcism ritual and sit by until the patient either recovered or died. If the patient recovered, another feather in the cap of the *Bhopaji,* if she died, he would say he had done his bit, the exorcism ritual, but they should have taken her to a doctor![48]

Strong SHGs are having an impact on the functioning of the PRI and making them more sensitive to the needs of poor women and children. Government officials are now interested in using the services of active SHGs and Mothers Committees to help provide effective linkages at the village level for passing on the incentives under various government schemes. The passing of resolutions to make the Mothers Committees as sub-committees of the concerned *panchayats* in many of the partner project areas, has been a step forward in building linkages with the PRI for mother and child health issues.

[48] This incident occurred on 22/6/02 when this consultant visited the village with the CARE FO and partner NGO workers.

THE DESIRE TO PASS ON THE INCENTIVES UNDER GOVERNMENT SCHEMES

The Block Development Officer (BDO), one Mr. Pandey, told this consultant that in Kotra, the entire *panchayati raj* system (local self-government system) has become so faulty that it is difficult to count the faults. He stated that for the tribal areas, there are clearly allocated funds for transportation in the case of institutional deliveries. If the communities wish to, or if they are, alternately compelled by circumstances, to take a pregnant woman to a hospital for a delivery, the government provides an amount of Rs. 500/ as transportation subsidy in each case, subject of course to certain paper work. Most communities are ignorant of these provisions and therefore the funds just lie around idle and unutilized.

Likewise, the BEO of Kotra, Mahendra Kumar Jain, in conversation with this consultant, said that he wanted to bring to book errant and absentee school teachers in the primary and secondary schools, but to take that action, he needed a complaint letter ratified by the local *Sarpanch*. This letter was impossible to procure because the absentee schoolteacher would bribe the Sarpanch, who would sit over the complaint letter and not ratify it.

A number of SHGs have been formed even in the non-partner areas under the ICDS program. The monthly contributions in the SHGs vary from ten to fifty rupees, decided as per the wishes of the members themselves and depending upon their economic capability.

There have been many instances of cooperation, convergence and accountability between the activities of SHGs and the AWCs. This opens the scope for more systematic interventions for the convergence of the role and responsibilities of the two village level women platforms. Exerting pressure on the local health worker and extending cooperation to her during the immunization drives, helping to carry the ANMs kit etc., especially during the monsoons to the villages not connected by roads, has also been reported from many SHGs. At one place, due to the demand of the SHG members, an ANM who was not regular was replaced with another. Several SHGs who were dissatisfied with the work of the ANMs were gearing up to follow the example.

The storage of grains as a SHG measure to fight the persistent food shortage, especially during the summer and the rainy season, has been an extremely popular activity under BHNP II. These **grain banks** are being seen as a much-needed solution to the perennial food scarcity in these parts of Rajasthan. Incentive of the matching amount of grain by the WFP has given an added impetus to the formation of grain banks. Norms and rules for loaning, purchase, interest rates and storage methods have been finalized in consultation with the grain bank members and NGOs.

Encouragement to nurture **kitchen gardens** is mainly serving a demonstrative role. Free seeds are distributed and the women are encouraged to grow around the well area, in some rows of their agricultural lands and near their huts. Matasula, Kheda and Bilwan villages have been successful examples of kitchen gardens, though elsewhere water scarcity continues to be a serious handicap.

Adoption of good and improved variety of seeds is being encouraged in the **seed banks.**

ACTIVE SHGs IN SALUMBER BLOCK

In Sadamanpur, a village in the Salumber Block in Udaipur District, members of the SHG, styled themselves as the *Dekhrekh Committee* and in a sudden and unexpected show of empowerment, dismissed the local *Aanganwadi* worker on charges of unexplained absenteeism. The AWW questioned their powers and jurisdiction, but the members of the SHG proceeded to submit a written complaint to the CDPO and the *panchayat*. As is the case in government functioning, nothing moved and the enraged and affronted members of the SHG proceeded to lock the door of the AWC, drew up a comprehensive list of the dates on which the AWW had not shown up at the AWC and proceeded to hand over the dates of the AWW's absence and the keys to the lock of the AWC to the *Sarpanch*. They categorically stated that they had no need for an absentee AWW and would not let her function in the village. The AWW in retaliation charged that the women beat her up and tried to loot the rations. The SHG members then moved through the Mother's Committee and the *panchayat* to demanded the replacement of the errant AWW. CARE's partner NGO in the area, *Prayatna Samiti* (PS), watched from a ringside seat, occasionally fanning the flames of fury and patting itself on the back. The CDPO held CARE responsible for inciting the women. The FO did a diplomatic disappearing act to let events run their natural course to aid sustainability. Finally, intervention of the CDPO resulted in the AWW ending a written apology to the SHG!

CONCLUSION:

Strong SHGs continue to function in a large number of villages of the intervention area. The capacity building of parther NGOs, undertaken by CARE has been very successful. Though the partner NGOs were, even before their partnership with CARE, very well bonded with local communities, it must be borne in mind that they used to be oriented to the activist mode. In all the cases – Rupi Bai's battle against the corrupt local administration in Abu Road, the Sadamanpur village incident of SHGs sacking the AWW and the SHG members mobilizing themselves to accompany the ANM to Bajaj Nagar in Mavli Block for inoculation campaigns amongst Bhil tribals who had beaten her up before (all three incidents narrated in boxes) – the partner NGOs provided active support to the protesting women, but did not join the battle themselves. One can only guess how much self-restraint they must have exercised in view of their earlier activist approach. Above all, it speaks for the resounding success of CARE's capacity building of SHGs as well as the partner NGOs and their orientation through meetings, workshops and discussions.

Chapter 6

CONTRIBUTORY GRAIN BANKS, VDF & OTHER ANR ACTIVITIES

Two previous chapters titled 'Introduction' and 'Situating The Project" give detailed pictures of the drought situation when BHNP II was initiated.

Suffice it to mention here that, the specter of famine had resulted in large scale death of livestock, brought the local communities face to face with the horrific prospects of starvation and forced *en block* migration of the local populace. The villages were almost empty of people, specially able bodied men and the local NGOs were engaged in relief activities *vis-à-vis* the remaining skeletal population which remained behind. In view of the prevalent situation, it seemed farcical to talk of development, at a time when the very survival of the people was at stake. In that desperate situation, there were hardly any takers for BHNP II health related messages. There were even fewer takers for other related messages like formation of Contributory Grain Banks (when people were actually starving), micro savings etc.

The partner NGOs were also disinclined, hesitant and embarrassed even to talk to the villagers about the collective storing of food or the collection of money in micro savings. They insisted that working on health related behavioral change at the community level was difficult, if not impossible, as the immediate need of the people was food and water.

For these reasons, as mentioned in the introductory chapter, even seven months after its inception, the project just failed to take off the ground. The Log. Frame. just had not taken into account the possibility of a severe drought. Targets remained unfulfilled, budget utilization was low and talks got underway with the donor officials to return the allocations and scrap the project. In the end, one last effort at implementation was agreed upon. For this purpose, a few administrative changes were made, a more flexible approach in the implementation process was agreed upon and after discussions with partner NGOs, the initiative areas mentioned in the Log. Frame were prioritized and a Feasibility Paper was drawn up.

A joint meeting of CARE Rajasthan, CARE India and UNWFP was held to discuss a contingent plan of action.

Two clear components of the Log. Frame. are – Improvement in Health and Nutrition and Improvement in Household Food Security (which included the **deepening of wells, community kitchen gardens, CGBs** – all mandated under the Log. Frame.). As part of the prioritized initiatives of BHNP II, it was decided that **creation of additional water points** should be taken up on priority basis in the drought affected needy villages to provide immediate relief to the local populace.

This was in consonance with the second component of the Log. Frame. The other interventions would be introduced gradually, whenever feasible. **Community kitchen gardens** were to be popularized to supplement the nutritional aspects of the communities while at the same time supplementing their dependence on grains. These community kitchen gardens were initially a by-product and a sequel to the well deepening activity as subsequent to one round of blasting, the waste-water needed to be drained out before the next round and this water was used for fostering nurseries for kitchen gardens in the immediate proximity to the wells deepened.

In this way, the mismatch between the ideals of the partner NGOs and CARE Rajasthan was resolved, the need of the community was met, making it possible to elicit their cooperation and the path was paved for an enmeshing of the efforts of all stakeholders.

For the purpose of structuring and convenience of the selective reader, this chapter has been organized under the following headings –

1. The Community Grain Banks
1.1. The Background
1.2. Capacity building initiatives for CARE officers, partner NGOs and representatives of local communities through training sessions pertaining to collection, storage, maintenance of grains, loaning principles, interest rates and recovery.
1.3. Determining the modalities concerning the operationalization of the Grain Banks.
1.4. Working out the rationale of 30kg. contributory and 30kg. matching grants.
1.5. Storage bins- different indigenous structures and metal bins.
1.6. Use of preservatives to prevent the grains from rotting.
1.7. Turnover of grains in the grain banks.
1.8. Considering the eventualities of non-recovery.
1.9. Initiation of new Community Grain Banks by existing groups.
1.10. Considering the prospects of withdrawal by the partner NGOs.
1.11. Difficulties encountered.
1.12. Sustainability and Future prospects.

2. The Deepening of wells – to meet the basic need of potable water.

3. Community Kitchen Gardens.

4. VDF and *Graam Kosh*.

5. Conclusion.

1.THE COMMUNITY GRAIN BANKS:

1.1. The Background:

Between June and August 2001, the project area received adequate rainfall and the formation of Grain Banks was the highest priority intervention in the month of September 2001 as the harvest was due in October. The CARE team had seen for itself, the magnitude of the food shortages the region experienced, so, even though, the remaining period of the project was short, nevertheless, the formation of CGBs was taken up as a priority in September 2001. Since the objective of the project was to bring about sustainable improvement in the health and nutrition status of pregnant women, lactating mothers and children below two years of age, the establishment of community grain banks was viewed as an important intervention in securing household food security amongst the vulnerable communities in the target blocks. In retrospect, this has also been one of the most successful interventions of BHNP II. Apart from the field visits, even a casual perusal of different reports, brings to light the galloping success of the intervention. While a Graduation Strategy Document,[49] prepared in February 2002 gives the number of Grain Banks formed till then as 52, an Annual Report of BHNP II states that against a total target of 50 Grain Banks to be formed in the project area, 86 had been formed by May 2002. This segment of the project had overshot its own target!

The norms for transaction had been developed in a completely participatory way and the BHNP team members along with the partner NGOs were attempting the sustainability of the Grain Banks as a central institution in the community.

Borrowing of grains from the Grain Banks by members was being widely reported. Complete transparency in transactions was being maintained through the determination and promotion of a normative process. Systematic bookkeeping was being done, accounting for the loans and repayments to each group.

[49] Report titled 'Graduation Strategy Document of BHNP II' prepared by Vandana Mahajan, dated 26/02/02, available in the CARE Udaipur office.

Finally, the preference of the group members was taken into consideration for the adoption of storage methods. Yet, all was not as sanguine when the intervention began.

Based on an analysis carried out by the BHNP team and the partner organizations at the community level, it was noticed that an average household in the project area owned 5 bighas of land, out of which only 2 or 3 bighas were available as arable land for food production due to its productive nature. The rest was used as grazing land. In an average family of 6 to 8 people, in normal rainfall years, the cereals produced (in this case maize) normally lasts for 7 months. One also has to bear in mind the fact that part of the food grains cultivated are sold out in the market to meet other daily needs of the family. Thus, an average poor household faced an overall food deficit of 60 to 80 kilograms per year, beginning from May until next harvest i.e. for 5 months.

This food shortage is partially met from wage labor earned through migration. However, due to availability of labor employment for a limited period, the wages on an average for a period of 15 days yields only Rs. 750 per month. Out of this, the person engaged in wage employment manages to save only Rs. 400 per month or so, incurring an expenditure of Rs. 350 per month in meeting his own needs, living and travel expenses etc. This net income of Rs. 400 per month stands so meager that if 50% of the amount earned i.e. Rs.600 in three months is spent on procuring food grains from the market, the household still continues to face a substantial food gap.

This food gap is fulfilled largely through cash borrowings from local moneylenders at exorbitant interest rates ranging from 15% to 25% per month. The loan borrowed, in a majority of cases, is used for the procurement of food grains from the local market. The inadequate income derived from limited employment options followed by rising credit burdens, thus, keep driving poor household into a debt and asset alienation trap.[50]

In order to address the issue of food scarcity, a few possible solutions, however limited, are available. The first option is improving the PDS system in food insecure villages. This option, though necessary and desirable, is not easy. The performance of the PDS suffers from organizational, logistical and managerial infirmities. The uneven income-earning pattern of poor households and episodic delivery of PDS foodgrains, leads to a situation where availability of cash and food rarely coincides. Generation of wage employment through 'Food for Work' is another available option, but this being a seasonal phenomena, it cannot relied upon.

In view of the above background, Community Grain Banks offered a number of advantages for ensuring food security of the vulnerable community. These Grain Banks made the food available to the people, nearer home, at times of distress. The communities borrowed the food on credit and repaid later at nominal interest rates, much lower than what they would have paid to private moneylenders. It would prove to be a valuable tool in regulating the grain markets too.

Finally, the management of the grain banks were firmly controlled by the beneficiaries and therefore it promoted both, their self-respect and self-help capacity. Communities were encouraged to save a particular amount of food grains at harvest, a 'matching contribution' was sought to be provided by CARE through the partner NGOs and thus a corpus of food grains was sought to be created for the Grain Banks. External support, by way of technical and financial inputs were sought to be provided by the development organization to the vulnerable communities in order to make the concept a success.

SISTERHOOD IN JAMALPURA VILLAGE

[50] These statistics are taken from a report titled 'Community Grain Banks in Udaipur District: Building on Health & Nutrition Project', submitted to the Department of Tribal Welfare, Govt. of Rajasthan, by CARE, Rajasthan.

In Jamalpura village, Reodar block, the son of a Grain Bank member died. She had already availed of her component of the CGB loan. She needed more grains to meet the family get-together and the rituals related to her son's death. Another female member of the CGB took the loan in her own name and passed it on to the woman whose son had died. Thus, the women were able to tide over the need without loss of self-respect and without falling into a debt trap.

The concept of Community Grain Banks is not new to India. Stocking of grains by the villagers is an age-old tradition in the targeted villages. The problem was the juncture. After three consecutive years of drought, the NGOs were not willing to listen to, or be a party to, any intervention, which ironically, was about to ask the starving villagers to save foodgrains. The cultural impropriety of the move, was all too apparent, even to the most casual observer.

It was targeted by CARE that at least 10 Grain Banks would be formed and operationalized in each block during the project period. The partner NGOs were not enthused. It was discovered that though the NGOs possessed considerable capacity in the area of ANR, they lacked adequate and precise knowledge on the modalities of forming and operationalizing grain and seed banks. Out of the proposed number, *Utthan Shoudh Sansthan* agreed to establish 5 grain banks through the existent self-help groups in Mavli. *Prayatna Samiti* (PS) and *Jagaran Jan Vikas Samiti* (JJVS) agreed to establish 5 grain banks each in the villages of Salumber. These Grain Banks were to be established either through operational SHGs or through the existent *Gram Vikas Kosh, Prayatna Samiti* being in favor of the latter model. *Jan Chetna Sansthan* (JCS) planned to form 10 Grain Banks through SHGs in Abu Road. The Society for All Round Development (SARD) agreed to form 4 Grain Banks. SARD did not have strong functioning SHGs in its area of operation and so, in Reodar, contrary to the existing pattern, the Grain Banks formation processes led to the emergence of SHGs. *Kotra Adivasi Sansthan* (KAS) reluctantly agreed to form 6 Grain Banks. *Manav Kalyan Society* was not too enthusiastic either. Clearly, the response of the partner NGOs was pretty lukewarm.[51]

Despite their initial lukewarm welcome to the concept of formation of Grain Banks, it is very interesting to note that, today, they have all surpassed their initial declared targets. The response of the local communities to the concept has been very enthusiastic, so that, today, *Utthan Shoudh Sansthan*, which proposed 5 GBs, now has 10 of them, *Jagaran Jan Vikas Samiti* which proposed 5 GBs now has 9 of them, *Jan Chetna Sansthan*, which proposed 10 GBs now has 31 of them, of which 2 have been formed without equal matching grants, largely through the initiatives of the local women. *Kotra Adivasi Sansthan*, which proposed 6 GBs now has 18 of them (2 of which were formed without matching contributions), *Manav Kalyan Society* has 4 CGBs and Society for All Round Development, which proposed 4 GBs now has 11 of them. Only *Prayatna Samiti* fell short of its target, largely due to its different underlying philosophy and functioning modality. This miracle of over-shooting the targets in a limited span of approximately 6 months or so, was achieved through rigorous training and capacity building workshops attended by the ANR Specialist of CARE, the NGO partners and finally the representatives of Grain Bank members and the members themselves.[52]

1.2. Capacity building initiatives for CARE officers, partner NGOs and representatives of local communities through training sessions pertaining to collection, storage, maintainance of grains, loaning principles, interest rates and recovery.

On 17-18 August 01, a two days cross visit of NGO partners to Grain Bank sites of Bharatiya Agro Industries Foundation (BAIF) at Ghatol, in Banswara district was organized by CARE Rajasthan. Since BAIF operational area falls close to Udaipur and possesses similar socio-economic profile of communities as the BHNP area, the cross visit was expected to facilitate the partner organizations to understand better,

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[51] These figures are taken from a CARE report titled 'Report of One Day Workshop on Grain Banks for NGO Partners of BHNP'.
[52] These figures were gleaned from conversations with the ANR Specialist, Zulfiqar Khan, SARD representative Brij Mohan Sharma and JCS representatives Richa Audichya, Laxman Bhai and Yogesh Yadav.

the operational system, modalities and institutional mechanisms of Grain Bank formation. The learnings from the exposure were expected to be replicated by the project partners in their respective areas.[53]

As the next step in training and capacity building, the ANR Specialist of CARE participated in a one day consultation on Food Security, Food Banks and Micro Credit, organized by the *Rashtriya Mahila Kosh* (RMK) on 13th. September 2001 at the India International Center, New Delhi. The purpose of the interface was to learn the institutional structure, management and other operational issues concerning Grain Banks. The knowledge gained by the ANR Specialist was intended to be transferred to the partner NGOs through capacity building events from time to time in the near future.RMK had successfully operationalized food banks in their respective area and presentations about five successful models of food banks, experimented within different parts of the country, by GO and NGO representatives was made. The interface dwelt on the idea of creating a food corpus with initial contribution by the development agency on behalf of the beneficiaries. Other aspects covered were training on management, record maintenance and monitoring of activities.[54]

Soon thereafter, on 20th. September 2001, a one day workshop on Grain Banks was organized for the NGO partners of BHNP by CARE Rajasthan in Udaipur. The objective of the workshop was to help the participants to develop an understanding of different models of Grain Banks promoted by other development agencies and to help the group to evolve an approach to operationalze Grain Banks under BHNP. Three different models of Grain Banks being implemented by developmental organizations in different parts of the country were pointed out, not for replication, but for the development of the participant's understanding. The *Grameen Vikas Trust* also shared its experience on the occasion.[55]

On 26-27 February 02, a two days training of NGO partners of BHNP II on Grain Banks and Kitchen Gardens management was organized in Udaipur. This training aimed at clarifying the doubts of the partners and the development of common norms. They were introduced to group dynamics through simulation exercises, the need for guarantors in case the loan amount was equal to the member's entire savings, repayment patterns and the situation of new members who joined late in a Grain Bank.[56]

This pattern of sustained interface, contact and training has been maintained with the partners and this has resulted in all but one partner overshooting its target.

1.3. Operationalization of the Grain Banks - Determining the modalities

.In every village, 20 households, most vulnerable to food insecurity were identified and mobilized to participate in the Community Grain Bank intervention. Each family was encouraged to contribute 20 kg. of grains (mostly maize) as their savings in the Grain Bank. A matching contribution of 20kg.was provided by CARE through its partner organization in order to build a corpus. Since a majority of the households participating in the Grain Banks intervention were also members of the SHG groups already in operation, the existing platforms were used in the operationalization of the Grain Banks. Only in one block – Reodar – the process was reversed. In Reodar, the formation of Grain Banks were instrumental in the creation and consolidation of local SHGs.

A Management Committee of active and interested female members of the Grain Banks was formed for the effective operationalization of the CGB. In a few places, as for example in Mavli and in Kalora Phalan (Abu Road), the Management Committees constituted of both male and female members. The committee was scheduled to meet once every month to discuss issues related to the operationalization and management of the CGBs. Training sessions were planned for the members of the Management Committee and it was hoped that this training would enable the Management Committee in streamlining internal lending, recovery and accounting procedures in the CGB.

The leadership structure was to include one President (*Adhyaksha*) and one Secretary (*Sachiv*). The *Adhyaksha* would be responsible for general supervision (calling meetings, forging cooperation and

[53] See report titled 'Cross Visit of NGO Partners to Grain Bank Sites of BAIF at Ghatol, District Banswara'.
[54] From the 'Trip Report on Visit to Delhi' submitted by Zulfiqar Khan.
[55] See 'Report of One Day Workshop on Grain Banks for NGO Partners of BHNP'.
[56] See 'Report of Two Days Training on Grain Bank and Nutrition Garden Management for NGO Partners of BHNP'.

building goodwill amongst members, supervising the preservation of the grains in the bank and taking an initiative in arriving at a final decision in the face of dissent). The *Sachiv* would update the necessary records from time to time (record keeping of loans availed by members, determining the quality of the grains, specially upon recovery and general account-keeping).

Each member was entitled to draw a maximum of 60kg. of grains in installments as per the needs of her household, provided other members of the group agreed. It was decided that a large loan (more than a member's own share of contribution) would be provided to a member either if one more member of the CGB submits counter guarantee of its repayment or if there is a general agreement. Different principles were adopted by different groups. However, a minimum of 25% of the buffer stocks were to be maintained in the CGB to meet emergencies.

Repayment of the loan would be the collective responsibility of the group. If a member defaults in paying her dues in the required time, then her membership would lapse and the grain would be recovered from the guarantor's account. The loan would be recoverable at the next harvest and the member was allowed to repay the borrowed loan either in cash or in similar grain.

The interest rate fixed was 25% (5kg. of grains to be levied as interest on a loan of 20kg. grains) per annum, though in Reodar, for purposes of easy calculation, it was fixed at 24%. *Prima facie*, it seems a steep rate of interest, but the NGOs informed this consultant that these figures matched the traditional lending rates and were therefore acceptable to the locals. Besides, the CGBs were in their infancy. With the passage of time and their consequent consolidation, the interest rates could be reviewed by the groups.

In the case of cash repayment, the recovery would be as per the market rate of grains prevailing at the time of lending.

The loan repaid in cash would be deposited in a separate bank account opened in the name of the group.

However, this consultant witnessed many cases where separate CGB accounts had not yet been opened. Instead, the cash was being kept in the SHG accounts, with internal bifurcation in account keeping. This cash was to be used later, in procuring grain from the local market at the time of harvest.

The transportation costs incurred at the time of purchasing and transporting grains from the local markets to the village were to be borne by the group.

The place of storage was to be decided by the group. It could be centralized or dispersed, depending upon the wishes of the group and the storage space available in the homes of group members.

As far as possible, the keys of the drum/room were to be kept by a person other than the person in whose house the grain had been stored.

If, by the time of the sowing season (in case of satisfactory monsoons predicting a good harvest) some grains remained in the CGB, then on account of its perishable nature, the remaining grain would be sold in the market and the money would be deposited in the account for buying fresh grains at lower rates during harvest. Alternately, the money could be given out as short term loans to members, returnable strictly before the next harvest for the buying of fresh grains at lower rates during the harvesting season.

Looking after the grains through the use of chemical or indigenous methods was the prime responsibility of the person in whose house the storage bins were kept, though the group was expected to help in the activity, as the grains were a collective asset.

The storage pattern to be adopted, was left to the choice of the group. In some places (as in Dhaan (Reodar), Malaphali (Abu Road), Dhamsara (Abu Road),Ghaati (Mavli) etc., traditional storage containers, variously called *Kothi* or *Porah*, were being used whereas elsewhere, as in Kheda (Kotra), Bidghas (Mavli), Cheepikheda (Mavli), Jirawal (Reodar) etc.metal drums were being used. The organization has provided material and skilled labor support in raising the traditional structures at appropriate locations or procuring

drums from the market on behalf of the community. Surplus grains, once developed, would be provided, as returnable loans, to form new grain banks covering other vulnerable community members.

1.4. Working out the rationale of 30kg. contributory and 30kg. of matching grants
The need for the provision of a matching grant to create an initial corpus for Grain Banks had been agreed upon in principle at the very outset. In fact, the WFP even proposes Grain Banks that have the provision of a corpus of 10 times the grains deposited by the community. Initially, in a hamlet comprising of 30 households, 20 families most vulnerable to food scarcity were sought to be mobilized to participate in a community grain bank intervention. Each member of the group was encouraged to deposit 30 kg. of maize as their savings to which an equal matching contribution was to be added by the organization. This figure of 30 kg. was also included in the guidelines to partner NGOs.

At the one day workshop on Grain Banks organized for the NGO partners of BHNP II by CARE Rajasthan on 20/9/01 at Udaipur, *Jan Chetna Sansthan* estimated that each member could be persuaded to deposit 50kg. of grain as their part of the savings in the Grain Bank.

The successful experience of BAIF in organizing Grain Banks under the *Laxmi Bachat Samuha* had recorded a deposit of 20kg. per household with a matching and equal contribution by BAIF.

Ultimately, in the field, in view of the consecutive three years drought, the practical figure at which the contribution of each household got pegged was 20kg. In the course of the field trips, enthusiastic members told this consultant that the 20kg. food grains per family figure was decided upon because the harvest had not been particularly plentiful that year. She suggested that in future years, if the harvest was plentiful, the members would decide to raise their contribution figure per family.

1.5. Storage bins- different indigenous structures and metal bins.
Traditionally, the storage of food grains in the area was done in indigenous structures called '*kotha*' or '*porah*'. These structures were of two types. One structure was made of bamboos and a coating of mud was used to plug the chinks between the bamboo matting in order to prevent the entry of moisture into the stored grains. Such structures were open from the top for the purpose of grain extraction. The other structure was made of straw, mud and horse dung with an extraction hole at the bottom, so that gains at the bottom of the container could be drawn out first to prevent the process of rotting. Generally this extraction passage was sealed and was opened only at the time of grain extraction. These indigenous bins were rooted in the ground and were immovable.

As contrasted to and different from the indigenous structures, were the metal bins. large and roomy with metal covers which could be locked. Some of these metal bins had castors attached for maneuverability. This was just as well as the residents of Khera found out.

Most new CGBs start with the indigenous storage system which costs about half the amount at which metal bins can be bought (the indigenous structures cost about Rs. 1500/ to erect whereas the metal bins cost around Rs. 2500/). As the CGB consolidates, its cash reserves build up. The Management Committee then buys metal bins for its grain bank.

1.6. Use of preservatives to prevent the grains from rotting.
The preservatives being used, were once again of two types – the indigenous and the chemical variety. Indigenous preservatives consisted of a mixture of sun-dried *neem* leaves combined with ash. The community had been trained to stack the grains with layers of preservative mixture placed between the layers of grains.

Communities which preferred to use chemical preservatives (as for example most of the communities in the Mavli block which is largely semi-rural and semi-urban), either used chemical tablets of insecticide placed between the grains, or they used a chemical which in local parlance is termed as 'injection'. It consist of a glass ampoule containing a chemical. This ampoule is wrapped in a thin piece of cloth, held in the hand, the

hand is inserted into the grains and the ampoule is crushed. It gives off an vapor of insecticide which is trapped inside the grains.

In the semi-urban areas of Mavli, the availability of the 'injection' is difficult. Since it is a lethal chemical, it is not available in the open market, as it is sometimes used by youngsters for committing suicides after failing in exams. alternatively, being jilted in love. Thus, the dependence of the communities on the local NGO (*Utthan Shoudh Sansthan*) for the procurement of chemical preservatives is likely to last for some time in the future. A representative of the NGO told this consultant that it was not easy for them either to procure the insecticides either. They are available at government godowns only and the NGOs have to prove their bonafides before the chemicals are sold to them.

1.7. Turnover of grains in the grain banks:

The grains are stored in the bins around October after harvesting. Occasionally, in the first few months, they are brought out for sunning. All the members of the group are expected to lend a had at the activity, though the primary responsibility is that of the person in whose house the grain bank is located. After the procurement and addition of preservatives, the grain is allowed to rest. From March onwards the loaning begins. By July-August, following the rains, it becomes clear if the next harvest is going to be in abundance. If some grains remain in the bank by August, the members are first asked if they would like to buy it. Otherwise, it is sold in the market at the prevailing high price. The money from this sale is either put in the grain bank account in the bank, or it is loaned out to members as a short term loan at 2% interest, to be repaid strictly before the next harvest, so that fresh grain can be bought for the CGB at the low prices prevailing at harvest time.

A large number of the CGBs visited by this consultant and the associate groups had come to comprehend very well the time frame, the economics involved and the modalities of running the grain banks.

To vulnerable communities, which had for generations lived in the shadow of food scarcity, it was a very welcome and empowering experience to be part of a grain bank and thereby ensuring their food security scenario. Their mood was upbeat, their confidence was brimming and their vision of consolidating their Grain Banks, knew no bounds. In fact, after the formation of the first round of Grain Banks, two groups had approached the *Jan Chetna Sansthan* to seek the NGO's support in forming their own Grain Banks. These groups were so highly enthused by the idea of having their own Grain Banks, that, when they were told that the NGO would not be able to provide a matching contribution to them, they did not seem to mind at all and said that they would go ahead on their own initiative. All they needed was some technical support from the NGO. In the end, Grain Banks were formed in both these communities and the NGO was able to provide them with some financial support, though not a matching contribution. One of these villages was Kalora Phalan in Abu Road, visited by the present consultant and the other is Badhwaj in Reodar – both resplendent examples of private enterprise.

1.8. Considering the eventualities of non-recovery.

Small loans were encouraged to rule out the possibility of non-recovery. This consultant, who accompanied the ANR Specialist into the field, found him taking great pains, to explain to the communities, the need to limit the grain loans to small amounts, thereby ensuring the feasibility of recovery. In the eventuality of large loans, other members of the community were required to stand as guarantors and the Management Committee was required to assess the needs of the member requesting the big loan. In conversation with the communities, at least on two occasions, this consultant asked them what they would do if a loanee did not return the loan amount of the grain. Their answers are symptomatic of the prevalent upbeat mood mentioned earlier. In one place (Vasni Kalan in Mavli block), the women said they will browbeat the person by saying 'its maize provided by the government; so you better hurry up with the repayment' (*sarkari makki hai; phataphat wapas do*). At another place (Cheepikheda), they said 'We'll get their whole fields auctioned; where is the question of not returning the loan?' (*poora khet neelam karva lenge; nahin dene ka sawal kahan hai?*).

RECOVERY IN DHAAN VILLAGE

In Dhaan village, Reodar block a CGB member took a loan for her daughter's marriage. She returned the loan in flat three days! After the marriage of her daughter, she collected the money given by friends and relatives as a gift and repaid her loan with that money.

However, the situation does not appear as upbeat or sanguine in places where the CGBs consisted of male members as well. Male members are part of the CGBs in areas where the CGBs were formed with money from the *graam kosh*, notably in Salumber, where the partnering NGO is *Prayatna Samiti*. A CARE FO, in conversation with this consultant, said that male members of CGBs were found to be more self-interest oriented and less conscientious than the female members as far as recovery was concerned. When they took loans from the grain banks, they, almost invariably, never returned it.[57]

1.9. Initiation of new Community Grain Banks by existing groups.

Initiation of new CGBs for more vulnerable communities by existing and consolidated CGBs was always a part of the CGB intervention. This was conveyed to the partner NGOs as far back as February 2002 at the two day training on Grain Banks organized by CARE in Jeevan Tara Resort, Udaipur. Yet, when, in the presence of this consultant, the ANR Specialist would tell the communities that they must assist the more vulnerable groups to form their own Grain Banks by loaning them grains, the communities looked rather baffled. Most groups were agreeable to the idea, but were confused about the modalities to be adopted as they themselves had received matching contributions from the NGOs. They did not completely understand if they were expected to part with their hard-earned stock of foodgrains as matching contribution to the more vulnerable communities. They were willing to give out their stocks as loans to start new Grain Banks, but were naturally keen to eventually recover it for themselves.

1,10.Considering the prospects of withdrawal by the partner NGOs.

Discussions concerning CARE's withdrawal as well as the withdrawal of partner NGOs always lent a wistful melancholy to the group. The ANR Specialist would explain to the communities that both CARE and the partner NGO had shown them the way to walk independently, just as one would teach a child to walk and then let go the finger. That henceforth they must learn to manage on their own. The community's sense of loss was apparent to the most casual observer. It was clear that until now, they had a reference point, to which they could turn for help and advice, whenever necessary. The new-found sense of empowerment, which these women had come to experience and enjoy, was proving to be a little shaky at the foundations. This was the psychological aspect of the prospect of withdrawal.

On a practical level, however, it was apparent hat the involvement of the partner NGOs would have to continue. Many of the communities were without a single educated member and so, the responsibility of account-keeping would still have to be done by the NGOs. One partner NGO, SARD had fixed the interest rate of CGBs in its operation area at 24% in the place of 25% in order to work on a round figure. It had then drawn up a chart for the calculation of interest rates and was training the community members to work on it. Despite this, the local communities would continue to remain dependent on the NGOs for technical matters like making the chemical preservatives available to the communities.

At least in one group observed, in Dhaan in Reodar, the emergent group dynamics were not sufficiently cohesive to ensure the smooth functioning of the CGB. Clearly, more inputs by the concerned NGO were called for in the situation.

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[57] In conversation with Ajinder Singh, FO, in CARE office, Udaipur, on 8/7/02.

It was brought to the notice of his consultant that Mr. Om Srivastava of *Astha,* a specialist on adult education, had structured a 10 day training capsule for record-keeping and account-keeping for uneducated villagers and it might be a good idea to train a few people from each village through the capsule.

1.11. Difficulties encountered.

INTER-CASTE GRAIN BANKS AN EXPLOSIVE ISSUE

In the Reodar block, different caste groups refused to come together for the formation of CGBs for fear of defilement and social ostracism. BAIF had encountered similar problems too. In the end, the solution lay in forming single caste Grain Banks!

One difficulty encountered, in the formation of Grain Banks, was a very specifically "Indian" problem. The vulnerable communities in Reodar comprise of Bhils, Meghwals, Mehthar, Jogis, Tooris and some poor Rajputs. In Beekanwas village, Reodar block, in the course of formation of the CGBs, the NGO partner SARD found that women from one caste group did not want to team up with other caste groups to form the CGBs. Matters soon came to a head between the Jogis and Meghwals. Each of the caste groups considered itself as higher on the hierarchical caste stratification ladder as compared to the other. Sharing a common grain bank with the other caste group meant defilement and was therefore unacceptable to both groups. In the end, following the BIAF experience in Hatore and Jamburi, single caste grain banks were formed and these are functioning well.

A BITTER EXPERIENCE OF THE PAST

In Abu Road, the collective exercise of CGB formation posed another problem. The representative of *Jan Chetna Sansthan* was completely taken aback when, one day, in one of the villages where the JCS works, she was confronted by an angry woman who told her 'You had better pick up your grain bags and disappear from here. We don't want any of it.' After a few more exchanges, it came to light that, some three or four decades ago, some development work termed as the *Daantiwara Pariyojna* had been undertaken in the villages of Abu Road. These activities had related to the construction of bunds and anicuts in that area. When the activities were undertaken, the villagers were given to understand that this was routine developmental activity sponsored by the government. In the end, it turned out to be a long term loan, for which the villagers were expected to pay. In the meanwhile some three or four decades had elapsed and the original beneficiaries had passed away. The new generation of villagers had no idea about what they were being asked to pay for. Thus, when JCS undertook the formation of Grain Banks in the area, vested interest groups, consisting mostly of money-lenders, whose interests would be hurt by the Grain Banks, instigated the villagers and told them that this would prove to be another *Daantiwara Pariyojna* experience, and one day they would pay dearly for benefits and services which they could not remember and had not availed.

Almost all the partner NGOs complained that the proposal for the CGBs came in for application rather late – only by November 2001. If only the proposal had come in for implementation earlier, the success levels and achievement would have been much higher. JCS said that it had underestimated the potential of the intervention and with sufficient time at their disposal, they could have formed 150 CGBs in the place of their present number of 31.

Almost all the partner NGOs complained that storage facilities were limited and expensive to procure. The CGBs could be expanded and proliferated but providing adequate storage structures was proving to be a difficulty.

A number of CGB members said that there were initial apprehensions that perhaps the grains collected in the CGBs would not be well looked after and might rot. This would be a major set back in food insecure communities. However, these apprehensions had proved to be unfounded.

Many members said that initially they had reservations about misappropriation of the grain pool. However, the functioning of CARE as well as the partner NGO had been so transparent and democratically decentralized that all such apprehensions had soon be laid to rest.

Another problem experienced by the NGOs is that at the time of recovery, traditional measuring gadgets are being used to measure the loan returned by way of grains. The CGBs do not have any weights or balances. Nor have CARE or the NGOs provided them with any. The worry was that grains equivalent to lesser weights than the borrowed weights were being returned due to the traditional weighing mechanisms and this would eventually undermine the CGBs.

MISTAKEN CONCEPTS OF SELF-RESPECT

In Reodar, Bhil communities, suddenly struck by a confused sense of self respect announced 'We don't accept charity'. Saying this, they refused to accept the matching contribution grains, so essential to the creation of the corpus, without which no CGB can function. A lot of explaining had to be done by SARD to clear the clouds of confusion.

SARD in Reodar faced another difficulty. Indigenous storage structures were far cheaper than metal drums (storage capacity being equal a *Kotha* costs Rs. 1500/ while a metal bin would cost Rs. 2500/), but most of the artisans capable of constructing indigenous storage structures had died and with them had died their age-old craft. Thus it was becoming more and more difficult to find artisans who could structure indigenous storage structures.

In Fatehpura in Abu Road, the grain collected in the CGB began to rot. It was sunned once, but that did not improve matters. There was some controversy amongst the members after which the grain was distributed as a loan, equally to all the members and consumed rather than being allowed to rot. In another place, Sonela village in Reodar, as soon as the grain began to deteriorate, it was sold in the market and the money was put in the bank.

1.12. Sustainability and Future prospects.

Most of the CGB members interviewed evinced an enthusiastic new-fond sense of empowerment and were determined to strengthen the existing grain banks and create new ones.

In Dhamsara village in Abu Road, the vulnerable population comprised mostly of the *nat* community. Here the local money-lender charged a 25% monthly interest for grain loans. Frequently, the poor villagers pawned their fields and jewelry for a few kilos of grains borrowed for food or seeds. Here, the CGB *adhyaksha* Rajibai, a rather mellow woman, is detested by the local money-lender because the CGB has functioned so well that marginalized farmers have stopped borrowing grains from money-lenders for food or as seeds.

Likewise, in many other villages, the vulnerable sections have found liberation from the whimsical interest rates dictated by local money-lenders.

Formerly, the villagers had to scout around for seeds, but now borrowing from the CGBs of which they are members, is more in consonance with their self-dignity and self-worth. Though the CGB in Dhaan village,

is not a very well run one, yet one woman there told this consultant 'I would say, we must not let this lapse for a moment.' (*Main to kahun ki ise ek ghari ke liye bhi tootne na doon*).

In Uplagarh, Abu Road, the State Government in cooperation with UNWFP is launching a massive CGB program in which the entire corpus is being donated by the government. An amount of Rs. 64000/ has been earmarked for each village and JCS, the partner NGO of CARE, on the basis of its past experience of CGBs with CARE, has been approached by the government to help organize the CGBs in Uplagarh.

In Reodar, the ICDS has requested the support of SARD in the formation of SHGs and in the support and implementation of the *Swayamsiddha* project, which is a woman related project.

At the *Mahila Sangam* (Women's Meet) organized by JCS with the support of CARE, the District Magistrate evinced a lot of interest in CGBs.

The enthusiasm of the group members and the interest of the government agencies, thus speak for the sustainability and the bright future prospects of this very important intervention.

From the point of view of genesis, the CGBs are thus classifiable under four heads – (1) those organized with equal and matching contributions (2)those organized through the use f seed capital (3)those organized with money from the *gram kosh* and (4) those organized with no contribution, purely through local initiative.

2. The Deepening of wells:

Well deepening for creating drinking water points had been successfully completed at a number of sites during the summer of 2001. In the peak of summer 2002, the community members were expressing satisfaction with the water levels in those wells. The local communities were all praise for the efforts of the BHNP team and the partner NGOs.

The following is a consolidated progress report on the well deepening work undertaken –

S. No	Partner NGO	Operational Area	No. of Wells Deepened	No. of Beneficiary Families	Labor Days Generated.
1.	Kotra Adivasi Sansthan	Kotra	16	313	1376
2.	Jagran Jan Vikas Samiti	Salumber	6	370	451
3.	Jan Chetna Sansthan	Abu Road	9	337	587
4.	Manav Kalyan Society	Kotra	2	98	80
	Total		33	1118	2494

The most poignant story related to the well deepening exercise relates to a village called Baansphali. The severity of the drought was graphically narrated by a FO who told this consultant that in the first year of the BHNP intervention, he was on his way to a place called Baansphali, a *phalan* in Uplagarh village in the Abu Road block of Sirohi district. He had to abandon his vehicle a few kilometers from his destination and cover the remaining distance on foot, as the scattered hutments were not accessible by any road. He was thirsty and decided that he would ask for some water on reaching the huts. When he reached the huts, he

found that sixty families of the *phalan* were drinking water from a stagnant, fetid pool located in a depression in the ground. As if that was not enough, the stagnant pool was shared by the sixty families with their surviving cattle. Thereafter, CARE undertook the deepening of wells in the area. In all, ten wells were to be deepened. In the end, nine wells were deepened while the tenth well could not be deepened due to technical reasons. The villagers of Baansphali cooperated in deepening a nearby well through the contribution of their labor. Today, the well is functioning and women who leave their homes for the forest, to collect *tendu* leaves, early in the morning as the first cockcrows, quench their thirst, late afternoon, at that very same well.[58]

3. Community Kitchen Gardens:
The promotion of kitchen gardens, a by-product of the well deepening exercise, was also intended to supplement the nutritional security of the households. To that extent, it formed an important component of the ANR intervention. The cultivation of kitchen gardens have been taken up in a big way in the two blocks where the Drought Relief Project was implemented. The partner NGOs have taken up the responsibility of providing seeds to interested households. About 280 households have been promoted to cultivate vegetables in their fields and near their houses. This consultant witnessed a kitchen garden training session at the Kotra Adivasi Sansthan center and saw flourishing kitchen gardens in Matasula, Bilwan and Kheda.

4. VDF and *Graam Kosh*.
One positive development of the intervention by CARE has been the focus on the money collected in the Village Development Fund (VDF), locally known as *graam kosh.* The *graam kosh* phenomena exists primarily in the two blocks of Salumber and Kotra where drought relief activities were undertaken. In the past, during the Drought Relief Operations and during other developmental activities, the money donated by the village people, through their labor, has resulted in the formation of collective corpuses which are termed *graam kosh*. During the construction of check-dams, gabions, anicuts and other structures intended to stop soil erosion, locally termed as *naari,* the village workers were generally paid a daily wage of Rs.70/ each, of which Rs.20/ was deducted and deposited in the *graam kosh*. Thus a village corpus came into existence, the purpose of which was to create a fund for the maintenance of the structures so that the development work undertaken could be made sustainable. This money is managed and administered by a 11 member committee called the Village Development Committee (VDC). The use and management of this money is through the facilitation of the partner NGOs and the decision of the VDC. The partner NGO thus assume a key role in ironing out controversies and squabbles.

The FOs informed this consultant that in about 70% of the villages in Salumber, the *graam kosh* money had been utilized for constructive purposes, such as well deepening, procuring agricultural inputs such as fertilizers, seeds etc., creating a corpus for the formation of CGBs, for individual loanings etc. In the Kotra block, in some villages the *graam kosh* money had been used to meet the costs of marketing seasonal fruits collected by the adivasis from interior areas and for individual loaning. In one place, the village residents had used the money for the construction of a temple!

This consultant enquired after the position of the *graam kosh* money in a few of the villages visited and wished to know what the local residents would like to do with the money. Their response was, to say the least, rather surprising. Most respondents sounded rather vague about the money but the few who did respond, seemed to prefer to have the money just lie around.

The accompanying FO suggested that they could plan to buy a tractor with that money. The tractor would be village property and could be borrowed by individual farmers to plough their fields. In addition in villages located in the interior, not connected by road links, the trolley could be used to market the agricultural produce and transport the sick persons to the hospital whenever necessary. At this, some of the respondents weakly protested that the tractor would actually end up becoming the property of the powerful and influential people in the village.

[58] Story narrated by Umashankar, FO, and collaborated by Richa Audichya of JCS and Zulfiqar Khan, ANR Specialist.

It is thus clear that there is neither direction nor clarity nor perspective planning amongst the villagers about the use of the *graam kosh*. This consultant fears that if urgent perspective building exercises are not undertaken by the partner NGOs, this corpus, so laboriously earned, could fritter away at the behest of the influential members of the village.

KHEDA VILLAGE: A MODEL OF ANR INTERVENTION

Kheda, a remote hilly village in Kotra block, is spread across two hamlets over a stretch of hills. These two sections are known as the *Rajput phalan* and the *Adivasi phalan.* The village was located at a crucial point of a small watershed and was identified by specialists as an ideal location for extensive ANR interventions, including water harvesting, land development, soil erosion control bunds, mini dams for water storage and new forms of agriculture. The services of a reputed consultant were hired and a comprehensive micro-project for one year was drawn up for the village. ANR interventions in land-bases activities generated a regular wage employment. The community contributed 30% of their wages and soon a sizeable VDF built up in Khera under BHNP II It was understood that this money was to be used for the requirements of the community, such as maintenance of structures, initiating new economic activities etc. Storage drums for CGBs were bought from the VDF money. A strong SHG, practicing saving and credit activities came into being, ginger was grown extensively and successfully as a cash crop and the community was enthused with a new sense of empowerment. Kheda became a model of successful ANR intervention.

Pending CARE's withdrawal, the ANR specialist felt that the training of the villagers regarding the prevention of excessive use of water resources could not be completed due to the shot time span available. Besides, the project was sanctioned in May 2001, the financial allocation became available in June 2001, so that the sowing period of 2001 was missed. May 2002 to the time of writing this report, the village was reeling under the socio-cultural impact of *vair*. Hence, the full impact of the interventions would come to light only after CARE's withdrawal, which was a tragedy.

Conclusion

By way of conclusion, it may be said that, the ANR sector of the BHNP II is one which is most welcomed by the local community. To that extent, it may be termed as one of the most successful activities. Being a quantitative component, its success can be objectively assessed. Several local NGO representatives, who have themselves worked tirelessly with CARE during the last two years, while talking about the health related interventions, wistfully told this consultant 'We have done a good job with the propagation of the message. They know it well enough by now. How far they practice those injunctions is anybody's guess.' In contrast to the above, the partner NGOs have been approached by community groups with the request to help them form CGBs, even without the matching contributions necessary for the creation of the initial corpuses. At least two partner NGOs (JCS and SARD) told this consultant that had the CGB intervention started a little earlier on in the project, they could have formed almost double the number of CGBs they have managed to form now. Clearly, the potential for success in this area is tremendous.

Chapter 7

MOTHER'S COMMITTEE

Beginning with the Log. Frame.

The Logistic Framework of BHNP II, under the heading "Project Purpose" sought to "Improve nutrition and health behaviors among pregnant women, lactating mothers and children less than two years of age". Besides, under the heading "Project Outputs", it stated the need for "Strengthening and intensification of the Government's provision of health and nutrition services". Finally the Log. Frame. stressed upon the need to "Involve *Panchayati Raj* Institutions and enlist their support in project implementation and monitoring" (4.3). On the ground, in the course of implementation of the project, the attempt to enmesh the above-stated three-fold objectives, gave rise to the interesting phenomena of the Mother's Committee and its induction as a sub-committee of the *panchayat* system.

The Log. Frame. under the title, "Process Indicators" mentioned the need for CARE's "Partnership with five NGOs, at least one NGO partnership in each block". In pursuance of this objective, the partner NGO in Abu Road Block was a local NGO named *Jan Chetna Sansthan*, (JCS), with headquarters in the city of Abu Road. The organization worked under the able leadership of a dynamic young couple, through a dedicated band of selfless workers who never counted the inputs or the costs, and, the organization had a good understanding of the ground realities in its area of work. The organization had an empathetic relationship with the local tribals amongst whom it worked, it enjoyed the confidence and support of the local communities and prior to its partnership with CARE, it had been involved in rabid activism over very serious local issues, which affected the local communities. These issues included the *tendu* leaf issue, which rocked national politics, the *jangal-jameen mudda*, (forest land issue) which affected the rights of livelihood of forest dwellers in the face of eviction from their traditional habitat by the Forest Department, the *girwin zewaraat mudda* (the issue of pawned jewelry), involving the usurpation of the jewelry pawned by the poor tribals through whimsical rates of interest determined at will by local money-lenders in complete contravention of the Indian Money-lending Act and finally activism and picketing against the free sale of liquor, through which the government sought to prop its coffers through the levy of Excise Duty on liquor sale, but which gave rise to a very serious and pernicious development of addiction to liquor by men, while the women and children starved, as family funds got diverted to liquor consumption.

The two Blocks of Sirohi District, Abu Road and Reodar, were supplied with WFP food through CARE, to augment the nutritional aspect of food intake by vulnerable communities, most of whom were tribals. On the ground level, this "food", literally a corn-soya blend (CSB) in powder form and refined vegetable oil, was distributed to members of the vulnerable community through the institutions of the *Aanganwadi* centers (AWCs), which fell under the jurisdiction of the Integrated Child Development Services program (ICDS), conducted by the Ministry of Social Welfare through its Women and Child Development Department (WCD).

The problem of pilferage of food in Abu Road Block:

In the Abu Road Block, where the BHNP II project of CARE was sought to be implemented through the participation and conjunction of its partner NGO, *Jan Chetna Sansthan*, 52 villages out of a total count of 72 villages in the area, fell under the area of JCS activity. In these 52 villages, WFP food continued to be supplied through CARE until March 2002. The entire period continued to be marred by complaints of pilferage of food, specially the oil segment, at the *Aanganwadi* level. While CARE continued to maintain a buffer stock of three months to ensure a regular supply, the local communities complained of not receiving

the food or of receiving whittled down rations. It came to be an open secret that some *Aanganwadi* workers (AWWs) used part of the rations for their own home consumption. Others, with even less of a social conscience, were suspected of selling part of these rations, specially the oil, to traders and shopkeepers, who then sold it at a profit in the open market. Some AWWs complained that being situated at the lowest rung of the ladder of the hierarchical organization of the ICDS structure, not being salaried employees of the organization, but rather the recipients of a pathetic stipend of Rs. 438/ per month (now likely to be raised to Rs. 1000/ per month in the future), the figure being gloriously termed as an "honorarium", having no security of service, defenseless against political and administrative manipulations and machinations of different kinds, they were susceptible to pressures from various quarters (such as from the Lady Supervisors (LS), also called the Sector Supervisors (SS), some members of the *panchayat* and above all, the Child Development Project Officers (CDPOs), under whom they worked, to siphon off pilfered oil to these superiors. Of course, it goes without saying that none of these superiors would even listen to, let alone concede to the possibility of these charges. Nevertheless, the local communities continued to complain of the non-receipt of food, while CARE continued to maintain a three months buffer stock. Being the partner NGO, this complaint of the local communities came to the doorstep of JCS too.

Being rather familiar with the activist mode of operation, urged by CARE to undertake a closer monitoring of the food distribution system at the *Anganwadi* level, moved by the vulnerability of the poor tribals being deprived of their due share of food donated by external agencies and feeling the need to take decisive action to uphold the sanctity of the confidence placed in the organization by the local communities, JCS was frequently ending up being daggers drawn with the local AWW, the Helper and the LS.

Whenever CARE enquired of the ICDS about the details of distribution of food to the vulnerable communities, a quick list would be forthcoming, theoretically and statistically sound on paper, but far removed and completely at variance with the ground reality. Being a trans-national development organization with the avowed and declared objective of working in conjunction and with the support of national governments, CARE was in no position to challenge the list, which it knew was a concocted and false one.

Meanwhile, the partner NGO JCS, continued to clash with the AWWs, the Helpers and the LSs, who sent their complaints against JCS, up-line to the CDPOs and the Regional Deputy Directors (RDDs).

The government machinery took the official position that, since it was WFP food chanelized through CARE, CARE had a *locus standi* to monitor its distribution, but JCS had no right to ask questions. In any case, the government had no love for JCS because of its previous record of activism and was therefore in no frame of mind to hold itself answerable to JCS, whom it accused of whipping up and thriving on popular agitations. Similar situations in lesser/greater degrees came to exist in other Blocks too.

Finding a no-go deadlock situation, CARE requested its partner NGOs, to mobilize local community support, specially the support of stakeholders, (in this case pregnant or lactating mothers and secondary target groups of mothers-in-law and older women), in monitoring and demanding the delivery of services. This nutritional supplement, was known in local parlance as *poshahar*. This decision, to motivate stakeholders to monitor service deliverables, led to a further escalation of animosity and clashes between the local communities and the service delivery machinery. The BHNP II team, specially the Project Coordinator, was the source of a novel idea and the initiative of the partner NGOs resulted in the quick establishment of Mother's Committees in every village and each of these Committees briskly went about the business of taking the AWWs and the LSs to task for their corruption and neglect of duty!

THE DYNAMISM OF MOTHER'S COMMITTEE IN SADAMANPUR

In Sadamanpur, a village in the Salumber Block in Udaipur District, members of the Mother's Committees, supported by the local SHG, in a sudden and unexpected show of empowerment, dismissed the local *Aanganwadi* worker on charges of corruption, negligence of duty and above all, unexplained absenteeism. The AWW questioned their powers and jurisdiction, but the members of the Mother's Committee held their ground! They then proceeded to submit a written complaint to the CDPO and the *panchayat*. Since the Mother's Committee did not have any official status, its dismissal action was ignored by all concerned - the AWW, the CDPO and the *panchayat*. The AWW continued to visit the AWC erratically and at will, as before. Enraged and affronted members of the Mother's Committee then locked the door of the AWC, drew up a comprehensive list of the dates on which the AWW had not shown up at the AWC and proceeded to hand over the dates of the AWW's absence and the keys to the lock of the AWC to the *Sarpanch*. They categorically stated that they had no need for an absentee AWW and would not let her function in the village. The AWW in retaliation charged that the women beat her up and tried to loot the rations. The Mother's Committee members however, demanded either a written apology from the errant AWW or her replacement. CARE's partner NGO in the area, *Prayatna Samiti* (PS), watched from a ringside seat, occasionally fanning the flames of fury and patting itself on the back. Clearly, matters had come to a head!

Composition and functions of Mother's Committees:

These Mother's Committees, variously termed as *Mata Committee, Dekhrekh Samiti* etc. generally comprise of 5 to 7 members. It includes at least two young women who are in the "pregnant and lactating mothers" category, at least two older women as secondary targets in the 40 to 50 age group and in places where the *Wardpanch* or the *Sarpanch* is a woman, she *ipso facto* gets included in the Mother's Committee. In selecting the members of the Mother's Committee, care is taken to ensure that preferably those women, who are active, bold and providing leadership in the local SHGs, are recruited as members of the Mother's Committees. The process of selection is a democratic and electoral one. In the villages where strong functional SHGs existed, the formation of the Mother's Committees did not require much investment of efforts on the part of the partner NGOs. At the time of writing this report, most of the Mother's Committees were 6 to 7 months old and functioning well.

The primary function of the Mother's Committee is to act as a watchdog of the delivery services and a facilitator in the service deliverables. This consultant noticed that members understood clearly that their role was not just negative in opposing corrupt and negligent AWWs but also positive in encouraging target groups to avail of the nutritional supplement food, encouraging young mothers to take their small children to the AWC for immunization on the Nutrition and Health Days (NHDs), if necessary, accompany young mothers and babies to nearby hospitals when they avail of the Referral System, encouraging expectant mothers to take IFA (Iron and Folic Acid tablets) and have tetanus vaccine administered, supervising and assisting the AWW and the ANM in the administration of their duties, including the carrying of their professional baggage from the road to the villages located in the interior, ensuring the use of the *Mamta kit* in home deliveries, encouraging women in the reproductive phase of life to adopt birth control measures, use the social mapping to identify beneficiaries, monitor commodity consumption, at least one of them should be present to endorse that the THR (Take Home Rations) are actually distributed, in general, to promote and propagate positive health behavior in their immediate neighborhood and the village and regularly report the developments in the AWC to the *panchayat*. They even go to the homes of the beneficiaries to ensure that the nutrition supplements as also the Iron and Folic tablets are consumed and not fed to the cattle.

Fear of Inoculations countered by the Mother's Committees:

This consultant was repeatedly told that initially the village women were extremely apprehensive of the idea of inoculations. Incited through the gossip of elder women, young mothers firmly believed that

inoculations would lead to the death of the babies. When a few enterprising young mothers did break out of the cordon of superstition to get their babies inoculated, the babies promptly got fever, as is inevitable after inoculations and the older women could not refrain from saying "we told you so". There also exists the common belief that if an expectant mother gets herself inoculated (the Tetanus Toxide vaccine), then she is sure to have a miscarriage.

The most regressive incident came from Bajaj Nagar, a village in Mavli Block in Udaipur District. There, the men of the local community, comprising mostly of Bhil tribals, in a drunken fit of resentment, beat up the ANM when she visited the village for vaccinations. Now, a team of women, comprising of members of the Mother's Committee and other active women of the SHG accompany the ANM whenever she visits Bajaj Nagar.

AN ACTIVE MOTHER'S COMMITTEE IN VAAS

In Vaas, a village in the Kotra Block of Udaipur District, the AWW was irregular and continually played truant. Predominantly a tribal area and home to very vulnerable segments of population, the residents of Vaas were greatly inconvenienced by the erratic showing up of the AWW. They never knew when the AWC would open, when it would close and they would walk for long distances, only to discover that the AWC was closed. The AWC was located some 5 kilometers from the village. Thus, they were continually deprived of their supplementary food. They were completely ignorant of the services delivered through the AWC until they saw the folk media based performances promoted by CARE and organized by the partner NGO *Manav Kalyan Society*. This folk media based performance, which they called *natak* (literally drama), was educative and gave the viewers an idea of the services delivered through not only through the AWC but also through the ANM. The Sector Supervisor of Vaas was as uncooperative, perhaps even worse than the AWW. Empowered with this newfound knowledge, the newly organized Mother's Committee reported to the *Graam Sabha* that they wished the removal of the AWW. They stated that they had learnt through the *natak* that *poshahar* comes to the AWC for distribution; so where is it?! They now have a new AWW who has a good equation with the community women and the Mother's Committee of Vaas today enjoys legitimacy by the local *panchayat* and frequently visits the AWC.

Problems encountered in giving the Mother's Committees a statutory legal basis:

Thus, the initiation of the concept as well as the establishment and the functioning of the Mother's Committees got off to a galloping start at the initiative of the BHNP II team and the partner NGOs. However, the remaining problem was that these Mother's Committees were a CARE sponsored organization without any statutory or legal basis. This situation was contributing to the undermining of the effective functioning of the Mother's Committees. The BHNP II team, next went about rectifying this situation. Since the Log. Frame. of the project sought to "involve Panchayati Raj Institutions and enlist their support in project implementation and monitoring", the next logical step was to link the Mother's Committees to the local *panchayats* and thereby legitimize them as sub-committees of the *panchayats* through statutory provisions.

However, the problem was the disinterest evinced by *panchayats* towards activities related to development concepts such as the Mother's Committees. When the BHNP II team and the partner NGOs initiated discussions with the *panchayats*, to consider ways and means of awarding a statutory status to these Mother's Committees, they discovered that though the PRI have a right to monitor the AWCs, the ICDS program or the AWC were not important issues for members of the *panchayats*. The members of the *panchayats* rather chose to focus on bigger and more central issues like watershed management or activities, which had large financial allocations. Issues like distribution of nutritional supplements to women of vulnerable communities or the propagation of positive health behavior, just was not important in their scheme of things. Clearly, the next requirement was sensitizing the *Sarpanchs* and other members of the *panchayats* on the CARE agenda.

Women's Jamboree – The *Mahila Sangam*:

Meanwhile, the BHNP II team motivated its partner NGOs to organize large, annual gatherings of local women to convey to the women an idea of an extensive sisterhood, the common problems faced by other women in the region and the solutions to these problems arrived at by different groups. Women's groups other than SHGs and Mother's Committees from CARE villages were to be invited to the meet, as also members of PRI, office bearers from the District administration, members from specialized agricultural institutes in the area and other organizations supportive of and sympathetic to the causes of local women were to be included in the meet.

One such extremely successful meet was organized by JCS in Abu Road in December 2001. The meet itself, styled as "Mahila Sangam" was organized in the precincts of an extensive *Jain Dharamshala* in Abu Road. It was a one-day meet. Membership of participants far exceeded the projected numbers. Food packets, ran short and hurried arrangements had to be made for more. JCS had requested the SHGs in its area of work to send not more than two or three participants from each village. There were 52 villages in the JCS area of work. In the end, 1500 participants attended the meet. This figure, of course, included representatives of SHGs from CARE-JCS villages and members of Mother's Committees, but it also included the dynamic and assertive Sarvey Bai, President of the Tendu Leaf Cooperative Society (*Tendupatta Cooperative Society*) and her team of members, Kali Bai, President of Single Women's Solidarity Organization (*Ekal Naari Shakti Sangathan*) and her team, the District Magistrate of Sirohi, the Tehsildar, representatives from the Agriculture Center, Sirohi (*Krishi Vigyan Kendra*, Sirohi), which imparted information on the cultivation of perennial tomato plants, the seeds of which were imported from Israel and the state of flourishing plants in Reodar, etc. The meet also included a large number of *Gram Pradhans*, male and female *Sarpanchs* of the area, many women *Wardpanchs* and other PRI members. Representatives of the Health Department were conspicuous by their absence and were later taken to task by the District Magistrate!

The topics discussed at the meet were many. All of them related to women's issues. The SHG representatives sang instantly composed extempore songs with health awareness related messages, such as safe deliveries, feeding newborns the first breast milk of mothers etc. The songs highlighted the solidarity of exploited women and the women present there resolved to shake off the yoke of exploitation in the future. They stressed upon the need for self-reliance in undertaking this momentous task. 25 kinds of recipes made with the supplementary food distributed by CARE through the AWC were demonstrated. The idea of setting up public display-boards at each AWC, giving an update of supplementary food, was popularized, as a step towards ending the prevalent pilferage of the food. One speaker, in an act of self-disclosure said she never knew what a meeting was, she did not know who or what the *Collector Sahib* was, until she assumed an active role in defense of women's rights. The idea of grain banks and Mother's Committees were also discussed. Kali Bai, President of Single Women's Solidarity Organization, herself a widow, talked about the socio-cultural gender bias against women in society. She pointed out that when a man loses his wife and becomes a widower, he is never stigmatized (*aadmi ka shagun khota kyon nahin hota hai?*), whereas when a woman loses her husband, she is negatively stigmatized as a "widow" (*raand*); why is she then not called the Chief of her family? By all accounts, the meet was a grand success.

Expansion and proliferation of the network of Mother's Committees:

The CARE initiative in the formation of Mother's Committees, thus began in the Abu Road Block, in JCS area of operation due to a maximum number of pilferage problems in that area and the accompanying difficulties of monitoring. Today, there are 53 Mother's Committees functioning in Abu Road Block alone. In January 2002, the idea was extended to include all other partner villages of CARE.

The State Government wakes up to the idea of Mother's Committees:

One very important fall-out of the above meet, relevant to our present topic of Mother's Committees was that, this was the first time that the district administration heard about such committees at the *Mahila Sangam*. Around the same time, a State Government minister from Rajasthan visited Andhra Pradesh, observed the working of Mother's Committees in the State and returned very impressed with the success achieved in Andhra Pradesh. There had been a growing debate in the country, about the disenchantment with government-sponsored development schemes (which were of course riddled with corruption) and their monitoring through *panchayats* (which themselves were not free of corruption and largely concerned with issues, which carried sizable financial allocations, offering the possibility of pilferage). Consequently, academic and public opinion had begun to veer in favor of decentralization of the powers of *panchayats* and encouragement of community-based institutions, such as Water User's Committees, stakeholder's monitoring of educational institutions funded by governments etc. The minister, on his return from Andhra Pradesh, mentioned the experiment of Mother's Committees there and the RDD (Regional Deputy Director) of Sirohi District, who had come across the concept at the above-mentioned Women's Meet (*Mahila Sangam*), quickly claimed that he had already been practicing the concept through the JCS! Thus, the organization and functioning of Mother's Committees came to form an integral part of ICDS departmental procedure and Sector Supervisors of the ICDS were instructed to encourage Mother's Committees in their Sectors.

Thus, the CARE initiative, in strengthening community-based, stake-holder's organizations (in this case, Mother's Committees), came to be later replicated at the state government level. The fine difference however was that, while the state government sought to achieve the objective through the ICDS, CARE sought to achieve the same objective through its partner NGOs, with ratification of these Mother's Committees by local *panchayats*. The 73rd. amendment to the constitution had already established that all line departments should work through *panchayats* at the local village level. In effect, the panchayats had been awarded supervisory powers over the village level activities of all line departments, such as health, irrigation, education, usage of ground-water etc. **The CARE initiative in forming and facilitating Mother's Committees, should thus, be viewed, in the same league.**

The process of linking the Mother's Committees to PRI:

However, there remained the task of sensitizing PRI representatives to local community-related needs, especially needs related to women of vulnerable communities. Two-days sensitizing workshop was thus organized for PRI representatives in Udaipur through a reputed NGO *Aastha*. Another training session for PRI representatives was organized to cover PRI representatives from Salumber and Kotra. The partner NGO in the Mavli Block, *Utthan Shoudh Sansthan*, organized a separate training for PRI representatives from their own area of work – Mavli. In these workshops and training programs, most of the *Sarpanchs*, hard-boiled cynics, began with a smug, self-assured attitude and viewed these programs as paid holidays. They were asked to draw up a list of AWCs in their *panchayat* areas. Most of them just about managed that. Next, they were told to draw up a list of the names of the AWWs attached to those centers. Most of them had a lot of difficulty in doing that as they hardly ever visited the AWC or interacted with the AWW. Thereafter they were told to draw up a list of the facilities available at these centers. By this point, they were quite uncomfortable because they had never bothered to find out anything about the AWC or the facilities offered. In the end, they were asked to define their own rights *vis-à-vis* the AWCs and the AWWs. This drew a blank. Thereafter, they were systematically educated and informed about their rights and duties with relation to the AWCs and AWWs.

On their return from these workshops, the sensitized PRI representatives zealously went about supervising the activities of the AWC in their *panchayats*. Until now, whenever the AWWs met the *Sarpanchs*, they complained about the dilapidated condition of the AWC buildings, the unsatisfactory conditions of work under which AWWs worked, erratic supply of rations etc. Now the tables were completely turned. *Sarpanchs* went about inspecting AWCs, threatened the AWWs with salary deductions in case they were found to be absent, insisted that the AWWs must report to them at least once a month, told them to stop complaining about the dilapidated conditions of the AWC buildings, asked to inspect the toys the AWCs

were supplied with to give to the children to play with etc. This zealous supervision of the PRI representatives got on the nerves of the AWWs and they complained to the Sector Supervisors and through them to the CDPOs. Not to be intimidated, the PRI representatives next went about disciplining the Sector Supervisors. In the end, the CDPO of Salumber complained to the CARE FO that the program was a good one, but that the *sarpanchs* were harassing her and her team of workers. Another CDPO told a FO 'I don't know what you have taught the *sarpanchs*, but now they are a headache for us' (*pata nahin aap logon ne in sarpanchon ko kya sikha diya hai; hamare liye to yeh sardard ban gaye hain*).

The final step in the establishment and effective functioning of the Mother's Committees lay in linking them firmly and statutorily with the local *panchayats*. At the regular and scheduled meetings of *Gram Sabhas* on 26th. January 2002 and 1st. May 2002, a number of Mother's Committees were recognized and ratified through formal resolutions and thus they came to enjoy formal legal status.

Conclusion:

Nearly 170 Mother's Committees have been institutionalized through the process of liking them to PRI in the five Blocks of Udaipur and Sirohi District.

Clearly, the Mother's Committees are an effective tool, provided they are properly facilitated and firmly enmeshed with the PRIs. It is an innovative effort, which assumes added significance in view of the fact that government efforts at community development have lost their focus. CARE's effort in fostering and nurturing these Mother's Committees has been a deep learning experience for the team members. Village women, uneducated, uncomprehending about local level politics or development issues, unable to hold their own in male dominated Rajasthan society, were drawn out of their homes and empowered to such an extent that they were ready to take on AWWs, Sector Supervisors, *sarpanchs*, et. al. They had come to grasp their rights, understand the importance of community level sisterhood linkages, the need to propagate and promote positive health behavior and firmly got the idea that power lay in collective action. They had learnt the first lessons of pressure politics and now they know that collective pressures can deliver the fruits.

Chapter 8

FEEDBACKS FROM TEAM MEMBERS & NGOs.

As mentioned earlier, BHNP II, as part of the INHP, failed to take off the ground even almost seven months after its inception. Partner NGOs were reluctant to cooperate in the achievement of CARE targets in partly view of the prevailing drought and partly due to incongruence of their visions with that of CARE. CARE Rajasthan reached a point where the allocated funds were about to be returned to the donor officials. Administrative changes were made in one last attempt to kick-start the project and a new Project Coordinator (the present one) was given charge.

All the members of the project team praised the flexibility offered to them by the Jaipur office, particularly the State Director, and were united in their opinion that without this flexibility, the targets could not have been achieved. This flexibility extended to budget modifications, initiating new activities, somewhat altering the action plan when necessary, openness to new ideas on the part of the State Director etc. In the follow up with NGO partners, in cross reviews etc. it was sometimes found that targets had not been met. To meet the situation, sometimes internal adjustment of funds were made and modifications were permitted.

The Project Coordinator, in conversation with this consultant, was emphatic that where bottlenecks cropped up, he found that cross visits were a very useful tool at problem-solving.

He mentioned that when JJVS, due to a mismatch of ideology, wished to withdraw midway from the partnership, He was called upon to muster all his leadership skills, negotiating skills and flexibility to keep the partnership going. In the end, the efficacy of the indigenous healing system is beginning to be apparent and is therefore beneficial to the communities in malnutrition cases. This is a very important finding as infant malnutrition continues to plague the project area in a big way.

The FO responsible for Kotra Block mentioned that initially, due to the drought, none of the partner NGOs was interested in the smooth implementation of the project.

In the Kotra Block, there were many quick transfers of CDPOs, Supervisors etc.

Many government posts lay vacant as nobody welcomed postings in Kotra Block. The remaining office bearers were overloaded with work and were frequently negligent.

The supervisory government staff did not have vehicles though Kotra is a big Block with difficult terrain. He would often ferry the government staff in his CARE vehicle to take them for inspection of AWWs etc. in his area of work.

Decisions at the government level were left pending for months. The line of command at the government level was badly disrupted.

The contractors responsible for the transportation of the nutritional supplements refused to have the food carried manually to AWCs located in villages not connected to roads. They left the bags of food on the roadside and the FO motivated the community to carry it to their AWCs. When supplies were erratic, the communities were motivated to supply firewood, salt etc. for cooking the food meant for spot feeding.

The ANMs were supplied with thick gauge injection needles and in poor communities in remote areas, frequent boiling those needles for mass vaccinations was a problem. Some ANMs bought thinner needles

with their own money. Sometimes, after the vaccination campaign in the villages, it would be impossible for the ANMs to return as the last bus would have left. The FO would go beyond his pale of duty and arrange for her return in a NGO vehicle or take an initiative in arranging her stay for the night in the village.

These problems were highlighted at the DLACs and their solutions were found. ANMs were supplied with thinner needles.

There was a complete dearth of educated people who could be used as staff by the NGOs. Greater inputs in capacity building were required in Kotra as compared to other Blocks.

Following a government directive to encourage the formation of SHGs and report back the details, the SS found the going very tough. So, they requested CARE's partner NGOs to give them a list of the SHGs formed by them, so that they might submit the same list to the government to claim that they (the SS) had formed the SHGs and fulfilled the targets. *Manav Kalyan Samiti*, CARE's partner NGO in Kotra got into a big fracas with the local SS. The FO had to play a mediatory role.

One big disadvantage in efficient work output was that the government came to expect that CARE would help in everything – vaccinations, supervision of AWWs and ANMs, distribution of supplementary food, even coping with an epidemic in Mewaron Ka Math. This was completely outside the project purview.

The ANR specialist was emphatic that, in the field, one cannot proceed with preconceptions as things seldom turn out the way one wants them to or anticipates. Flexibility and adaptability are the keywords in the field.

He held that NGOs seldom agree to cooperate on their own, but rather have to be coaxed, cajoled and brought round to the point of cooperation.

He felt that book-keeping was of paramount importance, specially in the formation and functioning of CGBs. He felt that CARE was withdrawing at a crucial stage, when lending and recovery had just started in the CGBs and supervision at this point, specially the supervision of book-keeping, was of paramount importance at this stage. He considered a system of incentives (such as the providing of a matching grant in CGBs), as an important step in evoking initial participation.

Despite all the difficulties of linking up with PRI, he felt that cooperation with the government is essential because it provides valuable experience in replicating the specific activity in other areas.

The FO for Abu Road and Reodar felt that the AWW was the keystone of the entire edifice. A good AWW made all the difference to service deliverables and other activities. Situated at the bottom of the ladder and paid a niggardly honorarium, she was the pivot on which all developmental activities rested.

The FO in charge of Mavli and Salumber mentioned that it was particularly tough to sensitize and build the capacity of PRI as they were a cynical and hardened lot. One first had to throw them off gear to rid them of their smug complacence and then begin the capacity building sessions.

THE RESOURCES & CAPACITY BUILDING OF PARTNER NGOs:

The two major partner NGOs in Kotra and Abu Road – *Jan Chetna Sansthan* and *Aadiwasi Vikas Sansthan*, an offshoot of *Aastha* – had an extensive background of social activism. Before the BHNP intervention and before their partnership with CARE, they had been firmly bonded with the local communities on two other major issues – the issue of exploitation of poor local communities through usurpation of **pawned jewelry** and exorbitant interest rates charged by local money-lenders (*girwin jewaraat*) and the issue of the rights of forest communities over the ***tendu*** **leaves**.

The agitation over the *tendu* leaves was an issue, which had rocked national level politics and caused one trans-national NGO to somewhat alter its economic assistance policies in favor of the poor agitators.

Besides these two major issues, they had mobilized the tribal women to agitate and participate in large-scale **demonstrations against the free sale of liquor**, which often resulted in their men folk living in a state of drunken stupor while the children starved. It frequently culminated in domestic violence and battering. This agitation had resulted in a state-level reversal of excise policies.

In addition to the above three agitations, they had mobilized the locals in an agitation against the Forest Department in favor the rights of forest dwellers to forest land (**jangal-jameen mudda**) and their rights against eviction from that land.

Thus, the partner NGOs were, even before the initiation of BHNP II well bonded with local communities. Through their able and successful advocacy of important issues, which touched the very existence of the tribals, they had won the trust and confidence of local communities. They were well conversant with the local traditions and customs, knew well exactly how far to intervene in socio-cultural matters and when to stop. They understood well the local mindsets and were sincere in their vision and efforts to strengthen local communities at the village level. They were determined in their efforts to end the exploitation of the locals by vested interest groups. The problem was that, since each of the above issues eroded the positions of vested interest groups (the local money-lenders, the contractors with tenders for the procurement of *tendu* leaves as well as the large *bidi* manufacturing houses owned by rich Gujerati businessmen, forest officials in league with hefty profit making contractors, local liquor barons and corrupt Forest Department officials), the partner NGOs had, naturally lapsed into a strong activist mode – fighting government departments, leading all-women rallies which picketed against liquor shops, facing police brutalities on agitation venues etc. These methods of activism were in direct contravention to CARE’s functioning. Hence, when the offer of partnership with CARE came up, there was apprehension on both sides. The NGOs, familiar only with agitational activism, wondered if, in switching over to the developmental mode, as required by CARE, they would lose a large part of their support base amongst the local communities. CARE, high in its resolve to further the capacity building of partner NGOs, wondered if they would ever be able to undertake a smooth transition from activism to development. The entire responsibility of re-orientation and capacity building came to rest on the slim shoulders of the FOs, the actual persons in the field and to some extent on the Project Coordinator.

Beginning from this mutually apprehensive position, together they designed and passed through many capacity-building exercises and training sessions at various levels and have today, developed a perfectly harmonious and mutually supportive as well as a mutually appreciative relationship.

Chapter 9

CONCLUSION

A large part of what will be said by way of conclusion has already found expression in the section titled "Executive Summary". However, a few observations remain.

LIMITS TO PRO - POOR GOVERNANCE:

Scattered inhabitation tracts, termed in local language as "*phalan*", limited spread of literacy amongst the communities, migratory economy of tribals who follow the hunter-gatherer lifestyles of migrants, the negligent attitude evinced by government functionaries towards official duty, (more specifically, some ANMs and some *Aanganwadi* workers), security of jobs granted by socialistic measures to these errant functionaries, rising expectations of community members concerning the execution of welfare measures by the government of the day, geographical inapproachability in negotiating the hilly terrain, specially in the rainy season when seasonal torrential streams overflow their banks to sever already tenuous communication links and thereby make impossible the regular supply of food to the communities, searing desert temperatures in the summers, tardy functioning of the government machinery resulting in conflict and clashes with local NGO functionaries and community women, investment of resources for welfare amongst non-taxable or minimal tax-paying communities, widespread drunkenness (compounded by socio-cultural acceptance of the phenomena) amongst the men of the tribal communities, are some of the limitations to pro-poor governance.[59] While most of these limitations can be ironed out with advance planning and determination, the existence and the impact of these difficulties cannot be overlooked. Even the determination of making development accessible to far-spread communities, in such circumstances, is indeed a Herculean task, by any standards.

In touring the operational area of the BHNP II, this consultant was struck by the poverty evident amongst the local communities, especially in the tribal belts. This consultant, having seen and traveled in rural prosperous areas of a border state like Punjab, ravished by repeated wars with Pakistan, yet resurrected like the proverbial phoenix, wondered why a similar rural metamorphosis could not be repeated here. The local people, successors of a feudal tradition, battled against water scarcity, lack of alternate income generating possibilities, insufficient health and educational infrastructural support in their daily lives. They were bereft of food security and security against natural disasters, such as the failure of rains and effects of the earthquake in the tribal block of Kotra, adjoining Gujarat. Yet their dignity was rock firm, evident for anyone who would choose to look at it.

Since the achievement of convergence in developing mediating structures is important for CARE, it would be in the fitness of things to state categorically that inter sectoral interventions taken up on a pilot basis in the project have, on the whole, been well received by the government functionaries, NGO partners and the village community, especially women. Capacity building of the PRIs for increased community participation, is a new intervention, which has broadened the scope of the project. Convergence, collaboration and partnerships with NGOs, community based groups and PRIs has been a very productive experience of the project. These have emerged as anchoring strategies and models for future interventions as the approach of direct interventions through project activities has a limited life outside the project time and resources.

It was observed that, the ANR sector of the BHNP II is one which is the most popular amongst the local community. To that extent, it may be termed as one of the most successful activities.

The roles of the FOs were not only central to the success of the project, but were time and again lauded by partner NGOs and community members.

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[59] For related themes, see Couto, R. with Catherine S. Guthrie, *Making Democracy Work Better: Mediating Structures, Social Capital and the Democratic Prospect*, Chapel Hill, NC and London: University of North Carolina Press, 1999. Also Bernstorff, Dagmar, "Why NGOs? Problems of Empowerment, Autonomy and Linkages in India and Pakistan" in Richter, Justus and Wagner, Christian (ed.) *Regional Security, Ethnicity and Governance*, Manohar Publishers and Distributors, New Delhi, 1998.

Village women, uneducated yet endowed with very strong commonsense, uncomprehending about the intricacies of local level politics (which have wheels within wheels) or development issues, unable to hold their own in male dominated Rajasthan society, were drawn out of their homes and empowered to such an extent that they were ready to cast off age-old rural gender perceptions and self-perceptions about their roles. They were takeing on AWWs, Sector Supervisors, *sarpanchs*, et. al. They had come to grasp their rights, understand the importance of community level sisterhood linkages, the need to propagate and promote positive health behavior and firmly got the idea that power lay in collective action. India claims to be the biggest functioning democracy in the world, yet we do nothing to teach our citizens the first lessons of democracy. These women had learnt the first lessons of pressure politics and now they know that collective pressures can deliver the fruits. CARE offered to them a non-confrontational form of participative democracy and they have proved worthy of it.

Chapter 10

APPENDIX

Appendix 1	Scope of Work for Dr. Jayati Chaturvedi Part B.
Appendix 2	Resource Structure for BHNP II..
Appendix 3	GoR invitation to partner NGO of CARE, SARD to help in training program for forming SHGs.
Appendix 4	Guidelines framed for the guidance of partner NGOs for the formation and operation of Grain Banks (Document in Hindi).