Community Action for Health

Case Study from Bihar and Jharkhand, India

SRC Publication, April 2008

Swiss Red Cross

Initiatives in Development Support

Community Action for Health
Case Study from Bihar and Jharkhand, India

Authors
Peter Eppler, Amitabh Sharma and Neeraj Labh

Study Design
Verena Wieland

Editing
Elena Krylova

Fotos
Peter Eppler

Swiss Red Cross Publication, April 2008

The case study was co-funded by the Swiss Agency for Development and Cooperation (SDC).

This case study from Bihar and Jharkhand is part of an international study of Swiss Red Cross covering experiences from projects in Ecuador, Eritrea, India and Kyrgyzstan and providing an in-depth analysis of individual country experiences and of cross-country comparison with regards to common course, differences and lessons learned.

FOREWORD

Since the early 1980s the Swiss Red Cross (SRC) through its international cooperation has been implementing various projects (mainly in remote rural areas in South-America, South and South-East Asia) that are known as "Community-based Health Projects". The World Health Organisation's Declaration of Alma Ata of 1978 on Primary Health Care and the later adopted Ottawa Charter for Health Promotion have been serving as point of reference for these interventions.

From the very start SRC put special emphasis on working at the community level and mobilising people's participation. Strengthening self-help abilities and the local resource base, along with the empowerment of community-based organisations are among the central concerns of SRC projects. General coordination with the official health system was always considered a precondition for avoiding duplication and building of parallel structures. Little systematic research has been conducted on the impact of different interventions in community-based health. This study contributes to filling in this gap and to enriching the conceptual discussion of approaches to community-based health.

India has made tremendous improvements in its economic and social development in the past two decades and is likely to realise even faster growth in the years to come. And yet there is a wide gap between the rich and the poor, a disparity which has only increased over the years, hurting anti-poverty efforts and possibly fuelling social unrest. For this reason, there is a dire need to reduce the high degree of income inequality and high incidence of poverty, especially in rural areas, through faster and more inclusive growth.

In North-Bihar and Jharkhand SRC has been addressing the needs of poor and vulnerable communities in some 202 villages for more than sixteen years, a humble but nevertheless important contribution to improve the living conditions of thousands of families belonging to the deprived section of society. "Community Action for Health, Case Study from Bihar and Jharkhand" describes and analyses some salient features and experiences of the SRC supported development programme implemented by a network of local NGOs. To its credit, the programme could claim considerable progress in health indicators, despite adverse initial health conditions including high rates of child malnutrition and incidence of communicable diseases. However, after some time it was realised that a sector specific approach alone was not sufficient to improve people's living conditions and achievements in the health sector could only be sustained by addressing other relevant development components as well. As a result, the programme emphasised increasingly on equal access to services, enhancement of gender and social equity, capacity building of local communities, resource mobilisation and income generation, and strengthening of local governance.

Social inclusiveness is particularly relevant in a society divided by caste, religion and ethnicity, and - as in Jharkhand - where tribal people constitute a significant minority. Fortunately, there is growing political concern and commitment to build infrastructure, particularly rural areas, to make government agencies more accountable and to improve their services in favour of a large segment of poor people, and to enhance local government institutions which are vital for inclusive development. It is hoped that these efforts will be continued and "make development happen" in near future.

Margrit Schenker

Head of Europe and Asia Department
Swiss Red Cross

TABLE OF CONTENTS

ABBREVIATIONS

BF	-	Badlao Foundation
BMVS	-	Bhusra Mahila Vikas Samiti
CDP	-	Community Development Programme
CBOs	-	Community Based Organisations
CEP	-	Community Empowerment Programme
GVP	-	Gram Vikas Parishad
IIDS	-	Initiatives in Development Support
NFHS	-	National Family Health Survey
NGOs	-	Non Governmental Organisations
PNDSS	-	Patna Notre Dame Sisters' Society
PRIs	-	Panchayati Raj Institutions
SHGs	-	Self Help Groups
SRC	-	Swiss Red Cross
SSVK	-	Samajik Shaikshanik Vikas Kendra

«The sun has not changed; the moon has not changed,
but our women leaders have changed our lives. »

Song of mahila sangham (women's group)

EXECUTIVE SUMMARY

Deprived rural communities of 202 villages in North Bihar and in Jharkhand, which was part of Bihar until 2000, have been supported by the Swiss Red Cross (SRC) from 1990 till 2006. In these years the programme has gone through programmatic changes and repositioning.

Community Development Programme (CDP): In the first phase covering 1990-95 the programme was guided by a service delivery model by which a cadre of trained people provided for mother and child health care, non-formal education and income generation support. The programme in its second phase (1995-2000) explored the possibilities of making the sectoral services sustainable by encouraging beneficiaries to pay for services rendered in education and health. But the approach did not have many takers as the target groups were either disinclined or lacked the ability to pay for the services that had been free till then under CDP. It was realised that parallel structures for delivering health and education services had little scope to become sustainable through community financing. As it was the responsibility of the state to make available these services to its citizens, a more viable and preferred option was to figure out ways and measures to make the state fulfill its commitment.

Community Empowerment Programme (CEP): It was the above mentioned premise that brought about a paradigm shift in the SRC programme and moved it from a sectoral approach into an empowerment approach, applied in the last seven years (2000-06). This case study highlights some key issues of the programme, with special emphasis on the past seven years.

The community empowerment goals, apart from strengthening community based organisations, mainly targeted objectives related to:

- equal access to health care, education and other government services
- social equity and justice especially with regard to gendered vulnerabilities
- sustainable resource mobilisation and income generation
- right to information and participation in local governance.

Experience proved that without secure foundations in these basic prerequisites sustainable improvement in health would remain elusive.

Despite extremely difficult socio-economic conditions, hundreds of self help groups (SHGs) and their federations have been empowered and the lives of thousands of women and men and their families have been considerably upgraded. Though community-based health care was the main entry point and catalyst of change, the project outcomes also contributed considerably to improved economic and educational status and tremendously enhanced the self-respect and confidence of local communities. It is noteworthy that two self-help group members, Tiliya Devi and Amrika Devi, who were trained and have been part of the project right from its inception, were among the 1,000 women nominated for the Nobel Peace Prize 2005.

1 CONTEXT DESCRIPTION

1.1 Bihar and Jharkhand – poverty in lands of plenty

In 1917 Mahatma Gandhi arrived in Champaran in North Bihar to lead an agitation against extortionist British indigo planters. Ninety years after his visit to Bihar and sixty years after India's independence the area is still poverty stricken with large sections of society being exploited and having to ensure survival under the most difficult conditions.

From 1990 till 2006 SRC has been addressing the needs of marginalised communities in 202 villages of Bihar and Jharkhand. In this period the programme, which has been co-funded by Swiss Agency for Development and Cooperation (SDC) and for some years by Interchurch Organisation for Development Co-operation (ICCO), has gone through programmatic changes and repositioning. At the outset it is worthwhile to provide a brief description of the geographical area.

Located in the very fertile gangetic plain of eastern India, Bihar is the third most populous state in India, with a total population of 83 million.[1] In terms of development it is the most backward state, with a very high proportion of the population living below the poverty line (44% in rural areas[2]). Also with respect to health[3], literacy rate and most of the other development indicators the state fares very badly.

The state's low development status, besides being an outcome of the poor economic performance of both agricultural and industrial sectors, is equally related to the iniquitous and exploitative socio-economic structure, lack of political leadership and almost total collapse of the administration, and law enforcement machinery - to the point where it is said that in Bihar "the state has withered away". Add to this the disaster proneness of the state, especially the almost annual recurrence of floods in North Bihar where three of the four SRC partner Non Governmental Organisations (NGOs) are located. These conditions have created a milieu of non-development in which even large-scale poverty eradication programmes have had little impact.

Jharkhand, which was carved out of southern Bihar and became an independent state in November 2000, has a population of 26.9 million.[4] Most of Jharkhand's agricultural land is not irrigable but rain-fed. Additionally, there are large forested areas inhabited by a predominantly tribal population. With around 40% of India's minerals the newly created state can be considered as enormously rich in natural resources and as having a phenomenal economic development potential. Quite in contrast to the wealth in minerals, the National Sample Survey in 1999/2000 assessed 49% of rural poverty[5] (rural population living below poverty line). Despite some progress in the past seven years Jharkhand remains a state with one of the highest poverty rates in India.

Looking at the present health situation in both states, the health related Millennium Development Goals cannot be reached if the present health outcomes and coverage of priority services[6] are not being considerably improved. The important issues which would have to be addressed are: grossly inadequate and inefficient public health infrastructure, substantial lack of essential requirements in terms of manpower, equipment, drugs and consumables in the primary health care institutions, the poor accountability of health care providers, and lack of equitable access to health care.

---

[1] Office of the Registrar General & Census Commissioner. Census of India 2001; Total Population. New Delhi: Office of the Registrar General & Census Commissioner.

<http://www.censusindia.gov.in/Census_Data_2001/Census_data_finder/A_Series/Total_population.htm>. 19.04.2008.

[2] Government of India Planning Commission 2006. National Human Development Report 2001. Table 2.21; New Delhi: Government of India Planning Commission: 166.

[3] For health related indicators of Bihar and Jharkhand refer to table 2 on page 9.

[4] Office of the Registrar General & Census Commissioner. Census of India 2001.

[5] The World Bank 2007. Jharkhand, Addressing the Challenges of Inclusive Development. Report No. 36437- IN. Washington: The World Bank: i.

[6] For health related indicators of Bihar and Jharkhand refer to table 2 on page 9.

In Bihar and Jharkhand economic growth and social service delivery have been far from being inclusive. *Dalits,* the scheduled castes, other backward castes and tribal communities were the least able to benefit from development programmes and had uneven access to the distribution of assets. In Jharkhand there is even evidence of an increasing inequality in rural landownership in recent years, especially in tribal areas.[7] These are favourable conditions for extreme left mobilisation and violence. The so called "Naxalite movement" has had an upsurge during recent years. Today most of the districts in both states are infested by leftist extremism. As there are daily reports of sparking violence across a wide swath of India, including Bihar and Jharkhand, Prime Minister Manhohan Singh described the underground movement as "the single biggest internal security challenge ever faced by our country".

1.2 Health system in India

The constitution has made health care services largely a responsibility of state governments in terms of service delivery but has left space for the centre to provide for national health policy and planning framework. The current government health care system comprises curative and preventive health services, from primary to tertiary level, throughout the country and free of cost to the user. As far as expenditure is concerned, state and local governments incur about three-quarters and the center about one-quarter of public spending on health. Wide variations in state income and capacity levels result in large disparities in health funding and outcomes. While some states such as Kerala and Tamil Nadu approach the standards of developed countries, others, such as Bihar and Jharkhand have health indicators that are amongst the worst in the world.

The public health delivery consists of a tiered system that was originally intended to refer users to the most appropriate level of care. Facilities include front-line sub-centers (village level) intended to be staffed by two multi-purpose health workers; primary health centers (block level) that take referrals from the sub-centers; community health centers with a small number of in-patient beds and district hospitals (district level).

Though India pledged, along with other World Health Organisation member nations, "Health for All by the Year 2000" at Alma-Ata in 1978, India's achievements in the field of health have been less than satisfactory. Annually 2.1 million children under five die from preventable illnesses,[8] 100,000 mothers continue to die of pregnancy related causes every year,[9] and half a million people die of tuberculosis[10]. Diarrhoea and malaria continue to be killers while 2.5 million people are suffering from HIV/AIDS,[11] and the overall burden of disease among the Indian population remains high.

Many of these illnesses could be prevented or treated cost-effectively with primary health care services for which an extensive government infrastructure exists. However, implementation has fallen short of the goals and varies widely from state to state. On average the performance of the public health care system is rather weak. As a result 70% households in urban areas and 63 % households in rural areas,[12] have to resort to expensive health care services provided by the largely unregulated private sector. Not only do the poor face the double burden of poverty and ill health, but the financial burden of ill health can push even the non-poor too into poverty. Despite this situation, India spends only 0.9% of its Gross Domestic Product on public health[13], which is grossly inadequate.

---

[7] The World Bank 2007: vi.

[8] Gareth Jones, Werner Schultink and Babille Marzio 2006. Child Survival in India. *Indian Journal of Pediatrics,* Volume 73, No. 6: 479.

[9] Ministry of Health and Family Welfare, Department of Family Welfare no year. Maternal Health Programme. <http://mohfw.nic.in/dofw%20website/MATERNAL%20HEALTH%20%20PROGRAMME%20%20.htm>. 19.04.2008.

[10] Mihai S. Jalba 2004. Forum. *Indian Journal of Tuberculosis* 51: 113.

[11] National AIDS Control Organisation 2006. *HIV Data*. New Delhi: National Aids Control Organisation. <http://www.nacoonline.org/About_NACO/Contact_NACO/>. 19.04.2008.

[12] International Institute of Population Sciences 2006. *National Family Health Survey (NFHS 3) 2005-06*, Volume I. Mumbai: International Institute of Population Sciences: 436.

[13] Bajpai Nirupam, Jeffrey D. Sachs and Nicole Volavka 2004. *Reaching the Millennium Development Goals in South Asia,* CGSD Working Paper No. 17. New York: The Earth Institute at Columbia University: 15.

1.3 Community profiles

The programme's activities are in favour of rural communities across three districts of Bihar and one district of Jharkhand. The communities comprise the most disadvantaged sections of the society, i.e. *Dalits* and tribal people along with populace coming from the backward and the extremely backward castes. Their poverty is largely due to structural inequities (caste and class inequities) which limit their access to, and control over, assets, education, health care and other constitutionally ordained entitlements.[14] Furthermore, these communities have been historically marginalised with literally no opportunities to participate in decision-making processes. Their exclusion even manifests spatially as they reside on the periphery of the settlements. The influence of the politically and economically powerful local elites coupled with the hard struggle of the poor to meet survival needs, hardly allow these communities to organise and to resort to development initiatives collectively.

Marginalised communities usually live in separate hamlets consisting of 75 – 80 households (400 – 550 inhabitants) on average in Bihar and 40 – 50 households (220 – 275 inhabitants) on average in Jharkhand. The discrepancy between the two states is due to the higher population density in North Bihar compared to Jharkhand. In Jharkhand, tribal communities (26.3% of the total population)[15] comprise an unusually high proportion of the society. In both states most households of marginalised communities are landless and depend on daily labour. As opportunities to work for big landholders, social government schemes or commercial enterprises are rather scarce; men often depend on seasonal migration to bigger cities or other states to secure their livelihood. For most of the year, predominantly women, children and elderly people are left in the villages. This is one of the reasons why SRC supported NGOs are concentrating on women oriented projects – in this context "community empowerment" means mainly "women's empowerment".

The literacy rate of women in both states is below the national average.[16] For hardly educated, unskilled women of low social status it is difficult to survive on their own in a male dominated society with feudalistic tendencies. And yet, while their husbands are often far away, they are the backbone of their families struggling hard to sustain their lives with quite often a good number of children to feed.[17] As there is little income opportunity, purchasing any type of private health services is out of scope or results in debts. On the other hand, free government health services also remain underused as they are perceived to be of poor quality and difficult to access. According to National Family Health Survey 3 (NFHS-3) the "percentage of households that do not generally use government health facilities" is a record breaking 93.3% in Bihar and 77.7% in Jharkhand.[18]

---

[14] The World Bank 2005. *Bihar – Towards a Development Strategy.* Washington: The World Bank: 1-2.

[15] Office of the Registrar General & Census Commissioner. Census of India 2001. Scheduled Caste & Scheduled Tribes Population. New Delhi: Office of the Registrar General & Census Commissioner. <http://www.censusindia.gov.in/Census_Data_2001/Census_data_finder/A_Series/SC_ST.htm>. 19.04.2008.

[16] Female literacy rate for women is 37% in Bihar and 37.1% in Jharkhand, the average female literacy rate for India is 55.1. International Institute of Population Sciences 2006. *NFHS-3 2005-06*, Volume I, Table 3.4.1: 62.

[17] Fertility rates of women in the 15-49 years age group are still astoundingly high in both states. Bihar with a fertility rate of 4% has the highest of all states in India. In Jharkhand the fertility rate is 3.31%. International Institute of Population Sciences 2006. *NFHS-3 2005-06*, Volume I, Table 4.3: 83.

[18] International Institute of Population Sciences 2006. *NFHS-3 2005-06*, Volume I, Table 13.13: 438.

2 GOAL, APPROACH AND PROCESSES

2.1 Selection and coaching of partner organisations

The Community Development Programme (CDP) 1990–1999 and the Community Empowerment Programme (CEP) 2000–2006 which had a cumulative life span of sixteen and a half years owed their origin to the 1988 earthquake which affected much of North Bihar and parts of Central Bihar as well. After a relief and rehabilitation phase, SRC decided to assist the poorest within the framework of long-term, sustainable development efforts for improving their living conditions - including health, education and income generation as key areas - and strengthening their self-esteem and self-help capacity.

On the recommendations of a project identification mission set up by SRC to identify local NGOs, development cooperation was initiated with a set of five local NGOs in July 1990. Although all organisations comprised committed and dedicated staff, they partly lacked the particular skills necessary for effective and efficient project implementation. The NGOs themselves said that they would be interested in SRC taking an active role to support them, not only with financial inputs but also by assisting them in the training of staff, and in getting consultancy on organisational and technical aspects as well as in conducive project cycle management. Therefore, SRC decided to designate local experts and to set up a SRC Programme Coaching Unit which later became a registered legal entity - Initiatives in Development Support (IIDS). A brief organisational profile of the SRC supported partner organisations is given at the end of the case study.

2.2 Linking health and poverty alleviation

The project viewed good health as an integral component of human wellbeing and an important social benefit. It is a fundamental human capacity that enables every individual to achieve her/his potential to participate actively in social, economic and political processes.[19] In this sense, there is a close link between health promotion and empowerment and economic development objectives. It is understood that a heightened awareness about health and preventive measures will have a positive impact on the morbidity profile of the region, thus salvaging the poor from being hurled deeper into the trap of poverty.

2.3 From service delivery to empowerment

The SRC approach over the years was designed to address both demand and supply constraints related to the health sector. There is a lack of demand for health services in the state due to low awareness levels of communities regarding the state's responsibilities and the entitlements of socio-economically deprived communities. Also the poor quality of health services, the limited access to these services and the influence of local cultural factors have severely dampened demands for public health services in the state. On the supply side there is a need for developing a coherent framework-based policy and a strategic plan that reflect the needs of the beneficiaries, the responsibilities of the service providers and the state, and which addresses key delivery constraints.

In the first ten years, as a response to the weak performance of public health care, the primary objective of the programme was to equip local NGOs in cooperation with Community-Based Organisations (CBOs) in delivering an effective Primary Health Care package with special focus on mother and child health. Services (such as ante/neo/post natal care, vaccination of pregnant women, identification of complicated pregnancies, growth monitoring, counselling on health issues, etc.) were delivered through a village health post manned by a trained health cadre. This service delivery component went hand in hand with health education wherein village health volunteers were trained to disseminate health messages and to mobilise people for health initiatives. Over the years the responsibility for curative and preventive health care initiatives was gradually handed over to CBOs with committed and capable leadership.

[19] Government of India. Special Task Force 2007. *Bihar: Road Map for Development of the Health Sector.* New Delhi: Government of India: 7.

SHG members in Madhubhani district, 2005

Since 2000 the SRC programme has been characterised by a shift to an empowerment approach wherein the communities were adequately enabled to develop appropriate structures and strategies.[20] They were also endowed with sufficient information to demand from the state the legitimate services for the poor and vulnerable. The empowerment approach crucially hinged on engaging the community in monitoring the process and achievements so that it had first-hand experience of the changes brought about by such services and were reasonably convinced that these were essential for their well being.

The realisation of the paradigm shift also depended on promoting and strengthening CBOs such as issue based committees, SHGs and their federations. These CBOs served as platforms to provide developmental inputs in health and education as well as to optimise economic and livelihood opportunities. This paradigm shift benefited from changes in the macro policy which favoured creation of SHGs as instruments for financial intermediation, an approach which combines access to low cost financial services with a process of self-management and development for women who are SHG members. In India, by March 2006 an estimated 33 million women had been linked to banks for financial services through 2.2 million SHGs.[21] In the context of the SRC programme in Bihar and Jharkhand SHGs and their federations also became active in village and development affairs, stood for local elections, and addressed crucial social issues.

2.4 Advocacy and empowerment for collective action

Advocacy was promoted in the empowerment phase to make governance accountable, transparent and need oriented. The set of actions comprised the following three steps:

Step 1: All NGOs gathered relevant information on government health facilities, such as health infrastructure, deployment of personnel in these institutions, facilities to be made available at various delivery points, equipments and drugs

[20] A more detailed description of this process has been published under: Eppler Peter 2004. *Vom Gesundheitsprojekt zum Empowerment von Frauengruppen in Jharkhand, Indien, Der lange Weg aus der Unterdrückung*, in: Bulletin of Medicus Mundi Schweiz, Nr. 94, pp 8-11.

[21] National Bank of Agriculture and Rural Development (NABARD) 2006. *Annual Report 2005-06*. Mumbai: National Bank of Agriculture and Rural Development. 5.

to be available at such institutions and the role of the state in promoting health. In a later stage the NGOs trained so called "community resource persons" to collect the necessary information on government outreach programmes.[22]

Step 2: Facilities, resources and services as committed by government rules and regulations were compared with the actual status on the ground. The findings were disseminated and discussed in village meetings and other appropriate platforms.

Step 3: Supported by their respective NGOs, the CBOs resorted to enter into dialogue with the relevant authorities, articulating the dichotomy between government commitments and the ground reality. If this did not yield any results, the CBOs eventually resorted to petitioning, demonstrations and sit-ins to highlight the malpractices and shortcomings within the government health system and force the authorities to undertake improvements.

Though community health comprised a key advocacy objective, the initiatives were broader and covered issues related to education, government development and welfare programmes, participation of deprived communities in local governance institutions, right to information, land rights and other relevant community issues. However, it needs to be mentioned that it is not just lack of political will and administrative efficiency that impedes proper implementation of government programmes and schemes but the incompatibility between values enshrined in the constitution and traditional socio-cultural practices (such as adherence to caste system) and religious values (such as fatalism) can be held equally responsible for the lacuna in the implementation of government programmes and policies. Hence, empowerment was perceived from an holistic social change perspective in which advocacy was conceptualised as a tool meant to go beyond mere public policy influence to the larger arena of influencing societal attitudes and practices so as to transform the oppressive value system to a more just and humane worldview.

These attempts met with a measure of success the extent of which can be gauged from the following case studies compiled by external evaluators during the course of programme evaluation in 2003.[23]

Case Study 1: Government gives in to collective power of women

Bhusra Mahila Vikas Samiti (BMVS) supported federation members once put up a protest at the Gaighat Public Health Centre to protest against the humiliation inflicted by the doctor to a member patient with tuberculosis. Following the incident, a local women's group held an emergency meeting to decide upon the future course of action. A three-point charter of demands was presented before the authority and the lifting of *gherao* (demonstration in front of government office) was made subject to compliance with all of them. The demands were as follows:

- Sustained treatment and eventual cure of all Tuberculosis patients in the area
- Regular service delivery by Auxiliary Nurse Midwife and doctors of Primary Health Center
- Family planning camps to be held at additional sub-centre

These demands were accepted and necessary corrective measures were initiated. Something like this was previously unthinkable and such success imparted dynamism to group building processes.

Instead of implementing the health and education programme vertically, the singular focus of all NGOs in the empowerment phase has been mainstreaming with the government facilities, and transforming the role of NGOs into that of a "watchdog" to ensure that people are receiving the services. In addition, CBOs were involved in overall development of the villages and not just in the interests of their members. The reasons cited by the SHGs for their formation are very interesting: greater strength in fighting social injustice and accessing rights and entitlements; resolution of problems/conflicts through group

[22] The Right to Information Act, 2005 gives citizens the right to access government owned information on documents and records, including all information on development and welfare programmes. Government of India. Right to Information Act 2005. Obligations and Responsibilities. New Delhi: Goverment of India. <http://www.rti.gov.in/rti_slides>. 22.04.2008.

[23] Neupane Ram and Kishore K. Singh 2003. *Evaluation of Bihar Community Development Programme*. Programme Document. Bern: Swiss Red Cross.

action; improvement of economic standard by creating employment opportunities through income generation activities and reduction of dependency on *mahajans,* village money lenders.

A key outcome of mobilising target group members into CBOs, including SHGs and their federations, has been the optimisation in resource use. Despite a progressively declining programme budget and reduced NGO staff outlay, the gains accruing to the communities have multiplied manifold due to their organised initiatives for asserting their rights, securing their entitlements and taking part in decision making. This can be best illustrated by the following case study.

Case Study 2: District magistrate's message makes SHG women ride tractor

On 15th March 2003, eight hundred members of SHGs facilitated by Patna Notre Dame Sisters' Society (PNDSS) participated in a function organised by the National Bank of Agriculture and Rural Development. Interactions with a number of district officers and bank managers about the benefits of SHGs brought a new confidence and, indeed, was a memorable experience for the participants. The District Development Commissioner dwelt upon the opportunities that might come their way in the forms of different development programmes. Overwhelmed by the confidence of the SHG members, the district magistrate wished "that a day will come when a bus owned by these women will be on the road transporting people from Jamalpur to Bengalwa." SHG members of PNDSS took this message to heart. They went back to their villages and mobilised others to discuss the matter with the SHG federation. During the meeting the members identified the need for a tractor as most urgent. They reasoned out that the possession of a tractor by the SHG would enhance the efficiency of sharecroppers who tilled the lands of others for their livelihoods. So they took the decision to pool all their savings and negotiate with bank officials for the loan. On the 1st of July 2003 SHGs of *Panchayat* Federation bought their own tractor worth Rs. 300'000. They formed a ten member committee to look after the management of the tractor. This year, for the first time, they had their fields tilled on time and are very happy.

In order to provide information to CBOs/ SHGs and individuals, a resource centre run by community volunteers has been set up at each NGO to collect and disseminate information on development schemes and programmes and on micro-loan schemes of financial institutions. It emerged that, within a year of its constitution, at least 200 families accessed information from the resource centres regarding various government schemes and programmes. Capacity constraints and lack of economic support are some of the operational difficulties encountered by these centres. The possibility of levying a user fee for the resource centre services is being explored.

2.5 Process extension and outreach through SHGs

The SHGs are distinctly characterised by strong autonomy in managing their affairs, taking decisions, resolving conflicts locally, eliciting cooperation of group members in sharing responsibilities and subscribing to common norms and rules of the group, enhancing resource mobilisation, and federation building. This has earned them legitimacy with most of the key stakeholders in the local context. Process extension has been characterised by a significant increase in the membership base of the SHGs, across 202 villages where the programme has been operational. The following table gives a comparative estimate of the increase in SHGs, which more than doubled over a span of 3 years; this shows a high degree of process extension:

Table 1: Increase of SHGs in three year period[24]

NGOs	SHGs in August 2003	SHGs in December 2006
Badlao Foundation (BF)	100	107
BMVS	121	245
Gram Vikas Parishad (GVP)	215	552
PNDSS	85	144
Samajik Shaikshanik Vikas Kendra (SSVK)	20	97
Total	**541**	**1'145**

Federation building has also witnessed a similar increase in geographic outreach and in enhanced representation of SHG members at all levels (from village to district level).

[24] Eppler Peter, Neeraj Labh and Amitabh Sharma 2005. *Assessment Mission Report 2005*. Bern: Swiss Red Cross.

3 ACHIEVEMENTS

3.1 Improvement of health situation

Community-based health care

One of the key contributions of the programme was to create a trained cadre of health personnel at the village level. The programme invested heavily in building up capacities of health workers, health promoters and traditional birth attendants. Almost the entire cadre belongs to villages where the programme has been operational: hence, the cadre would remain in the villages and sustainably render services even after the conclusion of the programme. Further, the project has generated a convincing level of awareness among the people on health issues leading to a definite decline in superstitious practices.

Village health committees have been at the vanguard in terms of monitoring health activities. They have also been responsible, in addition to the health promoters, in disseminating health messages and taking up health issues in group meetings.

Due to cultural factors the programme encountered difficulties in the initial phases in terms of identifying pregnant women and persuading them to avail themselves of health post services; gradually, however, women were helped to understand how ante/neo and post natal care are essential for the health of both mother and child. Eventually this component proved to be a resounding success with almost all pregnant women and lactating mothers voluntarily taking advantage of the services offered by the health post. The acceptance and appreciation of health post services are corroborated by the fact that women were, in many instances, willing to pay a notional user fee.

Compared with average health indicators for Bihar the programme area shows a much better situation which is set out in the table below:

Table 2: Comparison between working and non-working area

Indicators	Consolidated data for project villages from 5 NGOs (1999)[25]	Bihar* (National Family Health Survey 1998-99)[26]
Infant Mortality Rate (per 1000 live births)	14	72.9
Child Mortality Rate (under 5 years of age per 1000 live births)	22.3	105.1
Maternal Mortality Rate (per 100,000 live births)	(17)[27]	451
Ante-natal check up from a health professional (3 or more check-ups)	75%	19%[28]
Percent of children who received all vaccinations	74.6%	11%
Birth attended by skilled staff	89%	23.4%
Percent of children severely malnourished	5%	24.5%
Percent of children with diarrhoea who received Oral Rehydration Solution	73%	15.4%

* Jharkhand was still part of Bihar at the time of the survey.

[25] Schüth Tobias and Anil Chaudhary 1999/2000. *Evaluation of Community Development Programme, Bihar/Jharkhand*. Bern: Swiss Red Cross.

[26] International Institute of Population Sciences 1999. *National Family Health Survey (NFHS-2) 1998-99*.

[27] The figure here indicates actual number of maternal mortality cases in the project villages during 1998-99 and not the Maternal Mortality Rate.

[28] The figure here is from NFHS-3 2005-06. The earlier NFHS-2 1998-99 did not compile data on the basis of 3 ante-natal check-ups. From the trends it can be safely assumed that the figures must have been lower for 1998-99.

Overall the strategy of village health posts and voluntary health promoters has been effective. The main role of the village health posts has been the extension of health education, support to pregnant mothers and growth monitoring of children backed by counselling of mothers of malnourished children. Beyond that they supplied basic treatment with the small number of drugs they kept in store. Two evaluations (1999/00 and 2003) have confirmed the appropriateness of the health messages. Communication skills in health education were also found to be adequate. Health prevention, which was completely absent at the onset of the project, was now well internalised by the majority of the target group and put into practice. The communities were involved to varying degrees in these health programmes. All households provided financial contributions or unpaid volunteers. No community health post was able to recover all the costs, although the best ones came close. Village health committees were supervising the village health posts and some committee members even took part in monitoring exercises with the staff.

Village health post attended by paramedic

Demand creation

However, the most significant outcome of the project has been demand creation amongst a critical mass of villagers for essential health services. The last five years have witnessed an increasing articulation of the demand aimed at persuading or pressurising the state to deliver what it has committed itself to as part of its policy. The sustained pressure by communities and increasing instances of interface between communities in association with NGOs and relevant authorities has achieved reasonable success in shaking the government health infrastructure and service providers from a mode of inertia to a reactive mode. Making the government machinery pro-active still remains an elusive goal. Now at least the communities covered by the project have been able to secure a relatively more stable presence of health personnel at the sub-centre and primary health centre levels. Medicines are also in greater supply at these delivery points and are disbursed to the needy. A really noticeable change has been the establishment of regular immunisation camps in the villages with a well maintained cold chain by the authorities to ensure the efficacy of the vaccines.

3.2 Linkage building and resource mobilisation

In the arena of empowerment, linkage building has become increasingly institutionalised over the years. CBOs have been able to pursue linkage building efforts on their own and in a manner that it does not require mediation by the project. A natural consequence has been the reduction of the role of NGOs in this pursuit. Trained NGO workers are staffing government programmes, such as the Integrated Child Development Scheme and disaster preparedness training. Community initiatives have made considerable headway in successfully laying claim to entitlements through regular interface and exchange of information on government schemes/programmes and in accessing institutional finance such as bank loans as well as government subsidies and loans.

Another key feature has been enhanced internal resource mobilisation. The NGOs have deployed innovative strategies to enhance the capacities of CBOs towards greater mobilisation of physical, financial and human resources. The strategies deployed entail building up corpus fund; introducing higher rates of savings; linking CBOs with banks/financial institutions; introducing membership fee and improved management and marketing systems. Through savings alone groups have enormously increased their resources. The following table depicts the status:

Table 3: Comparative status of savings mobilisation in Indian Rupees[29]

Partner NGOs	SHGs savings in 2005	SHGs savings in 2006	% increase
BMVS	1'711'265	2'049'000	19.74
PNDSS	1'229'530	1'453'171	18.19
SSVK	758'997	833'643	9.83
GVP	5'151'860	5'945'916	15.41
Total	**8'851'652**	**10'283'736**	**16.18**

3.3 Conflict resolution and legal support

The ability to effectively resolve conflicts is perceived as one of the most significant benefits emanating from getting organised. This is particularly relevant across all working areas. Community representatives are unanimous in their opinion that SHGs and their federations have come to command adequate legitimacy to resolve household and village conflicts. Sanctions ranging from suspension to cancellation of group memberships have been put in place to make contesting parties abide by group decisions taken in this regard. With groups having internalised the need to create a win win situation for conflicting parties, SHGs rarely resort to imposing such sanctions. Diminishing trend in instances of domestic violence, greater acceptance of women in the role as a leader, declining expenditure pattern on legal cases, and decreasing trend in number of court cases are some of the indicators that reflect the enhanced conflict resolution abilities of CBOs.

Individual members of marginalised groups often find it impossible to appeal for justice. Only backed up by group solidarity and collective support can the individual hope for a fair trial. The following event, of the hundreds taking place, provides an example of the role of women SHGs in this regard.[30]

Case Study 3: Women accessing social justice

In Ramnagar, one of the project villages, Soni Devi, a scheduled caste woman experienced the wrath of people belonging to the dominant caste of the village. Soni Devi, one day ventured into the orchard of a rich landlord, to collect firewood. The landlord along with his son pounced on the poor woman and thrashed her so badly that she almost died. On hearing about the incident, a member of the village federation of SHGs promptly reported it to Prema Devi, the federation leader. She, along with other group members, rushed to the spot at once. After sending the victim to Gaighat hospital for treatment, the group contacted the village committee and the village *Mukhiya* (headman) to set strategy for further action. The group swung into action immediately and called for an emergency meeting of the village federation which was also attended by local politicians. It was collectively decided that, apart from a public apology, the culprit would have to pay Rs. 3'500 as penalty to the victim to compensate for the loss of her wages on account of her injury. The culprit was forced to offer an apology and pledge not to repeat behaviour of this kind in future.

3.4 Towards pro-poor governance

As part of taking democracy to the grassroots, Bihar, through the revival of Panchayati Raj Institutions (PRIs) has, since 2001, developed a three tiered local governance structure from the district level down to the village level. The various bodies of governance at the district, block and village levels are entrusted with planning, implementation and monitoring of developmental functions as provided for in the Bihar Panchayati Act. The health infrastructure roughly corresponds to these levels of governance and their functionality falls within the purview of the respective governance institutions. This has created an institutionalised space for articulation of the voices of the poor to improve social sector outcomes in areas such as health and education.

[29] Swiss Red Cross 2006. *Report for Humanitarian Foundation*. Bern: Swiss Red Cross.
[30] Neupane/Kishore 2003.

Amrika Devi: "Once you have knowledge, why should you depend on what others say? You start thinking for yourself."

In a bid to make the PRIs more effective, the SRC supported awareness programmes and capacity building measures aimed at conducting fair Panchayat elections and having community representatives elected to these local bodies. It subsequently built capacities of elected representatives of PRIs. CBO and SHG members were encouraged to select and support suitable candidates from amongst themselves.

As a result of sustained campaign and capacitation, in the 2006 elections the total number of elected members hailing from CBOs and SHGs of the programme area has taken a quantum leap when compared to the outcome of the 2001 elections. Whereas 137 target group members in all were elected to various offices of the PRIs in 2001, a total of 427 members were elected in 2006. Table 4 delineates the details of achievements attained in the 2006 elections in the working area of four NGOs in Bihar.[31]

Across all NGOs out of a total of 1'490 seats at various levels of PRIs, target group members contested 803 seats and were able to secure election to 427 seats (53%). Out of the 427 successful candidates, 90% were women (with the exception of SSVK, the other three organisations work exclusively with women and had fielded only women candidates).

The Bihar Panchayat Act, 2006, provides for 50% reservation for women in PRIs. The increasing participation of women in these institutions of local governance will in the long run necessarily ensure reduction in gender disparity in general and gender induced vulnerabilities in the area of health and education in particular. As of now, the enhanced participation in PRIs has had a definitive impact in inducing improved delivery of social sector services. For instance in health, Auxiliary Nurse Midwives, the first line health service providers, undertake regular village visits, the absenteeism of doctors and para medical staff shows a downward trend, and medicines are made available. However, due to limited devolution of financial powers to the PRIs, they have hardly any role in financial planning which continues being the prerogative of the state government.

[31] So far no PRIs elections were held in Jharkhand.

Table 4: Performance of target group members in local elections in 2006[32]				
Partner NGOs	**BMVS** **total seats / seats contested / seats won**	**PNDSS** **total seats / seats contested / seats won**	**GVP** **total seats / seats contested / seats won**	**SSVK** **total seats / seats contested / seats won**
Ward member[33]	53 / 41 / 28	143 / 29 / 25	210 / 93 / 61	220 / 163 / 95
Panch[34]	53 / 32 / 28	143 / 10 / 09	210 / 93 / 67	220 / 171 / 54
Mukhiya[35]	04 / 04 / 01	09 / 15 / 00	14 / 11 / 05	16 / 12 / 02
Sarpanch	04 / 02 / 01	09 / 09 / 01	14 / 11 / 08	16 / 14 / 05
Panchayat Samiti[36]	30 / 13 / 01	56 / 00 / 00	66 / 42 / 27	60 / 26 / 07
Zila Parishad[37]	03 / 02 / 00	03 / 02 / 00	05 / 05 / 01	03 / 03 / 01
Total	**147 / 94 / 59**	**363 / 65 / 35**	**519 / 255 / 169**	**461 / 389 / 164**

[32] Swiss Red Cross 2006. *Report for Humanitarian Foundation*. Bern: Swiss Red Cross.

[33] A Ward member is an elected representative of the hamlet within the revenue village, entrusted with development functions of the hamlet, who also assists the Mukhiya in his functions.

[34] A Panch is an elected representative of the hamlet within the revenue village, entrusted with judicial functions pertaining to the hamlet, who also assists the Sarpanch in his functions.

[35] The Mukhiya, along with the Sarpanch, is heading the Gram Panchayat (village council), which is the primary unit of PRIs. The Mukhiya is entrusted with administrative/developmental functions and the Sarpanch with quasi judicial functions.

[36] Panchayat Samitis, secondary units of PRIs, are responsible for planning, execution and supervision of all developmental programmes in the block. They also supervise the works of Gram Panchayats within their jurisdiction.

[37] Zila Parishad, the apex body of PRIs, is entrusted with execution of development schemes, providing civic functions in the district and looking after the duties of the government delegated with regard to certain departments as per guidelines.

4 SUCCESS FACTORS, LIMITATIONS AND CHALLENGES

4.1 Success factors

Some of the key factors that contributed to the success of the programme and/or to the achievements are highlighted below:

The programme addressed the actual needs of the communities and applied a participatory strategy which gradually adopted an empowerment mode. This strategy ensured the willingness of local communities to improve their health and overall living conditions through voluntary engagement in self-help initiatives. Leaders and volunteers of CBOs, SHGs and their federations realised the benefits of their efforts for the larger community and this added to their self esteem. Their key role, which became a driving force within the programme, entailed extending support to SHG management, information dissemination (pertaining to rights and entitlements for government programmes and schemes) and forging linkages with relevant institutions. Further, they acquired capability to mobilise both external and internal resources with minimal dependence on external agencies, thereby enhancing their own sustainability.

Significant inroads were made towards ensuring pro-poor governance by having a greater representation of target group members in the PRIs. It is expected that these elected representatives will take up and further the cause of the deprived and the marginalised.

An advantage has been the implementation through locally well established and credible NGOs coordinated by IIDS as SRC Programme Coaching Unit. The NGOs have concentrated on skill consolidation in areas of their core competence, which has definitely helped them carve a strategic niche for themselves. The capacitation inputs were designed in a manner conducive for facilitating the emergence of Badlao, GVP, PNDSS and BMVS as self-help promoting institutions. The programme has helped these NGOs to consolidate their core competences. In addition, the NGOs have acquired new capacities through workshops organised and facilitated by IIDS as well as their internal training programme. The workshops also led to practical experience sharing among management and staff of the different NGOs and helped to create a common vision.

After the Bihar assembly elections in 2005, the change of government has created a milieu of development with a more positive orientation towards NGOs and civil society organisations.

4.2 Limitations and challenges

The organisations continue to confront limitations and challenges inspite of significant advances made by the project in the area of health, group formation and consolidation and empowerment of the target communities. The challenges and limitations require priority action both on part of the NGOs and the government if the achievements and gains of the projects have to be sustained.

With regard to health intervention, there still remain critical issues to be addressed in a more comprehensive manner. This is especially true with regard to promotion of family planning measures which have not yielded the desirable results. This gets reflected in both field level experiences as well as in the crude birth rate, which overall is not declining. Hygiene and appropriate sanitation practices and behaviour are other weak areas wherein very little is discernible in terms of project impact. Latrine use and hand washing practices have significant bearing on health profile of communities. Although these issues were addressed through the health education component the results did not show a significant reversal in trends of latrine use and hygiene practices.

The challenge for interventions designed around a health post strategy is to strike a balance between health post activities and preventive measures such as health education and awareness campaigns which are not essentially health post centric. It has to be admitted that there has been a tendency to favour attention on health post activities.

Though the SHGs have witnessed expansion in their resource base through forging linkages with financial institutions, the coverage by income generating programmes still calls for improvement. On the supply side a major challenge is the state of financial institutions in Bihar which are severely wanting in terms of meeting credit needs of the SHGs, as bank officials still have not been sensitized enough to the potential of micro–financing through SHGs and women's role in development. Moreover, since CBOs and SHGs

are still young, the process of empowerment needs to be continued. This in large part would depend on proper enforcement of existing pro-poor policies and on promotion of new inclusive programmes and policies. Towards this end the NGOs have to be vigilant and ensure that these get effectively translated into grassroots action.

Local NGOs because of weak networking have failed to optimise on fund raising opportunities which have increasingly come to favour network funding. In order to remain competitive especially with regard to fund raising and resource mobilization the organisations also require to have a more nuanced understanding of the changing larger development scenario, its bearing on key stakeholders and steps required to meet the prevailing challenges. Documentation remains another weak area with most of the NGOs and this has hindered capturing key processes, experiences and learning generated through the project. Weak documentation also impedes effective showcasing of achievements and results which otherwise can be effective in mobilizing resources.

Flood proneness of North Bihar, where three out of five NGOs have their operational area, remains an overarching challenge. The increasing trend regarding frequency and scale of floods over the past decades is alarming. In 2007 alone, 21 million of people got affected. Given the absence of strategic flood coping mechanism in place this has a serious impact on the overall development and also robs grass root level development initiatives of some of its gains.

Flood affected hamlet, North-Bihar 2007

5 CONCLUSIONS AND LESSONS LEARNT

Community-based health care

During the first ten years (1990–99) CBOs, SHGs and their federations were capacitated and became functional in disseminating preventive health messages and organising village health posts. This balanced effort to promote healthy behaviour and provide essential care yielded very positive results. According to the programme evaluation in 1999 important health indicators in the working area were far better than the average situation in Bihar (see table 2). This proved that through training of local health promoters and village health committee members and the provision of basic infrastructure (materials for village health posts) it was possible to achieve relevant impact on health even under unfavourable conditions.

The improvement in the health situation was possible through continuous support over a generous time period of ten years. Although there were some set backs, it created a new awareness about health problems, their causes and the benefits of preventive measures, and led to behavioural changes, especially among women. Curative services as part of the village health posts were in high demand for mother and child health but community financing was weak and the services could barely be sustained without external support.

From service delivery towards empowerment

In 1999 it was realised that in the long term perspective there had to be other ways to bring health services to under-served villages in a sustainable manner. According to the community empowerment strategy, introduced in 2000, local community members and their organisations were endowed with sufficient information[38] to demand from the state the services that it is supposed to render the poor and vulnerable. During the last five years (2002-06) local communities, through unrelenting pressure, achieved reasonable success in influencing health care and other service providers to become more accountable and effective in addressing people's needs.

A long-term vision prior to the initiation of the development programme could have helped to achieve the current results in less time. Due to participatory planning and also to effective strategies for moving towards self-reliance the empowerment phase has been much more effective in terms of visible results compared to the previous years. Therefore, it would be wise to strike a balance right at the start of the programme in terms of investing in community based service delivery, at the same time allocating adequate resources for capacity building of the CBOs, promoting self-help for health initiatives, and establishing institutional linkages with government agencies. Such a strategy would be a more sustainable option than creating parallel programmes without any convergence. Measures to address demand and supply constraints pertaining to essential services should be incorporated in a singular programme phase instead of being spread over several phases.

CBOs, SHGs and their federations could be gradually developed as a common forum for all development activities. These organisations, which initially managed health and education activities, are now capable of addressing a broader range of development issues by networking with government agencies and other development actors. Skilled community resource persons play an important role here. However, to what extent the work of community resource persons and the functioning of community resource centres can be sustained without external support is still an unresolved question.

Income generation

Experiences have shown that only economically empowered community members or groups can address health, education and other development issues with full commitment. Besides, economic wellbeing is an important aspect of the empowerment concept that allows the poor to get out of the poverty trap and increase their abilities to cope with social problems. Thus, SHGs and their federations should gradually evolve into forums for broader development issues, including economic ones, instead of limiting themselves to health and education. Apart from that, income generation proves to be instrumental in challenging traditional gender relations and in raising the status of women within their families and the society at large.

[38] Based on the Right to Information Act.

Sustainability of CBOs and SHGs

The participatory and need-oriented approach enhanced the willingness of local community members to engage themselves on a voluntary basis in development initiatives. This commitment was reinforced through the realisation of positive achievements resulting from these initiatives. Apart from people's commitment, the sustainability of CBOs, SHGs and their federations depends to a large degree on their institutionalization, their organizational capacities and their financial self-reliance.

Institutionalization implies recognition by communities and local actors, as much as well-established relations with public organisations, governmental bodies and non-governmental stakeholders. In terms of organisational capacities, autonomy in handling their affairs, internal governance and management, capacity of conflict resolution, ability to keep members compliant with established norms and rules, as well as potential for building linkages and networks on their own prove to be central. The financial self-reliance of those grass-roots organisations implies their abilities to mobilise local resources, which depend on access and linkages to local financial institutions, governmental and non-governmental development programs, as well as a certain degree of up-scaling that allows for better efficiency and more leverage.

Although CEP has brought about significant improvements regarding the above mentioned factors of sustainability, these organisations are still young and the process of empowerment needs to be continued. It will also largely depend on the further emergence of pro-poor policies and programmes which are geared to support this process. The establishment of PRIs in Bihar with a 50% quota for female representatives, pro-poor government programmes, the concept of SHGs and favourable conditions for accessing bank loans and the Right to Information Act are some important improvements which in recent years have led to better conditions for grassroots organisations. It is hoped that the positive momentum that has been created will be continued.

Good governance and inclusion of marginalised groups

The empowerment approach is incomplete if it does not build on mechanisms of long-term government accountability and internalisation of good governance skills. The major mechanisms applied by CEP include the following: partnering of CBOs and SHGs with the government and supporting community initiatives in laying claims to entitlements regarding governmental schemes and programmes; assisting communities in contesting exploitative acts of the local power structures; encouraging participation of community members in various bodies created by the government for monitoring its programmes; and preparing community organisations for increasing their representation through elections in various bodies of PRIs.

The election of female representatives of marginalised communities into the various offices of PRIs gave them a strategic position for articulating their interests, making government bodies and their policies more pro-poor and securing development and welfare entitlements from the government. The elected representatives require further orientation and capacity building for discharging their functions effectively and maximising opportunities to influence local development plans and allocations.

Development initiatives such as CEP may provide important lessons for improving the situation in resource poor and poverty infested areas and for the empowerment of marginalised communities. However, they can only create pockets of improved grassroots level development unless there will be stronger partnership between the government and the civil society guided by desirable changes in the macro policy framework. While it is encouraging that the present central government envisages increased spending for education and health, higher spending should also be coupled with administrative and political reforms. Decentralization from the state to the local levels in these areas could lead to better access and control, and ultimately, to accountability of government officials, such as teachers and health personnel, especially in rural areas.

REFERENCES

Bajpai Nirupam, Jeffrey D. Sachs and Nicole Volavka 2004. *Reaching the Millennium Development Goals in South Asia*, CGSD Working Paper No. 17. New York: The Earth Institute at Columbia University.

Eppler Peter, Neeraj Labh and Amitabh Sharma 2005. *Assessment Mission Report 2005*. Bern: Swiss Red Cross.

Eppler Peter 2004. *Vom Gesundheitsprojekt zum Empowerment von Frauengruppen in Jharkhand, Indien, Der lange Weg aus der Unterdrückung*, in: Bulletin von Medicus Mundi Schweiz, Nr. 94, pp 8-11.

Gareth Jones, Werner Schultink and Babille Marzio 2006. Child Survival in India. *Indian Journal of Pediatrics,* Volume 73 (No. 6): 479-487.

Government of India. Right to Information Act 2005. *Obligations and Responsibilities*. New Delhi: Goverment of India. <http://www.rti.gov.in/rti_slides>. 22.04.2008.

Governemnt of India. Special Task Force 2007. *Bihar: Road Map for Development of the Health Sector.* New Delhi: Government of India: 7.

Government of India Planning Commission 2006. *National Human Development Report 2001*. Table 2.21. New Delhi: Government of India Planning Commission.

International Institute of Population Sciences 2006. *National Family Health Survey (NFHS-3) 2005-06*, India Volume I. Mumbai: International Institute of Population Sciences.

Mihai S. Jalba 2004. Forum. *Indian Journal of Tuberculosis 51*: 112-115.

Ministry of Health and Family Welfare, Department of Family Welfare. *Maternal Health Programme*. <http://mohfw.nic.in/dofw%20website/MATERNAL%20HEALTH%20%20PROGRAMME%20%20.htm>. 19.04.2008.

National AIDS Control Organisation 2006. *HIV Data*. New Delhi: National Aids Control Organisation. <http://www.nacoonline.org/About_NACO/Contact_NACO/>. 19.04.2008.

National Bank of Agriculture and Rural Development (NABARD) 2006. *Annual Report 2005-06*. Mumbai: National Bank of Agriculture and Rural Development.

Neupane Ram and Kishore K. Singh 2003. *Evaluation of Bihar Community Development Programme*. Bern: Swiss Red Cross.

Office of the Registrar General & Census Commissioner. Census of India 2001. *Scheduled Castes & Scheduled Tribes Population*. New Delhi: Office of the Registrar General & Census Commissioner. <http://www.censusindia.gov.in/Census_Data_2001/Census_data_finder/A_Series/SC_ST.htm>. 19.04.2008.

Office of the Registrar General & Census Commissioner. Census of India 2001. *Total Population*. New Delhi: Office of the Registrar General & Census Commissioner. <http://www.censusindia.gov.in/Census_Data_2001/Census_data_finder/A_Series/Total_population.htm>. 19.04.2008.

Schüth Tobias and Anil Chaudhary 1999/2000. *Evaluation of Community Development Programme, Bihar/Jharkhand*. Bern: Swiss Red Cross.

Swiss Red Cross 2006. *Report for Humanitarian Foundation*. Bern: Swiss Red Cross.

The World Bank 2005. *Bihar – Towards a Development Strategy.* Washington: The World Bank.

The World Bank 2007. *Jharkhand, Addressing the Challenges of Inclusive Development*. Report No. 36437- IN. Washington: The World Bank.

BRIEF PROFILE OF COLLABORATING PARTNER ORGANISATIONS OF SRC

Initiatives in Development Support

Initiatives in Development Support (IIDS) was registered as a partnership firm in 2002. IIDS owes it origin to the SRC Programme Coaching Unit which consisted of local experts mandated by SRC to provide consultancy to collaborating partner NGOs on organizational and technical aspects as well as in project cycle management. Over the years IIDS has acquired experience of working in diverse contexts with various NGOs of repute. Besides working with a number of organisations in Bihar, it has provided management and technical support to NGOs such as Self Employed Women's Association (SEWA), URMUL Trust, South Indian Federation of Fishermen Societies (SIFFS) and Social Need Education and Human Action in the state of Gujarat, Rajasthan, Tamil Nadu and Pondicherry respectively. IIDS has its headquarters at Patna and regional offices in Ahmedabad, Gujarat and Karaikal, Pondicherry.

Badlao Foundation

Badlao Foundation (BF) was registered as a trust in 1982. The long association with the socialist movement in general and the student movement led by the Indian freedom fighter and political leader Jayaprakash Narayan in particular, prompted the organizational leadership to work for the upliftment of the deprived tribal population. The displacement of the tribal population in the villages of Jamtara block, due to the building of a dam in the region, attracted the organizational leadership and BF started work in these villages towards alleviating the plight of the displaced tribal population. The initial focus was on the displaced *Sauria Paharia* tribe. The objective was to enhance the socio-economic status of these tribals and promote *tasar* silk spinning for income-generation. The organisation has since moved on to other community projects, establishing women's groups, called *mahila sabhas,* as micro-credit channels and thrift groups to promote and support entrepreneurial programmes. The foundation has succeeded in bringing about greater awareness of rights and entitlements amongst tribals. It is presently working, primarily with the deprived tribal population, in 445 villages in the six districts of Jamtara, Dumka, Deogarh, Godda, Pakur and Sahebganj in Jharkhand.

Bhusura Mahila Vikas Samiti

Bhusura Mahila Vikas Samiti (BMVS) was registered as a society in 1988. The organizational leader had his initiation into social work as a staunch follower of the Ghandian Sarvodaya movement in 1966. BMVS stands for the economic, social and political empowerment of the poor to ensure their effective and equitable participation in the societal mainstream. The organisation is at present working in 210 villages in Muzaffarpur District of North Bihar. The target group of the organisation primarily consists of the socially and economically exploited women and children particularly from the scheduled and backward castes. BMVS is working in the area of income generation, savings and credit programmes through SHGs, mother and child health care, education (non-formal and adult education), *panchayati raj,* and disaster risk management.

Gram Vikas Parishad

Gram Vikas Parishad (GVP) was registered as a society in 1987. The organization aspires for the establishment of an egalitarian society based on the principles of equity (including gender equity), justice and fraternity wherein collective endeavour has the potential of actualizing humane ends. GVP has been one of the pioneers of SHG movement in Bihar and has carved a niche for itself as a self-help promoting institution in the region. It provides the necessary support to a network of 11 NGOs in the area of self-help promotion. GVP is working in 275 villages of Madhubani & Darbhanga district of North Bihar. It is working with *Dalits* and other below-the-poverty-line caste groups, especially women and children, and on socio-economic, educational, political and health issues.

Patna Notre Dame Sisters' Society

Patna Notre Dame Sisters' Society (PNDSS) is a Catholic congregation with headquarters at Patna. Though the society is primarily concerned with running educational institutions, the collaboration with SRC occasioned a shift to facilitating programmes oriented at community

development and empowerment. Through its sister organisation located at Jamalpur in Munger district of Bihar, the organisation has been working with the *Dalit* and tribal population in the region with special focus on women and children hailing from these communities. The organisation is at present working in 45 villages of Munger district and is engaged with group formation, income generation, mother and child health care, education, educating communities on their entitlements and building linkages with government programmes.

Samajik Shaikshanik Vikas Kendra

Samajik Shaikshanik Vikas Kendra (SSVK) was registered as a society in 1986. The organizational leadership had its initiation into social commitment in the course of the 1974 students' movement that broke out all over Bihar. Consequently, SSVK was formed with a vision of establishment of an egalitarian society, devoid of any kind of discrimination and exploitation based on caste, class, gender, race or religion. The target group of the organisation primarily consists of below-the-poverty-line *Mushar* families. In addition, commitment is also to other below-the-poverty-line groups coming from other scheduled castes and depressed backward classes. The organisation is at present working intensively in 1399 villages in Madhubani, Saharsa, Darbhanga and Supaul districts of North Bihar. Besides working in the area of mother and child health, non formal education, eradication of child labour, the organisation has been engaged in supporting entitlement oriented movements, especially with regard to the land and water rights of the community. The formation of SHGs has not only reduced dependence on local money lenders but also enabled members to sustain many a struggle for their rights.

Swiss Red Cross
International Cooperation
Rainmattstrasse 10
3001 Berne
Switzerland
www.redcross.ch

Initiatives in Development Support
A1/50, Vivekanand Path
North S.K Puri
Patna 800013
Bihar
India
iids.2002@gmail.com

Authors
Peter Eppler, Amitabh Sharma and Neeraj Labh

Study Design
Verena Wieland

Editing
Elena Krylova

Fotos
Peter Eppler

Swiss Red Cross Publication, April 2008

The case study was co-funded by the Swiss Agency for Development and Cooperation (SDC).

This case study from Bihar and Jharkhand is part of an international study of Swiss Red Cross covering experiences from projects in Ecuador, Eritrea, India and Kyrgyzstan and providing an in-depth analysis of individual country experiences and of cross-country comparison with regards to common course, differences and lessons learned.