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GUJARAT WATER SUPPLY &
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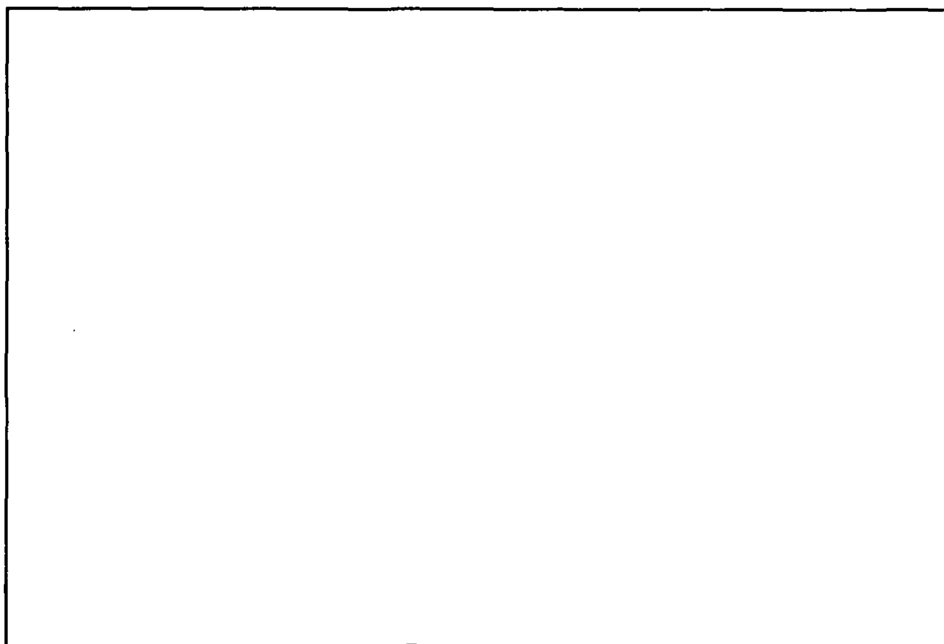
INDIA

REPORT ON REVIEW AND SUPPORT MISSION OF CHETNA HEALTH AWARENESS COMPONENT IN THE SANTALPUR REGIONAL WATER SUPPLY AND SANITATION SCHEME OF GUJARAT STATE



GUJARAT RWS/S

Review and Support Mission

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R 822 - 11925

CONTENTS

page

1. INTRODUCTION 1

2. ACKNOWLEDGEMENTS 4

3. HEALTH AWARENESS CAMPAIGN 5
   - 3.1 Objectives of Health Awareness Campaign 5
   - 3.2 Strategy and methodology of the Health Awareness Campaign 5
   - 3.2.1 Health Awareness Campaign 6
   - 3.2.1.1 KAP Study 6
   - 3.2.1.2 Field based village level operations 7
   - 3.2.1.3 Institutional strengthening of Existing Infrastructure 11
   - 3.2.1.4 Progress of Health Awareness Campaign 11
   - 3.3 Assessment of Health Awareness Interventions and Suggestions for Improvement 12
   - 3.3.1 Assessment of Health Awareness Interventions 12
   - 3.3.2 Proposed adjustments to Health Education Interventions and Communication strategy 15
   - 3.3.2.1 Proposed adjustments to Communication Strategy 17
   - 3.3.3 Monitoring and Reporting System 18

4. ENVIRONMENTAL SANITATION AND SANITATION AWARENESS 20

5. INSTITUTIONAL ASPECTS 22

6. CONCLUSIONS AND RECOMMENDATIONS 23

ANNEXES

ANNEX 1: TERMS OF REFERENCE OF CHETNA REVIEW MISSION
ANNEX 2: ITINERARY REVIEW MISSION OF CHETNA HEALTH AWARENESS COMPONENT
ANNEX 3: LIST OF AUTHORITIES AND RESOURCE PERSONS MET
ANNEX 4: PROCEEDINGS OF MEETING WITH STATE LEVEL AUTHORITIES

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LIBRARY, INTERNATIONAL REFERENCE CENTRE FOR COMMUNITY WATER SUPPLY AND SANITATION (IRC)
The Hague
Tel. (070) ... ext. 141/142
ISN 11925
LO: R822 INGU93

1. INTRODUCTION

During the past two years, CHETNA has carried out the health awareness campaign in the ongoing Santalpur Regional Water Supply and Sanitation Scheme, an integrated water supply, sanitation and health program. The Health Awareness Campaign is still in progress and it is expected that results and experiences will be incorporated in similar health related activities in the second generation projects under the Indo Dutch R.W.S. programme in Gujarat.

During the period from January 6 to 21, 1993, Mrs. L. Hoffman carried out a review and support mission, in collaboration with CHETNA staff, of the ongoing Health Awareness Campaign currently implemented by CHETNA. The objectives of this mission were twofold. Firstly to review the progress of the health awareness campaign and evaluate its approach and inputs in order to provide guidelines and recommendations for improvement and/or adjustments which will contribute to the sustainability of the remaining programme for the Santalpur RWS and its replicability for similar programmes.

Secondly to provide backup support to CHETNA in its development of a replicable module as well as to assist in initiating the institutional process of identifying potential partners from the District Health Department and NGO's who can carry on the implementation of the health education component at grassroots village-level, once CHETNA assumes a support role and is no longer involved in implementation.

The mission commenced with a review of the technical proposal and subsequent progress reports, followed by in-depth discussions with CHETNA staff. In the field, the Mission had the opportunity to observe and participate in CHETNA's ongoing Awareness activities, namely: a Children's Camp in Vauva, the first of a Health Educator's Training Meeting for a new cluster of villages in Radhanpur Block and a Village level Camp for Women in Mehamdavad. An attempt was made to assess the content of the activity and its objective as well as the methods of communication and visual aides used. Participation in the health awareness activities was followed by visits to six villages where Awareness activities are in progress, of which two villages had improved sanitation facilities under the pilot sanitation scheme. An attempt was made during these visits to assess the functioning, utilization and upkeep of the improved water supply and sanitation facilities as well as the overall environmental sanitation conditions in the villages. During home visits, an assessment was made of the beneficiaries' acceptance and utilization of the improved water and sanitation facilities, their level of awareness of the hygiene link between water, sanitation and health and of any improvements in the household's water use, sanitation and hygiene practices.

In addition to carrying out household interviews in all of the villages visited, group discussions with women, men and children were also carried out. An impromptu meeting in Sherpura was held with a group of men to discuss the possibilities for communal action for improvement of the village's cleanliness and environmental sanitation. During the discussion the men voiced their interest in receiving health education as well. Interest for setting up a children's health club was discussed with groups of non-school attendance children in both Lunichana and Abiyana. In Dantrana, a tail end village in which SEWA's income-generating

activities were already ongoing at the time CHETNA began its health awareness activities in the village, an impromptu group discussion was held with some of the village women. Participating in the discussion were both women who are receiving assistance from SEWA's income generating program as well as some who are not. The discussion centred on whether the women were experiencing any time gains as a result of using the improved water supply, how the women used the time and whether the women were able to accrue economic benefits. A comparison was made between the women benefitting from SEWA's assistance in producing handicrafts and those not part of the program and whether or not the increase in income has facilitated the household's adoption of improved health practices.

The field visits were carried out in a collaborative fashion together with CHETNA project field staff and trainers. Not only did the field visits provide the mission with the opportunity to have continual dialogue with CHETNA's field staff and learn from their experience but visits to the villages also presented the opportunity for the mission to provide on the job training in introducing some more participatory methods of carrying out home visits, group discussions and the monitoring of awareness inputs and behaviour changes.

Throughout the mission all findings were discussed in a participatory dialogue with the field staff and trainers in order to get feedback and the proposed adjustments or improvements were thoroughly reviewed jointly. During part of the field visits, the mission was accompanied by CHETNA's Communication and Visual Aides Specialist. His participation allowed for a collaborative review of the visual aides being developed for the communication kits and the opportunity to propose adjustments and additions to the kit.

Subsequent to the field visits, in-depth discussions were carried out at Division level with the Executive Engineer of the GWSSB and CHETNA field staff to discuss the sanitation pilot scheme and the possibilities for full sanitation coverage and for sanitation awareness activities. Also discussed were the role of the water committees and their responsibilities for community management and maintenance.

A Joint Meeting was then held at district level on 11/1/93 with the District Collector and District Health and Primary Education Officers, the ICDS Program Officer and Bansali Trust Representative, the EE of the GWSSB as well as CHETNA field staff. Following a discussion of the mission's major findings and recommendations, an effort was made to explore the possibilities for the future involvement of the Government Health MultiPurpose Workers, the Primary Health Care Staff as well as the ICDS (AWW workers) and their Supervisors in the implementation of the health awareness activities. The involvement of Primary School teachers in carrying out hygiene education, if properly trained by CHETNA in communication and health education methods and supplied with a visual aide kit, was also explored.

Following the meeting at the District Collector's office, more in-depth discussions continued in the afternoon with the District Health Officer and staff of the Health Department, ICDS officials together with CHETNA staff.

Subsequent to these district-level discussions, a meeting with State level authorities was held on 15/1/93 to discuss the issues further and initiate the process for the involvement of district level government and NGO personnel in implementing health awareness activities, particularly once CHETNA takes on a support role. The meeting was attended by the Executive Engineer of GWSSB as well as a representative of the GOG Health Department and the ICDS program as well as CHETNA staff (see further Annex 4).

Separate discussions were then held with the NGO partners SEWA and ESI, as they were unable to attend the district and state level meetings. Discussions with SEWA staff explored the possibilities for coordination of the income generating and health awareness activities and whether SEWA workers would be able to carry out hygiene education activities once CHETNA was no longer directly involved in implementation. Discussions at ESI centred on their approach and methods for implementing a sanitation awareness campaign.

Final discussions were held with CHETNA staff on 17/1/93 during which the mission's recommendations were discussed and a plan of action was jointly elaborated. The mission concluded with a debriefing at the RNE with the Water and Sanitation sector specialist and staff on 21/1/93.

2. ACKNOWLEDGEMENTS

The Review and Support Mission experienced a very constructive dialogue with CHETNA staff, GWSSB, SEWA and ESI. The field visits and meetings organized by CHETNA permitted the mission to work efficiently and effectively. The mission wishes to express its gratitude to CHETNA and GWSSB for their valuable assistance throughout the mission. Their gracious hospitality was very much appreciated.

3. HEALTH AWARENESS CAMPAIGN

3.1 Objectives of Health Awareness Campaign

The Santalpur Regional Water Supply and Sanitation Project is an integrated project which aims at the improvement of the health and socio-economic conditions of the rural population via the provision of improved water supplies, sanitation facilities, hygiene/health education and income generation. Both hygiene education and income generation are considered integral components. Hygiene awareness and promotion is seen as essential for changing the perceptions and behaviour of the community members in order to bring about an acceptance of the improved facilities and their sustained and hygienic use. Improving the income opportunities, particularly for women, is viewed as an essential factor for achieving success from hygiene education interventions. These inter-related project components are implemented by various NGO's. SEWA is responsible for the income generation component, CHETNA for the Health Awareness component, while both CHETNA and ESI have shared responsibility for the sanitation awareness component and ESI for the latrine/bathrooms construction.

In November 1990 CHETNA began implementation of the health programme and awareness campaign in 95 villages of the Banaskantha District which are served by an improved water supply, situated throughout the Santalpur, Radhanpur and Kankrej Blocks. The health awareness campaign activities are scheduled to continue through December 1993. The health programme's objectives include creating an awareness of the hygiene link between water, sanitation and health. In order to accomplish this, existing attitudes and practices related to water supply, sanitation and hygiene have to be assessed and appropriate health education designed and carried out, using communication materials and visual aides which take local conditions into account. An appreciation of the importance of safe drinking water, hygiene and sanitation should in turn lead to a gradual behaviour change and an adoption of improved water use, environmental sanitation and hygiene practices on the part of the community members.

The health programme's overall goals entail household and community management of the improved water and sanitation facilities; a sustained, hygienic and optimum use of the improved supplies and a reduction in water borne and water/sanitation related diseases. As it is expected that the results and experiences of these health-related activities will be of value for application in other integrated water projects, CHETNA is to develop a comprehensive communication strategy and health awareness module that can be replicated in other project areas. The production, testing and distribution of education and training material is also an important output of CHETNA's programme.

3.2 Strategy and methodology of the Health Awareness Campaign

CHETNA carries out a dual strategy of institutional strengthening and conducting field based village level operations in a phased manner throughout the 95 villages.

CHETNA's methodology consists of interventions at two levels:

- at the Grass-root village level by selecting women from the villages and training them to become health educators in their own villages, conducting health education camps for women in their villages and for school children at the primary schools.

- at the Infrastructure level by strengthening the existing government channels - the Health Department and its Primary Health Care (PHC) and para-medical staff and Block Extension Educators, the Integrated Child Development Scheme (ICDS) structure with its Anganwadi workers (AWW) and village child care centres, GWSSB staff and linemen - through training programmes, orientation workshops, field visits, etc., in an attempt to integrate the existing infrastructure in the health educational interventions at village level.

3.2.1 Health Awareness Campaign

3.2.1.1 KAP Study

CHETNA initiated its activities at grassroots village level by carrying out a KAP study in a sampling of 17 villages in order to collect baseline data and assess the existing attitudes and practices related to water supply, sanitation and hygiene, and based on the findings and local conditions to plan and design an appropriate health education campaign and design communication materials and visual aides. Of these 17 villages, 10 were selected from the Santalpur block, 4 from the Radhanpur block and 3 from Kankrej.

The methodology involved a qualitative approach of group discussions with focal groups of mostly village women and the collection of quantitative data via the use of a village level data form. Two group discussions were organized in each of the villages. The focus groups were mainly women of the age group of 20 to 65 years who for the most part belonged to the same caste or community, while the village level data was obtained from the Sarpanch or any other important person of the village. The AWW workers were instrumental in assisting CHETNA in the selection of the women for the focus groups. The villages were selected on the basis of geographical distribution representing the 3 Talukas and the various regional climatic and social cultural diversities. Additional criteria used for village selection were the village's location and distance from the main road.

Simultaneous to the carrying out of the KAP study, a bacteriological test was carried out of water samplings collected at the tap and in water storage containers from various households in four of the villages. The results showed the water in the household storage vessels to be contaminated, indicating that unhygienic water collection and storage habits were contaminating the drinking water.

An analysis of the KAP study revealed that to a large degree there was general uniformity in the knowledge, perceptions and practices regarding water supply, sanitation and hygiene in the village sampling. Based on these findings, it was therefore possible to develop a standardized communication package of five health education messages: on the importance of using safe drinking water from the tap and the maintenance and care of the water supply and standpost;

hygienic water collection and transport behaviour; water management and hygienic water storage and use at the home; personal and domestic household hygiene and improved environmental sanitation practices at the household level promoting the construction and use of latrines, soakpits and compost pits as well as the hygienic disposal of human waste when at the fields. Integrated throughout these themes are the cause, cure and prevention of water borne, water washed and water related diseases. These themes and messages are incorporated into a series of posters and flipcharts.

Not only does this KAP baseline study have an important utility in assessing the existing situation, but it also can serve as a valuable tool in providing baseline data which can be used for providing indicators for regular monitoring and evaluation to allow for timely adaptations of the programme and adjustments. Nevertheless, it should be pointed out that as the health awareness activities thus far have been concentrated in the Santalpur block, only the baseline data of the 10 villages of the Santalpur block would serve for monitoring and evaluation purposes at present. Only four out of these original 10 villages, however have been served by the pipeline water supply and have received health awareness interventions and therefore could serve for monitoring and evaluation purposes. These include the villages of Kalyanpura, Par, Barara and Varnosari. The remaining villages have either not yet been served with an improved water supply or were inaccessible to CHETNA due to flooding or an insecure political situation.

3.2.1.2 Field based village level operations

On the basis of these studies CHETNA has designed its training programmes, the women and children camps and workshops at village level. CHETNA's strategy includes targeting these educational messages at the grassroots village level to selected village women who are trained to carry out health education interventions in their respective villages. Other target groups include the village women attending the two day 'health camps' held in each village and primary school children attending the two day 'children camps' held at the primary schools.

At the infrastructure level, these health education messages form part of the basis for ongoing training of the GWSSB linemen, the village Anganwadi workers (maternal/child care centre workers) as well the primary health care staff and their Supervisors.

CHETNA has followed a phased approach in implementing its field based operations, and began its village level interventions in the Santalpur Taluka. This phased approach has first entailed organizing a village cluster comprised of 10-15 villages of geographical proximity. Health awareness interventions are then implemented in this cluster of villages. The experience from this first cluster of villages is then extended to the next cluster of villages, and so forth.
To date, awareness activities have been carried out in some 4 clusters, covering a total of 52 villages of the Santalpur Taluka. This experience forms the basis for the development of a module which, as per January 1993 is to be implemented in the Radhanpur Taluka, followed by Kankrej.

Large scale Women's Melas to introduce Health Awareness Campaign

As an entry point into the villages, two large scale Women's Melas or Fairs were held, attended by the Pani Panchayat (village water committee) women members and other interested women of the 20-25 villages in the vicinity. These fairs, which were attended by some 200 women, served to introduce CHETNA, its role in the water project and the Health Awareness Campaign. The fairs also served as a forum to share with the women the findings of the KAP study and information about the water and sanitation situation in their villages. The women voiced their water related concerns and problems. The importance of safe drinking water and the care, upkeep and management of the standpost were discussed. A case study and a series of posters depicting the problems a village water committee encounters in trying to manage the standpost - long waiting lines, fights breaking out between users and breakage of the pipes and taps - was used as a means to stimulate discussion on community management of the water supply and the roles and responsibilities of the Pani Panchayat (PP).

The most important issues that came out of these mela were that the water committee (PP) as a whole should be an active body with formal roles and have the authority to enact and enforce regulations concerning the standpost management and water use. Moreover, the women attending the mela expressed their interest in CHETNA intervening directly at village level, pointing out that these women's fairs would be far more effective if organized directly at village level so that all interested women could participate.

Organization of Village Clusters and Selection of Women Health Educators

The approach followed in organizing a cluster of villages and selecting the women to be trained as health educators consists of contacting the Sarpanch, PP women and lineman and organizing in each of the villages, a general meeting for the PP and other women and other interested women. At these meetings, the KAP findings are presented and discussed and an attempt is made to find out what the women's felt needs related to water are. Using posters to involve the women in a participatory manner, women are asked to examine the posters and identify problems which occur in their own villages related to the use of standposts, water handling practices, the prevalence of water borne and water related diseases, personal and domestic hygiene as well as problems they might have with their Sarpanch, water committee or lineman.

Problems with household water practices and village water supply management were the main concerns expressed. During these village meetings, the PP women were invited to attend a series of monthly training sessions whereby they would be trained to carry out hygiene education in their village. In some cases, the PP women seconded the names of two other women in their place who were willing and able to attend the monthly training sessions.

Training of Village women to be Health Educators

To date CHETNA has trained 4 clusters of health educators comprising 165 women from 50 villages. As per January 1993 the selection and training of health educators in the Radhanpur Taluka has begun. Two to three women are selected from every village and trained by CHETNA to carry out health awareness in their respective villages on a voluntary basis. Their duties as health educators entail attending the monthly training sessions, being the source of awareness information dissemination to the rest of the community and assuming the responsibility of voluntary workers for the development of their villages.

The only compensation the women receive, aside from remuneration for their travel expenses, is the status they receive from being Pani Panchayat members and health educators. Initially the maximum number of female PP members was set at two per village. However, the GWSSB has recently taken steps to legalize the status of these women so that they all village women trained as health educators will be able to have the status of PP members in their villages.

Monthly three hour training sessions are held at a location central to the cluster of villages. Training sessions include a variety of participatory methods of songs, games, role playing, group discussions, posters and flip charts and other participatory visual aides as well as field visits to the works of the water supply scheme. The major area of focus of the training sessions has been the five health awareness messages enumerated above. Environmental sanitation is an important theme, emphasizing the need for latrines and their use and upkeep. Measures for drainage and trash disposal are also stressed. Clothe water filters and ladles have also been distributed, with token contributions from the women, to promote the use of improved water storage and use practices in the home.

In addition emphasis has been placed on the health educator's role at village level in interacting with the community and carrying out health education in order to bring about an awareness of water and sanitation. Discussions have centred on the problems villages face in water management, the misuse of standposts and animal drinking troughs, the need to avoid washing clothes and dishes at standpost and the need for proper drainage of runoff water. During these discussions, the women proposed that CHETNA intervene directly at village level by carrying out health awareness activities for the women in a village as this would help the health educators in spreading health awareness information.

In some of the villages, CHETNA has taken efforts to formally introduce the women as PP members and health educators to their respective villages, explaining their role and responsibilities to the village women.

To date, two midterm evaluations have been carried out of the training received by the health educators. The evaluations indicate that the women have learned the messages and understood the material and discussions. Once the communication kit of visual aides, comprising of a set of posters and flip charts,is ready for distribution, the health educators will receive a kit for use in transmitting the health awareness messages at village level.

A problem experienced by the health educators, however, which was brought out during the evaluation, is that while knowing the subject matter, they do not know how to spread the awareness messages in an organized or systematic manner. Instead they do this informally, whenever they have the time. An additional problem the women encounter in spreading the awareness messages is the time constraints they face in carrying out health education in view of their household chores and heavy workload. They are expected to carry out health awareness as a community service on a voluntary basis. While they are very motivated to do this work, their voluntarism entails a high cost for them as attending training sessions and carrying out health education takes up time which they might otherwise use to engage in income generating activities to earn cash to pay for household expenditures.

Village level Shibirs (Women Health Camps)

CHETNA's village level interventions consist of carrying out 'Shibirs' or women's health camps of two day duration in every village. Conducting the health awareness activities directly in a village, facilitates the participation of women. To date women's camps have been conducted in 50 villages of the Santalpur Taluka. The linesmen and AWW workers assist CHETNA in making logistical arrangements and informing the village women of the shibirs.

The PP/health educators assist CHETNA in carrying out this health awareness activity in their own village. This is important as it provides a venue for introducing the PP/health educators to the women and establishing a rapport. Whenever possible the AWW workers and linemen also participate, as this activity serves as an important means for integrating them into the health awareness activities.

Using a variety of participatory methods of song, dance, role playing, games, visual aides, group discussion, a demonstration of microbes by use of a microscope as well as demonstration of preparation of ORS, health education on water and hygiene is carried out. Household sanitation is also an important theme. During these shibirs, a large number of the women have expressed a desire to have latrines constructed, if the cost is affordable. The cause, cure and prevention of various diseases, i.e. diarrhoea, typhoid, worms, scabies, and malaria is interwoven throughout the health education messages. For health awareness motivation of improved water use practices, a doya (ladle) is distributed at a nominal cost.

Primary School Children Camps

As per November 1993, the field based operations have included two day children's health camps held at the primary schools for school children of 10 to 15 years of age. To date 8 children's camps have been carried out at the primary schools. Health awareness on water, sanitation and hygiene is carried out, using a combination of participatory methods of song, dance, role playing, hygiene and ORT demonstrations. The school age attendance children are seen as important conveyors of health awareness messages not only to their siblings and other children who are not attending school but also to their parents.

3.2.1.3 Institutional strengthening of Existing Infrastructure

A basic strategy in the implementation of the Health Awareness programme has been to avoid creating new local level structures parallel to those already in existence and to deploy locally available infrastructure and resources as much as possible. Both the ICDS and PHC are the existing infrastructure which have a mandate to provide health and nutritional services to the village community. GWSSB has its own village based infrastructure, the linemen, for day to day water supply and maintenance.

CHETNA's strategy has been to train this staff in communication techniques and hygiene education in order to enhance their capacity for carrying out educational interventions at village level. The goal is that this staff will then continue to carry out water/sanitation hygiene education interventions as part of their regular work programmes. It is hoped in this way to provide for sustainability of the health awareness interventions once CHETNA is no longer actively involved in grass roots implementation.

The monthly meetings of the AWW workers, the linemen and the PHC staff, presented opportunities for CHETNA to carry out training for them in problem solving techniques and conflict resolution, communication methods to improve their capacity for carrying out educational interventions as well as health awareness on water, sanitation and hygiene. Hygiene education on the cause, cure and prevention of the water and sanitation diseases prevalent in the areas is also included.

CHETNA has also attempted to act as intermediary and liaison between the linemen and the PP and villagers as well as between the linemen and their supervisors in resolving the linemen's work-related problems concerning water supply system operation and maintenance.

3.2.1.4 Progress of Health Awareness Campaign

To date, during the past two years that CHETNA has carried out the Health Awareness Campaign, some 50 villages in the Santalpur Block in total have been covered by the field level operations of training village women as health educators and carrying out village level shibirs or village health camps for women. A total of 165 health educators from 50 villages have been trained.
Monthly training sessions have been conducted as well for the primary health care staff and AWW workers as well as the linemen of Santalpur and Varahi.
Coordination meetings are also held with the participation of CHETNA, SEWA and GWSSB to coordinate the various project components and activities.

According to the terms of the three year contract, the above-described health awareness interventions remain to be carried out in some 45 villages covering the Radhanpur and Kanrej Talukas (as well as a few remaining villages of the Santalpur Taluka). In addition, training of the AWW, PHC staff and linemen intervening in the Radhanpur and Kankrej talukas must also be carried out. As the Children Camps are a relatively new activity, these interventions also remain to be completed in all three talukas.

3.3 Assessment of Health Awareness Interventions and Suggestions for Improvement

3.3.1 Assessment of Health Awareness Interventions

The Mission is of the opinion that the field based operations for transmitting knowledge and raising the level of health awareness are effective tools for creating awareness of water, sanitation and hygiene. Interviews with AWW workers and health educators, who have undergone training and discussions with women and children who have attended the health camps and children's camps indicate a high level of enthusiasm and an appreciation of the health messages learned. Both the linemen and health educators saw evidence of improved water management and water collection behaviour at the standpost. Moreover, a large number of beneficiaries interviewed during village visits exhibited a knowledge and awareness of the relationship between water, sanitation and hygiene and their importance for health.

Home visits revealed that the majority of households of a higher socio economic level had already begun adopting improved water and hygiene practices. In Tembi, one of the villages in the pilot sanitation scheme, the majority of households have accepted the improved household latrines and are utilizing and maintaining them. Moreover in Dantrana, a village where income generating activities (handicraft production) have been introduced, a clear correlation could be seen between the improvement of income and the adoption of improved health practices.

Nevertheless, in spite of the fact that improved health practices had been adopted at the household level, little had been done by the communities to improve the overall cleanliness of the village, a situation that continues to pose a health risk to the inhabitants. Furthermore, with the exception of improved water collection and storage practices, very few of the low income households which were visited had begun to adopt improved water use, personal hygiene or improved sanitation practices at the household level. A general lack of environmental sanitation and cleanliness was also observed throughout these villages. This issue was taken up with a group of village men during field visits to Sherpura. The discussion centred on the possibilities for communal action for improvement of village cleanliness. The men pointed out that at present only their wives were receiving hygiene education. Yet if the men were expected to assume a role in village improvements, they would also need to receive hygiene education, themselves. Before they could take action, they first needed to be able to identify detrimental behaviours around water use and sanitation practices and village environmental conditions posing a threat to the community's health.

When questioned if their wives did not transmit the health messages they had learned to their husbands, the men replied that due to both a lack of time and implicit power relations between husband and wife, this rarely happens. Existing cultural norms and constraints also make it very difficult for the PP women trained as village health educators to provide hygiene education to the men in their villages. If CHETNA would be able to organize hygiene education sessions for the men, they would be willing to return from their fields at noon or else make time available in the evenings to attend such sessions.

The men went on to point out that taking action to resolve the village's environmental sanitation health problems would require additional skills as well such as learning how to solve problems, how to set priorities and identify feasible actions and how to organize themselves to work together.
Present during this discussion were also the village sarpanch and one of the male members of the Pani Panchayat water committee. While they felt that the committee should also have a role to play in guiding village action for environmental sanitation improvements, in addition to its role of managing the communal water supply, the committee to a large extent was not yet functional. Few villagers knew about it and only the sarpanch and linemen took responsibility for water problems.

The need to activate the village water committees was also an issue raised by women during the village shibirs (see Progress Report June 91-November 91 pg 9). The discussion centred on the problems the respective communities were encountering in the care and management of their water supply system. The women felt that the PP water committee should be responsible for managing the water supply and be an active body having formal roles and duties as well as decision making powers to enact regulations and enforce them.

Just as the men, the PP women expressed a desire for additional skills training. During a discussion between the Mission and a group of PP women undergoing hygiene education training, the women said that if they are to play a role in resolving community problems related to water and sanitation, they would like guidance from CHETNA as to how to go about it. How does one assume leadership in a village and how can problems be solved which arise out of conflicts? The PP members pointed out that while they now had a basic knowledge of hygiene and community water and sanitation problems they were not sure how to spread the messages learnt and felt they needed more assistance in learning how to work with the community.

While it is true that a very limited sampling of villages was included in the field work during the review mission, the Mission is of the opinion that the findings raise some important issues which have bearing on the effectiveness of the health programme.

Firstly, they underline the effectiveness of integrating income generating activities together with health awareness activities at village level and the importance this integration has for the success of health education interventions. Based on the interviews carried out with the women in Dantrana, it appears that access to income generating activities and an improved socio economic status, facilitates the women's adoption of improved household health practices. On the other hand, village women of Dantarana who have not participated in the income generating activities spoke of their daily effort to earn money to purchase food and basic necessities for the family. This time consuming activity left them with little time to attend to the household or take care of the children.
Attempts were made at the end of the Mission to meet individually with SEWA to present these findings to them and to explore the possibility of planning and scheduling the income generation interventions so that in a timely manner all villages receiving health education would also benefit from income generation assistance. SEWA explained that the fact that their interventions are need based makes any type of forward planning difficult.

A second issue these findings raise is whether awareness raising, by itself,is sufficient as a method to bring about sustained behaviour changes at household and community level and whether women and school children are sufficient target groups for these health education interventions.

As co-decision makers in the household, unless men understand the need to introduce changes in household practices, it is difficult for women to introduce improved practices at the household level without the men's approval and support. Moreover women and men have different roles and responsibilities, and it is the men who are responsible for decision making regarding community level environmental sanitation and organizing improvements. Children not attending school are also an important target group as they spend a great deal of their time caring for the younger children at home while their parents are absent. Discussions with children indicate an interest in taking part in hygiene education activities. The active involvement of all community members in health education activities could be an important factor for success.

The present strategy for bringing about behaviour change consists of transmitting knowledge and creating an awareness of the relationship between water, sanitation, hygiene and improved health.

Nevertheless an awareness of health issues does not automatically translate into action, particularly in more difficult villages of low income population groups who are slow in adopting new practices. Behaviour change cannot be expected from a single transfer of new knowledge and information.

Behaviour change involves an experiential learning process: new knowledge and information on water, hygiene and sanitation is provided; women, men and children must be directly involved in processing this information in order to integrate it into their prior experience and system of values and then assimilate it. The health educator has a key role to play in 'facilitating' this process. Once this information is assimilated by the community members, they can begin to critically analyze their own situation and with the guidance of the health educator identify practices in their own behaviour which are detrimental to their health which they want to change. The health educator can then assist them in prioritizing which behaviour they wish to change and which improved water use, sanitation and hygiene practices are feasible solutions which they wish to adopt.

CHETNA's approach, while very participatory, centers mainly on awareness raising. In order to incorporate this experiential learning process into the present approach, greater emphasis must be given during the health education interventions to ensuring the integration of the information, facilitating its assimilation and in a participatory manner, assisting the community members to identify the practices they wish to change. The use of additional participatory methods and visual aides, described below, will assist in this process.

As has been already mentioned, measures for improving the health of the community entail more than improving the hygiene practices of household members or improving the sanitation of the household. Little of these health improvements are feasible without a reliable supply of water and the community has an important role to play in community based water supply management to ensure the functioning of the facilities at community level. Moreover, the

cleanliness and environmental sanitation of the village are communal problems which must also be tackled by the community members, if any real reduction in water and sanitation-related diseases is to occur.

The project, in fact, has multiple objectives: (1) to provide improved water and sanitation, (2) to provide hygiene education and create behaviourial change necessary to reduce water-related diseases, and (3) to build community capacity for longterm management of water points and sanitation facilities. The expectations are that at the end of the project the communities will be capable of managing their own water and sanitation systems and practising proper hygiene. As a result, they should reap the benefits of improved health.

Communities are not only beneficiaries of the improved supplies but also have an active role to assume in ensuring the functioning of the water and sanitation installations. Capacity building and community organization are important tools for developing the groundwork for the communities to take on the management responsibilities. This entails strengthening the capacity of individuals, households and community members as a collective body to be aware and identify the water/sanitation and hygiene health-related problems posing a risk to their health, identify realistic solutions and take action.

Once behaviour change has occurred at the household level, measures are necessary to provide skills and catalyze collective action for the solution of communal health problems. This necessitates incorporating measures for promoting community capacity building and community organization into the present Health Awareness strategy. In addition to providing knowledge and raising the level of health awareness, further inputs are necessary to develop the capacity of community members to solve problems, set priorities, identify feasible actions and organize themselves to take action to improve village environmental sanitation and ensure management of the standpost, drinking water trough, school latrines, etc.

Capacity building and community organization will be necessary to develop the groundwork for a community to take on the management responsibilities of the improved supplies and to undertake development-related activities.

3.3.2 Proposed adjustments to Health Education Interventions and Communication strategy

Health education must go hand in hand with community development efforts in order to develop the capacity of the villagers to take control of the village health improvements and manage and maintain the water and sanitation facilities. This will entail broadening the content of the shibirs for women and the children's school camps to include training on simple problem solving, conflict resolution and organization methods. Similar health education activities should be organized for the men who are interested.

In addition to providing these health camps for the women, children and men, sustained inputs of hygiene education are also essential. Here, the PP women could play an important role in providing sustained inputs of hygiene education to motivated groups of women, children (and if feasible, men).

Rather than the PP women providing ad hoc hygiene education interventions as is now the case, the interventions of the PP women would be more effective if provided on a regular basis and targeted to interested focus groups of women, children (and possibly, men). Group sessions are a tool which will allow for more opportunities for an exchange of experiences and ideas. CHETNA could assist the PP women in the formation of these focus groups and develop a well-planned programme of step by step health education messages which the PP women can deliver, using the visual aides and themes in the communication kit.

There appears to be a strong interest on the part of children not attending school to participate in health education activities as well. School children have also expressed a desire to participate in extra-curricula health activities. Efforts should be made to investigate the feasibility of organizing village health clubs, wherein all village children could participate.

In order to be in a position to implement this enlarged scope of activities, the PP health educators themselves will require additional skills training. As pointed out they expressed a felt need to learn "how to spread the hygiene messages" which they have learned. Their training curriculum should be enlarged to include participatory communication methods of carrying out hygiene education. With the aid of the communication kit, they can learn the use of the various visual aides as communication tools to accompany the different methods appropriate to the target group and context. Skills in simple problem solving, conflict resolution and organization methods should also be incorporated into their training.

Discussions with some of the PP women during a training session indicated an interest on their part to carry out the activities described above. Regular and sustained village based hygiene education interventions are essential to the success of the programme. These activities could serve not only as a follow-up for re-enforcing CHETNA's interventions but also as a means of providing continued hygiene education to the community once CHETNA phases out its activities at grass roots level. The PP women could serve as a valuable human resource for the implementation of these activities at village level. Wherever feasible, attempts should be made to involve the AWW workers at village level in the implementation of these village based activities.

At present the PP women are working on a voluntary basis. It is important to point out that it will be difficult to expect the PP women to carry out this enlarged scope of work at village level and invest the additional time in training activities without making arrangements for them to receive financial remuneration. Various possibilities for remunerating the PP women for their health education work were discussed during the meeting held with State level authorities. The possibility of utilizing the funds from the District Panchayat budget needs to be explored (see further Annex 4).

Activating the PP water committee via training and backup support is also essential for the sustainability of the health programme. CHETNA is in a position, together with the Jal Seva Training Institute to develop a curriculum and provide training to the Pani Panchayat. Three day workshops for 30-35 participants could be organized, whereby the male and female committee members and linemen from several villages could be grouped together.

3.3.2.1 Proposed adjustments to Communication Strategy

CHETNA has developed a communication kit consisting of a series of posters and flip charts depicting the various themes concerning water supply management, correct water collection and storage practices and improved hygiene and sanitation practices.
These visual aides are found to be based on local conditions, appropriate and well designed.
It is proposed, however that two additional themes need to be included in the kit to provide the support tools for training in the management and maintenance of the water supply and sanitation installations. For example, a poster can be added which depicts the responsibilities of GWSSB and the linemen in water supply maintenance. Another poster is needed to depict the responsibilities of the water committee/community regarding management of the water supply system and its maintenance tasks. For the theme of sanitation, one poster is needed which depicts the household's tasks in operating and maintaining the latrines and bathroom as well as the measures necessary to switch pits once one is full. Another poster could depict the community's or school's responsibilities in the operation and maintenance of the school latrines and urinals.

As already discussed, health education aiming at behaviour change, entails a communication strategy which allows for a step by step process whereby new information is received, integrated into one's own realm of experience and then assimilated. Two different types of training and learning methods are involved in this communication strategy.
The first training approach, which CHETNA is presently using, centers on communicating new health information by use of posters and flip charts with set messages. Participatory exercises as songs, dance, role play, group discussions, microscope demonstrations are used to reinforce the poster messages and actively involve the participants. By its very nature, this is a more directive training approach requiring visual aides with a set content.

Once this first step takes place, however, very non-directive and open-ended training approach is necessary to allow for the integration and assimilation of the new knowledge. Using the type of visual aides and exercises described below, the participants capacity to be creative, generate new ideas, investigate, analyze, plan and evaluate is strengthened. These tools do not require literacy, yet can bring to the surface issues which are relevant to villagers:

- flexi-flans/flannelograph are a visual aide consisting of paper cut-outs of human figures with flexible arms, legs and torsos as well as cut-outs depicting typical scenes in a village in Banaskantha concerning the water supply, cleanliness of a home, environmental sanitation conditions in a village etc. These cut-outs can be placed on a flannel covered board (or any other material to which the cut-outs will stick) to illustrate a point of view or relate an incident or story. The participants are free to choose the cut-outs that best suit their purpose in depicting and recounting a story.

- story with a gap- in this exercise the participants are shown two contrasting pictures, one representing conditions existing before change has taken place -"an unsanitary village", the other "a clean village". Participants discuss the unsanitary village to speculate on why the village situation had detiorated.

The facilitator then introduces the "after" picture of the village looking clean. The group is then challenged to fill in the gap by explaining or illustrating with pictures or flexi-flans what actions steps took place to fill in the gap. This activity challenges the participants to develop a strategy for overcoming the "gap".

While both posters and flexi-flans are creative tools, depiction of a situation with flexi-flans is more open-ended, thereby providing for greater self-expression than posters with a set content. Both of these visual aides are effective tools in participatory intervention i.e the activity of "story with a gap" challenges the participants to identify the problems, consider solutions and develop a strategy for filling the "gap", i.e for improving the village's sanitary conditions. Both of these activities can be included in the women's shibirs or children's camps. These tools can be also be used to actively involve the participants in a needs assessment, for example, of what they perceive as 'health problems' in their water and sanitation behaviour which require improvement. These exercises could also be used to review and evaluate what they have learned.

Another participatory activity proposed for children is a village health walk. This is a non-directive activity where children in separate groups walk around the school or village and observe the existing situation at the school urinals and latrines or with respect to drainage, etc. The same can be done to observe the conditions at the standpost or the cleanliness of the village. Once back in the classroom, each group attempts to discuss what they observed and identify unhygienic conditions and develop a plan of action for solving the problem.

The integration of these activities and tools in CHETNA's communication strategy may allow for the type of non-directive, open-ended, learner-centered approach which is conducive to experiential learning.

3.3.3 Monitoring and Reporting System

The introduction of a systematic monitoring system using standardized indicators would be beneficial to CHETNA in monitoring the effectiveness of the health education inputs in bringing about sustained utilization of the installed facilities and an improvement in hygiene practices.
At present monitoring mainly consists of monitoring of the training activities to ascertain if the participants are satisfied with the organization, presentation and content of the training activities. Evaluations have also been carried out of the PP women's training to ascertain if the health education messages have been learnt. CHETNA also participated in the evaluation of the pilot sanitation scheme and documented the results on the rate of utilization and reasons for use and non-use.

While CHETNA's field staff do carry out home visits to monitor, for example whether improved water storage and water use practices have been introduced by the women in the households, these monitoring attempts are carried out in an ad hoc manner, whenever time permits and the results are not documented, but instead communicated verbally.

Putting into place a regular and standardized monitoring system to monitor whether the interventions are successful in bringing about the desired changes at village level would not only allow for timely adaptations of the health programme but also will facilitate the development of a module which can be replicated in the remaining blocks as well as in other project areas. The same indicators which were used during the KAP study can be used for ongoing monitoring and the initial data collected can be used as the baseline.
Monitoring the lessons learned from the experience in the Santalpur Block is instrumental for the development of such a module. Just as important for the development of a module is documenting the experience and lessons learned in the reports which CHETNA prepares. In addition to a description of the activities and the progress status as is now the case, these reports could also provide an analysis of what the objectives of each health education intervention were, whether or not they were achieved based on the monitoring results, and if not, why not and whether this resulted in adjustments.

4. ENVIRONMENTAL SANITATION AND SANITATION AWARENESS

During the mission an attempt was made to observe whether there were any differences in the two pilot villages, Kalyanpura and Tembi, in the level of acceptance, utilization, and feeling of ownership of the sanitation facilities. While the sampling of households visited was limited, it did indicate an important difference between the two villages, as there appears to be a much higher level of acceptance and utilization rate in Tembi. Moreover, in Tembi the households interviewed exhibited a sense of responsibility for the care and upkeep for the bathrooms and latrines. When asked if they felt a sense of ownership, the households replied that they had contributed towards their cost, therefore they considered the facilities to be their property. In Kalyanpura, on the other hand, the rate of utilization was lower and few of the households interviewed appeared to have a sense of responsibility for the upkeep of the facilities.

Two very different approaches, however, were used in the two villages. While in both villages, the households contributed labour and materials, only in Tembi did the households make a financial contribution towards the cost. In the 'demand-driven' type of approach applied, the financial contribution was used as an indication of the household's felt need and motivation for improved sanitation and only when the financial contribution was made, did construction proceed.

In Kalyanpura, on the other hand, in spite of the fact that voluntary contributions were made in labour and materials, it appears that a large number of the households were unable or unwilling to make a monetary contribution, yet the sanitary facilities were constructed anyway. This approach could be described as a 'supply-driven' one where the main concern was more one of achieving coverage rather than creating the conditions for sustainable latrines.

For wider application of the results of this pilot scheme, a strategy based on the demand-driven approach is more likely to create the conditions for sustainable latrines. Cost-sharing is also essential for creating a sense of ownership of the facilities. At present one standard latrine design is offered which while subsidized is rather high in cost. For sustainability, this model may be too costly to replace or repair if large scale maintenance is involved. Moreover the option of only one standard design may not favour replication of the sanitary facilities once project support is no longer available.
Discussions with GWSSB indicate that consideration is being given to offering a range of alternative designs varying in cost, in which the below ground and floor/ slab structure would be standardized but various options would be offered in the choice of materials for the superstructure.

Sanitation Awareness

Promotion and hygiene education are both necessary integral components of sanitation improvements. Before installation, both perceived needs and desirable improvements should be promoted and after installation specific use and care education given. Not only is it essential that these two components of sanitation awareness be provided in an integrated manner but it is also essential that the inter-relationship between good health, water, sanitation and hygiene improvements be made clear.

During the implementation of the sanitation pilot scheme, however, two different agencies were responsible for various activities. ESI was responsible for the promotion/motivation and hygiene education before installation and CHETNA for the use and care education after installation. This separation of tasks has not had a beneficial effect upon the beneficiaries. The strategy, approach and methodology of the two organizations is very different. The approach used by ESI is more one of social marketing and is almost solely targeted at the male household heads, ignoring the role of women that play in caring for the family's health. Separating the sanitation awareness tasks has had a confusing effect upon the beneficiaries particularly in Kalyanpura. In order to enhance project success, it is recommended that during wide-scale extension of the sanitation programme, one and the same organization carry out the sanitation awareness and promotion both before and after installation of the facilities.

5. INSTITUTIONAL ASPECTS

During the Mission, an attempt was made to assist CHETNA in initiating the institutional process of identifying potential partners from the District Health Department and NGO's operating in the project area, who can carry on implementation of the health education programme at grassroots village level once CHETNA assumes a support role and is no longer involved in direct implementation of the programme.

During meetings held at district and state level, efforts were made to explore the possibilities for the involvement of the Health's staff Multipurpose workers and Primary Health Care staff as well as the ICDS AWW workers, their Supervisors and the Block Education Extension Officers. Many of the staff have participated in training workshops organized by CHETNA.
Furthermore, also explored was the involvement of primary school teachers in carrying out hygiene education at the schools, if properly trained by CHETNA in communication and health education methods and provided with visual aides.

To date, efforts made by CHETNA in getting the Primary Health Care (PHC) staff or the AWW workers directly involved in programme implementation have not always been successful due to a number of constraints. The PHC system is understaffed and many vacancies exist, as it is not always possible to attract staff to work and live in the Banaskantha area due to the difficult conditions. As a result the existing staff has a heavy workload carrying out family planning interventions and malaria control interventions.
CHETNA has also approached the Bhansali Trust in an attempt to integrate the AWW workers more actively in implementation of the health education activities. At present, whenever the AWW worker has the time available, they have been very cooperative in participating in the women's shibirs. However, due to the current overburden of work and low honorarium paid to them, the AWW workers are not interested in being involved on a more permanent basis in such work. Furthermore the Bhansali Trust has not encouraged them to take on this additional task due to their overburden of work.

Recent discussions with the District Health Officer and his staff as well as ICDS staff however indicated an appreciation of the health awareness programme implemented by CHETNA and a desire to find institutional arrangements to continue the programme once CHETNA phases out its grassroots involvement. The District Education Officer also expressed a willingness for the teachers, after receiving training and necessary visual aides to carry on hygiene education in the schools. The problem, he pointed out, has been that up till now the teachers had not received the necessary training to carry out this activity.

The District Health Officer proposed that CHETNA develop a module and well worked-out programme which could be implemented by the Health Staff together with the AWW workers, with the schedule of interventions necessary and the time and manpower required. Once this information was available it would be possible to take more concrete steps in determining which staff would be available for implementation of this health awareness programme in the three blocks.

6. CONCLUSIONS AND RECOMMENDATIONS

To date, CHETNA is halfway in the implementation of its Health Awareness Campaign. Health education interventions have been carried out in some 50 out of the of total 95 villages designated in the original terms of reference. These 95 villages are spread throughout the three talukas of Santalpur, Radhanpur and Kankrej. Applying a phased approach, CHETNA's activities have centered so far in the Santalpur taluka. This leaves some 45 villages to be covered by health awareness activities before the completion of this year, when the original contract expires. The experience gained from the Santalpur taluka forms the basis for the development of a module which is now to be implemented in the remaining two talukas.

In addition to its village based health interventions, CHETNA's health programme also includes an institutional development and training component aimed at strengthening the government and NGO infrastructure intervening at village level in primary health care and maternal/ child care centres in carrying out health education interventions. Training inputs are also provided to the GWSSB linemen. The goal is that this staff, once trained, will continue to carry out water/sanitation hygiene education in support of the newly installed water and sanitation facilities and incorporate these activities into their regular work programmes and schedules. In this way it is hoped that the sustainability of the health awareness interventions will be provided for once CHETNA phases out its direct involvement.

CHETNA has also made provisions for providing for sustainability of health education interventions at village level by selecting and training village women to carry out health education. Evaluations of the effectiveness of the health educator's training, which CHETNA has conducted, indicate however that while the women have successfully learned the health education messages, they still require communication techniques and skills in order to be able to spread the messages and carry out effective health education.

The hygiene awareness activities such as the women's melas and the women's health camps and children's school camps have proven to be effective tools for creating a general awareness of water, sanitation and hygiene issues. Moreover a large number of the households of a higher socio-economic status have begun adoption of improved water and hygiene practices.

Clear evidence was seen of how an improvement in income can have a positive effect on the adoption of improved health practices, underlining the need to integrate these two project components and ensure the provision of income generating activities at the same time that health education activities are being carried out.

An approach centering only on awareness-raising may not be a sufficient, however, as a means for bringing about behaviour change in the more change-resistant, low income population group. Although many of the households of a higher socio-economic level have begun to introduce improved water and hygiene practices, there was little evidence observed of improved health behaviour being practised among family members of the low income households. Moreover the general environmental sanitary conditions in the villages remain poor, indicating

that improvements, if at all, are only at the household level, while little communal action has been undertaken to improve the unsanitary village conditions posing a threat to the community's health. Additional inputs are necessary to catalyze communal action. Problems also exist in the communal management of the water supply systems. Pani Panchayat village water committees are for the most part non-functioning.

Adjustments are necessary in the health awareness approach which will not only facilitate the behaviour change process but also provide the necessary skills for capacity building and community organization to take on the management responsibilities of the improved supplies and communal environmental sanitation improvements.

Proposed adjustments in the health awareness and communication strategy will include incorporating elements of a participatory experiential learning process into the present approach so as to enable the community members to integrate the new knowledge into their own realm of experience, critically analyze their own situation and decide which improved health practices they wish to adopt. Several participatory visual aides which can serve as tools in this process are proposed as additions to the communication kit.

Such an activist approach requires the direct participation and involvement of all population groups residing in a community - the target groups must be enlarged to include men as well as children not attending school. Skills training for the PP health educators in communication techniques for health education delivery is necessary to enable them to carry out their village level interventions.

These proposed improvements in health education must be accompanied by community development efforts to raise the capacity of villagers to take control of the village health improvements. This will entail organizing and working with groups of women, men and children who will receive regular inputs of health education. Activating the PP village water committees via training and backup support is also essential for the sustainability of the health programme. It is proposed that CHETNA, together with the Jal Seva Institute, prepare a curriculum and conduct 3 day training workshops for the Pani Panchayat members. Training skills are necessary in hygiene education, problem-solving, conflict-resolution and management skills. In the event that the water committees must assume responsibility for water tariff fee collection, bookkeeping and financial management training should also be provided.

Along with the proposed improvements, the introduction of a systematic monitoring system using standardized indicators is essential for monitoring the effectiveness of these health education inputs in bringing about the desired changes. This would not only allow for timely adaptations but also facilitate the development of a module which can be replicated in the Radhanpur and Kankrej talukas as well as in other project areas. Improving the quality of the report writing is also important for documenting the lessons learned. The inclusion of an analysis of the objectives of each health education activity carried out and whether or not the objectives were achieved as well as the reasons for the success or lack of it would improve the quality of the reports as tools for developing a module.

In order to provide for sustainability of the health education programme once CHETNA phases out its involvement, institutional efforts to involve the District Health and ICDS staff in the implementation of health education activities should be pursued. CHETNA should develop a realistic and feasible health programme which can be implemented by the Government Health Department and NGO staff, taking into account the time and manpower constraints of the existing staff. Based on a detailed programme which includes the manpower and time requirements, more specific follow-up action can be taken with the District Health in identifying the appropriate manpower and assessing their additional training requirements.

Follow-up action will also be required to further investigate the funding possibilities for financially remunerating the PP health educators, if their scope of work is to be enlarged.

In view of the positive effect that income improvements have upon women's adoption rate of improved health practices, further efforts will be needed to ensure the provision of income generating activities in villages where CHETNA is carry out health awareness interventions. Towards this end, CHETNA should pursue discussions with SEWA.

The Mission is of the opinion that it will not be feasible during the remaining 11 months to introduce the proposed modifications and implement them in the 50 villages of the Santalpur taluka which have already covered and in addition implement the revised health programme in the remaining 45 villages of the Radhanpur and Kankrej talukas.

During the remainder of the health awareness programme, in addition to its implementation role, CHETNA must also develop a programme module for wide scale application as well as provide on the job training for the Health Department and AWW staff so that this staff will be able to carry on its own once CHETNA phases out its involvement in implementation and assumes a support role. The transition for CHETNA from a direct implementation to that of a backup support and training role should be a gradual one.

To allow for sufficient time to implement the revised programme and develop the module for implementation in the remaining talukas as well as in other project areas, a two year time extension is proposed, commencing from January 1993.

ANNEX 1

TERMS OF REFERENCE

OF CHETNA REVIEW MISSION

ANNEX 2

ITINERARY REVIEW MISSION OF CHETNA HEALTH AWARENESS COMPONENT

ITINERARY REVIEW MISSION OF CHETNA HEALTH AWARENESS COMPONENT

Member: Mrs. L.F. Hoffman

Period: 05/01/1993 - 22/01/1993

ITINERARY:

Tuesday	5/1/93:	Transfer Amsterdam-Delhi
Wednesday	6/1/93:	Transfer Delhi-Ahmedabad. Review of CHETNA Progress Reports and documentation. Briefing at CHETNA office.
Thursday	7/1/93:	In-depth discussions with CHETNA staff.
Friday	8/1/93:	Departure to Radhanpur. Visit to Children's Camp at Primary School of Vauva.
Saturday	9/1/93:	Visit to village of Sherpura for interviews with beneficiaries. Visit to Health Educator's Meeting. Visit to Pilot Sanitation Scheme at Kalyanpura.
Sunday	10/1/93:	Visit to Village level Camp for Women at Mehamdavad. Visits to Lunichana and Abyana villages and interviews with beneficiaries.
Monday	11/1/93:	Departure to Palanpur. District level Meeting at Collector's office with District Health, ICDS and Primary Education Officers, GWSSB and CHETNA staff to discuss their involvement in implementation of health awareness activities. Return to Radhanpur in evening.
Tuesday	12/1/93:	Visit to Pilot Sanitation Scheme at Tembi. Home visits and interviews with beneficiaries. Visit to SEWA/CHETNA village of Dantrana; interviews with beneficiaries. Meeting and discussions with EE of GWSSB at Radhanpur.
Wednesday	13/1/93:	Visit to Sanitation Awareness Camp for Women at Primary School children at Kalyanpura. Return to Ahmedabad in the evening.
Thursday	14/1/93:	Formulation of conclusions and recommendations of the mission.

Friday	15/1/93:	In-depth discussions with CHETNA staff of conclusions and recommendations. Meeting at CHETNA office with GOG Dept of Health and ICDS officials to discuss their involvement and the sustainability of the health awareness programme.
Saturday	16/1/93:	Meeting at ESI. Meeting at SEWA office. Meeting at CHETNA office to review Health Awareness communication strategy, training materials and visual aides.
Sunday	17/1/93:	Final discussions with CHETNA staff to discuss proposed programme adjustments for Awareness Campaign, module for replication and future plan of action.
Monday	18/1/93:	Travel to Delhi.
Tuesday	19/1/93:	Finalization of conclusions and recommendations.
Wednesday	20/1/93:	- do -
Thursday	21/1/93:	Debriefing at RNE with Mr. P. Flik.
Friday	22/1/93:	Departure to Amsterdam.

ANNEX 3

LIST OF AUTHORITIES

AND RESOURCE PERSONS MET

LIST OF AUTHORITIES AND RESOURCE PERSONS MET

NAME	DESIGNATION
A. Royal Netherlands Embassy	
Mr. P. Flik	First Secretary Water Supply and Sanitation.
B. Government of Gujarat	
Dr. J.C. Gandhi	Deputy Director Epidemic Control, Health and Medical Services Department, GOG.
Mr. B.K. Shah	District Collector, Banaskantha District.
Dr. R.L. Patel	District Health Officer, Banaskantha District.
Mr. Gamethi	District Primary School Officer, Banaskantha District.
Mr. N.P. Raygor	District ICDS Programme Officer, Banaskantha District.
C. GWS&S Board	
Mr. C.C. Shah	Executive Engineer, PHW Division, Radhanpur.
D. NGO's and other Resource Persons	

CHETNA:

Mrs. Indu Capoor
Mrs. Palavi Patel
Mrs. Jyoti Gade
Mrs. Minaxi Shukla
Mrs. Harini
Mrs. Maheswari Vyas
Mrs. Varsha Bhatt

NAME	DESIGNATION
ESI:	
Mr. I. Patel	
ICDS/Bhansali Trust:	
Mr. V.V. Gothi	
Dr. D. Mavlankar (Consultant, Public Systems Group IIM)	
SEWA:	
Mrs. Renana Ihabuala	
Mrs. Reema Nanavaty	

ANNEX 4

REPORT OF PROCEEDINGS OF MEETING WITH STATE LEVEL AUTHORITIES

REPORT OF PROCEEDINGS OF MEETING WITH STATE LEVEL AUTHORITIES

Date : January 15, 1993
Venue : CHETNA Office
Time : 1400 - 1700 Hours
Participants: Mr. C.C. Shah, Executive Engineer, GWSSB
Dr. J.C. Gandhi, Deputy Director of Health, Epidemic Control
Dr. Dilip Malvankar, Public Systems Group, IIM (Consultant to ICDS)
CHETNA Team:
- Ms. Indu Capoor
- Ms. Minaxi Shukla
- Ms. Jyoti Gade
- Ms. Maheshwari Vyas
Mrs. L. Hoffman, Review and Support Mission

INTRODUCTION

Indo-Dutch bilateral project has been implemented in three blocks of Banaskantha District. They are Randhanpur, Santalpur and Kankrej. Project has an integrated approach combined with a sanitation component, the construction of household and school latrines and bathrooms, health/hygiene education and income generation activities. Community participation is the key strategy in implementation of the project. CHETNA has been involved in the Health Awareness component since January 1991. Up till now 50 villages of Santalpur block have been covered for the above purpose.

Mrs. Lane Hoffman, in the context of the Review and Support Mission of the CHETNA Health Awareness Component of the SWRSS, met with CHETNA staff, participated in health awareness activities and visited project villages during the period of January 6 - 17 1993 in order to monitor and review the progress of the health awareness activities. As part of the Review Mission's objectives, CHETNA and the Mission were concerned not only with improving the quality and impact of CHETNA's current health education interventions but also with the eventual continuity and sustainability of the Health Awareness component as a whole once CHETNA (possibly after December 1993) takes on more of a support role and is no longer actively involved at the grass-roots level in project implementation. With this in mind an effort was made to identify potential partners from Government or NGO organizations who could carry on the implementation of the health education component at the grass-roots village level in support of the continuing SWRSS project.

To explore the possibilities of the involvement of the Government Health Department, ICDS personnel and other Non Government Organizations intervening in the Banaskantha district, a meeting was held on January 11, 1993 at Palanpur in the Collector's office. Those attending to discuss the issues included the District Collector, District Development Officer, District Health Officer, ICDS Programme Officer and District Education Officer, Gujarat Water Supply and Sanitation Board members, other related functionaries, CHETNA project staff as well as the Review Mission Consultant.

After discussing the possibilities at district level, a follow-up meeting with State level authorities was organized to discuss the issues further and initiate the institutional process for involvement of district level and NGO personnel in carrying out, and eventually taking over, implementation of Awareness and hygiene education activities.

ISSUES DISCUSSED CONCERNING THE IMPACT AND SUSTAINABILITY OF THE HEALTH AWARENESS PROGRAMME

1) **Need for a combined strategy of health education and community development**

   Health education alone is not sufficient for bringing about an improvement in the quality of lives and a bettering of the village socio-economic conditions. In a water and sanitation project, health education must go hand in hand with community development in order to develop the capacity of the villagers to take control of the village health improvements and manage and maintain the water and sanitation facilities. This will entail on the one hand organizing and working with groups of women, men and children for carrying out health education and on the other hand, activating, training and strengthening the village water committees so that they can carry out their role of guiding the village action for improving environmental sanitation as well as managing and maintaining the community water supply.

2) **Water and Sanitation Awareness COMPONENT should communicate together and have uniform and integrated approach**

   Though CHETNA is involved in Health Awareness, the sanitation component is implemented by ESI. During the pilot phase household and school latrines have been constructed in Kalyanpura and Tembi village. The Strategy,

approach and methods adopted by these two organisations in their implementation of the water and sanitation health awareness and motivation Campaigns during the pilot phase differs a great deal. This diversity is inconsistent with the overall project aims of integrating water supply, sanitation and health education interventions and in conveying the message to the beneficiaries that a holistic approach is necessary in order to improve their health. Separating the water/hygiene and sanitation messages has had a confusing effect upon the villagers. In order to enhance project success and ensure sustainability, it is recommended that one and the same organization carry out the motivation, health awareness and operation and maintenance campaigns during implementation of the sanitation campaign.

3) **Involvement of men as a target group for health education**

Although at present women are involved in Health Awareness, in the cultural reality, the husband is also a co-decision maker in the household and without his understanding and approval, it is often difficult for women to implement the improved practices at the household level. Pani Panchayat (PP) members and other motivated women felt that organizing such health education meetings for men would be very beneficial. It was proposed that these sessions for village men be carried out by directly by CHETNA staff themselves as the PP women health educators are not in a position to communicate the messages directly to their men because of the implicit power relations, especially if the woman is the daughter-in-law of the village she cannot speak in front of village men.

Men are mainly responsible for the introduction of environmental sanitation improvements for the community. Thus without the participation and active involvement of the village men, the introduction of improved health practices in the home as well in the community may not be realized. Discussions with various groups of men in several villages during the Mission revealed an interest and motivation on the part of the men to receive health education directly from CHETNA trainers.

4) Involvement of non-school attending children as a target group together with school children in a health club

There also appears to be a strong interest on the part of the children who are not attending school to receive health education during their free time. Many of these children are unable to attend school, not out of disinterest but rather because they are obliged instead to assist their parents in agricultural work or in looking after their younger siblings at home.

5) Economic Concern and high cost of voluntarism of Women Health Educators

SEWA is giving income generation results of which can be visible immediately, but health education results are long term so community can not seen the immediate utility and productivity of this component.

A large number of the Women health educators regularly attending the monthly training meetings are now asking to be remunerated by daily wages for the time they invest in carrying out the village health education activities, time which is lost to them for otherwise engaging in paid work or an activity which generates income for paying the family's expenditures. They need time and preparation to hold the women's meeting at the village level. However, due to triple burden of work, neither PP members nor women of the villages can sit together to discuss the issue. At present many PP health educators who otherwise would attend the monthly training meetings or carry out village health education activities are unable to, because their husbands refuse to allow them to invest time in this unpaid activity.

6) To systematize monitoring and prepare Module for Replication

It is important to develop a module from the work in the Santalpur block for implementation in the other blocks as well as for general use. This is essential for replication of the programme CHETNA is developing particularly in view of the need to transfer the implementation tasks to Government Health and NGO personnel. The introduction of a more systematic monitoring of the project inputs, progress, utilization of the improved water and sanitation facilities and behaviour changes would facilitate the development of this module.

SOLUTION STRATEGIES DISCUSSED AT MEETING

1) **To convince people that Health Education has economic values**

Dr. J.C. Gandhi, suggested to have base line survey of the diseases in that area, this survey has already conducted by GWSSB. Then the problem should be projected in front of the community, the cost of morbidity and how much money and time they have to spend on medication, simultaneously also economic loss due to inability to work, as well as physical and emotional losses. So the community first of all should be convinced that Health Education includes a financial gain and has an economic value.

2) **Utilization of District Panchayat budget for the Health Education**

He also suggested to utilise District Panchayat budget of health. Out of their total budget 5% is allotted for health. Presently most of the allotment is utilized for the curative aspect. CHETNA together GWSSB can sensitize and motivate the District Panchayat to utilize this budget for the health education, especially to pay for the honorarium of the Health Educators who are regularly coming for the monthly meeting and willing to disseminate the messages in the community.

3) **Utilization of Gram Panchayat budget**

It was also mentioned that 10% of the above budget can be utilised for the HE and since this budget comes from District Panchayat, they can monitor the programme.

4) **Involvement of ICDS functionaries and Bansali Trustto continue the activity**

Bhansali Trust, a local NGO which is running the ICDS programme on behalf of the Government, already has a large health infrastructure in the district, so in principle, they could be involved in the Health education activities. Dr. Dilip Malvankar suggested trying to involve the AWW workers in the implementation of water and sanitation awareness activities as they are already doing similar type of work.

CHETNA replied that they had already approached them and tried to involve them, however due to the AWW's current overburden of work and the low honorarium paid to them, they are not interested in being involved in such type of work. Furthermore the Bhansali Trust has also not encouraged them to take on this additional task due to their overburden of work, although they have been very co-operative in helping in all the aspects of the HE.

5) **Involvement of Village Health Workers and other functionaries of Health Department**

Though the Health department is ready to involve the VHW's in the implementation of the water and sanitation health education activities, unfortunately many seats are vacant due to the non-availability of proper candidates as many Health workers are not willing to stay and work in the area due to the drought prone conditions and sometimes non-availability of primary needs. Also, in the PHC programme, a VHW is not available per village but instead on a population-wise basis, there is approximately 1 VHW for every 5000 inhabitants (approximately 1 VHW for 5 to 6 villages). It was also suggested that PP members should work till the proper structure of health functionaries is built, but the concern was that it will take quite a long time period before this to take place. It also was suggested that the Female Health Worker would be the right person to coordinate with AWW and Pani Panchayat members.

6) **Recovery of water taxes by GWSSB for remuneration of Health educators**

At present, the Board is spending Rs. 40-50 per capita/per person and they are collecting Rs. 6 only per capita/per person and if they pay on time Rs. 1 discount is given to the family. It was also suggested that GWSSB could increase this amount by Rs. 1 in order to have the funds to pay remuneration to the Health Educators. However, Mr. CC Shah said he does not have this authority, decision should come from the Government at the central level. The HE can not be separate from the maintenance of water thus the Board should take the responsibility to meet the villagers and involve them in the process right from the beginning. It was proposed to Mr. CC Shah to recruit and train Community Development Workers, because the HE can not be sustained without community development.

7) **Sanitation Awareness**

It was felt that sanitation awareness should be the part of the whole programme and should be implemented by the same agency who is involved in the HE. Soft ware and hard ware should go together and the soft ware interventions of health education are necessary before and after installation to raise the awareness for the need, acceptance and proper use of hardware. Chetna is already involved in pre and past awareness for use of latrine in UP. As well produced visual kit for the education. This experience and visual kit can be adopted in this programme for the same purpose.

8) **Involvement of children in the HE**

Women do come for the camp but maximum for only 2 hours a day besides they do not have time to communicate the messages in the community. CHETNA's previous experiences have shown that children are very effective messengers to their families/society and other children of the villages. Parents also accept their messages very promptly. CHETNA has already organised children's camps to involve school children so they can also teach to non going school children and form children's clubs to run the HE activity regularly. Training in communication and use of participatory method should be provided to the school teachers so that they can motivate school children. CHETNA can take this responsibility due to it's rich experiences in this field.

9) **Connection with other schemes**

The overall goal of the programme is to improve the quality of life, therefore attempts should be made to involve the project communities in other ongoing programmes so that they can benefit from other programmes such as TRYSEM who provide vocational training and DWACRA who provide better facilities of health, nutrition and awareness.

10) **To prepare Module and standard strategy for the replication**

It was suggested by Mrs. Lane Hoffman that CHETNA should develop a module in Santalpur block which could be replicated in the other blocks and project areas. CHETNA pointed out, however, that the KAP studies carried out reveal different results in the various blocks, therefore same module might not applicable. In response Mrs. Hoffman proposed that CHETNA

could develop a module for replication which would be based on a uniform strategy but allowed for site-specific differences in the emphasis of the messages. Putting into place a regular monitoring at village of the effect of health awareness activities on the village beneficiaries would allow for timely adaptations of the programme and facilitate the development of a module. It was emphasised by Dr. Gandhi, that a post evaluation of KAP study is necessary to find out the behaviour changes. For this purpose some simple indicators can be used such as, availability of ladder (Doya), soap, nail cutter, size of nails etc. Evaluation strategy should be the combination of physical observation, questionnaire, discussion etc.

To conclude the meeting, Mrs. Hoffman gave some practical suggestions for improving the health education activities carried out by CHETNA as well as the overall quality of the programme. They are as follows:

- More participatory methods should be used while imparting the health education such as visual aides as the pocket chart, story with a gap, flexiflans and flannel graph as well as a children's hygiene/sanitation walk to identify community health risks and identify feasible community solutions for action -- all participatory methods calling on the people's own direct experience which stimulate them to think and participate (appropriate examples of participatory visual aides developed in the SARAR methodology of UNDP-PROWWESS).

- To involve non-school going children together with school-attendance children in a club to educate them in the evening when they are free from their work.

- To involve community in taking collective action to improve environmental sanitation and cleanliness of their village as a whole, because even if the level of cleanliness improves at the household level, the unsanitary conditions prevailing in the public areas of the villages continue to pose a health risk for the villagers.

- If one can find a solution for financially remunerating the women health educators worker in the village (PP member) so that they will not have to work entirely on a voluntary basis and thus could have more time disposable to carry out health education activities in their respective villages, then their job could be assigned as follows:

* To conduct meeting for the children

* To conduct meeting for the women twice in a month (2 hours each)

* To conduct household visits (4 per week)

* To concentrate more on inculcating habits and bringing about behaviour change rather than just creating awareness

* Activating the PP Village water committees is a must so that they can carry out their role of community management and maintenance of the village water supply as well as that of organizing community action for improving the village environmental sanitation. This can be done by training the PP water committee members, male and female members, in hygiene education and simple managerial and organizational skills for the management and maintenance of village level facilities.

* CHETNA should pull out from the programme gradually and even if in future it will assume more of a support role, the above changes in strategy would have to be done in its present implementation work itself, so that transition from implementation to support role is smooth.

CONCLUSIONS

Meeting between Mrs. Hoffman, CHETNA staff and Government Officers who are decision makers was very fruitful and productive. CHETNA got an input to improve the quality of programme and to make it more participatory and community centred. As well found better hope for the continuation and sustainability of the programme. Now CHETNA will concentrate on the co-ordination with District Panchayat, block and Village panchayat from whom ray of hope is seen. Children's awareness on health will be focused where, CHETNA's Child Resource Centre would be helped to adopt effective participatory and child centred strategy for the training of teachers and to communicate messages in the community to inculcate the positive habits.

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