Ballia Rural Integrated Child Survival (BRICS) Project
World Vision of India
Dr. Beulah Jayakumar Email: ballia_India_adp@wvi.org

The Ballia Rural Integrated Child Survival (BRICS) Project was implemented from 1998 to 2002 in Ballia district of Uttar Pradesh state of India, funded by a cooperative agreement between USAID/Washington and World Vision United States.

Uttar Pradesh, the most populous state in the country, provides a microcosm of acute health needs of children, mothers, and families. Child survival, nutrition and reproductive health indicators for the state are way below national averages.

Ballia is one of the 70 districts of Uttar Pradesh state and has a total population of 2.7 million. Ballia is divided into 17 administrative units called "blocks." 80% of the populace is rural; fertile alluvial soil and abundant water supply fuel the agrarian economy, but about 60% of the population is landless, engaged in casual, seasonal labor with high seasonal migration. Only 23.7% of women are literate. Median age at marriage is 17 years for girls. Over 98% of the residents of the district are Hindu, and the rest, Muslims and Christians.

When the BRICS project began in 1998, the formal health sector in the district of Ballia was found to be staffed by weak and unmotivated personnel, a system in dire need of vision, resources, and successful models for replication.

BRICS was designed with the objective of assisting the Ballia Chief Medical Office, public and private partners to accomplish, sustain, document and replicate best practices to reduce fertility, infant, child and maternal mortality through an innovative child survival and reproductive health project in Beruarbari block of Ballia district over a four year period.

The project also planned to go to scale by replicating best practices in child survival and reproductive health to all the 17 blocks of Ballia district.

The intervention areas of BRICS are typical child survival priorities in developing nations – Increased immunization coverage, improved care during pregnancy and delivery, increased coverage of birth spacing/family planning services, Prevention of malnutrition and vitamin A deficiency, Essential care of the sick child and Essential care of the newborn.

The project's strategy was not to build a delivery system parallel to existing ones; instead, it worked on a three pronged strategy: strengthening existing public and private health service delivery; building awareness, creating demand and mobilizing communities; linking the beneficiaries with the health services.

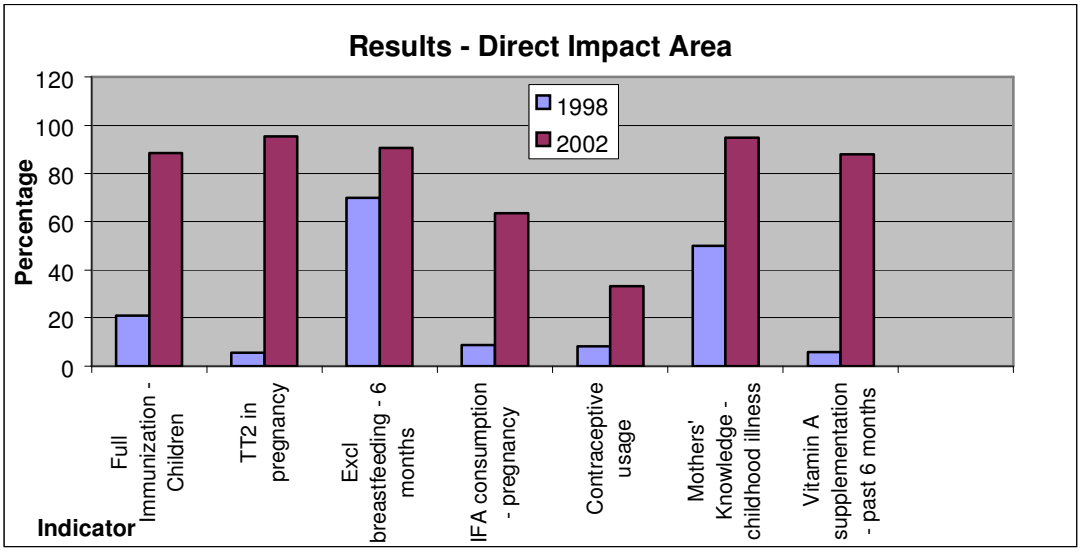
Geographic coverage for the first two years was the block of Beruarbari, with its population of 151,804 living in 83 villages – called the "direct impact area" of the project. From the third year on, the other 16 blocks of the district were covered through a variety of operating partners, including the local governance structures and local NGOs. These blocks form the project's "indirect impact area." Of the six interventions mentioned earlier, only the first two were scaled up to the district, the others to be taken up during the expanded, second phase of the Project.

The project's direct beneficiaries were 46,456 women and children and indirect

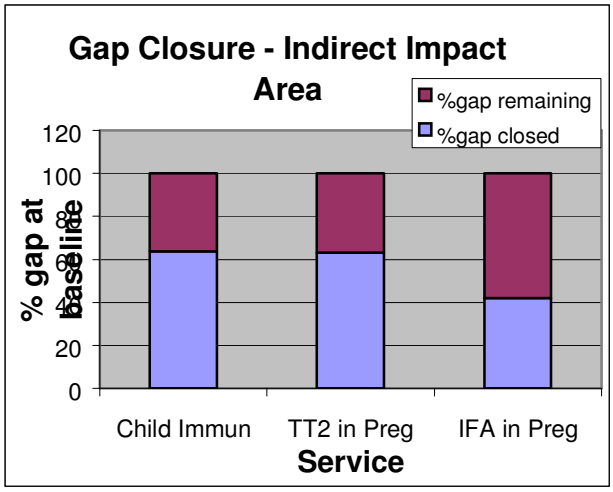
beneficiaries 796,489 women and children.

The project was completely integrated with the larger 20-year development program called Ballia Area Development Program (ADP). ADP is the core programming unit of World Vision worldwide, and Ballia ADP is one of the 105 ADPs currently operating in the country. This integration was embedded in the BRICS design, and occurs at all levels of operation, from grassroots activities, to supervision, administration, and program management.

The results of the project in each intervention area have been phenomenal – targets were met or surpassed in all indicators. In the direct impact area, 61% of the gap in services that existed at baseline was closed at the end of the project.



The graph to the left depicts the wide margin of success the project has had in its lifetime.



The potential impact of the project have been estimated in two areas – the proportion of mothers reporting an unintended pregnancy in the preceding 12 months fell from 31.6 to 6.2; an estimated 182 deaths due to measles have been averted owing to the increase in

measles immunization from 74% to 93.1% in the last year alone.[1]

In the indirect impact area, results have been more spectacular in that the increases were achieved in a span of two years. This is due primarily to the rapid scale up of activities. As is the case in many other under resourced locations, "gains have been the highest where the needs were the greatest"[2].

The graph to the right gives details of the extent to which the gaps in health service level outputs have been closed by the project.

In addition to the sensible strategy and approach mentioned earlier, many other factors worked in synergy to bring about the successes:

The focus of the project was not just to increase coverage in the intervention areas; comprehensiveness is evident in its activities - issues like cold chain maintenance, surveillance for Acute Flaccid Paralysis, sterilization techniques and injection safety were addressed at different points of time. A recent example is the contribution made by BRICS to improve the voltage stabilization aspect of the cold chain system of the entire district. This issue was identified during a workshop jointly organized by BRICS, Ballia Chief Medical Officer, and UNICEF. And this contribution made by the project has been well received, given the capricious voltage and power supply situation in the district. Integrating the project with the Area Development Program eased the administrative and managerial issues. It has also helped in reducing costs, improved ownership at all levels and built staff capacity in an extensive manner.

Capacity building has been the central organizing principle of BRICS, covering a wide range of partners – public and private health care providers, NGO partners, and local governance structures. Public health care providers, especially in the direct impact area, have been trained and supported in such a way that this sector is now more comfortable with the idea of public – private partnerships. In a district where about 85% of all deliveries take place in the home attended by Traditional Birth Attendants (TBAs) and the majority of curative care for sick children is provided by unqualified practitioners, BRICS has extensively built the capacity of these two cadres. These providers are now enabled to provide quality care, counselling and referral services. The six local NGO partners have learned to work in a systematic and thorough manner, with a strong monitoring element in their programs. They have rapidly realized the power of data in making management decisions.

Another cross cutting element in BRICS has been its communication strategy for behaviour change at the household level, in a repeated and targeted fashion. BRICS prepared a seven-module communication material in the local dialect, complete with a couplet for each key behavior. The increases in coverage testify to the changed behavior at the family level.

Recruiting an exceptional cadre of grassroots workers called the *Gramin Swasthya*

[1]Measles can have a case fatality rate of 15% and higher in developing countries and almost all non - immunized children are known to get the disease. In the direct impact area with an estimated 4200 under 1 population, there was an increase in measles immunization by 29% in the last year of the project. This translates to an additional 1218 children immunized and 182 (1218*15%) potential deaths averted.
[2] The CSTS Project, ORC Macro. Child Survival Grants Program Review, Nov 2001.

Sevikas, or GSS. These are resident women with minimal education, who are empowered to serve as change agents in the community. The tasks of the GSS in her village ranges from family level communication on key behaviors, demonstrating ORS preparation, organizing Self Help Group meetings and conducting Adult Literacy classes. "The GSS is the village doctor; she knows all that one needs to know for providing preventive and promotive care," says Mohammed Eslam, Health Education Officer, Beruarbari Primary Health Center.

Central to the task of the GSS are the community based registers. These not only help the GSS track each beneficiary in her area over time, but also serve as tools for monitoring the completeness and timeliness of services and for advocating for improved services.

The story of BRICS is incomplete without describing the transformation witnessed in the communities as a result of the four years of this project. At the heart of the ministry of World Vision is transformational development, a process through which children, families, and communities move towards fullness of life with dignity, justice, peace and hope[3].

Technical interventions such as the ones outlined in this paper are part of World Vision's programming for bringing about transformational development that is community based, child focused, value based, and sustainable.

BRICS staff has integrated intentional Christian witness without proselytism. In seeking to promote human transformation and justice, the staff witness to the good news of the Kingdom of God by word and deed. Every contact, every dealing with the community, health care providers partners and administrators were opportunities before the staff to demonstrate how lives can be lived in line with the values Jesus taught mankind. Field level staff that come in contact with the communities during the course of their daily work have made the most significant contribution to the spiritual impact of the project.

People gradually come to learn why we do what we do. Inevitably, this has led some to seek the Truth, and staff are glad to give them the good news at such opportune times. Over the past four years many of the GSS, and other community members have begun regular worship at the local church. They in turn, bring in others from their villages, sometimes entire families, to the church. As a recent example, one of the GSS who had occasionally attended church with other GSS, met with a fire accident, in which two of her relatives were badly burnt. She took them to the district hospital, and then called the project office to ask for prayer support.

The Final Evaluation of the BRICS project was conducted in September 2002, by a team of experts, local stakeholders and community members led by Dr Gilbert Burnham, from Johns Hopkins School of Public Health. This truly participatory evaluation was conducted as per guidelines issued by the donor, USAID, and looked at the accomplishments and constraints of the project, the factors that have contributed to or impeded progress, and identified lessons learned from the implementation of this project, to be communicated to the larger development community. Cross cutting issues like community mobilization and sustainability were also examined.

[3] From TDNet, a resource of World Vision Inc. Jan 2003.

What follows is a section of the Final Evaluation report[4]:
"This project has attempted a very ambitious program in which it has largely succeeded, and succeeded by a wide margin. These successes have established it as one of the most successful projects that the evaluation team leader can recall seeing.

"The strengths of this projects have been in its partnerships— partnerships with the public sector health services to strengthen service delivery, partnerships with traditional sources of health care, and partnerships with the community. These partnerships have been the heart and soul of this project, and have been the key to its outstanding achievements.

"By building on community structures, establishing Self Help Groups, and involving the Panchayat[5] and its members it has put health on the agenda for local organizations and local governance to see that this is the responsibility of the community itself."

"Beyond Ballia, the influence of the project has helped other NGOs and other World Vision ADPs to expand their horizon and put into place some of the methods and approaches developed in the BRICS project."

The constraints faced by BRICS were numerous. There were suspicions, especially from religious extremists; the staff of the public health sector felt threatened, particularly by the mobilization activities of the GSS; there were unrealistic expectations about what BRICS should deliver.

Heavy staff turnover coupled with the fast paced nature of the project led to increased work load on many staff. It also robbed the organization of valuable institutional capacity. The turnover was due to the poor living conditions in the district, and the lack of even basic amenities.

Despite these and other constraints, the team was unstinting in its efforts to build staff capacity and leave behind strengthened systems in the communities as well as in the health services.

What could have been done better? One area of regret for the BRICS management was that sufficient attention was not paid to the recording, reporting and investigation of maternal and infant deaths. The level of effort in this direction was not sufficient enough from the start of the project, despite an almost complete line listing of pregnant women and infants in the direct impact area. This issue would be sufficiently addressed in the second, expanded phase of BRICS.

The future of BRICS is bright – World Vision competed for a second phase to the BRICS Project and has been accepted by the Child Survival Health Grants Program of USAID. This expanded phase will cover two other districts in Uttar Pradesh State in addition to Ballia, and will begin in October 2003. This second phase proposes to take to scale the strategies and approaches tested and proved in BRICS, to a population of 4.7 million. It will also endeavor to document and disseminate methodologies and tools developed in the "population lab" of Beruarbari block, the direct impact area of BRICS.

[4] Burnham, Gilbert. Final Evaluation Report – Ballia Rural Integrated Child Survival Project. Oct 2002.
[5] Panchayat – Hindi term for local governance structures.