

PARTICIPATORY EVALUATION-STUDY

OF

CHILD SURVIVAL AND CHILD DEVELOPMENT PROJECT

OF

CHRISTIAN MEDICAL ASSOCIATION OF INDIA.

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**PARTICIPATORY EVALUATION - STUDY OF THE CHILD SURVIVAL AND
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INTRODUCTION :

This study follows the decision of the C.M.A.I. to

- look at how appropriate the CSCD project is,
- assess the progress and effectiveness so far,
- obtain guidance on future involvement of C.M.A.I. in
Child Survival and Child Development issues in India.

The details of the memorandum of understanding is in
Appendix - 'A'.

The format of presentation of the report is as follows :

I. C.M.A.I.

- Policy on Community health
- Philosophy behind CSCD project
- Objectives of CSCD programme

II. Process of the Evaluation Study

- Expectations of the C.M.A.I.
- Preparatory Phase
- Field Visits

III. Observations and recommendations for future of programme

- to C.M.A.I.
- to Project
- to Community

I. The C.M.A.I. - POLICY

The C.M.A.I. is the official health agency of the National
Council of Churches in India, whose membership is primarily
open to all Protestant and Orthodox Churches in India.

The C.M.A.I. policy priorities,

- appreciates that health is not a reality for many in India,
- is concerned with social justice in the provision and distribution of health services,
- believes that people have an important role to play in their own health, and
- recognises the right to health care.

The policy on community health is to create awareness, understanding and support for the principles and practice of community health with special emphasis on community based care. In this context to work closely within the health policy of the Government of India and to give priority where the needs and problems are greater.

On the Basic principles of Community Health, C.M.A.I. identifies

- Community participation as an essential component,
- that community health services should be appropriate, acceptable, easily available and affordable by the community,
- the importance, relevance and need for utilizing traditional, indigenous health practices and understanding them in the context of cultural and socio-economic situation of the people.

Philosophy behind CSCD projects :-

The CSCD project is an innovative approach to community health aimed at

- promoting health among people
- going beyond the traditional role, clientele and membership of the C.M.A.I. to do so,
- working through the church and related agencies for a more meaningful involvement in the healing ministry, and

- introducing the church to a holistic approach in making health and healing a reality for the people.

The CECOD is based on C.M.A.I.'s belief that

- health work cannot be viewed in isolation, but should be integrated with development and other related activities ;
- community health work could be done by people themselves towards a movement for health.
- non-hospital based christian and social agencies who are already working with people in various areas could take up health work also even if they do not have any prior experience in health related activities.
- to build a healthy nation, we need to focus attention on children of today.
- survival of all children in a community upto two years of age could be achieved with low-cost appropriate interventions among pregnant mothers and children upto 2 years age.

Objectives of CECOD :

The essential objectives of the CECOD Scheme is to introduce simple, low-cost and effective health interventions that can help women and children in the community.

It is meant to focus on communities of low socio-economic groups predominantly in rural areas.

To ^{Ensure} ~~age~~ that all children born in the community reach their second birthday.

II. PROCESS OF THE EVALUATION - STUDY :

The process included an intensive two day preparatory phase at C.M.A.I. headquarters, followed by field visits to projects to study and sample ground realities.

- Refer Appendix 'A'

PREPARATORY PHASE :

During this phase, discussions with key persons in C.M.A.I., dealing with the CSCD project took place, and one of the CSCD project Managers who visited CMAI was also interviewed.

In addition, all files and documents relating to the CSCD project were perused for information helpful to the study.

- Appendix 'B' for list of documents / papers perused.

An understanding of the CSCD project obtained from the above interactions as follows :-

The essential objectives of the CSCD project focusing on women and children was translated into a project-model. The plan offers 3 years of active support from the C.M.A.I. after which the process is expected to be self-sustaining.

This project model at micro level is expected to

- cater to a population of 3000 to 5000 ^{where all} ~~where upto 150~~ pregnancies ^{are} ~~would occur~~ in a year and ^{all these} ~~these~~ to be seen through safe deliveries and the survival of ^{all these} ~~the approximately~~ ^{born} ~~the~~ children for a period of 2 years.
- One CHV per 1000 population is identified for the health work involved, with a project manager taking overall responsibility for the CHV's work in the total population.

The components of the project are,

1. Identification of expectant mothers and provision of ANC Services.
2. Assurance of safe deliveries to all expectant mothers, and
3. Assurance of normal growth and development of all children under 2 years of age through appropriate services so that each new-born can live upto 2 years.

CMAI's Child Survival Development Programme will involve the following activities :

1. Identify interested Church related development programmes keen on introducing a health component and taking up this CMAI Scheme.
2. Through CMAI's programme development and advisory services to assist potential implementing agencies with application and preparation for implementation. This will include site *visits by* programme ~~implementing~~ staff. *of CMAI*
3. Each implementing agency who gets awarded a grant from CMAI under this scheme would be expected to
 - a. Identify the local community to be served (about 3000 - 5000 population).
 - b. Give special attention to women and children. This would include Ante-natal care, child health and family welfare services.
 - c. Follow up ^{*all*} ~~between 100 - 150~~ children born in the community from mother's pregnancy to second birthday ensuring there is proper nutrition, education and health education to mothers and immunization coverage for mothers and children.
 - d. Develop simple, community based primary health care services that emphasises FICMA (F : Family Welfare, I : Immunization, O : Oral rehydration, N : Nutrition of women and children and A : Vitamin A).
4. CMAI will provide advisory and follow up services to implementing agencies which includes training, monitoring, evaluation and financial support. Each project will be followed up for at least 2 years.

Implementation of the CSCD programme :

The CMAI started the CSCD programme in 1987 by inviting Christian/Social agencies working with people and interested in including community health in their range of activities.

The implementation of the project started in 1988 with Fifty-two (52) micro-projects approved and selected for CSCD intervention. Twenty (20) projects did not fulfil the requisite criteria and were not accepted of the total of Seventy-two (72) applications.

Of the fifty-two (52) projects started, thirty-one (31) are at present operational, while twenty (20) were closed for various reasons. One project completed three years.

The reasons for closure of these twenty (20) projects were mainly administrative, where the micro-projects had

- internal problems linked to their own organisation, offices, staff and area of work.
- not complied with the minimal reports and returns required.
- not shown adequate interest and initiative towards the CSCD programme, presumed to be due to preoccupation with other programmes they were involved in.

Training :

The CMAI organised an initial training programme of one-week duration in 1988 at three regional centres for Chief Executive Officers (CEO's) and Project Managers (PM's).

This was followed by six (2 - 3 days) short-duration regional workshops held during 1989 and 1990, where CEO's and PM's and Community Health Volunteers (CHV's) selected for the CSCD programme attended.

The training covered all aspects of the CSCD programme with pre and post evaluations.

Other activities of CMAI complementing CSCD program:
Publications from CMAI, like FICHA PLVS, Diarrhoea dialogue and Contact are sent to the microprojects to help

them understand wider community health issue. As part of technical support, FICNA manual and 'Where there is No Doctor' are supplied to the ^{by CMAI} microproject. 7.

Reports and Returns :

The initial format used for reports and returns was complicated and not understood by the participating micro-projects, and led to confusing initial reports, while mystifying the simple steps involved in CSCD implementation.

CSCD Manual :

Considering this, a very concise 'MANUAL FOR CHILD SURVIVAL AND CHILD DEVELOPMENT PROGRAMME' was put out by the CMAI, simplifying the CSCD message and also the format of reporting. This came into use from January 1990, after which, there is more coherence and understanding seen in the project activity.

Feed back :

The system of acknowledging reports/returns and feed-back to projects about their work has been streamlined, and seems effective in the micro-projects performance.

FILES AND INFORMATION AT CMAI :

The CMAI maintains updated files on each of the projects for financial transactions, correspondence and health reports / returns. In addition, registers prepared by the project officer gives data at a glance. This was very useful for rapid assessment of project status.

From these sources, information was extracted on the 31 micro-projects operating all over the country, with the help of a format.

- Appendix 'C'

The details looked for helped to look at variables in the projects which could affect the objectives of the CSCD programme.

The compiled master-chart is in -

- Appendix 'D'

In this context, it was interesting to note an office - assessment of the CMAI about the projects as Good (G), Above average (aA) and Average (A).

This classification is based on

- the micro-projects' understanding of CSCD programme,
- reliability and progress shown in micro-project reports and returns,
- micro-project milestones in health,
- handling of finances by micro-projects, and
- reports from field-visits to the micro-projects by CMAI staff.

This classification correlated well with the reported progress in micro-project activities and is also a reflection of the experiential assessment of CMAI Staff. Hence it is used for data-analysis which is presented below :

ANALYSIS OF DATA COLLECTED FROM CMAI FILES

| 1. <u>Location :</u> | | <u>Total</u> | <u>G</u> | <u>aA</u> | <u>A</u> |
|----------------------|----|--------------|----------|-----------|----------|
| <u>Rural</u> | -- | 25 | 17 | 2 | 6 |
| <u>Urban</u> | -- | 6 | 2 | 1 | 3 |
| <u>States</u> | | | | | |
| Maharashtra | -- | 8 | 5 | - | 3 |
| Tamilnadu | -- | 6 | 5 | 1 | - |
| Andhra Pradesh | -- | 4 | 2 | 1 | 1 |
| Kerala | -- | 3 | 2 | - | 1 |
| Karnataka | -- | 2 | 1 | 1 | - |
| Nagaland | -- | 2 | 2 | - | - |
| Manipur | -- | 2 | -- | - | 2 |
| Madhya Pradesh | -- | 2 | 1 | - | 1 |
| Himachal Pradesh | -- | 1 | 1 | - | - |
| Orissa | -- | 1 | - | - | 1 |

Comment :

- a) The urban projects are not doing as well as the rural.
- b) The States of Bihar / Uttar Pradesh / Rajasthan / Assam / West Bengal in the northern belt do not have representation in micro-projects, while national statistics show a poor state of health in these areas.
- c) Projects in the relatively well-off states (health-wise) of Maharashtra, Tamilnadu, Kerala, Karnataka and Andhra Pradesh seem to be doing well, and also, number of micro-projects are more in these areas.

2. Type of other development work done :

| | | |
|--------------------------|---|----|
| Social development | - | 26 |
| Economic development | - | 20 |
| Agricultural development | - | 15 |
| Water development | - | 2 |
| Vocational Training | - | 4 |
| Educational development | - | 5 |
| Health development | - | 3 |
| Non-specific development | - | 1 |
| Multipurpose development | - | 1 |

Comment :

- No significant correlation.
- The micro-projects with health and Educational development programmes are doing better than others.

3. Duration of work in area :

| | | <u>Total</u> | <u>G</u> | <u>aA</u> | <u>A</u> |
|--------------------|----|--------------|----------|-----------|----------|
| Less than 10 years | -- | 15 | 9 | 2 | 4 |
| 10 to 25 years | -- | 9 | 4 | 1 | 4 |
| more than 25 years | -- | 7 | 6 | - | 1 |

Comment :

- No significant correlation
- the older or newer project seem to be doing better compared to those between 10 to 25 years of age.

4. Year of CSCD project

| | <u>Total</u> | <u>G</u> | <u>aA</u> | <u>A</u> |
|-------------|--------------|----------|-----------|----------|
| Second year | 8 | 5 | - | 3 |
| Third year | 23 | 14 | 3 | 6 |

Comment :

- No significant correlation.
- Projects in third year, with more experience are better off.

5. Health care resources in area :

| | <u>Total</u> | <u>G</u> | <u>aA</u> | <u>A</u> |
|---|--------------|----------|-----------|----------|
| a) Nil in area with resources more than 10 k.m. away | 10 | 7 | 1 | 2 |
| b) Nil in area or within 5 K.Ms. (Resources 5 - 10 K.Ms. away) | 6 | 5 | 0 | 1 |
| c) Others - with clinics, Private / Mission Hospitals, Govt. health resources in area | 15 | 7 | 2 | 6 |

Comments :

- a) Micro-projects with less health resource in the area seem to be utilizing the CSCD programme better.

6. Access / roads / distance to nearest Health resource

The access has been classified as Good or Poor depending on the roads / distance and availability of transport facilities :

| | <u>Total</u> | <u>G</u> | <u>aA</u> | <u>A</u> |
|------------------|--------------|----------|-----------|----------|
| With Good access | 15 | 8 | 2 | 5 |
| With Poor access | 16 | 11 | 1 | 4 |

Comment :

- There is no significant correlation.
- The areas with poorer access utilize the CSCD better.

7. Attendance of Training Sessions :

All CEO's, PM's have attended the long-duration initial training and either they or their field staff have attended the short - duration training sessions. There is no correlation to attendance at training sessions and performance of the CSCD programme.

Remarks :

From this analysis it appears that the needy (rural / inaccessible / far from health resources) are taking up the CSCD programme more vigorously and having components of Health or Education in their development strategy helps in their getting the CSCD message to the people.

Another factor which relates to poor performance is where the turnover of field staff has affected the programme and when inadequate understanding of the need to record / report / assess the programme regularly is present.

FIELD VISITS :

Field visits were made to seven (7) micro-projects and one (1) Training and co-ordination centre. Two simplified formats of questioning was employed, one for the CSCD programme implementing staff (CEO / PM / CHV) and one for the group from the people (Mothers / others) who are 'beneficiaries' of the programme.

- Appendix 'E' & 'F'

The break-up of the interactions during these visits is as follows :

| <u>CSCD Micro-Project</u> | <u>Staff</u> | <u>Mothers/Others</u> | <u>Total</u> |
|---------------------------|--|-----------------------|--------------|
| 1. YMCA Nagpur | CEO + 2 CHV's | 3 | 6 |
| 2. E.L.C. Nagpur | PM + 3 CHV's | 15 | 19 |
| 3. YMCA, Hyderabad | CEO | 1 | 2 |
| 4. YMCA, Madras | CEO + 3 CHV's | 6 | 10 |
| 5. CTVT, Madras | 1 Co-ordinator of CSCD projects (8) | - | 1 |
| 6. CSI, Coimbatore | 1 CHV + 1 C.O. | 15 | 17 |
| 7. CSI, Boodithittu | CEO + 1 NW + 2 C.O. + 1 animator | 21 | 26 |
| 8. YMCA, Shimoga | CEO + 2 CHV's | 16 | 19 |
| 9. MVM, Nagpur | PM at CMAI Hqs. | - | 1 |
| Total | | | 101 |

07/08/81

The field visits involved a major effort in learning of the what, how, why, where of the CSCD programme implementation areas, with minimal time spent in the office and files and maximally in the field.

Constraints of a short-notice, distance of projects from headquarters/offices and non-availability of staff/mothers, did affect the process in some areas, but a reasonable understanding of the projects was obtained.

The selection of micro-projects was made covering samples of

- micro-projects in their 2nd and 3rd year of CSCD activity.
- those labelled 'Good' and 'Average'.
- States where more micro-projects were located.
- urban and rural areas.
- those not recently visited by CMAI Staff and taking into consideration time and travel connections and constraints.

A focus of attention was the people who were implementing the CSCD programme, their problems, feelings and understanding; the people of the area, their needs, relevance of CSCD intervention and the impact of the programme on children.

The responses collated from the prepared format (Appendix 'E') is detailed below to appreciate the range of ideas about the CSCD project.

1. Understanding of role :

CEO

- As coordinator implementor CSCD activities.
- Reaching the unreached.
- Overall development of people of area (Slum).
- Infusing confidence among people about their capabilities in tackling health.
- Educator of people / Trainer of CHV's.
- Co-ordinator and Liaison between Govt. and Private agency activities.
- To establish good relationship with Community.
- To promote total health of children / adults / pregnant women.
- To reduce IMR.

Understanding of Responsibility :

- Awakening potential in women and children and building up peoples confidence in themselves.
- Record keeping.
- Training of CHV's.
- Co-ordinating all health related activities.
- Implementing CSCD project.
- Relating health to development.
- Provision of health facilities / camps etc., where not available.
- Impart health education to community.

Understanding Future of Project :

- Requires weaning over next 2 years.
- Can be well integrated into other activity.

- Requires educational support / Technical support.
- Support to children above 2 years - creches etc.
- Requires good contacts with Govt. / Private health services for good follow-up.
- Salaries for health staff.
- Nearby hospitals will make this less effective.
- In spreading message of health among mothers.
- Ongoing even if CHAI withdraws.
- Adopt more villages into programme.

CHV's

Understanding of role :

- Motivation of people for better health.
- Educating mothers and children.
- As implementor of all health programmes.
- ANC / PNC / Immunization care takers of the community.
- Co-ordinator of health resource in area.

Understanding of Responsibility :

- Education of mothers.
- Recording Pregnancy / births.
- Monitoring health.
- All problems of people.
- For health of all children.
- Co-ordination of health activities.

2. Problems faced with project :

- Organising people.
- Motivation of girls (adolescent).
- No nearby health facilities / Services.
- Social / Economical / Cultural problems.
- Superstition.
- Resistance to change.
- Training CHV's, Staff and Commitment vs mediocrity in CHV's.

- Migration of CSCD mothers at delivery time.
- Other Volags not co-operating. *Voluntary agencies.*
- Private health enterprises.
- Illiteracy.
- Problems related to*
A 1 Vaccine supply by Govt.
- Accessibility and area of work distant.
- Timings of field work due to different working hours of different people.
- More CHV's needed for better coverage.

Problems faced with CMAI:

- Pressurised for prompt reports / returns.
- Earlier not clear in communication.
- Delay in release of funds.
- Social activities columns - not adequate need to fill-up.
- Suggest "input" as "service" - difficult in cash.
- Not willing to meet salary / expenses of Health Workers.

3. Training so far - CMAI Workshops :

- Training done apart from CMAI from local doctors / VHAI / RUHSA / CSI / PHC / Other Voluntary agencies.

CEO's - not availed any other training apart from CMAI.

CHV's - many local and other resources were used for training.

- Needs in future

- Health education for Mahila Mandals and People.
- Nutrition.
- Regional language needed for information transfer.
- Training in financial management of project.
- Balwadi / Day Care Centres.
- Adoption procedures / facilities.
- T.B.A.
- S.S.I. / Social and Economic development programme.
- Tackling disease in pregnancy and lactation.
- Minor ailment treatment.
- Supplementary Nutrition programme.

- Herbal medicines & drug / Non medical therapies.
- CHW training.
- School-health.
- Handicapped children.
- Adult Education.
- Conduct of Health Camps.
- Immunization training.
- To support child till 5 years age.
- Preventive health / Sanitation.
- Further training in all aspects.

- Suggestions for innovations :

- Circulating library.
- Adult Education.
- Fund-raising activities.
- To tag on to women's programmes.
- Polio/ disability rehabilitation for children / mothers.
- Use ^{transportation} ~~tpt.~~ staff / other office staff for Health Education.

Small-scale industries: S.S.I. / Income generation programmes to generate income for CSCs.

- Weighing Scale / bag.
- Schools for drop-outs by youth.
- Loans for economic development.
- Small savings / chits.
- Co-operatives.
- Mass health camps + Social awareness and Social Service Camps especially for immunization.
- School teachers for health.
- Concentrating delivery spacing in 1st year project with FPAI inputs.
- 'Rotating chick ' for income.
- Training CHW's by local Doctors.
- Interactions of CHW's with other organisations.
- Extending project beyond 2 years upto school (5 years).
- Folk media for Health Education.
- Setting up curative facilities when other health facilities not available.
- Social awareness / Social Service Camps / Baby Shows / Cultural Programmes / Debates on health issues.

Below are brief notes on each of the projects visited, not covering the aspects already covered in the analysis so far. It is a qualitative, observational, experiential account of the visits and includes the responses from the people, recorded as "perceptions of the people". "General Remarks" at the end covers areas uncovered by the analysis.

1. YNCA - Nagpur (Rural) :

Programmes :

Women's organisation, socio-economic programmes, vocational training, schooling, adult education.

CSCD :

Part-time doctor and clinic based approach / CHV's tag on to Government ANMs and now familiar with field conditions. Partly utilized by ANMs for record keeping - hence record-keeping style different, but all information obtainable. Good liaison with Government and Voluntary agencies. Have innovated own weighing scale and bag. Have innovative ideas for CSCD services to extend into other areas of activity.

Health needs / problems :

Water / Sanitation / Herbal Medicine / Health Education / Social organisation / TBA training.

Peoples perception :

A very useful programme for mothers and children. Should provide more services and education facilities.

Innovations :

+ bag

Weighing scales / Circulating library for adult education / adoption facilities / planned polio rehabilitation centre.

2. E.L.C. - Nagpur (Urban) :

Programmes :

Social organisation, Women's organisation, Youth groups, Health

work.

CSCD :

Part-time doctor for curative care at clinic. PM trained Health Inspector - under utilized. One CHV very dynamic and assumes leadership role in all problems of slum dwellers - overshadows others. If trained, can be PS and PM if needed. Utilize Government services well and obvious better conditions of children registered under CSCD seen.

Health needs / problems :

Water / Sanitation / TBA training / Minor ailment treatment / Herbal or home remedies / Health education.

Peoples perceptions :

Very useful at present for the slum-dwellers. Needs more facilities/ services. Requires some socio-economic programmes to help people.

3. YMCA - Hyderabad (Rural) :

Programmes :

Social organisation, Income generation, Women's programmes, Schools.

CSCD :

Field area distant, but well connected by road. PM dependant on CHV's for contact with people. One CHV on maternity leave. Other managing alone. Other Voluntary agencies working in same area being well utilized, like UNICEF / EPAI, etc. PM more familiar with schools and introduced innovative health programmes for children.

Health needs / problems :

Minor ailment treatment / Herbal indigenous medicines / Health Education.

Peoples perceptions :

Programme useful for women and children. See scope for development into health care for all.

4. YMCA - Madras (Urban) :Programmes :

In areas of schooling, vocational training, working with disabled and adult education.

CSCD :

- have part-time doctor for curative health care.
- CHV's clinic / curative / medical oriented. CSCD is only activity with preventive / promotive health inputs.
- buy own vaccines / medicines. Not utilizing nearby VHS / Corporation and other Voluntary / Government health services well.

Health Care needs / problems :

In areas of water supply, sanitation, health education, minor ailment treatment.

- temporary / illegal nature of slum settlement.
- migration of people in search of work.

People's perceptions :

- as a centre for minor ailment treatment and advice for mother and child.
- as a service providing centre which needs upgradation to hospital facilities.

Innovations :

Planning Balwadis to bridge gap between CSCD and School in child care.

5. C.T.V.T. - Madras :

- a co-ordinating agency for 2 CSCD projects in South India.
- monitor CSCD programme along with other activities in these projects - mainly in reports / returns and training areas.
- indirect contact with field and hence do not appreciate field-problems well.
- have good contact and liaison with large Voluntary agencies and Government organisations utilized for health work.
- believe health to be a good entry point for development and utilize CSCD for this.
- feel CSCD should support children till 5 years age to be really helpful to people, in technical and financial aspects. Also coverage of child population could be increased with appropriate funding for Health worker.
- problems faced are in areas of staff turn-over and private medical enterprises with profit motive.
- feel need for trained worker exclusively for water and sanitation hygiene.

6. C.S.I. - Coimbatore (Rural + 1 Urban Centre - Mettupalyam) :

Programmes :

In areas of Women's organisation, Socio-Economic development programmes, education and vocational training.

CSCD :

Mainly educative on FICNA; utilizing local Government and Voluntary agency facilities. Areas of work far-flung, but accessible by road/bus. Urban slum area at Mettupalyam very far and methods effective in rural areas not working. Single Health worker in charge of these areas and unable to adapt to urban slum problems. CEO was out-of-station but sent filled up questionnaire.

Health care needs / problems :

Water, Sanitation, Nutrition, Personal hygiene and minor ailments.
Need for TRAs and indigenous herbal medicine resources.

People's perceptions :

- as an education to mothers in taking care of children.
- as an issue which engages all members of the community.
- in the urban slum area, the pressures of earning a livelihood take priority over health care needs, though the effort is appreciated for its value.

7. C.S.I. - Boodithittu / Perivanatna - Mysore (Rural) :Programmes :

Schooling, Vocational training, Social organisation, Socio-economic development programmes and organising tribal population.

CSCD :

- nearby INA is the main source of medical support for camps, immunization programmes, etc.
- other Voluntary agencies in surrounding areas also co-operate in development efforts / CSCD efforts.
- distance from headquarters in Mysore is a limiting factor for adequate supervision.
- a well-trained active Field Supervisor having recently left after marriage has put a lot of pressure on the new incumbent.
- credibility of programme and CEO is high among people, and is helpful for community organisation.

Health care needs / problems :

- Competent curative facilities to back the CSCD nearer the area than the present Government Hospital which is 10 kms. away.

- Minor ailment treatments / Indigenous herbal medicines / Trained Birth attendants.
- Better connecting roads / Bus and other transport facilities.
- Pre-School children's care - Creche centres.
- Supply of Vaccines / drugs from Voluntary agencies. Since Government supplies unreliable.

People's perceptions

- as a good effort in health but needs curative - service inputs.

8. YMCA - Shimoga (Urban) :

Programmes :

Women's organisation, Socio-economic development activities, Vocational training.

CSCD :

Well trained, efficient Field Supervisor left. CHV promoted to FS is not dynamic and has not understood the CSCD programme well. No direct contact between PM and people, hence dependant on CHV's. Areas of work selected are very needy. Other Voluntary agencies and Government field staff to be co-ordinated with CSCD activity for improvement.

Health care needs / problems :

Water / Sanitation / Nutrition / Minor ailment treatment / Low cost curative care and all socio-economic problems of urban slum populations.

People's perceptions :

As a useful educative process. Government hospital nearby puts pressure for curative orientation which they believe in.

Suggestions :

Difficult to match CMI contribution in funding. Hence 'work' to be taken as local contribution to CSCD.

General Remarks :

The remarks are based on observations in general, and not applicable to particular micro-projects, staff or CHAI. They have a bearing on the CSCD project and its future.

1. The taking up of a health component by development projects usually has a 'medical' connotation and consequent 'awe' in tackling it. The time period for breaking this understanding and subsequently reaching the people is very variable depending on local conditions.
2. The tendency to employ a 'medical' person for the programme makes the process more difficult.

A need to confirm each step or innovation with 'medical' persons inhibits the capacity and freedom in innovating for health.

3. Feelings of inadequacy in tackling health issues diverts their attention to 'activities' and not processes. Quantitative reporting methods add to the confusion and become ends by themselves.
4. The need for relevant documentation useful for periodical assessments, marking milestones, planning and evaluation means paper-work. Development agencies in the urge to 'get-on' with 'work' usually neglect even basic documentation.
5. People view all new projects and activities as temporary phenomena affecting their lives. Planning for handing over people-oriented, people-directed programmes to the people requires strong social organisation as a pre-requisite.
6. The knowledge and attitudes transferred at training sessions usually suffer at the level of practice due to the above factors.
7. Transfer of the health message orally by health workers usually needs support with some health education material - locally evolved. This brings up their credibility in the eyes of the people who can understand logically why such interventions are needed.

8. Health activity is usually taken up separately, and not tagged on directly to development activity (its effects not being clear) in order not to jeopardise ongoing work. It is because, involvement in health work raises many questions on survival needs which may not be comfortable to face up to.

It is only after some experimentation that health is added on to other activities.

9. Health activity finances are thought to be related only to 'medical' work and so, are apprehensive about using funds for health activity.

RECOMMENDATIONS :

These recommendations are based on my appraisal of the CSCD project of CMAI detailed so far, and summarised below as strengths, weaknesses, needs and opportunities.

The CSCD project is successful innovation in community health oriented interventions, and presents the CMAI philosophy, policy and objectives in a nutshell. It has been a new experience to CMAI, promoting health with non-health groups, and also for the 'non-health' groups who have not dealt with health matters so far.

Strengths :

The CSCD project has

- been well conceived,
- evolved with flexibility in response to field conditions and needs,
- helped 'non-health' development agencies understand their capabilities and role in promoting health.
- put into action the philosophy of the Healing ministry towards wholistic life.
- focussed on national priorities in health and supports national efforts in a co-operative spirit, and
- reached out to those who need it most.

Weaknesses :

- CSCD expectations in health returns within a time frame is ~~Aspirational~~ *ambitious*.
- The pace at which people and development organisations work is dictated by local conditions and variables - and ^{as a} consequently the progress in CSCD project *is variable*.
- Centralised responsibility for training and monitoring health activity progress.

Needs :

The CSCD project needs

- to evolve qualitative and social process indicators to make appreciate the quantitative data realistically.
- to focus attention on poor performers in terms of personnel / technical / administrative / financial / evaluation help to learn from the experiences.
- to evolve methods of taking local organisations, priorities, language and socio-cultural problems into consideration to make the CSCD locally sustainable and grow.
- to look into economic sustainability of the CSCD by tagging it directly to economic activities of co-operatives, income generation activities, etc.
- to look into the turn-over of health workers and their job security.
- to help evolving local health education media and methods.
- to identify, encourage and publicise local innovations.
- to help development organisations in selecting areas of CSCD / health intervention.
- to help appraisal and utilization of all local health resources.
- to obtain self-appraisal reports from micro-projects for balanced

assessment of programme progress.

- to evolve networking arrangements at level of CHV's for direct information transfer at field level.

Opportunities :

The wider opportunities the CSCD project offers are,

- getting into crucial areas of health care, like safe water, sanitation and personal hygiene to tackle the commonest problems of communicable disease.
- extending the CSCD project to care for children upto school age, viz., Balwadis and Anganwadi where Government facilities are not available.
- promotion of school health interventions.
- enlarging scope of activity into Rehabilitation interventions for handicapped children.
- intervention in maternal care by training Traditional Birth Attendants.
- incorporating Minor ailment treatment of at least mother and child, and
- promotion of indigenous, herbal / home remedies for health care.

In areas where these interventions are felt-needs and likely to help the people.

The best opportunity CSCD affords is its scope for developing into a Community Development programme through Child Survival interventions.
to make a CHILD SURVIVAL and COMMUNITY DEVELOPMENT program.

Suggestions to CMAI :

1. The CSCD project encapsulates the philosophy, policy and priorities of the CMAI. It is a successful innovative approach to community health that requires encouragement.
2. To facilitate growth of CSCD into areas of community health and development that respond to people's needs.

3. To consider extension of CSCD into other development / social agencies that are working with people and interested in community health. ★

Suggestions to the Project :

1. To consider incorporation of elements of other projects like the CBPHC and Women's development programmes into CSCD to be able to respond to local needs.
2. To focus on areas of Education for Health in the project, involving all age groups in the community.
3. To consider extending the time period of the CSCD project to five years, with staggered inputs to include
 - a) an initial one year period of incubation with preparing of the micro-projects by selecting areas of work, assessing capabilities, computing logistics of the programme and understanding of aims / objectives / responsibilities.
 - b) followed by a three year period with an intensive first year, consolidating second year and withdrawing third year of work. The resources could be allotted according to needs of the phase, with weaning off over the third year. An additional period of one more year could be utilized to tackle unforeseen problems.
4. To strengthen the training component of the programme with
 - additional inputs.
 - decentralization to regional levels.
 - utilization of local resources, and
 - adding on of experiential perspectives from the present projects.

To enlarge the scope of training to include First aid, Minor ailment treatment, Indigenous herbal medicine inputs and training of Traditional Birth attendants.

5. To consider the inputs of post-graduate students in Health Care management in helping out in various problems of micro-projects as part of their training.
6. To help ensure job-security and commitment for the duration of support from field staff who are crucial for proper utilization of the CSCD idea.
7. To help evolve a socio-epidemiological perspective in micro-projects to make them self-sustaining health initiatives in the future.

Suggestions to the Community :

1. CMAI's initiative in promoting community health through the Child Survival and Child development project is a departure from its traditional role and clientele in an effort to make health a reality to the common man. It needs to be well utilized.
2. CSCD is people's health being handed back to people and requires the innovative approaches, ideas and initiatives generated by practical living conditions to make health a people's movement. It needs encouragement.
3. The CSCD focus on Women and Children is a recognised, tried and tested approach to ensure better health conditions for future generations. It deserves a committed approach to succeed.



Place : Bangalore

Date :

DR. SHIRDI PRASAD TEKUR.

CHRISTIAN MEDICAL ASSOCIATION OF INDIA.

CHILD SURVIVAL AND CHILD DEVELOPMENT PROJECT EVALUATION

Memorandum of Understanding.

Christian Medical Association of India, the Official Health Agency of Protestant and Orthodox Churches in India has decided to study the progress and achievements of its Child Survival and Child Development Programme in the field since inception in 1987. The over all goal in undertaking this evaluation is to :

1. Assess the progress of the CSCD Projects in the field and their achievements so far.
2. Get guidance on the future involvement of CMAI in Child Survival and Child Development issues in India.
3. To look at the appropriateness of the model undertaken at present, its effectiveness and suggestions to improve.

Dr. Tekur from Community Health Cell, Bangalore on invitation has kindly responded and had a dialogue with the General Secretary.

The agreement on the " terms of reference " has been as follows:-

- 1) The evaluation will done during March 1991 with the final report available on 31.3.1991.
- 2) This process will be " Participatory " involving CMAI, CEO's of the projects and staff working in these projects and the local community served.
- 3) CMAI Expectations :
 - a) Review of Child Survival and Child Development Projects of CMAI to examine the role, contribution and technical assistance of CMAI for these projects.
 - b) Review of a sample of the projects to examine the local processess, progress and performance.
 - c) Give suggestions to CMAI on the future of the programme.
 - Within CMAI
 - Within the project
 - Within the community
 - Within Churches.

1. Preparatory Phase :

- Review and study of all papers and related documents available with CMAI.
- Discussion and informal interview with Key CMAI Staff involved in implementing this project.

II. Field visits : A sample of few selected projects can be visited with the following objectives:

- Meeting with CEO's of implementing projects to assess their understanding of role, responsibilities and future of the project.
- Interviews with Project Manager and other staff involved in implementing the project.
- Meeting with the Mothers who participated in the program and get their feed back (Beneficiaries).
- Focus group discussions with :
 - Teachers
 - TBA's
 - Adolescent Girls &
 - Others.

The travel arrangements are to be made by CMAI whenever Dr. Tekur undertakes. CMAI will re-emburse all the cost of his travel when he travels on his own in relation to this evaluation.

The Field visits and the travel plan of Dr. Tekur accompanied by Mr. K.A. Antony has been worked out. Seven Institutions are selected for the field visit and the schedule of visits are as follows :

| ees | Mode of Travel & Transport | From | To | Institutions visited. |
|-----|-------------------------------|------------|------------|--|
| 91 | FLT.IC 469 & Taxi | Delhi | Nagpur | 1) YWCA of Nagpur Civil Line Nagpur - 440001. 2) Evangelical Lutheran Church in M.P. Civil Lines Nagpur-440001. |
| 01 | FLT.IC 269 & Taxi | Nagpur | Hyderabad | Stop for the night-Hyderabad |
| | | - | - | 3) YMCA Development & Social Concern Narayangunda Hyderabad, A.P. |
| | | - | - | Stop for the night at Hyderabad |
| .91 | FLT.IC 439 & Taxi | Hyderabad | Madras | 4) YMCA, Madras Boy's Town 233, Tiruporur High Road Madras -600 041. |
| | Train 6673 & Taxi | Madras | Coimbatore | Travel by night |
| .91 | Taxi | - | - | 5) CSI Package of Devt. for Rural & Urban Women in Coimbatore |
| | FLT. 534 | Coimbatore | Bangalore | Halt at Bangalore at night |
| .91 | | | | Halt at Bangalore |
| .91 | Bus & Taxi | Bangalore | Mysore | 6) CSI Bodithittu Project 2995, Five Light Circle Church Road Mysore-570 001 |
| | Bus&Taxi | Mysore | Shimoga | Travel by night |

19.3.91
TUS

Taxi

-

-

7) YMCA Child
Survival &
Devt. Proj.
Ashok Naga
3rd Cross
Shimoga -

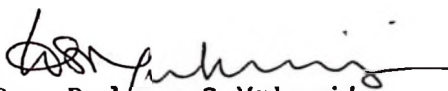
" Bus & Taxi Shimoga Bangalore


The Terms and Conditions of the contract are as follows :-

1. CMAI will cover all official travel for this Consultation involving second class AC sleeper or the most suitable mode.
2. Board and Lodging for the Consultation period will be provided by or its member institutes when visiting them.
3. Local incidental travel will be covered.
4. CMAI will pay a consultancy fee of Rs. 300/- per diem for the days involved in the Consultation.
5. No further expenses or fees will be covered.

CMAI expects a draft report to be discussed with us before the final report is submitted. When the final report is submitted CMAI expects 6 copies. We would also expect to be given the 'Floppy' if a word processor has been used.

In acceptance of the above Memorandum of Understanding it is signed by


Dr. Daleep S Mukarji.
GENERAL SECRETARY.
CMAI, NEW DELHI.


Dr. Shirdi Prasad Tekur
CHILD HEALTH CONSULTANT
CHC, BANGALORE.

Bibliography of Documents / material used to compile this report

1. Files of the 31 CSCD micro-projects currently in operation.
2. CMAI - Set of policy statements.
3. A manual for Child Survival and Child Development Programme
- Dr. Sukant Singh, CMAI.
4. Report on the CS and CD programme October 1990 - CMAI.
5. Child Survival and Child Development Programme - CMAI - 25/1/91.
6. Course outline - Orientation course for staff from CS & CD
project - CMAI.
7. Pre-test and post-test formats - training courses of CSCD
projects - CMAI.
8. CSCD projects - Service coverage report up to 30th June 1990.
9. FIONA - A manual for the Managers of Community Based Primary
Health Care projects - CMAI - 1987.
10. Job descriptions - Project Manager & CHV - CMAI.

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APPENDIX - U

| SL.NO. | PROJECT | STATE | CLASSIFICATION | LOCATION RURAL/URBAN | TYPE OF WORK | DURATION OF WORK IN YEARS | HEALTH RESOURCES IN AREA | ACCESS/ COMMUNICATION TO HEALTH FACILITY | TRAINING ATTENDED/ WHO? | HEALTH STATUS IMMUNIZATION COVERAGE MOTHER/CHILDO | | COMMENTS |
|--------|---|----------------|----------------|-------------------------|-----------------|---------------------------------|--------------------------------|---|-------------------------------|--|----|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | |
| 01. | Adivasi Kristiyo Samaj | Orissa | A | Rural | S/E/A/U/VT | 14 | C + MH | Good | CEO | G | A | - |
| 02. | Vadala Leprosy Control | Maharashtra | G | Rural | S/H | 33 | C | Good | CEO/PM/FS | G | G | Health Project. |
| 03. | CSI DEAP Trichy | Tamilnadu | G | Rural | S/E/A | 04 | Nil-G.H. 10 KM away | Poor | PM/FS | G | G | - |
| 04. | Ecumenical Centre, Trivandrum. | Kerala | A | Urban | S/E | 04 | GH/MH | Good | CEO/FS | - | - | Reporting not under- stood well. |
| 05. | YMCA Madras | Tamilnadu | aA | Urban | S | 20 | C/CH nearby | Good | CEO | a | G | - |
| 06. | YMCA Hyderabad | Andhra Pradesh | A | Rural | S | 75 | C | Poor | CEO/FS | bA | A | Trained F/S left |
| 07. | CSI Sodithittu,Mysore | Karnataka | aA | Rural | S/E/A | 04 | Nil-GH-MH 10 KM away | Poor | CEO | bA | A | Trained F/S left. |
| 08. | Adoni Area Rural Development Initiatives | Andhra Pradesh | G | Rural | S | 03 | Nil-GH 20 K.M. | Poor | CEO/PM/FS | G | G | BCG Coverage low. |
| 09. | Flora Samuel | Andhra Pradesh | aA | Rural | S/A | 08 | C/MH | Good | CEO | G | G | Adm., project problems. |
| 10. | YMCA Mullenkinavillai | Tamilnadu | G | Rural | S/E/A/U | 12 | Nil-PHC 10 K.M. away | Good | CEO/FS | G | G | Using MH Neyyur. |
| 11. | YMCA - Nagpur | Maharashtra | G | Rural | E | 86 | Nil - GH 10 K.M. away | Poor | CEO/FS | G | G | - |
| 12. | YMCA - Shimoga | Karnataka | G | Urban | S/E/VT | 06 | GH | Good | CEO/FS | G | G | FS left doubtful reporting. |

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | |
|-----|---|------------------|---|-------|----------------------------|----|-----------------------------------|------|------------|----|----|---------------------------------------|
| 13. | Nazereth Family Helper Project. | Kerala | G | Urban | S/E | 25 | Nil - GH/C 5 K.M. | Good | CEO/FS | G | G | - |
| 14. | East Kerala Diocese | Kerala | G | Rural | S/E/A | 04 | Nil - MH 6 to 7 K.M. | Poor | CEO/PM/FS | G | G | Good Records |
| 15. | CSI POPRW, Salem | Tamilnadu | G | Rural | S/E | 06 | Nil - GSC 10 K.M. away | Poor | FS | G | G | Good Govt., Services. |
| 16. | St.Mary's Church, Kotgarh. | Himachal Pradesh | G | Rural | H | 04 | GH | Poor | Doctor | G | G | Health Project. |
| 17. | Krist Sewa Kendra | Madhya Pradesh | A | Rural | S/E/A | 12 | C/MH PHC | Good | CEO/FS | G | BA | - |
| 18. | YMCA Bholachal | Tamilnadu | G | Rural | S/E | 25 | C/MH | Poor | CEO/FS/CHV | G | A | - |
| 19. | Maredumilly Tribal | Andhra Pradesh | G | Rural | S/A/VT | 03 | Nil - GH 10 K.M. away | Poor | PM | G | G | - |
| 20. | Mayon Naga Baptist | Manipur | A | Rural | Non-specified Dev. Program | 05 | Nil-G S/C nearby poorly equipped. | Poor | PM | - | - | Bad recording Bad reporting |
| 21. | Christian English School | Nagaland | A | Rural | S/E/A | 25 | Nil-GH 30 k.m. | Poor | PM/FS | G | G | - |
| 22. | Zeliangromg Evangelistic | Manipur | G | Rural | Multipurpose | 14 | Nil-GH 8 K.M. | Poor | CEO | A | G | Population 8000 covered |
| 23. | Lio-Longideng | Nagaland | G | Rural | S/E/A/Ed | 05 | Nil | Poor | PM/FS | - | - | not regular |
| 24. | CSRD Ahmednagar | Maharashtra | A | Urban | S/E/A/Ed | 29 | PHC | Good | PM/CEO | BA | A | Govt., effort not recorded. |
| 25. | CSRD Nepti | Maharashtra | G | Rural | S/E/A/Ed | 29 | PHC | Good | PM/CEO | G | A | Education and Motivation Stressed on. |
| 26. | CSRD Agadgaon | Maharashtra | G | Rural | S/E/A/Ed | 29 | PHC | Good | PM/CEO | G | A | |
| 27. | CSRD Shendi | Maharashtra | G | Rural | S/E/A/Ed | 29 | PHC | Good | PM/CEO | G | G | |
| 28. | Maharashtra Village Ministries, Nagpur. | Maharashtra | A | Rural | S/E | 07 | Nil-GH 18 K.M. | Poor | Dr/CEO/FS | BA | A | Not understate reporting. |
| 29. | Deep Day Care Centre | Madhya Pradesh | G | Rural | S | 07 | Nil-GH 10 K.M. | Poor | CEO | G | BA | - |
| 30. | CSI POPR and U.W. | Tamilnadu | G | Rural | S/E/A/VT | 06 | Nil- | Good | CEO/FS | G | G | - |
| 31. | E.L.C. Nagpur | Maharashtra | A | Urban | H | 15 | GH Nearby | Good | PM/CEO/FS | - | - | Not reported well. |

NOTED:

G - Good
 BA - above average
 A - average

S - Social
 E - Economic
 A - Agriculture
 W - Water
 VT - Voc. Trg.
 Ed - Education.

1-23: 1st yr. C - Clinic
 24-31: 2nd yr. MH - Mission Hosp.
 GH - Govt. Hosp.
 PHC - Primary health Centre.
 GSC - Govt. Sub Centre.

Good - 70% & above
 Average - 70-80%
 below average - below 50%

CEO / Project Staff

Name of the Project

1) Understanding of

a) Role

b) Responsibilities

c) Future of the Project

2) Problems faced with Project

Problems with CMAI

3) Training so far

3 a) Training done apart from
CMAI

Needs in future

4) M.I.S. Comments

5) Contacts with other Voluntary / Government Agencies

6) How do you relate the health component to Development components

7) Suggestions for innovations / other models /

Questions to Mothers/ Teachers/ TBAs / Others

- 1) What is your understanding of the CSCD Project ?

- 2) What are the benefits of this Project to the Community ?

- 3) Do you have any suggestions for improving the Project?