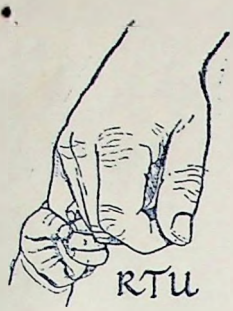
RF_DEV_2_A_SUDHA



REACHING THE UNREACHED
G. Kallupatti, Near Batlagundu,
Madurai District - 624 203.
Tamilnadu, INDIA
Phone : 30 Genguvarpatti

21st October, 1991.

Ref: AD/CHD/91/1240

To

Community Health Cell,
367, Srinivasa Nilaya,
Jakkasandra, I Main I Block,
Koramangala,
BANGALORE - 560 034.

Dear Sir/Madam,

RTU is an organisation involved in implementing programmes for social and economic development of the rural poor. Medical care, education, community health, housing, drinking water and income generation are some of the important programmes of RTU.

The community health and development programme is currently being implemented in 13 villages. In the earlier villages, community health was the entry point. Village health workers were identified and trained and programmes for health education and health awareness with the participation of the community were initiated. Subsequently in these villages, community development activities were also started by forming sangams of men and women.

We now wish to take up an evaluation of the programme to find out the impact of the programmes implemented in 6 of the villages where the programme has been implemented for 4 years or more (the longest period of intervention is 7 years and i.e. in case of 2 villages).

Oxfam has been involved in these programmes. When we discussed the issue of evaluation of the programme, Mr. J. Vimalanathan, Project Officer, Oxfam (Bangalore) suggested that we get in touch with you since he was of the opinion that your team was capable of conducting an evaluation with our staff. The evaluation is planned for the first quarter of 1992.

Rajkaai 23/10/91 (1001)

RN 23/10 23/X

This is to request you to consider the proposal and let us know at the earliest if you could take up this evaluation. On your confirmation, the other details could be worked out. I hope to hear from you at an early date.

Thanking you,

With regards,

Yours sincerely,

GIRISH MENON,
Assistant Director.

Cc: Mr. J. Vimalanathan,
Project Officer,
OXFAM, Bangalore.

Received
31/10/91.

5[illegible]:91

31-10-91

Mr. Girish Menon,
Assistant Director,
REACHING THE UNREACHED,
G.Kallupatti, Near Batlagundu,
Madurai District - 624 203,
Tamilnadu.

Dear Sri. Girish Menon,

Greetings from Community Health Cell!

Received your letter dated 21st October 91, regarding evaluation of your Community Health and Development Programme.

This is to confirm that a member of CHC - Dr. Shirdi Prasad Tekur and Dr. Gururaj, an Epidemiologist from NIMHANS-Bangalore are interested in participating in this proposal as a study-team. Depending on the need, this study team may add one or more members.

Our understanding is that:

a) We cannot 'evaluate' any organisation. We can participate with members of the same in a 'participatory study' of their work in an objective manner, to help see how they have evolved, where they are, and what could they do ahead.

b) This arrangement will be between the members of the study-team and your organisation as friends and colleagues and not for any funding agency, etc., to maintain objectivity. The study report may be used for your needs.

c) To understand the needs and areas of study, we require some background material from you (annual reports, earlier evaluations, base-line surveys and other such material) which will help in the study.

d) We could plan the study with you early to be able to brain-storm with other colleagues here and prepare the ground-work in advance.

..2

e) Dr. G. Gururaj being in Government service, may require an official request from you to be on the team. We will inform you about how to go about it.

f) CHC having registered as a'Society for Community Health Awareness, Research and Action' since May 1991, we will be putting this to our Executive Committee for confirmation as per rules.

g) Your terms and conditions for the proposed study may be intimated at the earliest for action here.

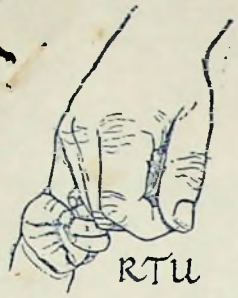
With regards and best wishes,

Yours sincerely,

21/X

Shirdi Prasad Tekur.

*spt/vnnr



REACHING THE UNREACHED
G. Kallupatti, Near Batlagundu,
Madurai District - 624 203.
Tamilnadu, INDIA
Phone : 30 Genguvarpatti

15th November, 1991.

Ref: AD/CHD/91/1472

To

Mr. Shirdi Prasad Tekur,
Community Health Cell,
No.367, Srinivasa Nilaya,
Jakkasandra, I Main,
I Block, Koramangala,
BANGALORE - 560 034.

Dear Mr. Shirdi Prasad Tekur,

Thank you for your letter dated 31.10.91 and your positive response for organising the evaluation of our Community Health and Development programme.

I endorse your view point that the evaluation has to be a participatory study and that it should be objective. The purpose of we desiring for external resource people is to ensure that the exercise is scientific and productive and that the inferences are neutral and unbiased. I would also like to point out that the need for an evaluation was felt by our staff and has not been suggested by Oxfam. The purpose of our contacting Oxfam was to get from them names of resource persons, because of which we could get in contact with you.

For a slightly better understanding of our organisation, I am sending you a copy of our latest annual report. We had not conducted any baseline survey before starting the programme. However, we have been conducting surveys at various points in time. We will be collecting the survey analyses from our staff and sending you the same shortly. Since then you would have the information, you could suggest on how best we could go about planning for the evaluation.

-2-

19/11/91

We shall put in an official request for Dr. G. Gunaraj to be on the team. Kindly let us know to whom it should be addressed and what specific points are to be made in the request. We also appreciate and understand that you will have to get your executive committee approval for enabling you to take up this evaluation.

Regarding terms and conditions, I would appreciate if you could make the suggestion. As I understand, the duration of the study would be anywhere between 7 to 10 days. We shall be making adequate arrangements for your boarding, lodging and transportation. Our support services (typing, cyclostyling, photocopying, cassettes and tape-recorder, accounting help and any other secretarial support service) will be made available to you to suit your convenience. In addition, we would be willing to pay the necessary consultancy charges, which should be specified by you.

I hope to hear from you at an early date.

Thanking you,

With regards,

Yours sincerely,

GIRISH MENON,
Assistant Director.

R.T.U. – Com. Health & Dev. Prog. villages

(A) NATALITY RATE (7 VILLAGES) FOR PER 1000 POPULATION

.NO.	PARTICULARS		SAMIYARMOOPANUR		KEELAKOTTAIPATTI		SRIRAMNAGAR		KOTTAIPATTY		KANIMARKOILPATTI		PALAPATTY		UTCHAPATTY	
			Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
1.		1988	-		-		10/239	(42)	-		4/256	(16)	1/372	(3)	3/309	(10)
2.	NATALITY	1989	13/397	(33)	-		-		4/143	(28)	3/268	(11)	6/373	(17)	3/312	(10)
3.		1990	12/409	(29)	4/346	(12)	10/242	(41)	-		4/271	(15)	4/377	(11)	2/314	(6)

NATALITY (BIRTH RATE)

TOTAL

YEARWISE	ALL VILLAGES
1988	18
1989	29
1990	39
TOTAL	83

CHW DEPT., RTU.. GVPT. (3) INFANT ANDADULT MORTALITY RATES (7 VILLAGES) PER 1000 POPULATION

S.NO	PARTICULARS		SAMIYARMOOPANUR M (%)	F (%)	KEELAKOTTAIPATTI M (%)	F (%)	SRI RAM NAGAR M (%)	F (%)	KOTTAIPATTI M (%)	F (%)	KANNIMARKCILPATTI M (%)	F (%)	PALAPATTI M (%)	F (%)	UTCHAPATTI M (%)	F (%
1.	INFANT MORTALITY (IMR)	1988	-	-	-	-	$\frac{1}{10}$(100)	-	-	-	-	$\frac{2}{12}$(166.67)	-	-	-	$\frac{1}{3}$(33
	0-1 Year	1989	-	$\frac{1}{13}$(76.92)	-	-	-	-	-	$\frac{1}{3}$(333.33)	-	$\frac{3}{4}$(750)	-	-	-	-
		1990	$\frac{1}{12}$(83.33)	$\frac{1}{12}$(83.33)	$\frac{1}{4}$(250)	-	-	-	-	-	-	$\frac{2}{3}$(666.67)	-	-	-	$\frac{1}{2}$(50
	1-5 Years	1988	-	$\frac{1}{6}$(166.67)	-	-	-	-	-	-	-	-	-	-	-	$\frac{2}{3}$(666.
		1989	$\frac{1}{13}$(76.92)	-	-	-	-	-	-	-	-	-	$\frac{1}{6}$(166.67)		-	-
		1990	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Above 5	1988	$\frac{4}{6}$(666.67)	$\frac{3}{6}$(500)	-	-	$\frac{1}{10}$(100)	$\frac{2}{10}$(200)	$\frac{1}{1}$(100)	$\frac{1}{2}$(50)	$\frac{1}{12}$(8.33)	$\frac{1}{4}$(250)	$\frac{1}{4}$(250)	-	$\frac{1}{3}$(333.33)	-
		1989	$\frac{2}{13}$(153.85)	$\frac{2}{13}$(153.85)	-	-	-	-	$\frac{2}{6}$($\frac{333.}{33}$)	$\frac{1}{3}$(333. 33)	-	-	-	-	-	-
		1990	$\frac{1}{12}$(83.33)	$\frac{1}{12}$(83.33)	$\frac{2}{4}$(500)	-	-	-	-	-	-	$\frac{2}{3}$(666.67)	$\frac{1}{4}$(250)	$\frac{1}{4}$(250)	$\frac{1}{5}$(20.0)	$\frac{2}{5}$

DEATH RATE - 0-1 YEAR

AGE GROUP	MALE	FEMALE
0-1	3	12
1-5	1	4
<5	$\frac{18}{22}$	$\frac{16}{32}$

(C) MORTALITY RATE PER 1000 POPULATION IN CHD PROGRAMME AREAS

	SAMIYARMOOPANUR		KEELAKOTTAIPATTI		SRI RAM NAGAR		KOTTAIPATTI		KANNIMARKOILPATTI		PALAPATTI		UTCHAPATTI	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
MORTALITTY RATE:														
1988	4/384 (10.42)	4/384 (10.23)	-	-	2/232 (8.62)	2/232 (8.62)	1/139 (7.19)	1/139 (7.19)	1/265 (3.77)	3/265 (11.32)	1/367 (2.72)	-	1/309 (3.23)	3/309 (9.71)
1989	3/397 (7.56)	3/397 (7.55)	-	-	-	-	1/143 (6.99)	1/143 (13.98)	-	3/268 (11.19)	-	1/373 (2.68)	-	-
1990	2/406 (4.92)	2/406 (2.44)	3/342 (10.77)	-	-	-	-	-	-	4/272 (14.71)	1/377 (2.65)	1/377 (2.65)	1/314 (3.18)	4/314 (12.73)

	MALE	FEMALE	TOTAL	
1988	10	13	23	
1989	4	9	13	
1990	7	11	18	
Total		33	54	= 87

PARTICULARS	SAMIYARMOOPANUR	KEELAKOTTAIPATTI	SRI RAM NAGAR	KOTTAIPATTI	KANNIMARKOILPATTI	PALAPATTI	UTCHAPATT
1. STILL BIRTH RATIO	$\frac{1}{13}$ x 1000	$\frac{2}{4}$ x 1000	$\frac{1}{10}$ x 1000	$\frac{1}{4}$ x 1000	$\frac{1}{3}$ x 1000	-	$\frac{1}{3}$
	(76.92) per 1000 children	(500 per 1000 children)	(100 per 1000 children)	(250 per 1000 children)	(333.33 per 1000 children)	-	(333.33 pe 1000 children

TABLE-5

HOUSING CONDITIONS

(K - KATCHA, P - PUCCA, SP - SEMI PUCCA HOUSES, E-ELECTRIFIED, NE - NOT ELECTRIFIED)

HOUSING CONDITIONS		SAMIYARMOOPANUR			KANNIMARKCILPATTI			UTCHAPATTI			KAMATCHIPURAM			PALAPATTI			KEELAKOTTAI PATTI			KOTTAI PATTI			SRI RAMNAGA		
		K	P	SP	K	P	SP	K	P	SP	K	P	SP	K	P	SP	K	P	SP	K	P	SP	K	P	SP
Types of Total Houses		78	1	7	-	-	62	3	1	121	15	17	70	-	-	100	59	3	23	=	-	40	27	1	30
NUMBERS OF ROOMS	1. E	2	1	-	-	-	20	1	1	-	10	8	-	-	-	8	5	-	3	-	-	2	2	-	3
	NE	11	-	4	-	-	42	2	-	121	5	9	70	-	-	92	36	-	15	-	-	38	24	-	27
	2. E	11	-	1	-	-	-	-	-	-	4	1	2	-	-	-	2	1	2	-	-	-	-	2	-
	NE	27	2	5	-	-	-	-	-	-	6	2	5	-	-	-	5	2	6	-	-	-	1	-	-
	3. E	-	-	1	-	-	-	-	-	-	-	2	-	-	-	-	1	3	2	-	-	-	-	-	-
	NE	9	1	4	-	-	-	-	-	-	-	-	1	-	-	-	1	-	1	-	-	-	-	-	-
	4. E	1	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-	-	-	-	-	-	-	-	-
	NE	6	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	5. E	-	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	NE	3	2	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
MORETHAN 5 ROOMS		-	-	-	-	-	-	-	-	-	-	2(E)	-	-	-	-	-	-	-	-	-	-	-	-	-
BATHROOMS YES		47	1	6	-	-	62	-	-	-	2	6	3	-	-	180	-	-	-	-	-	40	2	-	30
NO		28	-	4	-	-	-	-	-	121	2	-	89	-	-	-	-	-	-	-	-	-	-	-	-

DISEASES RATIO (IN PERCENTAGES)

S.No.	PARTICULARS	SAMIYARMOOPANUR	%	KEELAKOTTAIPATTI	%	SRI RAM NAGAR	%	KOTTAIPATTI	%	K.K.PATTI	%	PALAPATTI	%	UTCHAPATTI	%
1.	Point Prevalence Rate(persons)	131/397	x100(32.99)	78/346	(22.54)	110/242	(45.45)	41/143	(28.67)	109/268	(40.67)	145/373	(38.87)	101/312	(32.37
2.	T.B. Ratio (1989)	6/397	x100(1.51)	2/346	(0.58)	4/242	(1.65)	1/143	(0.70)	3/268	(1.12)	9/373	(2.41)	4/312	(1.28
3.	Leprosy (1989)	7/397	(1.76)	1/346	(0.29)	1/242	(0.41)	1/143	(0.70)	1/268	(0.37)	1/373	(0.27)	-	
4.	Vit. A Deficiency disease	14/397	(3.53)	6/346	(1.73)	8/242	(1.24)	3/143	(2.11)	7/268	(2.61)	18/373	(4.83)	6/312	(1.92
5.	Protein deficinecy	9/397	(2.27)	14/346	(4.05)	19/242	(7.85)	7/143	(4.91)	9/268	(3.36)	41/373	(10.99)	14/312	(4.49
6.	Vit. D. Deficiency	4/397	(1.01)	3/346	(0.87)	2/242	(0.83)	2/143	(0.31)	2/268	(0.75)	7/373	(1.89)	3/312	(0.96
7.	Vit. B. Complex	8/397	(2.02)	9/346	(5.49)	12/242	(4.96)	9/143	6.29)	13/268	(4.85)	27/373	(7.24)	19/312	(6.09
8.	Vit.C Deficiency	3/397	(0.76)	2/346	(0.58)	2/242	(2.83)	1/143	(0.70)	8/268	(2.99)	9/373	(2.41)	4/312	(1.28
9.	Anaemia Ratio	16/397	(4.03)	8/346	(2.31)	9/242	(3.72)	6/143	(4.11)	12/268	(4.48)	67/373	(17.96)	18/312	(5.77
10.	Diarrhoea cases	2/397	(0.50)	1/346	(0.29)	2/242	(0.83)	1/143	(0.70)	1/268	(0.37)	2/373	(0.54)	2/312	(0.64
11.	Skin diseases (including infections)	18/397	(4.53)	3/346	(0.87)	11/242	(4.55)	2/143	(1.40)	16/268	(5.97)	17/373	(4.56)	7/312	(2.24
12.	U.R.I.	4/397	(1.01)	2/346	(0.58)	6/242	(2.48)	1/143	(0.70)	3/268	(1.12)	11/373	(2.95)	1/312	(0.32
13.	Malnutrition	36/62	(58.06)	14/41	(34.15)	14/33	(42.42)	6/16	(37.50)	29/51	(56.86)	29/60	(48.33)	9/55	(16.36
14.	Handicapped (including polio)	2/397	(0.50)	1/346	(0.29)	-		1/143	(0.70)	1/268	(0.37)	-		2/312	(0.64

TABLE - 6

FOOD HABITS, LAND HOLDING

PARTICULARS		SAMIYARMOOPANUR (%)	K.K.PATTI (%)	UTCHAPATTI (%)	KAMATCHIPURAM (%)	PALAPATTI (%)	KEELAKOTTAI PATTI (%)	KOTTAI PATTI (%)	SRIRAMNAGAR (%)
KITCHEN GARDEN	YES	1 (1)	3 (5)	1 (1)	7 (7)	8 (9)	3 (4)	8 (25)	3 (6)
	No	85 (99)	59 (95)	120 (99)	95 (91)	92 (91)	82 (96)	32 (75)	54 (94)
FOOD HABITS (EAT) PER DAY	1 TIME	-	2(3)	2 (2)	-	-	-	-	-
	2 TIME	7 (8)	8 (13)	18 (15)	4 (4)	19 (19)	-	1 (2)	-
	3 TIME	79 (92)	49 (79)	101 (83)	98 (96)	81 (81)	85 (100)	39 (87)	57 (100)
INCOME PER YEAR	7500	2 (2)	6 (10)	2 (2)	-	7 (7)	3 (4)	-	-
	3600-7500	8 (9)	8 (13)	6 (5)	8 (8)	16 (16)	2 (2)	-	1 (2)
BELOW	3600	76 (88)	57 (92)	113 (93)	94 (92)	77 (77)	80 (94)	40 (100)	56 (98)
FARMERS	MARGINAL	6	12	11	9	21	9	4	4
i) IRRIGATED	SMALL	4	4	2	7	11	4	1	-
	BIG	2	2	2	1	6	2	-	-
ii) NON-IRRIGATED		6	4	3	36	34	9	3	4
LANDLESS		74	37	103	49	62	60	32	53
A) DEBITS		6	4	4	1	14	7	6	6
(OPINION)	GOOD	-	-	-	-	1 (1)	-	-	-
	FAIR	-	-	-	1 (1)	3 (3)	2 (2)	-	-
	BAD	86 (100)	61 (98)	121 (100)	101 (99)	94 (94)	82 (96)	40 (100)	57 (100)
INDIFFERENT		-	1 (2)	-	-	2 (2)	1 (1)	-	-

Dev 2A - 1

REACHING THE UNREACHED, G.KALLUPATTI

COMMUNITY HEALTH & DEVELOPMENT DEPARTMENT

BASIC POPULATION STATISTICS (SURVEY 1990) TABLE-I

A. SOCIO-ECONOMIC STATUS:

S.No.	VILLAGES	Total Houses	Types of Houses			POPULATION				Total Population	TYPES OF FAMILY				
			Katcha	Pucca	Semi Pucca	Male	%	Female	%		Nuclear	%	Joint	%	Total Families
1.	Samiyarmoopanur	86	78	1	7	208	52	189	48	397	27	31	59	69	86
2.	Kannimarkoilpatti	62	-	-	62	147	55	121	45	268	17	27	45	72	62
3.	Utchapatti	129	3	1	125	181	58	131	42	312	122	95	7	5	129
4.	Kamatchipuram	102	15	17	70	259	50	254	50	513	76	75	26	25	102
5.	Palapatti	100	-	-	100	188	50	185	50	373	31	31	69	69	100
6.	Keela Kottaipatti	85	59	3	23	166	49	176	51	342	48	56	37	44	85
7.	Kottaipatti Colony	40	-	-	40	70	49	73	51	143	33	82	7	17	40
8.	Sri Ram Nagar 11.12.1990	58	27	1	30	121	50	121	50	242	39	68	18	32	58
										2590					

TABLE:II AGEWISE DISTRIBUTION

Agewise Disiributiom	Samiyarmoopanur		Kanimar Koil Patti		Utchapatty		Kamatchipuram		Pallapatti		Keelakottai Patti		Kottaipatti Colony		Sriramnagar	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
0-1	5	8	7	3	6	4	9	6	5	8	8	5	1	3	5	3
1-5	22	27	29	12	31	14	31	22	25	22	14	14	5	7	16	9
5-10	26	38	37	21	28	19	38	35	13	26	17	22	7	9	32	29
10-15	43	21	33	29	41	27	44	37	21	23	13	12	3	5	17	14
15 and above	107	100	56	41	79	63	138	153	118	112	133	104	50	53	51	66

TABLE - 3

EDUCATIONAL STATISTICS

Sl. No.	Villages	ILLITERATE'S		LITERATES					
		No	%	1 - 5th	6 - 10th	11th & 12th	Beyond 12th	Technical	%
1.	Samiyar Moopanur	356	90	28	9	3	Nil	Nil	10
2.	Kannimarkoilpatty	216	81	39	17	2	Nil	Nil	19
3.	Uthapatty	304	97	4	2	2	Nil	Nil	3
4.	K.Kamatchipuram	268	52	61	38	4	1	Nil	48
5.	Palapatti	193	52	135	31	4	-	-	48
6.	Keela Kottaipatty	196	57	65	78	13	-	-	43
7.	Kottaipatty	54	38	22	15	2	-	-	62
8.	Sri Ram Nagar	222	92	11	9	1	-	-	8
	Total	1809		365	199	30	1	-	30
	Average %		70						

TABLE:IV

OCCUPATIONAL STATUS

S.NO.	VILLAGES	COOLIES	CATTLE HERDS/SHEPHERDS	PRIVATE JOBS	GOVT. JOB	BUSINESS	FARMERS
1.	Samiyar Moopanur	352	11	2	2	4	26
2.	Kannimarkoilpatti	212	13	4	5	5	18
3.	Utchapatti	259	9	1	1	2	4
4.	K.Kamatchipuram	302	9	5	2	18	21
5.	Pallappatti	186	11	3	2	8	29
6.	Keelakottaipatti	264	15	4	3	23	91
7.	Kottaipatti	86	1	1	-	2	6
8.	Sriramnagar	136	1	2	-	1	4

51:91 14-12-91

Mr. Girish Menon,
Assistant Director,
Reaching The Unreached,
G. Kallupatti,
Near Batlagundu,
Madurai District,
Tamil Nadu - 624 203.

Dear Thiru Girish Menon,

Greetings from Community Health Cell!

Thank you for your letter dated 30th November 1991 with enclosure of earlier survey reports.

I have discussed the matter with Dr. G. Gururaj, and we plan to visit RTU on 28th and 29th December 1991 to have a preliminary visit and plan the evaluation with you.

This is to enable us to be with you on 28th Saturday when offices are open, and any overflow to Sunday. We would like to be back at Bangalore on Sunday night itself, or latest by Monday morning. Please arrange bus/train reservations for the same. The details are :- 1. Dr. Shirdi Prasad Tekur / Male / 38 years

2. Dr. G. Gururaj / Male / 35 years.

We would like to know how we could get to your place, since we plan to leave Bangalore on 27th evening/night for Madurai. Also how do we contact you on phone? The CHC phone No. is 53 15 18 (9 A.M. to 5 P.M.). My residential number is 62 07 40 (before 8 A.M. / after 8 P.M.). Please inform by return of post at the earliest.

With regards and best wishes,

Yours sincerely,

Shirdi Prasad Tekur

*spt/vnnr

REACHING THE UNREACHED
G. Kallupatti, Near Batlagundu,
Madurai District - 624 203.
Tamilnadu, INDIA
Phone : 30 Genguvarpatti

29th November, 1991.

Ref: AD/CHD/91/1615

To

Mr. Shirdi Prasad Tekur,
Community Health Cell,
No.367, Srinivasa Nilaya,
Jakkasandra, I Main, I Block,
Koramangala,
BANGALORE - 560 034.

Dear Sir,

Further to my last letter to you regarding evaluation of our community health and development programme, I am enclosing survey analysis of surveys conducted by our team, which may be of use to you in understanding the type of our programmes. Kindly confirm your schedule at the earliest.

With regards,

Yours sincerely,

GIRISH MENON,
Assistant Director.

Encl: As above.

Received 14/12/91 Madurai

Madurai 3/12/91 (1141)

26.12.91

Girish Menon, 30
Assistant Director,
Reaching the Unreached, 624 203
G.Kallupatti, Near Batlagundu,
Madurai District.

REFER OUR LETTER 14.12.91(.) UNABLE TO COME(.)

Shirdi Prasad Te

C.James

reaching the unreached
of village india
Society Registered Dindigul
S. No. 42 of 1978

Postal Address:
GANGUVARPATTI
PERIYAKULAM TK.
S. INDIA 624 203

30/12/1991.

Ref: AD/CHD/91/1987

To

Mr. Shirdi Prasad Tekur,
Community Health Cell,
367, Srinivasa Nilaya,
Jakkasandra, I Main I Block,
Koramangala,
BANGALORE - 560 034.

Dear Mr. Shirdi Prasad Tekur,

I am in receipt of your letter of 14.12.91, which was received by me only on 26.12.91. Hence, I could not respond positively by agreeing to organise your visit. I regret the inconvenience that may have been caused to you. I request you to arrange to visit us on any day between January 20th to 25th. Kindly confirm.

With regards,

Yours sincerely,

GIRISH MENON,
Assistant Director.

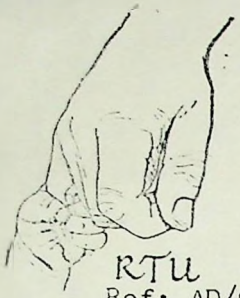
G.G. not free 20-25th
Free to fix on 2nd Sat of Feb.

Replied 18/1/92

1251

RN 6/1/92

A programme to give substantial care to leprosy patients, TB Patients, old people, malnourished babies and mothers, the homeless, abandoned children, the sick and handicapped and uneducated children of the village of India.



REACHING THE UNREACHED
G. Kallupatti, Near Batlagundu,
Madurai District - 624 203.
Tamilnadu, INDIA
Phone : 30 Genguvarpatti

21st January, 1992.

RTU
Ref: AD/GEN/92/180

To

M/S. Community Health Cell,
367, Srinivasa Nilaya,
Jakkasandra, I Main, I Block,
Koramangala,
BANGALORE - 560 034.

Dear Sir,

I wish to inform you that we can now access to courier services, the name of which is Franch Express Courier. The following is the location of the offices of this courier service in your city:

S.No.	PLACE	ADDRESS	STD CODE	PHONE
1.	BANGALORE CENTRE I	13/1 231, S.C. Road, Lakshmi Nivas Opp: Corporation Bank, Next to Hotel Kapila, Near Anand Rao Circle, BANGALORE - 9. Mr. H.S.P. JAIN.	0812	269434 269435 269436 269437
2.	BANGALORE CENTRE II	Swastic Complex, 2nd Floor, Subedhar Chatram Road, BANGALORE - 20. Mr. S. Periya Sukumar.	0812	361486

Please note that while addressing mail, do mention "Via. Sholavandan" on the address which will ensure faster receipt of mail.

Thanking you,

Yours sincerely,

GIRISH MENON,
Assistant Director.

28/1/92
1330

51:92 18-1-92

Mr. Girish Menon,
Assistant Director,
Reaching The Unreached,
Ganguvarpatti,
Periyakulam Taluk,
Tamil Nadu - 624 203.

Dear Mr. Girish Menon,

New Year Greetings from Community Health Cell!

Thank you for your letter dated 30.12.91.

I consulted with Dr. G. Gururaj and it is not possible for us to visit between 20-25 January 1992 as he is out-of-station du during that period.

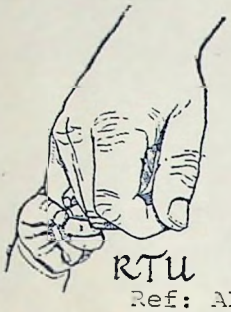
The next possible dates are 8th and 9th February 1992 (second Saturday). Please inform if these dates are convenient.

With regards and best wishes,

Yours sincerely,

V. N. Nalawade
for Shirdi Prasad Tekur.

*spt/vnnr



REACHING THE UNREACHED

G. Kallupatti, Near Batlagundu,
Madurai District - 624 203.
Tamilnadu, INDIA
Phone : 30 Genguvarpatti

28th January, 1992.

RTU

Ref: AD/CHD/92/232

To

Mr. Shirdi Prasad Tekur,
Community Health Cell,
367, Srinivasa Nilaya,
Jakkasandra, I Main I Block,
Koramangala,
BANGALORE - 560 034.

Dear Sir,

Thank you for your letter dated 18.1.92. I regret to inform you that the dates 8th and 9th of February are not convenient since I will be out of station. Could you therefore postpone the same to the next week end, that is, February 15th and 16th? The other alternative is during the week, that is, February 13th and 14th. I am indeed sorry in case any inconvenience is being caused to you.

Thanking you,

With regards,

Yours sincerely,

GIRISH MENON,
Assistant Director.

Replied
11/2/92
valsani

valsani
5/2/92
1368
6/2

51:92/ 11-2-92

Mr. Girish Menon,
Assistant Director,
Reaching The Unreached,
G.Kallupatti,
Near Batlagundu,
Madurai District,
Tamil Nadu - 624 203.

Dear Girish Menon,

Greetings from Community Health Cell!

Thank you for your letter dated 28th January 1992(Ref. No.AD/CHD/92/232).

The dates suggested by you are not possible due to prior commitments here.

I had contacted Dr. V. Benjamin, Retired Professor at CMC-Vellore and a promoter of Community Health to be involved in this request from you.

Unfortunately all three of us are busy right through February 92, and will not be able to get to your place.

Hence, I have decided that if you could indicate suitable dates between 5th to 15th of March 92, between the three of us, one or two could definitely make it convenient to visit you. Please write early.

Also, we do not know how to get to your place from Bangalore - bus/train routes etc. If you could send details of this in your reply it will help us inform you and plan the travel.

With regards and best wishes,

Yours sincerely,

Dr. Shirdi Prasad Tekur.

*spt/vnnr

REACHING THE UNREACHED
G. Kallupatti, Near Batlagundu,
Madurai District - 624 203.
Tamilnadu, INDIA
Phone : 30 Genguvarpatti

20th February, 1992.

Ref: AD/GEN/92/509

To

Dr. Shirdi Prasad Tekur,
Community Health Cell,
367, Srinivasa Nilaya,
Jakkasandra, I Main I Block,
Koramangala,
BANGALORE - 560 034.

Dear Dr. Tekur,

Thank you for your letter dated 11.2.92 (No.51:92). It is unfortunate that you will not be able to come here this month. Hence, I would suggest the following dates:
March 5 and 6 or March 13 and 14 or March 16 and 17.
I hope one of these dates would be convenient to you.

For reaching our place, you may take the KSRTC Super Delux Kodaikanal bus leaving Bangalore at 9.15 p.m. and get down at Batlagundu, which is [illegible] stop after Dindigul. This bus reaches Batlagundu at around 5.45 a.m. You will however have to take tickets upto Kodaikanal. From Batlagundu, you may take taxi which you can get from the taxi stand opposite the Batlagundu bus station. The distance is 10 kms. from Batlagundu to our place. You may ask the taxi to take you to G. Kallupatti High School. RTU campus is just opposite to the school. The taxi charge is likely to be about Rs.60/-.

Kindly confirm your programme at the earliest.

With regards,

Yours sincerely,

GIRISH MENON,
Assistant Director.

File (S)
Replied on 25/2/92 S1/92
N.C 24/2/92 IMH
VB - 5/6 May Convenient.
GG - 13/14 - "
25/2

Dr. VB & SPT discussed this & Girish Meeting of R.T.U. - info about these will be collected by R.T.U.

06 Mar 92 at R.T.U

REACHING THE UNREACHED, G. KALLUPATTI

Community Health & Development Program

Dev-2A - 2

Questions we need to address:

(A) GOALS of the CHD Program
OBJECTIVES in operationalized plan

(B) INTERVENTIONS developed
DEFINING focus population/sector
DESIGNING of mechanisms

(C) MONITORING procedures/mechanisms
ASSESSMENT provisions (in built)

(D) How this meshes into other RTU efforts + Government efforts.

at 3 levels → RTU (Office)
Field workers
Village/people

Additional info / What can fit into above:

1) History and Evolution.

2) Decision making process at village level
frequency of meetings/minutes/decisions/follow-up/Area including co-operation between ♂ & ♀ sangams

3) Monthly staff meetings .. Minutes, Decisions } follow-up review
enumerate difficulties encountered in follow-up.

4) Review VHW's medicine kit.

5) Content of Training - HWs / VAs / COs / NFE teachers + job responsibilities. - not clear.

6) Self-sustenance in health.

7) Special programmes for women & Strategies in areas of gender discrimination.

8) Communication process
- Health education - tools/processes/medias/
- People. - Hani sangams / film shows / trg. programs.

9) Adult education. - Review part.

10) Socio-economic development programmes including
- loans
- pensions, etc. } from govt. / motivation etc. by RTU.

(P.T.O.)

11) Mobile clinic & its use.

12) How participation is fostered.

13) Compare old & new villages in whichever areas of work taken up.

14) Traditional/other - herbal etc. measures utilized.

***

SANGAMs

1) Meetings - number
interval
attendance.

Classify
(a) village wise
(b) Men's Womens sangam wise

2) Issues discussed - prioritise.

3) Decisions taken - Success / failures.

4) Follow-up done

5) Sangam membership / executive committee.
frequency of change.

6) Men's / Women's Sangam differences / commonalities

(1) Staff meetings:

- Monthly meeting minutes
  - Decisions taken
  - Types of decisions (Success / Failures)
  - Follow-up measures (done / not done)
  - Reasons seen / Difficulties.
  - &

(2) V.H.W's Kit Review

- needs of Medicines.
- Changing patterns.
- New demands from VHWs. for Medicine.

Original Kit ← useful items / not useful. / new items needed.

(3) Disease pattern identification / prioritization.

- VHWs
- Mobile clinics
- Other Sources

→ common cases, type of drugs used. (for 6 months (to 1 year))

DW24-3

REACHING THE UNREACHED

C. KALLUPATTI

PLAN FOR 1992 JANUARY TO DECEMBER

Department : Community Health & Development Department

Serial Number	Planned Activities	Process (How?)	By Whom Internal	By Whom External	By When (Deadline) Starting	By When (Deadline) Finishing	Expected Result	Remarks
1.	Survey	Socio-Economic and Health	CHD-Dept		February	March 4th Week	Findout the Socio-Economic status of the Village people According to that Health and Develop ment programmes to be planned and Implemented.	
2.	Dhais Training	Campus Training : Safe Delivary Importance of Hygiene Immunization Follow up Visit	CHD Dept	Holy Redeemer Hospital Theni	February	February 3rd week	Avoid neo-natal deaths due to unsafe delivary conduction. Motivation for Health Care.	
3.	Vocational Training	Campus Training : Pickles and Pappadam Making	CHD Dept	RDSE Aundipatti	March	March 2 weeks	Self Employment and Additional Income for the Family	
4.	Leadership Training	Style of Leadership Strengthening Sangam Credit-Savings - Seminar and Discussion	CHD and Education Dept.	SIRD Usilai	April	April 2nd week	Strengthening the Qualities, Respon sibilities of the Leaders, effective Implemention of programmes.	

Serial Number	Planned Activities	Process (How?)	By Whom Internal	By Whom External	By When Starting	By When Finishing	Expected Result	Remarks
5.	Village Sangam Members Training	Awarness on Health, Team Building among Sangam Members, Simple Accounts, Introduction of Income Generation and Govt. Schemes: IRDP, THADCO etc.,	CHD, Education Accounts Administn	Panchayat Union of PERIYAKULAM & BATLAGUNDU	May	June 3rd week	Understanding of Sangam formation, Organise Sangam themselves, Beneficaries availing benefits from Government	
6.	Study Centre	Discussion with Village people regarding nee and programme design	CHD, Edu and Administn	Sangams	May	June Ist week	Running Study centre at Kottaipatti and Palapatti	Study, Sports, Social work, Arts
7.	School Health Programme	Permission from Schools, Selection of Schools Health Education	CHD, Edu and Admn.	MIO, Edu Dept	July	July IInd week	Improve Health and Hygiene for School Children through awarness	
8.	Afforestration	Selection of Beneficiaries, Discussion about the Scheme, Plantation of Seedlings, Follow-up	CHD	PHCC Gandhigram Annapack College Sang-Mems	August	November IInd week	Planned to Develop Private lands in Kamatchipuram and Samiyar Koopanur	
9.	Staff Training	Field Placement and Theory		SIRD Usilai	Nov. 3rd week	Dec. IInd week	Skills to Organise Sangams well, Motivation to get Govt. Schemes and Facilities.	

Serial Number	Planned Activities	Process (How?)	By Whom Internal	By Whom External	By When Starting	By When Finishing	Expected Result	Remarks
10.	Street Theatre Training	Awarness play on Socio-Economic problems and Savings, Develop Skills in Acting Drama	CHD	KEDS and Arogya Agam	March	December	Involve Sangam Members and Staffs	
11.	Evaluation	Individual and Team Evaluation Planning for Evaluation	CHD	Arogya Agam PACT Palamed Community Health Cell	December	December 4th week	Findout the Knowledge, Attitude and Practice of the people and Schemes improveme-nts and Sangams Activities (Success and Failure of the Programmes)	Depart-mental Evaluation will be done

DEV 24-4

COMMUNITY HEALTH & DEVELOPMENT DEPARTMENT

REACHING THE UNREACHED

CONSOLIDATED ONE YEAR REPORTS (FROM JANUARY TO DECEMBER 1991)

S.No.	NAME OF THE VILLAGE	Number of Cases Treated in 1991												IMMUNISED in ONE Year						BIRTH		DEATH		REMARKS
		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DPT	BCG	POLIO	D.T.	T.T.	MEASLE	M	F	M	F	
1	SRI RAM NAGAR	20	25	25	30	25	25	10	25	25	30	24	30	23	2	23	22	2		2	4	1	2	One Femal infant Cas
2	KAMATCHIPURAM	70	70	50	50	40	40	50	40	40	30	30	30	10	3	10		14	2	11	8	1	4	
3	KEELA KOTTAIPATTI	10	26	46	35		15		30	30	20	28	15		1			4		1	3	1	1	
4	KOTTAIPATTI COLONY	41	27	35	20		25	25	25	30	20	21	30	12	6	12	8	6	2	5	4	1		
5	SAMIYAR KOOPANUR	20	37	13	7	14	14	13	15	13	30	32	15	1		1		4	1	5	3	3	1	
6	KANNIMAR KOILPATTI								14	17	21	16					22	13		2	1	1		1 Female infanticid CASE
7	UTCHAPATTI	15		15	10	15	20	15	20	30	20	20	20	5		5		3		2	3		1	
8	PALAPATTI	40	40	50	20	20	40	50	45	50	40	21	20											

	HEALTH EDUCATION FILM SHOWS												Total	No. of Audience Present
1	SRIRAM NAGAR				1								1	200
2	KAMATCHIPURAM			1									1	250
3	KEELAKOTTAIPATTI					1							1	200
4	KOTTAIPATTI COLONY							1					1	50
5	SAMIYAR KOOPANUR								1				1	350
6	KANNIMAR KOILPATTI													
7	UTCHAPATTI	1												200
8	PALAPATTI											1	1	400
9	AMMAPATTI							1					1	200
10	KAILASAPATTI											1	1	400
11	SATHA KOIL PATTI								1				1	300
12	R.T.U. Campus (Clinic)			1	1			1					3	185
													12	2685

Street Play at Samiyar Koopanur 2 times conducted by Sangam Members Subjects on Co-operation, Family Planning & Sanitation
" " Satha Koil Patti 1 " Subject on NFE Importance

MOBILE CLINIC ONE YEAR REPORT

SERIAL NUMBER	NAME OF THE VILLAGE	NUMBER OF PATIENTS TREATED Male	Female	Total	ANC Checked	Number of Children Weighed	Remarks
1	SRI RAM NAGAR	49	44	93	3	80	
2	PALAPATTI	14	38	52	7	70	
3	KAMATCHIPURAM	62	94	156	35	93	
4	KOTTAIPATTI COLONY	10	32	42	13	51	
5	KEELA KOTTAIPATTI	37	57	94	6	56	
6	SAMIYAR KOCHANUR	66	106	172	20	75	
7	KANNIMAR KOIL PATTI	10	21	31			
8	UTCHAPATTI	30	29	59	1	49	
	Total	278	421	699	85	474	

SANGAM DETAILES 1991

SERIAL NUMBER	NAME OF THE VILLAGE	TOTAL NUMBER OF MEMBERS M/C	TOTAL NUMBER OF MEMBERS W/C	TOTAL NUMBER OF MEETING HELD M/C	TOTAL NUMBER OF MEETING HELD W/C	AVERAGE ATTENDANCE M/C	AVERAGE ATTENDANCE W/C	PERCENTAGE OF ATTENDANCE M/C	PERCENTAGE OF ATTENDANCE W/C
1	SRI RAM NAGAR	42	47	14	9	28.29	33.65	67.36 %	71.60 %
2	PALAPATTI	55	44	12	10	36.17	33.02	65.76 %	75.05 %
3	KAMATCHIPURAM	117	26	11	12	63.82	24.00	54.55 %	92.31 %
4	KOTTAIPATTI COLONY	30	34	11	10	19.00	27.00	63.33 %	79.59 %
5	KEELAKOTTAI PATTI	48	60	11	10	31.00	37.07	64.58	61.78 %
6	SAMIYAR MOOPANUR	86	54	11	11	74.82	37.45	87 %	69.35 %
7	UTCHAPATTI	76	48	11	9	60.09	24.65	79.07 %	51.35 %
8	KANNIMARKOILPATTI	56	30	5	1	40.04	30	71.05 %	100 %

NOTE : Both Men's and Women's Clubs meeting were Cunducted in one/two times for every month (one month Interval)

LIFE HISTORY & PROGRAMME OF CHW & DEPT. RTU, G.KALLUPATTI

Month & Year	Physical Caverage Villages	Total No.of ANC Checkupped	Total No.of Cases Treated at Mobile Clinic		Total No.of Treated	Total Cases Treated by VHWS (One Year).
			Male	Female		
January to December 1989	8- Villages	69	259	381	640	1455
January to December 1990	8- Villages	101 (10.89%) Per Month Checkupped	632	748	1380	1798

GOATS SUPPLIED DETAILS:-

FIRST KIDS GIVEN:-

Date	No of Kids	Villages	Upto Date No.of Beneficiaries
15.5.90	7	Samiyarmoopanur	9
13.6.88	4	Kottaipatti Colony First Given	14
28.6.90	9	Sriramnagar	15
[illegible].84	7	Utchapatti	36
[illegible].84	6	Kannimarkoilpatti	54

Month & Year	Name of Villages & Programme Implemented	High Lights	Problems	Others
October & December 1982	Selected Poolathur, Nandankarai & Kumbaraiyur. Survayed, free clinic, Youth Clubs.	-	Finance Problem, People no Co-operation, Over distance from RTU.	Stopped 3-Villages in December 1982.
December 1982	Selected-Bagavathi Nagar, Kamakkapatti, Kannimarkoilpatti, Kottarpatti, Veriappanayakkanpatti & Utchapatti-Community Health & Development Programme.	-	-	-
January & March 1983	Plan for new Programme (i.e) Self sufficient of Villagers. Conducted Sangam meetings.	Formulated Health Committee Members in each Villages	-	Selected VHWS (4 Male+ 1 Female) 2 Weeks Training 14th January to February 28th February 1983 to VHWS. Theme of VHWS Training:- (SCHEME) Personal hygiene Enviornmental Sanitation, Nutrition. MCH, Diarrhoea, and DRS, AN6, PNC, Anaemia, Leprosy, First Aid, Indigenous Medicine Methods of Survey & so On. Other work - Gidance to VHWS - Review Meetings.
April-June 1983	Family Health Insurance Cards implemented (Reg.Fee Rs3/-) Per Year	Priority given them on health treatment in the villages.		Salary for VHW Paid from this Collection.
9th May 83to14th May 83	Followup Meeting with INSA at Tanjoor.			SCHEME:- - Under five Cards - ANC - Primary Education - Analysis of Survey - report-Underfive

Month & Year	Name of the Village & Programme Implemented	Highlights	Problems	Others
July-& September 1983	- 20 Children for formal Education - Text books and Slates Donated - Valnable Practical Training - Followed road to health Cards	-	-	-
August 1983	All Children Weights taken & Vitamins tablets given.	-	-	HEALTH COMMITTEE MEETINGS DISCUSSED POINTS:- 1. Distributing drugs at very low cost by VHN 2. Guidelines to C.A.P. 3. MTU-Midday Meals to Students. 4. Organising Mahalir Mandram.
October.& December 1983	Soakage pits-Constructed Health Committee Meeting Frce Medication (Kottarpatti) BAGAWATHINAGAR:- - Under -5 Weighted - Vit-A Given	-	-	TRAINING: Audio-Visual aids One week Cours Health Meetings at Kottarpatti (Environmental Sanitation) Kottarpatti M/C & W/C.
August 1984 "	7- Goats Supplied to 7 Sangam Members in Utchapatti Village 6-Kids (Goats) given to 6 Members in in Kannimarkoilpatti Village on (15.8.1984)			

...4...

Month & Year	Name of the Village	Programme Implemented	R.T.U., Schemes Adopted	Highlight	Problems	Others
February 1985	Jegejeevan Nagar	Selected for Building Construction	-	-	-	-
October 1986	"	1. RTU Adult Education Runing One Year 2. Constructed RTU Houses 167(Total) J.N.Nagar46+ Dr.AmbedKar Nagar 126=167		85% Covered Community Health Development Programme.		
"	"	Started Mans Club (61 Members in this Club)	RTU Borewell Here 61-Houses Constructed by RTU By Support to DWH		Lackot Co-Operation among sangam members	
1987	"	Started Health Programme Started Womens Club (25 Women Members) RTU-Adult Education Programme running well (Animator Mr.Selvaraj)	'Soap Making' Training Planned to this people	28% Literocy got by this Adult Education Programme	Lackot Co-Operation So,Stopped all RTU Programme on September 1989 at Jegajeevannagar.	
January 1987	Selected 3 New Villages 1. Sriramnagar 2. Kottaipatti 3. Samiyarmocpanur	Village Health Worker Programme -Basic Health - Care M.C.H - ANC care - Health Education -3- Adult Education centres	- 3- Balwadi Schools		M/C & W/C formated all 3 new Villages	

...5...

onth & ear	Villages	Programme Implemented	Scheme Adopted	Highlights	Problems	Others
th May 987				'Mothers Clubs Seminar' (by Social Welfare Board-Extension Officer (Mrs. Lakshmi)		
6th Oct. 987	Utchapatti	Balwadi Started (16.10.1987)	Noon Meal Scheme Adopted			
987	Utchapatti	72-Housing Constructed by RTU				
ovember 987	Kottaipatti & Palapatti					Colera epidemic at Kottaipatti & Palapatti RTU actively Involved on couring & Preventing activities against it.
nuary 988	Sriramnagar Palapatti Jegajeevannagar Kottaipatti Utchapatti	In 1988 5-Villages Adult Education Programme Started	KottaipattiColony 4-Goats Supplied to Sangam Members at Kottaipatticolony	'EVALUATION' Done byohw Staffs		Sriramnagar: 24 Peoples got Buffaloes loan 6- Person-Sheep loan

....6...

onth & ear	No.of Training	No.of Participants	Villages	Programme Implemented	Scheme Adopted	Hightlight	Problems	Others
ctober 988	October 10th to 15th 1988 Sangam Members Training	42	All Villagers	-	-	-	-	-
ctober 988	-	-	-	-	-	Dr.Ambedkar Sheeprearing Society formated with 42 members by Utchapatti Peoples.		
ecember 988	Leadership Training Cours 1	18	J.K.Nagar	Health awarness 'DRAMA' here by Dindigul St.Joseph Hospital with support RTU CHP				
nuary 989	-	-	Bagawathinagar Sriramnagar J.K.Nagar Utchapatti & Other Project Covering Villages Kottaipatti & J.K.Nagar	-	-	Benefits from Govt. - 62 Persogot Govt. Benefits during this months in all 8 Villages - 28-Widow Pensioners - 5 Streetlight - 4 Water taps	-	People Contribution cost of Medicine Rs.33.90 No.of Cases Treated-27

...7...

onth & Year	Villages	Programme Implemented	Schemes Adopted	Highlights	Problems	Others
th February 989	Utchapatti	Non meal Programme Started at Utchapatti Balwadi Children	-	-	-	Childs Parents Contribute Rs.5/- per month.
	J.K.Nagar	Mens Club 160 Members	4-Borewell by RTU		Balwadi-Started Because of No-co-operation among people.	12-Water Taps from Govt.at J.K.Nagar. -7 O.A.P -11 Pregnant womens aid -4New Street light -Buffolow loan -8
ebruary 1989	J.K.Nagar			1. Jawahar well Digging loan sanctioned. - 13 Members (J.K.Nagar). 2.8 O.A.P 3. Forming sheep society 19 Widows and 1 Handicapted Persons		Sheep loan-2 No.of Cases Treated-72 People Medicine Contribution Rs.37.75/- No.of Patients Treated-196 Balwadi Share (Utchapatti) Rs.110/-
.rch 89	All Villages					
	Kannimarkoilpatti Palapatti and Kottaipatti				Female Infanticide (k.k.patti)	4-Street light & one Borewell and Water Tap

...8...

...th & ...r	No. of Training	No. of Partici Pants	Villages	Programme Implemented	Schemes Adopted	Highlights	Problems	Others
...ril 1989		-	All Villages J.K.Nagar Jegajeevannagar	-	-	-	-	No. of Cases Treated-137 Widow Daughters Marriage aid 3 Families
...y 1989		-	Palapatti Utchapatti Samiyarmoopanur	Filmshows	Road repaired	- M/C Registred at Dindigul Samiyarmoopanur	-	NO. of Casses Treated-104
...ne 1989	1 (Legal aid Meeting at RTU)	38	Kannimarkoil-patti Kottaipatti		RTU Construc-tion 58 Houses at Kannimark-Koilpatti	Registred M/C & M/C at Dindigul		5.6.89 New Things Supplied to Utchapatti Balva-di. Borewell and a Community hall from got by Kannimarkoilpatti M/C Sangam
...ly 1989		-	K.K.Patti Samiyarmoopanur Utchapatti	Filmshows (Healthcare) " "	-	-	-	No. of Cases Treated-123 one-got well digging (free) called Jevandhare-3 Womens got O.A.P
			Palapatti Kottaipatti	Awareness Street Plays		Registred M/C at Dindigul		All Villages Medicine Contri-bution Rs.27.85
	1 (Health Training)	4+7	26.9.89 Sengulathupatti K.K.Patti St.Josephvillage Vinobanagar & Thummalapatti	Filmshows Street Play Film shows	-	-	-	No. of Cases Treated-129 -1-person got sheep rearing loan (Utchapatti people contribution Rs.45.40

...9...

Month & Year	No.of Training	No.of Partici-pants	Villages	Programme Implemented	Schemes Adopted	Highlights	Problems	Others
October 89	-	-	10.10.89 Samiyarmoopanur 11.10.89 " Utchapatti 24.10.89	Street play Puppet Shows Street Play	-	-	-	No.of Cases Treated-117
November 989	1 (VHS-Seminar)	7	J.K.Nagar		-		-	No.of Cases Treated-149
			K.K.Patti		-	Formated a Prohibition Committee against. Female Infanticile at Kannimarkoil-patti	-	TWADB-Boreweel near RTU Balwadi at J.K.Nagar
			Palapatti	-	-		-	5-Street lights 4-Street lights 4-Street lights got by Mens Clubs
ecember 989			Kottaipatti	-	-	Compound wall against flood control by M/C Sangam at Kottainatti (Colony)	-	No.of Cases Treted 101 Got compound wall 4 street lights
			Palapatti					
			Sriramnagar	-	-		No-co-oper ation with all steps of RTU Programme by M/C Members	
ecember	-		K.K.Patti Samiyarmmoopanur	-	SPL Meetings Conducted by G.R.I for M/C & W/C Improvement (Advised & Planning)	-	-	-
							Sangan problem (Police cased (Senraman) Utchapatti.	

nth & ar	No. of Training	No. of Partici-pants	Villages	Programme Implemented	Schemes Adopted	Highlights	Any Items	Others
nuary , 1990			Samiyarmoopanur	Started a Valwadi	-	-	-	1. Health Drama at Iluvanam-patti 2. 135-Cases treated by VHW 3. Bullock loan-1 and sheep rearing loan-1 Sanctioned
bruary 90	-			Filmshows -2 (Healtheducation)	-	-	-	
th "	-				-	-	-	107- Cases Treated by VHWS.
rch 90			K.K.Patti	-	-	Sanectioned 4 Street lights 20-hut services 1-Preganant women aid from govt.(March90)	-	147- Cases Treated by VHWS
			Kottaipatti	-	-	2. Street lights Sanctioned		
ril'90	1 (Borewell repair Training)	12	Samiyarmoopanur Kottaipatti Sriramnagar	Filmshows Conduc-ted 3-Villages	-	3-O.A.I Sanctioned (S.Moopanur)	-	86- Cases Treated by VHWS
			Samiyarmoopanur K.K.Patti	Conducted Non-formala education Weekly 2-Days by VHWS	-	Motivation work done about 'CREDIT UNION' Scheme in Selected Villages (i.e) KeelaKottai Patti		

...11...

onth & ear	No. of Training	No. of Participants	Villages	Programme Implemented	Schemes Adopted	High light	Problems	Others
ay 1990	2 (C-Orgrs Health Training)	21+5=26 (Teachers (CHW) Awarness	K.K.Patti Palapatti Samiyar-moopanur "	Film shows Introduced new credit Union Method	- - 6-Kids (Goats) Supplied to 6-Sangam Members (15.5.90)	- Diggened Pits for Tamarind tree planting on either sides of link road (K.K.Patti)	-	168-Cases Treated by VHWS
Une 9th 990	-	-	Samiyar-moopanur K.K.Patti Utchapatti Keelakottai-patti Kottaipatti Colony Kamatchipuram Palapatti Sriramnagar	8-Village Covered Forums for Health & Education-1	-4 T	-4 Traings for VHWS -1844 Gases Treated by VHWS during 1990 -22-Review Meeting for VHWS in 1990	-	M/C & W/C created & Runing well - Fund collection done and it - Deposited to Bank
une '90	M/C+W/C+C/C Health Training	32+36+39=107	Utchapatti 20.6.90 Sriramnagar	Film Shows	- 9-Goats given firstly to 9 Families.	Shadowshed repaired, Soactage Pits Diggoned-2 near RTU Borewells		123-Cases Treated by VHWS
[illegible]	M/C+W/C+C/C Training	109	Palapatti Keelakottai-patti Kottaipatti-colony G.Kallupatti Utchapatti	- Film Shows	- -	Combined work done-Road repaired by Sangammembers Threshing floor from Union BTL (Utchapatti)	- -	175-Cases Treated by VHWS -

onth & Year	Villages	Programme Implemented	Scheme Adopted	High light	Problems	Others
eptember '90	Palapatti + Kottaipatticolony	-	-	Completely Road repaired and extented by people Union CO-operation (Palapatti)	-	166-Cases Treated by VHWS
ctober '90	Gandhipuram	Filmshows (24.10.91)	-	-	-	184-Cases Treated by VHWS
ovember '90	St.Peterschool (26.11.90)	"	-	-	-	210-Cases Treated by VHWS
	Kamatchipuram (21.11.90)	Health Filmshows	-	-	-	-
	Ammapatti (22.11.90)	" "	-	-	-	-
	Samiyarmoopanur	-	-	Link road Structured and repaired by full Co-operation of Sangam members at Samiyarmoopanur Village.	-	-
ecember '90	-	-	-	-	-	150-cases Treat by VHWS

RTV started '74

CH " '84 Vlgs -

James - CH? NFE for Health msgs

focus change CH to CH and D.

final strategy

Sangams { Men → other activities
Women → more on health

Vlgs - 8 + 5 expn → NFE - 6 & 16
1980/81 as entry pt.

↓

CH programme

What we looking for - Broad directions
- Second opinion to work so far
- future interventions

- Analysis of programme & strategies.
technical.

CH + Balwadis.
+ income-generation programs. - Small scale
Small investment
local etc.

IGP - goat rearing.
- rabbit "
- Kitchen gardens.
- NFE for non-school going children

next yr for school going children - Supplementary educ.

- Savings & credit schemes
- Pvt. land afforestn. of fallow lands. - rainfed.

C.H. in Dev.

- Trainer + Animators { 3F / 2M } (10th Std)

Community Organisers - 5 - 1 per village (Animator based)

Health workers - need not be literate

Khaja Mohideen
Manjappan.] C.Os - Orientation Trg. + other places visited] - Mallachi trust, Trichy.

Health Wksps
NFE trg. (Kodaikanal) / Org trg / Leadership trg!

Abdul Aziz - Office Asst.

NFE from SRC..

KM: ~3 days / wks - office wk 9 to 5 - Sangam meets / dev.
- Weekly plan - M to F
6 Villages per C.O.

Anim : 4-15 yr old. / NFE / M:F = 55:45.
Parents meetings every month.

{ NFE. / Sangam } separate meetings.

Anims { newspaper reading / Arithmetic.

Balwadis - Samiyarmoopanur / Utchapathi

- Seasonal variation
- migratory labour.

Achievement
Bus service to village.
Water supply - / Widows pensions. /
- No contacts c̄ Govt. panchayat system.
No gram sevaks.

Problems ē people

- 2parties / politics / land problems. / money power
  ∩ other organisations ē conflicting approaches.

- Ration cards ē all
- PDS not so well.

Govt. programs - Cloth / food grain distribution
- water.

Toyasem?/

Sangams - registered ē Govt.
∩ aims / objs. / bye-laws ē people
∩ Corruption in registrn / registrar office

Health Worker / Medical Worker.

Health - School
- Health Educn.
- Cooperation ē Govt immunizn program

- Female infanticide
  Using street theatre / etc at their clubs.

TINP + Media articles Madras → 16mm films - very good

- Suppl. interviews from Balwadis.
  (నిన్న రాత్రి).

Fatima Mary / Mrs. Rani.

Health problems:
TB / Leprosy (Scabies / Diarrhoea / Sore eye) — Early problems.
Allopathic medicine mainly.
+Herbal medicine (SPADE pattavayithalai
25 mts. from Trichy)
— No documentn.

(Homoeo PACT – near Madurai)

— Work diaries

Areas of confidence - Medicines at ½ price
- consultn. / referrals checked out.

P.H.C. – nearest at Gangvarpatti
Cluster I → (doing well)
Cluster II → (not doing so well)
Viralipatti.

F.P. → motivn. c̄ VHN (Village Health Nurse)

Effective Govt programs: - Immunizn. (every Wednesday)
(Motivn fellow-up etc by RTU) - Leprosy / T.B.
(Periyakulam – 27 deaths due to Cholera)

A. 1. History or Evolution.

B. 2. Decision making process at peripheral levels (village level).

C. 3. Documentation / minutes.

C. 4. Monthly staff meetings – minutes.
– decisions.

X 5. Local / traditional systems usage.

X 6. Siddha. / Homoeo / Ayurveda.

B 6. VHW – Medicine kit – review.

X 7. T.B.As – plans.

B 8. Content of Health Workers Trg.
Village animators.
Community Organiser.
NFE education Teacher.

B 9. Sangam organisation pattern
– freq. meetings
– minutes
– follow up action on decisions taken
– Areas of O & M cooperation.

B 10. Self-financing in health.

X 11. Specific programs for women / prevention of sex ~~discrimination~~ discrimination.

R 12. Communication ē people. + Health educ.

R 13. Adult education.

B 14. Loans & use.

B 15. Job responsibilities { Staff. Gangam leaders

B 16. Participatory methodology

B 17. Understanding of & Cooperation ē Govt. Health programs.

C 18. Usefulness of mobile clinic.

C 19. Wastage of resource. — Program design
is Program implementation.

C 20. Comparison of - same project earlier & now (just started / old)
- diff projects at diff stages

Required:

A
1) Identifying and describing the problem being addressed by the program (Goals)
2) Operationalizing objs of the program (objs.)

B
3) Developing the intervention
4) Defining the target population
5) Designing the delivery system.

C
6) Specifying procedures for monitoring the program
7) Assessing impact & estimating efficiency.

Designing delivery system:

- appropriateness of target population served.
- treatments & services provided
- qualifications & competencies of staffs.
- mechanisms for recruiting & obtaining cooperation of targets.
- means of optimizing access to the intervention
- referral & follow-up efforts.

April 24-25-26 - Next visit to R.T.U.

Each

$\frac{2357:60}{2} = 1178:80$

Train 204:00

974:50

VB to SPT
115
5
122

SPT to VB
75
50
125

974:80
408
1382:80

---

12 Mar 92 GG/SPT visit to RTU

SPT

12/3 Bus - 155:00 Paid by RTU
Auto - 18:00
Dinner - 94:00
Pantaraq - 4:00
Maggiqe - 2:00
Tea - 1:00
13/3 Tea - 3:00
Bus - 2:50 Paid by RTU
Fags - 25:00
Lunch - 88:00
Limcas - 9:00
Fags 10:00
Other 1:80
237:80

237:80 / 2 = 118:90

GG

12/3 Fags: 25:00
Both: 66:00
Fags: 13:00
Fags: 7:50
111:50 / 2 = 55:75

118:90
55:75
63:15 + 50.

13 Mar 92

Mr. Elango - Educn.

Documents

1) Progress reports to Oxfam
2) Health Workers Training < Syllabus, Aims & objectives.
3) Plan review of 1991.
   + Plan for 1992.
4) Village register.

- Sangam meeting attendance declines after housing prog.
  - ↓ members problems
  - ↓ Suspicion of corruption.
  - ↓ Caste problems /
  - ↓ Govt. programs for Harijans. < Houses / Sheds / Dhotis.

Palapattu

People looking at benefits / RTU trying to utilize all resources.

Housing for family.

Housing antagonism between { Govt / RTU } constructions.

=

- Vlg → Vlg Health Committee → VHW. (15 days Trg)
  Comes to Vlg for people to understand.

ILLITERACY

Sangam - members illiterate.
- Animators being trained for Adult Educn.

Traditional - caste based elders gps. sorts out personal / family / other problems.

Sathanarpatti Vlg - since 1991 onwards.

Health prog. started after 90 houses were constructed.

Perumalkoil patti vtg.

RTU fulfilling all needs. not going thru' Sanghas which is needed for sangam

Trg programs
Loans
] to strengthen Sangams.

Health Workers wages - sharing of wages by Vlg RTU. ~ failed!

Formation of Sangams:

- initial communication
- formation of sangam

Street theatre.

Sangams - qualitative analysis
- process

Women's sangams :- Savings / household utensils etc. scheme.

- Suppl. nutrn. preparation.
- Competition between sangams.

(= Inter-sangam interactions.)

Shift from RTU based planning & Vlg. plans implemented by RTU.

[SANGAM WORK REVIEW past 1 yr]

Health Worker's record : - Daily case diary.
- Death & Birth.
- Mobile clinic.

SANGAM WORK

Classify
1) Village wise
2) Men's / Women's

1) Meetings — no. / interval / attendance
2) Issues discussed — prioritize
3) Decisions taken — Success / failure
4) Follow-up done.
5) Sangam membership / executive committee composition.

6) Men's / Women's Sangam differences / comm

Health Services

- Mobile clinic
- Health Educn. — films → most effective medium.
  — Street-wise talks

. Health Trg
, School Health
, Health Camps

Areas — Nutrn./ANC/FP/Immunizn./etc. etc.

→ Health worker programs thru sangams (intermediaries betw RTU & people)
& discussed in Sangams.

→ Alcoholism very low prevalence.

[Some audio-visuals on SANGAMS Reqd.]

Govt supported in Immunizn./Lepr/TB/MCH/

Viralipatti – Mini PHC – Staff meeting attended.

→ Govt staff involved in trg. of Health workers
→ Good co-operation c Govt/. Local PHCs/miniPHCs.)

→ Madurai Medical College 60kg Deptt of CH. to be contacted.
Gandhigram 30kg → co-opern. etc.
Agriculture /Adult Educn./Med.-Hospital.
Leonard hospital Batlagundu →

8 Health Workers { 1st phase over.
2nd phase to start.

Literates managing well compared to Illiterates.

(Organisation → Film/Slides needed)

→ Govt nurse not supportive in teaching/monitoring/support-ion of VHWs. of RTV.

→ Exchange meet of PHC / RTV Health staff.

Times of visits of Govt HWs not suitable for people.

Records / Returns / Documents maintained.

- Who for ? →
- What for ? →
- How utilized ? →

minutes of feed back to Sangam.

Survey → not annual ('86-'87)

→ simplified proforma for HW.

→

VHWs → Daily diary time other literates.

Village note books → info. on all aspects of vlg. being made now

Documentation developing slowly.

Youth clubs?

Sangam meets < Harvesting season
Festival season.

→ Animal Husbandry camp.

1. Goals
   Objectives } RTU + Records + reports to oxfam

2. Interventions developed — A) VHWs
   B) Mobile clinic
   c) Health Education } Sangam formation & functioning

A) ~ HHh Committee Selection
   Training — 2 wks / 1 wk.
   Kit
   followup activities.
   News People Identified ?

B) Mobile clinic — Once a month to 8 villages + other villages.
   — half Subsidised
   — Minor ailments + referral.

c) Health Education — Methods used ?
   Effectivity ?
   Participation + awareness.

3. Defining population groups / Sector.
   ~ All residents.
   ~ Geographical definition.
   ~ Socio Economic — kitchen garden
   Goat, hen, Rabbit.
   ~ Training
   ~ Nutrition ; water.

4. Designing & Mechanisms.
   — Sangam — hunting — other areas.
   ~ health as not an Entry point & its Consequences.

5. Monitoring Procedures.
   ~ Sangam
   ~ reports.
   ~ register & audited accounts.

~ Inbuilt mechanisms - ?

6) RTU Efforts / Govt Efforts.

~ Dominated by their Efforts.
~ Possible resources from Govt - Electricity, water, loans, road, Plants & seeds,

7) RTU / People / Field workers.

→ only VHWS.

1. Coordination within RTU.

→ benefit to be availed as the motivating Point.

1. Records Review
2. Documents Review
3. Field visits / observation
4. Discussion ~ Key people at RTU ← Given John
5. Impressions from outside. John

→ too broad goals / too many activities.
→ lack of direction / no planning
→ lack of clarity / Experimental

} difficulty in learning that.

1- Additional Dept:

1) Goals & objectives / History & Evolution —

2)

Recomendations

1) feedback.

1- Simplification of documents. / Integrate with ongoing activities
2- Traditional medicine
3. TBA training
4. VHN training — reorganise & focus.
5. Adult Education.
6. Youth clubs.
7- Programing / Planing / Evaluation (Pribuilt) & activities for future.
8. Sangam. --- Promotion measures; Education measures.
9. Mobile clinic
10. Linkages ē local Govt, Non Govt, Gandigram, Medical college other agencies
11. Health Education.
12. " with other ongoing activities & RTO. like typing, E, P, Ma, C, W, - - -
13. Morbidity & Mortality Dept → Simple indicator. practical.
People's practices.
14. Utilising Services & building Programmes on their reasons
15. Disease pattern identification / monitoring.
16. Consolidate before Expansion. — How?
17. Feedback to & from Sangams.
18. Monthly HE activity — Monthly sangam discussion — Monthly activities — Declare monthly activity — Coordinate properly. / Training / Edu / disc / follows.

19. Programmes to be flexible as per People's Interests.

20. Changes in village Pr Eg
Road / liquor / water / Training / homes / . . . .

RTUs / Govt / Joint.

21. observations from available statistics
1. male / female
2. <5 / female ligures. / 10-15 — Table 2
3. Literacy progrs — Table 3
4. Occupation — Keelakottaipatti
5. IMR / NMR / PNMR / <5MR
Total Population
6. Empress disease ratio in other wards.
7. Table 7 (can remain as such
— Percentage)

} village Profile Info

14/8/92

→ Adult Educn. 5 villages - 1988 for 1 yr.
- not successful
- now changed to NFE - 6 to 14 yr. age gp.

Govt - thru' Gandhigram → Stopped Adult educn. programs.
- change in format of program expected since 3 animators.

- Liaison ē Govt. Officials for Loans / Pensions by RTV C.O.s.
- Mobile clinic - medical deptt.
- independant of CHD
- need started in new villages

[Vtw / Mob. Clinic differences in money collection]

- Want to Know
  - Records / filing systems.
  - Statistics.
  - Exposure to other projects doing similar work.

Work

23 Apr 92

Train tickets - Return = 309 = 00 / 315 = 00 } Travel agent B'lore

Auto to Rly. Stn - 20 × 2 - 40 = 00

(GG + SPT - 103 Rs)

Bus - Trichy to Dindigul - 12:10 × 3 - 36 : 30

Dindigul to Batlagundu - 4:80 × 3 - 14 : 40

B'gdu to G.K patti - 1.25 × 3 - 3 : 75

(B'fast at Dindigul - 35, Lime soda - 6) (12.50 SPT to GG)

25/4 Cigarettes 18:00 + 28:00 = 46:00

VB	GG	SPT
1200	1200	1200
624	62	637
20	362	563
1844	424	60
17	1200	62
1827	- 424	15
	776	690
	17	102
	760	792

1827
776
2603

3400
2600
800

24 Apr 92

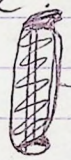
- Only CH. Dept. workers in these 8 villages.
- School children - Social service.

Health worker - Rs 100 p.m.
Animators - Rs 125/= p.m.

Children have started going to school now.
~ MShiva.
~ Started Balwadis in the villages.

Balwadi attendance.

Vlgs < Old - 8.
New - 5.



Notes

(Feedback to people) ?

Bus

Transport & Communication

- ✓ Water facilities — Potable water available but not adequate.
- ✓ Sanitation — needs improvement
- ✓ Kitchen gardens — not successful in survival.
- ✓ Schools are within 2 kms,
- ✓ Govt anganwadis functioning but balwadis in other places.
- ✓ Comm hall c̄ TV in one village.
- ✓ Street lights available but inadequate.

Orgn, Range of activities:

Sangham — VHW — Mobile clinic

1) Sangham — Constitution – M/F – M. held — Attendance – Activities Acheivements.

2) VHW --- Selection – Training – kits – Treatment – Acceptance – involvement – Strengths — lacunae.

3) Mobile Clinic --- village selection ... Clinics held --- Morbidity Pattern --- amount --- . Record keeping ... Referral --- .

4) Health Education --- Materials --- Contents – Channels – Sessions held ... Participation – discussion focused work ...

20% 43/188 70/185 30% 40/166 98/176 · 35/70 50% 34/73 50% 15% 24/181 78/131 =50% 37/121 30% 43/121 = 30% 10% 25/259 110/254 = 40%

Conclusion:

~ 'P - M - A - E' — Strong / weak.
~ Use of resources.

(1) Hypothesis: The use of 'health' as an entry point to community organisation through 'Sangam' formation can be considered as their hypothesized base of improving the quality of life of people

(2) The data collected ~~by~~ at the mobile clinics by VHW could help in their C-H. work.

(3) There were no measurable objectives.
- Stating objectives in measurable terms.

BACKGROUND INFORMATION:

No baseline survey at the beginning

Health committee

(1) Year of Starting : 1974
Com. hlth Started : 1984

~ Non formal Education giving health messages - Anual Susaing
→ to Com. health.
→ to Com hlth & development.

Mechanism — Creation of Sangams → Men — other
→ Women → health activities.

(3) RTU → Range of activities → Education, Agriculture, Industry, Development, Income generation, Nutrition, foster family, Balki, housing

Health → 8 villages (7 + 1 dropped + 1 dropped & restarted)
Small villages + Need based + lack of Services + Manageable & available resources.

Presently — 5 more for Consideration.

Com. hlth → (Sangam) → Deve activities
→ Balwadi → where no other Centre was there
→ Income → Goat, Sheep, loans.
→ welfare → thro' Govt. agencies
→ Balki → Com. deve like road, balki etc

Com. hlth → Sangam

Goals & Objectives → To reach out for a large number of people in distant villages / remote villages and Enable them to improve their quality and standard of life with their ~~parti~~ active involvement using health as an Entry point.

(2)

~~Ichem → 1954~~

Tanes → village workers → Sangam → Animators, VHW's
Baseline Survey →

Purpose of Evaluation:

Purpose → To find out the Impact of programmes implemented
- in 6 villages (4+) and 2 villages (7+)
  - expansion of Prog in 5 villages.
- (i) To Participate with members in a participatory study in an objective manner — (a) to see how they Evolved
  (b) to see where they are
  (c) what could be done later
- Need felt by the staff.
- People not Counselled to do Evaluation.
- no base line Survey — However 'periodical report' available from RTC focused on Popn, housing, Education, Sangam, Health aspects which gives only an indication and not the tone & status at present & hence ~~not~~ used for Evaluation as background material

Audiences → People presently 'project holders' of CH Prog

Not intended → 1) not for funding agencies.
2) Other activities of RTC Except Com. with even though they are in coordinated Effort.
3) not a Quantitative one

~~Methods~~ :

Reasons : 1) Time period (7 days : 3-2-2)
2) Not Emphasing Statistics, data, surveys, Quest Etc..
3) Language ...
4) Non availability of baseline info at the beginning

Methods adopted :

1) Review of annual report.
2) Review of their available data.
3) Discussion with team members of RTU (HQs)
4) Visit to villages & Examining field ~~data~~ observations (all 7 villages)
5) Discussion with Sangam members, VHWS, Village resident Balwadi teachers, NFE animators, & observing their activities.
6) Discussion with RTU Staff.
7) Review of documents → Sangam meeting minutes book, reports to Oxfam, VHWS trg Prog, village registers, future plans.
8) Review of health clinic records (registers & charts.)
9) Library & resource material.
10) Discussion with local referral hospital doctor.
11) Discussion with village people
12) Discussion with VHWS & Animators.
13) Review of Information ...

D
(a) Monthly meeting review
(b) VHWS list ✓
(c) Education activities review.
(d) Sangam details ✓
(e) Mobile clinic performance ✓
(f) Staff meetings.

Information Collected : (1) Discussion (2) Review (3) Observation
(4) Participation in activity (4) . . .

Limitation :

Results : SWOT ANALYSIS

1) Situation Analysis :

(1) Village situation.
(2) Orgn activities →
→ Sangam.
→ CH activities.
(3) activities Vis-a-Vis results.
(4) ~~CH Status~~ → ~~Health Problems~~
~~Health activities~~ →
(5)

(1) village Situation :

✓ Situation of 8 villages → Interior, inaccessible, remote.
✓ location away from main roads.
✓ Population ranges from 183 - 650.
✓ Housing → kutcha houses — RTU homes.
✓ Majority 4 : 4 35% - 97%
✓ Illiteracy status — ~~35~~ %. Among the rest major dropout is after primary level.
✓ Occupation — Labourers, farmers, shepherds.
✓ Housing status — 1-2 bathrooms, non Electrified with just bathrooms & no toilets

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BACKGROUND INFORMATION

(Reaching the Unreached)

ORIGINS and Regd in 1975 The project R.T.U. started in the year 1975 at G. Kalnpatti, Madurai Dt. in an attempt to reach the unreached. The felt need of medical aid in this area led to the starting of a small base health clinic and a mobile clinic to surrounding areas. This spread into other areas of felt need of the people, like housing, education, water, ~~sanitation~~, foster-families income-generation programs and other social welfare measures.

ORIGINS The community health program started ten years later (in 1984) using health as an entry point for overall development of the communities in this area. It began with non-formal education incorporating health messages, and slowly evolved into a community health program. In course of time this got transformed into a CH & D Development program.

GOALS & OBJS The goals of this CH & D program as stated in their progress report are —

TO REACH OUT TO A LARGE NO. OF PEOPLE IN DISTANT AND REMOTE VILLAGES AND ENABLE THEM TO IMPROVE THEIR QUALITY AND STANDARD OF LIFE WITH THEIR ACTIVE INVOLVEMENT USING HEALTH AS AN ENTRY POINT.

This is aimed at building up certain measure of confidence and self-reliance in the villages

and to initiate a process of common village development through formation of sangams (associations) of men and women.

EVOLUTION → (1) The earliest activity was the mobile clinic of R.T.U. (2) While pursuing this activity, (1981) eight villages were identified for basing mainly community health interventions towards overall development. These criteria for selecting these villages were,

a) lack of any health or dev. activity
b) remoteness from centres of dev^t. activities
c) being small (population size) and therefore manageable
d) predominantly belonging to backward & underprivileged sections of society. (people who dev^t had left behind)

(3) Formation of Local Health Committee & selection of V.H.W. by the Health (1982)

(4) Sangams formation and training
Formation of village level health committee was preceded by awareness building for health through street theatre and public meetings. This health committee selected & identified a health worker who was acceptable to the community. These V.H.Ws. were trained at RTU for a period of 15 days.

(4) Sangam formation: Sangams for men and women of the village were formed with the community which were intended to be the basis of all health and development activity. All adults were invited to join the sangams, and those interested joined the same. These sangams were registered and members contributed a fee for common expenditure.

If the chronological describe the evolution pattern

185-186 Stagnant because initiative left. 87 restarted.

Sangam members were to meet at least once a month to mobilise community support for developmental activities. These Sangam activities were facilitated by RTO to utilize, Governmental, ~~R-IT, &~~ ~~to~~ and ~~Local~~ Other resources. The sangams were instrumental in ~~activities~~ activities in health and also other areas like building of roads, provision of water & electricity, running of balwadis, ~~and~~ improving ~~opt~~ facilities and income generation activities for the community

PURPOSE OF EVALUATION:

Based on a felt need by the Community health department of RTO, the present participatory ~~evaluation~~ study was undertaken to find out the impact of Community health program in their ~~selected~~ villages. This participatory study by an external resource group was to see

a) how the Community health program evolved
b) the present status.
c) what could be the future.

~~This interactive~~ It is to be specially noted that this participatory interactive exploration of Community health & development activities was intended to facilitate ~~project~~ the Community health department for planning its future. This study focused on Community health and not on other activities of RTO. Since ~~there was~~ the baseline benchmark information was non available, a quantitative ~~Comparison~~ evaluation study was not feasible and hence a process Oriented Qualitative exploration ~~was~~ study was undertaken with

no emphasis on statistics at Data, Survey data & Questionnaires etc. However, the available periodical reports containg Quantitative data has been reviewed. There were also Constraints of time - total time for the study 7 days divided into 2 blocks of 3 days and one block of 3 days.

Methodology:

The present Qualitative approach to evaluation Consisted of (i) Review of available records (ii) discussion with Staff at RTC, ~~field level~~ field staff such as ~~a~~ level functionaries (~~village animators~~, ~~teachers~~ etc.) ~~(iii) field observations~~ (iii) discussion with members of Sangham & non Sangham members ~~and~~ (iv) Observations during field visits and (v) Eliciting Opinion from nearby health care delivery agencies.

(X) An elaboration on the above follows.

(X) The records reviewed included the annual reports, reports to funding agencies, reviews of past and future plans, mobile clinic records, records at health Centres, village registers, ~~Comments~~ training programes and their Curricula, diaries and registers maintained by field staff for the type of information and their relevance to ongoing Community health activities.

Discussions were held at RTC with Director, Asst. Director, manager and the two Community Organisers At the field level the village health workers, Balwadi teachers & their staff, NFE animators, traditional birth

attendants. ~~were contacted~~ and informal focussed discussions ~~discussions~~ with them on their work and attitudes were conducted in a non threatening manner

Sangam members, non Sangham members and Office bearers were also contacted in a similar manner and their views ~~on~~ were elicited.

~~Observations at~~ during visits to the village included studying the condition of housing, water, sanitation, kitchen gardens, nutritions programme at Balwadis, NFE classes and the quality of rapport between RTU staff and community members.

An interaction with the Medical officer and Medical Superintendant at the ~~near~~ nearby referral centre ~~at~~ Bathenguche (Leonard hospital) consisted of identifying local disease patterns, availability of health care services and pattern of utilisation.

The other components studied were library and I.E resource materials, VHW's kit, medical stores and other units of RTU especially the medical department.

In addition, the RTU staff participated with ready cooperation and made available existing documents and also ~~compiled~~ processed additional information ~~required by us~~ requested by the study team.

The present study was not focussed on measuring the health status of the community in quantitative terms but in the process and relevance of ~~aims & objectives~~ of community health & development ~~on~~ to enabling people for understanding the importance of the same to improve their quality of life

and hence the methodology stated above.

RESULTS

The results are presented as a situational analysis at the village and in the various activities of the C.H. deptt organisation.

a) Village: The 8 villages where the C.H. deptt operates are away from the main road, and relatively inaccessible. The population of these villages ranges between 200 to 700. ~~The~~ Illiteracy is ~~as~~ high and ~~the~~ ranges between 90 to 95% with a high drop-out rate noticed after the primary level of education. The occupation of the people is mainly as agricultural labour (seasonal) and ~~small~~ ~~and~~ marginal farmers and shepherds. ~~The housing~~ Most houses are kutcha houses, with one or two rooms, non-electrified and with no toilets. Even though potable water is available, it is inadequate. All villages have street lights, though inadequate. Most primary schools are within a distance of 2 kms. Transport and communications are ~~present but inadequate~~ generally available, but inadequate. Balwadis ~~of~~ organised by RTV are functioning where not covered by the ICDS scheme. Most villages do not have a community Television.

The villages are in two clusters, with a Govt. P.H.C. nearby each of the clusters, located at Gangavaripatti and Viralipatti. The Govt. health workers visit these villages mainly for immunisation and family planning activities. Programs on nutrition are conducted under the TINIP govt. program.

In RTV ~~villages~~ houses, ventilation is good as there is no smoke nuisance from the kitchen, since it has a chimney & is built away from the living ~~quarters~~ rooms.

Organisation activities :

1. Sangam :

The membership of the Sangams in relation to the total village population varies between 10% to 60% with a higher percentage of women being Sangam members compared to men.

The Percentage of attendance at Meetings
- in Mens meetings. - range 54 - 88%.
- in Womens " - " 51 - 100%.

On an average one meeting per month is held in both Mens & Womens sanghas. However, during harvesting and planting seasons, meetings are irregular.

The Sangams have been able to mobilise people to avail various facilities through Govt. schemes in areas of income-generation, roads, electricity, water supply, and obtaining of pensions for widows.

It is to be noted that a major contribution of RTU is in the area of providing housing facilities which the sangams has generated great interest & attraction among sangam members.

☆ Sangam leaders are given Leadership trg. at RTU periodically.

Some specific achievements are,

1986 - Construction of 167 RTU houses.] Irgiruvanagar
- Borewell - one.

1987 - 72 RTU houses at Utchapalli

1988 - Goats / Buffaloes / Sheeps - for income generation

~~1988~~ - Estd. Sheep rearing society.

1989 - Total 90 persons benefitted from Govt. schemes. ~~Streetlights~~ including 28 pensions for widows.
Streetlights & 4 water taps.
4 Borewells by RTU. + 12 water taps.
+ 4 Streetlights.

- Buffalo loans.
- Tavalvas well-digging loan sanction
- Sheep rearing society formed.
4 Street-lights / 1 Borewell / 1 tap.
- Road repairs
- Widow daughters marriage thirvi aid.
58 RTV houses / 1 Borewell / Community hall / 1 well / 3 old age pensions / 1 sheep rearing loan.
- Formation of Prohibition committee against female infanticide.
- Flood-control wall construction / 17 Street-lights.

1990 - Bullock & sheep rearing loans / 4 St. lights / 20 hut electrif. / 3 OAP / Credit Union formation / 6 Goats / Tree planting alongside road / 9 Goats / Shed repair / Soakage pits / road-repair / Threshing floor / Link roads brwtk/

1991 - (Extract from Annual report.)

Some problem areas:

Apart from minor differences and such problems as usually found in human groups, others noted were

- Corruption & leading to loss of faith in Leaders by them.
- Sangam participation & Enthusiastic participation from sangams generally peaked when houses were constructed and waned dramatically after the event.
- Internal land and caste factors interfered with sangam activity
- Traditional caste based elders who managed conflict felt threatened by the new sangam leadership

VHW: Village Health Workers selected by the Village Health committee ~~are~~ were women, a majority of whom were illiterate. They were given an initial training in community health for 2 weeks. A review of the curriculum showed that the contents were far too technical and voluminous to be covered in this short period. Subsequent refresher courses and clarifications at periodic meetings are continuing.

The VHWs are mainly involved in minor ailment treatments, helping (assisting) at RTU's mobile clinic & helping the Govt. health workers in their health activities. They ~~have~~ also are expected to visit 5 families a day and conduct health education.

The VHWs are provided with a kit containing ~~for~~ medicines for treating minor ailments, which is utilized to treat 20 to 30 cases on an average every month, at a subsidized rate. They also utilize traditional herbal remedies ~~in nothing~~, quite confidently on their own initiative. They also record the vital events of births & deaths with the help of a literate. An honorarium of Rs 100/- per is paid to them and this is given either by RTU or Sangam.

We observed that the VHW is well accepted and has a good rapport with the community. Record keeping activity is inadequate due to their illiteracy. Being Sangam members, they also participate in all other Sangam activities, but are considered by the people as mainly health resource.

Mobile clinic :- The mobile clinic operates twice a week, in the afternoon effectively reaching each of the 8 villages once a month. The team consists of the C.H.D. manager, a C.O., a person from the medical dept. and the local VHW. ~~The clinics are held.~~ They provide curative services ~~offer~~ to the whole population, with a focus on Ante and Post-natal care. The records show that they see an average of 60 patients a year per village, with 8 ANC patients and growth monitoring of 40 children apart from the above. Medicines are at a subsidized rate are distributed, ~~and~~ Health education imparted. The schedules of the mobile clinic are very variable ~~this depends~~ mainly because of dependance on availability of the van for transport of the team.

The health records are minimal, but they are encumbered by accounting procedures. The records do not provide a clear picture of disease patterns, but discussions with the team and the local referral centre indicated that the common ailments are diarrhoeas, skin diseases, eye diseases and problems of malnutrition. Tuberculosis and Leprosy are two common major problems ~~and there are~~ are treated with the help of Governmental sources. In cholera epidemics in the past, the health has been effective in tackling the problem with the Government.

Health Education :- In addition to H.Edn. given by the VHW and at the mobile clinic in a personalized manner, mass H.E. ~~activities~~ programs are conducted on an average of once a month in each of the village. This is mainly film shows and slide shows. Street theatre, puppet shows and drama are occasional events.

The topics covered include – Cooperation, F. planning, Sanitation & Hygiene, N.F.E., MCH & Nutrition. Health Education also forms a component of the training programs ~~at R.T.V.~~ and other meetings at RTV. Film shows are popular with the people.

CONCLUSIONS:

* (1) The RTV's CHDepartment has established a good rapport with the community as well as the Government agencies. (2) The formation of sangams has enabled the people to begin to understand their health & development problems and also evolve some solutions. (3) A large number of activities have been initiated in a short span of time inspite of meagre resources. (4) Curative efforts still form a major part of the ~~C~~ Health programme, while in development avenues for tapping available resources are being ~~not~~ efficiently explored.

(5) Since the selection of villages was based on criteria of poverty and ~~remoteness from~~ underdevelopment, the approaches and activities of RTV-CHD have been predominantly welfare oriented.

(3) Consequently, there ~~has been a~~ blurring ~~resources~~ ~~demarcation~~ of clarity and focus in their well-meaning efforts.

(6) The enthusiasm of the sangams seems to plummet as soon ~~as~~ as their immediate felt needs are met from external agencies. This seems to blunt ~~their~~ the potentiality of their initiatives. ~~based on their own resources~~ using ~~based on~~ their own resources.

(7) Cost-effectiveness of mobile clinic is low.

Recommendations:

To effectively strengthen the ongoing and proposed activities, the following recommendations are made.

1. Community organisation & participation:

Sangams have already been formed. This valuable resource needs to be fostered and strengthened with further training/exposure of staff and Sangam leadership. Interactions between RTU sangams and others outside is likely to help this process.

The large membership precludes intensive study and understanding of local issues. The suggested corrective is the formation of smaller working groups to take up specific issues. Planned training for these groups with the help of external expertise will be of help.

Mens and Womens sangams need to meet together at least twice a year reviewing their activities in the interim period and evolve better courses of action.

Practical solutions to problems of meetings during harvesting and planting seasons are to be evolved. e.g. the executive committee/working groups could attempt to meet briefly, or the meetings at these times are suspended and intensified subsequently (if this is found to be impractical)

Long-term comprehensive planning on all relevant development issues is to be initiated & followed up by the Sangams. Proper documentation & reviews of past decisions etc, will re-inforce this process.

Mechanisms for Comprehensive feed-back at regular intervals on decisions and proposed actions both at RTV and Sangam levels needs to be established.

Greater accountability ~~should~~ be fostered by open exchange of information on resources between RTV and sangams.

Invitation of local govt. officials to sangam meetings shd. be encouraged.

2. Appropriate technology for health & development:

People shd. be encouraged to utilize govt. health services and make them more responsive to their needs.

The mobile clinics being cost-ineffective need replacement with alternative approaches like decentraliza- transfer of medical stores along with reduction of team-size and upgrading of village resources (VHW & TBA). There ~~from~~ can be then withdrawn in a phased manner.

Where local/traditional herbal medicines are being utilized as alternatives, to allopathic ~~medicines~~ drugs ~~being~~ provided, as withdrawal of these may be withdrawn in a phased manner.

eg. Benzyl Benzoate replaced by Turmeric/Neem leaves for Scabies ~~treatment~~.

Explore alternatives sources of energy like bio-gas, solar cookers, solar-powered street lights etc.

Development of simplified record systems tailored to the needs of the community. eg. in anganwadis

3. Community support for health care:

Formation of local health working groups of at least 5 members each from the mens & womens sangams will be an important step. (a) This group will be specially trained to improve health education and will be responsible for monitoring all health activities and be an activist group to interact with government and other agencies for health.

(b) To explore ways and means of making the community self-supporting in terms of finance and other relevant resources

4. Health integrated with Development:

A health-education component is to be incorporated in all training and other programs of development both at RTU and at the village level. This is likely to make people more conscious of health and responsible for their own health.

A contributory health service scheme could be linked to income-generation programs. This is intended to promote self-sustenance at the village in health services.

At RTU level, staff from all departments are to be sensitised and oriented towards the importance of C.H. in development and shd. be encouraged & expected to contribute to C.H. concepts in their areas of work.

As a starting point, the medical depart could

take responsibility for all curative services, and step into areas of prevention and health promotion in the villages where the C/H Dept is active. All health programs can be jointly planned by these two depts. Similar programs can be co-operative efforts can be planned with other depts in their areas of work.

5. Education for health:

Considering the high levels of illiteracy in the villages, adult and NFE shd. be strengthened & ~~expanded~~ expanded with health as a major component.

The ongoing H. Edn. programmes in the village working shd. be trained to take up responsibility in all aspects of H. Edn. in the village. Some effort shd. be made to educate the working group on the elements of communication skills.

Education for health aims at creating awareness among people of all factors that affect health and promoting positive life-styles towards health. Literacy need not be a pre-requisite for this.

6. Involvement of traditional healers, Dais & indigenous systems:

The TBAs knowledge base to be increased. The TBAs in the village to be trained and ANC & PNC made locally sustainable. Indigenous systems practitioners in the village to be integrated into the C/H. program. Promote herbal gardens as part of kitch. garden scheme. Compile & document local herbs used, their effectivity, etc.

To CHW / VHW :

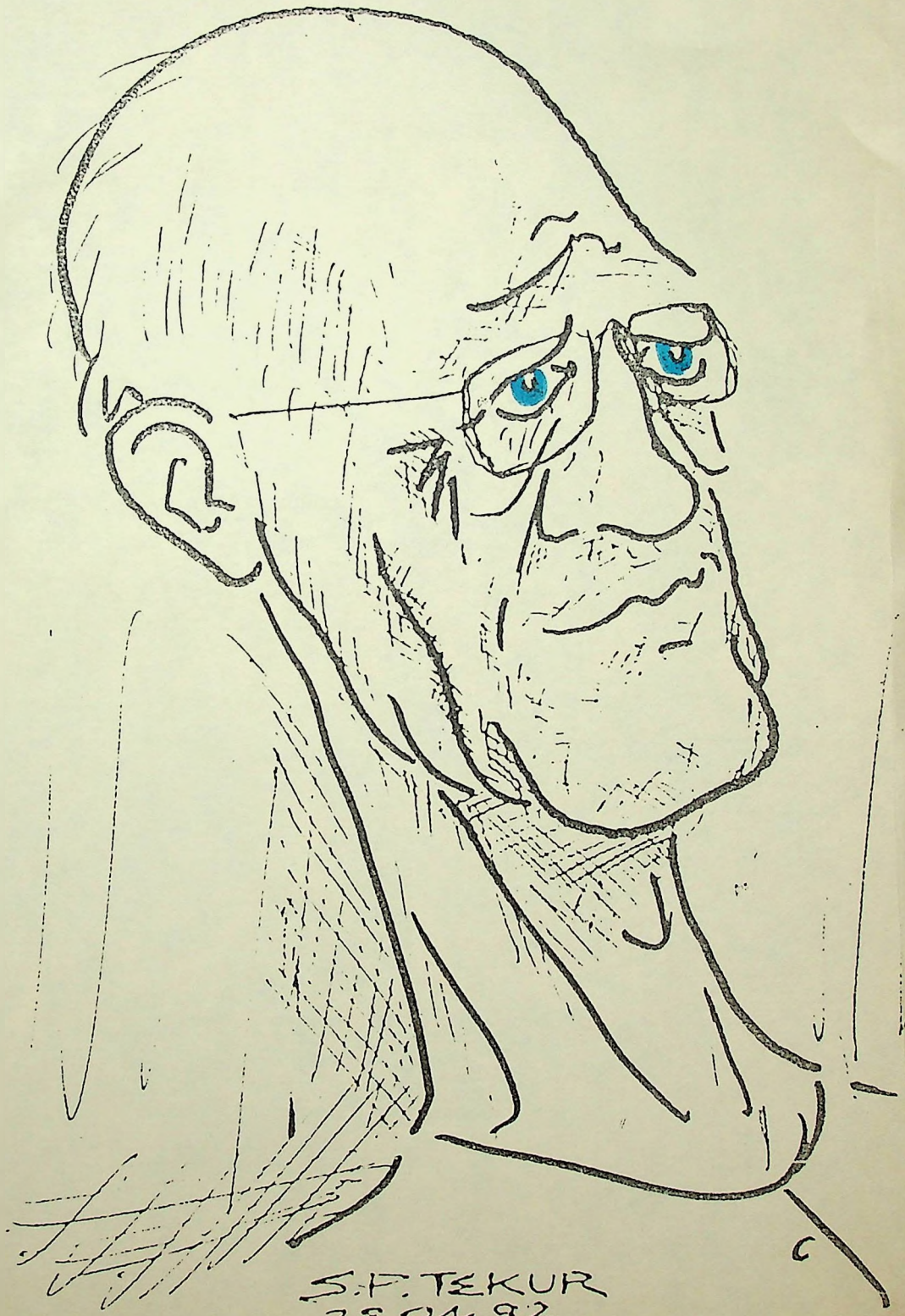
VHWs illiterate. 0% Functional literacy to tackle simple, meaningful record keeping / understanding health messages and for better communications is to be undertaken as part of their training. Their training also needs to be simplified to suit their limited role in minor ailment treatment. ~~More efforts are to~~ More efforts to Preventive & Promotive.

The job specifications depending on their capabilities & competencies is to be made & the training program tailored to suit this.

The VHWs skills to be upgraded & referral system to hospital / centre to be strengthened.

Bro. James Kimpton

DEV 2A - 6



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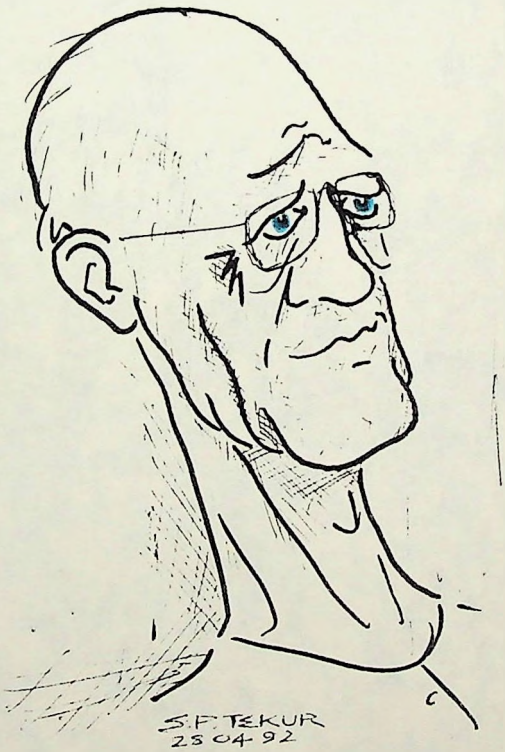
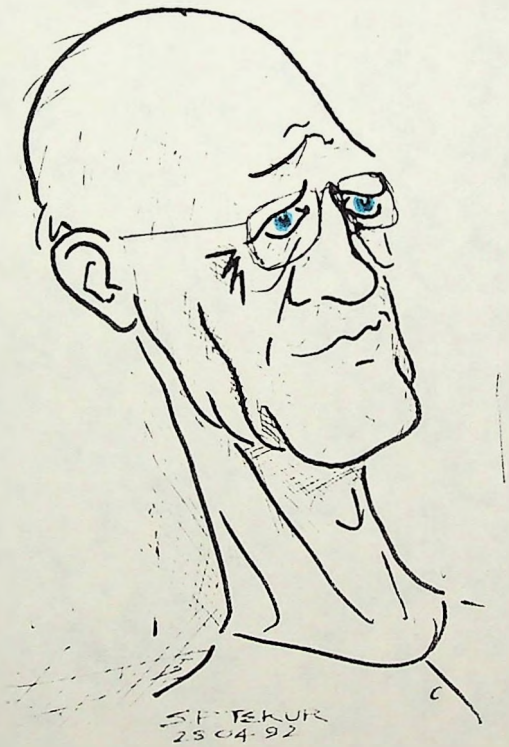
Bro. James Kimpton



Bro. James Kimpton



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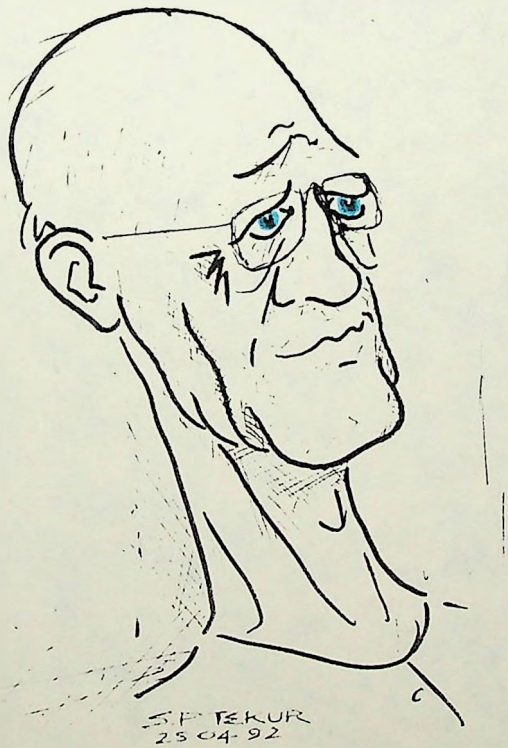

SUMMARY :

The Community Health and Development initiative of 'RTU' is an attempt at reaching a large number of people in remote areas through health measures with goals of actively involving people and enabling people to improve the quality and standard of their life.

The sangams (associations) of men and women is seen as the nucleus of all health and development initiatives.

The Community Health and Development initiative of RTU is an attempt at reaching people in remote areas through health measures. The goals are to actively involve people and enable them to improve their quality and standard of life.

The sangams (associations) of men and women is the means and the nucleus of all health and development activities. After the initial stages, a period of stagnancy

Sangams ~~in dev. of health~~
accept VHW.
" Mobile clinic
~~Get favourable~~ from Govt.

10

8. The Village H.W. is well accepted by the people, and functions effectively in ~~assisting Midwife~~ Bo and activities allotted to her. However her inability to maintain records makes it difficult for the CHD to ~~assess~~ make quantitative assessments of health parameters.

9. Health Education ~~is~~ remains largely an effort of CHD., ~~which~~ (which with its myriad activities and meagre resources) has not received the needed attention it deserves.

A year prospective time bound study of the mobile-clinic component in terms of input vis-a-vis output eg.

a) - no. of patients ~~benefitting~~ utilizing these services from within and outside the specified villages.
b) - hours / personnel / transport / costs etc. needed for this effort
~~c) - costs of medicines~~ medicine
c) - ~~increase~~ areas of non-clinic activities this caters to etc.

need, to be studied by the CHD team.

Appendix:

Suggestions for simplified, comprehensive, relevant record-keeping to enable future planning.

DW 2A - 7

1. A register allotted to each village only for records on health - to be kept at the village, accessible to the CHD and sangam health working group for updating.

2. The first 20 pages of register to be kept aside for indexing, comprehensive record of focussed activity (eg: immunization / ANC / Child births / PNC / Vital events etc)

3. One page per family for details eg. names of family members / house no. / type of house / illnesses in members (chronic) / sangam membership / facilities availed from sangams etc.

4. Start with families with ANC/PNC/Immunization care. Continue with other sangam members, then non-members, such that over a period of 3 to 6 months, complete village records will be available. This will also form the base-line data much needed for future evaluations and planning.

5. Examples of what is to be recorded:

a) village name / address on cover
b) page 1 - map of village (folded sheet can be pasted)
c) → page 2 to 9 for index of family by name / house number.
d) page 10 to 20 for comprehensive records

~~Immunization record:~~

Date	Total No. of children under two yrs age	No. of children completed 8 Gs	P.T.O No. of children completed DPT/OPV 1st dose	2nd dose	3rd do

Immunization records

	Dt.	Apr / May / Jun / Jul etc.
No. of children under 5yrs age	𝍸 𝍸 𝍸 𝍸	=
No. of children completed BCG	𝍸 𝍸 𝍸	
No. of children completed DPT/OPV 1st dose	𝍸 𝍸 III	
2nd dose	𝍸 𝍸	
3rd dose	𝍸 III	
No. of children completed Measles vaccine	𝍸 𝍸	
No. of children completed 1st booster dose	𝍸	
No. of children in Balwadi roster / receiving Suppl. nutrition	𝍸 𝍸 𝍸 𝍸 IIII	

etc.

ANC/PNC records from Apr 1992

	Apr	May	June	Jul	Aug. etc.
- No. of mothers pregnant	𝍸	𝍸			
- No. of mothers received T.T. inj.	𝍸	III			
- No. of live births					
" " Still "					

~~No of mothers in PNC.~~

	22/4	27/4	29/4
- Dates of delivery			
- Place of delivery (Village/outside	V	V	O
- Delivery conducted by TBA (tick	✓	—	—

No. of PNC . .

AND SIMILARLY FOR LOANS / OAPs / ~~etc~~ VITAL EVENTS / etc.

Education for health aims at creating awareness among people of all factors that affect health andpromoting positive life-styles towards health. Literacy need not be a pre-requisite for this.

6. Involvement of traditional healers, Dais and indigenous systems.

The VAWs knowledge base to be increased. The TBAs in the village to be trained and ANC and PNC made locally sustainable. Indigenous systems practitioners in the village to be integrated into the community health programme. Promote herbal gardens as part of kitch garden scheme. Compile and document local herbs used, their effectivity, etc.

7. CHW / VHW

VHWs illiterate. Therefore functional literacy to tackle simple meaningful record keeping / understanding health messages and for better communications is to be undertaken as part of their training. Their training also needs to be simplified to suit their limited role in minor ailment treatment. More efforts to preventive and promotive aspects.

The job specifications depending on their capabilities and community needs is to be made and their training programme tailored to suit this.

The VHWs skills to be upgraded to meet all local minor ailment needs. referral system to hospital/health centre to be strengthened. in the following ways developing an official liaison between RTU-CHS and Govt. or private referral centres

b) enabling the VHW to establish a rapport with the centres of referral

c) upgrade the VHWs knowledge to selecting the appropriate referral centres for specific problems.

2+3

~~DEV 24 : 8~~

DEV 24 : 8

Front Cover.

PARTICIPATORY STUDY
of
COMMUNITY HEALTH AND DEVELOPMENT PROGRAM
of
"REACHING THE UNREACHED"

G. Kallupatti
Madurai District
Tamil Nadu.

Study Group:
Dr. V. Benjamin
Dr. G. Gummaj
Dr. S. P. Tekur

05 Mar '92 to 26 Apr '92.

SUMMARY
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I SUMMARY

The Community Health and Development (CHD) initiative of 'Reaching the Unreached' (RTU) tries to reach people remote to development through health measures. The Goals are to actively involve people and enable them in improving their quality of life.

Sangams (associations) of men and women is the means and the nucleus of all health and development activities in the eight villages this program addresses. The Community Health in Development (CHD) program has gone through a phase of stagnation and re-activation in its evolution.

This study is in response to the need felt by the CHD to know about their evolution, their present status and pointers to the future to help plan ahead - to be done by an external resource group. Constraints limit quantitative assessments and the focus is on qualitative and process exploration.

The Village chosen are remote and in need of health and development inputs. Sangams of men and women are operational and function fairly well with limitations due to local circumstances. Village Health Workers are effective in minor-ailment management and are well accepted by the community. The mobile clinic initiative is not cost-effort-effective. Health education effort needs strengthening.

The conclusions of the study point to positive areas of good rapport, credibility and initiative while serving in areas of peoples needs. Numerous activities with small resources, a focus on curative approaches, problems of sangam dynamics and a need for upgrading Health Education efforts are the drawbacks seen.

Recommendations are for focussed activity, putting more efforts into making the sangams far-sighted, involvement of other departments of RTU in the CHD effort, exploring local and other Governmental resources and methods of documentation to help the CHD evolve relevant plans for the future.

II BACKGROUND ~~INFORMATION (REACHING THE UNREACHED)~~ 'Reaching the Unreached' (RTU)

The project ~~R.T.U.~~ started in the year 1975 and registered in 1978 at G.Kalupatti, Madurai District; ~~it~~ it is an attempt to reach people in the remote, unreached areas. The felt need of medical aid in this ~~area~~ place led to the starting of a small base ~~health~~ clinic facility and mobile clinic to surrounding areas. This spread into meeting other ~~areas of~~ felt needs of the people, ~~like~~ such as housing, education, water, foster-families for children, income generation programs and other social welfare measures.

(1) ORIGINS

The community health program started ~~ten years~~ later (in 1984/85) using health as an entry point for overall development of the communities in eight villages of this area.★ It began with non-formal education incorporating health messages, and slowly evolved into a community health program. In course of time this ~~it~~ transformed into a Community Health and Development (CHD) program, and the department of CH and D came into existence at RTU. ★★

(2) GOALS AND OBJECTIVES

The goals of this community health and development programme as stated in their progress report are:-

TO REACH OUT TO A LARGE ~~NO.~~ NUMBER OF PEOPLE IN DISTANT AND REMOTE VILLAGES AND ENABLE THEM TO IMPROVE THEIR QUALITY AND STANDARD OF LIFE, WITH THEIR ACTIVE INVOLVEMENT, USING HEALTH AS AN ENTRY POINT.

This is aimed at building up ~~certain measure~~ of confidence and self-reliance in the villages and to initiate a process of common village development through formation of sangams (associations) of men and women.

★ Two volunteers from RTU initiated a process of community organisation. The program remained stagnant during 1985-86 when their initiators left, and was restarted in 1987 by the present manager of the Community Health Department (CHD).

★★ Two community organisers have joined this department over the past two years to help the Manager who has been handling this program single-handed.

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III PURPOSE OF STUDY

~~Purpose of Evaluation~~" (see page 3).

IV EVOLUTION

To chronologically describe the evolution pattern:

1. The earliest activity was the mobile clinic of R.T.U.
2. While pursuing this activity, ~~(1982)~~, eight villages were identified for using mainly community health interventions towards overall development. The criteria for selecting these villages were:-
   a) lack of any health or development activity;
   b) remoteness from centres of development activities;
   c) being small (population size) and therefore manageable and
   d) people belonging to predominantly backward and underprivileged sections of society.
3. Formation of local Health Committee and selection of Village Health Worker (VHW) ~~(1983)~~

   Formation of village level health committees was preceded by awareness building for health through street theatre and public meetings. This health committee identified a male health worker who was acceptable to the community. These VHWs from 8 villages were trained at RTU for a period of 15 days. During 1985-86 the programme was stagnant because initiators left due to reasons not clearly identifiable. In 1987 when it restarted, **
4. Sangam formation:

   Sangams separately for men and women of the village were formed, ~~with the community~~. These sangams which were intended to be the hub of all health and development activity. All adults were invited to join the sangams, and those interested joined the same. Some of these sangams are ~~were~~ registered and members contribute a fee for common expenditure.

   Sangam members were expected to meet atleast once a month to discuss local issues and to mobilise community support for developmental activities. These sangams

* The male health workers stopped pursuing community health activities.

** female village health workers (VHWs) were selected from each of eight villages and given a similar fifteen day training. Guidance and supervision of these VHWs has been continuous and regular since then.

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activities were facilitated by ~~RTU~~ the CHD to utilize both Governmental and other resources. ~~The Sangams were~~ They were instrumental in initiating activities in health and also other areas like building of roads, provision of water and electricity, running of balwadis, improving transportation facilities and income generation activities for the community.

★ PURPOSE OF ~~EVALUATION~~ STUDY

Based on a felt need ~~by~~ of the community health department of RTU, the present participatory study was undertaken to find out the qualitative impact of the community health programme in the ~~8~~ eight villages they work in. This participatory study by an external resource group was to see

a) how the community health programme evolved;

b) ~~its~~ present status; and

c) ~~what should be the future.~~ to provide guidelines in planning the future.

It is to be specially noted that this participatory interactive exploration of community health and development activities was intended to facilitate the community health department ~~for planning its future~~. Hence, this study focussed on community health and not on other activities of RTU. Since baseline benchmark information was not available, a quantitative evaluation study was not feasible. ~~Hence~~ Therefore a process oriented qualitative exploration study was undertaken with minimal emphasis on statistics, survey data, questionnaire, etc. ~~However,~~ The available periodical reports containing quantitative data have been reviewed. There were also constraints of time - total time for the study being ~~7~~ seven days, divided into ~~4~~ two blocks of ~~2~~ two days and one ~~block~~ of ~~3~~ three days.

★⊙★ - refer page 5

V METHODOLOGY

The present qualitative approach to evaluation consisted of

a) review of available records;

b) discussion with staff at RTU, and field level functionaries;

c) discussion with members of sangam and non sangam members of the villages;

d) observations during field visits; and

e) eliciting opinion from nearby health care delivery agencies.

An elaboration on the above follows (a) the records reviewed included the annual reports; reports to funding agencies; reviews of past and future plans; mobile clinic records; records at health centres; village registers; training programmes and their curricula; diaries and registers maintained by field staff for the type of information and their relevance to ongoing community health activities.

(b) Discussions were held at RTU with the Director, Assistant Director, Manager and the two community organisers and staff of medical department of RTU. At the field level, the village health workers, Balawadi teachers and their staff, Non-formal Education (NFE) animators, traditional birth attendants, and informal focussed discussions with them and the people on their work and attitudes were conducted in a non threatening manner.

(c) Sangam members, their office bearers, and non sangam members ~~and office bearers~~ were also contacted in a similar manner and their views were elicited.*

(d) Visits to the village included studying the condition of housing, water, sanitation, kitchen gardens, nutrition programmes at Balwadis, NFE classes and the quality of rapport between CHD staff and community members.

(e) An interaction with the Medical officer and Medical Superintendent at the nearby referral centre at Batlagundu (Leonard hospital) consisted of identifying local disease patterns, availability of health care services and patterns of utilisation.

The other components studied were library and health education resource materials, VHW's kit, medical stores and other units of RTU ~~especially~~ including the medical department in relation to CHD activity.

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* on CHD and their staff, on sangams and their functioning — in relation to peoples problems.

In addition, the ~~RTU~~ CHD staff participated ~~with ready cooperation~~ readily co-operated in and made available existing documents and also processing additional information requested by the study team.

The present study was not focussed on measuring the health status of the community in quantitative terms, but on the process and relevance of community health and development (to enable people ~~for~~ understanding the importance of the same to improve their quality of life) and hence the methodology ~~slightly above~~ adopted.

VI RESULTS

The results are presented as a situational analysis at the village level and in the various activities of the organisation.

1) The Villages

The 8 villages where the community health department operates are away from the main road, and relatively inaccessible. The population of these villages ranges between 200 to 700. Illiteracy is high and ranges between 40 to 95% with a high drop-out rate noticed after the primary level of education. The occupation of the people is mainly as agricultural labour (seasonal) and marginal farmers and shepherds. Most houses are kutcha houses, with one or two rooms, non-electrified and with no toilets. Even though potable water is available, it is inadequate. All villages have street lights, though inadequate. Most primary schools are within a distance of 2 Kms. Transport and communications are generally available, but inadequate. Balwadis organised by RTU are functioning where not covered by the ICDS* ~~scheme~~. Most villages do not have a community television.

The villages are in two clusters, with a government health centre near each of the clusters, located at Ganguvaripatti and Viralipatti. The government health workers visit these villages mainly for immunization and family planning activities.

* Integrated Child Development Scheme

Programmes on nutrition are conducted under the (TINIP) ~~governmental programme~~.

In RTU built houses, ventilation is good and there is no smoke nuisance from the kitchen, since it has smokeless chulhas and is built away from the living rooms.

2 ORGANISATIONAL ACTIVITIES

a Sangam

The membership of the sangams in relation to the total village population varies between 10% to 60% with a higher percentage of women being sangam members compared to men.

The percentage of attendance at meetings:

- in Men's meetings - range 54 - 87%
- in Women's meetings-range 51 - 100%.

On an average one meeting per month is held in both mens and womens sanghas. However, during harvesting and planting seasons, meetings are irregular.

The sangams have been able to mobilise people to avail various facilities through government schemes in areas of income-generation roads, electricity, water supply, and obtaining of pensions for widows.

It is to be noted that a major contribution of RTU is in the area of providing housing facilities which has generated great interest and attraction among sangam members. Sangam leaders are given leadership training at RTU periodically.

Some specific achievements as per records are:

1986 - construction of 167 RTU houses
- Borewell - one
Jagjivannagar.

1987 - 72 RTU houses at Utchapathi

1988 - Distribution of Goats/Buffaloes/Sheep - for income generation.
Established sheep rearing society.

1989 - Total 90 persons benefited from government schemes including 28pensions for widows/
streetlights and water taps;/
borewells by RTU + 12 water taps
+ 4 streetlights.

- Buffalo loans
- Jawahar well-digging loan sanction;
- Sheep rearing society formation
- ~~4 street lights/1 borewell/1 tap.~~
- Road repairs
- Widow daughter's marriage through aid
- ~~58 RTU houses/1 borewell~~/community hall/~~1 well~~/ ~~3~~/old age pensions/~~1 sheep rearing loan;~~
- formation of prohibition committee against female infanticide and
- Flood control wall construction/~~17 street lights~~.

1990 - Bullock and sheep rearing loans/~~4~~ street lights/~~2~~ hut electrification/~~4~~ ~~Oil~~/Credit Union formation/~~9~~ goats/tree planting alongside road/~~9 goats~~/shed repair/ and soakage pits/road-repair/Threshing floor/link roads ~~built~~/ ~~pits/road-repair/~~

1991 - (~~Extract from Annual report~~)

Some problems areas :

Apart from minor ~~differences and such~~ problems, usually found in human groups, others noted were:

- Leaders becoming corrupt and leading to loss of faith in them;
- Enthusiastic participation from sangams generally peaked when houses were constructed and waned dramatically after the event;
- Internal land and caste factors interfered with sangam activity;
- Traditional caste based elders who managed conflict felt threatened by the new sangam leadership.

(b) VILLAGE HEALTH WORKERS (VHW)

Village Health Workers selected by the Village Health Committee were women, a majority of whom were illiterate. They were given an initial training in community health for 2 weeks. A review of the curriculum showed that the contents were far too technical and voluminous to be covered in this short period. Subsequent refresher courses and clarifications at periodic meetings are continuing.

The VHWs are mainly involved in minor ailment treatment, ~~helping~~ assisting at RTU's mobile clinic and helping the government health workers in their health activities. They also

are expected to visit 5 families a day and conduct health education.

The VHWs are provided with a kit containing medicines for treating minor ailments, which is utilized to treat 20 to 30 cases on an average every month at a subsidized rate. They also utilize traditional herbal remedies quite confidently on their own initiative. They ~~also~~ record the vital events of births and deaths with the help of a literate. An honorarium of Rs.100/- (per month) is paid to them and this is given either by RTU or sangam?

We observed that the VHW is well accepted and has a good rapport with the community. Record keeping activity is inadequate due to their illiteracy. Being sangam members, they also participate in all other sangam activities, but are considered by the people as mainly health resource.

(c) MOBILE CLINIC

The mobile clinic operates twice a week, in the afternoons, effectively reaching each of the 8 villages once a month. The team consists of the CHD manager, a C.O., (Community Organiser) a person from the medical department and the local VHW.

They provide curative services to the whole population, with a focus on Ante and Post-natal care. The records show that they see an average of 60 patients a year per village, including 8 ANC patients and growth monitoring of 40 children, ~~apart from the above~~. Medicines at a subsidized rate are distributed, and Health education imparted. The schedules of the mobile clinic are very variable, mainly because of dependences on availability of the van for transport of the team. The health records are minimal, while their work is encumbered by accounting procedures. The records do not provide a clear picture of disease patterns, but discussions with the team and the local referral centre

indicated that the common ailments are diarrhoeas, skin diseases, eye diseases and problems of malnutrition. Tuberculosis and leprosy are two common major problems and these are treated with the help of governmental sources. In cholera epidemics in the past, the CHD has been effective in tackling the problem with government and other agencies.

(d) HEALTH EDUCATION

In addition to health education given by the VHW and at the mobile clinic in a personalized manner, mass health education programmes are conducted on an average of once a month in each of the villages through film shows and slide shows. Street theatre, puppet shows and drama are occasional events. The topics covered include - Cooperation, family planning, sanitation and hygiene, N.F.E., MCH and nutrition. Health Education also forms a component of the training programmes and other meetings at RTU. Film shows are popular with the people.

VII CONCLUSIONS:

1. The RTU's CHD Department has established a good rapport with the community as well as the government agencies in areas of health and development.
2. The formation and nurture of sangams has enabled the people to begin to understand their health and development problems and also evolve some solutions.
3. A large number of activities have been initiated in a short span of time inspite of meagre resources. Consequently, there has been a blurring of clarity and focus in their well-meaning efforts.
4. Curative efforts still form a major part of the health programme, while in development, avenues for tapping available resources are being efficiently explored.
5. Since the selection of villages was based on criteria of poverty and under-development, the approaches and activities of RTU-CHD have been predominantly welfare oriented.

5. The enthusiasm of the sangams seems to plummet as soon as their immediate felt needs are met from external agencies. This seems to blunt the potentiality of their initiatives, in using their own resources.

7. Cost-effort-effectiveness of mobile clinic is low.

8. Ref. notes VHW. 9. Health Educn

RECOMMENDATIONS

To effectively strengthen the ongoing and proposed activities, the following recomendations are made.

1. Community organisation and participation

Sangams have already been formed. This valuable resource needs to be fostered and strengthened with further training/ exposure of staff and sangam leadership. Interactions inbetween RTU sangams and others outside is likely to help this process.

The large membership precludes intensive study and understanding of local issues. The suggested corrective is the formation of smaller working groups in each sangam to take up specific issues. Planned training for these groups with the help of ~~external~~ expertise will be of help.

Mens and Womens sangams need to meet together in addition to individual sangam meets, atleast twice a year reviewing their activities in the interim period and to evolve better courses of combined action.

Practical solutions to problems of meetings during harvesting and plantings seasons are to be evolved. e.g. the executive committee/working groups could attempt to meet, or (if this is found to be impractical) the meetings at these times are suspended ~~and intensified~~ and the frequency increased subsequently.

Long term comprehensive planning on all relevant development issues is to be initiated and followed up by the sangams.

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8. The VHW is well accepted by the people and functions effectively in activities allotted to her. However, her inability to maintain effective records, makes it difficult for the CHD to make quantitative assessments of health parameters.

9. Health Education remains largely an effort of the CHD (with its ongoing activities and meagre resources) and has not received the attention it deserves.

Proper documentation and review of past decisions etc., will re-inforce this process.

Mechanisms for comprehensive feed-back at regular intervals on decisions and proposed actions both at RTU and sangam levels needs to be established.

Greater accountability should be fostered by open exchange of information on resources between CHD and sangams at their meetings. as mechanisms for the same plans, activities, & achievements

Invitation of local government officials to sangam meetings should be encouraged.

2. Appropriate ~~technology~~ Strategies for health and development

People should be encouraged to utilize government health services more and make them ~~more~~ responsive to their needs.

The cost-effectiveness of the mobile clinics can be improved ~~being cost-ineffective need replacement~~ with alternative approaches like decentralization & transfer of medical stores along with reduction of team-size and upgrading of village resources (VHW and TBA) also utilizing govt. health resources. ~~These can be then withdrawn~~ This can be implemented in a phased manner.

Where local/traditional herbal medicines are being utilized as alternatives, allopathic drugs provided, may be withdrawn in a phased manner. e.g., Benzyl Benzoate replaced with Turmeric/Neem leaves, for scabies treatment.

Explore alternative sources of energy like bio-gas, solar cookers, solar powered street lights, etc.

Development of simplified recording systems tailored to the needs of the community. ~~as per in annexures~~ as explained in the annexure.

3. Community support for health care

Formation of local ~~health~~ working groups on health, consisting of atleast 5 members each from the mens and womens sangams working together as a team will be an important step.

a) This group will be specially trained to improve health education and will be responsible for monitoring all

A prospective time-bound study of the mobile clinic component in terms of
- patient utilization of services from within and outside the specified villages;
- hours/personnel/medicine/transport/costs etc involved; and
- areas of non-clinic activities facilitated

needs to be included in the future plans.

The VHW/TBA/NFE animators/Balwadi teachers and their equivalents from Govt. health sectors are to meet periodically and evolve ways & means of implementing Sangam decisions.

also function as
health activities and an activist group to interact with governmental and other agencies for health.

b) To explore ways and means of making the community self-supporting in terms of finance and other relevant resources.

4. Health integrated with Development

A health-education component is to be incorporated in all training and other programmes of development both at RTU and at the village level. This is likely to make people more conscious and responsible for their own health.

A contributory health service (CHS) scheme could be linked to income-generation programmes. This is intended to promote self-sustenance ~~at the village~~ of health services in the village.

At RTU level, staff from all departments are to be sensitised and oriented towards the importance of C.H. in development and should be encouraged and expected to contribute to C.H. concepts in their areas of work.

As a starting point, the medical department could take responsibility for all curative services, and step into areas of prevention and health promotion in the villages where the community health department is active. All health programmes can be jointly planned by these two departments. Similar cooperative efforts can be planned with other departments in their areas of work.

5. Education for health

Considering the high levels of illiteracy in the villages, adult and NFE should be strengthened and expanded with health as a major component.

(from next page (13))

In ongoing Health Education the village working group should be trained to take up responsibility in all aspects of health education in the village. Some effort should be made to educate the working group on the elements of communication skills.

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PARTICIPATORY STUDY

of

COMMUNITY HEALTH AND DEVELOPMENT PROGRAM

of

"REACHING THE UNREACHED"

G. Kallupatti,
Madurai District,
Tamil Nadu.

<u>Study Group</u>

1. Dr. V. Benjamin

2. Dr. G. Gururaj

3. Dr. Shirdi Prasad Tekur

05th March 1992 To 26th April 1992.

C O N T E N T L I S T

I. SUMMARY

The Community Health and Development (CHD) initiative of 'Reaching The Unreached' (RTU) tries to reach people remote to development through health measures. The Goals are to actively involve people and enable them in improving their quality of life.

Sangams (associations) of men and women is the means and the nucleus of all health and development activities in the eight villages this programme addresses. The Community Health and Development (CHD) programme has gone through a phase of stagnation and re-activation in its evolution.

This study is in response to the need felt by the CHD (to know about their evolution, their present status and pointers to the future to help plan ahead) to be done by an external resource group. Constraints limit quantitative assessments and the focus is on qualitative and process exploration.

The villages chosen are remote and in need of health and development inputs. Sangams of men and women are operational and function fairly well with limitations due to local circumstances. Village Health Workers are effective in minor-ailment management and are well accepted by the community. The mobile clinic initiative is not cost-effort-effective. Health education effort needs strengthening.

The conclusions of the study point to positive areas of good rapport, credibility and initiative while serving in areas of peoples needs. Numerous activities with small resources, a focus on curative approaches, problems of sangam dynamics and a need for upgrading Health Education efforts are the drawbacks seen.

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Recommendations are for focussed activity, putting more efforts into making the sangams far-sighted, involvement of other departments of RTU in the CHD effort, exploring local and other governmental resources and methods of documentation to help the CHD evolve relevant plans for the future.

II. BACKGROUND

The project 'Reaching The Unreached' (RTU) started in the year 1975 and registered in 1978 at G.Kalupatti, Madurai District; it is an attempt to reach people in the remote, unreached areas. The felt need of medical aid in this place led to the starting of a small base clinic facility and a mobile clinic to surrounding areas. This spread into meeting other needs of the people, such as housing, education, water, foster-families for children, income generation programmes and other social welfare measures.

1) ORIGINS

The community health programme started later (in 1982/85) using health as an entry point for overall development of the communities in eight villages of this area. Two volunteers from RTU initiated a process of community organisation. The programme remained stagnant during 1985-86 when these initiators left, and was restarted in 1987 by the present manager of the Community Health Department (CHD). It began with non-formal education incorporating health messages, and slowly evolved into a community health programme. In course of time this transformed into a Community Health and Development (CHD) programme, and the department of CH & D came into existence at RTU. Two community organisers have joined this department over the past two years to help the Manager who has been handling this programme single handed.

2) GOALS AND OBJECTIVES

The goals of this community health and development program

as stated in their progress report are:

TO REACH OUT TO A LARGE NUMBER OF PEOPLE IN DISTANT AND REMOTE VILLAGES AND ENABLE THEM TO IMPROVE THEIR QUALITY AND STANDARD OF LIFE, WITH THEIR ACTIVE INVOLVEMENT, USING HEALTH AS AN ENTRY POINT.

This is aimed at building up of confidence and self-reliance in the villages and to initiate a process of common village development through formation of sangams (associations) of men and women.

III. PURPOSE OF STUDY

Based on a felt need of the community health department of RTU, the present participatory study was undertaken to find out the qualitative impact of the community health program in the eight villages they work in. This participatory study by an external resource group was to see

a) how the community health program evolved;
b) its present status; and
c) to provide guidelines in planning the future.

It is to be specially noted that this participatory interactive exploration of community health and development activities was intended to facilitate the community health department. Hence, this study focussed on community health and not on other activities of RTU. Since baseline benchmark information was not available, a quantitative evaluation study was not feasible. Therefore a process oriented qualitative exploration study was undertaken with minimal emphasis on statistics, survey data, questionnaire, etc. The available periodical reports containing quantitative data have been reviewed. There were also constraints of time - total time for the study being seven days, divided into two blocks of two days and one of three days.

The present study was not focussed on measuring the health status of the community in quantitative terms, but on the process and relevance of community health and development (to enable people understand the importance of the same to improve their quality of life) and hence the methodology adopted.

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IV. EVOLUTION

To chronologically describe the evolution pattern:

1. The earliest activity was the mobile clinic of R.T.U.

2. While pursuing this activity, eight villages were identified for using mainly community health interventions towards overall development. The criteria for selecting these villages were:

   a) lack of any health or development activity;
   b) remoteness from centres of development activities;
   c) being small (population size) and therefore manageable; &
   d) people belonging to predominantly backward and underprivileged sections of society.

Some of the originally selected villages were dropped from the program and others added on depending on CHD assessments and village dynamics

3. Formation of local Health Committee and selection of Village Health Worker (VHW).

   Formation of village level health committees was preceded by awareness building for health through street theatre and public meetings. This health committee identified a male health worker who was acceptable to the community. These VHWs from eight villages were trained at RTU for a period of 15 days. During 1985-86 the programme was stagnant due to reasons not clearly identifiable. The male health workers stopped pursuing community health activities. In 1987 when it restarted, female village health workers (VHWs) were selected from each of eight villages and given a similar fifteen day training. Guidance and supervision of these VHWs has been continuous and regular since then.

4. Sangam formation:

   Sangams separately for men and women of the village were formed. These sangams were intended to be the hub of all health and development activity. All adults were invited to join the sangams, and those interested joined the same. Some of these sangams are registered and members contribute a fee for common expenditure.

   Sangam members were expected to meet atleast once a month to discuss local issues and to mobilise community support for developmental activities. These sangam activities were

facilitated by the CHD to utilize both Governmental and other resources. They were instrumental in initiating activities in health and also other areas like building of roads, provision of water and electricity, running of balwadis, improving transportation facilities and income generation activities for the community.

V. METHODOLOGY

The present qualitative approach to evaluation consisted of

a) review of available records;
b) discussion with staff at RTU, and field level functionaries;
c) discussion with members of sangam and non sangam members of the villages;
d) observations during field visits; and
e) eliciting opinion from nearby health care delivery agencies.

An elaboration on the above follows:

a) The records reviewed included the annual reports; reports to funding agencies; reviews of past and future plans; mobile clinic records; records at health centres; village registers; training programmes and their curricula; diaries and registers maintained by field staff;
- for the type of information and their relevance to ongoing community health activities.

b) Discussions were held at RTU with the Director, Assistant Director, Manager, the two community organisers and staff of medical department of RTU. At the field level, the village health workers, Balwadi teachers and Balwadi staff, Non-formal Education (NFE) animators, traditional birth attendants, and informal focussed discussions with them and the people on their work and attitudes were conducted in a non threatening manner.

c) Sangam members, their office bearers, and non sangam members were also contacted in a similar manner and their views elicited — On CHD and their staff, on sangams and their functioning - in relation to peoples problems.

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d) Visits to the village included studying the conditions of housing, water, sanitation, kitchen gardens, nutrition programs at Balwadis, NFE classes and the quality of rapport between CHD staff and community members.

e) An interaction with the Medical Officer and Medical Superintendent at the nearby referral centre at Batlagundu (Leonard Hospital) consisted of identifying local disease patterns, availability of health care services and patterns of utilisation.

The other components studied were library and health education resource materials, VHW's kit, medical stores and other units of RTU including the medical department in relation to CHD activity.

In addition, the CHD staff participated readily and made available existing documents and also co-operated in processing additional information requested by the study team.

VI. RESULTS

The results are presented as a situational analysis at the village level and in the various activities of the organisation.

1. The Villages

The eight villages where the community health department operates are away from the main road, and relatively inaccessible. The population of these villages ranged between 200 to 700. The villages are in two clusters, with a government health centre near each of the clusters, located at Ganguvaripatti and Viralipatti. The government health workers visit these villages mainly for immunization and family planning activities. Programmes on nutrition are conducted under the Tamilnadu Integrated Nutrition Improvement Programme (TINIP).

In RTU built houses, ventilation is good and there is no smoke nuisance from the kitchen, since it has smokeless chulhas and is built away from the living rooms.

From available data we found that illiteracy is high and ranges between 40 to 95% with a high drop-out rate noticed after the primary level of education. The occupation of the people is mainly as agricultural labour (seasonal) and marginal farmers and shepherds. Most houses are kutcha houses, with one or two rooms, non-electrified and with no toilets. Even though potable water is available, it is inadequate. Most primary schools are within a distance of 2 Kms. Transport and communications are generally available, but inadequate. Balwadis organised by RTU are functioning where not covered by the Integrated Child Development Scheme (ICDS). Most villages do not have a community television, commonly seen in other villages in Tamilnadu.

2. Organisational Activities

a) Sangam

The membership of the sangams in relation to the total village population varies between 10% to 60% with a higher percentage of women being sangam members compared to men.

The percentage of attendance at meetings:

- in Men's meetings - range 54 - 87%
- in Women's meetings - range 51 - 100%.

On an average one meeting per month is held in both mens and womens sangams. However, during harvesting and planting seasons, meetings are irregular.

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It is to be noted that a major contribution of RTU is in the area of providing housing facilities which has generated great interest and attraction among sangam members. [Sangam leaders are given leadership training at RTU periodically.]

Some specific achievements as per records are:

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Borewell - one }

1987 - 72 RTU houses at Utchapathi

1988 - Distribution of Goats/Buffaloes/Sheep - for income generation;
Establishment of sheep rearing society.

1989 - Total 90 persons benefited from government scheme including:

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1990 - Bullock and sheep rearing loans/street lights/hut electrification/old age pensions/Credit Union formation/ goats for income generation/tree planting alongside road/ road-repair/link roads/shed repair/soakage pits/ and threshing floors in the villages.

1991 - Sheep rearing loans/bullock cart loans/loans for petty trades/old age pensions/borewells/water-tank with taps/ monthly savings scheme started/threshing floor construction and allotment of house-sites.

Some problems areas:

Apart from minor problems, usually found in human groups, others noted were:

- Leaders becoming corrupt and leading to loss of faith in them;
- Enthusiastic participation from sangams generally peaked when R.T.U. houses were constructed and waned dramatically after the event;
- Internal land and caste factors interfered with sangam activity;
- Traditional caste based elders who managed conflict felt threatened by the new sangam leadership.

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b) Village Health Workers (VHWs)

Village Health Workers selected by the Village Health Committee were women, a majority of whom were illiterate. They were given an initial training in community health for 2 weeks. Subsequent refresher courses and clarifications at periodic meetings are continuing.

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The VHWs are provided with a kit containing medicines for treating minor ailments,which is utilized to treat 20 to 30 cases on an average every month at a subsidized rate. They also utilize traditional herbal remedies quite confidently on their own initiative. They record the vital events of births and deaths with the help of a literate. An honorarium of Rs.100.00 per month is paid to them and this is given either by RTU or sangams.

We observed that the VHW is well accepted and has a good rapport with the community. A review of the curriculum showed that the contents were far too technical and voluminous to be covered in this short period. Record keeping activity is inadequate due to their illiteracy. Being sangam members, they also participate in all other sangam activities, but are considered by the people as mainly health resource.

c) Mobile Clinic

The mobile clinic operates twice a week, in the afternoons, effectively reaching each of the eight villages once a month. The team consists of the CHD Manager, a community organiser, a person from the medical department and the local VHW. They provide curative services to the whole population, with a focus on Ante and Post-natal care.

The records show that they see an average of 60 patients a year per village, including ANC patients and growth monitoring

of 40 children. Medicines at a subsidized rate are distributed, and Health Education imparted. The schedules of the mobile clinic are very variable, mainly because of dependence on availability of the van for transport of the team.

The health records are minimal, while their work is encumbered by accounting procedures. The records do not provide a clear picture of disease patterns, but discussions with the team and the local referral centre indicated that the common ailments are diarrhoeas, skin diseases, eye diseases and problems of malnutrition. Tuberculosis and leprosy are two common major problems and these are treated with the help of governmental resources. In cholera epidemics in the past, the CHD has been effective in tackling the problem with government and other agencies.

d) Health Education

In addition to health education given by the VHW and at the mobile clinic in a personalized manner, mass health education programmes are conducted on an average of once a month in each of the villages. This is mainly through film shows and slide shows. Street theatre, puppet shows and drama are occasional events. Health Education also forms a component of the training programmes and other meetings at RTU. Film shows are popular with the people.

Records show that the topics covered include - Cooperation, Family Planning, Sanitation and Hygiene, N.F.E., MCH and Nutrition.

VII. CONCLUSIONS

1. The RTU's CHD Department has established a good rapport with the community as well as the government agencies in areas of health and development.
2. The formation and nurture of sangams has enabled the people to begin to understand their health and development problems and also evolve some solutions.

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3. A large number of activities have been initiated in a short span of time inspite of meagre resources. Consequently, there has been a blurring of clarity and focus in their well-meaning efforts.

4. Since the selection of villages was based on criteria of poverty and under-development, the approaches and activities of RTU-CHD have been predominantly welfare oriented.

5. The enthusiasm of the sangams seems to plummet as soon as their immediate felt needs are met from external agencies. This seems to blunt the potentiality of their initiatives, in using their own resources.

6. Curative efforts still form a major part of the health programme, while in development, avenues for tapping available resources are being efficiently explored.

7. Cost-effort-effectiveness of mobile clinic is low.

8. The VHW is well accepted by the people and functions effectively in activities alloted to her. However, her inability to maintain effective records, makes it difficult for the CHD to make quantitative assessments of health parameters.

9. Health Education remains largely an effort of the CHD (with its myraid activities and meagre resources) and has not received the attention it deserved.

VIII. RECOMMENDATIONS

To effectively strengthen the ongoing and proposed activities, the following recommendations are made:

1. Community organisation and participation

Sangams have already been formed. This valuable resource needs to be fostered and strengthened with further training/exposure of staff and sangam leadership. Interactions inbetween RTU sangams and others outside is likely to help this process.

The large membership precludes intensive study and understanding of local issues. The suggested corrective is the formation of smaller working groups in each sangam to take up specific issues. Planned training for these groups with the help of expertise will be of help.

Mens and Womens sangams need to meet together in addition to individual sangam meets, atleast twice a year reviewing their activities in the interim period and to evolve better courses of combined action.

Practical solutions to problems of meetings during harvesting and plantings seasons are to be evolved. e.g. the executive committee/working groups could attempt to meet, or (if this is found to be impractical) the meetings at these times are suspended and the frequency increased subsequently.

Long term comprehensive planning on all relevant development issues is to be initiated and followed up by the sangams.

Proper documentation and review of past decisions etc., will re-inforce this process.

Mechanisms for comprehensive feed-back at regular intervals on decisions and proposed actions both at RTU and sangam levels needs to be established.

Greater accountability and mechanisms for the same should be fostered by open exchange of information on resources, plans, activities, and achievements between CHD and sangams at their meetings.

Invitation of local government officials to sangam meetings should be encouraged.

2. <u>Appropriate strategies for health and development</u>

People should be encouraged to utilize government health services more and make them responsive to their needs.

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The cost-effort-effectiveness of the mobile clinics can be improved with alternative approaches like decentralization and transfer of medical stores along with reduction of team-size and upgrading of village resources (VHW and TBA) also utilizing government health resources. This can be implemented in a phased manner.

A prospective time-bound study of the mobile clinic component in terms of

- patient utilization of services from within and outside the specified villages;
- hours/personnel/medicine/transport/costs etc., involved; and
- areas of non-clinic activities facilitated, needs to be included in the future plans.

Where local/traditional herbal medicines are being utilized as alternatives, allopathic drugs provided, may be withdrawn in a phased manner. e.g., Benzyl Benzoate replaced with Turmeric/Neem leaves, for scabies treatment.

Explore alternative sources of energy like bio-gas, solar cookers, solar powered street lights, etc.

Development of simplified recording systems tailored to the needs of the community as explained in the annexure.

The VHW/TBA/NFE animators/Balwadi teachers and their equipments from government health resources are to meet periodically and evolve ways and means of implementing sangam decisions.

3. Community support for health care

Formation of local working groups on health, consisting of atleast five members each from the mens and womens sangams working together as a team will be an important step.

a) This group will be specially trained to improve health education and will be responsible for monitoring all health activities and also function as an activist group to interact with governmental and other agencies for health.

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b) To explore ways and means of making the community self-supporting in terms of finance and other relevant resources.

4. Health integrated with Development

A health-education component is to be incorporated in all training and other programmes of development both at RTU and at the village level. This is likely to make people more conscious and responsible for their own health.

A contributory health service (CHS) scheme could be linked to income-generation programs. This is intended to promote self-sustenance of health services in the village.

At RTU level, staff from all departments are to be sensitised and oriented towards the importance of C.H. in development and should be encouraged and expected to contribute to C.H. concepts in their areas of work.

As a starting point, the medical department could take responsibility for all curative services, and step into areas of prevention and health promotion in the villages where the community health department is active. All health programs can be jointly planned by these two departments. Similar cooperative efforts can be planned with other departments in their areas of work.

5. Education for Health

Education for health aims at creating awareness among people of all factors that affect health and promoting positive life-styles towards health. Literacy need not be a pre-requisite for this.

Considering the high levels of illiteracy in the villages, adult and NFE should be strengthened and expanded with health as a major component.

In ongoing Health Education the village working group should be trained to take up responsibility in all aspects of health education in the village. Some effort should be made to educate the working group on the elements of communication skills.

6. Involvement of traditional healers, Dais and indigenous systems

a) The VHW's knowledge base to be increased.

b) The TBAs in the village to be trained and ANC and PNC made locally sustainable.

c) Practitioners of indigenous systems in the village to be integrated into the community health programme.

d)PPromote herbal gardens as part of kitchen/garden scheme.

e) Compile and document local herbs used, indications for use, and their effectivity, etc.

7. CHW / VHW

The VHW is illiterate. Therefore functional literacy to tackle simple meaningful record keeping/understanding health messages and for better communications is to be undertaken as part of their training. Their training also needs to be simplified to suit their limited role in minor ailment treatment and more efforts put in to preventive and promotive health aspects.

Their job specifications depending on their capabilities and community needs is to be made and their training programme tailored to suit this.

The VHWs skills to be upgraded to meet all local minor ailment needs. A referral system to hospital/health centre to be strengthened in the following:

a) Developing an official liaison between RTU-CHD and government or private referral centres;

b) Enabling the VHW to establish a rapport with the centres of referral; and

c) Upgrade the VHWs knowledge to selecting the appropriate referral centres for specific problems.

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Appendix

Suggestions for simplified, comprehensive, relevant record-keeping to enable future planning.

1. A register alloted to each village only for records on health - to be kept at the village, accessible to the CHD and sangam health working group for updating.
2. The first 20 pages of register to be kept aside for indexing, comprehensive record of focussed activity (eg., immunisation/ANC/ Child births/PNC/Vital events, etc)
3. One page per family for details eg., names of family members/ house no./type of house/illnesses in members (chronic)/sangam membership/facilities availed from sangams etc.
4. Start with families with ANC/PNC/Immunization care. Continue with other sangam members, then non-members, such that over a period of 3 to 6 months, complete village records will be available. This will also form the base-line data much needed for future evaluations and planning.
5. Examples of what is to be recorded:
   a) Village name/address on cover;
   b) Page 1 - map of village (folded sheet can be pasted);
   c) Page 2 to 9 for index of family by name/house number;
   d) Page 10 to 20 for comprehensive records.
   e) page 21 onwards, individual family records, one page per family.

Immunization records

Dt. of recording — April/May/June/July/etc.

No. of children under 5 years age.

No. of children completed BCG

No. of children completed DPT/OPV

1st dose

2nd dose

3rd dose

Tally marks by VHW/CO.
- individual updating by name in family record.

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No. of children completed
Measles vaccine

No. of children completed
1st booster dose

No. of children in Balwadi
roster/receiving suplementary
nutrition, etc.

ANC / PNC records from April 1992

April / May / June / July / August

No. of mothers pregnant

No. of mothers received
T.T. injection

No. of live births

No. of still births

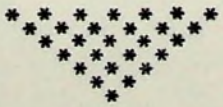
Dates of delivery

Place of delivery
(village/outside)

Delivery conducted by
TBA

No. of PNC

AND SIMILARLY FOR LOANS/OAPs/VITAL EVENTS, etc.



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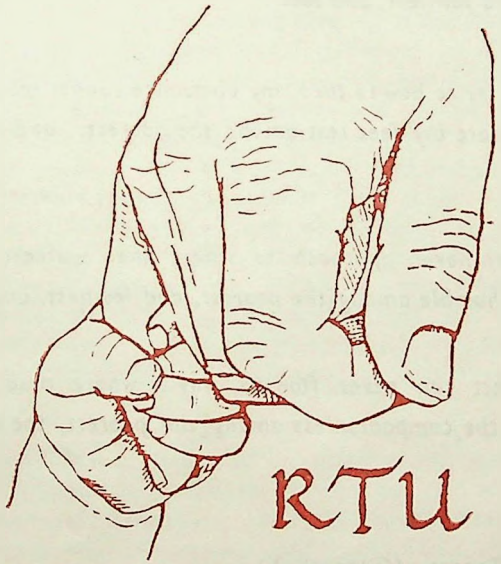
REACHING THE UNREACHED

INDIA



ANNUAL REPORT

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HERE is thy footstool and there rest thy feet where live the poorest, and lowliest, and lost.

When I try to bow to thee my obeisance cannot reach down to the depth where thy feet rest among the poorest, and lowliest, and lost.

Pride can never approach to where thou walkest in the clothes of the humble among the poorest, and lowliest, and lost.

My heart can never find its way to where thou keepest company with the companionless among the poorest, the lowliest, and the lost.

Rabindranath Tagore (Gitanjali X)

PRESIDENT'S INTRODUCTION

The sole purpose for our existence as an organisation is to reach the unreached those still hidden away by their poverty or remoteness or lack of power. It is vital for all of us to keep this in the forefront of all our planning and activities, otherwise there is the danger of stagnation or inbreeding, or worse still, selfishness. The Gandhi's and the Mother Teresa's of this world keep on reminding us of this, as does Rabindranath Tagore and indeed, Jesus Christ. This has been a year of quite remarkable growth in all directions, in efficiency as well as in improving the quality of life of an enormous number of people from day-old babies to the very old; from individual families to whole villages. A quick glance at this report for one single year of work will demonstrate just how wide and how deep is our outreach and our caring and how excellent are our techniques and enterprise.

Dedication is a word rarely used here but it is always in evidence every day of the year and in all the various segments of our work. It is positively evident to the many visitors who come this way and who often remark on the cheerful dedication of the staff who make up this whole programme and without whom none of it would be possible In all this, I feel that we need to keep much in mind that those we reach out to are individuals each of them with his or her own special problems and needs and joys It is sometimes necessary to actually meet these people and to communicate with them even if our work does not require this. Without these individuals the purpose of our being here would not exist. In a way the very poor are the be-all and the end-all of the whole of our work We must keep on striving to make sure that our work is people-centred and not project-centred. We who run this whole programme are no more human than the ones we try to help : they have as much right to our facilities and our influence as we have ourselves, and indeed, they have more right to them.

Once again it is my happy duty to thank all our staff for yet another year of hard work of development, of outreach in the best of ways and for their cheerful dedication at all times. Thank you It is also my bounden duty to thank all those who help us in any way. A large amount of our income comes from individuals who often make quite large sacrifices in order to show their solidarity with the poor. There are many times when I am deeply touched by the generosity and caring of so many people who work with us in this way. They cannot be here, as we are, but they still wish to share in what we are doing. To the big donors, who are after all a conglomeration of a lot of individual donors, and to the many individual friends in India and all over the world: many thanks. Do know that we deeply appreciate all you do to help us and those in our care.

BRO JAMES KIMPTON
REACHING THE UNREACHED
G. KALLUPATTY, NEAR BATLAGUNDU
MADURAI DISTRICT-624 203
TAMIL NADU, INDIA

MEDICAL PROGRAMME

The medical programme provides primary health services to the people of about 25 villages. This programme is project based and functions from the clinic in the project campus. The clinic functions in two sessions, morning and afternoon. The programme can be classified into the following :

1) General clinic
2) Ante-Natal Care
3) Mother and Child Health Care
4) Leprosy and T.B. clinic
5) Laboratory
6) Physiotherapy unit
7) Day Care Centre

In addition, the medical programme is also involved in health education, through house visits, mobile clinic for outreach villages and medical check-up and treatment for school children under RTU's education programme.

General clinic: During the year a total of 15,377 cases were treated. Most of these cases were common ailments like cold, cough, fever, skin trouble, burns, injuries etc. Earlier, the general clinic functioned only in the mornings. However, from this year onwards, the general clinic was operational in the afternoon sessions also for those who were not in a position to come in the mornings. Complicated or serious cases were referred to the government or private hospitals in Batlagundu. Of these, 47 cases were referred for treatment at RTU's expense. To improve the quality of diagnosis and treatment, a lady doctor was appointed to visit the clinic twice a week during the morning session. Her presence has strengthened the skills of the team of para-medical workers.

Ante-Natal Care: The ante-natal care for pregnant women is provided through the clinic on Thursday afternoons. It ensures that the women who are registered for treatment come to the clinic at least once in a fortnight. Registration begins from the third month of pregnancy onwards. A total of 1,498 cases of ante-natal care were provided treatment. On an average, there were 18 new cases per month. 40% of the women registered themselves for treatment between the third and fifth month of pregnancy, whereas most of the others registered between the sixth and

eighth month of pregnancy. The clinic recorded 160 normal deliveries among those who were registered in the clinic. 4 abortions, 3 premature deliveries and 4 still births were recorded. The condition of most of the women undergoing treatment and the children delivered by them was normal The treatment consists of providing iron and folic acid tablets and tetanus toxide doses. As part of health education, audio-visual shows on health and nutrition of women and children were arranged on a monthly basis.

Mother and Child Health Care : This is a follow–up of the ante–natal care cases. The medical team follows up the immunisation status of the children during the first year and motivates the mothers to get their children immunized through the government programme Immunizations are done by the government health staff in the campus to protect children against tuberculosis, polio, diphtheria, whooping cough tetanus and measles. During the year, this programme covered 749 children

Leprosy and T.B. Clinic : With the government leprosy programme active in the area, RTU's responsibility was restricted to motivation follow-up and rehabilitation. The government leprosy department visits the project campus every month When they dispense treatment for the leprosy patients. The medical team of RTU is constantly in touch with these patients to ensure that their treatment is comprehensive. The shoe making unit of RTU provided 115 pairs of micro-cellular rubber footwear to the leprosy patients A total of 3,773 leprosy cases were followed up. Under the TB programme, surveys were conducted in Kallupatti and Genguvarpatti villages to identify TB patients for treatment. 7, 713 cases of TB treatment were recorded. The number of patients on record at the beginning of the year (April 1990) was 27. to which 68 new cases identified during the year were added. A total of 40 patients completed the treatment and were declared cured, while 7 patients discontinued treatment. At the end of the year, there were 47 patients on record undergoing treatment. The TB patients came from 9 surrounding villages.

Laboratory: The laboratory plays a supportive role to the activities of the medical team. Normal clinic tests such as stool test, urine and blood test like widal, VDRL, HB % ESR, total counts and differential count test are taken up. A total of 4,276 lab tests were conducted, which are done by a trained lab technician.

Physiotherapy Unit: The physiotherapy unit had more cases this year. 35 Children were being treated in this unit. These children were in the 3–13 age group. During the year, 14 children suffering from various forms of physical disabilities were

operated by an expert orthopaedic surgeon Dr. John Karuppaiah. Six children who were operated in the previous year underwent rehabilitative treatment in the clinic. 24 sets of calipers and 15 sets of crutches were provided to the children. This unit is equipped with various equipment for exercising the limbs. Massaging is done with herbal oils Electro magnetotherapy is also provided. This unit functions in the early mornings and late afternoons.

Day Care Centre: The day-care centre is for children under three years of age who are severely malnourished. On an average, there were 25 children in the day-care centre at any point in time. They are provided with nutritious food consisting of milk porridge, vegetables, fruits and eggs. An additional helper for the centre was appointed to ensure that all the children are well cared for. The day care centre staff started a system of organising parents' meetings periodically to educate them on child care personal hygiene and sanitation

Mobile Clinic: The medical team visits two villages under the mobile clinic programme These villages are Kombaipatti and Gandhipuram. The number of patients treated during each visit is in the range of 10-20. Subsequently, the team undertakes house visits and advises the people on health related issues. The team undertakes mobile clinic visits on Monday and Friday afternoons. Each village is visited weekly. A third village, Dharmalingapuram, was dropped because of the inadequate response to the programme by the people.

House Visits : On Tuesday and Wednesday afternoons, the medical team undertakes house visits in Kallupatti and Genguvarpatti. This gives them an opportunity to meet and discuss with the people matters pertaining to health and hygiene. This also gives them a chance to follow up the treatment provided earlier to the people.

School health : During the year, the team conducted frequent medical check-ups and treatment to the children covered under RTU's education programme. The total number of cases checked and treated was 11,182.

A system of giving tetanus toxide doses to the staff and workers of RTU on a quarterly basis was started during the year. About 200 people are covered under this activity.

Through the system of voluntary contribution by the people, an amount averaging Rs. 300 per month was collected. This programme is largely supported by Caring for people (U.K), RTU (U.K) and other groups and individuals.

MONETARY ASSISTANCE PROGRAMME

This programme provides assistance to people in need. They constitute TB and leprosy patients, widows, physically handicapped, old aged, destitutes and sickly people. They can broadly be classified as under :

Leprosy patients	: 59
TB patients	: 7
Destitutes	: 96
Others	: 19
TOTAL	: 181

Some of these beneficiaries are given temporary assistance as a short term relief measure and are subsequently removed from the list when their condition improves. Most of them belong to the local villages and come to the project campus on Friday mornings to collect the assistance amounts. For those living in farther villages, arrangements are made to have the amounts disbursed at points nearer to their homes. The assistance amount is in the range of Rs 10 to Rs. 50 per week, depending upon the need of the beneficiary and the family situation. A constant review of the beneficiaries is done to ensure that only the most needy are benefitted. Six people are put on a monthly assistance and a few are also sent money by post if they are living in far away villages.

7 old aged people live in RTU's care in houses constructed by RTU. They are provided with food thrice a day and weekly assistance of Rs. 15. Their personal needs such as clothing are also attended to. In addition 17 old aged people are provided food thrice a day and a weekly assistance of Rs. 15 each. They come to the project campus to get their food.

Every year, on the occasion of Deepawali (an important festival), a set of clothes is gifted to each person. Some needy people, especially the old, are provided with blankets in the cooler season.

In August 1990, during an eye camp organised jointly by the Aravind Eye Hospital at Theni and RTU, many of these people were treated and some operated for various visual defects.

This programme is supervised by the medical department. It aims to ensure that deserving and needy people are provided with a certain measure of physical and emotional security.

This programme is supported by DWHH (Germany), SOIR-IM (Sweden), Frierds of Leprosy patients (U.S.A.), DCF (Denmark) and others.

COMMUNITY HEALTH AND DEVELOPMENT PROGRAMME

The Community health and development programme is implemented in 7 villages as part of the outreach programme. Community health is the main intervention in these villages, in the initial stages through formation of sangams (associations) of men and women. Subsequently community development activities are taken up. This is aimed at building up a certain measure of confidence and self-reliance in the villages and to initiate a process of common village development. Sangam meetings are held regularly, at least once a month. Each member pays a certain amount to the sangam every month for creating a fund to meet common expenditure. Meetings in the project campus, trainings, exposure visits and audio visual shows are also organised.

During the year, the programme was withdrawn from one of the villages, JK Nagar, due to consistently inadequate response to and interest in the programme. The programme in Kannimarkoilpatti was temporarily suspended when some of the members refused to abide by some decisions taken by the sangam in consultation with RTU and the inability of the sangam to sort out the differences within the group. On the positive side though, the programme was revived in Utchapatti in August 1990 after about 6 months, on repeated representations from the village people to RTU on this issue. The programme was implemented in a full fledged manner in Keelakottaipatti. Kamatchipuram was a new village in which the programme was introduced from October 1990 onwards. The team also established contacts with Vadivelpuram, Karuppamoopanpatti, Sathakovilpatti, and Perumalkovilpatti villages, where the programme is likely to be introduced in the near future. The villages where this programme was being implemented were: Sri Ram Nagar, Palapatti, Kottaipatty Samiyarmoopanur, Utchapatti, Keelakottaipatti and Kamatchipuram.

Community Health :

This component of the programme encompasses the activities of the village health worker (VHW), health education and mobile clinic. The village health worker is selected from within the village, who is trained in basic health care and dispenses treatment. Serious cases are referred by her to the nearest government health centre or hospital. She also promotes health messages. An average of about 200 cases were treated monthly by the VHWs in the 7 villages. Most of these cases were cold, cough, fever, aches, diarrhoea and skin diseases. 21 review meetings of health workers were conducted in the campus.

The mobile clinic supports the work of the VHWs. The clinic visits each village monthly and undertakes ante-natal care (ANC) checks, weighing of children under five, treatment and health education. 61 mobile clinic visits were made, during the course of which 109 ANC cases were given treatment. A total of 563 men, 659 women and 1177 children were also treated. An amount of Rs. 1,002 was spent on medicines towards which, the people contributed Rs. 573 as their share.

15 audio-visual shows were conducted in the villages using films and slides. These covered a variety of topics such as child care, nutrition, environmental sanitation etc.

Community development :

The following is a brief statistical account of the sangams :

Name of the village	Sangam Membership		Average attendance in meetings (%)		Sangam fund collection during the year (Rupees)	
	Men	Women	Men	Women	Men	Women
Sri Ram Nagar	37	43	65	87	340	75
Palapatti	43	70	54	63	90	100
Kottaipatti	35	34	59	82	303	352
Keelakottaipatti	40	48	71	91	560	900
Utchapatti	24	78	79	71	1,000	208
Samiyarmoopanur	37	112	75	86	1,110	517
Kamatchipuram	25	117	67	100	234	400
TOTAL	241	502	67	83	3,637	2,552

The sangams were largely involved in mobilising the people to avail benefits from the government Applications were made for loans for purchase of milch cattle, goats and sheep, petty trades and for social services Like old age and widow pension. Representations were made for water supplies, housing, electricity and roads. With the help of RTU they were also involved in running balwadies, developing kitchen gardens and tree plantation on homesteads. Disputes among groups within the village were also settled through the intervention of the sangams, for which, in a couple of cases, assistance of the local police was also sought.

One of the highlights of the programme was the co-operation among the sangams of Palapatti, Kottaipatti and Keelakottaipatti villages in getting a kutcha road laid with the assistance of the panchayat union and contribution from the people, on the basis of which, they managed to get a bus route connecting their villages to the nearest town, sanctioned. This was possible after several representations to the concerned authorities. The bus has however not yet started plying, and the people are determined to continue to press for their demand till the very end. This has stood out as an example for other sangams to emulate.

50 kitchen gardens were developed in 6 villages as a supplementary income generation activity. A variety of vegetables were grown. This met with a good response from the people, who intend to continue this activity. 850 trees were planted in homesteads in 7 villages, in addition to plantation along village roads. Some women of Keelakottaipatti were involved in preparation of a nutritious powder for children which was supplied to RTU. A group credit scheme for goat rearing was initiated in one village, involving a total of 9 groups of 5 members each. The balwadi in Utchapatti was re-started in September 1990, for which the people contributed Rs. 3,000 for purchase of materials. Since then, this balwadi and the one in Samiyarmoopanur have

been functioning satisfactorily. with the parents taking keen interest in the programme. Arrangements for feeding have been made in the village itself, which is being supervised by the parents. Each balwadi has 30 children with one teacher and two assistants for each balwadi. The health status of the children is monitored regularly. The education department provides the necessary support.

8 one day training sessions each for men women and children were held between May and December 1990 involving about 25 participants in each session. These trainings covered issues related to overall village development. Two trainings on leadership and health awareness were held for one day each, involving a total of 62 participants The departmental team too participated in these trainings, in addition to which they had their own meetings to review the programme implementation.

The programme had its share of problems too. The most common problems were those related to sangam leadership. Dishonest practices and instances of corruption among the leaders, apparent or perceived resulted in a loss of confidence among the people for their leaders. However, the sangams were strong enough to meet the demands of the situation and take remedial action. Internal village disputes, mostly related to land and caste, adversely affected the working of sangam, which too called for sangam intervention

The following is a brief account of the achievements of the sangams in their respective villages.

- **Sri Ram Nagar:** Sheep rearing loan for 15 members, bullock cart loan for 4 members, loans for petty trades for 4 members, old age pension for 5 people.
- **Palapatti:** Old age pension for 8 people
- **Kottaipatti:** Old age pension for 2 people.
- **Keelakottaipatti:** Borewell for drinking water from the government, monthly savings scheme for all members.
- **Utchapatti:** Sheep rearing loan for 24 members, construction of threshing floor by the government.
- **Samiyarmoopanur:** 112 house sites alloted, pension for 3 widows, water tank with 6 taps from the government.

These are an indication of the initiatives taken by the people to bring about village development.

This programme is being supported by Oxfam (U.K).

EDUCATION PROGRAMME

The education programme can be classified into the following components :

a) Balwadies (pre-primary schools) for children in the 3-5 age group.

b) Full-time primary schools for students in the 5-11 age group.

c) Supplementary schools for children in the 5-15 age group.

d) Trade schools for vocational skills for boys and girls.

e) Boys' hostel.

f) Scholarships for advanced studies.

The number of students covered under each of these programmes at the beginning of the academic year was :

Programme	Boys	Girls	Total
Balwadies	64	64	128
Full-time primary schools	174	177	351
Supplementary schools	847	432	1,279
Trade schools	7	27	34
Boys' hostel	23	—	23
Scholarships	13	6	19
	1,128	706	1,834

During the year, the retention rates of students for the three main programme of education were-balwadies 91%, full-time primary schools 97%, supplementary schools 82%. The major factor causing drop outs was, as usual, migration of families to other places in search of employment. In the case of supplementary schools, drop out among girls was also reported on their coming of age. As in the previous years, many drop outs were reported in the month of March when the government schools in which the supplementary schcol children are enrolled, close down for study holidays or conduct the final examinations. About 61.5% of the students enrolled were boys and 38·5% girls In addition, the education programme also supported two balwadies in the outreach villages which came under the supervision of the Community Health and Development programme, in the villages of Utchapatti and Samiyarmoopanur. Details regarding these balwadies are reported in the section covering the community health and development programme.

As in the early years, emphasis was laid on upgrading the skills of the teachers threugh trainings organised in the campus during summer and exposure visits to other schools involved in similar work. Regular meetings among the teachers were held to enable sharing among themselves. Teachers of each programme met monthly during which some of them took model classes, which were then evaluated by the others present. These meetings were in addition to the team meetings held in each school

and centre. For the purpose of co-ordination within the education programme those in charge of each education centre met monthly to share their experiences. It was with the purpose of strengthening the programme at the field level that the post of a Programme Assistant for the education department was created in early 1991. The Programme Assistant was expected to lend support to the teachers in teaching methods and planning. He was also expected to assist the Co-ordinator of the department in the implementation of the programme The post of an Administrative Assistant for the schools was created to reduce the administrative burden of those in charge of the two full-time schools and the two supplementary schools in Kallupatti and Ganguvarpatti.

Involvement of parents was high through a system of quarterly meetings, when the teachers and the parents discussed issues related to the overall development of the children with specific emphasis on academics. The purpose of these meetings was also to impress on the parents the need for them to take an active interest in the education of their children. The parents of the supplementary school students contributed at a rate of Rs 25 per student and Rs. 35 per student annually, for the primary and secondary level students respectively, while the parents of the students of the balwadies and full-time primary schools contributed Rs. 55 per student annually. During the year, an amount of about Rs 50,000 was received from the parents as their contribution to the programme. This amount was deposited in a fund for future exigencies The parents also took an active interest in the various extracurricular activities organised from time to time.

Balwadies:

The balwadies are for the children in the age group of 3–5. The activities in the balwadies include singing, dancing, story telling, games and simple art work. Tamil alphapets and numbers are introduced to the older children in the group to prepare them for their primary education.

There are 3 balwadies under the programme, of which 2 are in Kallupatti (Sisu Bhavan & Miriam Balwadies) and one in the neighbouring village of Pushparaninagar (Nirmala Balwadi). The children are divided into two groups, one group for the 3—4 age group and the other for the 4—5 age group. The Kallupatti balwadies have 1 teacher and 2 helpers each, while the Pushparaninagar balwadi has 2 teachers and 2 helpers The strength in each of the 3 balwadies is restricted to 40. The health and nutrition status of the children is given lot of importance as it is an integral part of the programme. The selection of children for the balwadies is done by the teachers such that only the children from the most backward sections of the village are admitted. Medical check-ups are conducted by the medical team every quarter.

Discussions in parents' meeting usually centre around child care. Towards the end of the year, the teachers held a feedback session with the parents regarding the programme, so that constructive suggestions coming from them could be incorporated in future implementation.

Primary Schools :

During the year, the St. Peter's School (Kallupatti) went up to standard 5 and the Arul Malar School (Ganguvarpatti) went up to standard 3. This necessitated construction of additional class rooms 3 additional class rooms for each school was constructed in mid-1990 to accomodate the additional students.

The schools follow the government syllabus prescribed for the students, in addition to which life oriented topics relevant to the village situation are added. Besides imparting literacy and numeracy skills the syllabus is designed to cover a wide variety of concepts and topics such as health, sanitation, personal hygiene, environment social issues etc. Importance is also given to extracurricular activities like art, handwork, singing tree plantation etc. The teachers adopt teaching methods which interest the children and hence enable them to grasp easily. Children are also encouraged to save by developing in them an attitude of thrift. During the year, children from the full-time schools collected an amount of Rs. 3,200 as savings. A system of giving additional coaching for students who were academically backward was started in December 1990. Teachers with the help of some students conducted these classes after normal school hours and on holidays. Special attention was also given to students of standard 5 to ensure that they were comfortable with the basic concepts and literacy and numeracy skills, which would form the foundation for their future studies Six-monthly medical check-ups for students were conducted by the medical department, which also followed-up the treatment taken.

Regular contact with the parents was maintained through meetings and house visits The parents gifted a steel water container to the St. Peter's School and a small sound system to the Arul Malar School on the occasion of Christmas. In the feedback session towards the end of the year, the parents asked the teachers to develop in the children capacity to memorize and an attitude for hard work in their homes.

The teachers were involved in a serious debate on the future of the programme. The question was whether to go beyond standard 5 and whether to seek government recognition for the schools After a series of discussions which included external resource persons, it was decided that the schools would go up to standard 8, when the students would appear for a public exam conducted by the government as private candidates. Hence, from the academic year 1991-92, these schools will go to the middle school level.

The administrative side of the schools was taken care of by St. Josephine, who spent sometime examining the system of maintenance of various records including those related to academics such as lesson planning. Her suggestions are expected to strengthen this side of the programme also.

Supplementary Schools :

The supplementary schools function in 5 villages in the mornings and evenings for about 2 hours each. These schools are in the villages of Kallupatti (Gandhiji School), Ganguvarpatti (Mother Theresa School), Sengulam (Valluvar School), Pushparaninagar (Nirmala School) and Dharmalingapuram (Avvai School). The purpose of the supplementary schools is to improve the standard of education and learning of the students going to the government schools, through providing them with additional coaching in academics and an opportunity to participate in several extracurricular activities for complete development. It also aims to make the children more responsive to the society and community to which they belong.

The highlight of the programme during the year was that the students of Avvai school scored a 100% result. All the students coming to this school who appeared for the examination in the government school were declared successful. This year saw a marked improvement in the relationship with the local government schools both in academics and extracurricular activities. This coordination is beneficial both for the supplementary schools and for the government schools, resulting in a much better input for the students.

A new system of vocational training for the students of standards 8,9 and 10 was started. This was a suggestion that came from the parents in one of their meetings 25 boys were selected for training in screen printing, electric wiring and carpentry. This training was to be imported to them on Saturdays and Sundays. Training in screen printing and electric wiring was imparted by the trade school while for carpentery, they went to a workshop in the nearby town of Batlagundu. This has received a good response from the boys.

An evaluation of the programme was conducted for the students of standard 5. 45 supplementary school students who had been enrolled in the programme for 3-5 years were tested and their scores compared with that of 20 students who appeared for the same test but did not come to the supplementary schools or attend private tuition classes. The test was for Tamil, Maths and Science subjects. It was found that the scores of the students coming to the supplementary schools was about 19% more than that of those not attending these schools. Though it was apparent that students coming from supplementary schools had an edge, certain areas of weaknesses in the programme were also identified, which will form the basis for further strengthening the programme in future.

The students were also involved in various extracurricular activities. Competitions were held in quizzes, oratory, essay writing and singing Students took up tree plantation and social work programmes in the villages. The students from three schools who were involved in savings, collected an amount of Rs. 2 300 during the year. The students were covered under the six-monthly medical check-up conducted by the medical team

Basic Trade Schools:

The trade schools aim to provide vocational skills to boys and girls above 15 years of age to enable them to be self-employed or seek gainful employment in future.

The trade school for boys imparts training in carpentry, electric wiring and screen printing Due to lack of adequate response on part of the trainees, this trade school increasingly concentrated on production activities. These included printing of cards, book binding works, photo framing works etc. A small group of 7 boys were given on-the-job training with a monthly stipend of Rs. 75. This training is for a period of 6 months. This school has earned a revenue of Rs. 16,000 for various works done during the year, including photocopying, which is done in this school

The trade school for girls imparts training in tailoring embroidery and handwork. This school was strengthened with the appointment of a trained and experienced teacher at the beginning of the academic year. The girls undergo a one year training at the end of which, they are made to appear for a government exam, which earns them a certificate on their being declared successful. This enables them to avail of bank loans for buying sewing machines. This school also started making marketable products and earned a revenue of about Rs. 1,500 through sale of dress materials.

Boys' Hostel :

The newly constituted boys' hostel started functioning in the campus form the beginning of the current academic year onwards The strength of the boys in the hostel was 23 in the age group of 10—16 (standard 5 to standard 10). Preference was given to complete orphans and sons of widows from very poor families. The boys attended the government schools in the village. A warden was appointed to supervise the hostel. Adequate arrangements for their boarding was made. Provision was also made for games and recreation. The parents/guardians contributed Rs. 10 per month for each hostel inmate. These boys also attended the supplementary school programme. Importance is given to their health and nutrition, which is taken care of by the medical department.

Scholarship :

This is a provision for students who have completed their basic academic courses and intend to study further. Preference is given to students seeking admission for vocational and professional courses like teaching, nursing, typewriting and various polytechnic courses. Scholarship amount is granted based on the economic and academic background of the student and on his or her gaining admission to a recognised institute. The scholarship amount is restricted to a maximum of Rs. 3 000 per year or two-thirds of the total amount required per year whichever is less and is given in monthly instalments The education department keeps a record of the progress made by the students during the course This is expected to benefit the students by enabling them to find gainful employment on completion of their courses. In some cases, RTU itself is in a position to provide employment. as in the case of those who have completed a course in teaching.

The following is a brief account of the activities of the students and teachers during this period :

- Annual examinations were conducted by the full - time and supplementary schools in April 1990
- Mr. Sathyabalan of Action Aid conducted a 5 day teachers' training programme to upgrade the skills and improve teaching methods in May 1990.
- The students and teachers of Arul Malar School started a child-to-child literacy programme for the non-school going children in the area in June 1990.
- Students' councils were formed by the students of the full-time schools in June 1990. The same month, they started savings.
- Planning for the academic year 1990–91 was done by the teachers of all the programmes in June 1990.
- On completion of construction of additional classrooms, the full-time school children took up tree plantation in front of the school building.
- In August 1990, RTU hosted a meeting of education co-ordinators of organisations funded by Action Aid. This was organised by Action Aid.
- All schools celebrated Independence Day on August 15, 1990.
- In August 1990, the supplementary school students formed student's councils in their respective schools.
- Two groups of full-time school teachers went on an exposure visit to Vikasana School, Bangalore and Kinder Garten School, Madras in October 1990.

- Children of the 3 balwadies went on an excursion to a nearby picnic spot in October 1990.
- A sports day for all the schools was held on November 14, 1990 to commemorate Children's Day.
- A group of supplementary school teachers went on an exposure visit to Kinder Garten School, Madras in 1990.
- Half-yearly exams were conducted in the full-time schools in December 1990. Special classes for academically backward students were started.
- Children's get-togethers were organised in each school on the occasion of Christmas Exhibitions and entertainment programmes invoving parents were organised ditferently in each school.
- A science exhibition was conducted by the full-time and supplementary schools in the government high school in Kallupatti in the month of January 1991.
- Half-yearly exams were conducted by the supplementary schools in January 1991.
- Inter-school competitions for quiz, essay writing and singing was organised by the supplementary schools in January 1991.
- Republic Day was celebrated on January 26, 1991.
- The annual day celebration involving all the schools was conducted in February 1991. A variety entertainment programme was staged.
- Social service groups of full-time schools students were formed in February 1991.
- The students of standard 10 of the supplementary schools gave feedback on the programme in March 1991.
- The evaluation of the supplementary school programme for the standard 5 level was conducted in March 1991.
- Sports day for the balwadi children was organised in March 1991. In the same month, students for standard 1 were selected from the balwadies.
- The students and teachers of the full-time and supplementary schools started preparation for the annual examinations on the conclusion of the academic year 1990—91, in March '91.

The education programme is supported by Action Aid (U.K.), DCF (Denmark) Enfants De L' Univers (France), SKIP (Switzerland), DWHH (Germany), RTU (U.K), St. Peter's School (U.K.), SECOLI (Rome) and other groups and individuals through sponsorship and non-sponsorship funding.

NUTRITION PROGRAMME.

Under this programme, food is provided to the children of the day care centre, balwadies, primary school, supplementary schools and boys' hostel totalling to about 1,600 children. 25 old people are also provided with food

Since the coverage of children under this programme is substantial, efforts are made to optimise the nutritional intake in a cost effective manner. The day care centre children are provided with a diet consisting of milk and porridge in the morning, lunch in the afternoon consisting of rice, pulses and vegetables and occasionally, fruits The balwadi children are provided milk in the morning, lunch in the afternoon and snacks before they leave in the late afternoon. Mid day meals and snacks are provided to the primary school children. Breakfast is provided to the supplementary school children attending the morning session and snacks to those attending the evening session. The boys in the hostel are provided with breakfast, lunch and dinner. Special meals or dishes are prepared on festive occasions. The children are provided with eggs once a week. Chicken or mutton is prepared once a month.

A comprehensive internal study of the programme with special reference to children under the education programme and nutritional intake was undertaken. The following were the important findings :

Programme	Calories		Protein		Vitamin-A		Iron		Cost per day (Rs.) per child
	planned intake %	present intake %	Planned intake %	Present intake%	Planned intake %	Present intake %	Planned intake %	Present intake %	
Balwadi	50	62	50	96	75	21	50	67	1 64
Full-time-Primary	50	23	50	52	75	14	50	38	1 48
Supplementary-Primary	25	13	25	26	35	45	25	32	0.60
Supplementary-Secondary	25	16	25	20	35	2	25	24	0.83
Hostel	100	127	100	178	100	23	100	61	8.73

The planned intake was a proportion of the nutritional requirement of the children for different age groups, proposed to be met through the programme and the present intake was a calculation of the actual nutritive value derived from the food supplied under the programme. The figures for cost included cost of ingredients required to prepare the food and excluded apportioned salaries of cooks and other general overheads. This exercise was based on a sample menu of one working week of 6 days. The study has enabled the department to plan the menu such that the actual nutritional intake is closer to the planned intake.

The food supplied is prepared in 6 kitchens located near the schools. One of these cater to the requirements of the old aged people.

The funds for this programme come from sponsorship amounts of the education department and from specific provisions under schemes funded by SKIP (Switzerland), DWHH (Germany) and caring for people (U.K.).

FOSTER FAMILY PROGRAMME.

This programme cares for children who have been abandoned or are in danger. We accept children who are saved from female infanticide or have been found on a roadside left to their own devices. Children who have lost both parents are also welcomed as well as those from single parent families whose remaining parent finds it impossible to care for them. They are entrusted to a widow or a virtual widow who is still young enough to wish to care for children and who has proved that she has the right qualities and motivation to accept these most deprived of children. We now have 98 children with 23 "mothers", each family group in its own house.

Of these 7 are foundlings left on the roadside, 6 have been saved from female infanticide, 13 are orphans and 6 are handicapped children. In the past 12 months 38 new children have been taken into the foster families and six new "mothers". Two of the older girls have started work in our handloom workshops and are doing well. During the year, 5 new houses had to be built to accomodate the influx of children and another water source had to be identified as the one existing supply was now not sufficient. A new water tower was built with a 5,000 litre capacity and this feeds into half of the houses.

A small library was started. More books are needed and would be a welcome gift for the children. The playground equipment was added to and an aviary for small birds is now happily alive. Once again we had a visit from our friends of SKIP in Switzerland who have been funding this project for some years. Sadly, they have decided to stop further funding. We must now look for another organisation which will help us with finance from 1992 onwards. We are deeply grateful to SKIP and, in particular, to Mrs. Meinberger for all their help.

One of the most outstanding achievements this year of reporting has been the full scale and deep evaluation that was done by Mr & Mrs. Rosario from Bangalore. With their own wide experience, a good study was made of the programme and suggestions have been made and accepted, which are now being followed up.

Another outstanding event of great happiness to all of us was the marriage of the very first child to be admitted to the foster mother project, It was because of her and her sisters and brother that the whole conception of foster-families originated. The marriage took place in our own chapel amidst much happiness.

Each child from the day it arrives into our care, no matter how young, is given a personal bank account. Over the years this savings account accumulated to a considerable sum and during the year, we invested the accrued amounts from the accounts of those who have been with us for more than a year into Unit Trust of India's Children's Gift Growth Fund. These sums cannot be touched by anyone until the child reaches the age of 18 and then, only the account holder can take the money. Thus the child will be assured of a handsome sum of money with which to start out life on its own when the time comes for this. The "mothers" receive training in dress making and at the annual sale of work in Kodaikanal in which RTU always participates, their products raised around Rs. 950. This is just a beginning and we hope that sales will increase.

The Foster-Mothers' Sangam has been running well since its inception and the mothers have their monthly meetings to sort out their own problems and to make decisions relating to their work. This same sangam has its own Credit Union and to date has a sum of Rs 13,930 in its account.

The whole compound of this home for children, called Anbu Illam, Place of Love, is now full of flowering trees and shrubs, carefully maintained by the families. Each family is also responsible for the care of one coconut tree on the playground.

We are deeply grateful to the many visitors who have encouraged us during the year and for the gifts that are given for this beautiful work among the poor.

RURAL HOUSING PROGRAMME

The main concentration of this programme was on group housing schemes. Individual (sundry) houses, campus buildings and works and construction activities for other groups and organisations were the additional works taken up during the year.

304 houses were constructed, of which 295 houses were in group settlements in the villages of Sathakoilpatti (95), Kannimarkoilpatti (59) and Kailasapatti (141) The other houses were constructed in the surrounding villages including Kallupatti and Ganguvarpatti. A meeting hall and a threshing floor were constructed in each of the 3 group settlements. 19 houses in Kallupatti and Ganguvarpatti were re-roofed. A new dimension to the programme was added by taking up construction of toilets, which is likely to gain significance in the local villages. The tally of the number of houses constructed in the villages as at the end of March 1991 stands at 2,455.

The construction measures taken up in the RTU campus consisted of 4 staff quarters, 5 houses for foster families, classroom extensions to the two primary schools, clinic building for the Ammapatti project, a weaving shed for the handloom unit, a workshed, a store room and water tanks for the tile making unit and other miscellaneous works.

RTU provided a clinic building for a group of nuns in Kavirayapuram and reconstructed the building for Anbu Illam (a Madurai based voluntary agency) by arranging for the funds required. An in-patient ward and staff quarters for Arogya Agam (a voluntary agency based in Andipatti) and a school building for a school run by the Presentation Convent sisters in Theni were the other works executed.

A rigorous system of identification and selection of beneficiaries from the socially and economically backward sections in the villages preceded the actual construction activity. Initial meetings were held to arrive at an agreement of understanding between the beneficiary groups and RTU on their respective roles and responsibilities. These were followed by fortnightly meetings to ensure smooth implementation of the programme. Digging of soak pits for draining waste water from the bathrooms, tree plantation and levelling of paths and lanes within the settlement were integral components of the programme. The average cost of a 289 square feet house with a cattleshed and bathroom in the local villages was around Rs. 9 000, while for those in the outreach villages, it was in the range of Rs 10,500 to Rs. 11,000.

Minor changes in the construction of houses were made as part of a continuing effort to modify and improve. Brick support pillars on the verandahs were replaced by cement pipes packed with cement mortar, which are stronger and more lasting and result in some saving of space. Complete window frames replaced two wooden supports for the windows to make it stronger. White (fibre concrete) tiles were used in a big way as roofing material. 92 houses, 2 meeting halls, a weaving shed and workshed and store room for the tile making unit were roofed with these tiles.

A significant development during the year was financial collaboration between RTU and the government in the implementation of a housing programme for 150 members of the Rani Mangammal Mahalir Mandram, an association of women from socially and economically backward groups, in the village of Pottapanayur, about

15 kms. from Madurai. This is a resettlement programme for the members of the association, a substantial share of whose earnings is currently being spent on house rents in and around Madurai city. The average cost of a house is estimated in the range of Rs. 15,000 to Rs. 16,000, of which Rs 8,500 was the Government's (Tamil Nadu Co-operative Housing Federation) share and Rs. 500 was contributed by the beneficiaries for each house. The balance amount was arranged by RTU, which also took the responsibility of execution of the work. Since the house sites were located on a tank bed, the work was extremely challenging. It had to be ensured that the foundation was strong enough to protect the house from the shifting clay soil in the dry seasons.

An association of the construction workers was promoted in September 1990. 85 workers enrolled themselves as members and started saving regularly. An amount of Rs 35,000 was collected as savings, which is managed by a committee of 7 members, nominated from among themselves. The contractors too started savings and collected Rs. 35,000. This amount is used to give loans to one or two contractors at a time to purchase materials in bulk and thus save on costs. This has obviated the need for RTU to give loans from its own funds. This will also enable them to pay compensation to RTU in case of incomplete contracts.

The staff attended four seminars on low cost housing conducted by the National Building Organisation, Madras and participated in seminars conducted by the Gandhigram Rural Institute (GRI) on rural technology. RTU is currently finalising with GRI plans to collaborate in civil construction works using low cost building technology for its campus works Visits were made to the ASSEFA project and to Trivandrum to see the houses constructed by Mr. Laurie Baker (a noted architect) by the staff to get themselves exposed to other initiatives in the field of low cost housing.

DWHH (Germany) was the largest supporter of this programme, in addition to which funds were also received from DCF (Denmark), RTU (U.K.), Weyer Trust (Germany), Mr. Michael Kimpton (U.K.), Mr. David Cassidy (U.K.), Caring for People (U.K.), Miriam Dean Trust (U.K.), De La Salle Brothers (U.K.), St. Augustine's (Coatbridge, Scotland) and others.

WATER DEVELOPMENT PROGRAMME

RTU continued to receive requests from the villages of Dindigul Quaid-E-Milleth District for taking up water development in remote villages. The main purpose of this programme was to ensure that water for domestic use, especially drinking, is made accessible to the rural masses. Efforts were made to ensure that one handpump was installed for about 50 families in the villages where this programme was taken up.

A total of 104 bores were drilled and handpumps installed at 96 points where water was struck. The entire divining work was done by Bro. Kimpton. The success rate in divining during this period was 92%. With this, the total number of handpumps installed by RTU is 742. An estimated 44,000 people benefitted under this programme Batlagundu was the nearest Panchayat Union where this programme was taken up, the farthest being the Palani Union. The farthest village where this programme was taken up was in Palani Union, at a distance of about 130 kilometres from the project campus. The following are the details of work executed .

Name of the Union	Completed water supplies	No. of people benefitted
Periyakulam	8	3 600
Batlagundu	16	7,250
Nilakottai	14	6,450
Kodaikanal	8	3,300
Sanarpatti	9	4,000
Gujiliamparai	13	6,250
Palani	7	3,450
Authoor	10	4,850
Vedasandur	8	3 500
Ottanchattiram	2	900
Dindigul	1	500
	96	44,050

The identification of villages for this programme was done by the District Collectorate. The need for handpumps in these villages was ascertained by RTU at the time of divining. It was ensured that the benefits of this programme reached the socially backward groups, which often faced problems of accessibility to a source of water even if it was available in the village. The panchayat unions provided transport and hospitality during divining. For drilling, rigs were hired on a contract basis. A team of mechanics, fitters and masons went around installing handpumps and constructing platforms. The usual time taken for completing the work from divining to installation and construction of platform was one week, at a cost of under Rs. 10,000 per completed water supply.

In addition, the programme also covered projects catering to the need for water supplies. The following is a brief account of such projects :

1) The well in the foster families' locality was deepened and a tank with a capacity of storing 5,000 litres of water was installed. Pipelines were also laid This has benefitted 22 families living in the locality.

2) 2 borewells were drilled for a Kallar (backward caste) high school in a village called Vilampatti. One of the borewells was fitted with a compressor motor with which water was pumped to a tank constructed for this purpose. Pipelines were laid to supply drinking water. On the other borewell, a handpump was installed. This has benefitted 800 students of the school.

3) A borewell was fitted with a compressor motor and a water tank constructed and pipelines fitted for supplying drinking water to the 500 children of the Nirmala supplementary school and balwadi.

4) 2 borewells were drilled for a girls' high school in a village called Chatrapatti, which is run by a voluntary organisation, the Gandhiji Seva Sangam. One of the bore wells was fitted with a compressor motor with pipelines for water supplies. The other bore was fitted with a handpump. This has benefitted about 1,000 students of this school.

The new programme taken up during the year was a training course for handpump maintenance for village youths. It was realised that the programme could be sustained in the villages only if there was a mechanism for handpump maintenance to ensure continued water availability. While the government has a system for maintenance of handpumps, timely maintenance is difficult and often impossible because of lack of adequate manpower and large areas to be covered. The problem is more acute in remote villages This training aimed at providing basic skills at the village level so that their dependence on outsiders could be reduced and that, in that sense, a certain measure of self reliance at the village level could be developed Since the cost of routine maintenance is low, the finances could be arranged for by the village itself through a system of contribution. A course was developed such that this training could be imparted in 3 to 5 days' time Theoretical lessons and practical sessions were arranged for the participants.

At the end of the course, each participant was given a set of reference notes which could be easily referred to. It was suggested that there should be two participants from each village. Two such trainings were held, one in the month of April for the villages of Batlagundu union and the other in the month of June for the Periyakulam union. A total of 30 participants from 15 villages attended the training. It is proposed to develop this programme further and offer this to other voluntary organisations who may be interested in their project area villages to be benefitted.

DWHH (Germany) was the largest supporter of this programme. British Society of Dowsers (U.K.), DCF (Denmark), Weyer Trust (Germany), Miriam Dean Trust (U.K.) were the other major groups who funded this programme.

ST. JOSEPH'S INDUSTRIES

This is the major income and employment generation unit of RTU, consisting of the handloom and batik sections. The handloom unit is primarily for employment generation for women, while the batik section was started as a rehabilitation centre for cured leprosy patients who are physically handicapped. The details of this unit are as under :

No. of looms : 66 No. of winding machines : 31

No. of people employed :	Handloom	— Men	5	Total ... 104
		— Women	99	
	Batik	— Men	6	Total ... 8
		— Women	2	

Handloom section	... Local Sales	... Rs.	1,173,523	
	Exports	... Rs.	217,751	
	Total sales	... Rs.	1,391,274	... (a)
Batik section	... Local sales	... Rs.	127,939	
	Exports	... Rs.	247,900	
	Total Sales	... Rs.	375,839	... (b)
Combined turnover	... (a) + (b)	... Rs.	1,767,113	

The average monthly turnover registered a 5% increase over that for the previous reporting period. The exports of handloom goods was less than that in the previous year. However, in the batik section, a healthy growth was registered with exports accounting for two-thirds of the turnover. This was a very encouraging sign since, in the previous year, there was a plan to shut down the batik section because of lack of orders.

During the year, a new weaving shed was constructed and 10 additional looms were installed. This provided an opportunity for diversification of handloom products. Lungies (loin cloth), mini jacquard towels and napkins and pillow covers were some of the new items produced. New designs for other products were also developed. In the batik section, sarees were made using the tie & dye printing technique.

In terms of marketing also, there were some positive developments. New groups like Almas–India, Madras and Victoria Technical Institute, Madras were identified for domestic and consignment sales respectively, in addition to three other outlets for consignment sales. A commission agent was also appointed for promoting local sales. Regular orders were forthcoming from MESH (New Delhi), Cottage Craft (Kodaikanal), Kriya Boutique (Pondicherry), CODES (Vellore), Asha Handicrafts (Madras) and others A substantial quantity of handloom goods was sold through the wholesaler in Madurai, Messrs. Christo Textiles. On the export front, orders were received from Oxfam Trading (U.K.) and Unravel Mills (U.K.) through SIPA, Madras, a federation of producer associations, of which RTU is a member. A substantial order for batiks was placed by OS3 (Switzerland) for the first time, which was routed through SIPA. A few overseas buyers from Germany and Australia also made enquiries and

placed sample orders A show room for retail sales was started in the campus in the later part of 1990. This has facilitated direct sales of products locally from the campus itself. This show room is also used as an outlet to promote sales of the products of the boys' and girls' trade school and the handwork items prepared by the foster mothers.

On May 1, 1990, on the occasion of Labour Day, the handloom and batik workers formed a Welfare Association, continuing the credit activity which they had started in the previous year However, this association has sought to be more broad based in terms of its objectives and scope of activities. During this year, the activities promoted by this association were savings linked credit scheme, fair price shop and literacy. The following are some details regarding the association :

Savings linked credit scheme :

Numbers of members	:	101
Membership fees collected	:	Rs 1,122
Savings collected	:	Rs. 11,538
Credit disbursed during the year	:	Rs. 78,900
Repayment of credit	:	Rs. 54,994

Fair price shop :

Initial deposit	:	Rs. 8,000
Turnover	:	Rs. 9,827

Literacy :

No. of participants	:	50
No. of teachers	:	3

The functioning of the association is supervised by an 11 member executive committee, which in turn has 3 office bearers selected from among themselves- President, Vice-President and Secretary cum Treasurer. The committee meets every month, while the general body meeting is held quarterly. The savings and credit scheme and the fair price shop are managed by a woman member who is paid for her services by the association under the supervision of the committee. In December 1990, the association declared a Re. 1 bonus per member from the distributable profits of the association.

This association is also used as a forum for discussing issues related to the department between the supervisory staff and the workers. Quality of production and productivity are issues invariably discussed in these meetings. To encourage productivity, for the first time since its inception, the unit declared a bonus to the workers at a rate of 8% of their wage earnings during the year 1990. It was very encouraging to see most of them receiving bonus in the range of Rs. 150 to Rs. 200 In addition, productivity awards were given to three workers each from three different categories of handloom workers (a total of 9 awards). It is expected that these measures would go a long way in boosting the morale of the workers and improving their well being

During the year, an amount of Rs. 82,000 was received as export incentive. Of this, an amount of Rs. 43,400 has been distributed to the workers in form of allocation for various activities of the association and bonus.

AGRICULTURE

This is a programme for internal revenue generation, expected to finance programmes such as medical and education in future. The gross revenue from sale of farm products was Rs. 369,640, the break-up of which was as under :

Particulars	Quantity	Amount	Amount
Farm :			
Coconut	8.1 4 nos.	13,817	
Coconut seedlings	5,748 nos.	37,247	
Cotton	1,340 Kg.	15,614	
Flowers	334 Kg	5,993	
Banana & Leaves	1,975 bundles	36 203	
Vegetables	6,040 Kg.	22,227	
Tomato	260 baskets	2 939	
Goat	—	400	
Meat	15 Kg.	465	
Sheep	2 nos.	3,797	
			138,702
Dairy :			
Milk	7 647 Lts.	33,053	
Cow dung	—	2,100	
Sale of cow	1 no.	2,000	
Sale of calf	1 no.	1,230	
			38 383
Poultry :			
Sale of chicken	12,653 Kg.	192,555	192 555
TOTAL			369,640

The monthly average gross revenue was about Rs 30,800, which meant an increase of more than 30% over that in the previous year. This was inspite of the fact that the rainfall in the area during the year was less than normal, resulting in lower yields and lower offtake of coconut seedlings.

A significant development was the purchase of an 8.5 acres farm adjoining to the present one in March 1991. with the financial assistance of DWHH. In addition to increasing revenues, it is also expected to cut down on costs due to economies of scale. Three bores were drilled for irrigation purposes of which two were successful. 2 compressor motors were installed to draw water from the bores, while the open well on the farm was fitted with an electric motor.

An additional poultry shed for 1,000 birds was constructed. With this, there are 6 poultry sheds.

The dairy farm with 6 cows, 7 calves and 2 bullocks, which was located in the project campus, was shifted to the farm early in 1991, to enable better supervision.

Plantation of 2,000 casuarina trees was done along the bunds in the farm. Production of thatch for sale was started with the increasing availability of dried palm leaves, A sheep rearing scheme which was started in mid-1990, was discontinued after about three months since it was not viable.

With the farm activities being labour intensive, the number of people working on daily wage basis regularly rose to 30 in the current year from 20 during the previous year, in addition to the permanent staff. The wages paid were in the range of Rs 10 to 16 per day.

Some of the farm workers started a savings scheme by contributing a certain amount each week. 11 workers saved to the tune of Rs. 4,000 during the year.

Many farmers from the area visited the farm to seek technical advice on cropping methods and use of agricultural inputs, especially pertaining to coconut plantation.

TILE MAKING UNIT

The tile making unit is involved in manufacturing fibre concrete tiles. The inputs for making these tiles consist of cement, sand, coconut fibre and water. The tiles are white in colour, bigger than the conventional clay tiles and lighter in weight too. These tiles cause the room to be brighter and cooler. RTU has been a pioneer inthe introduction of these rather unconventional tiles in this area. It is gradually gaining acceptance as an alternative roofing material. For RTU, it is also developing into an important income and employment generation programme.

This unit initially started with one vibrating machine. Towards the end of 1990, two more machines were added to the unit which were donated by the Weyer Trust (Germany) and supplied by Parry Associates, U. K.. One of these two additional machines became operational from January 1991 onwards and the other is likely to be operational later in 1991. With two machines operating, the daily average production has gone up to 540. The employment generation capacity has gone up to 24 daily wage earners, mostly women.

During the year, a total of 102,800 tiles were produced. In March 1991, the manufacture of ridge tiles and glass tiles were taken up on an experimental basis and has proved to be successful.

In terms of infrastructure also, there were some developments. A new work shed was constructed for the two new machines. A new store room was constructed for storing cement and other inputs. 5 new water tanks for curing the tiles were constructed Wooden boxes to enable transportation with minimum breakage were made

Of the total production during the year, tiles worth nearly Rs. 104,000 were used under RTU's rural housing programme and for various other works in the campus. Since February 1991, tiles were sold to private parties, which accounted for a gross revenue of Rs 8,500. With the popularity of these tiles increasing in the area, the sale of tiles to private parties is expected to grow in future. This has also been a useful source of feedback on the quality and utility of these tiles.

An exercise in costing and pricing of these tiles was taken up in January 1991 to enable better planning and formulating a pricing policy. This can now form the basis for cost and price revisions in future

The people working in the tiles making unit started savings and credit activity from February 1991 onwards. The group collected a savings of Rs 1,400 from its members, out of which it gave credit of Rs. 700 to its members.

AMMAPATTI

The Ammapatti project is a branch project of RTU, located about 35 Kms from G. Kallupatti. It is an integrated development project working in 13 villages, involved in community health, education and community development activities.

Community Health : The health team consisting of para-medical workers and a part-time doctor, cater to a large number of outpatient cases, the total number of which was 59.786 during the year. These mainly consisted of a variety, of primary ailments Treatment was dispensed through a clinic in Ammpatti in the mornings, which was rebuilt during the year to make it more spacious and enable unrestricted work While most of the patients came from the local villages, many cases of people coming from as far as 30 kms. away were also recorded, an indication of the credibility of the health services provided. The average number of cases per day which was about 200 in April, 1990, rose to about 350 in March 1991.

Under ante-natal care, 100 cases of pregnant women were registered, most of whom registered themselves by the fifth month of pregnancy. 67 deliveries including one premature delivery and 2 abortions were recorded. Due to lack of health services in the area, many deliveries, including complicated ones, were conducted by the health staff. The immunisation status of infants was monitored regularly in co-ordination with the government health staff. The vaccinations were provided by the government while the health staff motivated the mothers to get their children immunised.

Afternoons were devoted to village visits which had to be undertaken on foot by the health staff due to inaccessibility of villages and constraints of vehicle availability. Weighing, monitoring the nutritional status and providing supplementary nutrition packets to severely malnourished children under five years of age were the main activities taken up during the visits. On an average, there were 442 children on record each month. The weight of each child was taken monthly and the parents advised suitably on the health of the child. 42 children on an average each month were taken on under special care and provided with nutritional supplements.

Visits to the villages also enable the health staff to educate people on basic health care, hygiene and sanitation. Each village was visited 4 or 5 times during a month.

The day-care centre in Ammapatti functioned under the supervision of the health staff to provide care to severely malnourished children under the age of three. There were, on an average, 27 children in the centre at any given point in time. They were fed on a special nutritional diet from the centre, where they were looked after during the day.

There were 9 female village health workers, one for each village, who were from the respective village itself and were trained in primary health care by the project. Fortnightly review meetings were held, during which sharing sessions were conducted and skills and awareness upgraded through slide shows and discussions. Medicine stocks were supplied to the health workers to be supplied in their respective villages when needed.

Treatment of leprosy and tuberculosis (TB) were given special attention. This also involved health education, especially in case of TB which is highly infectious, to reduce its prevalence. Intensive door-to-door surveys were conducted in the project villages to identify leprosy and TB patients and motivate them to take treatment. The statistics of these cases were as under :

	LEPROSY	TB
Number of patients on record as on 1—4—90	54	93
Number of new patients added during the year	22	56
Total number of cases under treatment	76	149
Number of patients declared cured	22	42
Number of patients died	—	1
Number of patients discontinued treatment	13	43
Number of patients on record as on 31—3—91	41	63

Films were used to educate the people on health issues such as common ailments, child care, prevention and cure of diseases etc. 7 film shows were conducted during the year.

An eye camp was organised in September 1990, which was conducted by the Aravind Eye Hospital, Theni. Over 300 cases of visual defects of various kinds were examined and some operated.

The laboratory attached to the clinic provided useful support service in diagnosis of ailments. The test conducted by the lab included blood, stool, urine, ESR, sputum and smear tests. A total of 6,192 tests were conducted during the year by the lab technician.

Education :

The education programme consisted of three components – balwadi (pre–primary), supplementary school and non–formal education.

The balwadi in Ammapatti had 40 students – 22 boys and 18 girls in the age group 3 to 5. There were 4 drop outs during the year. The average attendance was in the range of 90% to 95%. In June 1990, at the commencement of the academic year the first batch of 23 students from the previous set were enrolled in the government primary school in the neighbouring village of Ammapuram, on their attaining the age of 5 The daily routine in the balwadi included imparting pre–literacy and pre–numeracy skills, songs, games and story telling. Nutrition of the children was given due importance and the children were provided with breakfast and lunch. The health staff attended to the medical check–up of these children and followed up the treatment required.

A supplementary school was started in July 1990 in Ammapuram for children in the standard 1 to 5 category. This school operated from the government school premises. The students of standards 1 to 3 attended the morning session and those of standards 4 and 5 attended the evening session. Supplementary nutrition was provided in the form of breakfast for the morning session students after the classes and snacks for the evening session students before the classes. In addition to coaching in academics, the students were involved in extra–curricular activities like games, quiz and social work. In its first year of existence, this school met with a very good response from the students and their parents alike. 125 boys and 77 girls (a total of 202) were enrolled in the school at the end of the period under report. There were 7 drop–outs during the year, registering thus, a retention rate of 97%.

The non–formal education (NFE) classes were conducted for non–school going children and adolescents and school drop–outs who were illiterate or semi–literate in the age group of 6 to 20, and included both males and females. The number of students in each NFE class was in the range of 15 to 30. The NFE classes were operational in 8 villages during the year – Ammapatti, Ammapuram, Kendikaranpatti, Vadapudupatti, Sokkathevanpatti, Meenakshipuram, Sakkaraipatti and Savadipatti. Of these the programme was discontinued in Ammapuram and Vadapudupatti villages in May and November 1990 respectively, while it was introduced in Meenakshipuram in August 1990 and in Sakkaraipatti and Savadipatti in October 1990.

The NFE classes were conducted late in the evenings or at nights at a public place which could be a school, a temple or a community hall, by a village animator who was a reasonably educated youth from the respective village with an aptitude for teaching. The course covered topics on literacy, numeracy and generel awareness. The participants were also involved in games and social work programmes. The following are the figures of average attendance in the NFE classes :

Village	Percentage attendance	
	Male	Female
Ammapatti	78	60
Kendikaranpatti	69	62
Sokkathevanpatti	59	38
Meenakshipuram	—	80
Sakkaraipatti	80	78
Savadipatti	88	75

Community Development :

This programme which had earlier been implemented only in Ammapatti with the formation and registration of a youth sangam in 1989, was extended to Sokkathevanpatti and Kendikaranpatti villages In both these villages. youth sangams were formed and registered in February 1991. A sangam was also formed in Savadipatti village in March 1991. The sangam members met regularly to discuss issues of common interest and mobilise people to approach the local authorities and avail benefits under government programmes. Some social work programmes like clearing village roads and clearing the government hospital premises, were taken up. The membership in each of these sangams was as under :

Village	Sangam membership
Ammapatti	70
Sokkathevanpatti	60
Kendikaranpatti	35
Savadipatti	25

During the year, the campus infrastructure was upgraded to facilitate the working of the team. The post of Programme Assistant was created to handle the education and community development programmes, under the overall supervision of the Programme Co-ordinator. Necessary administrative and technical support was provided by the staff in Kallupatti, when required.

In a significant development with positive long term implications, Action Aid, the Bangalore based donor agency, agreed to take over the management of the project including funding as a principal donor from July 1991 onwards, with the status of a large project initiative (LPI) and sponsorship based funding. This is expected to lead to horizontal and vertical expansion of the activities of the project, with an important addition of income generation and agriculture activities. A certain degree of change in policies related to programme design and implementation is also envisaged to make the programme more development oriented.

ADMINISTRATION

Co-ordination among the various departments and groups within the organisation, high level of motivation and morale among the staff, proper implementation of administrative and financial systems and staff development were the important concerns of the project administration. Efforts were made to ensure that the administration was dynamic and flexible to make it more responsive to changing circumstances This was with the realisation that a strong administration could greatly influence the quality of programme implementation

Monthly meetings of heads of departments were held on a regular basis to share information and decide on important issues related to the organisation as a whole. Each department convened interdepartmental committe (IDC) meetings quarterly to discuss policies and issues pertaining to a particular programme. An IDC for each department is constituted by the head of the respective department, two or three heads of other related departments, the Director and the Assistant Director. A system of internal auditing was introduced for each department towards the end of 1990 One of the heads of departments who was also a member of an IDC for a particular department (other than the one of which he is the head) was selected as an internal auditor for that department. Internal auditing was taken up on a quarterly basis from December 1990 onwards, which also focussed on the implementation of programmes. RTU's auditor, Mr. K. Shivakumar, conducted a seminar on internal auditing for the internal auditors to introduce them to the basic priniciples of internal auditing.

Two staff development programmes were held in June and December 1990 respectively, with about 60 participants in each programme from different departments, which also included the junior staff. This gave the participants an opportunity to explain to the group the programmes of their respective departments and discuss socio-economic issues which they encounter in their daily work. Issues like leadership and team work were also discussed and debated.

Heads of departments and departmental assistants were involved in a three-year planning exercise for the period 1991—93. This gave them an opportunity to reflect on the past programmes, conceptualise and sharpen their own planning skills. This was taken up during the last quarter of 1990. Based on this, the plan of implementation for 1991 was drawn up

A system of one day retreats for heads of departments was started on an experimental basis to give them a chance to take time off from their routine work and indulge in reading and reflection on matters pertaining to RTU's programmes. This was followed up by presentations in monthly meetings to develop their articulation skills and enable them to share their ideas with the others. It is also proposed to involve the departmental assistants in such retreats in future.

The new service conditions for staff came into effect from January 1991 which was comprehensive. This was aimed at improving the level of job satisfaction and security among the staff and streamlining personnel policies. The system of performance appraisals for staff was modified to make it more constructive and enable free and frank discussion on the working of the group within the departments. These were essentially self-appraisals.

Staff awards were instituted for outstanding performance during the year 1990. The awardees were selected through a process of nominations. 7 awards were presented. The award winners were presented with a certificate and a cash prize of Rs. 250. They were :

Mr, B. Ilango (Education),
Mrs. E. P. Kamatchi (Medical),
Mr. P. Subramaniam (Nutrition),
Mr. T. Raghavan (Education),
Mr. D. Kamaraj (Education),
Mrs. B Bharathi (Education)
Mrs. Jothimani (Foster families).

34 other staff members who were nominated for the awards were presented certificates,

The staff were motivated to form welfare associations to promote their own interests, which included activities like savings and credit. This was outside the purview of the organisation's activities. Four welfare associations were formed. Each of these received a small sum as corpus fund from the staff benefit fund of RTU. These associations were formed in August 1990.

RTU applied for and was granted exemption under Section 80 (G) of the Income Tax Act. This would enable RTU's donors in India to claim tax exemption for the amounts they donate to RTU.

Mr. K. Shivakumar continued as the auditor for RTU. His guidance and advice on financial planning, accounting and administrative systems were of immense value to the society.

To strengthen the society further, RTU enrolled new members who were active in diverse fields of rural development. RTU's association with them is expected to contribute positively to its development,

An important decision of participating actively in the management of Anbu Illam, (a voluntary organisation based in Madurai involved in assisting poor patients coming for treatment to the city hospital) was taken inlate 1990 in association with another voluntary organisation, Arogya Agam. Some staff members from RTU enrolled themselves as members of Anbu Illam and is represented in its executive committee by 4 of its members.

During the course of the year, RTU was visited by representatives of donor agencies, supporting groups, collaborating agencies, government and friends. These included Mrs. Ute Rossing (DWHH), Mr. D.K. Oza (Gandhigram Rural Institute), Mr. Ravi Narayanan and Mr Chris Stocks (Action Aid), Mr. Trevor and Mrs. Val-Dorey (Miriam Dean Trust), Bro. Terence Kay (U.K.) Miss Nelly Bouchardeau (Enfants De L' Univers), Mr Vimalanathan (Oxfam), Mrs. Francoise Meienberger (SKIP), Mr & Mrs Eric. Patton (Salford Housing Association), Mrs. Julie Marie George (Oxfam Bridge), Mr. John Cioffi (Volunteer Eye Surgeons International), Bro. Dominic (Rome), Mr. Panchaksharam (SIPA) and Mr. Manimaran (Collector, Madurai). A television group, CTVC, produced a film on Bro. Kimpton and RTU's activities for the BBC (Channel 4) for which it spent a week with RTU.

The strength of staff in each department as on 31—3—91 was as under :

Department	Full-time Staff	Part-time staff	Total
Accounts & Administration	9	1	10
Community Health & Development	4	—	4
Education	48	26	74
Farm	7	—	7
Foster families	1	—	1
Industries	6	—	6
Medical	13	1	14
Nutrition	9	6	15
Rural Housing	5	—	5
Tiles Unit	3	—	3
Water development	2	—	2
Ammapatti project	19	2	21
Transport	1	—	1
	127	36	163

ART LESSONS
IN ONE OF OUR
SCHOOLS

****

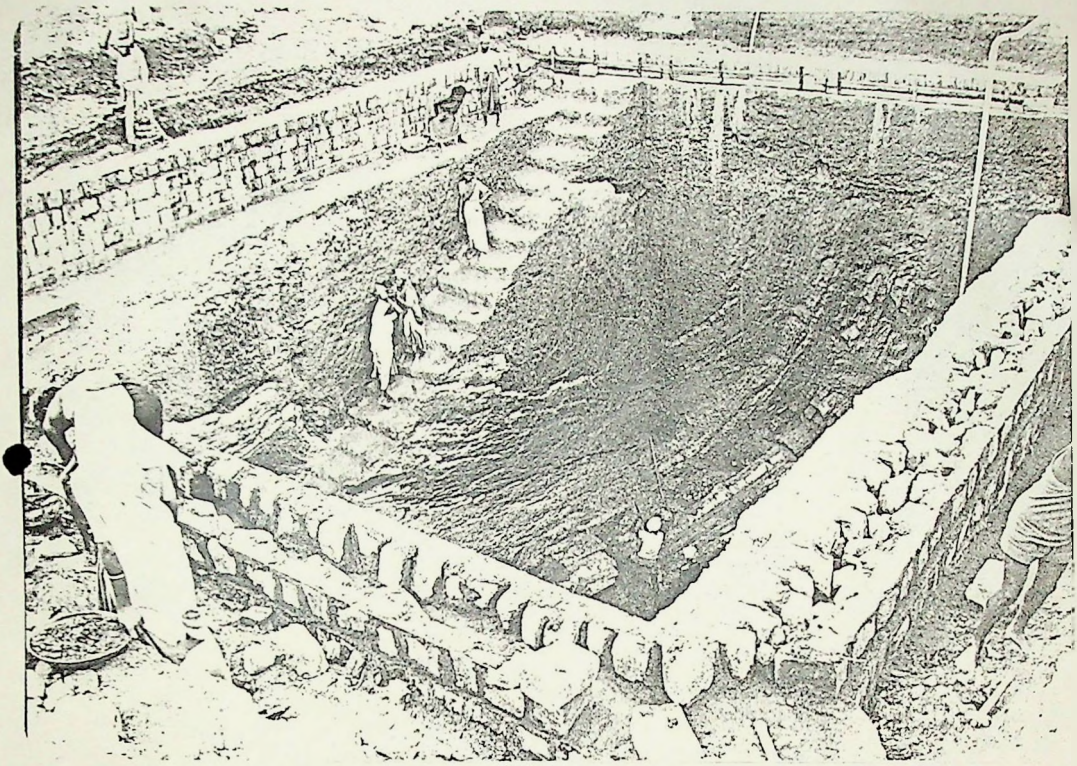
MEDICAL CARE
FOR
THE POOR

CHILDREN IN OUR DAY-CARE CENTRE FOR BABIES

****

A HANDICAPPED BOY HAS POST-OPERATIVE PHYSIOTHERAPY

****

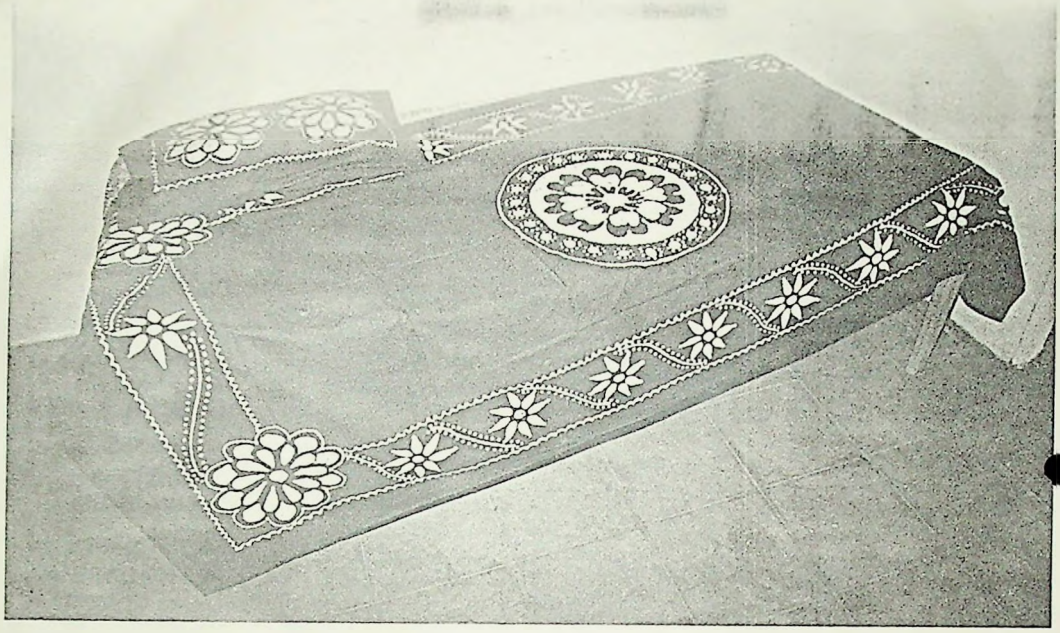


WATER SUPPLIES

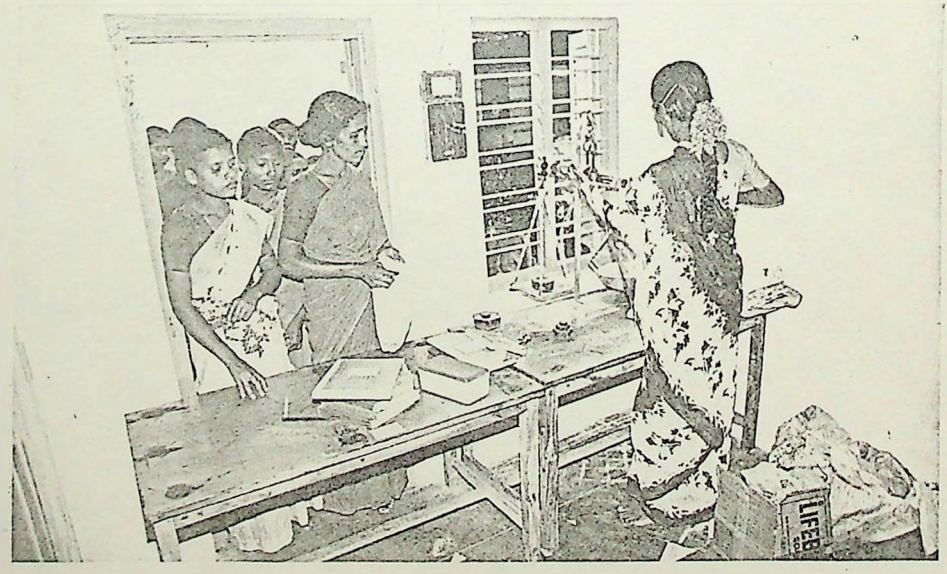
Very large supplies to entire village

and

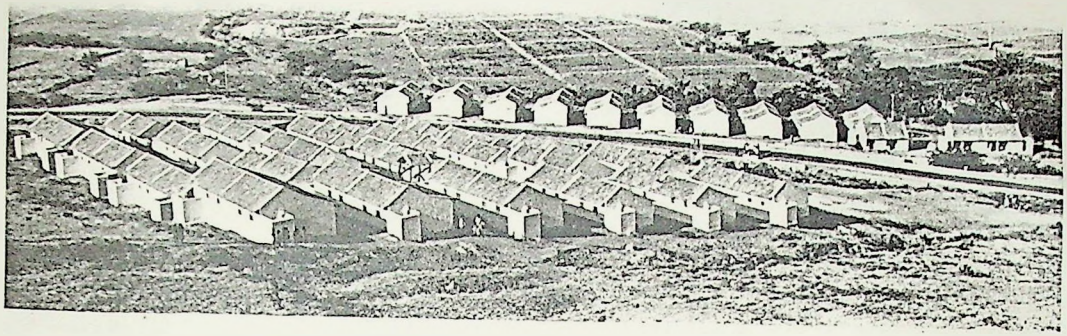
separate handpumps on a deep borewell



ONE OF THE MANY BATIK PRODUCTS



THE FAIR PRICE SHOP RUN BY THE WEAVERS FOR ALL THE STAFF



LOW COST HOUSING

HANDLOOM WEAVING

MEETING OF A WORKERS' COMMITTEE

A TYPICAL FOSTER-FAMILY FOR CHILDREN IN NEED

COMMUNITY HEALTH & DEVELOPMENT: ORGANISING THE PEOPLE TO HELP THEMSELVES

TRANSPORT

Transport is an essential requirement for the implementation of programmes. RTU's fleet of one van, two jeeps, five motorcycles and six mopeds provide useful support services to the various departments.

The van is mostly used for purchasing yarn and other inputs for the handloom and batik products, foodgrains and groceries for the nutrition programme, transporting materials for the water development programme and taking the foster children to school in the nearby town of Batlagundu.

The jeeps are used for the mobile clinic and village visits and for rushing emergency cases to the hospitals.

The motorcycles and mopeds have been allotted to the different departments, depending upon the nature of their work.

The trailer for the jeep was sold during the year as it was not put to much use. The moped allotted to the agriculture department was replaced by a new one.

PROGRAMMES AND ACTIVITIES FOR 1990–91 AT A GLANCE

Programme	Villages covered	No. of beneficiaries	Main activities	Financial outlay (Rs. in '000s)
Medical	25	N.A.	General clinic, tuberculosis, leprosy, antenatal care, mother & child health care, mobile clinic, day care centre, physiotherapy, laboratory.	389
Monetary assistance		198 people	Weekly, monthly cash assistance.	250
Community health and development	7	1,000 families	Village health workers, health education mobile clinic, sangam formation, balwadies.	84
Education and Nutrition	5	1,800 children	Balwadies, primary schools, supplementary schools, trade schools, hostel, scholarship, school meals.	1,383
Foster families	—	23 mothers, 98 children	Care for abandoned/orphaned children and destitute/widowed women.	497

PROGRAMMES AND ACTIVITIES FOR 1990–91 AT A GLANCE

Programme	Villages covered	No. of beneficiaries	Main activities	Financial outlay (Rs. in '000s)
Rural housing	5	304 families	House construction in group settlements, individual houses, campus works.	5,654
Water development	villages in 11 panchayat unions	44,000 people, 2,300 school children	Handpump installation for drinking water in villages, water supplies for rural schools, training in handpump maintenance.	1,121
St. Joseph's Industries	4	112 producers	Handloom weaving, batik printing, development programmes for workers.	1,864
Tile making unit	2	24 producers	Manufacture of fibre concrete tiles.	183
Agriculture	—	—	Farming, dairy, poultry for internal revenue generation.	941
Ammapatti	13	1,250 families	Medical care, community health, education, community development.	486

ACKNOWLEDGEMENTS

We acknowledgement, with deep gratitude, the assistance received from numerous donor agencies and groups, individual donors, friends and well wishers, both financial and otherwise, thanks to which, we have been able to keep up our endeavour of reaching out to the poorest and the most underprivileged. While concluding our report for the period January 1989 to Marh 1990, we would like to mention their names. The following names under the respective classifications, are in an alphabetical order.

Donor Agencies and Groups :

Action Aid, India (H.O. UK.)

British Society of Dowsers, UK.

Caring for People, UK.

Deutsche Welthungerhilfe, Germany.

Friends of Leprosy Patients, USA.

Kodaikanal International School, India.

Les Enfants de L' Univers, France.

Miriam Dean Trust, UK.

Oeuvres Hospitalieres Francaises De L' Ordre De Malte, France.

Oxfam (India) Trust, (H.O. UK.)

The Parishoners of St. Werburgh's Church, Chester, UK.

Reaching the Unreached Trust, UK.

Salford Community Housing Association, UK.

Secoli, Italy.

Stiftung Kinderdorf Pestalozzi, Switzerland.

St. Augustine's Coatbridge, UK.

St. Peter's Old Boys' Association, UK.

St Peter s School, UK.

Swedish Organisation for Individual Relief, Sweden.

Revd. Turner's United Benefice, Hampshire, U.K,

U-Landsfonden, Denmark.

Weyer Trust, Germany.

Individual Donors :

Mrs. Amy Bhabha, India.

Bro. Anthony Cheung, Malaysia.

Bro. Anthony Porter, UK.

Bro. Austin (Oxford), UK.

Mr. Claus Darmstadt, Germany.

Mr. David Cassidy, UK.

Mr. David Lobo, India.

Bro. Dennis Robert and Bro. Walgan, UK.

Bro. Etienne Pierre, France.

Mr. & Mrs. G. Oakshott, UK.

Bro. Henry Pang, Hong Kong.

Mr. & Mrs. J. Mansfield, Wales, UK.

Mrs Jean Brooks UK.

Mr. John Cioffi, USA.

Dr. John Karuppaiah, India.

Mr. John Motha, India

Dr. Kesavamurthy, India

Miss. Keya Ghosh, India

Mr. Michael Kimpton, UK.

Bro. Michael Jacques, Malaysia.

Mr. Michael Piou, France.

Mr. & Mrs. Norman Lindrea, Australia.

Mr. Paul Hooi, Singapore.

Miss. Ria De Meulenaer, Belgium.

Mrs. Sujatha De Magry, India.

Mr. V.C. Arnott, UK.

Mr. Yves Mille, France.

Friends and Well Wishers:

Almas-India, India.

Asha Handicrafts, India.

Canara Bank, G. Thummalapatti, India.

CODES, India.

The Collectorates, Madurai and Dindigul Q. E. M. Districts.

Cottage Craft Shop, India.

Mr.D.K. Oza, Vice-Chancellor, Gandhigram Rural Institute, India.

Mr. John Dalton, Arogya Agam, India.

Sr. Josephine, Presentation Convent, India

Karur Vysya Bank, Batlagundu, India.

Kriya Boutique, India.

Leonard Hospital, Batlagundu India

MESH, India.

Oxfam Bridge, UK and India.

SIPA, India.

State Bank of India, Ganguvarpatti, India.

Trustee Savings Bank, UK.

Victoria Technical Institute, India.

There are many more friends who have been a source of constant encouragement for our work, and it is not possible to name them all. There are also some very special individuals in the donor agencies whose support to our work goes beyond their organisational commitments. We value each one of those who have helped us in realising our objectives. We hope that we will continue to work with them for a long time to come. All of us at Reaching the Unreached join together in extending our best wishes and warm regards to each one of them.

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REACHING THE UNREACHED
G. Kallupatti, Near Batlagundu,
Madurai District - 624 203.
Tamilnadu, INDIA
Phone : 30 Genguvarpatti

28th April, 1992.

Ref: AD/CHD/92/1104

To

Dr. Shirdi Prasad Tekur,
Community Health Cell,
367, Srinivasa Nilaya,
Jakkasandra, I Main I Block,
Koramangala,
BANGALORE - 560 034.

Dear Dr. Tekur,

Thank you for visiting us as scheduled on April 24th and 25th. It was unfortunate that I could not meet you. However, Mr. James informed me about the discussions you had with the staff and people from the village. I hope you had a comfortable stay and that you were facilitated in data and information collection. Mr. James told me that you are in the report finalisation stage. We shall eagerly await the same.

Please find enclosed the first draft of the programme documentation of the Community Health department which is being done by a group called INTERVENTION based in Bangalore as part of the management study of RTU. You may find it useful for the purpose of your report.

With warm regards,

Yours sincerely,

GIRISH MENON,
Assistant Director.

Encl: As above.

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COMMUNITY HEALTH DEPARTMENT

1. BACKGROUND

Bro.James started his work in the Genguvarapatti, Kallupatti and other surrounding villages while he was in Boys' village during the period 1974-1977. RTU was established during 1977 and was operating from a small office at G.Kallupatti. Since its inception, RTU is running a clinic offering health care to villagers. The services included MCH, Immunisation, Leprosy and TB care, treatment of minor ailments etc.,

During 1982, RTU started a health outreach programme in its target villages. Youth Clubs were formed in 3 villages. However, the programme was stopped within few months owing to non-co-operation from the villagers.

During 1983, 6 new villagers were selected. Health Committees were formed and various health programmes were implemented at the village level. Family Health Insurance Cards (Fee: Rs.3 per year) was introduced. The fee was used to support a Village Health Worker. Mahila mandals were also formed in some villages.

During 1984, 9Ø households from 2 villages were assisted under the goat-rearing scheme (as a income generation activity). Each household was given an average of 6 goat kids.

During 1984, Mr.Keith and Ms.Caroline (volunteers from UK) and Mr.Keba (who was involved in the clinic) participated in a training programme on community health conducted by International Nursing Service Association (INSA), Bangalore. Consequent to this training, 8 villages were selected to implement a health outreach programme on a systematic basis.

2. AIM

To improve the health status of the community through effective community health programme

3. OBJECTIVES

> To offer health services at the village level in the selected villages
> To establish health workers at the village level who can provide health services to the community
> To integrate other developmental activities along with health programmes

BANGALORE
APRIL 1992

Pr. at 113Ø Hrs
on 2Ø April 1992

4. STRATEGIES

1. The main strategy used by RTU is to develop a village health worker network in the target villages through identification of a appropriate person and imparting health training.

2. Another strategy is to initiate other developmental activities once the health programme is well established.

The outreach programme envisaged the following activities:

* Village Health Programme
* Health Committees consisting of village leaders
* Training programme on community health
* Provision of medical kit
* Health education

5. PROGRAMMES : GROWTH AND DEVELOPMENT

There are 4 distinct phases in the programme life of Community and Health Department, as follows:

I PHASE : 1982-84

The programme implementation has already been described in the background section.

II PHASE : 1985-86

1985 and 1986 were dull years for this department when not much of activities were undertaken. During 1986, Mr.Keith and Ms.Caroline left RTU resulting in further setback to the programme implementation.

III PHASE : 1987-88

1987

During 1987, Mr.G.James took charge of this programme. Mr.James was with RTU since 1985 (in the clinic). He has a Diploma in Community Health and has also undergone training in Audio-Visual Aids (from Centre for Development and Communication) and in Rural Health Programme (from INSA, Bangalore).

After Mr.James took charge of this programme, out of the 8

villages selected previously, 6 villages were dropped for various reasons. 3 new villages were identified and the programme was implemented in a total of 5 villages. The selection of villages was based on the following criteria:

> Extent of poverty in the village
> Health status
> Population of village (smaller village was preferred for operational convenience)

During this year, there was not much of community participation. Sangha formation was initiated. The health activities included:

* Ante natal care
* Under-five immunisation and growth monitoring
* Health education

The sangha activities included:

* Formation of men and women clubs (registered)
* Regular meetings
* Leadership training
* Regular subscriptions (about Rs.2 per month)

Adult education was initiated but was discontinued within one year due to ineffective planning and implementation.

During this year, the programme staff was only Mr.James who was assisted by 5 village health workers.

1988

During this year, the programme was expanded from 5 to 8 villages. The department recruited 2 more staff and 3 more VHWs.

Non-Formal Education was also initiated to benefit school dropped-out children in the age group of 6-14 years. The programme covered about 3Ø children on an average in 5 villages. 24 households were assisted with credit for rearing buffaloes and 42 households for sheep-rearing. A sheep-rearing society with 42 members in Utchapatti village was formed.

IV PHASE : 1989-Till date

1989

ADMINISTRATION

Girish Menon joined RTU as the Assistant Director who initiated

steps to streamline programme implementation and monitoring systems of all departments including Community Health & Development department.

During the year one more staff was recruited.

PROGRAMMES

Government Benefits:

On the programme side, benefits under various government schemes like Widow-pension, street lights, drinking water taps etc., were mobilised. Noon-meal programme was initiated in a balwadi in one of the village.

Income Generation Programmes:

Another sheep rearing society was formed with 19 members.

Health

Street plays, film-shows etc., were organised in many villages as part of health education. Other health activities were carried out in all the programme villages.

1990

HEALTH

One Balwadi was started at S.Moopanur village. Other health services were carried out in the selected target villages.

Community Organisers' training was organised in which teachers also participated.

INCOME GENERATION ACTIVITIES

Poultry : 2 hen and 1 cock each was provided to 31 beneficiaries as a source of supplementary income.

Rabbit rearing: A new breed of Rabbit called New Zealand white (Meat purpose only) was provided to 2 beneficiaries on an experimental basis as a source of supplementary family income.

Goat rearing : 45 beneficiaries were assisted to purchase goats.

Savings & Credit scheme :

Under this scheme, the sangha members save a prescribed (Rs.5 onwards) every month. Amount is collected and is lent among the

members at a reasonable interest rate.

1 village - 45 members - Rs.15 per month regular saving i.e., Rs.16,2ØØ savings in 2 years + Interest

Kitchen Garden :

Seeds were distributed at 5Ø% cost. In two villages, tree planting was also taken up.

1991

5 more villages were selected.

HEALTH

II phase of health training of VHWs was undertaken

The Leprosy programme was handed over to the government. However, surveillance and monitoring of treatment is being continued.

NON-FORMAL EDUCATION

Non-formal Education (NFE) was introduced in 5 villages. The animators were given training for 3 days. However, no special curriculum is being used.

INCOME GENERATION PROGRAMMES

Poultry - 3Ø families in 5 villages were assisted to purchase 7 poultry birds each which will provide them with supplementary income.

Vocational Training - The women sangham members were given a training in pickle making, vegetable preservation and pappadam making. About 32 women participated in the training programme conducted by Gandhigram.

OTHER PROGRAMMES

Tree Planting - 8 villages was provided with 125Ø tree saplings and seedlings for planting them in the private lands. However,

owing to poor monsoon, more than 6Ø% of the seedlings have been destroyed.

Kitchen Garden - About 158 families in 9 villages were provided with vegetable seeds to be cultivated in the homesteads. The programme met with mixed success.

Puppetry training - A puppetry training was conducted in which about 25 selected individuals from the target villages participated.

Balwadi - In S.Moopanur village, RTU constructed a building to house the Balwadi for which the community contributed 1/3 of the cost.

Afforestation : Though an afforestation programme was planned during the year, the programme could not get off the ground due to lack of motivation among the villagers.

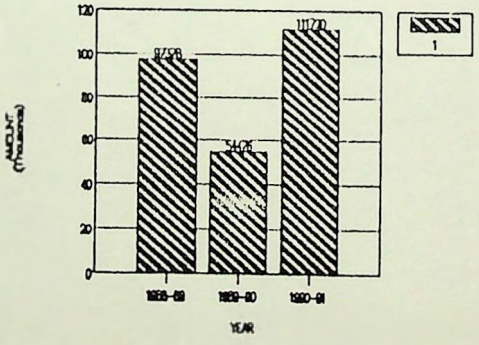
R.T.U

COMMUNITY HEALTH & DEVELOPMENT

SL. NO.	YEAR	AMOUNT
1.	1988-89	97378
2.	1989-90	54476
3.	1990-91	111720
	TOTAL	263574

COMMUNITY HEALTH & DEVELOPMENT

Plan Allocation



51:92 15-07-92

Mr. Amal Susairaj,
Community Health & Development
Programmes,
Reaching The Unreached,
G. Kallupatti,
Near Batlagundu,
Madurai District,
Tamil Nadu - 624 203.

Dear James,

Greetings from Community Health Cell!

Enclosed is a photocopy of experiments on "Eco-restoration" from Rajasthan. Pass it on to Girish and Bro. James too.

This is to enable you to understand the magnitude of involvement, its logistics, and the extensive ground/field information and organisation required for such a venture.

Since such an idea has been conceived by you, it will help you to begin the ground work as you consolidate your health and development program. It will facilitate a well - planned venture in the future.

Hope you and your team have been able to go through the study-evaluation report and initiate some action.

Please keep in touch.

With regards and best wishes to all at RTU,

Yours sincerely,

Shirdi Prasad Tekur,
Member Incharge-Training & Advisory Services.

Encl: paper on eco-laboratories (Xerox copy)

*spt/vnnr

51/92 15th June 1992

Mr. Gibish Menon
Assistant Director,
Reaching the Unreached,
G.Kallupatti,
Near Batlagundu,
Maduari District,
Tamil Nadu 624 203.

Dear Girish,

Greetings from Community Health Cell !

Thank you for your letter alongwith the copies of the report of the Study group from Bangalore.

Below is a list of typographical errors noticed in the printout which you can get corrected in the floppy.

1. Content list page - V. Methodology
   to be added - VI. (d) Health Education
2. Page 1 - 2nd para - last line: stagnation
   - last para -last line: Education
3. Page 2 - last para -10th line: In course of time
4. Page 3 - 1st para - 2nd line: as stated....
5. Page 4 - 2.a) - health
   2.c) - manageable
6. Page 5 - V.b) - 2nd line - Manager....
   B.c) - last line - in relation to.....
7. Page 6 - 1st line - included
8. Page 7 - one line between 1st and 2nd line is missing :
   -- smoke nuisance in the kitchen, since it ~~has~~ was smokeless.....
9. Page 9 - 3rd line - initial
10. Page 10 - 3rd line - of 40 children
    - 2nd para 2nd line - encumbered
    - 2nd para 2nd lastline - tackling
    -- (d) last line - MCH
11. Page 12 - 3rd para 2nd line - harvesting and plantings.
12. Page 13 - 2nd para last line - included
13. Page 14 - 5. 3rd line end - need

The rest of the thing is okay.

With regards and best wishes,

Yours sincerely

Shirdi Prasad Tekur

51:92 08-05-1992

Mr. Girish Menon,
Assistant Director,
Reaching The Unreached,
G.Kallupatti,
Near Batlagundu,
Madurai District,
Tamil Nadu - 624 203.

Dear Girish

Greetings from Community Health Cell!

Enclosed is the finalised report of the study group on the Community Health and Development program of R.T.U. for

- review and correction of any factual inaccuracies;
- seeking of clarifications and elaborations;
- any details required for implement-action in the future.

I am sure the CHD staff will be able to review this and send it to us at the earliest for our signatures, etc.

You may be able to put this on your computer and send copies to the members of the study team.

With regards and best wishes,

Yours sincerely,

Shirdi Prasad Tekur,
Member Incharge-Training & Advisory Services.

Encl:
Finalised report of the study group on the CHD program of RTU.

*spt/vnnr

PARTICIPATORY STUDY

of

COMMUNITY HEALTH AND DEVELOPMENT PROGRAM

of

"REACHING THE UNREACHED"

G. Kallupatti,
Madurai District,
Tamil Nudu.

Study Group

1. Dr. V. Benjamin

2. Dr. G. Gururaj

3. Dr. Shirdi Prasad Tekur

05th March 1992 To 26th April 1992.

Dev 2A - 9

C O N T E N T L I S T

I. SUMMARY

The Community Health and Development (CHD) initiative of 'Reaching The Unreached' (RTU) tries to reach people remote to development through health measures. The Goals are to actively involve people and enable them in improving their quality of life.

Sangams (associations) of men and women is the means and the nucleus of all health and development activities in the eight villages this programme addresses. The Community Health and Development (CHD) programme has gone through a phase of stagnation and re-activation in its evolution.

This study is in response to the need felt by the CHD to know about their evolution, their present status and pointers to the future to help plan ahead to be done by an external resource group. Constraints limit quantitative assessments and the focus is on qualitative and process exploration.

The villages chosen are remote and in need of health and development inputs. Sangams of men and women are operational and function fairly well with limitations due to local circumstances. Village Health Workers are effective in minor-ailment management and are well accepted by the community. The mobile clinic initiative is not cost-effort-effective. Health education effort needs strengthening.

The conclusions of the study point to positive areas of good rapport, credibility and initiative while serving in areas of peoples needs. Numerous activities with small resources, a focus on curative approaches, problems of sangam dynamics and a need for upgrading Health Education efforts are the drawbacks seen.

..2

Recommendations are for focussed activity, putting more efforts into making the sangams far-sighted, involvement of other departments of RTU in the CHD effort, exploring local and other governmental resources and methods of documentation to help the CHD evolve relevant plans for the future.

II. BACKGROUND

The project 'Reaching The Unreached' (RTU) started in the year 1975 and registered in 1978 at G.Kalupatti, Madurai District; it is an attempt to reach people in the remote, unreached areas. The felt need of medical aid in this place led to the starting of a small base clinic facility and a mobile clinic to surrounding areas. This spread into meeting other needs of the people, such as housing, education, water, foster-families for children, income generation programmes and other social welfare measures.

1) ORIGINS

The community health programme started later (in 1982/85) using health as an entry point for overall development of the communities in eight villages of this area. Two volunteers from RTU initiated a process of community organisation. The programme remained stagnant during 1985-86 when these initiators left, and was restarted in 1987 by the present manager of the Community Health Department (CHD). It began with non-formal education incorporating health messages, and slowly evolved into a community health programme. In course of time this transformed into a Community Health and Development (~~CHE~~) ← programme, and the department of CH & D came into existence at RTU. Two community organisers have joined this department over the past two years to help the Manager who has been handling this programme single handed.

2) GOALS AND OBJECTIVES

The goals of this community health and development program

as stated in their progress report are:

TO REACH OUT TO A LARGE NUMBER OF PEOPLE IN DISTANT AND REMOTE VILLAGES AND ENABLE THEM TO IMPROVE THEIR QUALITY AND STANDARD OF LIFE, WITH THEIR ACTIVE INVOLVEMENT, USING HEALTH AS AN ENTRY POINT.

This is aimed at building up of confidence and self-reliance in the villages and to initiate a process of common village development through formation of sangams (associations) of men and women.

III. PURPOSE OF STUDY

Based on a felt need of the community health department of RTU, the present participatory study was undertaken to find out the qualitative impact of the community health program in the eight villages they work in. This participatory study by an external resource group was to see

a) how the community health program evolved;
b) its present status; and
c) to provide guidelines in planning the future.

It is to be specially noted that this participatory interactive exploration of community health and development activities was intended to facilitate the community health department. Hence, this study focussed on community health and not on other activities of RTU. Since baseline benchmark information was not available, a quantitative evaluation study was not feasible. Therefore a process oriented qualitative exploration study was undertaken with minimal emphasis on statistics, survey data, questionnaire, etc. The available periodical reports containing quantitative data have been reviewed. There were also constraints of time - total time for the study being seven days, divided into two blocks of two days and one of three days.

The present study was not focussed on measuring the health status of the community in quantitative terms, but on the process and relevance of community health and development (to enable people understand the importance of the same to improve their quality of life) and hence the methodology adopted.

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IV. EVOLUTION

To chronologically describe the evolution pattern:

1. The earliest activity was the mobile clinic of R.T.U.

2. While pursuing this activity, eight villages were identified for using mainly community health interventions towards overall development. The criteria for selecting these villages were:

   a) lack of any health or development activity;
   b) remoteness from centres of development activities;
   c) being small (population size) and therefore manageable; &
   d) people belonging to predominantly backward and underprivileged sections of society.

☆ Some of the originally selected villages were dropped from the program and others added on depending on CHD assessments and village dynamics.

3. Formation of local Health Committee and selection of Village Health Worker (VHW).

   Formation of village level health committees was preceded by awareness building for health through street theatre and public meetings. This health committee identified a male health worker who was acceptable to the community. These VHWs from eight villages were trained at RTU for a period of 15 days. During 1985-86 the programme was stagnant due to reasons not clearly identifiable. The male health workers stopped pursuing community health activities. In 1987 when it restarted, female village health workers (VHWs) were selected from each of eight villages and given a similar fifteen day training. Guidance and supervision of these VHWs has been continuous and regular since then.

4. Sangam formation:

   Sangams separately for men and women of the village were formed. These sangams were intended to be the hub of all health and development activity. All adults were invited to join the sangams, and those interested joined the same. Some of these sangams are registered and members contribute a fee for common expenditure.

   Sangam members were expected to meet atleast once a month to discuss local issues and to mobilise community support for developmental activities. These sangam activities were

facilitated by the CHD to utilize both Governmental and other resources. They were instrumental in initiating activities in health and also other areas like building of roads, provision of water and electricity, running of balwadis, improving transportation facilities and income generation activities for the community.

V. METHODOLOGY

The present qualitative approach to evaluation consisted of

a) review of available records;
b) discussion with staff at RTU, and field level functionaries;
c) discussion with members of sangam and non sangam members of the villages;
d) observations during field visits; and
e) eliciting opinion from nearby health care delivery agencies.

An elaboration on the above follows:

a) The records reviewed included the annual reports; reports to funding agencies; reviews of past and future plans; mobile clinic records; records at health centres; village registers; training programmes and their curricula; diaries and registers maintained by field staff;
for the type of information and their relevance to ongoing community health activities.

b) Discussions were held at RTU with the Director, Assistant Director, Manager, the two community organisers and staff of medical department of RTU. At the field level, the village health workers, Balwadi teachers and Balwadi staff, Non-formal Education (NFE) animators, traditional birth attendants, and informal focussed discussions with them and the people on their work and attitudes were conducted in a non threatening manner.

c) Sangam members, their office bearers, and non sangam members were also contacted in a similar manner and their views elicited — On CHD and their staff, on sangams and their functioning - in relation to peoples problems.

d) Visits to the village included studying the conditions of housing, water, sanitation, kitchen gardens, nutrition programs at Balwadis, NFE classes and the quality of rapport between CHD staff and community members.

e) An interaction with the Medical Officer and Medical Superintendent at the nearby referral centre at Batlagundu (Leonard Hospital) consisted of identifying local disease patterns, availability of health care services and patterns of utilisation.

The other components studied were library and health education resource materials, VHW's kit, medical stores and other units of RTU including the medical department in relation to CHD activity.

In addition, the CHD staff participated readily and made available existing documents and also co-operated in processing additional information requested by the study team.

VI. RESULTS

The results are presented as a situational analysis at the village level and in the various activities of the organisation.

1. The Villages

The eight villages where the community health department operates are away from the main road, and relatively inaccessible. The population of these villages ranges between 200 to 700. The villages are in two clusters, with a government health centre near each of the clusters, located at Ganguvaripatti and Viralipatti. The government health workers visit these villages mainly for immunisation and family planning activities. Programmes on nutrition are conducted under the Tamilnadu Integrated Nutrition Improvement Programme (TINIP).

In RTU built houses, ventilation is good and there is no smoke nuisance from the kitchen, since it has smokeless chulhas and is built away from the living rooms.

From available data we found that illiteracy is high and ranges between 40 to 95% with a high drop-out rate noticed after the primary level of education. The occupation of the people is mainly as agricultural labour (seasonal) and marginal farmers and shepherds. Most houses are kutcha houses, with one or two rooms, non-electrified and with no toilets. Even though potable water is available, it is inadequate. Most primary schools are within a distance of 2 Kms. Transport and communications are generally available, but inadequate. Balwadis organised by RTU are functioning where not covered by the Integrated Child Development Scheme (ICDS). Most villages do not have a community television, commonly seen in other villages in Tamilnadu.

2. Organisational Activities

a) Sangam

The membership of the sangams in relation to the total village population varies between 10% to 60% with a higher percentage of women being sangam members compared to men.

The percentage of attendance at meetings:
- in Men's meetings - range 54 - 87%
- in Women's meetings - range 51 - 100%.

On an average one meeting per month is held in both mens and womens sangams. However, during harvesting and planting seasons, meetings are irregular.

The sangams have been able to mobilise people to avail various facilities through government schemes in areas of income-generation, roads, electricity, water supply, and obtaining of pensions for widows.

It is to be noted that a major contribution of RTU is in the area of providing housing facilities which has generated great interest and attraction among sangam members. [Sangam leaders are given leadership training at RTU periodically.]

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Some specific achievements as per records are:

1986 - construction of 167 RTU houses } Jagjivan Nagar.
Borewell - one

1987 - 72 RTU houses at Utchapathi

1988 - Distribution of Goats/Buffaloes/Sheep - for income generation;
Establishment of sheep rearing society.

1989 - Total 90 persons benefited from government scheme including

28 pensions for widows/streetlights and water taps/ borewells by RTU/Buffalo loans/Jawahar well-digging loan sanction/Sheep rearing society formation/ Road repairs/Widow daughter's marriage through aid/Community hall construction/formation of prohibition committee against female infanticide/ and Flood control wall construction.

1990 - Bullock and sheep rearing loans/street lights/hut electrification/old age pensions/Credit Union formation/ goats for income generation/tree planting alongside road/ road-repair/link roads/shed repair/soakage pits/ and threshing floors in the villages.

1991 - Sheep rearing loans/bullock cart loans/loans for petty trades/old age pensions/borewells/water-tank with taps/ monthly savings scheme started/threshing floor construction and allotment of house-sites.

Some problems areas:

Apart from minor problems, usually found in human groups, others noted were:

- Leaders becoming corrupt and leading to loss of faith in them;
- Enthusiastic participation from sangams generally peaked when RTV houses were constructed and waned dramatically after the event;
- Internal land and caste factors interfered with sangam activity;
- Traditional caste based elders who managed conflict felt threatened by the new sangam leadership.

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b) Village Health Workers (VHWs)

Village Health Workers selected by the Village Health Committee were women, a majority of whom were illiterate. They were given an initial training in community health for 2 weeks. Subsequent refresher courses and clarifications at periodic meetings are continuing.

The VHWs are mainly involved in minor ailment treatment, assisting at RTU's mobile clinic and helping the government health workers in their health activities. They also are expected to visit 5 families a day and conduct health education.

The VHWs are provided with a kit containing medicines for treating minor ailments, which is utilized to treat 20 to 30 cases on an average every month at a subsidized rate. They also utilize traditional herbal remedies quite confidently on their own initiative. They record the vital events of births and deaths with the help of a literate. An honorarium of Rs.100.00 per month is paid to them and this is given either by RTU or sangams.

We observed that the VHW is well accepted and has a good rapport with the community. A review of the curriculum showed that the contents were far too technical and voluminous to be covered in this short period. Record keeping activity is inadequate due to their illiteracy. Being sangam members, they also participate in all other sangam activities, but are considered by the people as mainly health resource.

c) Mobile Clinic

The mobile clinic operates twice a week, in the afternoons, effectively reaching each of the eight villages once a month. The team consists of the CHD Manager, a community organiser, a person from the medical department and the local VHW. They provide curative services to the whole population, with a focus on Ante and Post-natal care.

The records show that they see an average of 60 patients a year per village, including ANC patients and growth monitoring

of 40 children. Medicines at a subsidized rate are distributed, and Health Education imparted. The schedules of the mobile clinic are very variable, mainly because of dependence on availability of the van for transport of the team.

The health records are minimal, while their work is encumbered by accounting procedures. The records do not provide a clear picture of disease patterns, but discussions with the team and the local referral centre indicated that the common ailments are diarrhoeas, skin diseases, eye diseases and problems of malnutrition. Tuberculosis and leprosy are two common major problems and these are treated with the help of governmental resources. In cholera epidemics in the past, the CHD has been effective in tackling the problem with government and other agencies.

d) Health Education

In addition to health education given by the VHW and at the mobile clinic in a personalized manner, mass health education programmes are conducted on an average of once a month in each of the villages. This is mainly through film shows and slide shows. Street theatre, puppet shows and drama are occasional events. Health Education also forms a component of the training programmes and other meetings at RTU. Film shows are popular with the people.

Records show that the topics covered include - Cooperation, Family Planning, Sanitation and Hygiene, N.F.E., MCH and Nutrition.

VII. CONCLUSIONS

1. The RTU's CHD Department has established a good rapport with the community as well as the government agencies in areas of health and development.
2. The formation and nurture of sangams has enabled the people to begin to understand their health and development problems and also evolve some solutions.

3. A large number of activities have been initiated in a short span of time inspite of meagre resources. Consequently, there has been a blurring of clarity and focus in their well-meaning efforts.

4. Since the selection of villages was based on criteria of poverty and under-development, the approaches and activities of RTU-CHD have been predominantly welfare oriented.

5. The enthusiasm of the sangams seems to plummet as soon as their immediate felt needs are met from external agencies. This seems to blunt the potentiality of their initiatives, in using their own resources.

6. Curative efforts still form a major part of the health programme, while in development, avenues for tapping available resources are being efficiently explored.

7. Cost-effort-effectiveness of mobile clinic is low.

8. The VHW is well accepted by the people and functions effectively in activities alloted to her. However, her inability to maintain effective records, makes it difficult for the CHD to make quantitative assessments of health parameters.

9. Health Education remains largely an effort of the CHD (with its myraid activities and meagre resources) and has not received the attention it deserved.

VIII. RECOMMENDATIONS

To effectively strengthen the ongoing and proposed activities, the following recommendations are made:

1. Community organisation and participation

Sangams have already been formed. This valuable resource needs to be fostered and strengthened with further training/exposure of staff and sangam leadership. Interactions inbetween RTU sangams and others outside is likely to help this process.

The large membership precludes intensive study and understanding of local issues. The suggested corrective is the formation of smaller working groups in each sangam to take up specific issues. Planned training for these groups with the help of expertise will be of help.

Mens and Womens sangams need to meet together in addition to individual sangam meets, atleast twice a year reviewing their activities in the interim period and to evolve better courses of combined action.

Practical solutions to problems of meetings during harvesting and plantings seasons are to be evolved. e.g. the executive committee/working groups could attempt to meet, or (if this is found to be impractical) the meetings at these times are suspended and the frequency increased subsequently.

Long term comprehensive planning on all relevant development issues is to be initiated and followed up by the sangams.

Proper documentation and review of past decisions etc., will re-inforce this process.

Mechanisms for comprehensive feed-back at regular intervals on decisions and proposed actions both at RTU and sangam levels needs to be established.

Greater accountability and mechanisms for the same should be fostered by open exchange of information on resources, plans, activities, and achievements between CHD and sangams at their meetings.

Invitation of local government officials to sangam meetings should be encouraged.

2. <u>Appropriate strategies for health and development</u>

People should be encouraged to utilize government health services more and make them responsive to their needs.

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The cost-effort-effectiveness of the mobile clinics can be improved with alternative approaches like decentralization and transfer of medical stores along with reduction of team-size and upgrading of village resources (VHW and TBA) also utilizing government health resources. This can be implemented in a phased manner.

A prospective time-bound study of the mobile clinic component in terms of

- patient utilization of services from within and outside the specified villages;
- hours/personnel/medicine/transport/costs etc., involved; and
- areas of non-clinic activities facilitated, needs to be included in the future plans.

Where local/traditional herbal medicines are being utilized as alternatives, allopathic drugs provided, may be withdrawn in a phased manner. e.g., Benzyl Benzoate replaced with Turmeric/Neem leaves, for scabies treatment.

Explore alternative sources of energy like bio-gas, solar cookers, solar powered street lights, etc.

Development of simplified recording systems tailored to the needs of the community as explained in the annexure.

The VHW/TBA/NFE animators/Balwadi teachers and their equivalents from government health resources are to meet periodically and evolve ways and means of implementing sangam decisions.

3. Community support for health care

Formation of local working groups on health, consisting of atleast five members each from the mens and womens sangams working together as a team will be an important step.

a) This group will be specially trained to improve health education and will be responsible for monitoring all health activities and also function as an activist group to interact with governmental and other agencies for health.

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b) To explore ways and means of making the community self-supporting in terms of finance and other relevant resources.

4. Health integrated with Development

A health-education component is to be incorporated in all training and other programmes of development both at RTU and at the village level. This is likely to make people more conscious and responsible for their own health.

A contributory health service (CHS) scheme could be linked to income-generation programs. This is intended to promote self-sustenance of health services in the village.

At RTU level, staff from all departments are to be sensitised and oriented towards the importance of C.H. in development and should be encouraged and expected to contribute to C.H. concepts in their areas of work.

As a starting point, the medical department could take responsibility for all curative services, and step into areas of prevention and health promotion in the villages where the community health department is active. All health programs can be jointly planned by these two departments. Similar cooperative efforts can be planned with other departments in their areas of work.

5. Education for Health

Education for health aims at creating awareness among people of all factors that affect health and promoting positive life-styles towards health. Literacy need not be a pre-requisite for this.

Considering the high levels of illiteracy in the villages, adult and NFE should be strengthened and expanded with health as a major component.

In ~~The~~ ongoing Health Education, the village working group should be trained to take up responsibility in all aspects of health education in the village. Some effort should be made to educate the working group on the elements of communication skills.

6. Involvement of traditional healers, Dais and indigenous systems

a) The VHW's knowledge base to be increased.

b) The TBAs in the village to be trained and ANC and PNC made locally sustainable.

c) Practitioners of indigenous systems in the village to be integrated into the community health programme.

d) Promote herbal gardens as part of kitchen/garden scheme.

e) Compile and document local herbs used, indications for use, and their effectivity, etc.

7. CHW / VHW

The VHW is illiterate. Therefore functional literacy to tackle simple meaningful record keeping/understanding health messages and for better communications is to be undertaken as part of their training. Their training also needs to be simplified to suit their limited role in minor ailment treatment and more efforts put in to preventive and promotive health aspects.

Their job specifications depending on their capabilities and community needs is to be made and their training programme tailored to suit this.

The VHWs skills to be upgraded to meet all local minor ailment needs. A referral system to hospital/health centre to be strengthened in the following:

a) Developing an official liaison between RTU-CHD and government or private referral centres;

b) Enabling the VHW to establish a rapport with the centres of referral; and

c) Upgrade the VHWs knowledge to selecting the appropriate referral centres for specific problems.

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Appendix

Suggestions for simplified, comprehensive, relevant record-keeping to enable future planning.

1. A register alloted to each village only for records on health - to be kept at the village, accessible to the CHD and sangam health working group for updating.

2. The first 20 pages of register to be kept aside for indexing, comprehensive record of focussed activity (eg., immunisation/ANC/ Child births/PNC/Vital events, etc)

3. One page per family for details eg., names of family members/ house no./type of house/illnesses in members (chronic)/sangam membership/facilities availed from sangams etc.

4. Start with families with ANC/PNC/Immunization care. Continue with other sangam members, then non-members, such that over a period of 3 to 6 months, complete village records will be available. This will also form the base-line data much needed for future evaluations and planning.

5. Examples of what is to be recorded:

   a) Village name/address on cover;
   b) Page 1 - map of village (folded sheet can be pasted);
   c) Page 2 to 9 for index of family by name/house number;
   d) Page 10 to 20 for comprehensive records.
   e) page 21 onwards - individual family records - 1 page per family

Immunization records

	Dt. of recording	April/May/June/July/etc.
No. of children under 5 years age.	𝍸 𝍸 𝍸 𝍸	
No. of children completed BCG	𝍸 𝍸	
No. of children completed DPT/OPV	𝍸	
1st dose	𝍸 ||||	
2nd dose	𝍸 ||	
3rd dose	𝍸	

(Tally marks by VHW/CD - individual updating by name in family record.

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No. of children completed Measles vaccine — ||||| ||||

No. of children completed 1st booster dose — |||| ||

No. of children in Balwadi roster/receiving suplementary nutrition, etc. — |||| ||||

ANC / PNC records from April 1992

	April	May	June	July	August
No. of mothers pregnant	|||||	||	|||	||	
No. of mothers received T.T. injection	|||			
No. of live births	||||			
No. of still births					
Dates of delivery	22/4 23/5 etc.				
Place of delivery (village/outside)	VVO	VO	OOV		
Delivery conducted by TBA	√√-	√-	--√		
No. of PNC	|||			

AND SIMILARLY FOR LOANS/OAPs/VITAL EVENTS, etc.

RTU

REACHING THE UNREACHED

G. Kallupatti, Near Batlagundu,
Madurai District - 624 203.
Tamilnadu, INDIA
Phone : 30 Genguvarpatti

29th May, 1992.

Ref: AD/CHD/92/ 1446

To

Dr. Shirdi Prasad Tekur,
Community Health Cell,
367, Srinivasa Nilaya,
Jakkasandra, I Main I Block,
Koramangala,
BANGALORE - 560 034.

Dear Dr. Tekur,

Thank you for your letter of 8.5.92 and the enclosed report of the study group on the Community Health & Development programme. Your report is fairly clear and articulate and at the moment, we do not need to seek clarifications from you. We are happy to see the details in to which you have gone inspite of the short span of the study. The community health staff will soon be sitting together to discuss with report and take corrective actions wherever necessary. As required by you, I am sending 3 copies of the report for the members of the study group. We do hope to keep in touch with each other.

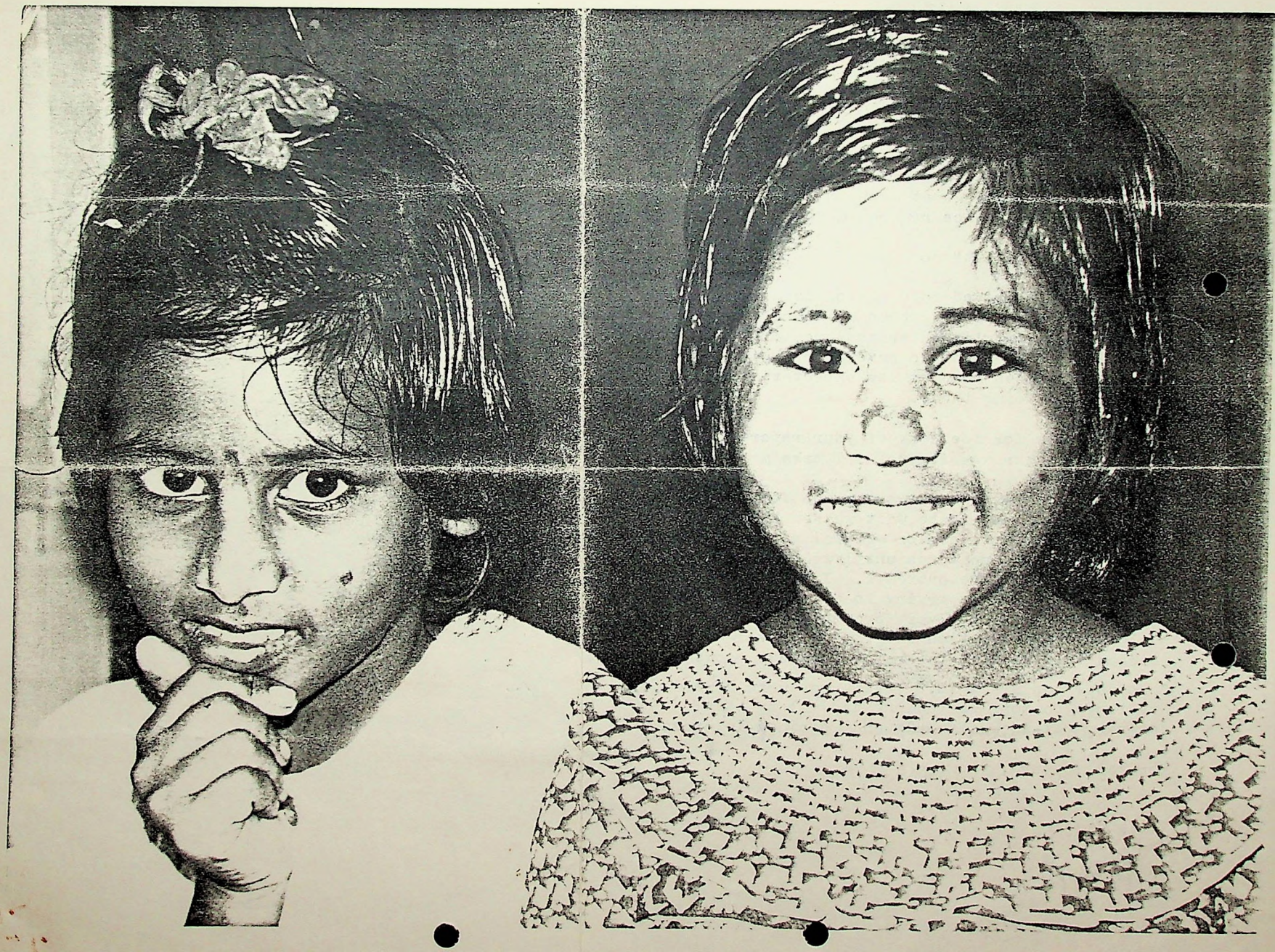
With warm regards,

Yours sincerely,

GIRISH MENON,
Assistant Director.

92/64

Replied 15-6-92



REACHING THE UNREACHED
G. Kallupatti
Periyakulam Tk. 624 203
S.India

11.5.92

Dear Doctor:

Many thanks for your letter and the thank you from your daughter. That such small gifts should bring such nice rewards means a lot.

I hope the "portrait" does not frighten her!

Just today I received good photos from a wealthy Parsee lady who has long been a friend of RTU. They were of her g'daughter and are truly beautiful. She wishes to have a portrait done and I hope I can rise to her expectations. I will enjoy doing them.

Thank you too for the copy of your report. I have glanced through it and will make a study of it eventually.
One of the things I most want to do for at least a year is to consolidate what we now have in hand, which will allow for natural growth but hold off any new ventures until we have stabilised and can support more outreach. I think we are being IMprovident by trying to do more for the sake of doing more. Every project needs a period of consolidation and I do believe we have reached that stage after rather furious growth.

I do hope you are well. I wish you were closer ...
Greetings to your companions and all my thanks for your off-the-cuff help and genuine interest.

Cordially yours,

James Kimpton

JKimpton

kalugumalai 13/5/92 (159) File

DW 2A - 80

PARTICIPATORY STUDY

of

COMMUNITY HEALTH AND DEVELOPMENT PROGRAM

of

"REACHING THE UNREACHED"

G. Kallupatti,
Madurai District,
Tamil Nadu.

<u>Study Group</u>

1. Dr. V. Benjamin
2. Dr. G. Gururaj
3. Dr. Shirdi Prasad Tekur

05th March 1992 To 26th April 1992.

C O N T E N T L I S T

I. SUMMARY

The Community Health and Development (CHD) initiative of 'Reaching The Unreached' (RTU) tries to reach people remote to development through health measures. The Goals are to actively involve people and enable them in improving their quality of life.

Sangams (associations) of men and women is the means and the nucleus of all health and development activities in the eight villages this programme addresses. The Community Health and Development (CHD) programme has gone through a phase of stagnation and re-activation in its evolution.

This study is in response to the need felt by the CHD (to know about their evolution, their present status and pointers to the future to help plan ahead) - to be done by an external resource group. Constraints limit quantitative assessments and the focus is on qualitative and process exploration.

The villages chosen are remote and in need of health and development inputs. Sangams of men and women are operational and function fairly well with limitations due to local circumstances. Village Health Workers are effective in minor-ailment management and are well accepted by the community. The mobile clinic initiative is not cost-effort-effective. Health education effort needs strengthening.

The conclusions of the study point to positive areas of good rapport, credibility and initiative while serving in areas of peoples needs. Numerous activities with small resources, a focus on curative approaches, problems of sangam dynamics and a need for upgrading Health Education efforts are the drawbacks seen.

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Recommendations are for focussed activity, putting more efforts into making the sangams far-sighted, involvement of other departments of RTU in the CHD effort, exploring local and other governmental resources and methods of documentation to help the CHD evolve relevant plans for the future.

II. BACKGROUND

The project 'Reaching The Unreached' (RTU) started in the year 1975 and registered in 1978 at G.Kalupatti, Madurai District; it is an attempt to reach people in the remote, unreached areas. The felt need of medical aid in this place led to the starting of a small base clinic facility and a mobile clinic to surrounding areas. This spread into meeting other needs of the people, such as housing, education, water, foster-families for children, income generation programmes and other social welfare measures.

1) ORIGINS

The community health programme started later (in 1982/85) using health as an entry point for overall development of the communities in eight villages of this area. Two volunteers from RTU initiated a process of community organisation. The programme remained stagnant during 1985-86 when these initiators left, and was restarted in 1987 by the present manager of the Community Health Department (CHD). It began with non-formal education incorporating health messages, and slowly evolved into a community health programme. In course of time this transformed into a Community Health and Development (CHD) programme, and the department of CH & D came into existence at RTU. Two community organisers have joined this department over the past two years to help the Manager who has been handling this programme single handed.

2) GOALS AND OBJECTIVES

The goals of this community health and development program

as stated in their progress report are:

TO REACH OUT TO A LARGE NUMBER OF PEOPLE IN DISTANT AND REMOTE VILLAGES AND ENABLE THEM TO IMPROVE THEIR QUALITY AND STANDARD OF LIFE, WITH THEIR ACTIVE INVOLVEMENT, USING HEALTH AS AN ENTRY POINT.

This is aimed at building up of confidence and self-reliance in the villages and to initiate a process of common village development through formation of sangams (associations) of men and women.

III. PURPOSE OF STUDY

Based on a felt need of the community health department of RTU, the present participatory study was undertaken to find out the qualitative impact of the community health program in the eight villages they work in. This participatory study by an external resource group was to see

a) how the community health program evolved;
b) its present status; and
c) to provide guidelines in planning the future.

It is to be specially noted that this participatory interactive exploration of community health and development activities was intended to facilitate the community health department. Hence, this study focussed on community health and not on other activities of RTU. Since baseline benchmark information was not available, a quantitative evaluation study was not feasible. Therefore a process oriented qualitative exploration study was undertaken with minimal emphasis on statistics, survey data, questionnaire, etc. The available periodical reports containing quantitative data have been reviewed. There were also constraints of time - total time for the study being seven days, divided into two blocks of two days and one of three days.

The present study was not focussed on measuring the health status of the community in quantitative terms, but on the process and relevance of community health and development (to enable people understand the importance of the same to improve their quality of life) and hence the methodology adopted.

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IV. EVOLUTION

To chronologically describe the evolution pattern:

1. The earliest activity was the mobile clinic of R.T.U.

2. While pursuing this activity, eight villages were identified for using mainly community health interventions towards overall development. The criteria for selecting these villages were:

   a) lack of any health or development activity;
   b) remoteness from centres of development activities;
   c) being small (population size) and therefore manageable; &
   d) people belonging to predominantly backward and underprivileged sections of society.

Some of the originally selected villages were dropped from the program and others added on depending on CHD assessments and village dynamics.

3. Formation of local Health Committee and selection of Village Health Worker (VHW).

Formation of village level health committees was preceded by awareness building for health through street theatre and public meetings. This health committee identified a male health worker who was acceptable to the community. These VHWs from eight villages were trained at RTU for a period of 15 days. During 1985-86 the programme was stagnant due to reasons not clearly identifiable. The male health workers stopped pursuing community health activities. In 1987 when it restarted, female village health workers (VHWs) were selected from each of eight villages and given a similar fifteen day training. Guidance and supervision of these VHWs has been continuous and regular since then.

4. Sangam formation:

Sangams separately for men and women of the village were formed. These sangams were intended to be the hub of all health and development activity. All adults were invited to join the sangams, and those interested joined the same. Some of these sangams are registered and members contribute a fee for common expenditure.

Sangam members were expected to meet atleast once a month to discuss local issues and to mobilise community support for developmental activities. These sangam activities were

facilitated by the CHD to utilize both Governmental and other resources. They were instrumental in initiating activities in health and also other areas like building of roads, provision of water and electricity, running of balwadis, improving transportation facilities and income generation activities for the community.

V. METHODOLOGY

The present qualitative approach to evaluation consisted of

a) review of available records;
b) discussion with staff at RTU, and field level functionaries;
c) discussion with members of sangam and non sangam members of the villages;
d) observations during field visits; and
e) eliciting opinion from nearby health care delivery agencies.

An elaboration on the above follows:

a) The records reviewed included the annual reports; reports to funding agencies; reviews of past and future plans; mobile clinic records; records at health centres; village registers; training programmes and their curricula; diaries and registers maintained by field staff;
—for the type of information and their relevance to ongoing community health activities.

b) Discussions were held at RTU with the Director, Assistant Director, Manager, the two community organisers and staff of medical department of RTU. At the field level, the village health workers, Balwadi teachers and Balwadi staff, Non-formal Education (NFE) animators, traditional birth attendants, and informal focussed discussions with them and the people on their work and attitudes were conducted in a non threatening manner.

c) Sangam members, their office bearers, and non sangam members were also contacted in a similar manner and their views elicited — On CHD and their staff, on sangams and their functioning - in relation to peoples problems.

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d) Visits to the village included studying the conditions of housing, water, sanitation, kitchen gardens, nutrition programs at Balwadis, NFE classes and the quality of rapport between CHD staff and community members.

e) An interaction with the Medical Officer and Medical Superintendent at the nearby referral centre at Batlagundu (Leonard Hospital) consisted of identifying local disease patterns, availability of health care services and patterns of utilisation.

The other components studied were library and health education resource materials, VHW's kit, medical stores and other units of RTU including the medical department in relation to CHD activity.

In addition, the CHD staff participated readily and made available existing documents and also co-operated in processing additional information requested by the study team.

VI. RESULTS

The results are presented as a situational analysis at the village level and in the various activities of the organisation.

1. The Villages

The eight villages where the community health department operates are away from the main road, and relatively inaccessible. The population of these villages ranges between 200 to 700. The villages are in two clusters, with a government health centre near each of the clusters, located at Ganguvaripatti and Viralipatti. The government health workers visit these villages mainly for immunization and family planning activities. Programmes on nutrition are conducted under the Tamilnadu Integrated Nutrition Improvement Programme (TINIP).

In RTU built houses, ventilation is good and there is no smoke nuisance from the kitchen, since it has smokeless chulhas and is built away from the living rooms.

From available data we found that illiteracy is high and ranges between 40 to 95% with a high drop-out rate noticed after the primary level of education. The occupation of the people is mainly as agricultural labour (seasonal) and marginal farmers and shepherds. Most houses are kutcha houses, with one or two rooms, non-electrified and with no toilets. Even though potable water is available, it is inadequate. Most primary schools are within a distance of 2 Kms. Transport and communications are generally available, but inadequate. Balwadis organised by RTU are functioning where not covered by the Integrated Child Development Scheme (ICDS). Most villages do not have a community television, commonly seen in other villages in Tamilnadu.

2. Organisational Activities

a) Sangam

The membership of the sangams in relation to the total village population varies between 10% to 60% with a higher percentage of women being sangam members compared to men.

The percentage of attendance at meetings:
- in Men's meetings - range 54 - 87%
- in Women's meetings - range 51 - 100%.

On an average one meeting per month is held in both mens and womens sangams. However, during harvesting and planting seasons, meetings are irregular.

The sangams have been able to mobilise people to avail various facilities through government schemes in areas of income-generation, roads, electricity, water supply, and obtaining of pensions for widows.

It is to be noted that a major contribution of RTU is in the area of providing housing facilities which has generated great interest and attraction among sangam members. [Sangam leaders are given leadership training at RTU periodically.]

Some specific achievements as per records are:

1986 - construction of 167 RTU houses } Jagjivan Nagar.
Borewell - one

1987 - 72 RTU houses at Utchapathi

1988 - Distribution of Goats/Buffaloes/Sheep - for income generation;
Establishment of sheep rearing society.

1989 - Total 90 persons benefited from government scheme including:

28 pensions for widows/streetlights and water taps/ borewells by RTU/Buffalo loans/Jawahar well-digging loan sanction/Sheep rearing society formation/ Road repairs/Widow daughter's marriage through aid/Community hall construction/formation of prohibition committee against female infanticide/ and Flood control wall construction.

1990 - Bullock and sheep rearing loans/street lights/hut electrification/old age pensions/Credit Union formation/ goats for income generation/tree planting alongside road/ road-repair/link roads/shed repair/soakage pits/ and threshing floors in the villages.

1991 - Sheep rearing loans/bullock cart loans/loans for petty trades/old age pensions/borewells/water-tank with taps/ monthly savings scheme started/threshing floor construction and allotment of house-sites.

Some problems areas:

Apart from minor problems, usually found in human groups, others noted were:

- Leaders becoming corrupt and leading to loss of faith in them;
- Enthusiastic participation from sangams generally peaked when R.T.U houses were constructed and waned dramatically after the event;
- Internal land and caste factors interfered with sangam activity;
- Traditional caste based elders who managed conflict felt threatened by the new sangam leadership.

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b) Village Health Workers (VHWs)

Village Health Workers selected by the Village Health Committee were women, a majority of whom were illiterate. They were given an initial training in community health for 2 weeks. Subsequent refresher courses and clarifications at periodic meetings are continuing.

The VHWs are mainly involved in minor ailment treatment, assisting at RTU's mobile clinic and helping the government health workers in their health activities. They also are expected to visit 5 families a day and conduct health education.

The VHWs are provided with a kit containing medicines for treating minor ailments, which is utilized to treat 20 to 30 cases on an average every month at a subsidized rate. They also utilize traditional herbal remedies quite confidently on their own initiative. They record the vital events of births and deaths with the help of a literate. An honorarium of Rs.100.00 per month is paid to them and this is given either by RTU or sangams.

We observed that the VHW is well accepted and has a good rapport with the community. A review of the curriculum showed that the contents were far too technical and voluminous to be covered in this short period. Record keeping activity is inadequate due to their illiteracy. Being sangam members, they also participate in all other sangam activities, but are considered by the people as mainly health resource.

c) Mobile Clinic

The mobile clinic operates twice a week, in the afternoons, effectively reaching each of the eight villages once a month. The team consists of the CHD Manager, a community organiser, a person from the medical department and the local VHW. They provide curative services to the whole population, with a focus on Ante and Post-natal care.

The records show that they see an average of 60 patients a year per village, including ANC patients and growth monitoring

of 40 children. Medicines at a subsidized rate are distributed, and Health Education imparted. The schedules of the mobile clinic are very variable, mainly because of dependence on availability of the van for transport of the team.

The health records are minimal, while their work is encumbered by accounting procedures. The records do not provide a clear picture of disease patterns, but discussions with the team and the local referral centre indicated that the common ailments are diarrhoeas, skin diseases, eye diseases and problems of malnutrition. Tuberculosis and leprosy are two common major problems and these are treated with the help of governmental resources. In cholera epidemics in the past, the CHD has been effective in tackling the problem with government and other agencies.

d) Health Education

In addition to health education given by the VHW and at the mobile clinic in a personalized manner, mass health education programmes are conducted on an average of once a month in each of the villages. This is mainly through film shows and slide shows. Street theatre, puppet shows and drama are occasional events. Health Education also forms a component of the training programmes and other meetings at RTU. Film shows are popular with the people.

Records show that the topics covered include - Cooperation, Family Planning, Sanitation and Hygiene, N.F.E., MCH and Nutrition.

VII. CONCLUSIONS

1. The RTU's CHD Department has established a good rapport with the community as well as the government agencies in areas of health and development.
2. The formation and nurture of sangams has enabled the people to begin to understand their health and development problems and also evolve some solutions.

3. A large number of activities have been initiated in a short span of time inspite of meagre resources. Consequently, there has been a blurring of clarity and focus in their well-meaning efforts.

4. Since the selection of villages was based on criteria of poverty and under-development, the approaches and activities of RTU-CHD have been predominantly welfare oriented.

5. The enthusiasm of the sangams seems to plummet as soon as their immediate felt needs are met from external agencies. This seems to blunt the potentiality of their initiatives, in using their own resources.

6. Curative efforts still form a major part of the health programme, while in development, avenues for tapping available resources are being efficiently explored.

7. Cost-effort-effectiveness of mobile clinic is low.

8. The VHW is well accepted by the people and functions effectively in activities alloted to her. However, her inability to maintain effective records, makes it difficult for the CHD to make quantitative assessments of health parameters.

9. Health Education remains largely an effort of the CHD (with its myraid activities and meagre resources) and has not received the attention it deserved.

VIII. RECOMMENDATIONS

To effectively strengthen the ongoing and proposed activities, the following recommendations are made:

1. Community organisation and participation

Sangams have already been formed. This valuable resource needs to be fostered and strengthened with further training/exposure of staff and sangam leadership. Interactions inbetween RTU sangams and others outside is likely to help this process.

The large membership precludes intensive study and understanding of local issues. The suggested corrective is the formation of smaller working groups in each sangam to take up specific issues. Planned training for these groups with the help of expertise will be of help.

Mens and Womens sangams need to meet together in addition to individual sangam meets, atleast twice a year reviewing their activities in the interim period and to evolve better courses of combined action.

Practical solutions to problems of meetings during harvesting and plantings seasons are to be evolved. e.g. the executive committee/working groups could attempt to meet, or (if this is found to be impractical) the meetings at these times are suspended and the frequency increased subsequently.

Long term comprehensive planning on all relevant development issues is to be initiated and followed up by the sangams.

Proper documentation and review of past decisions etc., will re-inforce this process.

Mechanisms for comprehensive feed-back at regular intervals on decisions and proposed actions both at RTU and sangam levels needs to be established.

Greater accountability and mechanisms for the same should be fostered by open exchange of information on resources, plans, activities, and achievements between CHD and sangams at their meetings.

Invitation of local government officials to sangam meetings should be encouraged.

2. <u>Appropriate strategies for health and development</u>

People should be encouraged to utilize government health services more and make them responsive to their needs.

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The cost-effort-effectiveness of the mobile clinics can be improved with alternative approaches like decentralization and transfer of medical stores along with reduction of team-size and upgrading of village resources (VHW and TBA) also utilizing government health resources. This can be implemented in a phased manner.

A prospective time-bound study of the mobile clinic component in terms of

- patient utilization of services from within and outside the specified villages;
- hours/personnel/medicine/transport/costs etc., involved; and
- areas of non-clinic activities facilitated, needs to be included in the future plans.

Where local/traditional herbal medicines are being utilized as alternatives, allopathic drugs provided, may be withdrawn in a phased manner. e.g., Benzyl Benzoate replaced with Turmeric/Neem leaves, for scabies treatment.

Explore alternative sources of energy like bio-gas, solar cookers, solar powered street lights, etc.

Development of simplified recording systems tailored to the needs of the community as explained in the annexure.

The VHW/TBA/NFE animators/Balwadi teachers and their equipments from government health resources are to meet periodically and evolve ways and means of implementing sangam decisions.

3. <u>Community support for health care</u>

Formation of local working groups on health, consisting of atleast five members each from the mens and womens sangams working together as a team will be an important step.

a) This group will be specially trained to improve health education and will be responsible for monitoring all health activities and also function as an activist group to interact with governmental and other agencies for health.

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b) To explore ways and means of making the community self-supporting in terms of finance and other relevant resources.

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At RTU level, staff from all departments are to be sensitised and oriented towards the importance of C.H. in development and should be encouraged and expected to contribute to C.H. concepts in their areas of work.

As a starting point, the medical department could take responsibility for all curative services, and step into areas of prevention and health promotion in the villages where the community health department is active. All health programs can be jointly planned by these two departments. Similar cooperative efforts can be planned with other departments in their areas of work.

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Education for health aims at creating awareness among people of all factors that affect health and promoting positive life-styles towards health. Literacy need not be a pre-requisite for this.

Considering the high levels of illiteracy in the villages, adult and NFE should be strengthened and expanded with health as a major component.

In ongoing Health Education the village working group should be trained to take up responsibility in all aspects of health education in the village. Some effort should be made to educate the working group on the elements of communication skills.

6. Involvement of traditional healers, Dais and indigenous systems

a) The VHW's knowledge base to be increased.

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Suggestions for simplified, comprehensive, relevant record-keeping to enable future planning.

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No. of children under 5 years age.	𝍸 𝍸 𝍸 𝍸	
No. of children completed BCG	𝍸 𝍸	
No. of children completed DPT/OPV		
1st dose	𝍸 ||||	
2nd dose	𝍸 ||	
3rd dose	𝍸	

(Tally marks by VHW/CO.
- individual updating by name in family record.

..17

No. of children completed
Measles vaccine

No. of children completed
1st booster dose

No. of children in Balwadi
roster/receiving suplementary
nutrition, etc.

ANC / PNC records from April 1992

April / May / June / July / August

No. of mothers pregnant

No. of mothers received
T.T. injection

No. of live births

No. of still births

Dates of delivery

Place of delivery
(village/outside)

Delivery conducted by
TBA

No. of PNC

AND SIMILARLY FOR LOANS/OAPs/VITAL EVENTS, etc.

DEV 2A-10

=

DEV 2A - 9.

PARTICIPATORY STUDY

of

COMMUNITY HEALTH AND DEVELOPMENT PROGRAM

of

"REACHING THE UNREACHED"

G. Kallupatti,
Madurai District,
Tamil Nadu.

Study Group

1. Dr. V. Benjamin
2. Dr. G. Gururaj
3. Dr. Shirdi Prasad Tekur

05th March 1992 To 26th April 1992.

DEV 2A-1814

CONTENT LIST

I. SUMMARY

The Community Health and Development initiative of 'Reaching The Unreached' (RTU) tries to reach people remote to development through health measures. The Goals are to actively involve people and enable them in improving their quality of life.

Sangams (associations) of men and women is the means and the nucleus of all health and development activities in the eight villages this programme addresses. The Community Health and Development programme has gone through a phase of stagnation and re-activation in its evolution.

This study is in response to the need felt by the CHD (to know about their evolution, their present status and pointers to the future to help plan ahead) - to be done by an external resource group. Constrains limit quantitative assessments and the focus in on qualitative and process exploration.

The villages chosen are remote and in need of health and development inputs. Sangams of men and women are operational and function fairly well with limitations due to local circumstances. Village Health Workers are effective in minor-ailment management and are well accepted by the community.

The conclusions of the study point to positive areas of good rapport, credibility and initiative while serving in areas of peoples needs.

Numerous activities with small resources, a focus on curative approaches, problems of sangam dynamics and a need for upgrading Health Education efforts are the drawbacks seen.

Recommendations are for focussed activity, putting more efforts into making the sangams far-sighted, involvement of other departments of RTU in the CHD effort, exploring local and other governmental resources and methods of documentation to help the CHD evolve relevant plans for the future.

II BACKGROUND

The project 'Reaching The Unreached' (RTU) started in the year 1975 and registered in 1978 at G. Kallupatti, Madurai District; it is an attempt to reach people in the remote, unreached areas. The felt need of medical aid in this place led to the starting of a small base clinic facility and a mobile clinic to surrounding areas. This spread into meeting other needs of the people, such as housing, education, water, foster-families for children, income generation programmes and other social welfare measures.

1) ORIGINS

The community health programme started later (in 1982/85) using health as an entry point for overall development of the communities in eight villages of this areas. Two volunteers from RTU initiated a process of community organisation. The programme remained stagnant during 1985-86 when these initiators left, and was restarted in 1987 by the present manager of the Community Health Department (CHD). It began with non-formal education incorporating health messages, and slowly evolved into a community health programme. In course of time this transformed into a Community Health and Development programme, and the department of CH & D came into existence at RTU. Two community organisers have joined this department over the past three years to help the Manager who has been handling this programme single handed.

2) GOALS AND OBJECTIVES

The goals of this community health and development program as stated in their progress report are :

TO REACH OUT TO A LARGE NUMBER OF PEOPLE IN DISTANT AND REMOTE VILLAGES AND ENABLE THEM TO IMPROVE THEIR QUALITY AND STANDARD OF LIFE, WITH THEIR ACTIVE INVOLVEMENT, USING HEALTH AS AN ENTRY POINT.

This is aimed at building up of confidence and self-reliance in the villages and to initiate a process of common village development through formation of sangams (associations) of men and women.

III. PURPOSE OF STUDY

Based on a felt need of the community health department of RTU, the present participatory study was undertaken to find out the qualitative impact of the community health program in the eight villages they work in. This participatory study by an external resource group was to see

a) how the community health program evolved;

b) its present status; and

c) to provide guidelines in planning the future.

It is to be specially noted that this participatory interactive exploration of community health and development activities was intended to facilitate the community health department. Hence, this study focussed on community health and not on other activities of RTU. Since baseline benchmark information was not available, a quantitative evaluation study was not feasible. Therefore a process oriented qualitative exploration study was undertaken with minimal emphasis on statistics, survey data, questionnaire, etc. The available periodical reports containing quantitative data have been reviewed. There were also constraints of time - total time for the study being seven days, divided into two blocks of two days and one of three days.

The present study was not focussed on measuring the health status of the community in quantitative terms, but on the process and relevance of community health and development (to enable people understand the importance of the same to improve their quality of life) and hence the methodology adopted.

IV. EVOLUTION

To chronologically describe the evolution pattern :

1. The earliest activity was the mobile clinic of R.T.U.

2. While pursuing this activity, eight villages were identified for using mainly community health interventions towards overall development. The criteria for selecting these villages were :

   a) lack of any health or development activity;
   b) remoteness from centres of development activities;
   c) being small (population size) and therefore manageable;
   d) people belonging to predominantly backward and underprivileged sections of society.

   Some of the originally selected villages were dropped from the program and others added on depending on CHD assessments and village dynamics.

3. Formation of local Health Committee and selection of Village Health Worker (VHW).

   Formation of village level health committees was preceded by awareness building for health through street theatre and public meetings. This health committee identified a male health worker who was acceptable to the community. These VHWs from eight villages were trained at RTU for a period of 15 days. During 1985-86 the programme was stagnant due to reasons not clearly identifiable. The male health workers stopped pursuing community health activities. In 1987 when it restarted, female village health workers (VHWs) were selected from each of eight villages and given a similar fifteen day training. Guidance and supervision of these VHWs has been continuous and regular since then.

4. Sangam formation :

   Sangams separately for men and women of the village were formed. These sangams were intended to be the hub of all health and development activity. All adults were invited to join the sangams, and those interested joined the same. Some of these sangams are registered and members contribute a fee for common expenditure.

Sangam members were expected to meet atleast once a month to discuss local issues and to mobilise community support for developmental activities. These sangam activities were facilitated by the CHD to utilize both Governmental and other resources. They were instrumental in initiating activities in health and also other areas like building of roads, provision of water and electricity, running of balwadis, improving transportaion facilities and income generation activities for the community.

V. METHODOLOGY

The present qualitative approach to evaluation consisted of

a) review of available records;

b) discussion with staff at RTU, and field level functionaries;

c) discussion with members of sangam and non sangam members of the villages;

d) observations during field visits; and

e) eliciting opinion from nearby health care delivery agencies.

An elaboration on the above follows :

a) The records reviewed included the annual reports; reports to funding agencies; reviews of past and future plans; mobile clinic records; records at health centres; village registers; training programmes and their curricula; diaries and registers maintained by field staff;

   - for the type of information and their relevance to ongoing community health activities.

b) Discussions were held at RTU with the Director, Assistant Director, Manager, the two community organisers and staff of medical department of RTU. At the field level, the village health workers, Balwadi teachers and Balwadi staff, Non-formal Education (NFE) animators, traditional birth attendants, and informal focussed discussions with them and the people on their work and attitudes were conducted in a non threatening manner.

c) Sangam members, their office bearers, and non sangam members were also contacted in a similar manner and their views elicited - on CHD and their staff, on sangams and thier functioning - in relation to peoples problems.

d) Visits to the village included studying the conditions of housing, water, sanitation, kitchen gardens, nutrition programs at Balwadis, NFE classes and the quality of rapport between CHD staff and community members.

e) An interaction with the Medical Officer and Medical Superintendent at the hearby referral centre at Batlagundu (Leonard Hospital) consisted of identifying local disease patterns, availability of health care services and patterns of utilisation.

The other components studied were library and health education resource materials, VHW's kit, medical stores and other units of RTU including the medical department in relation to CHD activity.

In addition, the CHD staff participated readily and made available existing documents and also co-operated in processing additional information requested by the study team.

VI. RESULTS

The results are presented as a situational analysis at the village level and in the various activities of the organisations.

1. The Villages

The eight villages where the community health department operates are away from the main road, and relatively inaccessible. The population of these villages ranges between 200 to 700. The villages are in two clusters, with a government health centre near each of the clusters, located at Benguvarpatti and Viralipatti. The Government health workers visit these villages mainly for immunization and family planning activities. Programmes on nutrition are conducted under the Tamilnadu Integrated Nutrition Improvement Programme (TINIP).

In RTU built houses, ventilation is good and there is no chulhas and is built away from the living rooms. From available data we found that illiteracy is high and ranges between 40 to 95 % with a high drop-out rate noticed after the primary level of education. The occupation of the people is mainly as agricultural labour (seasonal) and marginal farmers and shepherds. Most houses are kutcha houses, with one or two rooms, non-electrified and with no toilets. Even though potable water is available, it is inadequate. Most primary schools are within a distance of 2 Kms. Transport and communications are generally available, but inadequate. Balwadis organised by RTU are functioning where not covered by the Intergrated Child Development Scheme (ICDS). Most villages do not have a community television, commonly seen in other villages in Tamilnadu.

Smoke nuisance in the kitchen, since it has smokeless..

2. Organisational Activities

a) Sangam

The membership of the sangams in relation to the total village population varies between 10 % to 60 % with a higher percentage of women being sangam members compared to men.

The percentage of attendance at meetings :

- in Men's meetings — range 54 - 87 %

- in Women's meetings — range 51 - 100 %

On an average one meeting per month is held in both mens and womens sangams. However, during harvesting and planting seasons, meetings are irregular.

The sangams have been able to mobilise people to avail various facilities through government schemes in areas of income-generation, roads, electricity, water supply, and obtaining of pensions for widows. Sangam leaders are given leadership training at RTU periodically.

It is to be noted that a major contribution of RTU is in the area of providing housing facilities which has generated great interest and attraction among sangam members.

Some specific achievements as per records are :

1986 - Construction of 167 RTU houses } Jagjivan
Borewell - one } Nagar.

1987 - 72 RTU houses at Utchapatti

1988 - Distribution of Goats/ Buffaloes / Sheep - for Income generations;

Establishment of sheep rearing society.

1989 - Total 90 persons benefited from government scheme including 28 pensions for widows/streetlights and water taps/ borewells by RTU/Buffalo loans/Jawahar well-digging loans sanction/Sheep rearing society formation/ Road repairs/Widow daughter's marriage through aid/Community hall construction/formation of prohibition committee against female infanticide/ and Flood control wall construction.

1990 - Bullock and sheep rearing loans/street lights/hut electrification/old age pensions/ Credit Union formation/goats for income generation/tree planting alongside road/road-repair/link roads/shed repair/soakage pits/and threshing floors in the villages.

1991 - Sheep rearing loans/bullock cart loans/loans for petty trades/old age pensions/borewells/water-tank with taps/monthly savings scheme started/threshing floor construction and allotment of house-sites.

Some problems areas:

Apart from minor problems, usually founck in human groups, others noted were:

- Leaders becoming corrupt and leading to loss of faith in them;

- Enthusiastic participation from sangams generally peaked when RTU houses were constructed and waned dramatically after the event;

- Internal land and caste factors interfered with sangam activity;

- Traditional caste based elders who managed conflict felt threatened by the new sangam leadership.

b) Village Health Workers (VHWs)

Village Health Workers selected by the Village Health Committee were women, a majority of whom were illiterate. They were given an initial training in community health for 2 weeks. Subsequent refresher courses and clarifications at periodic meetings are continuing.

The VHWs are mainly involved in minor ailment treatment, assisting at RTU's mobile clinic and helping the government health workers in their health activities. They also are expected to visit 5 families a day and conduct health education.

The VHWs are provided with a kit containing medicines for treating minor ailments, which is utilized to treat 20 to 30 cases on an average every month at a subsidized rate. They also utilize traditional herbal remedies quite confidently on their own initiative. They record the vital events of births and deaths with the help of a literate. An honorarium of Rs.100.00 per month is paid to them and this is given either by RTU or sangams.

We observed that the VHW is well accepted and has a good rapport with the community. A review of the curriculum showed that the contents were far too technical and voluminous to be covered in this short period. Record keeping activity is inadequate due to their illiteracy. Being sangam members, they also participate in all other sangam activities, but are considered by the people as mainly health resource.

c) Mobile Clinic

The mobile clinic operators twice a week, in the afternoons, effectively reaching each of the eight villages once a month. The team consists of the CHD Manager, a community organiser, a person from the medical department and the local VHW. They provide curative services to the whole population, with a focus on Ante and Post-natal care.

The records show that they see an average of 60 patients a year per village, including ANC patients and growth monitoring of 40 children. Medicines at a subsidized rate are distributed, and Health Education imparted. The schedules of the mobile clinic are very variable, mainly because of dependence on availability of the van for transport of the team.

The health records are minimal, while their work is encumbered by accounting procedures. The records do not provide a clear picture of disease patterns, but discussions with the team and the local referral centre indicated that the common ailments are diarrhoeas, skin diseases, eye diseases and problems of malnutrition. Tuberculosis and leprosy are two common major problems and these are treated with the help of governmental resources. In cholera epidemics in the past, the CHD has been effective in tackling the problem with government and other agencies.

d) Health Education

In addition to health education given by the VHW and at the mobile clinic in a personalized manner, mass health education programmes are conducted on an average of once a month in each of the villages. This is mainly through film shows and slide shows. Street theatre, puppet shows and drama are occasional events. Health Education also forms a component of the training programmes and other meetings at RTU. Film shows are popular with the people.

Records show that the topics covered include — Cooperation, Family Planning, Sanitation and Hygiene, N.F.E., MCH and Nutrition.

VII. CONCLUSIONS

1. The RTU's CHD Department has established a good rapport with the community as well as the government agencies in areas of health and development.

2. The formation and nurture of sangams has enabled the people to begin to understand their health and development problems and also evolve some solutions.

3. A large number of activities have been initiated in a short span of time inspite of meagre resources. Consequently, there has been a blurring of clarity and focus in their well-meaning efforts.

4. Since the selection of vilages was based on criteria of poverty and under-development, the approaches and activities of RTU-CHD have been predominantly welfare oriented.

5. The enthusiasm of the sangams seems to plummet as soon as their immediate felt needs are met from external agencies. This seems to blunt the potentiality of their initiatives, in using their own resources.

6. Curative efforts still from a major part of the health programme, while in development, avenues for tapping available resources are being efficiently explored.

7. Cost-effort-effectiveness of mobile clinic is low.

8. The VHW is well accepted by the people and functions effectively in activities alloted to her. However, her inability to maintain effective records, makes it difficult for the CHD to make quantitative assessments of health parameters.

9. Health Education remains largely an effort of the CHD (with its myraid activities and meagre resources) and has not received the attention it deserves.

VIII. RECOMMENDATIONS

To effectively strengthen the ongoing and proposed activities, the following recommendations are made:

1. Community Organisation and participation:

Sangams have already been formed. This valuable resource needs to be fostered and strengthened with further training/exposure of staff and sangam leadership. Interactions inbetween RTU sangams and others outside is likely to help this process.

The large membership precludes intensive study and understanding of local issues. The suggested corrective is the formation of smaller working groups in each sangam to take up specific issues. Planned training for these groups with the help of expertise will be of help.

Mens and Womens sangams need to meet together in addition to individual sangam meets, atleast twice a year reviewing their activities in the interim period and to evolve better courses of combined action.

Practical solutions to problems of meetings during harvesting and plantings seasons are to be evolved. e.g. the executive committee/working groups could attempt to meet, or (if this is found to be impractical) the meetings at these times are suspended and the frequency increased subsequently.

Long term comprehensive planning on all relevant development issues is to be initiated and followed up by the sangams.

Proper documentation and review of past decisions etc., will re-inforce this process.

Mechanisms for comprehensive feed-back at regular intervals on decisions and proposed actions both at RTU and sangam levels needs to be established.

Greater accountability and mechanisms for the same should be fostered by open exchange of information on resources, plans, activities, and achievements between CHD and sangams at their meetings.

Invitation of local government officials to sangam meetings should be encouraged.

2. Appropriate strategies for health and development:

People should be encouraged to utilize government health services more and make them responsive to their needs.

The cost-effort-effectiveness of the mobile clinics can be improved with alternative approaches like decentralization and transfer of medical stores along with reduction of team-size and upgrading of village resources (VHW and TBA) also utilizing government health resources. This can be implemented in a phased manner.

A prospective time-bound study of the mobile clinic component in terms of

- patient utilization of services from within and outside the specified villages;

- hours/personnel/medicine/transport/costs etc., involved; and

- areas of non-clinic activities facilitated, needs to be included in the future plans.

Where local/traditional herbal medicines are being utilized as alternatives, allopathic drugs provided, may be withdrawn in a phased manner. e.g., Benzyl Benzoate replaced with Turmeric/Neem leaves, for scabies treatment.

Explore alternative sources of energy like bio-gas, solar cookers, solar powered street lights, etc.

Development of simplified recording systems tailored to the needs of the community as explained in the annexure.

The VHW/TBA/NFE animators/Balwadi teachers and their equivalents from government health resources are to meet periodically and evolve ways and means of implementing sangam decisions.

3. Community support for health care:

Formation of local working groups on health, consisting of atleast five members each from the mens and womens sangams working together as a team will be an important step.

a) This group will be specially trained to improve health education and will be responsible for monitoring all health activities and also function as an activist group to interact with governmental and other agencies for health.

b) To explore ways and means of making the community self-supporting in terms of finance and other relevant resources.

4. Health integrated with Development:

A health-education component is to be incorporated in all training and other programmes of development both at RTU and at the village level. This is likely to make people more conscious and responsible for their own health.

A contributory health service (CHS) scheme could be linked to income-generation programs. This is intended to promote self-sustenance of health services in the village.

At RTU level, staff from all departments are to be sensitised and oriented towards the importance of C.H. in development and should be encouraged and expected to contribute to C.H. concepts in their areas of work.

As a starting point, the medical department could take responsibility for all curative services, and step into areas of prevention and health promotion in the villages where the community health department is active. All health programs can be jointly planned by these two departments. Similar cooperative efforts can be planned with other departments in their areas of work.

5. Education for Health:

Education for health aims at creating awareness among people of all factors that affect health and promoting positive life-styles towards health. Literacy needs not be a pre-requisite for this.

Considering the high levels of illiteracy in the villages, adult and NFE should be strengthened and expanded with health as a major component.

In ongoing Health Education, the village working group should be trained to take up responsibility in all aspects of health education in the village. Some effort should be made to educate the working group on the elements of communication skills.

6. Involvement of tratitional healers, Dais and indigenous systems:

a) The VHW's knowledge base to be increased.

b) The TBAs in the village to be trained and ANC and PNC made locally sustainable.

c) Practitioners of indigenous systems in the village to be integrated into the community health programme.

d) Promote herbal gardens as part of kitchen/garden scheme.

e) Compile and document local herbs used, indications for use, and their effectivity, etc.

7. CHW / VHW:

The VHW is illiterate. Therefore functional literacy to tackle simple meaningful record keeping/understanding health messages and for better communications is to be undertaken as part of their training. Their training also needs to be simplified to suit their limited role in minor ailment treatment and more efforts put in to preventive and promotive health aspects.

Their job specifications depending on their capabilities and community needs is to be made and their training programme tailored to suit this.

The VHWs skills to be upgraded to meet all local minor ailment needs. A referral system to hospital/health centre to be strengthened in the following:

a) Developing an official liaison between RTU-CHD and government or private referral centres;

b) Enabling the VHW to establish a rapport with the centres of referral; and

c) Upgrade the VHWs knowledge to selecting the appropriate referral centres for specific problems.

APPENDIX :

Suggestions for simplified, comprehensive, relevant record-keeping to enable future planning.

1. A register alloted to each village only for records on health - to be kept at the village, accessible to the CHD and sangam health working group for updating.

2. The first 20 pages of register to be kept aside for indexing, comprehensive record of focussed activity (eg., immunization/ANC/Child births/PNC/Vital events, etc.)

3. One page per family for details eg., names of family members/house no./type of house/illnesses in members (chronic)/sangam membership/facilities availed from sangams etc.

4. Start with families with ANC/PNC/Immunization care. Continue with other sangam members, then non-members, such that over a period of 3 to 6 months, complete village records will be available. This will also form the base-line date much needed for future evaluations and planning.

5. Examples of what is to be recorded:

   a) Village name/address on cover;

   b) Page 1 - map of village (folded sheet can be pasted);

   c) Page 2 to 9 for index of family by name/house number;

   d) Page 10 to 20 for comprehensive records.

   e) Page 21 onwards - individual family records - one page per family.

Immunization records:

	Dt. of recording	April	May	June	July	etc.
No. of children under years age.	𝍸 𝍸 𝍸 𝍸					
No. of children comleted BCG	𝍸 𝍸					
No. of children comleted DPT/OPV						
1st dose	𝍸 ||||					
2nd dose	𝍸 ||					
3rd dose	𝍸					

(Tally marks by VHW/Co)
individual updating by name in family record:

		April	May	June	July	August	etc.,
No. of children completed Measles vaccine	𝍸 𝍸 𝍸						
No. of children completed 1st booster dose	𝍸 III						
No. of children in Balwadi roster/receiving supplementary nutrition, etc.	𝍸 𝍸 𝍸 III						
ANC / PNC records from April 1992:							
No. of mothers pregnant	𝍸		II	III	II		
No. of mothers received T.T. injection	IIII						
No. of live births	IIII						
No. of still births	I						
Dates of delivery	22/3 23/4 etc						
Place of delivery (village/outside)	V/V/O		VO	OOV			
Delivery conducted by TBA	✓✓—		✓—	——✓			
No. of PNC	𝍸						

AND SIMILARLY FOR LOANS/OAPs/VITAL EVENTS, etc.

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