Participatory
STUDY - REFLECTION
ON
K.S.S.S. - C.H.D.P.

V. Benjamin
Bhanmathy V.
S.P. Tekur

PARTICIPATORY STUDY-REFLECTION ON KSSS-CHDP

This is a consolidation of the interactions between the KSSS-CHDP team, the CHC team and the Study team spread over the past two years, recorded under the following heads :

1) The Background and Process
2) Appendices of
   a) Reports generated during the process and
   b) Bibliography of KSSS-CHDP reports / records in the process.

THE BACKGROUND AND PROCESS

A letter dated 26.01.89 from the Co-ordinator KSSS-CHDP requested the CHC to

a) help in evaluation of their work, and
b) help them "look ahead" after 16 years of efforts in the field.

The CHC proposed a brain-storming to evolve a process with the CHDP team about the idea, methodology and type of evaluation. It also clarified the concept of "participatory", as participants of a common process and not as outside consultants or experts. A study of all the past evaluations was proposed to start with and build-up on the past.

Observations :

There has been a variance in the understanding of the KSSS-CHDP with the CHC proposal despite repeated clarifications. The KSSS-CHDP has been expecting an "evaluation" even quite late in the process.

At a meeting of the support group on 8.2.90 discussing the KSSS-CHDP 'evaluation', it was an unanimous decision that the focus of in' rest was on the project, its team members and the people of the area, and not on the needs of any

funding agency. Hence, the terms 'evaluation' was sought to be changed to 'Participatory-Study-Reflection" on the KSSS-CHDP.

The Process involved,

a) Brain-storming sessions at CHC

b) Reports/minutes of these sessions and the reactions of the KSSS-CHDP personnel and grass-root workers at the MMs to these

c) A visit of the 'study-team' consisting of Dr. V. Benjamin, Ms. Bhanumathy Vasudevan and Dr. Shirdi Prasad Tekur from 16th to 21st April 1990.

d) Reports of the visit prepared at various stages of the process

and

e) A final meeting of the KSSS-CHDP team with the study team / CHC team at Bangalore on 3rd January 1991.

The process then started with a brain-storming session of the KSSS-CHDP and CHC team on 29th and 30th May 1989.

The session evolved a set of questions looking at the broad aspects of KSSS-CHDP, mainly,

- it's long and short-term goals
- internal democratic processes in the KSSS-CHDP
- the issue of CRS food and its effects on their working,
- the Staff, C.O.S, Village level workers, Mahalir mandrams and their dynamics
- the training needs and
- record keeping

For details - Appendix 'A'

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Note : Through out the report, the following abbreviations have been used. M.M. - Mahalir Mandrams
C.O. - Community Organisers.

The KSSS-CHDP team initiated a process of gathering views and opinions of the KSSS-CHDP staff, the Executive Committee of the MM Staff, as a follow-up of this session.

The questionnaire addressed 4 questions, viz.,

1) Is there a need for evaluation?

2) Why there is a need?

3) Whose need is it?

4) Which aspects of the programme needs evaluation?

A non-edited version of the replies to the questionnaire was sent to CHC, which was not clear about the needs.

For details - Appendix 'B'

In a subsequent interaction, the ideas expressed earlier were clarified, and suggested areas of "evaluation" to start with were sent to CHC.

They were,

- the specific health services in relation to the whole programme,
- the evolution of concepts in community health and how far an integrated approach was reached,
- regarding personnel; the understanding of community health,
- how far is the goal of social health reached, related to the understanding of the workers and the people (beneficiaries and members),
- a critical constructive assessment of these aspects and any other aspects needed.

For details - Appendix 'C'

Meanwhile, a second brain-storming session at CHC on 18th July 1989 was held after perusing KSSS-CHDP reports of the past, produced a collation of ideas, views, reactions and questions which were transmitted to KSSS-CHDP for reactions.

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The issues highlighted were,

1) The project since inception, the original vision, its evolution, directions, reasons thereof and the programmes this was translated into. A plea for assessment of interactions with other KSSS and non KSSS groups, the resources available and why a focus on social health was also made.

2) The components of the project were tackled under the heads of

   a) personnel and their understanding / influence on KSSS-CHDP.

   b) Mahalir mandrams, composition, expectations, participation in and activity directed towards the KSSS-CHDP goals.

   c) Relevance, need and utilization of Documents and Records.

   d) CRS food and its impact.

   e) Savings programme, other programmes and

   f) Exploring of funding avenues.

Comment :

The ideas that emerged at this session were shelved by the KSSS-CHDP and the suggestions from the earlier interactions was projected as a need.

For details - Appendix 'D'

Brain-Storming session - 20th October 1989

At this stage it was suggested by the CHC team that the KSSS-CHDP should form a committee from their staff with enough powers to look into all matters raised by the above questionnaire. The steps they would follow would be prioritization from the list, assessment and mobilization of resources and fixing a time frame.

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Other suggestions given were, consolidation of all internal evaluation reports at all levels, and considering the insecure arrangement of CRS food supplements urgently not necessarily linked to a larger evaluation effort.

If, at this stage, external assistance was required to look into specified areas, other resource groups / persons could be contacted.

It was now understood that the task was primarily their own, with CHC acting only as a facilitator.

For details - Appendix 'E'

At the subsequent request for a further involvement, a study team consisting of Dr. V. Benjamin, Ms. Bhanumathy Vasudevan and Dr. Shirdi Prasad Tekur was formed, with the others who interacted so far supporting the effort in brain-storming and background work.

For details - Appendix 'F'

The support group and study team met on 8.2.90 at CHC and some important points which emerged were,

- the study to be focussed on needs of the people and project - not the interest of funding agencies.
- discomfort with the term 'evaluation', which could be modified to 'participatory-study-reflection'.
- need for looking at CHDP's goals for a start.
- perusal of all reports / studies of KSSS-CHDP by the study team.
- a field visit to be finalised by the study team after Dr. V. Benjamin's initial visit.

Further Brain-storming meets of the study-team and support group with other resourcers were held at CHC, and an outline of the aspects of KSSS-CHDP needing study was compiled.

For details - Appendix 'G'

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A meeting of the support team on 28th February 1990 looked into the areas of KSSS-CHDP which needed studying.

For details - Appendix 'H'

Dr. V. Benjamin paid a short visit to KSSS-CHDP and met Sr. Leive, Fr. James, and other members of the KSSS-CHDP. Specific areas to be looked into were divided between the three members of the study team visiting KSSS-CHDP.

For details - Appendix 'I'

This was followed by a visit to KSSS-CHDP between 16th to 21st April 1990, by the study-team consisting of Dr. V. Benjamin, Ms. Bhanumathy Vasudevan and Dr. Shirdi Prasad Tekur.

During the five days at KSSS-CHDP, Nagercoil, field visits were made at random to village health centres, keeping in mind that coverage of coastal, plain and hill regions was fulfilled. In addition, sessions of interactions with the COs, Central Committee, Doctors, MM Staff as well as members, was organised. Meetings of MMs were also attended, a couple of sessions of training programme was attended by the team members, records / reports in the office were perused and library visited.

The outcome of this visit were reports on the Health Services and Social dimensions of the KSSS-CHDP by Dr. Shirdi Prasad Tekur and Ms. Bhanumathy Vasudevan. Dr. V. Benjamin deferred his report till there was a reaction to the above from KSSS-CHDP and also since some changes were on, to allow them to stabilize.

The report on the Health Services dimension initially records the concepts and understanding of KSSS-CHDP and its origins among the staff and MM members. The observations are then recorded - at the village level / the Doctor and his role, and at the central committee, training and co-ordination. The strengths, weaknesses and opportunities are explored in these areas.

For details - Appendix 'J'

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The social dimension has been explored under the headings, strengths, blocks, opportunities followed by recommendations.

For details - Appendix 'K'

A feed-back to these reports with the evolving changes at KSSS-CHDP was sent to CHC.

for details - Appendix 'L'

The reflections of Dr. V. Benjamin based on his visits, the earlier reports and response of KSSS-CHDP to these reports was compiled and sent, dated 30.11.90.

For details - Appendix 'M'

Following this, a report of the evolution of CHDP with details of decentralization was compiled and sent to CHC dated 13.12.90. This could form part of the historical study.

for details - Appendix 'N'

Three members from the KSSS-CHDP then visited Bangalore and interacted on all the earlier reports on 02/03 January 1991. They sent back their understanding of the interactions at CHC, Bangalore.

For details - Appendix 'O'

A compilation of all interactions so far was suggested to form this Participatory-Study reflection report.

It is upto the KSSS-CHDP now, to look at the various ideas emerging in this process and utilize them in their evolution towards social health.

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Place : Bangalore,
Date : 08 Mar 91

for STUDY TEAM,

DR. SHIRDI PRASAD TEKUR.

BIBLIOGRAPHY OF KSSS-CHDP reports and records utilized in the study.

- Copies with KSSS-CHDP and CHC.

REPORTS FROM COMMUNITY HEALTH & DEVELOPMENT PROJECT (CHDP) OF KOTTAR SOCIAL SERVICE SOCIETY (KSSS)

A List of Documents with CHC

1. KSSS Annual Report, 1974
2. KSSS Annual Report 1976-77
3. A report on the CHDP of KSSS, Nagercoil, Tamilnadu by WHO/UNICEF Joint Committee on Health Policy - Primary Health Care, 1976
4. KSSS - Development at the grassroots : The organisational imperative by John Osgood Field, The Nutrition Institute, Tufts University, USA 1978-79 (KSSS Publication)
5. KSSS - An Approach to Community Health, 1981 (KSSS Publication)
6. The evolution of a Community Health Programme from the womens' point of view, by Nalini Nayak 1987
7. Longitudinal Cohort Study of malnutrition, morbidity and mortality interaction of children 0-2 years - a study proposal by Dr Vanaja Ramprasad, Dr P M Mulkarni, Dr S Carbin Joseph, Dr J John Christdas, V Gaspar Mary and Sr S Christy.
8. Report with particulars of the decentralisation of the CHDP - 1985
9. KSSS-CHDP Annual Report 1985
10. KSSS-CHDP Annual Report 1986
11. KSSS-CHDP Annual Report 1987
12. KSSS-CHDP Annual Report 1988
13. Syllabus for Women Animators Training - 1989
14. Syllabus for Women Animator cum Technical Training - 1986 / 1988
15. Syllabus - Health Guide Training Course
16. Syllabus - Four month training for Community Health Educators
17. Syllabus - Five month training course for Community Health Workers
18. CHDP - Health returns proforma
19. Schedule for Training Programmes, Seminars and Meetings for 1990.

APPENDIX 'A'

CHDP Evaluation

Policy of CHDP

Long term goal : Social Health for social change

Short term goal : Education, people's participation mobilization
(Health programmes - Preventive, social Analysis, Meetings Semrinars, Camps, Local issues etc)

1. Have we achieved the policy of short tern goal. Are we in the line of our long term goals?
2. If not why? Is so, where to go from here?
3. Present reality of CHDP, What prevents CHDP from chaieving democracy?
4. Is there a need for a ' Central Committee ' for Community Health development programme?
   If so what will be the role of such a committee to promote democracy and participation of the people at all levels?
5. CHDP's policy is to become a movement for social change, but in reality CHDP remains a Community Health development programme Why?
6. We understand that CRS supplementary food has been a great incentive and a means to organise women of the community. But the same CRS has become a block for growing awareness among the community. Often CHDP'S involvement appears as if it is for the maintenance of the staff, and the staff are depending more than the community on the CRS, very much on CRS food. In the absence of the CRS food, staff are affected more than the community.

   What alternative or remedy and strategy can be worked out?

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COMMUNITY ORGANISERS

1. We need an evaluation of the role of community organisers in the CHDP. At present we feel they are functioning as supervisors and inspectors.

VILLAGE LEVEL

1. Health Team: Is it working with and for the felt need of the community, or just implementing the activities that are decided by the CHDP Committees?

2. The type of relationship that exist between the community and the staff (acceptance of the community and availability of staff to the community) Have the staff gained the confidence of the people?

3. Are the community and the Health team aware of the process that are taking place in community especially Mahila Mandrams and CHDP, so on.

4 Does the Training given by CHDI to the Staff enable them to identify the felt needs/processes of the community.

Mahila Mandram Level

Mahila Mandram consists of representatives of the community.

1. How far the Mahila Mandram are functioning with democracy, to identify, analyse and to decide and make policy for the needs of the community etc., what prevents them for being democratic?

2. We need to know the process - study for certain projects that we have taken up.

3. Does the Training given to the village staff by CHDP allow them to be one among the community and work with the community towards the long term goal?

4. Relevance of record keeping at all levels of CHDP.

K.S.S.S. COMMUNITY HEALTH DEVELOPMENT PROGRAMME

Views and opinions regarding C.H.D.P. Evaluation:

Collected from:

- the Executive Committee members of Mahalir Mandrams
- the staff of Mahalir Mandrams
- C.H.D.P. staff

The method used:

The Community Organisers were communicated of the need for collecting views and opinions. They in turn contacted each Mahalir Mandram executive committee and its staff at each village and communicated and collected the views. Finally it was consolidated at C.H.D.P. Centre.

20% of the women
10% of the Health team } have not understood the point

- There should be a different method used for clear communication.

The questionnaire given by C.H.D.P. Central Committee for the collection of opinion as follows:

1- Is there a need for Evaluation ?
2- Why there is a need ?
3- Whose need is it ?
4- Which aspect of the programme needs evaluation ?

Questions from Community Organisers:

1. C.H.D.P. Training who's need ?
2. Cohort is to be co-ordinated by Central Committee ?
3. Is it possible to have CRS and Democratic Mahilar Mandrams ?
4. How long can we work in the area where other organisations is working ?

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5. (five community organisers) Evaluation not needed, because there is a regular evaluation held periodically.

6. Have the people become aware of the long term goal of CHDP/M.M.

7. To critically evaluate our yearly evaluation.

Views and Opinions of M.M.Women

Reasons for Evaluation	Whose Need	Aspects for Evaluation
-To know the strength and limitation of C.H.D.P. mahalir Mandrams.	- C.H.D.P. activities staff.	- People's participation in villagelevel activities M.M. Social Health partici-
- To know whether the benefits reaches to the needy	- Staff of Mahalir Mandrams	- pation of people.
- To assess the need of the people to plan a better programme, thus develop M.M.activities.	- People's need	- Training of C.H.D.P.
- For the total development of CHDP	- C.H.D.P.Centre and people C.H.D.P. Staff	- C.H.D.P. activities
- To find the ways to reach the long term goal.	--the women's need and mothers.	- the method used to conduct seminars and meetings and women's activities.
- To find out the Democracy present in existing M.M.s	- staff and women of M.M.	- All the aspects. Local issues and the ways people are mobilised.
- 17 years activities and its need for continuation.	- C.H.D.P. staff, Central Committee, M.M.Executive committee, M.M. Staff.	- Home visit
- For more radical commitment	- Those in authority need.	- C R S activities
- Joint work of M.M.within M.M. General body and executive.	- All the staff.	- Income generation
- Need to evaluate the activities and commitment of all the staff since C.H.D.P asked.		- C.H.D.P. Co-ordination
		- Ways that are used to generate awareness among women.
		- Role of Community Organisers.

Views and opinion of M.M. staff

Reasons for Evaluation	Whose need	Which aspect needs evaluation
- Know C.H.D.P.'s development	- C.H.D.P. staff - M.M.Staff	- Health activities - Fair price shop
- Find the ways for job security	- Beneficiaries - CRS & M.M.	- Training of CHDP
- To have more knowledge of health	- Doctors	- Relationship between M.M. & C.H.D.P. staff & women.
- To know who are the most affected mpeople.	- Community organisers M.M. Women	- Accounts.
- To plan new policy		- M.M.activities- seminars and meetings
- To know whether we are reaching our motto" social Health for Social Change"	- Community Organisers	- Implementation of CHDP
	- M.M.Women and staff	
- To find out an alternative for CRS		- Relationship between M.M. staff and beneficiaries.
- To know CHDP'S historical evaluation	- People's need	
- To know the present activities	- C.H.D.P.	- All the aspects.
	- M.M. Staff.	- Income generation.
- To know the present democratic function and develop it.		
- To know whether our existing short term goal is towards the long term goal.	-C.H.D.P. administration.	- Executive committee formation.
		- CRS activities.
- To know the laternative for C R S		- Relationships : - C.H.D.P. & M.M. - C.H.D.P. & M.M. Staff - M.M.Staff and M.M. - C.H.D.P. staff & M.M.
- To realize whether C R S has enabled us for politicalization.		
To know the need for C H D P Central Committee.		

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Views of C.H.D.P. STAFF

Reason for Evaluation	Whose need	Aspects which needs evaluation
· Role of Community organisers. Development of people through our programme.		- Training programme - Health programme
To know the opinion of people about C.H.D.P. & M.M.		- M.M. activities & women's participation
To know the role of training Centre.		- Income generation
To know who is benefiting staff, people.		- Centre level activities - C.H.D.P. is making policy - M.M. Policy - Evaluation.

APPENDIX 'C'

Letter from Christy, Co-ordinator, CHDP, Dated 24.11.89

In continuation with the discussion we had with some of your Health Cell members we are fully aware that the proposed field of Evaluation are varied and include many aspects of our services.

We also see more and more the urgent need for an evaluation and further guidance.

During this year the treands emerging are organisational work among the women for strengthening the larger movements and secondly to give importance to alternative training for women where resources are still available or could be revived as

- Construction work
- Roof water harvesting
- Rubber tapping
- Briquitte making
- Fish paste
- Bee keeping
- Carpentory

These all do not seem part of a health programme, but seen from the aspects of resource preservation and women's employment they should contribute to the integrated aspects of health.

We wanted to communicate this to inform you that all the same time the direct health services and all other aspects of the programme are at present very little related. This is because of the attitude

of the two medical doctors with whom there is practically little communication, therefore no team work.

We are making all efforts to improve this situation, but we are convinced that an evaluation on these aspects is most urgently needed.

✓ We would suggest that, to start with you evaluate!

- The specific health services in relation to the whole programme
- The evolution of concepts in community Health and how far did we reach an integrated approach
- Regarding to personal: The understanding of community Health
- How far is the goal of social health reached, related to theunderstanding of the workers and the people (beneficiaries and members)

A critical constructive assessment would help us for further planning and work.

We do request you from your side to conduct these evaluation at the realiest.

Ofcourse it is left to you to include any aspect you feel needed and we do thank you in anticipation for your early and favourable response.

K.S.S.S. - C.H.D.P. - Evaluation Planning

This is a collation of ideas, views, reactions, and questions emerging out of -

- the 'brain-storming' session with the CHDP team,
- a study of the annual reports of CHDP with us, and
- individual as well as group reflections.

It is presented for convenience of reporting as,

I The Project
II The Components of the Project
III Exploring avenues

I The Project:

Since its inception in 1971, the KSSS-CHDP has encompassed a wide range of activities, whose organisation and extensive documentation for a project of this magnitude is remarkable indeed. The Project's deep commitment is expressed by the need to evaluate its various aspects at different points of time in its evolution. Some actions which could help in this evaluation are,

a) the original vision of the CHDP
b) the process of its evolution to the present stage with positive and negative aspects considered
c) the pattern of development to locate
   - points where rapid expansion took place
   - directions of expansion
   - points of crisis and how it altered, weakened or strengthened original commitments.
d) the evolution of concepts in Community Health over the years
e) the long and short term goals and how they weretranslated into programms
f) whether programmes were meant as 'ends'or'means'- are they leading towards planned or desired goals?

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2. A study of the interactions, relationships with and the attitudes of CHDP towards

- other K.S.S.groups like the various co-operatives and other non-health related activities
- Governmental agencies, and
- other non K.S.S.S services organisations in the area, and also in any other part of the country.

to Understand:

a) how much of their resources were available/ tapped/ utilised
b) if this can be quantified, and
c) how these above agencies react to, interact with or understand the work of CHDP

3. The activities of CHDP are predominantly oriented towards Social health, with the physical and mental aspects of health given lesser importance.
   - Why ?
   - any other studies/ data which might help in considering these aspects ?

II Components:

1. Personnel

Considering all personnel of the project from decision making level to field staff, it would be relevant to look at the following,

i) the understanding of community health toward KSSS-CHDP goals
ii) the proportion of acitivity directly related to health
iii) how participatory within themselves and the 'beneficiaries' are the decisions
how flexible are the decisions made ?
E.g. Can 98 different views from 98 different Mahila Mandrams be accommodated.?

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4. G.R.S. Food

- its impact on preventing malnutrition
- is it needed for the people?
- how consistent is it with KSSS- CHDP goals?
- have alternative local solutions been explored?
- hasit promoted 'dependence??

5. Savings Programme

- its magnitude in comparision to CHDP outlay
- can this resource be tapped for Community Health work?

6. Any other Programmes

- which have been stopped/deleted and why ?
- have National Programmes, for e.g., TB/ Leprosy/Immunization/ Malaria/ Fileria etc., been taken up before ?
- what is the scope for utilising available National Programmes for health in KSSS- CHDP areas?

III Exploration Avenues

1. Funding:

Since funding by the Community is an essential factor for Community development and independence of Health activity, the following may be considered :

* involvment of other Co-operatives etc with health activities of KSSS-CHDP
* can the "25-paise scheme" which was successful earlier be tried again for health?

2. Will more emphasis on physical and mental health in addition to social health be helpful towards CHDP goals?

3. Can KSSS-CHDP be able to withdraw from certain activities and step into other areas where more development is needed-without affecting the programme already initiated?

4. Can CHDP evolve a newer vision by incorporating the needs and aspirations of the local population.

5. Can criteria for admission to Mahilar Mandrams be enlarged to encompass a larger number of people including non-beneficiearies.

6. What is the scope for 'Kutumba Mandrams' to enable men, women and children to be involved in health together.

Community Health & Development Programme of Kottar-Social Service Society

Summary of discussion held on 20th October 1989 between CHDP team, consisting of Sr Christy, Ms Savasam and Ms Ambrosia and CHC team consisting of Gopinath, Mani and Shirdi at CHC office

Background

CHC team had previously held a 'brainstorming' session with the CHDP team, subsequent to this they circulated a questionnaire among their team members and the Community they were serving to develop a framework for an avaluation that they were intending to undertake. A non edited summary of the responses was sent to CHC.

Discussion summary

CHC team requested the CHDP team to go over the events that took place after the last meeting, as the report, "views and opinions regarding CHDP evaluation" sent by them was confusing.

CHDP team narrated that on the basis of the discussion with CHC the Central Committee of CHDP prepared a questionnaire to obtain information/reaction from the various groups of people involved in the project, namely Mahila Mandrams (MM) members, MM staff, CHDP staff and Community Organisations. The following questions were asked

1. Is there a need for evaluation?
2. Why is there a need for evaluation?
3. Whose need is it?
4. Which aspect of the programme needs evaluation?

(This questionnaire did not take into account the report 'KSSS-CHDP Evaluation Planning' sent by CHC as it was received late)

The questions were discussed by Community Organisers who then communicated them to the various groups of the project mentioned above

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and brought back their responses. The non-edited summary of these responses is the report 'views and opinions regarding CHDP evaluation' Annexure.

To the first question - 'Is there a need for evaluation', majority felt there was a need. There were diverse responses to the remaining three questions. These responses were read out and clarified in the discussion, during which process some aspects of the structure and functioning of the MMs and CHDP team also became clear.

The CHC team pointed out that a large list of areas to be evaluated has been suggested in these responses. The next step was for a committee with enough powers to prioritize this list of areas to be evaluated taking into account the resources. CHDP could mobilise for an evaluation and the time duration during which the evaluation was to be completed.

Another suggestion was to consolidate the reports of evaluations in the various subsectors made over the years and make decisions on the basis of that, namely

1. yearly facilitation done by Ms Nalini
2. C.O's evaluation
3. Health Guides training Evaluation

It was also pointed out that some aspects that were brought out, for example the insecurity related to possible stoppage of CRS food assistance, needed to be looked into more urgently, without being necessarily linked to a larger evaluation.

After these steps were taken if CHDP Committee felt external assistance was needed in particular areas to be evaluated, they were to communicate with Mani Kalliath of CHC or other resource persons/group involved in CH support wotk in India.

Sr Christy of CHDP said at the end of the discussion that they now understood evaluation in a different perspective, whereas initially they had understood that it was a task that CHC will take over and perform.

They now understood it is a task that was primarily their own with CHC acting only as a facilitator. Hence the CHDP team would have to sit together and reflect through their experience using questions raised by CHC team as pointers and their own internal audit, exploring and discovering new directions for the future.

APPENDIX 'F'

10th Jan 1989.

KSSS - CHDP Evaluation

Discussion with Dr V.Benjamin at CHC - a minute

1. Dr Benjamin has agreed to be involved , but would like to work with a team. A group of three would suffice for the field visit. Besides himself. This would include Dr Shirdi Prasad of CHC. We are actively looking for a third person - a women with a social science background fluent in Tamil as KSSS is largely a womens programme. Ravi Narayan contact Valli Seshan in this regard. She is very interested in KSSS but already has several comittments However she will think over the idea and contact us during the next few days. She also knows a Dr Saraswathi (?) in Madras who has a good background for the sort of work. She is due to be in Bangalore in the next week and may contact CHC.

2. A supportive brain storming group will also be involved in the process. This will include Mani (?) and Thelma Narayan of CHC.

3. Dr Bemjamin will be in Kerala at the end of February for some work and will try and meet Ms Nalini Nayak of the Marianad Community Development Project and have informal discussions. This will be between 23rd to 25th February. We will also try and visit Kottar and meet some of the central team members for preliminary discussions. Also Sr Lieve and Fr James if possible. His contact address in Trivandrum is - C/o. Mr. C Titus, 43 Tagore Gardens, Trivandrum - 11. He will be writing to Ms Nalini and Kottar in this regard.

4. A meeting of the brainstorming group will be held at CHC on the 2nd of Feb 1990, Friday at 10.00 am. to draw up a framework for the evaluation.

5. Dr Benjamin will be free between the 4th - 18th of March to work intensively on the project including a field visit for three days. Details, dates etc to be worked out by mutual consultation of the team.

6. Thelma Narayan has written to Sr Christy / Sr Lieve about these decisions for their reactions and also asked for some reports (refer letter)

7. We will also try and find out if anybody currently in ISI was involved with KSSS and try and meet them.

8. Dr Benjamin will be available in Bangalore till the 13th of January and also on the 22nd and 23rd of January and then on the Ist of February. He will return the WHO -KSSS report before the 13th.

COMMUNITY HEALTH CELL
Bangalore

Date: 8-2-1990

KSSS-CHDP Evaluation

Meeting of the support group on the KSSS-CHDP evaluation held on 2-2-90 at Community Health Cell - a minute

Those present at the meeting were Dr. V. Benjamin, Valli Seshan, Bhanumathy Vasudevan, Mani Kallath, Shirdi Prasad Tekur and Thelma-Narayan.

Valli expressed her inability to participate in the entire study as she already had several committments during the coming months. She introduced to the group, Banu, an applied social scientist with training in Anthropology and Personnel Management who has been working with Govt. and NGO groups conducting workshops on human resource development. She has also been involved in the evaluation of large health project in Karnataka.

There was a brief discussion about CHC and its activities , CHDP and its functions and as to how we got involved with the KSSS - CHDP evaluation process. A background note regarding the evaluation of the process during the past year has been circulated.

Some important points that emerged during the discussion were:

a) The importance of keeping in mind in whose interest the study/ evaluation is being undertaken. It was unanimously felt that the focuse of interest was on the project, its team members and the people of the area and not on the needs of any funding agency.

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b) There was a discussion as to whether it should be called an 'evaluation? People felt more comfortable with the term 'participatory assessment' (Perhaps 'Participatory study-reflection on CHDP' would convey the meaning of the effort being made). Basically, we are getting involved in a common search with CHDP reflecting on the experience ofthe past 17 years of its existence, trying to understand the present situation as it prevails in the region and brain-storming around what could be the future directions the project could take. This process would be guided and structured by a scientific spirit of enquiry which could draw upon experiences and approaches from the field of community health and social and behavioral sciences.

c) As a starting point we would need to look at the goals of CHDP. The long term goal of "social health for social change" is very broad. We would need to clarify what was / is meant by social health - both by the CHDP group as well as by us. What would be the indicators of social health that one would try to look for both quantitative and qualitative, keeping in mind the limitations of the same. The goup would collect information/papers on this area. We would also try and meet Dr. Saraswati from Madras, a friend of Valli's, whose research interest is in this area. This would possibly be on the 12th or 13th of Feb.

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d) A number of annual reports/studies of CHDP-KSSS are available at CHC for the members of the group to read. After going through these, each of us would write down our thoughts about the objectives and methodology of this participatory assessement. We will meet again on Monday, the 12th of February at 10.00 am at CHC to work on details of the framework that we are going to use. This will then be discussed with the CHDP group when Dr. Benjamin visits Kottar for preliminary discussion on 23rd/ 24th of February.

e) The following three person would be going for the field visit Dr. V. Benjamin, Dr. Shirdi Prasad Tekur and Ms.Bhanumathy-Vasudevan. Dates convenient to all three were in the last week of March. We are to contact CHDP to find out if these dates are suitable for them. It was also considered whether a second visit in April would be necessary. This will be finalised on the 12th of February.

f) At CHDP's request, we also need to workout the financial implications of the study. We will enlist the help of Mr. Gopinathan of CHC to work on the draft budget, which will be finalised with CHDP during Dr. Benjamin's preliminary visit.

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28 February 1990

STUDY-REFLECTION ON THE COMMUNITY HEALTH DEVELOPMENT PROGRAMME (CHDP)

OF KOTTAR SOCIAL SERVICE SOCIETY(KSSS)

An outline of the various aspects of the CHDP that could be looked at during the study has been given. The group can decide how much of this is necessary/feasible and also work out details of methodology. This note is primarily for discussion and to evolve a framework/structure for the study.

1. Background - an introductory note on how this study came about

2. General objectives

   a. To study the conceptual understanding of community health (CH) as it has evolved in the CHDP of KSSS over the years.
   b. To study the implementation of the community health programme in all its dimensions by the CHDP in the context of the overall programme of KSSS.
   c. To study the perceptions of the community of the CH work of CHDP.
   d. To suggest further developments in the community health programme for the future.

3. Specific Objectives

   A. Conceptual understanding of Community Health

      a. To study:
         - the definitions and parameters of CH as understood by CHDP
         - the long and short term goals, and
         - the strategies/methodology adopted to achieve these goals.
      b. To study the evolution in this understanding over the years i.e what were the changes that occured, how, why and when did they occur.
      c. To study the present understanding of CH by different people participating in the programme, viz.,
         - Mahila Mandram(MM) members
         - CHDP staff at MM/village level

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- CHDP training staff
- CHDP Central Committee
- Other KSSS programme members i.e fishermen's sangams
  potters' sangams

B. Implementation of Community Health programmes

a. To study the translation of the understanding and goals into programmes/strategies of action

a.1 long term goals and strategies

a.2 short term goals and strategies

b. To review the various aspects of activity of the CHDP historically

c. To understand the present operational structure and style of functioning of CHDP.

c.1 To study the functioning of the MMs, the functioning of health workers at this level and their linkages with CHDP staff and programmes

c.2 To study the day-to-day functions/job responsibilities of CH staff, viz.,

- Health workers
- Health guides
- Health educators
- Community organisers
- Medical Officers
- CH training staff

c.3 To understand the functioning of CHDP in the areas of:

- physical health
- mental health
- social health
- primary health care

raising community awareness around health issues

- community participation in health programmes

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parameters for the same especially Second health

c.4 To understand/evolve ~~social health~~

c.5 To look at the time spent by CHDP's staff on different aspects of their work.

c.6 To study the records maintained by CHDP staff and the use that is made of them in the running of the programmes.

c.7 To review in detail the training programmes in CH (looking at content and methodology) for all the staff.

- orientation session
- Health workers
- Health guides and educators
- Community organisers.

c.8 To study efforts in continuing education on community health issues for all staff.

c.9 To understand the dynamics of team functioning of CHDP

- sharing session
- use of feedback from the field
- decision making
- choice of priorities
- division of responsibilities

c.10 To look at the personnel management aspects of the CHDP staff

d. To understand linkages between CHDP and Government health programmes.

e. To understand linkages between CHDP and other KSSS programmes.

f. To understand the role of CRS supplementary food and its impact on the CHDP programme.

g. To understand linkages between CHDP and other NGOs - health and non-health in the region.

h. To explore linkages with other health groups in the country

VHAI/TNVHA
CHAI
MFC
AIDAN
LSPSS
ACHAN, etc

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C. To study perceptions of the community regarding CH work of CHDP Vix., from:

- members of MM
- current beneficiaries of supplementary feeding
- past beneficiaries of supplementary feeding
- non-members of MM - women and men
- youth
  * who have attended camps
  * those who have not
- previous staff of CHDP now residing in the area
- school teachers
- panchayat members
- doctors in the area

METHODOLOGY

Only general points are suggested . This will need to worked out in greater detail

1. Literature review
   - All CHDP-KSSS Annual Reports, Training programmes curriculu, Evaluation reports.
     Reports of studies on various aspects of KSSS
     (see list given in background note)
   - other literature on health programmes and their evaluation.
2. Field Visit
   a. Data Collection
      - existing records eg., from CHDP and analysis made from them
      - data from local PHCs, DHOs on health indic tors ?
      - demographic data from District Census Handbook
   b. Focus group discussion
      on certain areas with a chcaklist of questions for different groups.
   c. Questionnaire ?

APPENDIX 'I'

KSSS-CHDP EVALUATION

Minutes of meeting of study team - 03 March 1990

Members attended :

Dr. V Benjamin (VB)
Ms. Bhanumathy Vasudevan (BV)
Dr. Thelma Narayan (TN)
Dr. Shirdi Prasad Tekur (SPT)

A gist of the proceedings

1) Dr. V Benjamin acquainted the team about his meetings with Fr. James, Sr. Leive, Gaspar Mary and some other members of the KSSS-CHDP, and his impressions.

2) A field visit of five days duration would be adequate if proper planning is done

3) The team would be able to meet the central committee, Mahaila Mandrams, other CHDP team members, participate in activities which are on during that period and evolve plans for a future visit if needed during these 5 days. The field visit dates agreed upon were,
- leaving Bangalore on 15 April 90 to 22nd morning
- at KSSS-CHDP 16th evening to 22nd morning
- leaving Nagercoil 22 April 90 morning

The field team would consist of Dr. V Benjamin, Bhanumathy Vasudevan and S.P. Tekur.

4) The areas of responsibility during field visit to focus study on was,

VB - Personnel/Management/Administration/Training in Health

BV - Women's Groups and Activities/ Social Health

SPT- Child health and Health related activities in general.

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The team at Bangalore would interact for 2 more sessions (9 and 10 April 90) in the afternoon at CHC prior to field visit and later, dp depending what evolves from the visit.

5) The budget for the v evaluation was agreed upon (copy attached)

6) A short study of available health data/related data/history of K KSSS-CHDP to be prepared before next meet.

7) Methodology for participation involvement of KSSS-CHDP personnel in the i evaluation to be evolved by individual members and brain-stormed at next meet.

8) Inform KSSS-CHDP of visit dates and any other requirements for the study

9) To contact Ms. Nalini Nayak at Bangalore during field visit.

OBSERVATIONS ON THE HEALTH SERVICES DIMENSIONS OF KSSS-CHDP during the visit of the study team between 16th to 20th April 1990.

OBJECTIVES : The objectives of this exercise were,

a) to understand the role of the Health services in the KSSS-CHDP long term goal of 'Social health for social change.'
b) to understand the strengths, weaknesses and opportunities available in these services.

METHODOLOGY :

Field visits were made to Village health centres picked up at random by the study team. Coverage of all four taluks of Kanyakumari district representing coastal, hills and plains regions were ensured, to understand any variations among these areas.

CONCEPTS / UNDERSTANDING OF THE STAFF:

The following concepts/understanding of the health services were picked up from the members of the central committee, community organisers and village health teams.

- The health services component started in 1972 in Kanyakumari district through a few dispensaries, mainly as a maternal and child health program.
- it started with the felt-need on Diarrhoel disease management.
- the focus from the beginning has been on women, utilising Health Education as an entry point to working with them.
- all staff, except the Doctor have been women.
- the services expanded rapidly to cover 126 villages from 92 Mahalir mandram centres.

OBSERVATIONS :

The observations of the study team are recorded at the following levels -

1) the village level,
2) the Doctor and his role, and
3) the central committee, training and co-ordination.

The strengths, weaknesses and opportunities at these levels are explored.

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1) The village level :

Strengths :

a) all health related activity takes place from the Mahalir mandram centres which are located in Church premises of the village. This gives a certain official sanction to their work.

b) the village staff are usually a team of 2 to 3 women - a Health Guide (training one year), a Health Worker (training six months) and an Animator. Despite designation, their areas of work overlap and all are equally competent and mutually supportive-

c) the health team members are resident in the same or adjoining village as the Mahalir mandram/Health centre.

d) the team are employees of the Mahalir mandram with a salary ranging between Rs 600 to Rs 800 and working experience between 6 to 9 yrs.

e) they are involved in all activities of the Mahalir mandram, including CRS food distribution, running of fair-price shops, tailoring classes and other income generating activities.

f) despite lack of CRS food supplies in the past few months (which is the main source of the Mahalir mandram income, hence their salaries) they have a positive approach to their work.

g) they feel competent to tackle minor ailments and render first-aid. They handle simple drugs in their day to day activity and relate well to the doctor.

h) they enjoy a good reciprocal relationship with the local Govt. health staff and utilise Govt. health facilities for immunization, major ailment treatment and National health programs.

i) in addition to the above, other health related activities include,

- Health Education to mothers during pregnancy and after delivery,
- Identification and monitoring of malnutrition in children, including nutrition education to mothers,
- House visits and Health education during visits,
- Organising health check-up, diagnostic and therapeutic camps with the doctor,
- Encouraging the sanitary-latrine concept through inputs from the CHDP, and
- Conducting camps and seminars for youth on social-awareness issues.

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Weaknesses:

a) Being employees of the Mahalir mandrams, they are not members and do not take part in decision making processes.

b) The flexibility seen in their working hours is limited to an 8 to 4 or 9 to 5 pattern, when working women of the village may not be able to take part in their activities.

c) Their focus of activity is restricted to members of the Mahalir mandram and directed more towards CRS beneficiaries.

d) Drugs supplied to patients are free or on payment, depending on CHDP directives and not on patient needs.

e) There is no formal arrangement for referrals for major ailments. Hence no responsibility is taken beyond minor ailment treatment and the patient is left to fend for herself/himself.

f) They are not trained in Health promotion or Rehabilitation aspects of preventive health care and do not initiate any such activities.

g) A large part of their working time is taken up in maintaining extensive records/reports/returns (23 books and 6 reports per month) the importance of which they do not perceive.

h) They feel the need for security, formal recognition and incentives in their work.
e.g. - they are employees of the Mahalir mandram, while their activities are directed and supervised by the CHDP. They are answerable to both.
- their salaries are dependant on CRS food supplies and other income generating activities of the Mahalir mandram which are not always dependable.
- they are supervised by the community organisers whose focus of activity is on social awareness, while the Doctor is clinically oriented , with very little time devoted to on-the-job learning or teaching as well as encouragement at the village health centre.

i) they are looked upon by the people more for initiation of social action and not for health related work.
e.g. they are approached more for water/womens/employment problems than for community health problems.

2. **The Doctor** :

There was only one Doctor during the study-team visit, the other having recently left for alternative employment.

The Doctor's activities are predominantly diagnostic and curative during visits to health centres. He is able to visit one to three centres every day on a monthly plan submitted to the CHDP. He is also involved in health camps with a diagnostic/curative orientation depending on the local demands.

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STRENGTHS:

a) The Doctor is responsible for all technical (health) training of the village health workers, and is responsible for all their health activities. This puts him in a position of having a good overall view of health activity in the CHDP.

b) He works in a milien where social awareness is already high and mechanisms for social action are functioning.

c) He enjoys a good rapport with the health workers, and hence, support in health related activities.

d) He has popular people's support for diagnostic and curative health camps.

WEAKNESSES:

a) The area of responsibility is large geographically and technically for only one or two persons to handle. The spacing of visits to cover all 126 centres, leads into depth of local health needs.

b) Good co-operation and proper co-ordination is required at all levels for the Doctor to be able to discharge his responsibility.
e.g., when the study team visited a village health centre on the Doctor's planned schedule, there was nobody at the health centre due to lack of information to health staff from the community organiser.

c) The Doctor expressed diffuculty in trying to balance health activity with social awareness activity at village level, since the ultimate implementors of either would be thevillage health staff. They would not be able to undertake too many things simultaneously.

d) The mushrooming of commercialized private enterprise in health in Kanyakumari District puts excessive demands on his technical skills and ability to move towards more rational and cost-effective means of health care.

e) The lack of a formalized referral system limits his responsibility to tackling of minor ailments only, and adds to his inability to cater to health demands of the people.

f) Being involved only in the technical aspects of health training of the village team, predudes from a wider understanding of their needs.

g) The Doctor feels marginalised in the CHDP central committee where social awareness activities dominate over health matters. Even here, his expertise is restricted to "allopathy".

e.g., the central committee decision to train health workers in "siddha" system of medicine was based on the popularity of this system amongst people, and not related to their disease pattern and health needs.

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3. THE CENTRAL COMMITTEE, TRAINING AND CO-ORDINATION:

The Central Committee of CHDP has 11 members including the Doctor, Co-ordinators of Training and Nutrition, representatives of the Community Organisers and the Executive Director of K.S.S.S.

Strengths:

a) The central committee plans, executes, monitors and supervises all activity of the CHDP related to Health, Social awareness and CRS food supplements.

b) The facilities for training of health workers are good and time tested.

c) Members of the central committee get indirect feed back through community organisers, while most of them also directly interact at the village level - to a limited extent.

d) Members of the central committee attend seminars/courses/ workshops regularly as a method of staff development, which encorages cross-pollination of ideas.

e) They organise regular formal meetings where decisions are taken jointly.

Weaknesses:

a) Training

-The initial pattern of training of Health Workers was based on that of the Government health services. This has not changed.
-Innovations in training methodology and modifications suitable to emerging local needs have not been explored.
-Continuing training programs are social-awareness oriented and not adequately linked to health.
-The Doctor is used as only a technical trainer for health and does not form part of other training activity.
-The introduction of training in "Siddha" system has not been directed towards specific health needs of the people.

b) Co-ordination:

-The co-ordination of health activity is considered secondary to other activity. It is predominantly related to making of reports, returns and time-tables.

c) Nutrition:

-The "Health Mix" has too many ingredients which makes it costly. More appropriate cost-effective methods of supplementation have not been explored.

d) Other aspects

-An inadequacy of leadership in health matters as well as planning of need-based focussed programs in health has put health matters to secondary importance.

-Utilization of health statistics, reports, and returns as well

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as the studies conducted to update and modify health programs is not explored.

-The health aspect of the CHDP program has not been truly decentralized in practice, which entails a flexible ap roach to felt needs of the community served.

-Co-ordination of health work with the other Government and private health resources in the KSSS-CHDP areas does not have formal sanction and required liaison at the central level.

RECOMMENDATIONS:

a) Forming of Health Committees representatives of village level health workers, people, the Doctor, Government Health Services and Private Health Services representatives to look into the Health needs at local level and adopting flexible approaches to be explored.

b) Forming of a Health team at the central level with representatives as detailed above to be considered.

c) Revamping of Recording systems to enable identifying of health needs and also to reduce paper-work at the periphery to be explored by Health Committees.

d) Revamping of Training methods/content and continuing education in health by a team with representatives from all levels (trainers to trainees) to be considered.

e) Delinking of village level workers salaries/security needs from CRS based and other income generation activity to be considered.

f) Health Education methods to be updated and more emphasis on Promotive, Preventive and Rehabilitative aspects of Health to be explored and tailored to local needs.

g) A middle level cadre of health personnel like public-health nurses to be considered to deliver more meaningful maternal and child health care as well as good technical supervision.

h) Introduction of alternative systems of medicine to be explored on the basis of local needs, cost-effectivity, rationality and acceptance by the people.

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Funding - 7 health cess / insurance

A. STATE OF ART OF PROJECTS ADDRESSED TO WOMEN AND SOCIAL HEALTH (DEVELOPMENT PROCESS) IN KSSS-CHDP AND EMERGING RECOMMENDATIONS.

Since social health andwomen's movement are inter-linked in any rural development process, the paper is addressed to deal with them simultaneously.

For a fair understanding of the 'state of art', the observations and comments are picturised under three headings-strengths, blocks and opportunities, followed by recommendations.

I. CORE STRENGTHS:

1. A very obvious and evident strength is the name/repute CHDP has earned today in rural development and women's work through its solid, massive and intensive work for 2 decades, culminating in a network of 92 registered MMs for rural women and their associated processes. This can be claimed by very few organizations in India today. This can be compared to a torrential waterfall/river which is available and has the potential either to waste aaway, falling/ running or put to use to transform the drier areas into fertile pastures bringing life and work as energy multipliers.

2. The above strength of KSSS-CHDP has resulted in the development and growth of emotionally and professionally developed vil age staff, who possess skills in delivery of MCH and have also gained the confidence of the local population, who consult them even after consulting the PHC or a local doctor. Besides, these women genuinely have a very keen interest to work with and for people in the areas of conscientization, education and economic freedom and have a flair for activist work. In our sample villages the team witnessed these factors vividly. Provided even 50% of the 92 MMs have such staff, it is a commendable achievement in the area of transformation and such a strength is now like a new found t treasure. Everyone of them whom we interviewed had not received their salary for nearly three months and in spite of it they were in high spirits/morale generally.

3. The process and development of delivering MCH over the years has resulted in a kind of women's special clinics in these villages where they can find their space socially, emotionally and psychologically. This is one of the unique and special features of the programme which is also a great asset to the project.

4. During the course of the project, the leadership of Sr.Leive has motivated a large band of women who have the fire, zeal and commitment to work for women. This has been witnessed during our field work. CHDP has built up gradually a team that believes in commitment to women, relentless hardwork, and who possess a conviction that women need to stand together despite differences. This has given rise to a friendly, supportive atmosphere where each others mistakes are tolerated/accepted. This team has clarity of concepts on social health andare willing to reflect/introspect for any required future course corrections.

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5. Further, reflecting on the galloping phase of the project, where in the initial stages the village centres shot up from 5 to 11 in 1970-75 and the number of women's clubs multiplied to the present status of 92 registered MMs, it seems to suggest the occurence an extra-ordinary phenomena. One of the reasons which strongly manifests is that the entire project work is looked upon as diocese work and hence God's work. The very fact that the project is held by a diocese team to bring in acceptance of the local population due to the rural religious fervour and sentiments, though the work of the project has a feminist and activist orientation. There seem to be a general sanctity and sanction due to this for the MMs to exist and function. (that most of the MMs are housed inside th church compound is a revealing expression of this factor).

6. Rural women in these villages by virtue of their association with CHDP have become aware of their rights and responsibilities and generally moved from a fatalistic attitude to one of awareness of the possibilities before them. They are conscientised not only on health related matters but also in their social realm. CHDP has achieved this over 2 decades and now it is one of the most powerful strengths in hand.

II. BLOCKS TO CONTINUED GROWTH IN THE QUALITY OF THE PROGRAMME AND A CAUSE FOR THE CURRENT STAGNATION.

1. At present, there is a visible lack of leaders who have the vision and the capability of leading the organization in new (creative) paths towards its goals, those who can operate with a feminist orientation and perspective timpered with diplomatic and strategic skills, objectivity and co-ordinating and net-working strengths. This is the need of the hour at CHDP. This block has perhaps lead to stagnation blocking the flow of new energies within and outside the organization. In our observation and field work, we saw that work routine is well attended to so that the organization can sustain its functioning. In terms of handling situations which need confrontation, taking charge, risk taking and decision making, it is everybody's forte and nobody's responsibility. Since Sr.Lieve is weaning off and Sr.Christie has given her resignation and is awaiting clearance (attending to routine and administrative jobs) and Gasper Mary has not positioned herself in a co-ordinater's role (prefering to be back-stage), there is an apparent confusion on who is to lead, or can we all lead? In such circumstances, the non-vocal members remain at the periphery with almost nil-contribution in a given situation and the vocal animators occupy the stage. The animators work being conscientization of rural workers and MM members and helping to conduct camps, debates and training programmes, most of the work in in the project is only in these directions presently. In short, the animators work becomes the agenda of the project and the rest of the work takes back-stage. This is leading to a situation where the persons who are accountable for the performance (co-ordinator) of the project are not aware of their personal accountability and therefore feel that the central committee will take care of all that is needed to be done and looked into. The nature of the work climate being what it is-(friendly atmosphere

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where mistakes are tolerated/accepted and a strong belief that as women we need to be united and bury our differences at any cost) it perpetuates such un-professional, subjective and non-functional situations. Further, though the animators as a group are of a militant feministic orientation they seem to lack the perspective (context/frame of reference) to translate it into their organisational work ethos (characteristic/spirit) in a broadframe, keeping in view the environment, organisational handicaps and strengths and the ultimate target and goal of development of the rural population especially women.

2. Alienation of village staff (who are referred to as one of the core-strengths) gradually from the mainstream of CHDP is gathering momentum presently. An intriguing process, perhaps developed over the last 2-3 years, is that inspite of the strict reporting/controlling relationship and annual learning inputs through training programmes/refresher courses, there is a consistent message given to them that they cannot emotionally belong to CHDP but to the MMs, since MMs are in 'letter' their 'employers'. Another interesting process happening alongside is the current attitude and action of CHDP/central committee who feel they have nothing to do with village staff except supervision of their work and record maintenance of CRS food. An ambivalent (co-existence of contradictory feelings about an action) process that is happening alongside is the village staff emotionally possess a sense of belonging to CHDP and look upon them as an organization that cares for them and wishes to nurture their growth and development. There is a big gap between CHDP and village staff in the way they perceive each others work relationship.

3. A wide gap between belief in people's participation in the project and the way it is implemented/translated in the project and organizational processes. It is evident for example in the controlling relationship between CHDP and the village staff (more in tune with a corporate office dealing with their units- an industrial model), non-representation of village staff and MMs in the central committee as a participatory step in decision and policy making processes, the inclusion of a clause in the bye-laws of MMs which says MMs should be under the control CHDP and the very process of decentralisation at CHDP which has retained decision making power at the centre with responsibility down below.

4. At present an excessive pre-occupation of CHDP central committee (especially animators, co-ordinator and community organisers) on debates on women's issues like dowry, rape etc., seems to be blocking the organization from evolving creative. alternate approaches at the grass root level for social health and emancipation of rural women. Besides CRS food, MCH awareness

and debates, youth camps are undertaken by the respective MMs and they also possess the capability of drawing up local resource as well which was apparent in our field work.

5. Certain attitudes that seem to be operating in CHDP central committee-women members also might be contributing to stagnation. To mention a few of them which remain as un-examined assumptions:

i) In the work-related areas

-Decentralisation means decentralising work load and retaining decision making and authority at centre.
-The higher the authority invested in the ranks of the central committee members, the lesser field work or nilfield work is in order. (e.g., the co-ordinator and nutrition-coordinator have no field connections responsibility necessitating field visits, but this is only optional if they choose to). Invariably because of higher administrative work load, they do not find enough time to visit vil ages and do so only rarely during organized meetings.
-CHDP has to act as 'brain and power centre' for MMs.
-Application of uniform rules and regulations are essential with MMs and village staff irrespective of regional/cultural, socio-economic differences in each region, for e.g., 9 A.M. to 5 P.M. working hours in a village, where mothers go to work during that period (especially the poorest of poor) and would be free only later in the evenings.
-CRS food and ongoing linkage and partnership with KSSS is the cause for a lot of problems in CHDP. If both are removed, CHDP will not have much problems.

ii) Working as a group of women in central committee

As a team of women-unity means burying differences, objectivity, tolerating the colleague for all mistakes/shortfalls even if it affects the organization. A friendly andsupportive atmosphere can be built at the cost of the task. We can be aggressive, rebellious but not confront each other whenever thereis a need since it would be considered unfriendly.

-Following this, with a lack of objectivity, the assumption that seems to be operating is that the organisational structure is on paper and for operating purposes it can be shelved and we can together do everything. Perhaps since we are women it is not necessary for us and we can operate like a family where tasks are carried on somehow whether each one contributes, feels accountable or otherwise.

-Observation of joint meetings of CHDP and village women seem to reflect the current attitude of the central committee that 'we are working for women and not so much with women. One example of this is MM members are not given enough space to voice what they

feel but given opportunity only to answer the questions put forth by the animator and almost forced to answer them to prove their participation.

-Another assumption following this could be that allowing more space for rural women to talk freely would mean inviting problems and therefore suppression is a better strategy.

-For any socio-economic project for rural women, a large amount of capital is required and non-examination of the process of encouraging rural women to start micro-enterprises and become entrepreneurs.

Opportunities before CHDP as of now

A tremendous scope exists for converting the strengths mentioned into channelised energy.

-For creating a rural women's movement in socio-political areas

-To bring forth economic freedom to the poor rural women

-To network with other women's organization

-To learn from each other and work together

-To utilise state and central government schemes to the maximum

-To utilise the doctors

-To train health guidesphealth workers, and

-To devise training programmes for other women outside CHDP and the 92 villages since talents are readily available.

The opportunities before KSSS-CHDP are unlimited.

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Mrs. Bhanumathy Vasudevan

I. RECOMMENDATIONS

To Build an Effective Professional Work Culture:

1. As a team of central committee (CC) members make efforts to include the doctors and the KSSS representative and Chairman, Fr.Lawerence, so that initially they can have an opportunity to sort out differences, confront issues and become a functional contributing committee. It is a tough task and would need an external process consultant for the initial few meetings to maintain objectivity. A team building programme should be taken up for the CC.

2. CHDP central staff and their co-ordinators meet outside their territory for 2 days (to be free of interruptions) and look at unexamined assumptions unconsciously operating, which they are not aware of ~~at~~ and look at what alternatives are possible from each one of them as an individual. It is preferable that every member be present all through the three days. These 3 days would not deal with their organizational structure, responsibility and the like but their personal attitudes, beliefs, agendas that influence CHDP's functioning as an organization. This would also need an external process consultant so that the task declared for the event and the objectivity can be maintained. This meeting should also result in personal action plans and commitment from the individual for the organization's effectiveness.

3. Women in the central committee together look at what are their feministic orientations and how do they translate it for the development of rural women, in economic, social, political and personal realms?

4. Conduct a programme with an objective of achieving application of Management skills for the CHDP central committee members, since there seems to be a lack of management skills in the organisation.

II. In the Area of Social Health and Women's Development

1. Take stock of the nature of membership in each MM as to what is the percentage of women who have a fixed income through their husbands/sons in the family, women who need to earn a wage to fulfill their basic needs (poorest of poor) and percentage of 1 leaders who can take initiative, and have a concern and commitment to work for the poorest of poor women in their village. Accordingly, develop a fair balance of all kinds of members by consciously recruiting those who need the benefits and those who can be pro-active.

2. Cover 20% of these members in all categories through a short survey of specific 2 or 3 questions (open ended) as to what direction they would like CHDP to move, what else they would like

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CHDP centr
CHDP to do, besides CRS food and health. None of the CHDP central committee members should be part of this survey. The MM should independently conduct the survey. Besides, MM should also conduct the same survey with 20% of non-members in their village. This would give a fair direction for CHDP and in what direction they need to move to fulfill the needs of the people they are working with and be aware of the specific current rural realities of each village.

3. CHDP central committee to examine the nature of women's issues they are taking up in meetings, training programmes, and debates. Our observation suggests it is getting very rhetorical, a streotyped way of conscientising, almost an overdose to the same group repeatedly. For e.g., the songs generally sung by groups as women's special songs reflect self-pity, inability to assert, powerlessness and helplessness instead of being motivating, empowering, hope-building, dealing successfully with everyday problems. Another point of view could be if dowry/rape is not an issue with poor rural families in a village, over-importance to this issue is futile and mere activity. There may be specific burning issues of women in a particular village and perhaps dealing with that issue in forums would be functional. Since CHDP has become a large organization covering 92 MMs their training programmes, the issue being dealt with, the way of functioning need not become one single way/direction but build in flexibility in these areas to deal with specific issues of a particular village, and adopt functioning methods and programmes accordingly, e.g., in a particular village women may not get the same wages as men irrespective of the work being same. Perhaps such issues need to be addressed too.

4. Dealing with specific realities of rural women is a sensitive and delicate work requiring perseverance, courageement and diplomacy on the part of CHDP. To enable themselves to work in these areas, it is very important to build local support-the parish, locally respected and 'powerful' men and women, and local NGOs and Government agencies as friends and well wishers of the project. Very consciously linkages and bridges should be built so that the community in the village looks at women's work as relevant and meaningful in their minds, as ultimately development of the village is brought forth through these women. Our observation suggests that CHDP almost works in isolation in villages, whereas MM staff are aware of building linkages as a natural way of support system.

5. If the philosophy of collaboration is adopted, rather than working in isolation, it would be a greater strength to CHDP to counter communalism spread through RSS and such forces. Collaboration with central agencies like CAPART, Central Social Welfare Board, Appropriate technology forums, other NGOs operating in the area with similar ideology and objectives is the imminent need of CHDP now. This would also bring in 'development' orientation

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in the place of 'activity' orientation. Ine possible cause of 'stagnation' the central committee is talking about in our field work could be due to this 'activity orientation' where there are lots of activities visible but growth is relatively low. CHDP needs to explore the process of their work and what orientation they are moving to perhaps very unconsciously. For e.g. conscientisation helps women to become aware of what is happening and her rights and responsibilities for developing herself and to live as a respectful human being. Now that, this has taken place in the last 2 decades of CHDP's work, the present question is- where do they move from here to translate their awareness and understanding in her personal, social, political and economic life. It would then mean asserting in the employement market, taking visible authority positions in society, socially and politically, becoming self-employed enterpreneurs, etc. For this at the CHDP central committee, there are no examples. May be they shy away from such positions. Due to extensive and intense work with women are very much aware, trying to unshackle the societal pressures on women and now there is a strong possibility that this can be converted with less efforts and support into a women's movement itself.

6. CHDP may explore the possibility of decentralising their training programmes and debates at village level in collaboration with MMs. This would enlist more men, women andyouth to take part, if they are conducted in the villages. This would also bring more contacts with field realities for the central committee members. Already MMs have started taking initiative and conduct debates, youth programmes, etc., this can be further developed so that MMs start operating as change agents besides delivery of MCH services. This would also relieve many central committee members and give them more time to work <u>with</u> people. This is a possibility where the village staff and the existing body of MM (which are few of the core strengths of CHDP) can hear a multiplier effect.

7. Our observation suggests that CHDP will have to address itself to socio-economic programmes for women. This came up very strongly in our field visits. Women are very eager now in the villages to gain economic freedom and consistent income . One possibility is networking projects wherever necessary. Work with central and local institute for entrepreneurs and small business development in the region, local department of industries and commerce, so that rural women can experiment, explore to become micro-entrepreneurs individually or engage as a group of local women in an economic venture.

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APPENDIX 'I'

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FEEDBACK ON THE OBSERVATIONS BY THE C.H.D.P. COMMUNITY ORGANISERS WOMEN & HEALTH TEAM ON YOUR PRELIMINARY REPORT ON THE HEALTH SERVICES DURING THE VISIT OF YOUR STUDY TEAM LAST APRIL 1990

.....

As mentioned already in our letter dated 21.9.'90 we have been working with your various papers and therefore it has taken time to get the feedback from all sides. In the meantime situations and circumstances of which we will give more details below have already helped us together with your observations and recommendations to make a major transition in the approach of health services and activities.

To be able to give the feedback of what we have been able to consolidate from the various discussions, we keep to the order of your reports.

1. First part observations

We feel that this part gives a few very short observations of the objectives, methodologies and concepts and we agree that it is difficult to put the history of nearly two decades in a few lines. As for example the initial goals were never thought of diaroheal disease management, but primary especially in the coastal villages on the felt need of hygiene sanitation, nutrition, education, women's employment etc.

1. In the village level weaknesses:

We do appreciate your observations and they have helped us already in radical transition of our approach.

Especially to:-

b) Workin hours. It has taken quite some discussions and adjustments to reach an agreement of working hours according to the needs of the women, for example most of the Sundays are working days now. So also evening programmes and other adjustments.

c) till f) will be reacted on later as we give the new experiment and work plan.

g) While agreeing on your observation we wish to say that most of the records are required by C.R.S. and also registrar.

From our own experience we wish to add that unless data and reports on various activities are maintained, No follow-up and valuable continuation can be expected, since we don't have professional people among us, but all have started as village community workers.

We wish to give you also a clarification to the overall observations you made regarding job security etc ... All of us started as voluntary workers, and one of the initial goals was, to make use of the high percentage of educated young girls in our district by training them for future life, inservice to the larger community.

Uptill the early 80, hundreds of young educated girls have been trained and served as health workers and health guides uptill they got married when they left the programme and others were taking their place.

It was at a time of decentralisation and registration of the local Mahalir Mandrams that rightful demands were made for continuation of work after marriage. What was first intended as a "Preparation for life inservice to the larger community" had to be adjusted with all the unforeseen tensions and demands this might involve, and there were plenty which have helped us towards the present transition. We hope this clarifies many of your observations.

2. The doctors

Most of us do not think that you have been able to understand the lack of collaboration of the doctors with the community health workers.

During all these years it was the first time that we experienced this tense relationship. Dr.Mani will surely confirm this. This last few years the first negative experience. The doctors exclusively stressing curative care and the goals of the programme being preventive and promotive. Also very much the dimension of social health, the total well being of the person. This attitude has confused the health teams and community organisers.

Last April one doctor resigned and Dr.John also resigned in June, since both got Government employment. Since then we have been able to clarify our objectives and we have appealed to the P.H.C. doctors to help in the different areas and also with the service of two part-time doctors of different health systems we try the approach of more integrated health services through different activities.

3. The Central Committee, Training and Co-Ordination

In the process of transition, having very much in mind your valuable observations and recommendations the above committee is not functioning and we are working on a modified work plan of which we will give more details below. We have been trying to get the service of a public health nurse and the last enquiry gave a positive response.

Feed back on the report of Mrs.Bhanumathy Vasudevan

1. Recommendations

This report has been mostly appreciated and recommendations studied, related to the first part we said already above that in the transition experiment the Central committee is not functioning. Having in mind the given recommendations we found it better to integrate ourselves in the different units of the present activities. Still we need badly to achieve management skills. We had a few intensive workshops with the help of Sr.Lieve. She has accepted to help us till we have the right committed person.

II. In the area of Social health and Women's development

We are in the process of taking stock of the nature of membership in the Mahalir Mandrams. The survey papers of a few areas have come in, but we have not studied yet the trends. Any way we keep this very much in mind and see the need to which direction we should move.

All the other points have helped us very much in the planning of an experimental transition we are working out now.

III. As a response to your paper as the last part of your preliminary report with its

I Core strengths
II Blocks

We have taken time to study the same and since June '90 we are attempting on all together different approach. We had several sessions to work out the work plan and the start has not being easy. We are all happy with the new orientation and we give here below a summary of:-

Work plan of new phase of Health Services & Women's Activities in C.H.D.P.

Introduction:

All C.H.D.P. activities are worked out and implemented through local organisations mainly through Mahalir Mandrams.

1.- Mahalir Mandrams are organised by C.H.D.P. Community Organisers

- The members of Mahalir Mandrams are not related to C.R.S. Programme but open and responsible for all activities, and have a concern and interest in the continuity of the Mahalir Mandrams.
- Therefore, though Mahalir Mandram members may be eligible for C.R.S. food for a period, they will not be accepted as Mahalir Mandram members if not interested in a continuity of membership before and after their eligibility of C.R.S. supplementary food.
- For the period they are eligible for C.R.S. food, they will not be eligible to be elected as President or Secretary of the Mahalir Mandrams.

2. Mahalir Mandrams conduct local activities, take up issues and link up with larger movements with the help, support and follow up of the C.H.D.P. Community Organisers.

3. C.H.D.P. Community Organisers collaborate with other groups and organisations having a similar vision, goals and objectives:

- B.C.C. (Basic communities)

  Mainly for Health education and services and issues on women, family, village.

- C.A.T. (Centre for Appropriate Technology) for alternative women's employment schemes.
- implementing scheme in appropriate technology for women etc. at village level.

- Direct Organisational movements of women - workers for environment, ecology, polution, protection of natural resources etc., taking up issues, struggles demands for their basic rights.
- All activities are people oriented, therefore not directly related to any political party.

There is a growth awareness of the distressing reality of the situation of women in the family, the village and society, the continued urgent need for preventive and promotive health, the destruction of material resources and the need for education and participation in activities to protect and preserve nature, specially related to water and water management, fuel a nd alternatives, basic needs, and alternative employment for women. Taking up women's issues and organisational work in the fields of discrimination of women and workers' movement.

The C.H.D.P. has entered a major transition, making efforts to take up these needs.

1. The C.R.S. applied Nutrition Programme which was till now a sustaining incentive to many of our health programmes and women activities, has also made the same dependent on it's continuity. In view of facing out gradually this programme, a transition is made to work with and through the local organisations of people, specially of women. The C.H.D.P. is also giving it's support to the growing number of Basic communities to ensure the continuity of preventive and promotive health services. At present there are about 450 basic communities of some 30 families each. There is a voluntary health worker, also a woman promotor in each of the communities. The urgent task is to give these health workers and promotors a basic training through short courses and sessions, which has already started.

An experience has been made in some villages in what is called "health camps", these include home visits, health surveys, evening s-essions, audio-visual shows, exhibitions of native therapies, sharing on home remedies, cultural items etc.

The C.H.D.P. has also made efforts for some integrated health services making use of different health systems and a herbal garden has been started. Unfortunately we are having a severe drought and a tremendous scarcity of water, therefore consequently most of the plants of the herbal garden have dried up.

A Nursery teacher's training is also very much stressed and asked for by the women's associations. More women are aware of the need of pre-school education, and therefore nurseries and creches answer the need of working women.

2. The C.H.D.P. has made experiments in alternative training and employment for women and would like very much to pursue this in the coming years in collaboration with C.A.T. (Centre for Appropriate Technology).

A first experiment in masonry training has been made. 20 women participated in the preliminary course and it was foreseen to construct

4 low cost houses with latrines in the respective villages of the women. One of the houses has been successfully completed and the three others have been delayed by C.A.T. due to financial constrains. But it is assured that the other three houses will be constructed within the year.

Last year we made an initial break through with training of women in rubber tapping. Pre-judices had to be overcome, but this experience has brought a new awareness of women's potentialities. The 49 women who followed the training last year have been followed up and 37 of them are working as rubber tappers and another 7 are working occasionally. They are earning Rs.210/- to Rs.300/- per month according to the number of trees they are allotted for tapping.

With this incentive the training in rubber tapping and the follow-up of women will be continued.

Initial studies have been made for bricket making from the waste of the coconut fibre. All along the coastal belt there are small cottage industries in rope and mat making. The waste is piling up, polutes the area and is a health hazard to the people. The C.A.T. has made an initial study. During the coming year an experiment will be made to process this waste into brickets as an alternative fuel for firewood. The women will profit in both ways, making use of the fuel and a possibility of employment.

3. Some of the C.H.D.P. Community Organisers have started exploring situations of women working in the tourist sector, handicraft business etc., and also touched the tremendous problem of accute water shortage, it's causes and need for action specially in the area of Cape Comorin which is a fast developed tourist area with all it's consequence of people's especially women's discrimination. They will further work in this line in view of building up awareness among the oppressed women, organise them for possible action, in other areas and sectors of the District.

They will also support movements organising the most oppressed, specially the fishworker community and collaborate with all efforts taken to protect and renovate the environment from destruction, polution, etc., specially related to the accute water problem.

4. The C.H.D.P. will also collaborate and take initiatives in the non formal education programme launched by the Government mainly through the voluntary organisations aiming at 100% literacy in the District.

5. In service of all these health, and education, awareness and employment programme, cultural groups will be trained from among the youth and women who participated in camps and seminars. Songs, short social dramas, street theatre and role plays have proved to be very effective and appreciated, these will also be used in the basic community meetings.

6. C.H.D.P. will also continue to conduct seminars, and meetings for women, youth and children and closely follow up these groups at the village level. These have been effective in creating awareness in the larger village communities.

7. Also the Sanitation Programme remains a priority in C.H.D.P. An evaluation shows that up to 60% of the people are conscious of the need of private latrines and there is demand for the continuation of the sanitation programme in the coming years. As before the procelain sets with pipes will be given as incentive after the construction has been done.

Different Activities

1. Integrated health services

a) Make an assessment of local needs through interaction with members of Mahalir Mandram, Basic communities.

b) Start Herbal garden at Thirumalai C.H.D.P. Training centre.

c) Organised short & long training programmes in above services for interested volunteers of Mahalir Mandrams & Basic communities.

d) Make the services available in the different Mahalir Mandrams & B.C.

II. C.R.S. Programme

As said above C.R.S. programme will be gradually faced out. Therefore a minimum of six C.H.D.P. Community Organisers will continue to work in this section and make all efforts for a valuable transition.

III. Collaboration with Basic communities

Six C.H.D.P. Community Organisers will give their services which as already been specified above, with special stress of building up an infrastructure to provide the needed health services in collaboration with the Mahalir Mandrams as the members of both are very often the same persons.

IV. Collaboration with Centre for Appropriate Technology

Related to all activities of alternative employment and preservation of natura-l resources.

Training and follow-up of
- Masonery
- C-arpentory
- Smokeless chulas
- Water management
- Bricket making

V. Direct Organisational work

Eight C.H.D.P. Community Organisers will be responsible for studying and taking up social evils and issues related to women.
- Women, children's discrimination
- Dowry problem and issues
- Alcoholism
- Wife beating etc ...
- Organise women's solidarity groups to give temporary protection and if needed shelter to battered women till a possible solution is found
- Link up with larger movements for women, protection of environment, ecology, natural resources and human rights.

6 Any other initiatives coming up at the village level.

IV. Cultural Groups

4 C.H.D.P. Community Organisers will be responsible for organising and training interested young girls and women, area wise in cultural activities.

- Songs and short plays
- Street corner plays and dramas.

They will make themselves available in different activities of C .H.D.P. for:

- Awareness building
- Education process
- Celebrations.

During the transitory period for atleast six months weekly half day meetings will be held for the different groups of C.H.D.P. workers according to the proposed involvements, to assess, evaluate and plan the work.

All C.H.D.P. Community Organisers and co-ordinators are responsible for strengthening, organising and working with Mahalir Mandrams, Basic communities, women and people's movements.

They will submit their monthly work schedule and work report.

Conclusion:

As quoted in the introduction the C.H.D.P. Community Organisers are involved in various activities but all aiming at strengthening the women's organisations and the larger women's and people's movements towards participation in the process for better health and life and for having a share in the basic human needs required.

In the past, much of our work has been directed on working through C.R.S. programme. But realising the need of building up valuable women's programmes and activities independant of C.R.S. food, we have divided our involvements and responsibilities in different activities so that women's organisations may emerge in their own rights and we may work with them on a participatory basis.

The different activities are complementary in a mutual support of the same vision of "Social Health for Social Change"

We hope that our above feedback will give you some clarity as to the radical transition the C.H.D.P. is trying to make and we will be happy and grateful for your interaction on this efforts.

V Caspar Mary

C.H.D.P. Co-Ordinator.

Consultant.

Thirumalai
1.10.1990

K.S.S.S. - C.H.D.P.

Reflections of Dr. V. Benjamin on aspects of a) Personnel, b) Administration and Management, and c) Training, based on the visit of the Study-team during 16 April to 21 April 1990 and the response of the CHDP to earlier reports by Ms. Bhanumathy Vasudevan and Dr. Shirdi Prasad Tekur from the study-team.

1. Personnel :

This issue is dealt with at the three levels of Mahalir Mandrams (MMs), Community Organisers and Central Committee.

a) M.M. Staff and B.C. animators :

- need measures to ensure job-security in terms of pay/leave facilities and other benefits.

- matched with the responsibility of work they undertake, decision-making powers are to be delegated to these staff.

- this, in other words means that there is a need for more freedom to innovate, with adequate backing by the CHDP.

- M.M. Staff should be members of the Mahalir Mandram with no voting rights to help more active involvement in M.M. activities.

b) Community Organisers :

- need skills in community-health management to be able to plan/monitor/evaluate work in the MMs.

- need skill-training in areas of promotion of participation and methods of identifying the needy in, and, needs of the community.

- need not be members/holders of responsibilities in Mahalir Mandrams.

- need to take major responsibility in the field in matters related to Accounting / reporting / co-ordinating activities

at the village level.

2. Central Committee / Management / Administration :

- needs adequate representation from all levels in addition to the present team forming the central committee (viz., community organisers / Medical officers / Co-ordinators only)

- needs frequent meetings to solve internal team problems satisfactorily, to develop a team-spirit and evolve group leadership with management skills - so that problems inherent in individual leadership are avoided in the future.

- needs to decentralize responsibilities with adequate decision making powers within the team itself.

- the accounting, record-keeping and reporting responsibilities should be well distributed, preferably to staff separate from other activities.

- a committee to be formed to study the past records of at least one to three years - to identify problems and problem areas which require more attention.

- These should be prioritized and put into the action plans of the next year.

- now, since fairly permanent staff are at the village level, immediate steps to be initiated to ensure job-security.

- there does not seem to be a need for a Doctor to visit the village clinics.

- A panel of local doctors can be formed to advise and help solving health-issues at the village.

- A good and satisfactory liaison should be developed with local government and voluntary agencies for medical problems - curative purposes.

3. Training Programs :

All the training programs need to be looked into by a committee

..3

which focuses on (cont'd.)

- need for training / relevance,
- content of training,
- training methodologies and evolving / integrating newer methodology,
- pre and post evaluation of training,
- on-going training,
- scope for training personnel other than CHDP staff,
- and any other relevant aspects.

It is only after this that adequate interaction for training can take place. This should form part of the next year's plans.

4. Reactions to the response from CHDP to earlier reports of Ms. Bhanumathy Vasudevan and Dr. S.P. Tekur, and work plan of new phase in CHDP.

This follows the format of the response :

Page 3 Item No. 2

- Mahalir Mandrams conduct local activities ..... and look for only facilitatory functions from the community organisers.

Page 4 Item - Direct Organisational Movements of Women Workers

- the Mahalir Mandrams should take up mainly local issues and concentrate for sometime on them till some progress is made.

  For example, a struggle for basic rights in relation to a specific pollution problem can be pursued till a satisfactory solution is found. While doing this, other general ecological problems may be highlighted, but need not be attended to immediately.

Page 4 Item No. 1

- emphasis is required to accelerate the process of weaning off CRS food through active steps taken so far.

Page 5 Item No. 2 (contd.)

- With reference to training women to take up activities generally carried out by men, competition and confrontation is to be avoided; rather, we should look for other areas where there is good employment potential.

  eg. Recycling of coconut-fibre wastes is worth pursuing as a major women's activity.

Page 6 : Item No. 1 - Integrated Health Services :

- initially a prioritization of health problems has to be done. Then, a planned intervention with Integrated Health Services is to be promoted to solve specific problems.

Page 6 Item No. IV : Collaboration with C.A.T. :

- items related directly to women's problems like smokeless chulas / water-management / Bricket making and sanitation should get a priority.

Page 7 Item No. IV : Cultural groups :

- this should form a major focus of M.M. activity, with popularisation of folk media, and encouraging people to 'specialize' in various art-forms to carry health messages.

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Place : Bangalore,

Date : 30 Nov 90

- Signed -

DR. V. BENJAMIN.

COMMUNITY HEALTH DEVELOPMENT PROGRAMME

Report on the EVOLUTION OF C.H.D.P. with details of DECENTRALISATION

A short summary of the history and the ongoing structural change will show that the programme has continously adjusted itself to the needs of the people. At it's stage this has been studied and evaluated, and has been a preparation leading to the decentralisation towards local Women's Associations.

- The programme started in 1971 with an intensive preparation of village surveys with the help of the voluntary services of local educated young girls and women.
- By April 1972, the first under 5 clinics with a C.R.S. applied nutrition programme were organised through Mobile Health teams mainly in the coastal villages. Short training courses were held during the weekends.
- By October 1973, we were ready to start the first 5 months Residential Training course for health workers.
- Since it became more difficult to obtain the services of qualified nurses, from August 1975, the already trained health workers continued their training as H-ealth Guides following the syllabus of the Government A.N.M. (Auxiliary Nurse Midwife) with additional subjects as -Community Organisation - leadership - Village situation etc to prepare them as team leaders in the H-ealth centres.

With the 25 paise scheme of which details follow below, Health Education not only to the women but to the youth, children was the felt need. To answer this need a training course of 4 months prepared the already trained H-ealth workers or unemployed graduates for giving health education in schools, nylon net webbing and other craft centres. This was temporary since after a few years it was felt that the teachers themselves were the right persons to do this and on the contrary made use of the C.H.D.P. Health Educators to take for themselves, more free time and leave. With the mechanisation of nylon net webbing all this coastal women lost their employment and these centres closed down one by one.

With the evaluation of the programme towards more awareness, education and looking for income generating activities which at the same time answered a need in the village, the course for Women Animators was conducted from 1986 onwards.

- From October 1973 till 1980
  215 followed the five month's health worker training course.
- From August 1975 till December 1988
  299 were trained as Health Guides (a course of one year duration)
- From 1975 till June 1979
  91 Health Educators participated in a 4 months training course.

- From February 1986 till December 1989
  78 Women Animators followed a nine months course.
  22 followed a course for Nursery teacher
  705 followed one of the different courses.

By July 1974, after 2 years of health and nutrition education, the need was felt to do something about it, from which originated the '25 paise scheme'. All the women pooled together 25 paise twice a month. The Women's contribution was around Rs.18,000/- a month which was divided in 6 votes so that 6 Health Centres at a time could start with the implementation of the most needed development programme related to health. The women themselves decided on the priorities - cleaning of public wells, drainages - latrines - Community centres etc.... After the first round of all the votes in the villages the 25 paise scheme continued as 'the village development fund'

- From 1976 the village development fund and an additional fee of 50 paise per clinic (twice a month) made it possible to start working with residential Health Teams in the villages. This answered the need of a continuous presence for preventive health care and education. By January 1978 there were Residential Health teams in all the villages.

During this period there were 359 trained full time workers and an average of 3 or 4 centre, in each there were about 340 voluntary village workers. After 2 to 3 years of inservice training, the voluntary village workers followed one of the Long training courses. There has never been any appointment made in the history of CHDP since the goal was to give a preparation for life to as many as possible educated youth in service to the larger community. At the time of m-arriage the health workers of all catagories left the programme and were continuously replaced by the inservice trainees.

- By 1980, different factors pointed to a further move for more direct participations of the women.
- Through the transfer of the funds still pooled together to their own local centres.
- The programme so far was served by un-married educated young women who followed the training courses in preparation of their future life and in service to the community, they were living in small groups of 3 to 5 in different localities in rented houses or community centres.
- Due to the worsening economic conditions of the people which affected mostly the women, so that even without employment, there was little chance of a marriage partner, the Health team mepers then in service demanded to be allowed to continue their service after marriage. This could only be possible through local Mahalir Mandrams and on a basis of self reliency. The first Health Guide who wanted to continue her service postponed her marriage till the local Mahalir Mandram was

registered. It was at that time that all Health team members signed on agreement (resignation letter) that if they continued to work after their marriage they would be the employees of their local Mahalir Mandram and be relieved as KSSS- CHDP health workers.

The CHDP section co-ordinators and community organisers continued their service directly under KSSS-CHDP since they were not related to any Mahalir Mandram.

During this transition period the presence of the CHDP Co-Ordinators, Animators, and Community Organisers was essential for bringing about this evolution.

This Decentralisation took nearly 4 years from July 1980 till March 1984 to be completed and to start a NEW PHASE of Community Health and Women's Organisation through 'Women's Association' and from that time no new Health workers have been taken in the programme.
As on 30.6.1990 there are: 156 Health Guides
73 Women Animators and
12 Health workers
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241 Total Health team members are working in 85 teams, under 92 registered Mahalir Mandram.

We hope this above report gives the evolution of the C.H.D.P. specially related to the workers at all levels. All of them know very well about the conditions and possibilities of work and we are sure that our creative social health services only can earn the credibility and support of the people.

13.12.'90

V Caspar Mary
C.H.D.P. Co-Ordinator.

APPENDIX 'O'

COMMUNITY HEALTH DEVELOPMENT PROGRAMME

A UNIT OF KOTTAR
SOCIAL SERVICE SOCIETY
NAGERCOIL

THIRUMALAI ASHRAM SOCIAL CENTRE
CHUNKANKADAI P. O., 629807
TAMIL NADU, S. INDIA

Date .....

CONSOLIDATED REPORT OF THE MEETING WITH THE COMMUNITY HEALTH CELL AND C.H.D.P. ON JANUARY 2 & 3rd JANUARY 1991 AT BANGALORE

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The team from Community Health Cell were:

1. Dr.Shirdi Prasad Tekar
2. Dr.Benjamin &
3. Ms.Thelma Narayan.

The C.H.D.P. were: 1.P.Sarasam
2. C.Alphonsal
3. Sr.Tresa.

On the whole it was an informal session with sharings, questions and clarifications in connection with the visit of Community Health Cell to C.H.D.P. in K.K.District. More clarifications and discussions on the following topics were done.

- Decentralization of C.H.D.P.
- Functioning of Mahalir Mandrams
- Job Security for village Health Teams
- Cohort study conducted by C.H.D.P.

Two days dialogue was summarised under three main headings:

1. Mahalir Mandrams and its functions
2. Health Programme and its perspectives
3. C.H.D.P. - the Central staff and its task.

1. <u>Mahalir Mandrams</u>:

- Strengthen Mahalir Mandrams with regular classes on history goals, and strategies of CHDP to have a common understanding.
- Initiate them to Income generating programmes: Mahalir Mantrams or co-operatives.

- Classes to be organised for Mahalir Mandram committee members and representatives in the village level as well as in the central level.
- Select the active Mahalir Mantrams and give special guidence and support to their programmes.
- Mahalir Mandram membership should not be related to CRS beneficiaries as they are only temporary in the programme. Also there has to be an equal representation of working women and House wivies.
- Need a followup of all ex-trainees of CHDP and participate them in and Mahalir Mandram activities in order to utilise their training for the people.
- At least 2 representatives from Mahalir Mandrams have to be included in the core group of CHDP.
- Each Mahalir Mandram can concentrate on one important issue for their area and work towards solving the problem with the help of other Mahalir Mandrams as and when needed.
- Two or three Mahalir Mandrams can join together to start co-operatives or work on interested projects like kitchen garden, small saving scheme, credit union etc.
- Make a survey of Mahalir Mandram members with a short questionnaire on women's needs, problems and suggestions to solve it.
- Mahalir Mandram health teams also need updating and ongoing education in health and other programmes of Mahalir Mandrams.
- There is a need to have common perceptions for Mahalir Mandrams and its workers about the programmes.

II. <u>Health Programmes</u>

- Evaluate the medicine supply in each centre by the followup of 2 weekly medicines given; how it is used, its effectiveness and other sources utilised for the same.
- Introduce wholistic health programmes for preventive and promotive health.

- Immunization has to be made available to the people by constant contact with PHCs and organise protest rallies when needed.
- Introduce school health programmes. Check the healthy atmosphere in the schools, class room, ventilation, clean water supply, Latrines, play grounds, library etc.
- Find out interested teachers and train them as health promoters in the schools.
- Make known CHDP's six goals and the present work, to the Government hospitals, private hospitals, and other health officials for referal cases.
- Instead of being satisfied with one part time doctor, have contact with a team of doctors who have the social orientation, including a Gynacologist.
- Form a cultural group for education and conscientisation.
- Investigate the possibilities of reducing the price of "Health mix" with few grains of nutritive values.

III. Community Health Development Programme (G.H.L.P.)
Core group, Community Organisers

- Proper documentation and reports on all activities have to be maintained in the central level. i.e. Leprosy patients contacted, Filariasis study report, Mahalir Mantram participation in local issues etc.
- A small group has to be given responsibility to study three years reports and draw out emerging trends.
- Three days seminar has to be arranged for CHDP for management skills and group building by an outside resource person. This will facilitate open dialogue, sharing and a new leadership has to emerge from the group to fill the gap, of leadership. The names suggested as resource persons are Ms. Bhammathy and Ms. Valli.
- CHDP has to find a better net-work of relationship with other organisations and groups of same orientation

(specially health). The present work with CAT and PHD (Programme for human development) is appreciated much.

- Tap the Government resources: Central, State, District and block.
- Ongoing education and training of CHDP Community Organisers has to happen within CHDP and with other organisations. Also CHDP Community Organisers can be resource persons for other agencies.
- Pre-planning and post evaluation is a must for all training programmes.
- New methodologies and scientific datas has to be introduced in the training programmes - especially in health.
- Build up a healthy relationship within the diocese,; explain the vision, goal and strategies of CHDP wherever needed.
- CRS Programme and KSSS seems to be hindrance in the growth of CHDP into an independent women's movement. (There is a lot of paper work and other records to be maintained by CRS which does not free the Mahabir Mandram teams for other involvements.
- CHDP Community Organisers need to come up with new ways of growing together, standing together in solving problems.
- CHDP has to emerge into women's movement with linkages of state and national women's movements.

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Sr. Theresa

For the Study team