OKHLA NEIGHBOURHOOD COMPREHENSIVE HEALTH AND WELFARE PILOT PROJECT

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1. INTRODUCTION

In cooperation with the Delhi Municipal Corporation the area of Delhi South zone, between Mathura Road and Agra Canal is a composite community area presently consisting of 12 separate villages and/or semi/rural areas. The population of this area is estimated about 15,000 people and is culturally composed of Muslims, Hindus and Christains. Two percent of these people are landowners, 38% shopkeepers, teachers, clerks, etc., 60%, are labourers at Rs. 100% month or less. The contracts of this marginal village area and the rapidly expanding high income housing areas, like Maharani Bagh and Friends Colony as well as the living patterns evidence the need for developing the health, welfare and educational facilities in the area for the development and uplifting of the community.

11. SERVICE AREA

For the geographic layout (See Diagram) the diameter of the service area is 1½ mile. The radius from the Holy Family, Jamia Millia or Don Bosco is as follows:

Mathura Road to Okhla	1 Mile
Holy Family Hospital to Bharat Nagar	1/4 "
Holy Family Hospital to Khizzorabad	3/4 "
Holy Family Hospital to Julliana	1/8 "
Holy Family Hospital to Masigarh	1/4 "
Holy Family Hospital to Okhla	1/2 "
Holy Family Hospital to Nuru Nagar	1 "
Khizzorabad to Masigarh	1 "

From Jamia Millia eastward the cultural grouping is Muslim. The remainder of the area is Hindu with the exception of one small section of 12 to 13 homes of Masigarh which are Christain. The residents of Joga Bahai, Gafoor Nagar and Nuru Nagar are landless unauthorized dwellers.

111. BACKGROUND AND HEALTH SURVEY CONTENT

A. Cultural

The 12 villages are culturally very separate due to religious and social differences. Okhla, Batola House, Joga Bai, Gafoor Nagar, Jamia Nagar and Nuru Nagar is primarily a Muslim Population. The remaining villages are Hindu with the exception of Masigarh which is populated by Christian who have lapsed back to a type of Hinduism. There are about 20 Christian families in the total area, of these, 12 families live in a Christian settlement removed from the main Masingarh population and attached to the Church. Because of the religious and traditional caste distinction these villages and setups are all very separate and distinct communities with no communication, awareness of community sense or concern.

B. Family Population

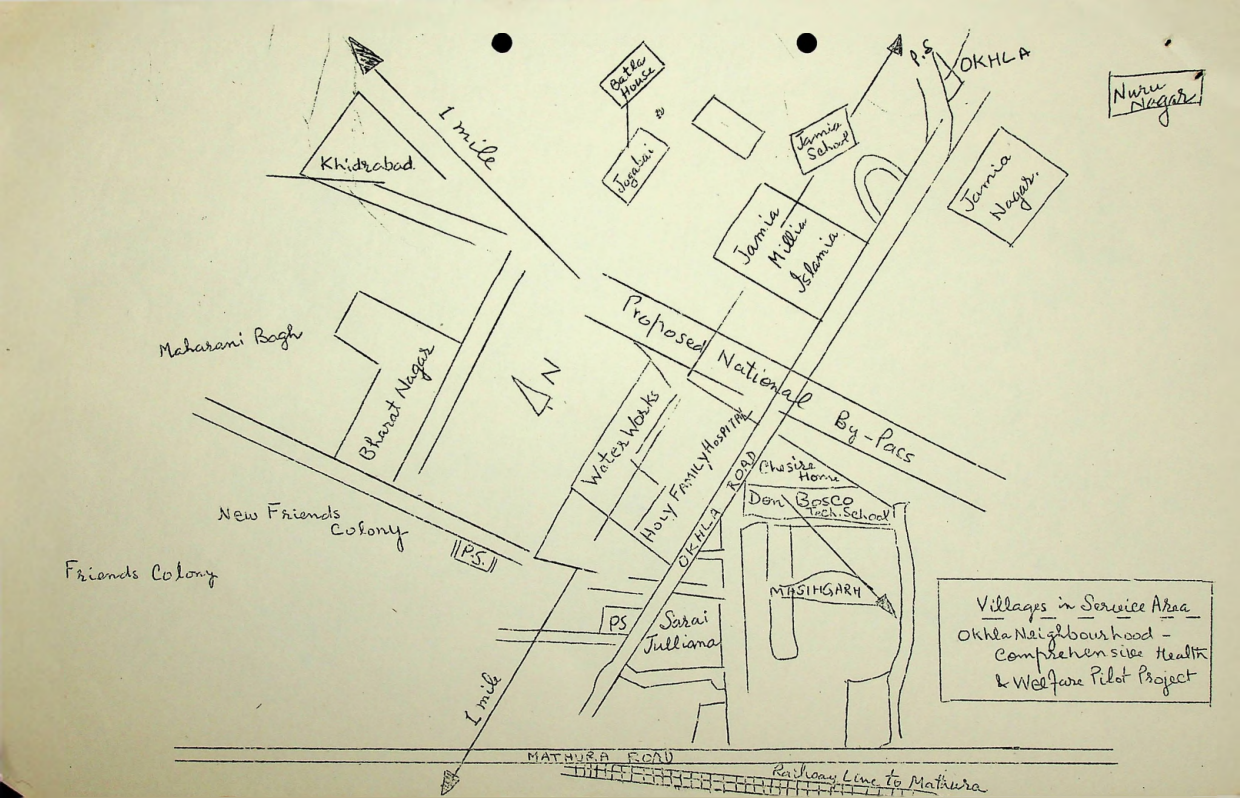
Total families	2,174
Infants	755
Toddlers	2,100
School Age	3,100
Antenatals	398
Total Population: Estimated	15,100

C. Economic Population-of the above family population

1. Income below Rs. 100/- month - 68%
2. Income above Rs. 100/- month - 32%

Of 32 income above Rs.100/-

1. Labourers - 60%
2. Teachers, Shopkeepers, Clerks, etc. .. 38%
3. Farmers
4. Landed leaders income Rs. 2,000/- 2%


Batla House
Jogabai
Jamia School
P.S
OKHLA
Nurse Nagar
Khidrabad
1 mile
Jamia Nagar
Jamia Millia Islamia
Maharani Bagh
Bharat Nagar
Proposed National By-Pass
Water Works
Holy Family Hospital
Bhasira Home
Don Bosco Tech. School
OKHLA ROAD
New Friends Colony
P.S.
Friends Colony
MASJIDGARH
PS
Sarai Julliana
1 mile
MATHURA ROAD
Railway Line to Mathura
Villages in Service Area
Okhla Neighbourhood - Comprehensive Health & Welfare Pilot Project

D. Social Status & Condition

1. The social conditions of Rs. 100/- month and less are as follows: Landless daily labourers meaning the wage earner and his wife together are employed only about 50% of the time- this means if a job is abailable there is some income for food. If it is not available the few resources are rapidly exhausted during the unemployment time, anxiety builds, family problems are heightened, diet is minimal e.g. Joga Bhai resident - major diet is Chapati and Chili. From this the health problems of marasmus, nutritional difficiences, common sessonal infective and accident or other medical problems are neglected. This is due to ignorance of facilities available and there are no facilities in the area that are within their economic means. In this remaining 38% (shopkeepers, teachers, clerks, etc.) Who maintain a little higher social status, the following pattern has emerged. Even though their income is Rs. 100/- month in addition clothing and educating their children on the present wage. These families are lucky to break even each month. Should serious health family or legal problems arise they are neglected as their economic means places these amenities at this time for them a luxury.

2. The social background and condition of the women presents the belief that a women very seldom and with exception accepts any kind of medical attention or welfare assistance unless she is seriously ill or extremely depperate this emerges in the following pattern. A medical check-up or literacy classes are considered luxury. Health and welfare services are considered necessary but if charges are attached to them it is received as a service beyond their means hence they will not participate and make use of such services. Unless health service are given at a minimal fee they are not accepted or participated in.

3. In the service area there are abslutely no social or recreational facilities available to any of the residents.

4. 70/80% of the women of the area are working mothers, that is, they are occupied with other household duties such as tending to buffaloes, cutting grass, etc. About 10% of the women go to Okhla Industries of building sites as daily labourers hence the social problems of children are numerous. Children have to lead the family buffalo and because of these commitments and economic scarcity they are unable to attend school. Some are just idle all day and become destructive. Because of limited family guidance their most formative years their psychological and social maturity is impaired. Due to high rent, congested living and lack of privacy, the children are exposed and involved in their parental social activity and family problems which they are too young to understand, but which deeply influence them and they are unable to cope with. This problem emerges and shows itself in the children's inability to be constructive or concentrate. This contibutes to school dropouts and delinquency.

E. Facilities and Factors in Service Area

1. These villages are administratively under the Lajpatnagar Welfare Centre wish due to overpowering population of its service area and georgaphic distance from them leaves the residents of 12 village areas with very little assistance.

2. Nearby within 1 mile of Holy Family Hospital are the Okhla Industries which employs certain percentage of the population here. It will be reasonable and beneficial to incestigate the areas of technical training and cooperation with Okhla Industries for future trained employees coming from the population described. The Don Bosco Vocational School will also be of value here.

3. The three doctors in the villages are not qualified, they hold L.M.P. & L.C.Ps.) and there are no other medical or welfare facilities available. There are still quite active untrained dais who take even now 1/5 of the deliveries. In Gafoor Nagar there has been a high incidence of neonatal death & stillbirths with an occasional maternal death.

4. In this area there are positive and negative factors which influence the health. The positive factor is that there is a generally good water supply. The negative factors are:

a) inadequate and ill ventilated houses
b) open drains
c) city dumping areas just adjacent to Okhala, Nuru Nagar & Julliana (this has caused an enormous fly problem)
d) There are little or no facilities for animal shelter hence goats, cows, buffaloes and chickens reside in the house.
e) Sweepers who clean the drains leaves all day to dry. As these streets are only areas for children's play, they are daily exposed to and play in these piles.

Within Okhala, Khizerabad, Nurunagar and Julliana which are not traditional Indian villages, there is very little if any community sense within them. Consequently the existing chaupals (which in Hindu tradition have been recreational and meeting places for the elders) are sitting idle 90% of the time. It is felt that in the villages they could be quite effective. It is felt that if the village contribute these chaupals, they could become the proposed sub-centres. Because they are ideally located in the centre of villages, they could be quite effective. It is felt at this time that the cooperation from the village leaders is excellent.

F. Health Analysis Comparison

Village	Family	Toddlers	Infants	Antenatal
Julliana	Shopkeepers Educated employed Cottage Industry	Weaning mal Nutrition, Deficient Character formation 80% primary smallpox sec. vacs. done DPT and other immunization nil Psychological development training nil Pre-school preparation nil	Intestinal & other infection due to sanitation	70-80 per cent untrained dai delivery infection Anaemia
Masigarh	Farmer	Same as above	90-95 per cent worms	Same as above
Bharat Nagar	Holy Family Hospital employees shopkeepers educated employed Cottage Industry	Same as above	Same as above	Anaemia
Gagoor Nagar	Class IV employees at Jamia Millia Unemployed daily labourers	Same as above, but &	Undernourished due to infection Intestional infection due to sanitation	98 per cent village dai delivery indication of extraordinary high stillbirth and neonatal birth Few witnessed maternal deaths

F. Health Analysis Comparison (Contd.)

Village	Family	Toddlers	Infants	Antenatal
Jogabai	98 percent	acute malnutrition due to family diet of mainly chappati and chili street children acute dismalnutrition No schooling	Under nourished due to infection and diet high incidence of diarrhoea, worms URI	Ante-natal anaemia dai delivery infection
Batla House	Teachers of Jamia Millia	Generally active healthy children need for immunization	Immunization	98 per contained dai delivery
Okhla	Professors Law income labourers middle class few land-owners	Intestinal infections Emotional and psychological problems Anemia Rickets	High infant death , Marasmus intestinal infections	early marriage; there fore high incidence of grand multiperas Anaemia

IV. PROJECT AIMS & OBJECTIVES

A. The project aims and objectives are:

1. Neighbourhood development.
2. Total Family Care through integrated health and welfare and educational services.

B. By providing total family care as well as suitable recreational activities, economic betterment and education to give rise to the general development of the area with the purpose of evolving common programmes for families of whole service area neighbourhood to be.

V. PROPOSED PROGRAMME

In order to achieve the aims and objectives of IV, we plan to coordinate the service activities of the following existing agencies or institutions:

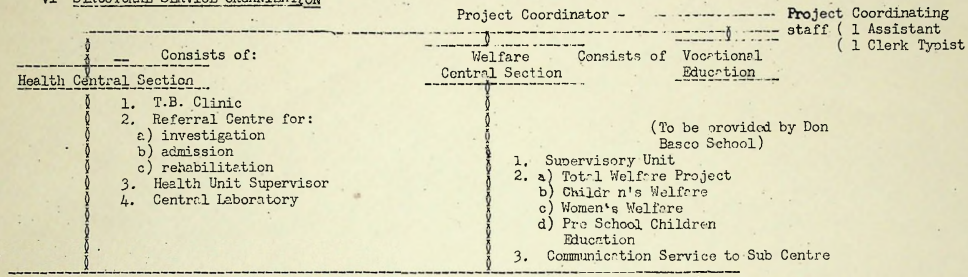
1. Jamia School of Social Work training programme
2. Dr. Zakir Hussain Memorial Welfare Society
3. Holy Family Hospital (as referral for treatment)
4. Holy Family Hospital Community Health Department (to promote the health of the area).
5. The educational and referral facilities of Don Bosco technical training school.

For information regarding the services provided by the above see Structural Service Pattern in subsequent section (Section VI, page 4A).

The immediate aims of the proposed programme will be to coordinate the already functioning Health Service with the proposed Welfare Service in the following phases:

Phase 1. Actual Coordination and Community curricular planning.

VI STRUCTURAL SERVICE ORGANIZATION



Health	Welfare
1. Maternity Child Health and Family Planning	1. Women's Welfare Classes
2. School Health	a) Tailoring Classes
3. Communicable Disease	b) Adult Literacy Classes
4. Nutritional	c) Cooking & Nutrition Classes
5. Medical Care	d) Child Prenatal, Postnatal Care
6. T.B. Screening	e) Talks, demonstrations on all above
7. Delivery coordination	2. Balwadi (Children's School)
8. Health Education	3. Play Centre
	4. Case Work and Counselling Services

N.B. Don Bosco School of Vocational Training will be used for referrals. The Don Basco School of Vocational Training will be represented on the executive committee. None of the existing institutions or agencies lose autonomy.

Phase 11. Implementation of the coordinated health, welfare and educational activities for short term plan of three years.

Phase 111. Evaluation. Progress based development.

VII STAFFING PATERN (JOB SUMMARY)

A. Community Health

2. Public Health Nurses: Post-graduate nursing in Public Health - one in supervisory capacity of main centre and subcentre, one for school health.

2. Doctors: MBBS with 5 months Public Health to serve main centre and two or three sub-centres as well as schools in his area.

2. Social Workers: MSC Medical Social Work, Medical Case Work in sub-centre and referrals and follow up in welfare program (coordinate with welfare Social Workers)

1. Nutritionist: BSC, Applied Nutrition program and follow up to all centres and co-ordinate with Women's Welfare program.

1. Lab. Technician: 3 years - Do all lab. incestigation.

6. Lady Health Visitors: 2½ yrs. diploma course programme, MCH specialist, in charge of all village families, health supervision of sub-centre and trainer of dais.

5. Auxiliary Nurse Midwife: 1 year auxiliary nursing in midwifery, to take all deliveries in her area.

5. Trained Dais: Local dais having completed a 3 months course of necessary hygine and procedures.

Village level Motivators: Women of local village who are accepted by peers; somewhat capable of influencing women in their area-cum work assistant, cleaner of subcentre.

2. Receptionist-cum-clerk/typist:- Sub-centre registration and record keeping and clerical work concerned.

B. Welfare

1. Chief Welfare Organizer: M.A. Social Work. Minimum of 5 years experience organizing welfare activities
Administrative, supervisory, c/o central office. Responsible for women's Welfare in subcentre.

1. Child Welfare Organizer: M.A. Social Work with specialisation in child Welfare

i) supervising all children's activities including Balwadi & Children's Club.

ii) takes care of all reports

1. Family case Worker: M.A. Social Work with specialization in Psychiatric Social Work or Family Case Work.

i) c/o family guidance, problems - referrals from centres.

1 Office Secretary 1) Accounts
ll) Charge of maintenance of records
lll) Supplies

1 Women's Welfare Worker: Higher Secondary graduate with diploma in home Subcentre science craft.

B. Welfare (Contd.)

1. Pre-School Worker Subcentre : Higher Secondary graduate with diploma in nursery education.

1. Children's Club Worker: Higher Secondary graduate with training in social Work, Honors or ordinary degree with diploma in Social Work.

1. Full time Centre Worker Sub-centers (Attendant) Local Women who will be work assistant cum-cleaner.

VIII. FINANCIAL REQUIREMENTS

A. Health

Staff Salaries	Rs. 1,07,640.00	
Recurring expenses	1,20,500.00	
Non Recurring expenses	24,850.00	
	2,52,990.00	
Less Estimated income	1,04,500.00	
Welfare		1,48,490.00
Dr. Zakir Hussain Memorial Welfare Society	32,700.00	
Children's Club	27,550.00	
Pre-School Education	40,185.00	
Women's Welfare	49,325.00	
		1,49,760.00
C. Vocational Training	10,000.00	
D. Project Coordinator and Central Overhead	27,000.00	
Total	Rs. 3,35,250.00	
(1.00-Rs. 7.50)	44,700.00	

HOLY FAMILY HOSPITAL COMMUNITY HEALTH DEPARTMENT.

A. Budget Portion

Health :

1. Staff Saleries

2. Doctors Rs. 625/per month)			Rs. 15,000.00
2. Public Health Nurses (Rs. 450/-per month)			Rs. 18,800.00
2. Social Workers	(Rs. 450/-	")	Rs. 10,800.00
6. Lady Health Visitors	(Rs. 350/-	")	Rs. 25,200.00
1. Nutritionist	(Rs. 600/-	")	Rs. 7,200.00
5. Auxiliary Nurse Midwives	250/-	")	Rs. 15,000.00
2. Village Lovel Motivators	(Rs. 125/-	")	Rs. 3,000.00
1. Driver	(Rs. 300/-	")	Rs. 3,600.00
5. Dais (trained)	(Rs.120/-	")	Rs. 7,200.00
2. Receptionist-cum-clerk	Rs. 250/-	")	Rs. 6,000.00
1. Lab. Technician	(Rs. 320/-	")	Rs. 3,840.00
	Sub Total :		Rs. 1,07,640.00

2. Recurring

Medicine	...	Rs. 35,000.00
Van Maintenance etc.	...	Rs. 6,000.00
Supply	...	Rs. 500.00
Miscellaneous	...	Rs. 2,500.00
Referrals	...	Rs. 30,000.00
Student Education (integration of Public Health)	...	Rs. 36,000.00
Vaccination drugs	...	Rs. 6,000.00
Rent of centres	...	Rs. 2,500.00
Maintenance	...	Rs. 2,000.00
Total	...	Rs. 20,000.00
		Rs. 1,20,500.00

3. Non Recurring

Tables (3)	...	Rs. 900.00
Cupboards (2)	...	Rs. 1,200.00
File Cabinets (2)	...	Rs. 600.00
Examining Table (2)	...	Rs. 800.00
Baby Scale (2)	...	Rs. 300.00
Adult Scale (3)	...	Rs. 500.00
B.P. Apparetus (2)	...	Rs. 250.00
Diagonstic Set (1)	...	Rs. 20,000.00
Jeep		
Total	...	Rs. 24,850.00

A. ESRIMATED INCOME PORTION

OXFAM	...	Rs. 30,000.00
Delhi Administration	...	Rs. 16,000.00
Municipal Corporation	...	Rs. 6,000.00
Land Owners	...	Rs. 2,500.00
Holy Family Hospital Auxiliary	...	Rs. 50,000.00
Total	...	Rs. 1,04,500.00

** in excess of medicines and vaccines contributed by Government
*** Not available until april 70 -estimate (not firm)

N.B.

All the Nutritional Supplies are aided by C.R.S.
U.N.I.C.E.F. has promised audiovisual aids

Service aid :- Grail teams are giving their service twice a week in health teaching and demonstration.

B. Welfare Portion (Dr. Zakir Hussain Memorial Welfare Society)

S.NO.	Particulars	Amount per month	Amount yearly	Total Income
1. Salaries				
i)	Chief Welfare Organizer	800/- fixed	9,600.00	
ii)	Child Welfare Supervison(1)	450/- "	5,400.00	
iii)	Family Case Worker (1)	450/- "	5,400.00	
iv)	Office Secretary (1)	350/- "	4,200.00	
v)	Typist/Clerk (1)	300/- "	3,600.00	28,200.00
2. Contingencies			2,500.00	2,500.00
3. Non-recurring				2,000.00
Typewriter	(one)		2,000.00	32,700.00

Total Expenditure	Rs. 32,700.00
Total Income	Rs. Nil
Total Deficit	Rs. 32,700.00

B. Welfare Portion (Children's Club)

S.No.	Particulars	EXPENDITURE Amount per month	Amount per year	Amount for 5 centres
1.	Salaries Full time worker (1)	300/-Fixed	3,600.00	18,000.00
2.	Contingencies	500/- "		2,500.00
3.	Non Recurring	1,500/- "		7,500.00
				28,000.00

Total Expenditure	Rs.28,000.00
Estimated income From fees	450.00
Deficit	Rs.27,550.00

B. Welfare portion (pre-school Education)

S.No.	Particulars	EXPENDITURE Amount per month	Amount per year	Amount for 5 centres
1.	Salaries full time worker (one)	300/- Fixed	3,600.00	18,000.00
2.	Contingencies	1,200/- "		6,000.00
3.	Non-recurring	3,597/- "		17,985.00

Total expenditure	Rs. 41,185.00
Total Income	Rs. 1,200.00
Total Deficit	Rs. 40,185.00

B. Welfare Portion contd. (Women's Welfare)

S.No.	Particulars	Amount per month		Amount yearly	Total	amount for
1. Salaries						
i)	Fulltime worker (one)	300.00	Fix	3,600.00		
ii)	Attendant (one)	170.00		2,040.00	5,640.00	28,200.00
2. Contingencies		1,200.00				6,000.00
3. Non Recurring		3,600.00				
Deficit		48,325.00				

C. Coordinator's

Salaries

Coordinator's salary	Rs. 1,500.00 per month	x 12	18,000.00
Asst. Coordinator's salary	Rs. 450.00 "	x 12	5,400.00
Clerk, Typist	Rs. 300.00 "	x 12	3,600.00
			Rs. 27,000.00

IX. SUMMARY OF THE PLAN

OKHLA NEIGHBOURHOOD COMPREHENSIVE HEALTH AND WELFARE PILOT PROJECT

A. Aims and objectives

1. The primary objective as a pilot study is to show how a hospital can leave its walls and become involved with the total approach to comprehensive health. By encouraging other agencies available in the area to join with us in a community effort we hope to demonstrate what can be done to combat social and health problems of the community. The specific objective is to improve the health of the entire family.

2. Neighbourhood development through total family care by integrated health welfare and educational services.

3. The above objective will be accomplished by:

a) Reducing the high incidence of morbidity among the vulnerable group (infant and toddlers) and the damage and death due especially to the diseases such as gastrointestinal diseases caused by intestinal worms, giardia, anceba, etc. Almost 80% of the children are infected with one or more intestional parasties like these. During the bi-weekly children's clinic and school health visits, a routine examination is made. These children whose HB is below 10 mgs are given a routine stool examination. Also those children who attend clinics with any gastrointestinal diseases are investigated. Treatment and follow-up are done on these cases, i.e. deworming process through medicine, proper and repeated health education to the family. The general health of the children is built up by giving iron vitamins and protein supplements. (See the Nutritional Progress report) Through the adults clinic other members of the Family who are suffering from the same diseases are given a similar investigation and treatment. A family folder is kept for each family under our care. These cases are followed up and strongly encouraged to come to the clinic every week. So far the result has been good. Many factors are involved in the causes of gastrointestinal disease. The local water supply, examined through a sample survey, was found to be good. However, the drains are still open and general sanitation is poor. We are constantly approaching the Municipal Corporation and stimulating the people toward getting closed drains we hope for success soon.

b) When anemia occurs, many factors, again, are involved. We are trying to incestigate and treat any infections diseases within the vulnerable group (almost 70-75% of the children are anemic) in the first instance before it become chronic. For this, much health education is needed. The concept of disease is such that not until one is chronically or seriously ill does the patient seek help. Giving early antenatal care and building up the mothers HB% **is** another step in fighting anemia. The child who will be born will have a good HB% with which to start life. The Nutrition team and the women's welfare group of Jamia are trying to educate these mothers on introduction of solids and other Nutritional education for the maintenance of good health. The responsibility of parents in the upbring of their children is emphasized.

c) Reducing nutritional deficiency disease such as marasmus and rickets. Cases of marasmus and rickets which are diagnosed from the bi-weekly clinics or found through home visits are referred to the nutrition clinic. Milk, protein, cereals, etc. are given. If the child in the family is seriously malnourished due to socio-economic or other family problems the family is contacted by the social welfare team under the Dr. Zakir Hussian Memorial Welfare Society. (See Page. 12-13: Family Welfare Programme). Education is given in every possible aspects.

d) Protecting this vulnerable group from communicable disease especially tuberculosis and whooping cough. (See the Immunization programme and the T.B. programme, attached).

e) Enlarging the social and psychological development of these children. This is going to be fulfilled by the Welfare Team through organization of children's welfare, pre-school education. Women's welfare and marriage counselling programmes. The objective can be achieved only if the mothers are given and are receptive to proper education, making them aware of their responsibility in bringing up their children. (See pages 13 to 15 Welfare Programme)

f) Decreasing death rate and accidents due to home deliveries which are conducted by untrained village dais and there by to improve the health of the mother and child - most of the deliveries are conducted by these untrained personnel even today. It is hoped to decrease the problems by 1) decillary maternity service, 2) early antenatal attendance at clinics 3) conduction of home deliveries and postnatal care, 4) referral to the hospital of all cases needing special investigation and treatment. 5) training of village dais, 6) counselling and educational efforts of the welfare team.

g) Reducing the high rate of T.B. This is almost 10 in 1000 population. Our aim is to bring down the high incidence of T.B. cases to 1/2 or to nothing. (See T.B. Programme). Another Public Health Problem at present is the high level of air-population due partly to industrial development and chemicals used for agricultural. development. A few incidences of lung collapse in T.B. cases were discovered. Is this collapse due to T.B. ? a foreign body from the air? In spite of the efforts being made at present, the result can be counted only after 5 to 10 years.

h) Making the villages aware of health and disease in order to make them responsible for their own health and feel the need and seek the avail - ability of facilities in their midst. All the efforts of our health education through various combined channels are geared toward this purpose. (See the Welfare and Health Education Programmes: pages 12 to 27)

i) An example of specified targets on immunization would be seen as

D.P.T. and BCG.

First year (1970) Second year and third year (and after)

innoculated 500 children (25% of the total pop) the percentage will be higher, however the number will be less.

According to our programme we are planning to give D P T to all the children below 5 years, and B C G below 12 years in the school and clinic. This we can active within two years. After this, DPT and BCG are given once for a life time.

will be increased. According to the 1970 data 20% of the total population was innoculated. It is hoped that in the year 1971 we will increase innoculations by 40-50% of the population. There after, we are hoping to cover the whole population by 80% in a mass scale yearly vaccine.

Small pox
Typhoid
Cholera

B. Participating Agencies

1. Holy Family Hospital
2. Jamia School of Social Work
3. Dr. Zakir Hussain Memorial Welfare Society
4. Don Bosco Technical Training School

C. Machinery for Coordination and Financial Administration

It is necessary to develop an efficient machinery for coordination and financial administration of the proposed comprehensive health and welfare pilot project in which many agencies will be participating. Keeping this in view it is is proposed to have an executive (coordination) committee consisting of the representatives of the participating agencies. The following will be the composition of the committee:-

1. Administrator of the Holy Family Hospital (Chairman)
2. Two representatives each of the participating agencies
3. A full time coordinator (Convenor)

D. The functions of the Executive Committee will be as follows:

1. To consider and approve the proposals of community curricular planning.
2. To approve the instalments of grants-in-aid to be disbursed, on the basis of the approved annual budget, to the participating agencies after the funds are received from the financing agency.
3. To approve reappropriation of the budgeted amount from one head to another on receiving proposals in this regard from the participating agencies.
4. To consider and approve peridocial reports and the proposed annual budgets of the participating agencies after they are consolidated by the coordinator for the purpose.
5. To consider and approve periodically the consolidated statement of the accounts for the project.
6. To report to the administrator of the Holy Family Hospital on duties and functions of the coordinator and his staff.

E. By approaching the problems of out community in this manner we are endeavouring to demonstrate how the institutions of an area can cooperate to treat the whole man in this environment. Joining hands will be Muslim, Hindu and Christian elements in this effort. We will not only bring health to the villager or slum dweller who may not even realize he needs the assistance but we will also attempt as part of the team effort whatever is required to help the man whole. Not only will we work on his physical environment but will try to develop a community awareness to his other needs be they sociolgical or educational. We hope to show in this pilot project how the mission hospital can act as a catalyst in promoting an integrated system of comprehensive health care in the community. We feel also that this will put into action what so many have talked or written about as the way our work should adjust to the realities of the localities we serve.

2. BACKGROUND INFORMATION PAPER

Paper No. 1.

The Dr. Zakir Hussain Memorial Welfare Society has the following aims and Objects:

1. To foster friendly and harmonious relations among the Children, youth and families belonging to different Communities and thus promote emotional integration amongst them.

2. To promote Welfare service for the Children, the Youth and the Family

3. To organise for their recreational, social and cultural activities on the local level.

4. To organise, guide and co-ordinate Children's, young Men's and Women's Clubs.

5. To organise camps, tours, picnics and other joint functions for the members of the affiliated clubs.

6. To maintain one or more Model Community Centre in Delhi for the Child, Youth and Family Welfare.

7. To prepare and/or public he such literature specially for children, as would be conductive to the aims and objects of the Society.

8. To provide field work placements for the students of the Jamia School of Social Work, New Delhi.

9. To do all such other acts and things are necessary of conductive to the said objects.

The Proposed Project For Child Welfare

The need to organise activities for children in order to keep them gainfully busy during their leisure time and provide them opportunities for the healthy development of their personalities has long since been recognised in our country. In all big cities of India there are many child welfare agencies. In Delhi also there are a number of agencies working in the field of child welfare. But right from Nizamuddin to Okhala now a single agency can be located which runs any out of school programme for the children. There is an urgent need for organising such activities in this area as many slums have developed and are still developing. The children living in slums are more prone to fall prey to bad habits and may create problems by increasing the rate of juvenile delinquency in the area.

In view of such conditions, the Society proposed to develop children's clubs in these localities in which various recreational cultural and social activities can be organised and thus the children could be kept busy. The society also proposed to organise programmes of inter-club activities for providing the children of different localities and opportunity to miz with each other. The following are the aims and objects of child welfare programme organised by the Society.

1. To prepare children as worthy citizens of tommorrow by prodiding them with opportunities to elect their own leaders, plan their own leaders, plan their own programme organised by the Society.

2. To provide for children as many opportunities for self-expression as possible by helping them to organise cultural and recreational programme,

3. To bring children of all castes and creeds together on the basis of their common interest for building up the social harmony and solidarity that our country, needs so much today.

4. To prevent juvenile delinquency, vargrancy and other such problems in the area.

Besides organising children's club in local communities, the following activities and programmes shall be undertaken by the child Welfare Section of the Society to achieve these objectives:-

1. To make arrangements for educational tours, summer camps and exhibitions.

2. To make arrangements for a mobile library.

3.- To organise recreatio ml activities and sports.

4. To organise film shows.

5. To supply milk and other nutritional food.

6. To provide "Health Services".

THE PROPOSED PROJECT FOR NON-STUDENTS YOUTH WELFARE

Youth has a vital place in any society and they must be given an oppertunity to make their contribution to constructive activities. Theirparticipation should be based on personal inclination and intterest and they should be encouraged to become members of organisations that carry out specific programmes. The enthusiastic participation of youth is required in programmes and activities for promoting physical fitness, recreation and growth of health citizenship.

1. Initially, it is proposed to contact youth who have organised, or have a desire to organise themselves locally for recreational social or cultural activities.

2. The society shall pick up from amongst them, those who show promise of inttiatve and drive, and to invite them to meet and share their experiences with one another, share each other's experiences, seek and get each other's help, formulate joint programmes and evolve common concepts of youthwork. The specific purpose of such courses would be:

   i) To orient them in the concept, objective, function and leadership required in the organisation of programmes for differents sections of the people (child, youth and Women etc)
   ii) To introduce them to the potentialities of wide variety of programme media to cater to the varied interests and needs.
   iii) To bring home to them the concepts of democracy, secularism, socialism welfare activities and of the human relationships applied to meet the day to-day needs.

Lectures by renowned persons, discusions and demonstrations would be the main content of such courses.

3. The Society shall pick up from amongst them those who show promise of initiative and drive, and to invite them to meet and share their experiences with one another, and discuss the problems facing them and their people at the local, state and national levels.

Follow Up:

The Society would not adequately discharge its responsibility by organising the orientation programme alone. It will be necessary for it to keep the contact with the volunteers alive in order to know their progress, difficulties and to determine the efficiency of the orientation training received by them. This will be supplemented by feed back services, the need for which may arise from time to time.

The Content of the Orientation Programme:

The orientation programmes shall be prepared according to the expressed needs of the participants. Their content may consist some of the following:

1. Indian social, economic and cultural problems and the need for social Welfare.
2. Welfare State and introduction to the fields of Social Welfare.
3. Meaning of Democracy.
4. Secularism and Indian Constitution.
5. National Integration and Social Conflict.
6. Programme Media in youth Welfare.
7. Methods of working with people.
8. Constructive programmes as leisure time activities for Youth Welfare Programme.

The content of the orientation programmes shall be covered through:

1. Lectures by University teachers.
2. Talks by others on national issues.
3. Discussions and Seminars.
4. Demonstration of programme Media such as group games, dramatics, arts and crafts, adult education, vocational guidance and conselling and visit to Welfare Agencies.

It is proposed to organise at least three such orientation programmes or one week duration each year.

THE PROPOSED PROJECT FOR FAMILY WELFARE.

The Jamia School of Social Work is surrounded by semirural areas which are developing as slums and lack welfare services for Women and Children. The School has started working in these areas with a view field work experience to the trainees. The response of the residents of these areas to the preliminary work organised by the trainees has been very encouraging and the society, therefore, peoposed to establish two or three such Centres for Family and Child Welfare.

Activities:

Initially the following activities are proposed to be taken up:

1. Tailoring Class: From the reports of the trainees placed in the village for field work it seems that most of the women folk are interested in attending tailoring classes. In the tailoring classes it is proposed to teach art of stitching various types of garments within a period of four to five months on rotational basis.
2. Adult Literacy Class: An effort is to be made to make the ladies of the locality literate as most of the women folk of the area are illiterate.

3. Cooking and nutrition class: Talks shall be arranged on how to preserve the nutritional contents while cooking vegetables along with the demonstration of the methods by the Home Science teacher of the School

4. Pre-natal and Post-natal Care: Talks and demonstrations shall be discussed. Pre and Post-natal care of the expectant and nursing mothers shall be discussed and demonstrated with the help of Health Teacher.

5. Balwadi: Under the scheme a Balwadi is proposed to be started for the children in the age group 2½ and 6 years. This shall cater to the following needs of the children:

   (a) Physical check-up
   (b) Supplementary nutrition
   (c) Informal education through play activity
   (d) Providing smooth transition from home to school.

6. Play Centre: For the Children between the age-group of 6 to 11 years the centre shall provide the following activities:

   (a) Recreational and cultural activities.
   (b) Work interest
   (c) Referral services for children in need of special care.
   (d) Mid-day meal (if possible).

7. Case work and counselling services: The services shall be extended in due course through the expert teachers of the school in the field of problems ranging from marital discord, family discord, institutionalization of mentaly handicapped child, family planning. Scholastic difficulties of children, and referral to medical and psychiatric facilities and legal aid.

THE PROPOSED PROJECT OF A NEIGHBOURHOOD CENTRE.

The proposal to establish a neighbourhood centre is a natural out come of the objectives envisaged in the proposed constitution of the Society. It would facilitate an integrated approach to serve the community better as it combines welfare services for all age groups on need base formula.

OBJECTIVES OF THE CENTRE.

The neighbourhood centre shall attempt to achieve the following objectives

1. To organize social groups of children, youth and adults such as friendship groups, acquintance groups, clubs, councils, committees etc. around their leisure time interests.

2. To foster friendly and harmonious relations among children, youth and adults belonging to different communities.

3. To motivate people to develop the habit of organising voluntary association for all kinds of civic and social purposes.

4. To help community to draw benefit from other existing Welfare agencies and wherever necessary and wherever necessary, to seek help and assistance of welfare organisations in strengthening the programms of the Centre.

5. To render case work services.

6. To undertake surveys and research for strengthening the policies and programmes of the Centre.

SERVICE PROGRAMME

The proposed service programme is designed on the basis of known and anticipated needs of the community proposed to be served by the centre. While it is not possible in this preliminary planning stage to lay down pricrity order of various items of activities to be taken up by the Centre, it however be stated that the programme for children and youth should get preference over the programmes for adults in early states.

1. Children's Programme:

i) Day care Centre (age-group 3-6)
ii) Children's after School Programmes,

- Arts and Crafts
- Dance - Drama-music,
- Special events and camps,
- Games, sports gymnasium,
- Trips, picnics, recreational & Cultural activities,
- Children's Council for planning of special programmes.

11. 111. Youth Programme:

- Recreational-cultural activities
- Adult classes to help them in their educational pursuits
- Women's clubs.
- A council for Neighbourhood Planning to undertake such work which would promote neighbourhood relations as well as civic and social facilities in community life.

111. Case Work Services

The Services-programme will be incomplete without case work services. Individualized help will be given to children, youth as well as adults in dealing with their personal and social problems.

lv. Mass-Recreational and Free Play:

Besides approaching the people through various groups, mass-recreational and free play activities will contribute to integration and development of neighbourhood

STARTING POINT.....

A modest beginning has been made to achieve the ends through phased-programme-development. In the early stages the society has decided to organise such activities which can be carried on with the help of the students of Jamia School of Social Work and the trainees of Family and Child Welfare Training Centre under the expert supervision of the teaching staff. The activities are so selected as not to involve heavy expenses, Thus, financial implications in the early stage have been kept to the minimum,

Child Welfare:

The Society organises children's club in different localities with the help of the students and the trainees of the Jamia School of Social Work./beenit has/ decided to organise every year an inter-club competition in cultural activities and games for the age-group of 10-14 years on 8th February, the birthday of the late Dr. Zakir Hussain.

Youth Welfare:

The Society is planning to organise on experimental bais an orientation course in constructive work for the benefit of non-student youth during the year 1970-1971.

Family Welfare:

The Society runs two family welfare centres, one at Okhla and the other at Noorunagar. The centres run Nursery Classes for the children of age-group 3-5 and craft classes for women.

These programmes shall further be developed after the Society is able to raise the required funds.

Financial Requitement:

The Society would require considerable funds for its annual expenditure when all its proposed programmes come into operation. It is expected to meet this expenditure out of the regular folow from the reserve fund and from the rent of the external portions of the proposed buildings which can be let out for a commercial purposes. The society, therefore proposes to raise funds to the tune of rupees ten lakhs which can partly be utilized for creating the reserve fund and partly for constructing buildings and pruchasing furniture and equipment.

X. BACKGROUND INFORMATION PAPER

Paper No. 11.

FROM THEORY TO PRACTICE

Comprehensive Rural Health Service

S. Kaithathera
H. Kendrick
K. Kukowski

In 1968, Holy Family Hospital, situated in the Delhi South Zone, conducted a survey of the hospital and its surrounding areas. This general, 175 bed hospital has been in operation since 1956. As a result of the survey, it was found that the most pressing need, in line with the government's planned medical development, was rural preventive medicine. It was, therefore decided to set up a comprehensive rural health service based on the Primary Health Centre in pattern and set-up, i.e. to give total family care both at home and in clinics in the way of curative and preventive measures.

This Comprehensive Rural Health Service (CRHS). Located in the Delhi South Zone, started functioning in 1969 in cooperation with the Delhi Municipal Corporation.

The villages in the area, nine in number, are marginal villages, combinations of urban-rural, Muslim, Hindu and Christian populations, on the fringe of the rapidly developing and expanding city of Delhi. The area's population continues to increase every year due to migration of mostly unskilled, illiterate, daily labourers from the nearby states of Uttar Pradesh, Rajasthan, Punjab, etc. Drought crop failure and the promise of higher wages attract the families to this fast growing city. With such a transient population, there are numerous problems vary in degree from village to village. The cost of housing is perhaps the highest in the country. The city of Delhi is classified by the Government as Class "A" (an extra allowance for housing is provided to Central Government employees). In some of the villages, the families live in hutments or juggies, others live in better constructed housed. There is an upsurge of factories in the area; the Okhla Small Industries Estate has over 85 factories employing some of their labourers from these villages. Along with the factories come new housing developments, soon a shopping area and the like. The villagers range from the extremely poor to the highly educated, some being lecturers and teachers at the Jamia Millia Islamia.

PROJECT SERVICES

The goals of the CRHS are embodied in the service which have been developed for the promotion of prevention in the village communities:

1. Health Education: Introduction of health ideas in order to develop a personal family and communal awareness of health aspects of life. Those fundamental concepts are integrated by way of individual counselling, demonstrations, displays, camps, clinics, into every single aspect of this programme.

2. Maternal and child health: Maternal service is the preliminary stage of any health service. Its purpose is to build up maternal health in order to bring forth a healthy living child through antenatal, natal and post-natal care. The child care, which includes infants and toddlers, concerns itself with the physical, psychological and social and social need of the growing child. Through this, the child is prepared for school and is followed through preliminary education.

3. Family Planning: It is hoped that through guidance and counselling a degree of responsible parenthood could be achieved to enable the parents to accept the obligations of the parental role in our society.

4. Applied nutrition: Through applied nutrition, it ishoped that acute nutritional problems can be reduced and those suffering grom the deficiencies can be assisted to a certain degree of normalcy. This can be achieved through the following:

a) Feeding programmes for mothers and children (egg, milk, fortified foods)

b) Kitchen garding to provide vegetables at minimum costs, enabling families to take on basic nutritional values.

c) Demonstrations of cooking methods to heighten their awareness of the value of foods. Displays and audio-visual techniques are used to assist the educative process. This will be done in the village as well as in theweekly clinics.

5. Medical aid: This service is to establish firm foundations and reduce the already prevalent diseases and illnesses.

6. School Health : This is a continuation of the maternal and child health. As the child grows, health care and guidance are necessary for his continued physical and psychological well-being.

7. Communicable disease assistance control: This is to be achieved through immunization and vaccination with smallpox, B.C.G., cholera and typhoid. This will be given to all infants, toddlers and other family members. Along with this , communicable disease education is given on enviromment and higiene.

8. Basic hygiene education: This will introduce the individual and families to the basic information of hygine and is given through spontaneous, group or clinic talks and advice.

9. Social Family Welfare Service: Because family and individual problems are closely related to the socio-economic, social and home circumstances, a family fuidance and referral service is necessary to assist and fuide families to solve their problems.

10. Nursing rural health training: Nursing students are offered rural experience to give them an understanding of village life and the family, social economic and personal problems of the people. There is specific training in the value of preventive medicine which enable the student nurse to carry this into her own community as well as into her hospital work.

11. Statistical data collation: To establish a firm basis for progressive research in all priority and evolving problems.

STAFFING PATTERN

The team consists of a part-time doctor and volunteer doctors, public health nurse, four lady health visitors, nutritionist, social worker part-time lab technician Municipal family planning worker, village motivator-cum-auxiliary, driver and full-time vounteers.

SPONSORING AGENCIES:

This programme is need-based as it is directly the result of a survey carried out in the area. Maternal, child health and nutrition were given the highest priority. The applied nutrition programme is sponsored by three agencies: UNICEF, through poultry maintenance programme, audio

Sponsoring agencies: (contd).

Visual equipment and feeding equipment; Government of India, which is expected to donate Balahara, protein-fortified wheat; Catholic Relief Services, which has given oil, bulgar wheat and milk powder. The Delhi Administration, through a Public Health Grant is assisting with education and some salaries. The Communicable Disease Assistance Control is aided by the Municipal Corporation with vaccination and immunization drugs, and it also cooperate with family planning workers and sanitary inspectors for the area.

PHASE DEVELOPMENT

To achieve these goals, there phases of operation have been designed. In phase I, through a comprehensive health survey, the CRHS was introduced to the villagers and non-official village leaders, those influential in the village such as doctors dais, teachers, landowners, etc. was secured phase II is started as a short term programme. It consists of (1) Maternal and child health and family planning, (2) Applied nutrition, (3) School health, (4) Communicable disease control.

The villages and schools have been entrusted to the four lady health visitors. Their work in these villages is to give total family care through home visits and clinic service referral. Family care includes all health education, motivation and follow-up. Each lady health visitor (LHV) has, at present, about 275 families under her care. Each is responsible for about 1400 school children as well.

The ante-natal care is as follows:

I) The early booking of cases for home delivery. This is done during the LHV visits.

II) Periodic check-ups which include lab. tests examination, treatment and follow-up.

III) Referrals of two types will be made, one to the nutrition clinic, that is, mothers with anaemia and/or other nutritional deficiencies, the other will be those cases unsuitable for home delivery to be referred to the hospital.

The Natal care is follows: For all of the booked cases home deliveries will be arranged, These deliveries will be followed up through the postnatal care consisting of daily visit for 5 to 6 days and tenth day after delivery.

The infant care will consist of the infants attending monthly clinic and being visited at home each month over a period of one year. This is in order to give the necessary immunization and follow-up their growth and development. For the infants with nutritional problems, referrals will be made to the nutritional problems, referrals will be made to the nutritional clinic and difficult cases to the hospital.

The pre-school or toddler care concerns itself with the children from one year until school age. This is through clinic attendance every three months as well as home visits every three months. Referrals are the same as for the infant programme.

In the home visits immediate health education is given and followed up. In the clinics there will be a set pattern of health education through use of visual aids.

The whole programme includes family care : i) family counselling to work out or assist in marriage and family problems, (ii) employment referrals, cottate industry, insurance and small business loans and (iii) medical aid.

The second aspect of the Phase 11 programme is applied nutrition. This is a priority concern and is directly integrated into every level of service, specifically in a referral clinic for nutrition. There are cooking demonstrations of the available foods to impart knowledge of food values, vitamin, vitamin maintenance in preparation, the "how" of increasing the nutritional content of the family diet. Food Care will be given to nutritionally deficient mothers and children.

Another aspect of the applied nutrition programme is kitchen gardening already implemented and carried out by a village motivator in Joga Bhai village. Poultry raising is to be started through UNICEF Paultry Maintenance Programme (this supplements both family diet and income).

School Health Care consists of toddler follow-up, complete yearly physicals by doctor treatment and follow-up and immunization. Classes will be held for teachers in hygiene, home nursing and first aid. Referrals will be made from here to the nutritional clinic or hospital, if needed.

The fourth aspect of Phase 11 is communicable Disease Control which will be assisted by Delhi Municipal Corporation with immunization teams, sanitary inspectors and drugs for immunization. These immunizations will be given in clinics and home visits. Small pox, DPT and cholera are of particular concern work is being done on the detection and referral of infections. Domicilliary care will be given to a small number of T.B. cases. With the aid of the sanitary inspector water will be tested and treated when necessary; insect eradication will also be undertaken.

The CRHS programme has helped 950 families and nearly 1500 infants and toddlers. This required an investment of Rs. 78,000/- Financial assistance was received from the Holy Family Hospital Auxiliary and Catholic Relief Services, and the Delhi Administration which contributed over Rs. 10,000/-

HEALTH ANALYSIS

Village	Family	Toddlers	Infants	Ante-natal
Juliana	Shopkeepers Educated Employed Cottage Industry	Weaning mal-nutrition, Deficient Character formation 80% Primary smallpox Sec. Vacs. done. DPT and other immunisation nil. Psychological development training -nil Pre-school preparation nil.	Intestinal & other infection due to sanitation	70-80 per cent untrained dhai delivery infection Anaemia
Masigarh	Farmers	Same as above	90-95 percent worms	Same as above

Village	Family	Toddlers	Infants	Ante-natal
	Holy Family Hospital employees shopkeepers educated employed Cottage industry	Same as above	Same as above	Anaemia
Gafoor Nagar	Class IV employees at Jamia Milia unemployed daily labourers	Same as above	Undernourished due to infection intestinal infection due to sanitation	98 per cent village dhai delivery anaemia Indication of extraordinary high still birth and neonatal birth few witnessed maternal deaths
Joga Bhai	98 percent unemployed daily labourers residing in mud juggies	Acute malnutrition due to family diet of mainly chapatti and chili. Street children acute diseases due to malnutrition No. Schooling	Undernourished due to infection and diet high incidence of diarrhoea, worms URI.	Ante-natal anaemia Dhai delivery infection
	Teachers of Jamia Milia	Generally active healthy children. Need for immunization	Immunization	98 percent trained dhai delivery
	Professors Low income labourers middle class Few landowners	Intestinal infections. Emotional and psychological problems anaemia rickets	High infant death Marasmus Intestinal infections	Early marriage; therefore high incidence of grand multiparas Anaemia

BENEFICIARIES

VILLAGE	FAMILIES UNDER CARE	INFANTS UNDER CARE	TODDLERS UNDERCARE	ANTENATAL UNDER CARE
1. Okhla	291	95	339	38
2. Batla House	40	17	50	6
3. Gafoor Nagar	64	12	68	5
4. Joga Bhai	59	20	66	7
5. Jamia Dairy	23	8	30	4
6. Bharat Nagar	161	55	164	27
7. Julliana	221	94	207	27
8. Masigarh	81	40	92	7
Total	940	341	1016	116

PARTICIPATION

The CRHS now operates in two centres to cover all the villages. The Family Planning Centre in Okhla was given by village resident as a base for the clinics. In Masigarh another centre, donated by the parish, is set up for clinics to service the remaining villages.

The Jamia Millia School of Social Work initiated on March 31, 1970, the Dr. Zakir Husain Memorial Welfare Society. The aims and objectives of this society are the promotion of service for the family within the community through the following five standing committees.:

i) Child Welfare - need for organizing children's activities in order to keep them gainfully busy during their leisure time and to provide them opportunities for healthy development of their personalities.

ii) Youth Welfare a proposal to contact youth, a large segment of India's population, through meetings and conferences, to eventually organize Leadership Training Courses, orienting the young toward democracy, secularism, socialism, welfare activities and applies human relations.

iii) Family Welfare - to establish suitable activities for recreation, economic betterment and education.

iv) Neighbourhood Centre - enabling an integrated approach to serve a community better as it combines all the welfare services on a need-based formula.

v) Ways and Means - finances.

This Welfare Society will work in partnership with CRHS. The aims and objectives of both will provide one another with the vehicles necessary for increased social welfare.

Jamia Millia Islamia has also contributed to the area through the Mukhya sevika training project. The trainees from various states in the country required a certain amount of field experience. Several village have been the recipients of these projects - Mahila Mandal (home economic for women) at the Balwadi (children's education).

Generous efforts have been made by the village women volunteers in the sewing and cooking project. One women from the village has joined the CRHS staff as a village level worker helping to stimulate the women to an acceptance of the women to an acceptance of the project.

ON - GOING STUDY AND RESEARCH

During the survey, a sample study of infant and toddler deficiencies was conducted by a pediastrician from Irwin Hospital. Based on the children's histories, blood and stools were examined and the report indicated a high incidence of Kwashirkor, Marasmus and Bilateral trachoma. Clinic attendance, to date, has evidenced a very high incidence of anaemia, particularly among the pregnant mothers and toddlers. Rickets is prevalent in the very poor.

Two research projects are being designed at present to supplement the survey in the sense of more in-depth investigation into what responsible parenthood really is in these situations as well as an area awareness study to determine the level of the community's response.

EVALUATION AND PROJECTION

Phase lll of this programme is an overall evaluation of existing services after one or two years based on the short tearm programme. Following this will be the implementation of the long term measures based on evaluation data.

Although programmes of this type, sponsored by private voluntary organisations, are only beginning, it is conceivable that with government consent, available finance and resource assistance, they could be set up with a minimum of Rs. 67,000 for adequate staff and other expenses. A programme of this sort could easily be considered as one unit. Multiple units of four to five could be administrator and one supervisor.

BACKGROUND INFORMATION PAPERS
Paper No. 3.

The Project services of the Comprehensive Rural Health Service:

1. Health Education

Introduction of health ideas in order to develop a personal, family and communal awareness of health aspects of life. Those fundamental concepts are integrated by way of individual counselling, demonstrations, displays, camps, clinics, into every single aspect of this programme.

2. Maternal and child health

Maternal service is the preliminary stage of any health service. Its purpose is to build up maternal health in order to bring forth a healthy living child through antenatal, natal and post-natal care. The physical, psychological and social needs of the grounding child. Through this, the child is prepared for school and is followed through preliminary education. This service will be given both in the clinics and families.

3. Family Planning

It is hoped that through guidance and counselling a degree of responsible parenthood could be achieved to enable the parents to accept the obligations of the parental role in our society. Referral to Government Family Planning Centres.

4. Applied Nutrition

Through the applied nutrition, it is hoped that acute nutritional problems can be reduced and those suffering from the deficiencies can be assisted to a certain degree of normalcy. This can be achieved through the following:

a) Feeding programmes for mothers and children (eggs, milk, protein fortified foods).
b) Kitchen gardening to provide vegetables at minimum costs, enabling families to talk on basic nutritional values.
c) Demonstrations of cooking methods to heighten their awareness of the value of foods. Displays and audio-visual techniques are used to assist the educative process. This will be done in the village as well as in the weekly clinics.

5. Medical Aid

This service is to establish firm foundations and reduce the already prevalent diseases and illnesses. This has been taken as one of the priorities in the short term programme.

6. School Health

This is continuation of the maternal and child health, as the child grows, health care and guidance are necessary for his continued physical and psychological well-being. A complete medical check up is given to each child and the treatment and follow up is done. The necessary immunization also is given.

7. Communicable Disease Assistance Control.

This is to be achieved through immunization and vaccination with smallpox, B.C.G., Cholera and Typhoid, DPT. This will be given to all infants, toddlers and other family members. Along with this, communicable disease education is given on environment and hygiene.

8. Basic Hygiene Education

This will introduce the individual and the families to the basic information on hygiene and is given through spontaneous, group or clinic to like and advice.

9. Social Family Welfare Service

Because family and individual problems are closely related to the socio-economic and social and home circumstances, a family guidance and referral service is necessary to assist and guide families to solve their problems.

10. Nursing Rural Health Training

Nursing students are offered rural experience to give them an understanding of village life and the family, social, economic and personal problems of the people. There is specific training in the value of preventive medicine which enable the student nurse to carry this into her own community as well as into her hospital work.

11. Statistical Data Collection

To establish a firm basis four progressive research in all priority and evolving problems.

12. Rotating Interm ship programme

Where doctors will be offered practical training and experience in village health work.

X. BACKGROUND INFORMATION PAPER

The five standing committees of the Dr. Zakir Hussain Memorial Welfare Society:

Child Welfare

1) Need for organizing children's activities in order to keep them gainfully busy during their leisure time and to provide them opportunities for healthy development of their personalities.

2) Youth Welfare

A proposal to contact youth, a large segment of India's population, through meeting and conferences, to eventually organize Leadership Training Courses, orienting the young toward democracy, socialism, welfare activities and applied human relations.

3) Family Welfare

To establish suitable activities for recreation, economic betterment and education.

4) Neighbourhood Centre

Enabling an integrated approach to serve a community better as it combines all the welfare services on a need-based formula.

5) Ways and Means-finances

PROGRAMME OF ACTIVITIES:

1) Tailoring Class

From the report of the trainees placed in the villages for field workit seems that most of the women folk are interested in attending tailoring class. Under the class, it is proposed to teach art of stitching various types of garments within a period of four to five monthson rotational basis.

2) Adult Literacy Class

Talks the An eneavour is to be made to make the ladies literate of the locality as most of the women of the village are illiterate of the locality as most of the men.

3) Cooking and Nutrition Class

Talks shall be arranged on how to preserve the nutritive content while cooking vegetables along with the demonstration of the Home science teacher of the school.

4) Child Prenatal and Post-natal Care

Talks and demonstration shall be arranged in the subject. The physical and emotional needs of the child shall be discussed. Pre and postnatal care of the expectant and Nursing mothers shall be discussed, and demonstrated with the help of the Health Teacher.

5) Balwadi

Under the scheme a Balwadi is proposed to be started for the children in the age group of $2\frac{1}{2}$ and 6 years. This shall cater to the following needs of the children. a) Physical check-up, b) Supplementary nutrition and milk, c) Informal education, d) Providing smooth transition from home to school.

6. Play Centre

For the children between the age group of 6 to 11 years. The Centre shall provide the following activities:

a) Recreational and cultural Activities
b) Work Interest
c) Referral Services for children in need of special care
d) Mid-day meal (if possible)

7. Case Work and Counselling Services

The services shall be extended in due course through a family case worker of the society in the field of problems ranging from martital discord, family discord, institutionalisation of a mentally handicapped child, family planning, schomastic difficulties of children, and referral to medical and psychiatric facilities and legal aid.

This coordinated service will be implemented for two to three years as a short term plan. The priority of the long term programmes will depend upon the evaluation of the short term experiment.

NURU NAGAR SURVEY

Nuru Nagar had 245 families and a total population of 1366. There were 38 joint families, as defined by each surveyor, and 207 single families.

The average number of members per family was 5.5. 15 families had only 2 members, and only 6 had more than 10 members. The following is a breakdown according to size of families:

No. of members	No. of families
3	32
4	42
5	37
6	36
7	33
8	28
9	8
10	7

A breakdown according to age is given below:

Infants (under 1 year)	45
Toddlers (1 to 5)	85
School age (6 to 16)	423
Antenatal	14

The incomes recorded were monthly total family incomes - i.e. the sum of all income earned by family members. Those included in the definition for semiskilled were: clerks, teachers, tailors, drivers, cooks, shopkeepers. The 19 bear walahs were also included in the semiskilled category (all but 5 earned Rs. 100 or below). 67 families or 28% had incomes of Rs. 100 or less. Of these, 52 were labourers and 15 were semiskilled. 99 families or 40% of the total no. of families had incomes between Rs. 100 and Rs. 200. 76 families, or 30%, had incomes above Rs. 200. Of these, 34 were labourers and 42 were semiskilled. In this high income group, incomes ranged up to Rs. 500 and Rs. 1000.

HOME AND ENVIRONMENT

178 or 73% of the total families had one room; 47 or 9% had two rooms: 18 or 8% had three rooms or more. 60% of the total had a water source outside the house. 191 or 78% owned their own housing. Of the 36 families who pay rent, 15% 9 had incomes Rs. 100 or below, and paid from Rs. 5 to Rs. 20 for rent. 16 had incomes Rs. 110 to Rs. 200 and paid Rs. 30 to Rs. 50 per month. 21 had incomes above Rs. 200 and paid from Rs. 15 to over Rs. 200 per month. 28% of the total families had electricity.

IMMUNIZATIONS

Vaccination	all members vaccinated	none of the members	some of the members
smallpox	209/85%	6/2%	30/13%
BCG	67/27%	140/57%	38/16%
TABC	59/24%	160/65%	26/11%
Folio	24/10%	197/80%	24/10%
DPT	26/11%	199/91%	20/8%

HEALTH

Of the family members above 5 years of age, the following ailments were listed in five of more cases: rheumatism, having a cough for a long time, headaches, stomach pains, asthma, diarrhea, backache, menstral problems. Of those under five years of age, most common were: sore eyes, worms, diarrhea, cold, distended stomach, and general weakness.

SOCIAL PROBLEMS

14% of the total population indicated that they worry about money. Also mentioned as a common concern was the marriage of a daughter

NUTRITION

26 families or 16% of the total were begotarian; 84% were non-vegetarian. 69 families or 28% never drink milk; 16 or 7% had milk for other than tea; and 65% had it for tea. 222 or 91% never had fruit. 199 or 80% never ate eggs; and 9% ate eggs daily. 65 or 26% never bought meat; 23 or 9% had meat daily; 99 or 41% had meat once a week. Below is a breakdown of meal habits:

a. most families had only chapatti and tea for breakfast
b. 13% had only vegetable for one meal, 3% had it for two meals
c. 15% had only dal for one meal
d. 9% had vegetable or dal for one meal, 9% had it for two meals
e. 12% had dal or vegetable or meat once a day, 12% had it for two meals
f. 7% of the total families had only one meal a day other than breakfast, and had either vegetable or dal
g. 20% had dal and vegetable once a day, 14% had it twice a day
h. Only 2% had dal and vegetable and meat once a day, 2% had it twice a day
i. 6% are suject for one meal, 6% ate dal and subji for one meal

Case Study I

67.2

ANNUAL REPORT FOR 1973 OF THE COMMUNITY HEALTH DEPARTMENT HOLY FAMILY HOSPITAL

The Pilot Project was inaugurated on February 8, 1972, as a comprehensive programme of health, welfare and education.

The general objectives of this programme are:

1. Neighbourhood development
2. Total family care through integrated health and welfare services and educational services.

In order to develop a common programme for families of the whole service area - our neighbourhood - recreational activities, economic uplift and education are steps towards total family care and an overall social improvement.

Through the coordination of the following existing agencies and institutions we are able to achieve the aims and objectives set up:

1. Jamia School of Social Work training programme
2. Dr. Zakir Hussain Memorial Welfare Society
3. Holy Family Hospital (as referral centre and specialized treatment centre)
4. Holy Family Hospital Community Health Department
5. Holy Family Hospital School of Nursing and the department of medicine and DCH for training
6. The educational and referral facilities of Don Bosco Technicial Training School.

Review of the work in 1969 - 1972

HEALTH PROGRAMME

In 1969 we selected an area out of the Delhi South Zone between Mathura Road and Agra Canal, in cooperation with the Delhi Municipal Corporation. The population of this area is about 20000 and its has a mixture of Christians, Moslems and Hindus.

Some 60% of the breadwinners in the families are daily labourers, 38% are shopkeepers, clerks, teachers etc. and only 2% landowners. Out of that 60% had an income below 100 Rs. per month, 30% had an income between 100 - 300 Rs. per month and 2% are earning 200 Rs. or more monthly. The average family size was 5 - 7 family members.

The health problems were of quite an extensive type in this initial stage of the project. Maternal deaths, malnutrition, anaemia and worm infestations were found to be the most common

cont. ..2..

diseases. Almost 80% of the families in the area have a one room accommodation only and this causes several socio-economic problems. We also found the sanitation and drainage system to be very poor in the area.

After the initial survey of the area in which the above facts and needs were discovered, we made a family folder for every family including separate record cards for infants, Toddlers, antenatals and adults.

In order to start the work and set the priorities we made the following our aims:

1. To reduce the high incidence of morbidity among vulnerable groups and to reduce damage and death caused by gastro-intestinal diseases.
2. To reduce the number of anaemic cases. 75% of the children were duffering from anaemia.
3. To reduce nutrition deficiencies.
4. To reduce maternal deaths.
5. Protection from communicable diseases among the "under fives", through immunization programmes.
6. To reduce the high rate of TB, by clinics and referrals, TB, cases were 10/12 - 1000 in the population.
7. To make the villagers aware of health needs through health education and to encourage their own initiatives in using and developing health services provided.

The goals were set for each year to achieve these aims and evaluations.

During 1970 we made it a task to emphasize a growing link between our department and the rest of the hospital. At the same time the stress was laid on the completion of the comprehensive health survey and on the full implementation of the nutrition and immunization programmes. Curative services were integrated with the preventive sector. Our estimation was that the first two years would require more emphasize on medical care than in the later stage of our programme.

The above 1970 aims were materialized through daily medical clinics and nutrition clinics set up in the villages, as well as through health education, school health services and referrals of serious cases to the hospital. It was also carried out through deliveries conducted at home by our staff, being on day or night duty.

Along with this we started to provide students of nursing a good rural experience and health education. By periodic service evaluation and in-service training for our team we were able to see the positive and negative aspects of our work more clearly.

During 1971 and 1972 the above programme was strengthened. More attention was given to the integration of health and welfare services. The total immunizations of DPT, BCG, polio, Smallpox and cholera for children under five was set up as a definite goal as well as to conduct a Dai training. The health education was extended by a planned curriculum and a cleanliness drive was started in one of the most needy villages. Finally we also started to prepare the village population for a future self supporting programme. One more health centre was opened in 1972, making the total of four centres and five welfare centres. The total number of families under care in 1972 was 1853, members of whom came came to ante-natal, under fives, family and nutrition clinics according to their age, school health and home visits were continued. In 1972 we also moved into a new office, giving us more space to work in than previously.

For 1973 we had set the Goals as follows:

1. Completion of the whole immunization programme
2. More home visits for health educational and nutritional purposes.
3. Resurvey to evaluate new needs and attitudes of each family.
4. More involvement of local leaders in our work.
5. More referrals to other hospitals and centres
6. Filtre-clinic, i.e. treating routine complaints in the clinics with standing orders.
7. Starting preparations for a health insurance scheme.
8. Strengthen the school health programme with planned Health Education
9. T.B. Case finding.

RESURVEY.

The year 1973 started with a total resurvey of the whole service area. In order to find out new needs of the families as well as their reactions and attitudes, effects towards our programme we made a Comprehensive questionnaire, covering both the welfare and the health aspects. At the same time it was a tentative preparation for a self supporting scheme. 1664 families were surveyed.

This however excludes the village of Nuru Nagar, consisting of 336 families, since that village was surveyed one and a half year ago, before opening its centre.

By asking the villagers how much they would be willing to contribute towards a health insurance scheme in 1974 we found out their economic capacities for self support and their response to bearing an increasing responsibility for health services. As the statistical reports of this resurvey show, some 15-20% of the population are in favour of an insurance scheme whereas many others had not yet made up their mind. Among those giving a definite response of approval 60% are willing to contribute 1 - 2 rupees per family per month the rest more. Asked the question whether continued health services are preferred to the threat of closing clinics for lack of funds, 75-80% replied that our centres and work should go on by whatever means possible. They will pay for the medicine. The general knowledge of our work among the villagers is shown by the resurvey to be good and there are hardly any cases where our work has not been heard of at all. Only 29 families in the whole service area stated complete ignorance of our clinics.

As for the items the community expects from us, the majority replied that medical care, nutrition and immunizations were the most essential. Among the points to be improved some mentioned more personalized relations with the staff through home visits (a fact well known from previously), some mentioned the need for latrine facilities in the centres and some other families stressed the fact that patients had to wait for quite some time in the clinics due to the crowd(15%) Another percentage of the population, about 4, 5%, stated economic poverty to be one of the reasons for not coming regularly to the centre, as a nominal fee is charged there.

The structure of this resurvey differs somewhat from the initial survey we made in 1969. The latter was aimed at finding out concrete socio-economic facts and figures health needs whereas this resurvey stresses attitudes and preferences of the Community. Yet even from this resurvey it can be found that the general health and welfare level has been raised considerably. The monthly income of the majority of labourers has increased. Approximately 10% of the families have a monthly earning of below Rs. 50/- whereas the larger part of the population (30%) earn between 100-200 rs/- per month and 20% of the families 200 to 300 Rs. per month and the remaining 40% between above 300 up to 800. Only two families in the area have a monthly income of 1000 - 2000 or more. According to the resurvey no family is entirely unemployed.

The distribution of work has not changed its pattern much since 1969. The number of daily labourers, part time workers, hockers and factory or field labourers form the largest professional group in the area. About 420 families, including sweepers, peons and servants, are working in this sector. At the same time there is a fairly large group of tailors, carpenters, welders, masons, blacksmiths, dhobis and the like, making for a lower middle class. Some 300 families can be included in this category. The are two large scale shopkeepers in the area and 78 families having small scale shops of the juggi type. There are eight doctors in the community as well as 74 teachers. Clerks and typists, an occupation sprung from the urbanization of the area, were found to be the breadwinners in 68 families. Only 3 families were earning their livelihood through begging. However, due to the shortage of wheat and other grains, the women who were working in the modi mills and other shops as daily labourers, are now sitting idle in the home. As a whole it is clear that there is a general trend away from the traditional agricultural work and daily labourers' occupation to new means of subsisting, found in a city.

As for the educational level it clearly shows a growing equality between both sexes in comparison to the previous generation. Among the adults of the villages about 1650 inhabitants were found to be illiterate, of whom females twice as much as the male group. Throughout the various stages from primary school up to college twice or thrice as many men were found to be educated as women. Only in the field of private studies we found 10 educated women in comparison to 3 men. Among the children of school going age however the distribution was fairly equal, except for colleges where the figures showed 47 male against 19 female. In technical schools however the level was the same. (4 males to 4 females) The largest bulk of students are found from nursery classes up to the middle school included. Again the female dominance is striking when it comes to private studies - 5 females to 2 men.

The immunization coverage, health education and curative care have made people more aware of the values of medical service and right hygiene and the community is giving a

growing place in its time and spending capacity to health betterment. Also it is prepared to give support and help in whatever way possible. According to the survey report those who are educated promised their parttime help, doing for instance typing or helping in the centres. Those who are not educated - especially women - help us in cleaning, prepacking, etc.

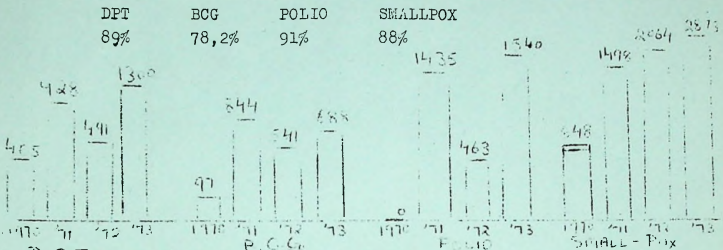
THE UNDER FIVES' CLINIC

Our goal to cover the whole area with a total family care is fully implemented. The under fives' clinic is an integrated clinic of medical aid, immunizations, nutrition, family counselling, health education and all children can attend the clinic, whether well or ill.

Through the medical check up in the centre and the resurvey and home visits more cases of malnourishment and marasmus in the early ages could be found. These children have immediately been referred to our nutritionist and we now have a regular follow up of those cases, combined with health education on proper diet, cleanliness etc. for the mother.

The disease pattern has also taken a new shape. The percentage of severe diseases has been reduced and approximately 55-60 % of the daily diagnosis in the centres are confined to 3-4 common diseases, partly conditioned by the prevailing season. General weakness, URI, fever, boils and diarrhoea cases are very frequent. The variety of diseases is less and the rate of morbidity has decreased considerably. This can also be seen from less clinical visits for the same complaint. Among toddlers and infants this decrease of revisits is 40% and 60% respectively as compared to 1972, and among adult patients the revisits have gone down slightly.

The goal to cover all the children under five by a complete immunization programme comes close to an end. The statistics show the following figures of coverage for 1973:



D.P.T Likewise the over all improvement of health can be seen in the results of hemeglobin and stool tests. From various group checks in the villages the average figures were far more satisfactory than last year.

Another important move is that the frequency of admissions into the hospital has been brought down due to an intensified treatment in the department of patients coming after clinic hours. Doctor and staff, being on night and day duty, are ready to give help to patients even of a more serious kind, like pneumonia or gastrointestinal cases. This has helped us considerably in our efforts to reduce the current expenses of our programme. Statistical reports show that referrals for specialized treatment have gone down by 40% since 1972, the referrals for admissions by 60 % since last year. Also this effort has made it possible to refer patients needing no emergency care, to other hospitals, like the Government run Safdarjang Hospital or the New Delhi TB Centre in Kingsway Camp. Such outside referrals have increased by 35 % since last year. The integration of welfare and health in the project has been further consolidated. Referrals to the welfare section of the project have increased by 50% since last year.

In one of our villages, Okhla, the Delhi Administration has set up a dispensary, providing daily services. With this dispensary we cooperate in such a way that we refer adult patient from the centre to the dispensary for dressing and treatment whereas patients from the dispensary will come to us for medicines and immunizations. One effect of this is that the number of adult patients in our Okhla centre has decreased, leaving more time for home visits.

At present the distribution of our patients is as follows:

Infants under care	Toddlers under care	School age under care	Antenatals under care
336	1907	3541	138

Adults under care	TB patients under care
5989	29

Nutrition:

One of the nutritional changes during 1973 is that in November the family nutrition was stopped, due to shortage of supplies. Instead all children under 6 years of age are given at birth a PRC card (Patient's retained card) in which the monthly height and weight is registered on a scale. Likewise hemoglobin and immunizations are marked in this card. After the age of 3 months we provide a protein mix for all these children (WSB + milk or CSM + milk, given by the CRS) Through the follow up on the cards and by home visits the progress of the child is properly surveyed. On the card, below the normal weight sector on the scale, we divide the malnourishment into three degrees, of which the second and third degree children are constantly followed up by home visits. It is also to be noted that a normal Hb, weight and height lasting for some months does not necessarily mean that the child's malnourishment has been turned into permanent health and resistance. Through pneumonia or intestinal diseases many of the cards show that the child's line on the scale can suddenly drop from normal to a lower degree. Due to this fact a constant and individualized follop up is important.

For the near future we foresee to introduce a new product, called Okhla Mix, consisting of Bengal roasted gran (20%), of wheat (60%) and jaggery (20%). This mixture has an over all effect along with the milk powder. We want to start this in three phases:

The first phase is: we prepare the mixture and the family has to buy from us. The second phase: the family itself will prepare the mixture, with our supervision. The third phase: the mixture has become a natural part of the daily menu for the child.

The nutritional statistics of this year show a clear trend towards success in our fight against malnutrition. In the initial stage 56 % of the infants were suffering from a 2nd or 3rd degree malnutrition. Only 13% were normal. At present 41% of the infants have a normal weight, height and HB and only 23% belong to the 2nd or 3rd degree level. Among the toddlers in the area only 22,3% had a normal weight in the beginning phase. Now 56,5% are safely within the normal sector whereas the 2nd and 3rd degree malnutrition still prevails among 19% of the toddlers.

Case study:

Case of Chandra Wati (marasmic child): A three year old child, Chandra wati, was found lying in the house during the home visit by our LHV. The mother's name is Kisan Devi. The father, Chandan, is a dhobi. The parents are busy with their daily work as dhobis. The child was born normal, weight being 7 lbs. Till one year the child was keeping normal weight. Within a year the mother had her 6th baby and she was unable to look after the two younger ones and her daily work. She took the child to her village in U.P. and entrusted it to the grandmother. The child stayed there for two years and became severely marasmic. The eye sight was gone. The grandmother treated the child with the help of the village priest and mantras. She believed it is the evil eye which made the child marasmic and the child is blind because during pregnancy the mother must have looked at something evil or unpleasant or she must have looked at a dead body. At last the mother went to the village and brought the child back. When we found the child she could not sit or stand and the weight was 7 kg. She could not see, not swallow anything and her body was just skin and bones. The child was seen by the Public Health Doctor and eye specialist. One of the health visitors goes to the family twice a day and helps the mother to cook special diet for the child and feed the child. Also she gives high protein mix and Vitamin A + D. Within three months the child can now sit up

The weight came up to 12 kg. It can see and recognize the people, We had about five or six such cases - all are now doing well. (Report of the LHV)

Taking care of a premature baby at home: a challenge to mid-wifery students during their Public Health experience.
Bero delivered a premature baby girl. The weight was 3 lbs. Having 4 boys the mother was very happy to have a girl. We made an improvised incubator with blanket pieces and a soft pillow as a mattress. The students visited the home 3-4 times a day and once a night during 4 days. (the home was near to the department) We taught the mother the feeding of the baby with dropper, how to give bath etc. After that we visited the child daily and early night. After 3 months the baby's weight came up to 4 kg. Now the baby is 6 months old, weight 14 lbs. We had four such cases, at present having a premature baby from the village with the weight of 2 lbs at birth. Being very active, it progresses.

HEALTH EDUCATION

Along with the clinics running, health education has been broadened and one Lady Health Visitor has been specially trained as a health educator to give several talks daily, before the rush sets in in the clinics. With the help of demonstration articles such as posters, flash cards and play materials she stresses various topics, such as right diet, sanitation, personal hygiene, cleanliness, need for immunizations, mother's craft etc. All together 1592 health talks were given in the clinics and 4135 in the homes, making it a total of 11% more health talks than last year.

Jointly with this health education is also carried out by an annual exhibition and by 3 periodical exhibitions in the villages, all of them dealing with the importance of right and clean diet plus personal hygiene so as to prevent intestinal diseases. TB and its prevention was also one of the topics. Those latter exhibitions were a joint cooperation between our staff and students from the Central Health Education Bureau, New Delhi. Those students did a very valuable work, being highly experienced in various fields of health.

Film shows featuring a three hour long movie in which family welfare/planning topics were pointed out in between, have been shown once a month in four localities. These were replaced in November by daily mime shows (for six weeks) in each village

dealing with antenatal care, cleanliness, sanitation, diarrhoea, worm infestations, proper diet, necessity of medical check ups and introduction of solids. Puppet shows were presented several times in each village, and they were arranged by Public Health Students from outside institutions.

Finally our home visits also partly belong to the field of health education. By on-the-spot advice the effect is more personalized. Yet it needs to be stressed that for the nutritional follow up of malnourished children we need more home visiting. By instant teaching how to apply the nutrition and how to feed the child we can assure regular mother care. It has been noticed that the mother of (for instance) a marasmic child will start feeding preparations only at that time when our staff enters the home, for a visit. Through home visits the links of confidence between staff and community are strengthened. During 1973 many visits have been performed by a planned scheme. The days when a centre-in-charge has no clinic to run, she goes for home visiting in the area for which she is responsible. This means that she goes out for home visiting at least 2-3 days a week. On Fridays the whole staff goes for home visits, including the nutritionist, health educator and social worker. The clinics on that day are opened for a few hours during the morning, for giving injections.

The statistics show that the increase of visits to the families have been very high compared to 1972. Last year we made 1627 visits whereas this year the figures show 2902 family visits. It is also to be noted that the home visits connected with post natal care have gone up by more than 1000 (120 visits made in 1972, 1328 visits in 1973). The reason is that we now have 4-6 weeks post natal care of the mothers and babies, the first 15 days of which we make daily visits to the home.

ANTENATAL AND HOME DELIVERY

In every village centre we have once a week an antenatal clinic. At present we have 138 patients attending these clinics, the progressive total of the year being 3791 . Those who are attending the antenatal clinic are booked for home delivery. These deliveries are conducted at the patien's home by a Midwifery student, trained dai and supervised by one of the LHV staff. Emergencies or abnormal cases are referred to the Holy

Family Hospital. In the clinics the Hb, urine and antenatal check ups are made once a month. However the patients are encouraged to attend the clinic every week so that we can give the necessary health education as well as the weekly supply of iron, vitamins and nutrition. In this way we can assure that the medicines are regularly taken and we also encourage the mother concerning preparations for home confinement and mother craft. All the staff are expected to learn epistemy and switchering to avoid unnecessary referrals and to meet the situation without a doctor. Since there is only one doctor working with us and two different clinics are held simultaneously in two different villages (under fives clinic in one village, antenatal in the an other clinic we manage the antenatal clinics without a doctor. Abnormal cases or any other complications arising, the patient is called to our central office where one of the senior OB & GYN comes every Saturday to see the referral cases.

SCHOOL HEALTH

In 4 primary schools and 5 balwadis the total number of children consists of 1178. At present we are able to do physical check ups of all the children once a year with referrals and follow up of all the special cases. A routine Hb. and stool test is done once a year. Two afternoons and one morning the doctor and a team consisting of laboratory technician, LHV and student go out to the village schools. One of our 1973 goals was to introduce a health education programme in schools and to get more cooperation from the teachers. The LHV who is in charge of the school health programme visits the schools daily and gives health talks on personal hygiene, hand washing, TB, smallpox etc. These talks last at least for 15 - 20 minutes in each class. The LHV displays various health posters in the classrooms. Also there are periodical cal film shows, exhibitions etc. (arranged by the students coming to work with us as a part of their training in different health fields) Smallpox and cholera immunizations are given every year to the students and teachers before the hot season starts. Likewise BCG is given whenever it is available. During 1973 students from the CHEB have done a special programme on TB control in one of the schools. BCG VACCINATIONS WERE GIVen to all the students aged 5-12 in that school. A health drama on TB and its preventation was acted out by primary class students and an exhibition was held in the school on TB control, In 1974 we are planning to give strength to these health educational programmes. It is our hope that the education department of the Delhi Municipal Corporation will give us the necessary permission to make health education a part of the curriculum and subject to evalu-

ation and grade. We are really happy to see that some of the schools authorities who were not cooperating in the beginning have now given their full support to carry out the school health programme.

TB. PROGRAMME

At present we have 29 patients coming to our clinics (twice weekly in the department). During the years 1970 - 1973 inclusive the total number of TB patients has been 112, of which 25 have been definitely cured, 15 ruled out as not suffering from TB after detailed investigations, and 3 patients referred to other hospitals for hospitalisation. Also 18 patients have left the area and continue now their treatment elsewhere. Six patients have died and 16 have discontinued the treatment after one year treatment. Repeated home visits and persuation have failed to bring them back to treatment.

Cases finding: for those with a cough for more than 2 months or other symptoms, three sputum examinations are done and if the sputum is negative while doubts prevails, X-ray is done. All suspected cases are sent for consultation to a specialist (Dr. Pamra, New Delhi TB Centre), before starting the treatment, and according to his advice, measures are taken. All the patients and their reports are checked by Dr. Pamra every three months. Twice a week in the afternoon, at 2.30 P.M. to 4 P.M., we have the TB clinic in our department where patients come to get the treatment and their medicines. A close follow up of all the TB patients is done by home visits. This is meant to give a continuous treatment for at least 2 years and to avoid drop out. Periodical health talks are given in the clinics so as to warn against irregular treatment. Our aim and hope is that every family will be able to detect the early signs and symptoms of TB and report it to us. This type of case finding is every family's responsibility. The cases are detected during home visits and clinic. The families of the suspected cases are also investigated and treated. The children are given BCG. Adults are given Mx-test and sputum test.

The programme is aided by the New Delhi TB Centre and considered as part of their TB Control Programme. BCG is given to all the children under five and to school children whenever BCG vaccine is available. We still have to make lots of effort for case finding and irregular treatments.

STAFF EDUCATION

Most of the LHV's are studying or attending night classes for their B.A. or M.A. as a preparation for their higher education in different health fields. One of the staff will be finishing her PHN from Calcutta this year. Two other LHS:s who finished their academic B.A. are planning to go for a Health Education Course or for M.A. Sociology;Career ladder is encouraged very much among the staff.

Senior LHV's are working as medical assistants when necessary and some of them help with the over all planning in the department, though all are encouraged.

The village motivators and young girls from the village who can read and write are given the training in first aid and home nursing. Yet inspite of the illiteracy of some of the village women they do not lack intelligence. Some of them do the dressing in the clinics or take the temperature and the like. Also we have started literacy classes for these women, making them able to read and write the Hindi alphabet. Our next step for those women is to teach themcertain health talks combined with demonstrations. If this is successfull our aim is to use them as village health educators.

The young girls from the villages are trained in first aid, home nursing etc. also in giving immunizations. Some of them also get practice for clerical work, sterillizing the articles, giving health talks etc. Our aim is to make them fully prepared to carry out the work with minimum supervision. This can certainly reduce the number of staff, in clinics, and pave the way for new activities.
The clerical staff is encouraged to learn typing and driving, so as to meet all needs of a village development work.

Finally five dais have been given training and final certificate. They now work as full members of our staff. They are able to conduct all the home deliveries. However the midwifery students, being in training, also have to take many delivery case in the villages. The dai call us from where ever we are so as to enable the student to come on the spot instantly.

It also ought to be mentioned that we have biweekly meetings for the benefit of self evaluation and close follow up of our work. Our staff is further professionally trained through lectures and readings about all aspects of Public Health. At least every second Tuesday afternoon is reserved for such activities.

Classes have been given dealing with interpersonal relations and psychological self evaluation. Role plays have been performed showing certain typical working situations and reactions. The LHV's also attend classes on pharmacy in order to keep up to date their knowledge.

Voluntary services have been given by some people living nearly the hospital. In particular for compiling and counting connected with the resurvey, these services have been of value.

FILTER CLINIC

This was introduced in the beginning of 1973. A booklet is printed which has the standing orders for most of the seasonal and common diseases. It was approved by the Medical director, Chief of Medicine and Paediatrics of the HFH. In every clinic, especially in the under fives, the doctor and the LHV together examin the patients. The LHV screen all the patients. Those cases being serious, doubtful or complicated are referred to the doctor immediately. In the initial phase the doctor had to spend a lot of time teaching and checking the LHV. However it was worth trying. Now both the LHV and the doctor have enough time to give individual attention and health education.

SOCIAL SERVICE

We have a full time trained social worker in our team. There are many families in the area having several social problems which the social worker can solve or relieve, especially this area, being on the fringeof a fast moving city and its new way of life, frictions between old and new patterns and values are more frequent than in an entirely rural area. Our social worker also has to deal with many moral problems- especially among the school going, and young people, due to lack of privacy at home. Our social worker also helps to find out the family the means of meeting expenses for hospitalization or specialized treatment.

Every year one or two students from the Delhi School of Social Work are sent to our team to get their field practice in social work and these students are taken care of and initiated into the programme by our social worker.

Case of deafness: During my home visit I experienced an interesting meeting with an old Baba, named Firoz Ahmed, aged 55 years old. One day when I was going for home visits Old Baba was sitting and warming himself near the fire. I greeted him and asked "how are you"? (in Hindi) He did not give me any answer but he looked at me and smiled. I smiled back. Then he went inside the house and brought a rubber tube, gave me one end and kept the other end in his ears. Then I understood that he is deaf. I greeted him again and talked through the rubber tube. He looked very anaemic. So I asked him to come to the Okhla Centre to see the doctor but he said that he was not sick. Then I explained that he looks anaemic and this may make him sick later. When he came to the Centre we took his Hb and found it to be 5,2 gr. We gave him a course of iron injection. The stool test was normal. Now even his wife comes with him regularly to the Centre, to get the iron therapy. All the conversation is carried out through the rubber tube. Now his Hb is 11,2 gr. and we are all happy. (extr. from Mrs. U. Kapur, LHV, staff meeting report)

SPECIAL STUDENTS PROGRAMMES

Every year different training schools send their students for field work to our team and villages. In 1973 we had two students from the Delhi School of Social Work who are in their final year of M.A. social work. In addition to this we had 9 Public Health Nursing students from Lady Reading Health School for their one month rural health experience. In November 12 health education students from the CHEB came for 6 weeks field practice. Furthermore we had 2 master students from the College of Nursing, as well as continuous groups of nursing students from Holy Family Hospital. From the New Delhi TB Centre health visitors came to get experience in TB cases. Needless to say it is hard work for our staff to take care of all these students and yet be fully involved in the daily work. However we take it as a challenge and a valuable experience for the staff.

ACTIVITIES BY THE STUDENTS

The social work students had taken as their responsibility to help some families in the Jogabai village with their socio-moral problems. They arranged film shows every week. They also worked in one of the primary schools in close cooperation with the teachers to detect some of the causes for school drop outs and to give special attention to the physically handicapped and weak students.

The public health nursing students took as their special programme to give first aid classes to the hospital employees, working

in the kitchen, maintenance and house keeping sections. They also helped us in the resurvey. They arranged role plays for the staff, so as to help us consider the patient as a person, not a case or a number. It was very inspiring. These students also gave a helping hand in our daily clinical work.

The health education students concentrated on personal and environmental hygiene, TB control, BCG immunizations and prevention of intestinal diseases. They formed four groups, working in 3 villages and one school. The also arranged puppet shows, film shows, exhibitions, group meetings and encouraged a lot of village participation in all these activities.

Our midwifery students took as their challenge to take care of a premature baby at home, in an improvised incubator. The baby was only 3lbs. but within 4 months the baby increased to 4 kg. The students taught the mother in all possible ways how to give a good and regular care to the baby.

INTERNAL COOPERATION

Our staff continues to help in other areas of the hospital as this engenders comprehensive thinking rather than departmentalization. Our family welfare councellor sees patients in the Out patients department,(antenatal and postnatal) three afternoons a week. One of our Public Health Nurses in the school of nursing, available for counselling and facilitating. Literacy classes have been given to the hospital maintenance employees. One LHV and one R N R M conducted first aid classes to the employees of the maintenance, kitchen and housekeeping departments. After examination the certificate and a first aid box is given to the successful candidate. The department head of Community Health is also teaching Community Health to the Nursing students and Ward Sisters.

There is a very close cooperation between our department and the pharmacy, OPD, Laboratory, X-ray and Nursing Service departments and we are very grateful to all the senior doctors for their special attention to our patients, eg. OB GYN, Pediatrics, Eye specialist, Surgery and Medicine specialists, and all the other departments.

THE TEAM

We have 4 Lady Health Visitors as Centre incharge in 4 health centres (One in each centre) and one LHV as in charge of school health. One experience PHN and one LHV and a male Social Worker in family Counselling team and a health team with a doctor, trained social worker, PHN supervision, one LHV as pharmaisit, one LHV as Vaccinator for all immunization and injections, one LHV as Health Educator, One LHV as nutritionist and one as relief/village motivators aids and driver as clerical staff, to do minor treatment and dressing, help with the nutrition demonstration, cleaning and setting up the clinic etc. The team moves from clinic to clinic on Monday to Saturday, Once a week the whole team goes for home visit with centre in charges, for different follow-ups. The same Staff takes turns to stay back in the central office for night class for home deleveres.

A SHORT SUMMARY

This year is the end of our first five year plan and the end of a team programme started three years ago. So far we have achieved the full cooperation and involvement of the villagers, Our four buildings for the village clinics are given by the people and for any health educational initiative we have the entire support of the community. In spite of the fact that the villagers can give little financial or material help they do give a lot of personal and moral support and encouragement.

From the over all evaluation it is found that the morbidity has decreased considerably (see the statistical report in the last page.) and that repeated visits with the same disease are less frequent than before. When we made the first survey in 1969 that in every family some one or the other was suffering from a disease and that this fact urged us to curative care of already existing diseases before any preventive action could be taken. Thus the priority during these first 3 years was given to full medical care whatever the cost may be. Gradually the morbidity rate came down and with it the current expenses (almost 50%). At the same time the villagers grew more aware of the value of health services. By the end of the three years period the preventive and curative aspect of medical care was integrated in such a way that it now has become a natural part of the villagers' needs.

The next five years we plan to be the first phase of a self supporting programme. At present the whole project is being materialized through the help of funding agencies. Whatever contributions we received from the community itself [illegible]

(nominal fees charged in clinics) we are investing in a self supporting programme. Therefore it is hoped that in the next five years the funding agencies will be able to meet half of the current expenses, for instance the payment of salaries, whereas the other half will be contributed by the community (for medicine, part of referrals etc.) This scheme devised is possible if some of the following aspects are taken into consideration:

a) decrease of morbidity
b) peoples cooperation and contributions
c) the awareness of health value and regular care especially for the child.
The community feels the need and is prepared to give so as to receive.
d) Home Nursing

The third five year plan would then be the 2nd phase of a self supporting project, in which for instance only 25% of the expenses continue to be met by funding agencies, while the last phase aims at full self-support. Another satisfactory trend connected with this gradual transformation is that the fast growing nearby city offers more jobs and more views of a better income to the villagers. Added to this economic uplift of the community there are possibilities of enlarging and diversifying various production centres (cottage industries) within the villages.

We are also planning to have a self supporting nutrition programme as soon as the food crisis is over.

In the beginning of our programme we were using only the HFH as the referral hospital. The expenses were met completely by OXFAM. However the referrals also had to be included in our striving towards self support. We gradually prepared the people to use other existing Govt. hospitals in Delhi, except for emergencies. However we also tried to improvise the treatment of serious patients in the home or department itself, taking care of premature babies, giving IV fluids to dehydrated children, typhoid cases etc. This also reduced the referral costs. The villagers were encouraged to bring the patient as early as possible so that further complications would not arise and the need for admission would not occur. Thus the expenses came down from Rs. 4000/- to almost 300-400 Rs. per month as far as goes referrals and hospital admissions. By giving training to the women in the village on home nursing we can reduce the admission of the patients to the hospital.

In view of the above facts we ask every funding agency to be patient with us in our efforts towards a self supporting project. Finally it should be noted that the real credit for all these achievements goes to our Lady Health Visitors and their team, having given their time, energies, talents and enthusiasm for the benefit of the community, and a special thanks to devoted voluntary workers and students.

We and the people in village thank all the funding agencies:

Zentralstelle,
Delhi Administration,
Delhi Municipal Corporation,
New Delhi TB Centre,
OXFAM,
Catholic Relief Services,
Caritas,
Holy Family Hospital Lady's Auxillary
UNICEF,
All the referral hospitals and participating agencies.

Without their help and cooperation we cannot carry out or continue this work.

GOALS FOR 1974

1. Home nursing and first aid courses to all the village ladies in small groups of 8 - 10 in order to make each home a domiciliary care unit and each mother a nurse. These courses given daily will be covering the whole area and done by our staff according to a planned curriculum. Having the classes in the homes it gives a direct effect and after some time the village mother will be able to trace and detect common diseases herself, be it in her own family or among neighbours. As the majority of diseases at this stage of the project are of a non-complex nature it has become easier for the mother herself to take both curative and preventive actions with the aid of the drugs we provide. The trend so far has been to refer the patient from the centre to the hospital. The 1974 plan aim at referring the patient from the home to the centre, assuming that our clinics will continue to have a good medical equipment. Gradually there can be developed a cadre of village health workers through this scheme and the awareness of the community will be further awakened
2. Continue the same service in the target area (with modifications)
3. More home visits and home care, combined with cooking and cleaning demonstrations at home.
4. Village level motivators and aids appointed as assistants to centre-in-charge. (after necessary training)
5. More emphasize on filtre clinics
6. Health education programme for trained dais and aids to make them health educators.
7. Completion of unfinished 1973 goals, especially immunizations
8. Prepare the dais and aides to identify malnutrition, anaemia and other minor diseases, and TB case finding.
9. Get the approval of the Delhi Municipal Corporation, Education dept., to introduce into the current school health programme curriculum for health education, if possible subject to evaluation and grade.
10. Periodical meetings of the school teachers and the school health team
11. Maintain 100% immunization coverage of under fives', including typhoid.

12. More coordination with the welfare agency and help to initiate more production centres.

13. Arrange informal village committees.

14. Involve youth clubs in various project, such as health education. (puppet shows, health dramas, entertaining programme)

15. Continue and strengthen night classes for men (if we find a suitable place)

16. Build up more team spirit and increase the interpersonal relation by giving the staff in-service education.

17. Arrange periodical seminars and discussions with in the department to improve the professional knowledge of the staff

18. Encourage the staff for higher education.

19. Arrange more health educational activities in the area in which people's participation will further grow.

20. Improve integration of Public Health in the nursing curriculum

21. Survey new villages, ie. Tambu Nagar and Khizzerabad or sunlight Col ny.

22. Once or twice a week a mobile medical service and immunization in these villages.

23. Health Insurance scheme (if people are ready for it)

24. Encourage the community to support our work.

25. More home visits and home care

26. Involvement with diocese and other institutions to help and strengthern the Community Health programmes.

Expanation of abbrevations:
LHV = Lady Health Visitor
P.H. = Public Health
WSB = wheat and soya beans
CSB = corn and soya beans
CRS = Catholic Relief Services

REPORT OF FAMILY WELFARE COUNSELLING

We have just crossed the second mile stone in the Family Welfare Counselling programme and an overall dent appears to be significant. The area covered being neither purely rural nor urban, a mixture of urban and rural problems, customs and culture had to be taken into consideration. Even the womenfolks are not as simple and amenable to reasoning as the rural women generally are, nor are they sophisticated and understanding as the urban women. While there are now no religious objections as such to family planning as at the beginning, there was always the weight of customs, and tradition, apathy and inertia, probably due to poverty, low income and illiteracy. In the absence or lack of provision for basic needs, which affect the physical, psychological, mental, Social and cultural and intellectual development of the adults, their indifference to acceptance of family planning as a way of life is easily discernable. Boys getting married as early as at the age of 16 - 18, which is a common practice in the villages especially amongst the very poor, is an impediment to birth control. The excuse for such practice is to prevent boys running after girls.

A heart to heart discussion on the pros and cons as to how family welfare planning is going to benefit the family and the future generation, falls on deaf ears merely due to the non-Co-operation of the husbands and sometimes the mothers-in-law. Generally the men would have anything done on their wives rather than themselves and yet there were cases where men refused permission for tubectomy as they feared that the women would run after other men, as there is no fear of getting pregnant. The following incident will illustrate their prejudice against sterilisation. A woman was admitted to the Holy Family Hospital for leucorrhoea and she had electric and she had electric cauterisation. The rumour spread in the village that she had tubectomy got done. The infuriated husband almost turned her out, but for the timely intervention by one of our Social Workers, who explained the whole process and thus pacified him. On the other hand there are women who want more children as a public evidence of their fertility mainly because of the slanderous utterances of their neighbours, that some women are having fewer children than they or that they are capable of producing only girls after girls. Sustained and continued education over a long period of time, using various media seems to be the

answer to overcome their prejudices and suspicions, and make them change their attitudes. In this context, a novel method, ie. Mime shows have again been used in our area more extensively and intensively than last year, to emphasise the need for good and regular habits for healthful living to improve the total health and welfare, including family planning. The regular film shows also have been continued. Family Welfare Counselling as has already been reported, covers every aspect of the total family health care. Since family planning is recognised as an intrinsic part of health care, our comprehensive health and welfare programme, which includes, health education, immunisation, nutritional supplements etc., provides an ideal environment for family welfare counselling and many women seem to have learnt the value of such programme for their benefit. To cite an instance of their awareness of food hygiene, a woman's statement, while counselling on prevention of diarrhoea(as her baby had diarrhoea) and how flies carry infections, is quoted "I have learnt all about the dangers of fly nuisance from the centre and am practising what I have learnt. Come and see my house how clean it is and how I keep the food covered".

It is also encouraging that those who have been motivated for the use of contraceptives come more willingly without any reservation and ask for replenishment of their stock, whereas at the beginning they were shy and waited to be called and given. The cafeteria approach is being encouraged where couples can choose the method suitable to them either for spacing or when they are not willing for sterilisation. Request for abortion is on the increase. That high level incentives helped in promoting a large number of persons especially from the lower income strata for sterilisation is evident from the fact that we were able to persuade 10 cases to get sterilised last year at the sterilisation camp, when the monetary incentive was Rs. 60/- whereas only 3 took advantage of the camp this year as only the regular amount of Rs. 28/- was offered. The excuse of those motivated for sterilisation was that they would wait until they can get Rs. 60/-. However against 21 sterilisation cases during 23rd October 1971 to December 1972 (ie. one year, 2 months and a week) we have had 30 cases in 1973, directly referred by us to the New Delhi Family Planning association. This figure includes 8 cases motivated at the O.P.D. clinics. But the above figure does not include all those who were motivated for sterilisation and took consent forms signed by both husband and wife as they did not report back nor responded to correspondence. Such cases pertain to those contacted in the O.P.D. There were also cases referred to the Family Welfare Counsellor by the gynaecologists

either from the C.P.D. or maternity wards and who were in turn referred for sterilisation, abortion etc., but there was no response from them either.

The extention educator, who was appointed in July 1973 has succeeded in establishing 5 depots for distribution of Nirodh in our area for those who do not attend our Health Centres. Out of the 5 Voluntary depot holders, three are private medical practioners and two are general merchants. All of them live in the villages. The distribution of Nirodh seems to be satisfactory in these depots,

The extention Educator had a few meetings with the village leaders to enlist their co-operation. He has been instrumental in getting work for a few young men as unskilled labourers in the nearby factories and the emoluments amount to Rs. 84/- per mensem. Apart from contacting the men in the evenings regarding family planning, he assists the other two Social Workers of the community health department in their work if and when necessary, especially in the field activities.

In our report forwarded on 25.5.1973., it was pointed out that we had taken over Masihgarh with 57 target couples to be wholly responsible for Family Planning Programme, but only 18 were traceable. But after the survey we have got on record 73 target couples listed as under, and the follow-up work on these cases are done by the Extension Educator.

Sterilisation	Using Nirodh	..	47
	(Vasectomy	..	6
	(Tubectomy	..	2
	Not using any method	..	18
	Total		73

It will be noticed that the pap smear item has been omitted from Table No. I, as the programme has been discontinued, being a research project.

The number of clinics has gone down from 10 to 7 as the adult clinics in two centres have been amalgamated with childrens' clinics and there is an ante-natal clinic fortnightly only. The overall attendance in the clinics have also shown a considerable decline, which in turn has affected the councelling

attendance, resulting in a fairly low number. However a significant fact is that revisits in 1973 have increased proportionately, which shows that in spite of the decline in general attendance, family counselling has evoked a very good response among the average, eg. the Nirodh users in 1973 are 929 revisits against 106 first visits. This is evident from Table No. II attached herewith. It is a known fact that it is easy at first to motivate a few people while sustained efforts are needed to motivate the hard core of the population. Thus the achievements in the subsequent years will not be the same as in the first or second year.

In 1972, 1228, i.e. 61,4% of the 2000 eligible couples in our rural area, was covered. This year out of the remaining 772 couples, 144 have adopted family planning methods, i.e. roughly 18,65 % of the remaining population. Thus it is clear that the overall performance is reasonably satisfactory.

In order to promote family welfare planning and to create a better awareness for acceptance, it is envisaged to arrange regular puppet shows on family planning, through the Directorate of Field Publicity, Ministry of Information and Broadcasting, and the Directorate of Family Planning, Delhi Administration. A library with family planning books, leaflets, pamphlets etc. , will also be started in a small scale. This library will be in each centre under the supervision of the Extension Educator, in the spare time hours of the beneficiaries.

OKHLA COMPREHENSIVE HEALTH AND WELFARE PROJECT

The Department of Community Health, Holy Family Hospital New Delhi

Report for the Year 1973.

Particulars of the Care	Progressive Total of the Year		Corresponding progr. total of the previous year	
I. COVERAGE				
a) Families	2182		1875	
b) Adults	5989		2563	
c) School Age children	3541		3	
d) Toddlers	1907		1788	
e) Infants	336		342	
f) TB patients	29		44	
g) Ante-natals	138		136	
II. DELIVERIES CONDUCTED (Home)	203		205	
a) home (normal)	179		179	
b) hospital (abnormal)	24		26	
III. CLINICAL VISITS	New Sickness	Revisits	New Sickness	Revisits
a) Adults	2621	855	5701	4386
b) School Age children	1305	668		
c) Toddlers	5850	1736	6235	4545
d) Infants	2019	702	2484	2108
e) Ante-natals	359	3791	382	3580
f) TB patients	16	1217	24	1222
IV. WELL BABIES	8133		33542	
V. HOME VISITS				
a) Family	2902		1627	
b) Ante-natals	129			
c) Post-natals	1328		120	
d) TB cases	64			
e) Family Counselling	790			

Particulars of the care	Progressive total of the year	Corresp. progr. total of the previous year
VI. HEALTH EDUCATION		
a) lectures		
1) in the clinics	1592	3592
2) at the home	4135	1381
3) in the schools	154	159
4) in the welfare centres	75	123
b) Demonstrations		
1) in the clinics		
2) at the home		
3) in the schools		
4) in the welfare centres		
c) Audio-visual aids	36	
d) Treatments		
1) at home	117	951
2) in the schools	1456	1106
VII. REFERRALS		
a) Holy Family Hosp.		
1) major laboratory examinations	269	3363
2) minor lab. exam.	5506	
3) X-rays	84	345
4) specialists' care	412	736
5) admissions	105	316
6) physiotherapy	8	
b) TB clinics/hosp.	132	106
c) other hospitals	56	
d) welfare dept. of the project	66	31
e) other welfare agencies	1	
VIII. IMMUNIZATIONS		
a) T.A.B	420	
b) Cholera	2049	1768
c) D.F.T.	1300	2097
d) B.C.G	688	541
e) Smallpox	2873	2064
f) Polio	1540	2302

Particulars of the care	Progressive total of the year	Corresp. progr. total of the previous year
IX. NUTRITION		
a) distribution	96 250	87572
1) antenatals & post-natals	4698	3832
2) children below 6 yrs	26287	24394
3) families	9519	6050
4) school children	54900	52063
5) TB cases	846	1233
X. SCHOOL HEALTH		
a) School children under care	196	1670
b) physical examinati n	1177	1276
c) follow ups	289	
d) laboratory tests	2	
e) others (X-ray)	2	
XI. FAMILY PLANNING/ COUNCELLING	2045	2250
a) Councelled at first visit	736	1210
b) Councelled upon revisit	1309	1038

	First visit	Re-visit
c) distribution		
1) niredh/jelly	180	953
2) foam tablets	8	10
3) oral contraceptives	1	6
4) diaphragm	2	
5) I.U.C.D		12
6) tubectomy	13	
7) vasectomy	17	
d) pap smear test		

Particulars of the care	Progressive total of the year		Corresp. progr. total of the previous year
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XI. FAMILY PLANNING/ COUNCELLING	2045		2250
a) Councelled at first visit	736		1210
b) Councelled upon revisit	1309		1038
	First visit	Re-visit	
c) distribution			
1) nirodh/jelly	180	953	
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3) oral contraceptives	1	6	
4) diaphragm	2		
5) I.U.C.D		12	
6) tubectomy	13		
7) vasectomy	17		
d) pap smear test			

are developing good habits. We do not have language teaching in the syllabus of our balwadies but on the demand of the parents, the teachers now started giving some instruction about language such as Hindi, Urdu and English. The children were also given some training in counting numbers. They were also engaged in various indoor and outdoor games. They were taken out for picnics periodically. The children who have crossed the age of 6 years were referred to the schools available in the neighbourhood for primary education. The number of such children who were admited to other schools during the year was 47.

Craft Classes:

The number of trainees attending the craft classes in the welfare centres is given in the Appendix 2. After one year of conducting the craft classes in five welfare centres it was felt that some follow up studies of these women should be made. It was found that majority of women who have learned the craft are doing their tailoring jobs in their homes and save some money they were giving to the tailors for stitching the clothes. About 50 women of these neighbourhood are working with various business concerns in the neighbourhood or outside. Many others who had training are looking for some jobs. It was the felt need of the women in the neighbourhood that some programme should be started to provide job opportunities to them. Looking into this demand, the craft class for women in Okhla centre was stopped from 1st April, 1973 and this centre was converted into full fledged Production Unit. The trainees of this centre were transferred to other welfare centres mainly to Nooru Nagar and Jogabai.

Fabric Painting Classes:

A special 11 days fabric painting classes were organised in the four welfare centres in the month of March. These classes were organised with the help of Narula Paints. 78 women participated in these classes. An examination was conducted after these classes. The result of the examination was declared in the month of July and it was found that all the women who appeared in the examination have passed. These women were given certificates.

Literacy Classes For Adult Women:

The response of the women in the community towards the literacy classes was not very encouraging. There are many reasons for the decrease in the

number of women attending the literacy classes. Most important factor is that these women actually come to the welfare centres for attending the craft classes and they are not interested in the literacy. On the other hand some knowledge of the measure and simple arithmatic is required for teaching the craft of tailoring and embroidery. It was felt in the month of June that a new scheme of functional literacy may be started in these welfare centres and the Governing Body of the society has set up a committee to finalise the syllabus but so far the syllabus of the scheme could not be finalised. Apart from this literacy classes some of the girls of the community are coming to the welfare centres for free coaching which help them in their regular school education.

Extension Lectures:

Some of the topics of these extension lectures which are the regular feature of our welfare centres are: common diseases in the neighbourhood such as cholera, typhoid, malaria, small pox etc.; first aid training, pre-natal and post-natal care, drinking water, good habits; rules of hygiene; family planning etc.. These lectures were mainly organised by the Community Health Department of the Holy Family Hospital. In the month of August, Mobile Grail Team approached the society for some demonstrations and extension lectures. The team has organised 9 extension lectures in Neeru Nagar and Bharat Nagar welfare centres. The topics covered by the Grail Team were on Home Economics, Cooking and Child Care. The society is thankful to the community health department of the Holy Family Hospital and Mobile Grail Team for their co-operation in organising these extension lectures and demonstrations. The number of women in these extension lectures ranges from 20 to 60 in each centre.

Social and Cultural Activities for Women:

The girls and women of the craft classes, Condensed Course and other women welfare programmes in all the five welfare centres were taken out for outings and picnics to the various places. A weekly social get-together of the women in the craft class has become a regular feature. Periodically the Parent's Meetings of the children of the Balwadies and the trainees of the craft classes were organised in all the centres to acquaint them about what their wards are doing in the centres. Special variety programmes were organised in these occassions. Some of the major activities of the centre

under Social and Recreational Programmes include: a visit to zoo, a visit to Asia 72, a visit to National Museum, celebration of various National days such as Republic and Independence days, Celebrations of local festivals like Basant-celebration, celebration of Id etc.

Healthy Baby Contest:

The Healthy Baby contest was organised on 11th September, 1973 in the Masigarh welfare centre. About 57 children participated in this contest. These children were in the age group of 3 to 6 years. An entry fees of 25 paise per child was collected. A team of Doctors, public health nurses and social workers examined these children and awarded the grades. The prizes were given to the children who were declared 1st, 2nd and 3rd. Sweets were distributed to all the children of the community. A small get together of the women of the community was also organised to explain them the importance of child care in daily life.

II. CHILD WELFARE ACTIVITIES:

The children's clubs which were started in April 1972 for the children in the age group 7 to 14 years continued its activities of indoor and outdoor games, recreational and cultural activities with the help of part time child welfare workers till 30th April, 1973. In the month of May these clubs were stopped as it was decided that the full time Child and Youth Welfare Workers were to be appointed for the evening activities of the welfare centres. Five Child and Youth Welfare Workers were appointed in the month of May 1973 and after an orientation programme of one week, they were sent to the various welfare centres to run the Children as well as the Youth Clubs. Masigarh and Bharat Nagar clubs started functioning in the month of June while the other two clubs of Nooru Nagar and Jogabai started functioning in the month of July. The club in Okhla centre was started in the month of September as we could not get any accommodation earlier for organising the activities of the Children's and Youth Clubs. The number of children attending the various clubs is given in the Appendix 3.

Inter Club Competition:

To sustain the interest of the members of the club, the annual Inter Club Competition was held on 7th February, 1973. 250 children from various clubs and other welfare institutions of the city participated in this annual

function. The students of Jamia School of Social Work participated in these competitions as a part of their field work training. The function was organised in collaboration with the Jamia School of Social Work and its National Service Scheme Unit on the birth anniversary of Dr.Zakir Husain. Shri.Krishan Swaroup, the Executive Councellor, Incharge of Social welfare, Delhi administration distributed the prizes to the winners.

Children's Film Shows:

Five children's films were screened for the members of children's club. Apart from these films the members of the club were shown many other films on Television. The children have shown lot of interest in these films and other programmes on T.V.

Inter Club Activities:

The inter club activities in various indoor games such as chess, carromboard, chinese checker were periodically organised among the members of five children's club. A competition was also organised in drawing and painting. The group discussion and essay competition was organised in the month of November. The prizes were distributed to the winners of the various competition.

Picnic and Outings:

Three picnics were organised for the members of children's club in the month of February, August and December. Apart from these picnics the children were also taken out to the Dolls Museum, Bal-Bhawan, Zoo and a Circus during the year.

Children's Library:

The children's library which was started in the year 1972 continued. This year some weekly, fortnightly and monthly magzines for the children were also purchased and distributed among the children for reading. Efforts will however, be made to secure more books and magzines from various sources.

Children's Camp:

A Holiday cum Social Service Camp was organised in Ghitorni village of Mehrauli block of Delhi during Dusshera holidays in the month of October 1973. This camp was of 7 days duration. 83 children of the neighbourhood participated in this camp. This camp has become a regular feature of the society. The camp was organised in collaboration with the Jamia School of

Social Work served as camp counsellors. The staff of the camp consisted of four trained social workers, one incharge of administration, one Audio-visual-aid Operator and various experts in sports and games, dramatics, songs and music, craft etc.. The children also participated in cook-outs, sight seeings, picnic, film shows and games competition organised during the camp period.

Applied Nutrition Programme:

About 800 children of the Service Area under the age of 5 years were getting milk-bread through our welfare centres under the scheme of Delhi administration.

III. YOUTH WELFARE PROGRAMME:

With the appointment of five child and youth welfare workers in the month of May 1973, the Youth Club started functioning in the month of June. The youth in the age group of 16 to 35 years were approached to become the members of these clubs. These youth clubs are mainly organised for providing the recreational, social, cultural, and educational activities for the youth of the Area. Through these youth clubs the society aim to orient the youth of the Neighbourhood in the concept, objective, function and leadership required in the organisation of various programmes for the different section of the people living in this Neighbourhood. The strength of the various youth clubs is shown in the Appendix 4.

Inter Club Activities:

Various inter club activities were organised in indoor and out-door games among the members of the youth clubs periodically. An inter club Volley Ball competition was organised in the month of November. The members of the Youth Club participated in the mime shows organised by Community Health Department of Holy Family Hospital and helped them in organising and maintaining discipline. A few cultural programmes were also organised in these clubs.

Literacy Class for Men:

In Moorunagar welfare centre, a literacy class for men was started in the month of November. Under this programme the illiterate men who are working in various positions in the neighbourhood or outside are given instructions in Urdu language by a part time teacher employed for this purpose. The strength in this literacy class at present is 18. With the starting of

this class more and more youth clubs are demanding such literacy classes in various languages such as Hindi, Urdu and English. We hope to start more such classes in the next year.

Television Programme:

The members of the children and the youth clubs participate on various alloted days in different television programmes including film shows. The television set was given by All India Radio to the society for this purpose.

IV. NEIGHBOURHOOD CENTRES PROGRAMMES:

The society has planned to establish a neighbourhood centre for organising common programmes for the residents of Okhla Neighbourhood. As we did not have the required funds and building for the purpose, much has not been done in this regard. A few experimental projects however could be started either in some welfare centres or in other rented building for the purpose. The following are some of the programmes.

Condensed Course of Education for Adult Women:

Out of the 28 women and girls who were enrolled for this course, 3 had left due to personal and family problems. The remaining girls appeared for Part-I examination of Higher Secondary. Out of which 11 passed in all the four subjects and the rest 14 were promoted to the next class with permission to reappear in one or two subjects in which they had failed. In the month of July the classes for the 2nd year of Higher Secondary started. Two more part time teachers were appointed to teach History and Drawing in the month of July. All the 14 girls who had failed in one or two subjects of Part-I appeared for the supplementary examination held in the month of September. At present there are 18 girls in this class who will appear in their final examination in the month of April 1974.

Socio-Economic Programmes:

Two socio-economic programmes were started this year to supplement the family income of the poor and needy people of the Okhla Neighbourhood. These two programmes are:

(a) Training-cum-Production Unit - Doll Making

(b) Training-cum-Production Unit - Tailoring and Embroidery

Training-cum-Production Unit - Doll Making was started on 7th February 1973 in the Julliana village of Okhla Neighbourhood. A local craftsman who

was doing this business of his own was identified and employed as the instructor in this Production Unit. When we took over the business of that craftsman the number of workers was only 5. Now the number of workers who come to the unit daily is increased to 25. In addition to that about 10 women and children take work to their homes on piece-rate basis. The monthly wages of these workers vary from Rs.60/= to Rs.400/= per month. At present the unit is producing about 900 dolls in a month. There is still scope of increasing the strength of the workers and thus increasing the production of dolls.

Training is the integral part of this unit. The women are firstly trained for few months and during this period of training they are paid at least Rs.2/= per day. As the worker shows improvement, the wages are gradually increased. So far we have exported dolls worth about Rs.30,000/= to various countries such as Holland, Switzerland and Belgium. In addition we have also sold dolls in local market as well as in various sales and exhibitions organised in Delhi.

A grant of Rs.35,000/= was received from Caritas-India through the Coordination Committee of the Project to initiate the work in the production unit in the month of February 1973. We expect that it will take another two years to run this unit on self-sufficient basis.

Training-cum-Production Unit - Tailoring and Embroidery was started on an experimental basis during the year 1972 in Okhla Welfare Centre together with the tailoring and embroidery classes. Later in April 1973 the tailoring and embroidery classes in this centre were stopped and the unit was changed into a full fledged production unit. At present about 15 needy women are working in this production unit as and when required. The production work of the orders from the Holy Family Hospital and from business concerns exporting various garments are undertaken. We hope that the unit will be getting some orders in the coming future when the samples sent abroad are approved.

The unit at present do not have sufficient staff, equipment furniture and money for the purchase of raw material and distributing wages to the workers. Efforts are being made to secure funds from governmental and non-governmental organisations. With these funds available we hope that more than 25 women will be provided employment in this unit who will be earning

from Rs.60/= to Rs.200/= per month.

Kinder Garten School:

On the consistent demand of the parents with a monthly income of more than Rs.300/=, the society has started a Kinder Garten school for the children of these parents. Two teachers were appointed to give instructions to 23 children. The parents helped the Society to raise funds for this programme. The School was started in the month of July, 1973.

Fund Raising Campaign:

The society has published a 3 years Progress Report in the form of a Souvenir and through advertisements in this Souvenir collected Rs.2,590/=. Apart from this donation of Rs.3,063.50 was collected from other sources. During the year 1973, Rs.8,539.50 were collected through the fees. This way, the Society has collected a total amount of Rs.15,280/=. We hope that this fund raising campaign will continue and show more progress in the year 1974.

Staff Development:

Apart from the regular meetings of the centre incharges and weekly supervisory staff meetings a one week orientation programme was organised for newly appointed child and youth welfare workers. Two combined meetings of the Okhla Pilot Project were also convened for seeking better coordination in the two components of the Project.

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Attendance in the Nursery Classes

Appendix - 1

Centre	Jan.	Feb.	March	April	May	June	July	August	September	October	November	December
Okhla	81	81	83	83	85	86	80	70	77	75	69	71
Jogabai	48	48	48	48	52	55	51	49	49	49	50	46
Nooru Nagar	40	45	48	42	27	25	25	43	46	40	32	37
Masigarh	35	37	39	37	35	30	25	23	25	24	24	25
Bharat Nagar	47	49	52	53	54	35	33	36	36	29	29	00
Total	251	260	270	263	253	231	214	221	233	217	204	179

Attendance in the Craft Classes

Appendix - 2

Centre	Jan.	Feb.	March	April	May	June	July	August	September	October	November	December
Okhla	50	50	50	-	-	-	-	-	-	-	-	-
Jogabai	27	25	22	39	39	39	55	54	48	40	26	29
Noorunagar	25	30	35	25	23	33	29	33	27	22	17	10
Masigarh	40	38	36	33	33	52	39	37	42	35	28	26
Bharat Nagar	30	30	27	31	27	27	31	29	36	29	20	14
Total	172	173	170	128	122	151	154	153	153	126	91	79

Case Study II

67-3 Case Study-2

VOLUNTARY HEALTH ASSOCIATION OF INDIA
C-45, SOUTH EXTENSION PART-II, NEW DELHI-110049
Phone : 616308, 78433 Telegrams : 'VOLHEALTH New Delhi-49'

COMMUNITY HEALTH CELL
47/1, (First Floor) St. Marks Road
BANGALORE-560 001

VHAI-1006

Community Health Case Study

One person's experience in trying to do village health work.

1967. I was working in a 100 bed hospital which was never full. There were other hospitals in the same city. During the year, a doctor friend lent me a book to read called Medical Care in Developing Countries. I started village clinics within a few months of reading this book. We had no idea of community health care. The clinics succeeded in some villages but not in others. We found it difficult to collect enough in fees to cover our petrol, and staff costs. We had no special funds for this and there were more pressing problems in the hospital.

1968 Transferred and working in another hospital, I wanted to do village health work, but

* the administrator said it was an unwise thing to start, as income could not be obtained to make it financially safe.

* the nursing superintendent did not want her nurses living in the villages where we could not guarantee their safety.

* the medical superintendent wanted the available housing for doctors, meaning doctors working in the hospital.

* I did not know where to get the money from.

* I did not know how to do village health work, except clinics.

1969. Despite heavy hospital duties, I was getting tired of signing death certificates - despite good curative work by experienced doctors, many died of preventable diseases such as anaemia, tetanus etc.

When another doctor was absent, I ran the well baby clinic for a few weeks. It was not popular, and service given was slow. It was held once a week on Wednesday afternoons.

At this time the nursing superintendent wanted a public health nurse to improve the examination results of her nurses in that subject. The Public Health Nurse came.

In the same month, a sample of the Morley Road to Health card was sent to the hospital from a donor agency. With the help of the hospital printer, we got this printed in the local language.

The public health nurse and I started a daily 'mother and child clinic' with the approval of the Managing Committee.

We obtained some vaccines from Kasauli by purchase, and some free from Government. Nursing Superintendent supplied nursing students to work in the clinic.

We had to work on the medical records to allow patients to get their records without waiting 1 hour or more.

1970 The clinic was very popular and we recorded 10,000 patient visits in the first year.

We started running similar clinics in the City nearby, financed out of our morning clinic.

The nurses could now pass their examinations in public health, though we visited no villages.

People from nearby towns wanted to open similar clinics in their town. The hospital morning clinic was now busy enough to afford a paediatrician to run it.

I then started to plan a larger programme.

During that year, Dr. Sundaram then Director of CAHP visited and gave us encouragement to plan big, saying that there would be plenty of funds for community health.

1971 All this year, we waited for our money and then our vehicle to come. The grant application took 3 months full time work to get ready. There was delay in getting the donor agency's representative to visit. He had some objections. Approval took 3 months but then there was a postal strike in the U.K. before we knew the result. There was also a delay of 9 months because the local bank did not notify us that our funds for starting staff housing had arrived. Then we had to buy the vehicle, after the money actually arrived. The hospital old vehicles were not able to be used with regularity for village work, in case they were needed to attend Board meetings, so we had to wait for our own community health vehicle. We had just got started when war broke out, and the Army moved in and the town was evacuated.

1972. After the war it took several months to get back to normal. Troops were camped in the fields for many months after the war.

We expanded our mother and child clinics.

During this year a new medical superintendent came and he felt that we should have a village programme rather than clinics.

1973 I left the area during this year, and a paediatrician took over. He worked hard for 2 years, and improved immunizations and illness care. He had not had any previous orientation to village health and we did not think to send him anywhere for orientation first. One of the hospitals own trained nurses was sent away for 1 years public health training. This was the first such nurse from the hospital who was agreeable to specialising in public health. She was bonded to return to the hospital. She proved very helpful when the other public health nurse left in 1976.

1975 By this time the paediatrician was losing interest, preparatory to entering private practice in the District.

In fact project income from clinics fell, and there were other difficulties.

An experienced public health trained doctor joined, and she was able to start caring for one village, and trained 3 village level workers.

1976 She decided to leave, due to the fact that she did not want to shift to a branch rural hospital 25 miles away, as requested by the Medical Superintendent

Difficulties.

Fees charged at the clinics were now high. Petrol prices had risen greatly in 1973, so distant clinics had to be stopped.

Land reform had been only partial, so that Harijans were poor, and toddler malnutrition among the Harijans was common, still.

Costs. At the most, the programme was costing Rs. 100,000 per year, and was employing about 12 full time workers.

The hospital has benefited to the tune of Rs. 5 lakhs of buildings obtained from another donor agency for very good quality staff housing.

Benefits.

The underfive clinic idea for sick and well babies has lasted for 7 years, and survived several paediatricians who had not met such an idea before. But future paediatricians could possibly revert to not using growth charts. In fact hospital clinic charges are high, and those who need growth charts cannot afford hospital clinic charges.

One cannot help thinking that although thousands of children have benefited somewhat through this programme, it is difficult to measure this benefit, because clinic patients come from all over the place, and one cannot easily measure the target population.

Nurses during their training have benefited.

Three doctors who have entered private practice in the last 5 years after working at this hospital, have introduced many of the ideas they saw used in the programme.

Staff working in the project have found the clinics stimulating and satisfying.

The hospital became even better known in surrounding towns.

Discussion.

1. Thoughtful concerned people who circulated books (1967) new ideas (1969) and a hopeful forward look (1970) played an important role through doing seemly unimportant little things.

Do we always share our best ideas?

2(a) There were many ups and downs. Considerable delays and unforseen circumstances occurred - mail strike, war, inefficient banking service.

(b) Determination and persistence over the ups and downs period was therefore necessary to achieve good results.

(c) Many things had to coincide at the same place and time.

* staff full time for this work 1969-1970
* funds or hope of funds 1970
* good records 1969-1970
* vaccines 1969

5. There were very severe pressures from the hospital on its community health project. This project was expected to

* house all its own staff
* provide its own vehicles
* find its own income

The institution's survival always took precedence over the project's survival.

On the other hand the hospital provided some advantages -

* abundant supply of nurses trained or being trained but hospital was unwilling to let them work in villages.

* hospital had excellent reputation in the area making village contacts easy.

* hospital back-up services were reliable for

  - book keeping
  - pharmacy
  - vehicle maintenance.

Question: Was the hospitalmore a help than a hindrance in this situation? What other solutions could have been considered?

6. Notice the constraints or boundary conditions that determined the shape of this project:

* Doctor had nocommunity health orientation

* Finance was a problem (1968) and in 1976 was still a main problem (high fees).

* Unwillingness of trained doctors to serve in rural areas (1976) was also a problem

* Security for female staff in rural areas was a major factor in planning from 1968 on.

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* Security for female staff in rural areas was a major factor in planning from 1968 on.

7. Can you think how to develop a community health programme more rapidly?

8. How was the problem of security for female staff in rural areas eventually solved. What are the chances that this problem was permanently solved if the public health doctor in charge of the project has left in 1976.

9. How can the leadership of a hospital be involved in its health project to prevent project and institution being seen as rivals to each other?

Case Study 3

67-4

C O N T A C T 10

Christian Medical Commission World Council of Churches 150 Route de Ferney 1211 Geneva 20 Switzerland

August 1972

COMPREHENSIVE RURAL HEALTH PROJECT

Jamkhed, India Rajanikant S. Arole, MD

(Address given to the CMC at its annual meeting in June 1972)

My wife and I were both concerned about the medical care of the rural population of India, and soafter graduation we both went to a hospital situated in a rural area and worked there for about five years. To our amazement, at the end of five years, we found that all we had done was to take care of patients who came to the doorsteps of the hospital, but we had done little for the general health of the community around us. To give you a simple example, we served a populatioon of about 100,000. There must have been 4000 deliveries each year, but we were taking care of only 300 of them. We asked ourselves, "What happened to the remaining 3700 deliveries?" There was nobody besides us in the area.

Examples such as this made us realize our need for public health training to enable us to reach out to the community. Therefore, we went to Johns Hopkins University and took a public health course. A lot of material that we read came from the Christian Medical Commission. The books and articles written by many members of this Commission helped us to formulate a programme.

Since the problems in rural areas relating to health are many, we set the following priorities:

1. To make available facilities and personnel in rural areas;

2. to do something about the rapid population explosion;

3. to attempt to reduce the high infant mortality and continued mortality and morbidity up to the age of five;

4. to take care of certain chronic diseases which not only contribute to mortality but also morbidity in the society and which, more than that, deprive the people of their dignity, especially those suffering from leprosy.

So the goal was to develop a programme which would be fitted to the needs of the community but which would also be compatible with the resources available to the community.

The METHOD we adopted was to take a specific area for our responsibility. The selected area is within a ten mile radius of a village called Jamkhed in Maharashtra State. This area has a total population of 80,000 living in 55 villages. We cannot take cate of the whole area right now, so we have PHASED this as follows:

Phase 1	20,000 population - in two years
Phase 2	40,000 population - in the next two years
Phase 3	80,000 population - by the end of six years

The method will be to establish a main centre in the central area - i.e. at Jamkhed - where we shall have diagnostic help, facilities for emergency surgery and emergency medical care. The there will be ten subcentres in ten surrounding villages, the maximum distance between the central village and the subcentres being ten miles. For this programme we will need to use auxiliary workers and paramedical workers; we will need the coopeation and involvement of the indigenous practitioners, other health officials, schoolteachers and dais (indigenous midwives). There will be cooperation with other government programmes. And finally at the end of six years this will have to be a self-supporting programme. For a programme to be self supporting, motivation will have to be developed in the community nd the community leaders, the local state and the central government taking responsibility for this kind of work.

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Objectives

1. reduce birthrate from 40/1000 to 30/1000

2. reduce under-fives' mortality by 50 per cent

3. identify and bring under regular treatment leprosy and tuberculosis patients

4. train indigenous workers and offer field training to health workers

To achieve our objectives, the main activities will be

- the establishment of under-fives' clinics - these clinics should be mainly for supplementary feeding programmes, immunization, treatment of minor illnesses;

- family welfare programmes consisting of antenatal care, delivery and postnatal care;

- family planning programmes making use of all known contraceptive devices and operations;

- detection of leprosy and tuberculosis patients and treating them in a well-integrated programme;

- curative services in the main centre for obstructed labour, acute surgical and medical emergencies and diagnosis;

- mobile clinics;

- school health programme.

This, in short, is a summary of the project we are trying to develop. Today I am going to share with you mainly the community involvement in arrving at certain decisions in regard to the programme.

While we were studying in the United States, we decided that we would go to an area where there was no Christian witness because we wanted to establish a Christian witness in an entirely non-christian area. Secondly, we wanted an area where there was an acute need for medical care and where was no possibility of any future development, not only development in the health field but also in other fields, so that after five years there would be no other factors to account for the changes that take place. We chose this area in Maharashtra, where there is no possibility of any major industrial or agricultural changes planned for the next five years. This area, like many other rural areas of India, has a very strong caste system. About 50 per cent of the people are cultivators or farmers; 20 per cent are untouchables - the people who are very poor and usually landless labourers - who socially have no status. The villages have a governing board with an elected head called Sarpanch. Most of the leadership comes from the farmer caste who are the decision--makes for the community. In addition to these two castes, there are wealthy farmers, schoolteachers and other educated government employees who are the accepted leaders of the community. One cannot enter any community by passing the leaders because if a leader feels that he has not been given due recognition, he can become hostile and uncooperative.

We were completely unacquainted with the community and leaders of this area. We wrote several letters in the local language to the political leaders and to the village leaders. In our letters we described the entire programme that we had in mind. We said, "If you want us to come into your area, there are certain things that you should be prepared to do. We shall be about 20 to 25 health workers coming into your area without having any housing facilities. We expect you to make some arrangements for accommodation for about 20 people. You should also give us temporary buildings for our clinics and our diagnostic facilities, and if after a six-month period we find that your interest in us remains, you should donate us land to build permanent structures in your area".

There were varied reactions to our letters. In one area (my home village) wealthy farmers who owned sugar factories wanted to build a modern, well-equipped

....3

hospital to cater to their own curative needs. In another area the influential indigenous practitioner felt threatened, so he did all he could to prevent dialogue with the community leaders in his village. In a third village there was a community leader responsible for health planning of a district of 2 million people, and he immediately saw the benefits for his area in our proposal. There was also a minister at the state level, a state of 32 million people who happens to come from this area. These two saw the many advantages for their community andsaw the political advantages for their own re-elections. Therefore, they went into the community, into different villages, and got resolutions passed by these villagers inviting us to come and start work in this area.

As stated, we laid conditions under which we would be willing to go to the area, and they were willing to fulfill these conditions. They emptied out an old veterinary dispensary, about 30 x 10 ft, which we used as our outpatient department. They gave us a storage place for inpatients and rented a place for us to live. It was a very simple arrangement - no electricity, no running water and all 20 of us having to live in a 20 x 30 ft area.

We started work in real earnest in January 1971. We formed a consultative committee which consisted of not only members of this local village but others from different areas, representing different communities, especially the poor 'harijan' (untouchable) community. The first responsibility we gave this committee was to find accommodation for us and accommodation for our health centre. We then asked them to find us staff. Most of our staff, like nurses and paramedical workers, had to be brought from the city. This staff had to be Christian because we were there to establish a Christian witness and at the same time give medical care. This Christian staff formed a nucleus where we were all like minded; all had a Christian dedication because though they were coming to this particular area and leaving their jobs, they were not going to get any extra remuneration. So money was not the thing that was bringing them there; on the contrary, they were going to have a lot of inconveniences.

Besides this nucleus of Christian staff we needed other people - the nonprofessionals and the community. We asked our consultative committee to hire these for us. This had an advantage as they wanted to do their best for us, for we had told them that if within six months we did not have a good response from them, we would find some other place to work. So they found good, honest, hardworking staff of another 10 to 15 people from the local community. They also went around and found building contractors and other people to supervise and plan the buildings for the future. All this work done by the committee was in an honorary capacity.

After that we went around from village to village, holding meetings in each village. Our first objective was to get an idea of the felt needs. In certain villages they just did not feel that there was any need for medical care and were quite happy with what they had. But there were villages where the people felt that they did not have competent physicians, especially for care of their emergency illnesses, like obstructed labour or fractures and other medical emergencies. They did not have any diagnostic facilities. In the north there is a hospital 50 miles away; in the south there is one 130 miles away; in the east one is 150 miles away; and in the west one about 70 miles.away. We discussed with the members of the community our interest to improve their health, but they felt that curative care should take precedence over other programmes that we were proposing to them. We told them if they were willing to pay for these services, we would start with these. They all agreed to this; so from the first day we have been self-supporting as far as curative work is concerned. They understand that they have to pay for any curative work that they get from us.

This is what happened at the local village. As the news spread to the nearby villages, people became aware that they could come and negotiate with us to go to their villages. Here again we said, "The decision to start work in your village area is entirely up to you. These are our conditions; If you want us to come to your village to start health work, you give us a place to work, give us your cooperation, give us your help in child care and immunization of children, give full cooperation to our team, and care for our nurses when they stay in your villages."

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Our original plan was that we would start at a central village with a population of about 7,000 people and work within a radius of about five miles around this village to make up a population of 20,000, but we soon realized that we could not follow this plan because the first village that was most interested in us was 12 miles away. The people there were so interested that they already had a building for us and had accommodation for our nurse They were willing to contribute monthly for our services to them. Though this did not come into our original design of work, we had to modify the plan because of the rapport and relationship with the community.

We are located at the border of three counteies. If we were in one county, the political leaders would probably feel that they could put pressure on us; but located as we are, we can move from one county to another to avoid such pressures. We asked one of the local men how we could get away if we did not get the required cooperation within six months. He suggested that we build a centre using tin sheets as a shed; we were fortunate as we were able to get enough money to put up a prefabricated aluminium tin structure. (The aluminium does not get hot in the summer, and we are comfortable.) Our main building has a 30-bed capacity and an outpatient clinic. The entire building can be dismantled and reconstructed within 15 days by the firm which built it.

I would now like to describe a typical encounter with a village. We usually go in the evening because that is the time when the villager is relaxed, and we go and call the village leaders. The leaders feel important that a doctor has left his place and come all the way to their village. We are usually given tea, and we start our discussion. Very often we find that the uppermost thing in their mind, even when talking to a doctor, is not health; the usual question is food. This was especially so because there was a famine when we entered the area. We take their lead and discuss food for the children. Then we go into the topic of malnutrition, and we come with a proposal and say, "Your children do not have enough food. Maybe we can get some agency involved and interested in getting some milk for your children. What will you do in return?" And the villagers sit down together, and they come up with the idea that they will bring some things from their own homes and make a common meal for the children. Those who are able would donate some money, and those who have no money would contribute labour.

So right then and there we form a committee, and we say that from Church World Service we can try and get wheat or milk powder or soybeans, but this committee is responsible for cooking the food. The responsibility means purchasing fuel and utensils, maintaining daily records, and getting the children together for the meal. This committee then appoints people who will collect the money for the fuel and utensils and taken charge of the feeding programme. In this way these villages have about 3000 children which are being fed every day. We give a supplementary protein diet to them. We did not impose this programme on them. We went and talked about their felt need, and the felt need was food, and gradually we translated that into a supplementary feeding programme for children under five.

At the same time we realized that the Church World Service food may not continue for ever or any gifts from abroad may stop, and we have to plan ahead. We realized that the second most needed item is water for farming and drinking. So we put another proposal to the villagers. We told them, "Your children are being fed by this method now, but this is not going to be permanent. Why don't we think of something else which will be more permanent and lasting?" We propose making wells which will make paupers into rich men. We then ask if when they become rich, they would share their riches with the others. They say they will. We then form a committee, and this committee decides which farmer or farmers are likely to have water in their fields or which farmers will be willing to produce food for the children and which one are likely to be generous after they get the wells sunk in their land.

So the committee decides how to find a permanent solution for the undernourished children in he village by getting a well sunk. Then we translate this community action into a scientific action. There are agencies in that area which are working with boring machines for watersupply and sinking wells. We get this team to come and do a survey, and then out of the four or five names the community has suggested, this team picks out two or three

names and decides which is thelikely place where they shall strike water for a well. Up to date there are ten wells where we have struck water, and six of these wells have enough water for irrigation. So after this monsoon we shall have 15 acres of land to grow rich protein food. Now we are sure that when this experience works, there will be more farmers who will be interested and will make land available for feeding children of the entire village. So again we helped the community to decide just by encouraging them and helping them to arrive at the decision we wanted them to make.

We do not always go and listen to the problems of the villagers. Sometimes we sit with the village people and talk to them about our problems - for example, the problem of getting to their villages because the roads are so bad - and if they really want us to come to their villages, what can they do? Already the villagers have made a seven mile road connecting two centres; the minister has had 50 miles of road paved to the villages. Making the roads or paving the roads is not important, but what is important is that the people wanted us and the care we could offer them so that they were willing to pay for the care and share the responsiblity for it as well as make roads for us.

Children are immunized at the centre. Immunization in the villages is only done when the villagers fulfill certain conditions we have laid - namely, the village people must collect at least 80 per cent of the children, list their names, weigh them, and then send us word to come to inoculate them. When we arrive at the village, we get the school teacher or the Sarpanch to tell the people the reason for our being there and what to expect as possible reactions from the immunizations given. We usually give some drugs such as aspirins to the Sarpanch, and he tells his people that if they should have any reactions, he will give them medicines.

In school health the school teachers take a major part. They list the children, test their sight, weigh them, and help us during their examinations. We leave with them drugs for treatment that may be required.

Leprosy is a social problem. We have tried to integrate leprosy treatment into our daily work. When we go into a community, we ask if there are any leprosy patients. I say to the people, "I would like to see them; please take me to their home." I go to their home; I meet the patient; I shake hands with him; and the people will say, "Doctor, please wash your hands." I say, "I will wash them later." I ask the patient, "What are your relations with these people?" And the leprosy patient says, "I'm fine; I'm all right; I live in my place, and they leave me alone." Then I say to the people, "This man has leprosy; another man has tuberculosis; but both are caused by the same germ; both can be cured by very simple medicine. Why do you want to treat leprosy different from tuberculosis?" Then I ask if they would please let this man come to me when other patients come to see me. Maybe the others come for coughs or colds, but this man needs medicine just as the others do.

We try to break down the barriers in this way. We do not have separate clinics for leprosy patients. We do not go to the leprosy patients' homes; they all come to the centre. To my amazement the real objection was not from the community but from our own nurses. One marvels at the capacity of the village community to understand what is said.

Our survey work is done by a team, not by one person alone. Usually in the team there is a nurse, an auxiliary nurse midwife, a special family planning worker, a basic health worker and a laboratory technician. The team goes from house to house. Nobody knows who is looking for a leprosy patch. The team ~~goes from house~~ surveys a family for antenatal patients, for children under five, for patients with a chronic cough, and for tose with a skin lesion. So child care, antenatal care, treatment for leprosy and tuberculosis can be given. The nurses are supplied with simple drugs and can give antibiotic injections.

Over the last 18 months we now have 460 leprosy patients under treatment. Some of these are very early cases with only a patch and/or a thickened nerve They would probably not have come for treatment until they had got deformities. We have impressed on these patients the value of coming for treatment regularly, as otherwise the disease will worsen and they will get deformities.

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In rural work due respect has to be given to the indigenous practitioner. These indigenous practitioners are usually rebuffed by trained doctors. We are naturally a threat to them. So we have established a rapport with them, taken steps to ensure their friendship, making sure not to bypass them or belittle them. We seek their cooperation in feeding programmes for children, treatment of leprosy and tuberculosis. We give them drugs and so involve them in the treatment of village patients. We have also explained to them the important role their wives can play in the care of antental cases. Two wives of indigenous practitioners are already attending the hospital for help towards giving such services. During the school vacation we are involving the school children in areas of nutrition, sanitation, and family planning. We have found that these youth groups can play an active part, particularly in family planning.

Often we underestimate the community, but this is a practical example of how our trust in the community has involved them in health care programme.

Survey

7 ANTENATAL WOMEN

14 REGISTERED REVISITS

2 DELIVERIES

5 ORAL CONTRACEPTIVES

4 TUBECTOMIES

2 VASECTOMIES

5 NEW T.B. PATIENTS

30 OLD TREATED

800 MEN WORKING ON WELLS

5 NEW LEPROSY PATIENTS

25 TREATED OLD

10 MOBILE CLINICS

14 HEALTH TALKS

240 CHILDREN UNDER FIVE CLINIC FOR ILLNESS

30 SCHOOL CHILDREN EXAMINED

1 MULTIPURPOSE CLINIC

908 SICK PATIENTS SEEN

233 LAB. TESTS

60 X-RAYS SCREENINGS

8400 MEALS SERVED

136 CHILDREN IMMUNIZED

Case Study-4 (COPY)

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SERVICE RESPONSIBILITY OF A DEPARTMENT OF COMMUNITY MEDICINE THROUGH A HEALTH CO-OPERATIVE

by

*MAJ GEN B MAHADEVAN PVSM AVSM MBBS DPH., DTM & H.,FRIPHH.,FCCP.,FFPHA

INTRODUCTION

A good and well informed faculty with modern concepts of medical education, has a capacity for extensive research in the organisation and delivery of health services through experiment, models and pilot projects. Medical educators in general, and faculty staff of departments of Community Medicine in particular, must assume their share of responsibility for meeting the quantitative as well as qualitative needs of the people and must be concerned not only with the basic mission of the University or Government which is learning, but also actively help the people of a locality or region in organising and running their own Primary Health Care Services.

For establishing an effective and viable Primary Health Care system, the cooperation of the local community must be ensured. In fact, the people should be adequately motivated, involved in decision making and actively participate in health programmes, so that ultimately it becomes their own "peoples programme". Local resources such as co-operatives, agriculture, manpower, buildings and most important of all local leadership, should be used to solve and finance the local health programmes. It is desirable that the Primary Health Care system should be a self-sufficient fiscal entity. Community priorities are more likely to be met if the people themselves raise and spend the resources required. A "total health" approach is essential. Promotional, Preventive and Curative care need to be completely integrated.

THE CONVENTIONAL APPROACH

Health facilities in rural areas in the country were provided through Primary Health Centres started as part of a national rural development scheme called 'Community Programmes' in 1952, with a very modest staff in each centre to form the nucleus of integrated health services and cater to the need of about 60,000 population in a Block. There are now over 5,200 Primary Health Centres, each Centre serving a population of 80,000 to 120,000. The annual expenditure of medicine permitted for each Centre ranges from Rs. 4,000/- to Rs. 6,000/- and this had to take care of such a large population. The scheme was extended to involve Medical Colleges in rural health work and through deliberations of many committees, the status of health centres were improved both qualitatively and quantitatively. An integrated approach of providing health services to the rural people, with the provision of two doctors to every Primary Health Centre and a basic health worker with an auxiliary nurse midwife (ANM) to every 10,000 population, was attempted.

A Pilot Mobile-cum-Training-cum-Services Hospital Scheme was introduced in some Medical Colleges with a view to involving medical and nursing students in rural community medicine. The intention was to establish ultimately one mobile hospital per medical college. More Medical Colleges were established with the sole purpose of providing rural health services. Specialist Camps were organised for cataract operations, vasectomy and tubectomy. Although the Government's

*Professor and Head of the Dept. of Community Medicine,
St.John's Medical College, Bangalore 560 034.

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idea is to train doctors for rural areas, these doctors are not attracted to such areas. The migration of Indian doctors to the more developed countries continues. Even passing of a Parliament Act which empowers government to oblige doctors and engineers below age of 30 to work for a period of 4 years in rural areas, remains unsolved as we are unable to provide reasonable living conditions for them in villages.

Some Medical Colleges like Vellore Christian Medical College incorporated in their teaching programme, the rural dimension in a significant way. The organisers of the Community Health Centre, have found that it costs about Rs.8.50 per person per year, which includes preventive, promotive and curative services. The Administration is not very happy about this project due to the high recurring costs.

The Kerala Government with Government of India initial one time grants, has established Health Co-operatives in 11 districts. Doctors are encouraged to seek self-employment in these Co-operatives. Doctors and paramedical staff take shares in these co-operatives, a certain fee is levied on services, and medicines are also paid for. One is looking forward anxiously to the success of the scheme. The initial reaction of the people has been good.

Voluntary agencies have established a large number of hospitals in urban areas. However, funds are not available to these hospitals for any significant rural health work, although an increasing number of dispensaries are being opened in rural section of the country.

A NEW STRATEGY

From the facts and figures just given, it is clear that Government in spite of its herculean efforts has not been able to seriously tackle the problem and with the scarce allotments made for the health services, no tangible improvement is possible in the near future. No voluntary agency can hope to embark on a scheme where even the government has failed but is in a better position to try out new methods through pilot projects.

When planning rural health services, one has to consider two components, namely the delivery of package of rural health services in villages and the formation of personnel who will deliver the same. At the same time, there is an inescapable need for complementary services which will develop the village economy and education of the rural people. Many rural health schemes taken up enthusiastically at the beginning flounder for lack of popular support that has to be expressed by financial contributions. This is the crux of the matter. Any health delivery scheme should be a self-sufficient fiscal entity. This may be a limiting factor but the only sound way of attempting to solve rural health problems, is to start it in places where conditions are favourable for the introduction of self-supporting schemes.

Funds for rural health schemes may be raised through many ways:

(a) Tagging health services to co-operatives.

To start health co-operatives by themselves is difficult, as health holds a low priority in the felt needs of the people and may not get the required support in the initial stages. The procedure of tagging on health services to existing co-operatives has many advantages - good leadership, a ready made

frame work of community administration for introduction of effective health services and community involvement, as channels of communication with the people have already been established. Co-operative Dairying and Marketing Co-operatives of different commodities like grains, cereals, cottage industrial products etc., lend themselves admirably to this type of health services.

(b) Running health services with assistance from factory administration where labourers are from villages nearly.

A minimal deduction at the source of salary and a contribution from the factory management will help to build up the required funds and formation of a health co-operative. Geographical location of industries and rural labour in close proximity are limiting factors but is worthy of trial, in special areas.

(c) Assistance from Panchayat

Places where Panchayats and the people are interested in health services and are willing to contribute to the same, may venture on this method but unless sufficient funds are forthcoming regularly and persistently, the scheme will collapse.

(d) Starting with services and evolving a cooperative at a later stage.

A devoted team of health workers can establish themselves in a village and build up the required clientele and popular opinion. The people can then be induced to form a cooperative and directly employ the doctor and essential para-medical staff. Until such time, a central agency or other funding agency may have to meet the expenses. This can be attempted even without forming a cooperative in areas of affluence, where people are willing to pay for the health services and employ the doctor and other staff through collection of revenue for the purpose.

THE MALLUR MILK CO-OPERATIVE (M.M.C.)

Mallur is a village in Kolar Dist of Karnataka, situated 35 miles from the city of Bangalore. The Mallur Milk Co-operative (MMC) was an established concern with a sound and progressive leadership and had been functioning for many years. In addition to production and sale of milk, it provided other benefits like provision of fodder and cattle foods, tractor facilities and loans at low rates of interest.

Besides the people of Mallur, two other villages, Muthur and Kachahalli were members of the Co-operative and the total population covered was about 3,000. These villages had a milk farm cooperative besides cooperative dairying. The economic position was satisfactory, and, therefore, all conditions were favourable for the introduction of other self-supporting schemes.

The inspiration for establishment of a Comprehensive Health Care Programme for the Co-operative Members and their families of these villages, came from Sr Anne Cummins of Coordinating Agency for Health Planning (CAHP) and Fr Jonas of the Catholic Bishops Conference of India (CBCI). With these pioneers, the Dean and the Department of Community Medicine of St John's Medical College, representatives of the Karnataka Government and Bangalore Government Dairy with leaders of the Mallur Milk Co-operative, worked out a scheme for tagging on a health service to the existing MMC.

The main objectives of the Mallur Health Project were:

a) to study and devise methods by which the financial base needed for effective health services could emerge from the people themselves in a self-sustaining manner;

b) to help in the establishment of rural health centres with the staff and rendering of effective health services to a wide circle of needy people without distinction of race, caste or creed;

c) to study the required strategy and methodology for the effective rendering of primary health care in rural areas by trying to determine the priority areas in health care and devising the structure found suitable to village conditions;

d) to help in those developmental activities which are very necessary to ensure effective rendering of health services in rural areas; and

e) to train intern doctors, nurses and other medical and para medical staff for the purpose of rendering assistance in rural areas.

The St John's Medical College and its Department of Community Medicine, were to be mainly concerned in acting as a catalytic agency, in the formation of a self-sustaining rural community health scheme, fulfilling the above objectives.

It was estimated that a monthly budget of Rs.2,500-3,000 would be required for running the Health Cooperative and financial support was forthcoming by a joint contribution of 3 paise per litre from the MMC and Bangalore Dairy, in a phased formula as shown in Table I below. Ultimately the MMC was to completely finance the scheme.

TABLE I (Contributions to the Health Co-operative)

Year	Contributions/litre	
	Milk Co-operative	Bangalore Dairy
1st	1 p	2 p
2nd	2 p	1 p
3rd	3 p	nil

This budget was adequate to support a health programme, organised by a Medical Officer, Nurse, Compounder and an Ayah. The staff were appointed by the Health Co-operative Committee.

The Health Co-operative Committee included the following members:

Chairman, MMC
Secretary, MMC
Dean, St John's Medical College, Bangalore
Head of the Dept of Community Medicine, St John's Medical College, Bangalore

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Director/General Manager, Bangalore Dairy
Representative of State Health Service
Medical Officer, Mallur Health Cooperative (Secretary)

The composition ensured integrated planning between the MMC and Health Co-operative.

The Health Co-operative got off to a good start by being inaugurated on 19 March 1973 by the Minister of Animal Husbandry. Dr VK Rajkumar a Senior House Officer in St Martha's Hospital, joined as Resident Medical Officer in charge of the Co-operative. This Medical Officer by dedicated work and self-sacrifices, made the Mallur Health Co-operative a successful enterprise.

The Health Co-operative in November 1973 was joined by another dedicated worker Maria, an Italian Public Health Nurse. She with her companion Cathy, a Volunteer from Canada, looked after the Maternal and Child Health Work.

THE BREAK THROUGH IN THE ECONOMICS OF THE HEALTH CO-OPERATIVE

Within five months of starting the project (August 1973) the cost of fodder went up and milk production of the Milk Co-operative fell as some members began to sell out on higher rates. The MMC took a decision, much to the discomfiture of the Government Dairy Authorities, to sell directly to private parties in Bangalore, who offered better prices. The Govt Dairy therefore stopped its contribution of 2 paise per litre as health subsidy, and the Health Co-operative was in a critical situation. It is at this stage a momentous decision was taken by the responsible village leaders who were more than convinced of the positive role of the Health Centre and its staff in improving the health status of the people in Mallur and other villages. The Milk Co-operative was doing well and decided to contribute 5 paise per litre for health and took over financial responsibility for running the Health Centre. This financial strategy on the part of village leaders resulted in the Project becoming a viable unit. The Milk Co-operative has borne the entire recurring costs of the health project ever since, and the table below gives the Income/Expenditure position for the period July 74 to June 75.

TABLE II (Recurring Costs)
(Year - July 74 to June 75)

Total Milk Production	6,27,898 litres
Income estimated at 5 paise/litre	Rs.31,394.90
Actual income received from MMC	Rs.33,100.00
Total expenditure for the year	Rs.33,790.74

Although the Mallur Health Project is mainly financed by the Mallur Milk Co-operative, it also receives help and technical direction from St John's Medical College and the Government Health Service. These inputs are shown in Table III.

TABLE III (Shows the various inputs)

Source	Capital	Recurring
1. Mallur Milk Co-operative	Buildings, Furniture, Refrigerator, Health Education Material	Salaries Rents/electricity Drugs General stores Petrol
2. St John's Medical College	Physicians and Midwifery Kit Minor Surgical Equipment Lab Equipment Motor cycle (on loan through UNICEF)	Interns services Specialist services Rent for interns quarters
3. Government Health Services	Nil	Vaccines, Vit A, Iron, Folic Acid supplementary FP Devices Surveillance of communicable diseases (through IHC Sidlaghatta) Health Education films (through Health Education Department of DHS)

SERVICES RENDERED THROUGH COMMUNITY PARTICIPATION

The St John's Medical College, adopted this Health Co-operative as a rural training centre for Interns. Visits by specialists of other departments including specialist camps were organised. At present, 4 interns are attached at any one time for whom residential accommodation has been provided by the MMC on a rental basis. The interns conduct base line demographic surveys, immunization and school health programmes, special health projects and mass health education programmes.

The Health Co-operative Committee meets by turns, at Mallur and St John's Medical College, to discuss progress and plan for the future.

The Health Team comprising of Dr Rajkumar, Miss Maria and Interns under the technical supervision of Dept of Community Medicine has made good contact with the villagers and a comprehensive health care programme has been introduced. The community of Mallur and other member villages actively participate in all programme. They have no unreasonable expectations or demands, as the health project is their own programme brought about through their own contributions. This is a basic difference between Health Centres organised through Co-operatives and Governmental Agencies. The leaders are actively involved in the planning

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and organisation as the Chairman, MMC is the Chairman of the Health Co-operative Committee and the Secretary MMC its member. Paramedical workers are drawn from the village community and trained for Community Health work. The Young Farmers Association actively assists in many of the health programmes. They help interns in their surveys, programmesof immunizations and environmental sanitation including chlorination of wells and construction of sanitary latrines. They also organise the physical arrangements for the Mass Health Education Programmes. The Mahila Mandal under the dynamic guidance of Mrs Rajkumar, runs a nursery school and acts as a forum where health education, applied nutrition programmesand mothercraft are taught to the womenfolk of the villages.

The Health Team and interns organise the following services with community participation.

PERSONAL SERVICES

1. Curative clinic (daily outpatients)
2. Maternity and child health services:
   - i. antental care;
   - ii. midwifery (domiciliary)
   - iii. postnatal care
   - iv. under-5 clinics(domiciliary)
3. School health services for village schools
4. Immunization programmes for smallpox, triple antigen, tetanus toxoid, BCG, typhoid and cholera
5. TB and Leprosy case detection, treatment and follow up
6. Motivation for family planning
7. Specialist camps at Mallur (periodical visits by St Martha's Hospital specialists)
8. Hospital referrals
9. Family record maintenance

COMMUNITY SERVICES

1. Protection of well water supplies by chlorination
2. Popularisation and construction of sanitary latrines and soakage pits and other advise on environmental sanitation
3. Collection of health data through periodical surveys
4. Coordination and cooperation with government health personnel in National Health programme activities
5. Health education at personal, group and village levels
6. Nutrition education and nutrition supplementation programmes.

Members of the Milk Cooperative and their families are entitled to all the above mentioned services free of cost. Non-members coming from other surrounding villagas pay for drugs/dressings and minor surgery. All preventive and promotive work are given free to all categories. Table IV below shows the percentage of member and non-member families in each village.

TABLE IV
(Percentage of member and non-member families in each village)

Village	Families		
	Member	Non-member	Total
Mallur	188	202	390
Muthur	63	124	187
Kachahalli	30	21	51
Bhatoranahalli	17	14	31
Harrulunagenahalli	6	18	24
	304	379	683
	45.%	55.5%	

CONCLUSION

Our experience over the last two and half years have shown that:

i) A health function can be grafted on to an economic cooperative

ii) A sound cooperative such as MMC can support substantially the recurring costs of a health programme

iii) Tagging on of a health function to a co-operative, benefits not only the members and their families but also the non-members who get indirect benefits of professional services, preventive and promotive programmes.

The Department of Community Medicine and its staff, was mainly concerned in acting as a catalytic agent, in the formation of a self-sustaining rural community health scheme. An experiment was embarked upon and the Mallur Project is this experiment. A Total Health Care Programme can be effectively delivered through a Cooperative in rural areas. The Mallur Milk Co-operative is even contemplating construction of a 15 bedded hospital at Mallur, with the help of Government and its own funds.

Further, the Health Centre with its working philosophy, has indirectly helped the Department of Community Medicine to conceptualise a primary health care system for training of future physicians, so that they play their rightful role in a contemporary society.

The Health Team and interns have played an important role in the development of the village in general and health aspects in particular. Attempts are being made to increase the membership of the milk cooperative by purchase of more cows and increasing enrolment. Other economic activities such as development of village/cottage industries and handicrafts and ensuring sale of products, are contemplated. We are fully aware that in the planning of such self-supporting programmes, the Health Team

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have to be actively supported by other members who will attend to [illegible] development activities of the society. Success or failure would depend on tackling the financial side efficiently.

The quality of promotive and curative services would have to be improved. Simpler skills, cheaper drugs and intermediate technology have to be introduced to suit rural conditions. A drive to improve the education of the people including health education, is to be attempted through use of Village Level Workers. Their training programme is being organised. Whether there has been an improvement in the morbidity and mortality statistics at Mallur, subsequent to the introduction of these co-operatives in comparison with other areas in the vicinity, needs study and this has been taken up as a health project.

The question of introducing such self-sustaining Co-operative Schemes to other areas around Bangalore is under active consideration. These are challenges that have to be met in rural India and we hope that with the cooperation and participation that is readily forthcoming from the simple rural folk, our economic and health projects will meet with success.

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M E D E X

help for the family doctor BY urmila devgon

A UNIQUE PROGRAM DRAWS ON THE SKILLS OF EX-MEDIC L CORPSMEN AND TEAMS THEM WITH THOSE OF GENERAL PRACTITIONERS TO PROVIDE COMMUNITY HEALTH CARE IN MANY PARTS OF RURAL AMERICA.

IF it weren't for Medex - a new program representing a significant break with traditional methods of providing health care services - the small town of Davenport in the Pacific Coast State of Washington would probably have lost its last doctor.

Located in a prosperous wheat farming area, Davenport (population 1,363) once boasted three physicians to serve the town and its surrounding area. Then one of the doctors left; soon another decided to do the same. As a result, Dr. Marshall Thompson faced the prospect of handling alone a practice he estimates was close to 9,000 patients. "The task was monumental," he recalls. "If I didn't get help, I planned to leave." As it was, he had little time to spend with his wife and five children or to keep up with new developments in the field of medicine - and almost none for relaxation or recreation. His plight was a familiar one to rural doctors throughout the United States: There just aren't enough doctors to go around.

Yet today Dr. Thompson is still in Davenport. His practice is thriving, his patients happy. The answer is Medex (from the French medicin extension or extension of the physician). "MEDEX," says Dr. Thompson, "has been a lifesaver for me".

What Medex accomplished was to give him an extra pair of hands--and highly qualified ones at that. They belong to Ron Graves, 29, an ex-U.S. Navy hospital corpsman who had six years of medical experience during his service career. Ron is one of some 30,000 medically trained personnel discharged annually from the American armed services. About 6,000 of them have provided what is called primary medical care and have often served as the only medical man abroad a ship or at an isolated station. Highly skilled, they have had from three to 20 years of valuable experience and may have received upto 2,000 hours of formal medical training in such fields as medicine, surgery, pharmacology or orthopedics. Yet when they returned to civilian life they were rarely able to use this specialized knowledge. Until recently, the only civilian medical job open to them, says the president of the American Medical Association, has been that of hospital orderly.

This paradox in American medicine--a shortage of family doctors on the one hand and an untapped pool of highly skilled medical corpsmen on the other - is what gave birth to Medex, the brainchild of Dr.Richard A. Smith, an innovative young black physician who is associate professor of health services at the University of Washington in Seattle and director of the Medex program. Medex draws on the skills of the ex-medical corpsman, teaming him with a general practitioner and making him what Smith calls "the first totally new health professional in family medicine in this century".

Smith, who holds both doctor of medicine and master of public health degrees, was senior Peace Corps physician in Nigeria and served later in Peace Corps headquarters in Washington, D.C., and in the office of the

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U.S. Surgeon General. When he went to Washington State in 1968 he learned there was not only a severe manpower shortage in the medical profession but a constantly declining physician-patient ratio in rural areas. In addition, the age of general practitioners in rural areas was steadily increasing. Something had to be done, Smith felt, to increase the capacit of doctors already in rural areas and also to make small town general practice more attractive to new physicians. In the Seattle area, he noted, there was one doctor for about 500 patients; in some rural areas the ratio was one doctor to 5,000 patients! We found doctors who were working 14 to 16 hours a day, he said. Some hadn't had a vacation in seven years.

Enlisting the cooperation of a group of general practitioners who volunteered to participate in the program, Medex was launched in mid-1969 as a demonstration project sponsored by the Washington State Medical Association and the School of Medicine of the University of Washington. Funding was provided by the Federal Government. Interested medical corpsmen were contacted at military installations and, after careful screening, 15 were selected to begin a three month intensive training program at the university. This academic phase emphasized areas like pediatrics and geriatrics, in which the corpsmen had had the least experience, and stressed the psychological adaptation from military to civilian medicine.

Meanwhile the Medex met the participating physicians and,with their families, visited them in the communities where they practiced. The physicians agreed to train the Medex in their offices during a 12 month preceptorship of following the academic training and then to hire them if the team arrangement worked out. Great care was taken in matching Medex and preceptor for, as Dr. Smith noted, "the Medex is an extension of the physician, not a substitute." It was essential that the two work well together.

Medex (the term applies both to the program and to the new professionals) take patients' histories, do delegated parts of physical examinations, stuture minor lacerations, apply and remove casts and assist physicians in surgery, all under the supervision and responsibility of their physicians. Statistics from eight doctors indicate they handled 25,000 more patient visits in the first year as the result of their Medex. One rural physician saw 63 per cent more patients during his first year with a Medex than he had the previous year when he was alone.

So successful has the project been that it is continuing in the State of Washington - and several other states have started similar Medex programms.

Medex is an excellent program, says Dr. Thompson. It provides relief for a lot of overworked physicians. It is a plan that works. It established a goal and got the job done.

Fr Dr. Thompson, Ron Graves provides a much needed addition to the health care team. Graves screens patients, takes histories, conducts physical examinations. "He knows when something is wrong, says Thompson, even though he may not know exactly what it is - and this is important.

The two men share night and week end duty. Thompson estimates that each typically works a 65 hour week. People have a great deal of confidence in Ron's judgment, Thompson says, and I have a great deal of confidence in his judgment. Patients know that if she feels more advanced care is needed, he willcall me. He never ceases to amaze me. Sometimes the practice of medicine is intuitive.

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He's beginning to develop this sense. It's part of the art. They can't teach it to you in medical school. Some of the art of medicine, I think is lost in our technological society. You are treating people - not diseases but people with diseases, Ron gets on very well with people; I have yet to meet anyone who didn't like him.

Ron and Linda Graves, both from small towns in Iowa, feel at home in Davenport. They are active in their church, have bought a house and look forward to raising their three small children in Davenport. People have gone out their way being friendly to us, says Linda.

Medex offered Ron the career he wanted but hardly dared hope for. In fact, he almost didn't apply when he first heard about the project because it just sounded too good to be true. Now, he admits, I couldn't be any happier. He likes the wide range of experiences Medex offers and the opportunity for further training. He has already taken courses in cardiology, electrocardiogram interpretation, pharmacology and drug interaction. He sees over 300 patients a month, scheduled appointments at the clinic every half hour (Dr. Thompson's are every 15 minutes). It takes me more time to evaluate a case, he says, and then I like to let people talk. If you listen long enough they tell you what they really came for. It isn't always what they said at first.

Ron has the knack of putting people at ease. He is especially good with the young and the old. "Being lonely is probably the worst disease older people have," he observes. "They want to talk. I have the time to listen. They need to know someone cares. He visits the local nursing home about four times a week, making a point of spending time with each patient.

The people who go to the Davenport Clinic are delighted with Medex. "It's a wonderful program," says Connie Walker, mother of three, who travels 45 miles to the clinic. Graves has taken care of her baby since the child was two months old. He is very careful, very thorough and efficient, Mrs. Walker says. "He explains things so well that you know exactly what to do when you're at home. He just doesn't take chances."

Another Graves enthusiast is Debra Portch who lives 40 miles away. "My little girls just love him," she says. "He's really got a way with kids. We wouldn't travel 40 miles for nothing, would we?

A medical assistant at the clinic adds: He is certainly an asset not only to the clinic but to the town. He and Dr.Thompson have a fabulous relationship.

What do the professionals think of Medex? Dr. Walter Bornemeier, former president of the American Medical Association, raises a question that occurs to many. "Are these men competent?" he asks. "Well, one of them found a hairline fracture in a patient which both the doctor and a hospital radiologist and missed. That is one example of competence".

Medex founder Dr. Smith, who has traveled widely in Africa, the Near East, Asia, Latin America and Europe, believes the basic elements of the Medex program provide a technological tool that can be used to train individuals with or without previous medical experience. That is part of our objective, he says, to adapt the concept's technique of training and deployment of health personnel to the existing needs and available resources in any geographic area. I do not think I would be exaggerating if I said this approach can be applied in most of the 45 countries that I have visited or worked in.".

Case Study-6 DELHI - 8

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PROPOSAL FOR ANANDGRAM - 'THE JOY VILLAGE'

A Cultural Village Complex for Itinerant

Performing Artists and Traditional Craftsmen

A. A Statement on Alternative Reserttlement

B. Background

C. The Cooperative

D. Anandgram

E. Budget

F. Appendix

Bhule Bisre Kalakar Sahakari Samiti

C/O Rajeev Sethi
Flat 4, Shankar Market
New Delhi 110001 India
tel. 45107

April 10, 1978

RESETTLEMENT : OUR ALTERNATIVE

A statement from the people of Shadipur Depot Jhuggi Colony, New Delhi, May 1976

We are, all of us - traditional puppeteers, singers, bhopas balladeers, jhoola-wallahs, animal trainers, jugglers, circus artists (nuts), toy-makers, wood-carvers, peep-show wallahs, street entertainers, etc.

Nowhere else in the country is there to be found such a close and compact community of professional performers and craftsmen; nowhere in the country would such a community be as extensive or contain quite such a variety of skills.

We are mostly itinerant but we need a base which we can call our home.

We began to migrate to this city 20 years ago; and 10 years ago we came together as a community in an area of 3 acres in Shadipur Depot. We are now about 150 families. This has become our home; and it has developed in such a way that strangers to the city, and indeed, many city-dwellers themselves, would not have believed possible.

We have preserved our rural life-style intact even as we respect and observe the civic laws of the city.

Indeed, we have become an integral part of the city's varied culture. Anyone who needed our skills knew at once where and how to contact us. Traditional artists who visited this city were able to located us with ease. We can honestly say that we feel our community has benefited the larger community of the capital.

We have entertained foreign dignitaries as we have the man in the street. We have given their children toys to play with. Our decorative crafts have reached the homes not only of Delhi's citizens but of the world.

We feel that our community of 150 families represents a major crafts industry of the capital.

We find we are now being moved to resettlement colonies such as Sultanpuri and are scattered far away from one another. This spells the break-up of our community and our way of life.

How can we organize in the future as we have so far ? How will those people who draw on our professional skills find us when they need us ?

For sometime now we have been thinking among ourselves about a small but permanent theatre where we would have regular showings of our puppetry and other performing arts both for the citizens of Delhi and for those visiting from abroad.

Side by side with this, we feel we should benefit from having a sales-outlet that we could manage ourselves without intervention or financial under-cutting by middlemen.

We feel it may benefit the Government to build a Cutlure and Tourist Centre and yet with very little outlay; for where else would it find such skilled and centralized human resources ?

Maybe you, the Government can help us to organize ourselves as responsible citizens with land to live and work on. The question of resettlement itself would be not problem for us; but please let this not interfere with our aspirations !.

We, the undersigned, are willing to surrender the land-allotments given to us as separate members in favour of an area where we can live and work side by side.

Signed by 138
Heads of families
May 1976

ANANDGRAM - 'THE JOY VILLAGE'.

A Cultural Village Complex for Itinerant performing Artists and Traditional Craftsmen.

B. Background.

Less than a decade ago, residents and visitors who cared to walk the streets of an Indian city could easily find a peep-show wallah gladly showing all comers his picture scroll of "twelve-maund washer-woman", or chance upon a magician holding audiences spell-bound with his clever showmanship and street 'hypnosis'. The passerby could also witness an animal trainer convince his monkey to take a bride, watch his dog leap through a wheel of fire, or see the 'bhalluwallah' asking his bear to ride an onlooker's bicycle.

A family of acrobats whose children would put a professional gymnast to shame could be found looming over the heads of a standing crowd gathered for a'Tamasha'. One could easily locate jugglers performing in an open square or a puppeteer performing his traditional ballad plays with hilarious comic interludes. A'behrupia,' the street impersonator, would arrive in a market square and create a spontaneous crowd of laughing shoppers.

Street urchins would shout and run in delight as the familiar sound of drumming announcing these wandering performers was heard approaching the neighborhood. The more well-to-do will remember how the puppet-show wallah always turned up to erect his little stage in time for the children's birthday party.

Nowadays, we see fewer and fewer of these 'pilgrims of joy'. Decades ago they left their villages to come to the cities in search of new patrons. Now they have started to leave again: "Life is not what it used to be.....Too many rules and regulations."

One of the definitions of beggary in the Bombay Prevention of Beggary Act of 1959, which is still in force in Delhi, is "Soliciting or receiving alms in public places - under any pretence such as singing, dancing, forture-telling, performing or offering any other article for sale."

No one has cared to allot special places around Delhi, in parks, open grounds or mohallas, for instance, where these professional street artists can earn their daily bread with dignity.

Today, puppeteers and ballad singers wait in abject lines outside development agencies for contracts to do message-loaded 'folk dramas'. Others have deserted the street and the courtyards altogether, preferring

to be called "stage artists", because prestigious academics have made them self-conscious about their 'art'. Too many have been forced to compromise traditional expression with the vulgar requirements of the drunken rich at weddings and qawwali evenings straight out of Bombay films.

Most continue to joint the wretched stream of the unemployed.

It is not that these performers have lost either a sense of discernment or their native skills. It is a question of survival - for the performers themselves and their timeless craft.

The result is confusion, lack of direction, and a debilitating sense that their skills are no longer of use. Perhaps, too, those who are concerned to see the city grow have not yet gauged the potential of such communities.

The wandering performing artists of this country must number in thousands, There has never been any census and nor have they been identified as a special group. Most of them have never benefitted from any development programme of the Government or other agencies for professionals. They remain scattered and forgotten, wandering from place to place and living wherever they can pitch up a ragged ten and put three stones to mark their hearth.

C. The Cooperative Society of Neglected and Forgotten Artists.

One hundred and fifty families of Delhi street performers had somehow managed to survive as a village community unitl their Shadipur Depot Jhuggi Colony was bull-dozed. Many have returned to Shadipur to camp in makeshift tents or on the open ground, but there is a constant threat of harrassment from the police and others without a vision. Under the current resettlement schemes of the Emergency resettlement, they will be evicted yet again and dispersed to far-flung colonies unless another alternative is found.

Resettlement itself is not under question, but how to make it work better, both for the Government and the people, is the main purpose behind this proposal.

In June 1977, to unite against impending dispersion and for recognition as traditional performers and craftsmen, the squatters of Shadipur Depot and elsewhere - the puppeteers, singers, magicians, acrobats, jugglers, musicians, toy and instrument makers, etc. - banded together to form India's first "Cooperative Soceity of Neglected and Forgotten Artists", the Bhoole Bisre Kalakar Sehakari Samiti.

The Cooperative is being registered as an Industrial Cooperation under the Cooperative Registration Act of India. The members are required to pay Rs. 50/- as share capital and Rs. 10/- as member entrance fee. Only traditional performing artists and craftsmen can become members of the group. The members are selected by a Selection Committee composed of the performers themselves. The office holders are elected by members. There are no outside patrons of Board of Directors. Those professionals interested in helping the Cooperative are called Friends, and receive Rs. 1/- honorarium. The Cooperative, however, can hire the services of any outside person according to the wishes of the Managing and General body.

The Cooperative today has about 60 members who have been selected and another 30 associate members who have paid their share capital. There are many more who have filled their forms and are collecting money to become members.

The members have already earned more than four times their share capital.

What the Cooperative has done so far :

June 1977

After holding several meetings with Government officials, media people, etc. for almost six months, the group finally decided to form themselves into an Industrial Cooperative. All other forms of Cooperatives could not cover the professional aims of our proposed members.

A unique function was held on the lawns of Smt. Kamala Devi Chattopadhyay's residence in the presence of about thirty guests and 150 performing artists.

July 1977

26 puppet shows sponsored by the Sangeet Natak Academy were distributed for Rs. 75/- each. The shows were performed in Public Hospitals, schools, and houses for handicapped and the aged. At the hospitals the members were also helped to get their medical examinations.

The Cooperative provided transport fees to groups who went for subsequent check-ups.

August 1977

The National Institute of Design contracted the Cooperative to perform in the Theme Pavilion of the Agri-Expo. A repertory of twelve types of shows was prepared and members earned from Rs. 50/- to Rs. 150/- each depending upon the programme required by the client.

contd.....6

January 1978

In the fall of 1977, the Guardian newspaper of U.K. wrote a one-page article on the functions of the Cooperative. As a result, the BBC sent a film production team from its World About Us series to film a 50 minute colour documentary on the social history of the group, and the formation and activities of theCooperative. The film is to be released in May 1978, and the Cooperative will receive a free print. Each member of the Cooperative earned Rs. 75/- from the film, and about Rs. 10,000/- was distributed to other performing artists from outside. Delhi.

The Cooperative participated in the PATA Conference by staging a most' unusual fair for the Taj Group of Hotels, . The show was held at the construction site of their forthcoming hotel in New Delhi. Every member, including associate members, received Rs. 125/- from the show. About 30 non-member performing artists from outside the Cooperative were also employed.

May - December 1978

A book on the tales of wandering performing artists and traditional craftsmen is being prepared for publication.

A format for puppet-training workshops is being prepared for educational institutions and development agencies.

The main task for the Cooperative is to start building Anandgram, the cultural village complex described in this proposal.

D. ANANDGRAM - " THE JOY VILLAGE ".

Recently, it has been a felt need that Tourism should also emerge out of its 'Five Star' western-oriented culture. Tourism itself is changing its value-patterns and shows an inclination to step out of highways, cabaret lounges and plush bars frequented largely by the local nouveau riche.

The New Tourist is here for more than a comfortable visual experience. He wants, however idealistically, to get into the 'soul' of the place: "The Real India". Too many already have been tempted to drive cadillacs into the village to catch a glimpse of "the vanishing past". Others have virtually converted villages into show-laces for tourist where the villagers themselves can be hired to demonstrate 'culture'. Needless to say, this is as damaging as it is unrealistic.

Yet the need for a 'rural experience' cannot be overlooked. We need to create an ethnic environment where professional showmanship is a way of life.

Anandgram, which is to be the pioneering project of the Bhoole Bisre Kalakar Cooperative will be a Cultural village complex to permanently house the families of the members,. To be situated on ten acres of land in convenient relationship to the city, Anandgram will include a complex of indigenous style habitat for 150 families, several courtyard theatres, a fok arts museum with special emphasis on puppetry and theatre crafts, and common facilities for handicrafts such as woodcarving, embroidery, pottery, straw-work, and the construction of toys and musical instruments. The Cooperative will promote these and other traditional skills through training courses and experimental workshops for popular performing arts. It will also maintain a hostel for itinerant folk artists that visit the capital from different regions of India. The complex will house a research component for indigenous cosmetics and homemade medical remedies. The complex will consist of market squares with craft shops and retail and wholesale outlets along with several street stalls for ethnic foods and spices. There will also be other community facilities to make the village more self-sufficient and self-sustaining.

The visitor to Anandgram, whether a tourist or a resident, will gain an immediate experience of the craft process. In addition, the complex would provide a ground for popular media that could actively feed the entertainment and information industries. Their skills already reach about 30,000 people a day, in and around Delhi.

Offering a continuing carnival of ethnic jhullas and other amusement circuses and a variety of lesser known performances, Anandgram will be an effective catalyst for the permanent reintegration of India's traditional popular folk performing artists and the urban community.

The most important factor to keep in mind at present is the urgency with which the project must proceed before the scattered and individual families begin to send down roots wherever they have been displaced to, and before they leave their Delhi base. At the moment, the people are ready to build. One hardly experiences such initiative for self-help housing.

E. BUDGET.

The project will be implemented in three stages :

A. Phase One - Preparation of a Comprehensive Scheme and Site.
B. Phase Two - Workshop for Review and Presentation of Scheme.
C. Phase Three - Construction of Village Complex.

This proposal requests initial funding for pPhases One and Two. Phase One will cover expenses incurred in locating a suitable building site and developing the comprehensive building plan. Phase Two, to begin after the completion of the comprehensive plan, is a special workshop on indigenous building techniques and human settlements to be held in Delhi . Professionals such as Dr. Hassan Fathy will be invited to analyse and review the work done. The workshop may be coordinated with organizations such as the National Institute of Design Ahmedabad and the All India Handicarafts Board. The purpose of the workshop will also be to prepare a multimedia portfolie for the presentation of the plan to prospective funding organizations and other interested people.

Cost estimates for Phase Three, the construction of the complex itself, will be determined after completion of Phases One and Two.

Phase One - Location of a Suitable Building Site and Preparation of Comprehensive Building Scheme.
Duration : 3 months.

1.	Salaries for Design Team - Architect, Civil Engineer, Design Consultant, Draftsmen, Graphic Designer, Master Masons, Theatre Expert, Crafts Consultant, Copy Writer, Secretary, Accounts Officer, Community Representatives, Project Coordinators :	Rs.	43,000
	(The above does not include Govt. Rep. Delhi Administration Tourism, Education, Culture, University etc.)		
2.	Rental for Office/Shed :		1,500
3.	Office Facilities and Supplies :		1,200
4.	Telephone, Postage, Telegrams :		3,000
5.	Model, Blueprints, Drawing Equipment for Exhibit of Plan :		5,000
6.	Display for Exhibit of Plan :		3,000
7.	Transportation :		6,000
8.	Miscellaneous and 10% Contingency :		7,300
	Subtotal	Rs.	70,000

Phase Two - Workshop and Presentation.
Duration : 15 days, New Delhi.

1.	Travel Grants and Per Diems for Dr. Hassan Fathy, two other international experts, & 15 professionals from India :	Rs.	80,000
2.	Rental of Workshop Premises :		5,000
3.	Honorariums to Performing Artists and Professionals to be included in the Presentation (about 80 people) :		15,000
4.	Mobile Stage Sets, Theatrical Props, Costumes, etc.		15,000
5.	Telephone, Postage, Telegrams, Stationery		1,500
6.	Transportation :		2,500
7.	Miscellaneous and 10% contingency :		11,000
	Subtotal	Rs.	130,000
	GRAND TOTAL	Rs.	200,000

SUNANDA MOBILE MEDICAL UNIT COROMANDEL K G F 563118

1. Background Information :
   1. Door No- / M. No. .....
   2. Street/Ward .....
   3. Hamlet .....
   4. Panchayat .....
   5. Taluk .....
   6 Serial No. of the Family .....
   7. Name of the head of the family .....
   8. Religion / Caste .....
   9. a] Type of house :
      Pucca [ ] Kuchca [ ] Hut [ ]
      d] Owned ( ) Rented ( )
   10 b] Electrified : Yes [ ] No [ ]

11. Family Members :

		Baseline	II	III	IV
Adult :	Male	.....	.....	.....	.....
	Female	.....	.....	.....	.....
Children :	Male	.....	.....	.....	.....
	Female	.....	.....	.....	.....
Total :		.....	.....	.....	.....

II. Environmental Sanitation :

A. Water Supply :

Source :- Within the House [ ]
Outside the House [ ]
Type :- Tap ( ) Protected Well [ ]
Pond ( ) Stream [ ]
Others :- [ ] Specify.
Condition of source.

B: Latrine :

Latrine in the house Yes ( ) No. ( )
If Yes, type :- Flush [ ] Service ( )
Pit ( ) open air [ ] Others ( )
Whether in use : Yes ( ) No ( )
Space available for construction :
Yes [ ] No [ ]
Willingness to construct : [ ] Yes/No ( )

C. Sullage Disposal :-

Soakage pit ( ) Drain ( )
Kitchen garden [ ] Stagnation [ ]
Others [ ] No arrangements [ ]

Refuse disposal :

Burning [ ] Manure pit [ ]
No arrangements ( )
Others ( ) Specify :-

III. Services in regard to Environmental Sanitation rendered during various visits,

A, Water Supply

Latrine ;

Sullage disposal

Refuse disposal

IV. Particulars of Members of the Family:-

S. No.	Names of the Family Members	Relationship	Year & Month of birth	Sex	Marital	Education	Occupation	Annual Income	Residential Status	Smallpox: Presence of pox marks (P)	Smallpox: reserve of scar marks	Immunisation status-If not done at first Survey, write 'No'. If done already, put date: B. C. G.	D. P. T. (0-5): I Dose	D. P. T. (0-5): II Dose	D. P. T. (0-5): Booster	D. T. (5-11): I Dose	D. T. (5-11): II Dose	D. T. (5-11): Others if any	Deficiency diseases if any	Suspected or Known Cases of Leprosy or TB. Leprosy: If Suspected duration	Leprosy: K. C. No.	Tuberculosis: If Suspected duration	Tuberculosis: K. C. No.	Remarks
1	2	3	4	5	6	7	8	9	10(a)	10(b)	11	12 A. B. C.	13 B.			14		15	16	17	18	9	20	21

V. Particulars of eligible couples in the family :

S. No. of E.C. in the family	Names of eligible couples	Ages of Husband and Wife	Living Children: No. including those living elsewhere: M.	F.	Youngest child: Age	Sex	Date & Nature of termination of last conception	Specify E. P. method in use if any-when, from, where?	If discontinued since when reasons	If changed over to other methods specify, when	If pregnant, pregnancy in weeks	If she had any abortions no. of abortions	Changing in eligibility starts with date	classification and Remarks
1	2	3	4 a	4 b	5	6	7	8	9	10	11	12	13	14

1. In III on the front page, enter the services rendered for the house, from time to time, under appropriate headings.
2. In IV, on the next page, in the column 2 enter all the members of the family unit starting with S. No. 1 as the husband (head of family) then, the wife and unmarried Children. Add other relatives who are permanently residing in the household.

Col. 3:- Enter relationship of each member to S. No. 1. (eg.) W/o 1, M/o 1, B/o 1, S/o 1 etc.
Col. 7:- State the level of education completed (eg.) M.A.,B.Ed., 1st year Arts, 9th std. and so on.
Col. 8:- Occupation F for farmer, W for weaver, SK for keeper T for teachers, L for casual labour such as cooly, carpenter, mason etc., g.s. for govt. servant.
Col. 10 [a] If small pox marks are present put down P. If vaccination scars are seen, put S 1 or S 2 S 3 S 4 according to number of scars found
Col. 16:- If Vit. 'A' deficiency is seen, put A. If B deficiency B. Protein calorie malnutrition - PCM, Kwashiorkar - K, Marasmus - M, Anaemia - An
In col. 21, Mention where treatment is being given - Government (Govt.) or Project (Pjt)

3. In VI, below the date and month of each visit note the services rendered for each member of the family, using the following abbreviations for the several services :- F (fever) B (blood smear) D (drugs given for fever) F. P. (Family Planning) D. P. T., T. D., B. C. G., etc. for the various immunisations, V. S. for birth & death recording, E. I. epidemic intelligence, A. N. C. & P. N. C. (antenatal & post natal care) N. for nutrition services. Tt for Tb for treatment of Tuberculosis; Tt for Lep. for, treatment of Leprosy, Tt for MA., for, treatment of Minor Ailments

Months and dates of visit

Month and date of visits	Sl. No. of eligible couples	Family Planning Educational activities carried out	Family Planning services rendered arranged/accepted	Month and date of visits	Sl. No. of eligible couples	F. P. educational activities carried out	F. P. Services rendered/ arranged/accepted

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SUNANDA MOBILE MEDICAL UNIT COROMANDEL K G F 563118

I. Background Information :

1. Door No- / M. No. .....
2. Street/Ward .....
3. Hamlet .....
4. Panchayat .....
5. Taluk .....
6. Serial No. of the Family .....
7. Name of the head of the family .....
8. Religion / Caste .....
9. a] Type of house :
   Pucca [ ] Kutcha [ ] Hut [ ]
   d] Owned ( ) Rented ( )
10 b] Electrified : Yes [ ] No [ ]

11. Family Members :

		Baseline	II	III	IV
Adult :	Male	.....	.....	.....	.....
	Female	.....	.....	.....	.....
Children :	Male	.....	.....	.....	.....
	Female	.....	.....	.....	.....
Total :		.....	.....	.....	.....

II. Environmental Sanitation :

A. Water Supply :

Source :- Within the House [ ]
Outside the House [ ]

Type :- Tap ( ) Protected Well [ ]
Pond ( ) Stream [ ]
Others :- [ ] Specify.

Condition of source.

B: Latrine :

Latrine in the house Yes ( ) No. ( )
If Yes, type :- Flush [ ] Service ( )
Pit ( ) open air [ ] Others ( )
Whether in use : Yes ( ) No ( )
Space available for construction :
Yes [ ] No [ ]
Willingness to construct : [ ] Yes/No ( )

C. Sullage Disposal :-

Soakage pit ( ) Drain ( )
Kitchen garden [ ] Stagnation [ ]
Others [ ] No arrangements [ ]

Refuse disposal :

Burning [ ] Manure pit [ ]
No arrangements ( )
Others ( ) Specify :-

III. Services in regard to Environmental Sanitation rendered during various visits,

A. Water Supply

Latrine :

Sullage disposal

Refuse disposal

IV. Particulars of Members of the Family:-

S. No.	Names of the Family Members	Relationship	Year & Month of birth	Sex	Marital	Education	Occupation	Annual Income	Residential Status	Smallpox: Presence of pox marks (P)	Smallpox: reserce of scar marks	Immunisation status-If not done at first Survey, write 'No'. If done already, put date: B. C. G.	D. P. T. (0-5): I Dose	D. P. T. (0-5): II Dose	D. P. T. (0-5): Booster	D. T. (5-11): I Dose	D. T. (5-11): II Dose	D. T. (5-11): Others if any	Deficiency diseases if any	Suspeted or Known Cases of Leprosy or TB.: Leprosy: If Suspected duration	Leprosy: K. C. No.	Tuberculosis: If Suspected duration	Tuberculosis: K. C. No.	Remarks
1	2	3	4	5	6	7	8	9	11(a)	10(b)	11	12 A.B.C.	13			14		15	16	17	18	9	20	21

V. Particulars of eligible couples in the family :

S. No. of E.C. in the family	Names of eligible couples	Ages [of Husband and Wife]	Living Children: No. including those living elsewhere: M.	Living Children: No. including those living elsewhere: F.	Living Children: Youngest child: Age	Living Children: Youngest child: Sex	Date & Nature of termination of last conception	Specify E. P. method in use if any-when, from, where?	If discontinued since when reasons	If changed over to other methods specify, when	If pregnant, pregnancy in weeks	If she had any abortion's no. of abortions	Changing in eligibility starts with date	classification and Remarks
1	2	3	4[a]	4[b]	5	6	7	8	9	10	11	12	13	14

1. In, III on the front page, enter the services rendered for [redacted] house, from time to time, under appropria[redacted]eadings.
2. In IV, on the next page, in the column 2 enter all the members of the family unit starting with S. No. 1 as the husband (head of family) then, the wife and unmarried Children. Add other relatives who are permanently residing in the household.

Col. 3:- Enter relationship of each member to S. No. 1, (eg.) W/o 1, M/o 1, B/o 1, S/o 1 etc.
Col. 7:- State the level of education completed (eg.) M.A.,B.Ed., 1st year Arts, 9th std. and so on.
Col. 8:- Occupation F for farmer, W for weaver, SK for keeper T for teachers, L for casual labour such as cooly, carpenter, mason etc., g.s. for govt. servant.
Col. 10 [a] If small pox marks are present put down P. If vaccination scars are seen, put S 1 or S 2 S 3 S 4 according to number of scars found
Col. 16:- If Vit. 'A' deficiency is seen, put A. If B deficiency B, Protein calorie malnutrition - PCM, Kwashiorkar - K, Marasmus - M, Anaemia - An
In col. 21, Mention where treatment is being given - Government (Govt.) or Project (Pjt)

3. In VI, below the date and month of each visit note the services rendered for each member of the family, using the following abbreviations for the several services :- F (fever) B (blood smear) D (drugs given for fever) F. P. (Family Planning) D. P. T., T. B., B. C. G., etc. for the various immunisations, V. S. for birth & death recording, E. I. epidemic intelligence, A. N. C. & P. N. C. (antenatal & post natal care) N. for nutrition services. Tt for Tb for treatment of Tuberculosis; Tt for Lep. for, treatment of Leprosy, Tt for MA., for, treatment of Minor Ailments

Months and dates of visit

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SUNANDA - COROMONDAL - KGF 563 118

30-18

INDIA

" I bring you news of great joy,
a joy to be shared by the whole people."

- Luke: 2/10

About one hundred kms East of Bangalore, the capital of Karnataka in South India, we have Kolar Gold Fields, a golden place with the deepest pit in the world; golden with the sincere hearts of simple folks; golden with a rich harvest of huts and hovels, labour and poverty; a place where Christ the Liberator would easily have been born. Well in such a golden place, in 1970, at Coromondal was 'SUNANDA' born.

S U N A N D A (means) THE BRINGER OF JOY

The joy of truth
The joy of justice
The joy of peace
The joy of love
The joy of liberation of the whole man.

This is the mission of Jesus Christ. This is the objective of Sunanda: to continue the mission of Jesus Christ.

SIMPLE BEGINING:

Sunanda was actually nameless for five years, though her institutes of Commerce (Shorthand and Type-writing) and Tailoring worked under the name of 'SARAL NIKETAN' meaning 'HOME OF SIMPLICITY'.
Another strange thing about Sunanda is that she started her work with School teachers and with young men and women who had no special qualification for Social work- except the conviction of the necessity to transform the Society with dedicated work.

TRAINING:

In 1976, Sunanda started training her members by Short courses in India and other countries, through scholarships from DRF, COADY, CAFOD, SEARSOLIN and CISRS and through Sunanda Funds.
To-day, she has forty in her team, twenty three men and seventeen women. Another five are undergoing training in Community Development and Organisation at Madurai and Bombay.

SUNANDA DAY:

Jesus Christ, the Supreme Liberator and Victor, is her model and fittingly enough the Easter Day, the day of final triumph of Jesus Christ over death and the dark forces of this world was chosen early in 1981, as the Sunanda Day, for Sunanda too is trying to overcome the dark forces of this world and bring the joy of Liberation to the people.

I. SUNANDASHRAM: (1970-1971)

This is the 'Temporary Relief Home' for children from broken homes, complete orphans and a few who are really in great need of help. They are 15 at the moment. They live with a house mother. They study in different Schools and live in a rented house. They are settled when they are of age. OURS is supporting them partly and some well--wishers are of help.

II. INSTITUTE OF COMMERCE: (1972-1973)

There are about 200 students both for Type-writing and Shorthand. It is recognised by the State Government. It is self supporting. It was helped by ICSSS and CARITAS INDIA in the initial stages. We have a library attached to this Institute which is becoming a Circulating library.

III. INSTITUTE OF TAILORING: (1972-1973)

We are having very informal training for the poor children and Youth. During 1974-1975 it became partly a production centre which provides job- full time or part time depending on the amount of orders we get. Just like the above Institute of Commerce it was aided by Caritas--India and ICSSS at the initial stages. Every effort is being made to make this Institute self supporting.

The special features of the above 3 institutions are that, we meet every student and guide him in his problems- among these students was started the YOUTH ORGANISATION which has contact with many Youth Groups in the Mining area and in the Rural areas. Leadership training is given to these young men. Sports and games are conducted- Career guidance is also given.

SUNANDA SAVING SCHEME: (1981)

Which at the moment is being re-organised, was also started among the above students. Today classes are being conducted to different groups regarding the necessity of Wise spending and planned Saving and it stands open for all in the Mining and Rural areas.

IV. CCF - FHP: (1972)

This is sponsorship programme which helps about 380 families in different areas. Though it is very helpful to these particular families, it makes it difficult to organise the whole community since very few only are in this programme. So we have started substiuting widows, widowers and handicapped. We hope that it becomes a Community oriented programme.

V. HEALTH AND NUTRITION: (1975).

Along with curative Health programme, much stress is given to preventive health programme. Regular education and demonstration classes are given and Health Camps are being conducted with the help of the Government Primary Health Centre and a local Doctor from the Mining-

Hospital. We work hand in hand with the PHC for programmes like Immunization, pre-natal and Post-natal care etc. Our team works in about 22 villages teaching them the value of Herbal Medicines and is training one or two persons from each village for further continuity of this programme..Classes are being conducted in the sheds put up by CIDA. In 1978 Caritas India helped us with an Ambulance and initial expenses. From March 1980 Christian Aid has given us full support and encouragement for its extensive services.
It was CRS that helped us for the MCH programme from 1975. Then CASA entered our villages in March 1979 to decrease the infant mortality with the co-operation of the community. Caritas Neerlandica sends Milk powder which together with CASA helps the growth of children. Occasionally we recieve medicines from DRF and CMMB. We have registered our Health work with CHA - New Delhi.

VI. NON- FORMAL EDUCATION: (1979)

This is being conducted in 40 centres both in rural and Mining areas. There is much concentration on Social Awareness and Social Action. The Animators are being trained regularly. 10 more centres 40 kms away from our village will be started on the 1st of May 1981.
A cultural group is under formation which goes round for street plays depicting the present situation of the village and of the country- thus paving the way for Group Action. This is supported by CEBEMO through AICUF. Our hope is to cover the whole Taluk within 5 years.

VII.COMMUNITY ORGANISATION: (1980)
This team which was supported by CISRS for its training, straightaway contacted the communities starting from one village to the other- was able to form Panchayats (local Governing body) approved by the Government. A few Panchayats, together, have formed one Association called ROSI (Responsible Organisation for Slum Improvement). Through this registered ROSI, people have succeeded in approaching and obtaining from the Municipal and Government authorities their rights regarding water, light etc., ROSI hopes to gather a number of villages under her wing to get her fair share of rights and human dignity.

VIII.SUNANDA SCHOLARSHIP SCHEME: (1980)

With the help of Caritas Neerlandica, Sunanda was able to help 30 young men and women to get themselves trained in job-oriented courses. It hopes to build up a revolving fund by 1985 with the repayment of loan either partly or fully from the beneficiaries.

IX. SUNANDA MYTHRI SAGAR: (1980)

As years went by Sunanda felt that she needs a centre to gather her members for ~~evaluation~~ orientation, planning and evaluation regarding her objective, retreats, seminars for herself as well as for other groups and to have it as a home of Friendship and Fellowship. So She

has provided a temporary shed in one portion of the property belonging to the Resource Farm and named it 'MYTHRI SAGAR' meaning 'AN OCEAN OF FRIENDSHIP'. We have all our quarterly meetings, camps, orientations and retreats for different groups. We do hope that this place will be a centre to experience God's love and Communion among his people.

X. AGRICULTURE: (1980)

Our working in so many villages brought home to us very clearly the need to organise the farmers, Sunanda's long felt need was to build up a Resource Fund for its future - placing both these thing together we purchased some land along with a house, with the help of Caritas Neerlandica in 1979. The three staff we have at the moment are for the Resource farm as well as for the organising of farmers. Relationship with the farmers is being built up. We have not had any rain for the past 2 years. Our District is declared as drought area. So no work has been started yet. Here again we have sought expert guidance from ICAR through our Government Agriculture office and OXFAM.

XI. WOMEN'S ORGANISATION: (1981)

Because of our Health Programme, Non-formal Education, Youth Organisation and Community Organisation the need to form an Association of Women took birth. 4 Groups have been formed. There are plans to start co-operative Home Craft, etc. above all to make them aware of the oppressive structures and traditions of Society regarding women and to encourage them to unite and initiate them to action.

In the near future YMCA will join hands with Sunanda in its continuous and constant effort to build a just Society.

Sunanda is grateful to all her benefactors including those whose names are not mentioned and ever remembers them as she proclaims the Good News of Liberation especially among the Poor and Oppressed.

" Bring us out of the prison of Self and Security Lord
that we may go forth to proclaim the Good News. "

Date: 16-4-1981.

TSR/