EV - 10

A REVIEW OF PROCESSES IN IMPLEMENTATION OF THE CHILD SURVIVAL AND CHILD DEVELOPMENT (CSCD) PROJECT OF THE CHRISTIAN MEDICAL ASSOCIATION OF INDIA

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C O N T E N T S

EXECUTIVE SUMMARY

A PROCESS REVIEW of CMAI's Child Survival and Child Development project was done at the end of the current phase covering 25 micro-projects, between March and May 1996. Twenty two (22) of the twenty five (25) microprojects were visited and studied during this period, with preliminary, quantitative data analysis done in a two-month phase earlier. The compiling, reporting, etc., was completed in the month following the field visits.

The service component is well-tried, tested and established as a workable model, addressing the varied needs of the poor scattered all over the country - at a low cost.

The abililty of non-hospital-based development and service organisations to take up such work for children and mothers, creating awareness and promoting participation in services available from the Government and Voluntary agencies in the area has been confirmed. The needed training, monitoring and technical support have been well-planned and delivered.

The direct contact with people in need and raising of awareness levels and participation abililties have emerged as the highlights of the project - as seen on field.

The microprojects implementing the CSCD project have also been enabled to identify and initiate other health-related activity depending on local needs - eg. logical extension of child care beyond two years of age / non-formal education of mothers for health / reviving of traditional and home-based remedies for minor ailments / nutrition education, supplementation and other technical support, etc.

Discovering of the complexity of factors affecting health and promoting action according to peoples' needs has delayed microproject initiatives towards sustainability of the CSCD component.

The working conditions at microproject level being far from ideal, the three year phase of support planned for CSCD needs to be extended for a further period of two to three years to make the efforts truly fruitful.

Further training and networking within the microprojects and with Government and Voluntary agencies is needed to meet the emerging needs of the people, in areas of - First-aid / Minor ailment management / Integrating into other development activity, etc.

Decentralization, Communication in regional/local language and generation of locally relevant health education material are logistic problems which need to be addressed, considering the scattered and remote location of microprojects.

B A C K G R O U N D:

The CMAI has taken up the Child Survival and Child Development project
- as part of its broader approach to Community Health;
- to enable non-hospital based agencies working in other areas development to take up health as an area of concern; and
- to evolve a demystified/simple approach addressing the most needy among people in an area of work that could make a visible/palpable impact on their lives - viz. in taking care of their children.

This project is implemented through 25 micro-projects attached to voluntary agencies who have taken up social-service as an activity, all over the country.

An earlier phase covering 50 projects was tried, and monitored between 1988 and 1991. This was evaluated for suitability of approach, and for learning in early 1991.

The present phase was started between 1993 and 1994, selecting suitable organisations, training the personnel from micro-projects and monitoring their progress over 2 1/2 to 3 years.

A need to review the 'processes' generated by the CSCD project was felt towards the end of the planned 3-year phase to deepen the understanding of this 'intervention'.

The Community Health Cell was informed of this, and Dr. Shirdi Prasad Tekur who had earlier been involved lin the 1991 study-evaluation, agreed to take it up between March to May 1996.

This 'Process-review' is a study of these projects from documents, field-visits and discussions with the micro-project personnel and people at these locations.

PROCESS AND METHODOLOGY ADOPTED

Preliminary activity:
An initial meeting in mid-February between the reviewing team and CMAI personnel evolved a plan of action for the review, keeping in mind the review needs. Over the week, the following were done -

a) A travel plan to cover 22 of the 25 projects between 18th March '96 to 6th May '96.
b) An overview of each project prepared from available documents, and
c) The most suitable methodology that could be adopted to cover the needs of the review.

While a) and b) above were handed over to the Programme Officer CSCD, c) was evolved by the reviewer in consultation with colleagues and other library material on why? how? etc. of such a review.
(Ref. Appendix - A)

By end February 1996, the Programme Officer CSCD CMAI had
- prepared overviews of each project which were studied,
- analysed all quantifiable data from the microprojects, and
- informed micro-projects about field visits and what was planned, making necessary travel, stay and financial/adminis -trative arrangements for the same.

(Ref. Appendix -B for Map with project locations, Travel schedule, etc.)

Meanwhile, a format for the process review planned was made and approved.

Confirmation and review of all the above was completed three days prior to the field visits, which started on 18 march '96.

Field Visits:
Field visits were made as planned to all 22 micro-projects by
- the reviewer - Dr. S.P. Tekur; and
- the CSCD Programme Officer - Mr. Justin Jeba Kumar, and,
- Ms. Reena K. Nair, a CHC Associate, who accompanied and helped the team during 8 project visits in South India.

During micro-project visits, the review team
- reviewed documents at the micro-project HQs, and discussed problems faced in documentation/reporting,
- visited field areas covered by micro-project and interacted with project personnel, people directly involved by the CSCD project and others.
- discussed with the project implementors and their Board, and
- prepared concise notes for purposes of the report at the end of each project visit.

PEOPLE/PERSONS MET/TALKED WITH during field visits

A.	YMCA Board members/others related to the project not directly implementing CSCD	- 66
B.	CSCD Project Executive members viz: CEOs and PMs	- 31
C.	CHVs employed part/full-time to implement CSCD project	- 76
D.	Other Health Professionals in area connected or not to CSCD Project	- 19
E.	Pregnant women and mothers influenced by CSCD Project	- 187
F.	Other village persons not connected with CSCD	- 192
	TOTAL	- 571

- Details of personnel interacted with and areas of questioning are in Appendix-C.
- Details of observations, and discussions at the micro-projects are recorded separately for each project.
- Appendix D -(Details of 22 micro-projects)

Reporting:

Following the project visits, ending 06 May '96, the review team of Dr. S.P. Tekur, and CSCD Programme Officer, Mr. Justin Jebakumar met
- the Co-ordinator, Community Health Department,
- the Community Health team members, and briefed them about the impressions gathered prior to finalizing the review report.

The finalized report prepared by the reviewer was circulated in draft form to all these members of the field review team to consolidate and confirm
- the format of reporting, and its contents,
- the completeness of the document, and
- to add to/modify/elaborate on aspects which need mention to make this review - useful.

This process reached the last week of May 1996. The draft was circulated to all the review team members and CMAI, and finalised by end-June 1996.

APPENDIX 'A'

REVIEW OF PROCESSES OF IMPLEMENTATION OF CSCD PROJECTS

The CSCD project of CMAI has been conceived and implemented as an innovative approach to Community Health with the objectives of

- introducing simple, low-cost and effective health interventions that can help women and children in the community.
- focussing on communities of low socio-economic groups predominantly in rural areas, and
- ensuring that all children born in the community reach their second birthday.

The project is implemented in the current phase as 25 micro-projects across the country, each working with an identified community of approximately 5000 or more population, with a high Infant Mortality Rate and between 100-150 births occuring each year. The life of each micro-project is three years.

A participatory study-evaluation of 50 minor projects in an earlier phase was done in 1991 confirming the ability of such attempts to address the objectives adequately.

The CSCD project is part of the CMAI's broader approach to Community Health

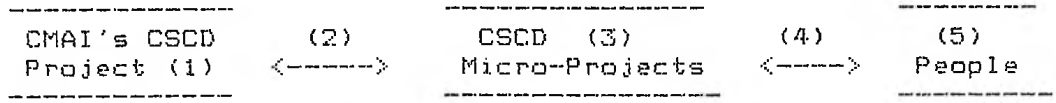
- Believing that people have an important role to play in their own health, and that
- non-hospital based Christian and Social agencies already working with people in various areas could take up health work also even if they do not have any prior experience in health related activities.

The project focusses on these aspects in its approach, design and implementation, as seen in the study of 1991 cited earlier.

PROCESS REVIEW METHODOLOGY

A review of the PROCESS of implementation in the project's current phase covering 25 micro-projects will be therefore pre-dominantly qualitative, with quantitative data analyzed to offer support or otherwise to it, since adequate quantitative data is already available as part of the implementing and monitoring mechanisms of the project.

The Review will consider the processes between and within the following three key groupings of the project.



1. CMAI's CSCD PROJECT: to consider

   a. Importance of CSCD project in its CH approach.
   b. CSCD Program Officer - role, responsibilities & Processes set up to tackle these.

2. CMAI's LINKS WITH THE MICRO-PROJECTS

   a. Process through the Program Officer like
      - identification of projects
      - training of personnel at micro-projects
      - reports, returns and follow-up on them,
   b. Training, Support and Monitoring activities,
   c. Any other - Resource mobilization and Networking.

3. CSCD MICRO-PROJECTS

   a. CEO's, Project Managers - Roles, Responsibilities, activities,
   b. Community Health Volunteers,
   c. Integration efforts into other activities of the micro-project.
   d. Documentation, information sharing.

4. MICRO-PROJECT LINKS WITH PEOPLE

   a. Community organisation and participation for Health - How?
   b. Information dissemination - modes and effectivity,
   c. Services offered - nature, need and effectivity,
   d. Steps taken for sustainibility.

5. PEOPLE

   a. How people view and utilize the CSCD attempts,
   b. Acceptance, Appropriateness of CSCD project,
   c. CSCD impact/effect on internal processes already operating in the community.

In the above format, the process review will have to consider persons and processes these persons are involved in from the project and individual points of view.

Persons will be interviewed in an open-ended manner in the spirit of a "shared interview', where both interviewer and interviewee make a joint search for a genuine, hsared understanding of the processes seen/evolved during CSCD project implementation.

All aspects of the CSCD project will be explored during the interviews, and evidence looked for in quantitative or qualitative terms to substantiate the shared understanding, eg.,

1. The history and evolution of the project.
2. The Information and services planned, provided and problems, solutions evolved etc.
3. The utility and effectiveness of links with CMAI and the people for the project goals.
4. Innovations, setbacks and other such variations seen in project implementation.

Specific other areas that will be covered during the interview will include both positive and negative aspects of

- Evidence pointing to ENABLING AND EMPOWERING processes.
- Evidence pointing towards SELF-SUSTENANCE processes.
- Signs of commitment, cohesion and solidarity to CSCD goals.
- Improvement in Technical competence, and Managerial ability.
- Capacity for collective reflection, analysis and action.
- Flexibility in approaches to suit local needs.

These are likely to yield pointers on MECHANISMS and DIRECTIONS of the processes in the CSCD projects.

Apart from these, the CSCD micro-projects attempts will be influenced by

a. Other/External processes in the Community which influence the project i.e., governmental/NGO activity in the area that help/retard project activity.
b. Processes within the Community itself which will be influencing/influenced by the CSCD project.

Being a qualitative review, other interesting directions/process independent of the CSCD project, goals/intentions which may have occured will also be looked for.

APPENDIX 'B'

TRAVEL SCHEDULE FOR CSCD PROJECT EVALUATION

DATE	TRAVEL DETAILS
18.3.96	Bangalore to Mysore by Bus Visit Mysore Rural Development Project Mysore to Bhadravathi by Bus
19.3.96	Visit YMCA Bhadravathi Project. Stay.
20.3.96	Bhadravathi to Davangere by Bus.Project visit. Stay.
21.3.96	Continuation Project visit. Davangere to Bangalore by Bus.
22nd & 23rd	Bangalore - discussion & further planning.
24.3.96	Bangalore to Adoni by Bus
25.3.96	Visit Adoni Area Rural Development Project Adoni to Hyderabad by Bus.Stay.
26.3.96	Visit YMCA - Narayanguda Project.Stay.
27.3.96	Hyderabad to Vijayawada by Train Visit SAMATA project
28.3.96	Continuation of Project Visit. Vijayawada to Vizag by Train.Vizag to Koraput by bus.
29.3.96	Project visit - YMCA Koraput
30.3.96	Koraput to Bhilai by Train Visit YMCA - Bhilai. Stay at Bhilai
1.4.96	Bhilai to Amaravathi by Bus.Stay.
2.4.96	Visit Rural Evangelical Mission Project Amaravathi to Nagpur by bus.
3.4.96	Return to Delhi/Bangalore

II PHASE

15.4.96	Bangalore to Madurai by Train
16.4.96	Madurai Project Visit Madurai to KanyaKumari by bus. Stay.
17.4.96	Visit YMCA Mullankinavilai & YMCA Moolanchal
18.4.96	Visit Vinnarasu Association. KanyaKumari to Madras by Train.
19.4.96	Madras YMCA Boys' Town visit. Stay.
20.4.96	Madras to Calcutta by air & stay.
21.4.96	Calcutta to Silchar by air. Silchar to Aizawl by bus.
22.4.96	Visit YMCA Tanhril. Stay
23.4.96	Visit Salvation Army & YMCA S.Hlimen
24.4.96	Visit YMCA Zemabawk & YMCA Lungdai
25.4.96	Aizawl to Silchar by bus
26.4.96	Silchar to Imphal by air Imphal to Yaripok by bus. Stay.
27.4.96	Visit STNBA Project. Yaripok to Imphal. Stay.
28.4.96	Imphal to Kohima by bus. Stay.
29.4.96	Kohima to Chizami by van.
30.4.96	Chizami to Dimapur. Stay
02.5.96	Dimapur to Calcutta by air. Calcutta to Patna by train
03.5.96	Visit YMCA Patna. Patna to Delhi by train.
04.5.96	Stay at CMAI, New Delhi. Consolidating Visit Reports.
06.5.96	Meeting with CMAI Community Health Team.
07.5.96	New Delhi to Bangalore by air

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FORMAT - SELF ADMINISTERED QUESTIONNAIRE

-1-

	AREA	INDIVIDUAL SCORE	WEIGHTAGE	TOTAL SCORE
1.	Training	10	2	20
2.	Community Org. & participation	12	1.25	15
3.	Staff	10	1.2	12
4.	Health Education	9	1.11	10
5.	Health Services	51	0.196	10
6.	Sustainability	9	1.11	10
7.	Development Prog.	24	0.416	10
8.	MIS	4	2	8
9.	Financial Report	3	1.66	5
				100

The format in detail is enclosed.

I. Training

a. Project co-ordinator/Manager attended
- No review meeting 0
- 1 review meeting 1
- 2 review meeting 2
- 3 or more review meeting 3

b. Percentage of CHVs trained
- 50% 1
- 75% 2
- 100% 3

c. CEO attended meeting with CMAI
- none 0
- one 1
- all 2

d. Project co-ordinator/manager trained at RUHSA / Jamkhed
- No 0
- Yes 2

Max. score 10
Multiply with 2

II. Community participation/organisation

a. Mahila Mandal or womens' co-operative
- Formed 1
- Registered 2

b. Other functionary groups (eg. Youth/farmers)
- Formed 1
- Active 2

c.	Local advisory committee formed	1
	Meets once a year	2
	Meets twice a year	3
	Meets twice or more per year	4
d.	Representation of women in local advisory committee	
	nil	0
	upto 30%	1
	31 % to 50%	2
	more than 50%	3
	Max. score -	12

Required 15 Multiply total score with 1.25

III. Staff

a.	Staff in position	50%	1
		75%	2
b.	Staff continuing in the program since inception		
		50%	1
		75%	2
c.	Percentage of staff skilled	50%	1
		75%	2
d.	Project co-ordinator/manager's understanding of the objectives		
		nil	0
		fair	1
		good	2
c.	CHVs understanding of their role		
		nil	0
		fair	1
		good	2
		max. score	10
		multiply with	1.2

IV. Health Education

a. Topics covered in one year (expected 12 per year)

Less than 15%	0
15 - 25%	1
26% - 50%	2
More than 50%	3

b, Health education sessions held per month
(expected 4 per month per CHV)

Less than 10%	0
10% - 25%	1
26% - 50%	2
more than 50%	3

c. Participants at the session
(Expected 10 per session
So, 10 x 4 = 40 per month per CHV)

less than 25%	1
26 - 50%	2
more than 50%	3

Max.score 9
Multiply with 1.11

V. Health Services
a. Maternal care
Women receiving 3 visits by a professional

less than 30 %	0
30 - 49 %	1
50 - 74%	2
75% and more	3

Women receiving full TT coverage

less than 30%	0
30% - 49%	1
50% - 74%	2
more than 75%	3

Deliveries conducted by trained personnel

less than 30%	0
30 - 49 %	1
50% - 74%	2
75% and more	3

b. Care of under 1
Infant exclusively breast-fed upto 6th month

40%	1
60%	2
90%	3

Infants weaned at 5 months of age

40 %	1
60%	2
90%	3

Immuni ion -
BCG coverage

40%	1
60%	2
90%	3

3 OPV coverage	40%	1
	60%	2
	80%	3
3 DPT coverage	40%	1
	60%	2
	80%	3
Measles coverage	25%	1
	50%	2
	75%	3

c. Care of under 2

Children with diarrhea received ORS

50 - 74%	1
75 - 89%	2
90 % & above	3

Vit.'A' supplementation given to

25 - 49%	1
50 - 74%	2
75 % & above	3

ARI cases identified and reported 1
Appropriate action taken 2

Growth monitoring
(Give maximum score only)

50 % childrdn weighed once in 3 months	1
75 % " " "	2
50 % children weighed once in 2 months	3
75 % " " "	4

Malnutrition

50 % suffer from any degree of malnutrition	0
25 % " " " "	1
10 % " " " "	2

d. Family planning :-

Women accepting family methods post delivery
(New acceptors)

25% - 39%	1
40% - 49%	2
50 % and more	3

Couples practicing temporary methods for more than 10 months
(denominator - all uses of temporary method)

25 - 39%	1
40 - 49%	2
50 % and more	3

e. Minimum Medical care available		1
	not available	0
	Maximum score	51
	Multiply with	0.196

VI. Sustainability

a. Financial contribution by Church/Agency		
	50%	0
	51 - 60%	1
	61 - 75%	2
	more than 75%	3
b. CHVs salaries as a percentage of total budgeted salaries		
	25 - 39%	1
	40 - 49%	2
	50 and more	3
c. Government support	No	0
	Yes	1
Other NGO support	No	0
	Yes	1
Support from Church bodies		
	No	0
	Yes	1
	Total =	9
	Multiply with	1.11

VII. Development activities

a. Vocational training started		
	10 people participate	1
	15 " "	2
	20 " "	3
b. Bank loan is available		
	5 families benefitted	1
	10 " "	2
	15 " "	3
c. Village crafts started		
	5 families benefitted	1
	10 " "	2
	15 " "	3

d. Govt. programms introduced

5 families benefitted	1
10 " "	2
15 " "	3

e. Assistance available from other NGOs

5 families benefitted	1
10 " "	2
15 " "	3

f. Beneficiaries of loan or training employed or self employed

Less than 25%	0
25 - 39 %	1
40 - 49 %	2
50% and more	3

g. Adult education / nonformal education started

10 people benefited	1
15 " "	2
20 " "	3

h. Other developmental activities started Environmental upgradation eg.
- afforestation
- smokeless chula
- construction of toilets etc.

5 families benefited	1
10 " "	2
15 " "	3

Max. score	24
Multiply with	0.416

VIII. MIS

a. Registers maintained	1
b. Reports received regularly	1
c. Quality of reports good	2
Max. score	4
Multiply x 2	

IX Financial Report

a. Report sent regularly	1
b. audited statement sent	2
Max. score	3
Multiply with	1.66

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sh/kd

CSCD PROJECTS ANALYSIS DETAILS - (STATEWISE)

LOCATION	TOTAL	PERFORMANCE RANKING				REMKS
		GOOD	A.AVER	AVER.	POOR	
RURAL	23	5	7	5	6	
URBAN	2	-	1	1	-	
	25	5	8	6	6	
			STATES			
A.P.	4	2	2	-	-	
T.N.	5	2	3	-	-	
KARNATAKA	3	1	2	-	-	
MAHARASHTRA	1	-	1	-	-	
M.P.	1	-	-	-	1	
ORISSA	1	-	-	-	1	
H.P.	1	-	-	1	-	
RAJASTHAN	1	-	-	-	1	
BIHAR	1	-	-	-	1	
MANIPUR	1	-	-	1	-	
NAGALAND	1	-	-	1	-	
MIZORAM	5	-	-	3	-	
TOTAL	25	5	8	6	6	

C S C D PROGRAMME - DETAILS OF TRAINING

S.No.	Dates	No.of Days	Venue	No.of Participants
1	09-13.03.93	05	Bangalore	23
2	06-10.08.93	05	Aizawl	34
3	24-28.08.93	05	Madras	56
4	07-10.11.93	04	Mussouri	26
5	21-22.03.94	02	New Delhi (CEOs)	16
6	22-24.10.94	03	New Delhi	11
7	22-24.11.94	03	Aizawl	29
8	23-25.02.95	03	KanyaKumari	41
9	25-26.10.95	02	New Delhi (CEOs)	16

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Topics covered during training for CSCD projects

- Pre & Post test questionnaires administered.

01. Primary Health Care and its principles
    Community Based Health Care
02. Ante-Natal Care
03. Child birth and complications
04. AIDS and Community Response
05. Post-Natal Care/Breast feeding/Immunization/Diarrhoea/ORS.
06. Child Development/Growth Monitoring
07. Family Planning
08. Community Organisation & Participation
09. Field Visits
10. Community Health Volunteers & their responsibilities
11. Sustainability of CSCD Programmes
12. Individual project assistance.

Resources Used - CMAI Staff Resource
- Local resource from area (Medical personnel on Medical topics)
- CSCD project CEOs sharing of experience.

CSCD PROJECT'S ANALATEMENT 1993 & 1994

1994

ñSLñNAME OF PROJECTS	No. P	2ñ	3 AN	No. B	No.de	BCG	DPT/OPV1	DPT/OPV2	DPT/OPV3	Meas	Vit	Boos	FP - T
ñ ñ													
ñ1 ñSocio Economic Devet.	76	76ñ	66	59	2	63	59/58	61/57	61/57	58	57	—	59/48
ñ2 ñRural Evangelical Mission	74	57ñ	51	73	1	169	177/177	169/169	173/173	155	2/3	151	1026/96
ñ3 ñYMCA - Bhilai	—	—	—	-	-	-	-	—	—	-	-	-	-
ñ4 ñYMCA - Bhadravathi	102	41	102	77	6	53	41/41	39/39	39/39	—	51	39/39	48/23
ñ5 ñYMCA - Davangeri	120	88	88	89	3	98	93/93	79/79	80/80	42	300	39/39	—/15
ñ6 ñYMCA - Narayanguda	39	56	13	52	—	64	78/78	54/54	54/54	73	56	26/26	145/41
ñ7 ñAdoni Area Rural Devt.	130	16	4	102	2	80	76/76	75/75	60/60	46	50	—	23/23
ñ8 ñYMCA - Korraput	34	34	25	30	1	27	27/27	36/36	37/37	—	—	—	—
ñ9 ñYMCA - Mullankinavilai	79	67	69	72	1	72	36/37	46/30	37/35	48	75	41/37	30/12
ñ10ñMadras YMCA Boys town	90	96	—	17	—	47	65	64	—	-	76	75	9
ñ**ñMysore Rural Devt.proj	144	122	30	144	—	122	92/92	80/80	73/73	56	78	29/26	122/54
ñ*ñVinnarasu Association	75	79	71	66	5	107	103/103	103/97	132/95	78	107	101/103	63/19
ñ**ñSAMATA	75	52	62	82	8	78	74/74	72/72	96/96	75	45	65/131	46/121
ñ**ñSocial service society	153	154	154	116	—	113	127/127	110/110	112/112	151	151	247	425/182
ñ**ñSTNBA	5	13	14	10	1	15	15	—	—	13	30	—	0/
ñ**ñYMCA - Tanhril	106	73	73	115	—	99	105	74	55	28	138	24	157/35
ñ**ñYMCA - Lungdai	41	36	32	21	—	43	32	42	35	44	108	45/	71/2
ñ**ñYMCA - Zemabawk	22	46	49	54	—	123	96/95	100/110	106/105	124	15	111/105	371/6
ñ**ñYMCA - S. Hlimen	—	—	—	—	—	—	—	—	—	—	—	—	—
ñ**ñYMCA - Moolachel	100	57	56	57	—	41	34/36	40/40	41/41	15	—	—	0/35
ñ**ñChristian English school	49	48	46	55	2	45	54	54	55	50	40	45	31/6
ñ**ñYMCA - PATNA	—	—	—	—	—	—	—	—	—	—	—	—	—
ñ**ñPankajam Carlin H. Centre	55	15	15	30	—	—	—	—	—	—	—	—	—
ñ**ñThe Salvation Army - Aizwa	—	—	—	—	—	—	—	—	—	—	—	—	—
ñ**ñThe Methodist Church - Madi	—	—	—	—	—	—	—	—	—	—	—	—	—

DSCO PROJECTS PERFORMANCE RANKING

	1	2	3	4	5	6	7 & 8		9	10	11
NAME OF THE INSTITUTION	TRAINING 20	COMM. ORG. 15	STAFF 12	HEALTH EDU. 10	HEALTH SERVICES 10	SUSTAINABILITY 10	DEVP. PROG. 10	MIS 5	FINANCIAL REPORT 5	TOTAL SCORE 100	RANKING
1.1.93 Socio-Eco.Prog(U.P.)	12-60%	12-80%	6-50%	5-50%	5-50%	6-60%	5-50%	4-80%	2-40%	57	A
Rural Evan. Miss(M.S.)	16-80%	12-80%	9-75%	6-60%	7-70%	7-70%	7-70%	5-60%	3-60%	72	AA
YMCA - Bhilai	10-50%	8-53%	5-41%	5-50%	5-50%	5-50%	3-30%	1-20%	2-40%	47	P
YMCA - Bhadravati(Karn	14-70%	11-73%	9-75%	6-60%	7-70%	7-70%	5-50%	5-100%	3-60%	67	AA
YMCA - Davangere(Karn.)	16-80%	12-80%	10-83%	7-70%	8-80%	7-70%	6-60%	7-140%	4-80%	77	G
YMCA - Narayanguda(A.P.	18-90%	13-86%	10-83%	8-80%	9-90%	8-80%	8-80%	6-75%	3-60%	83	G
Adoni Area Rural(A.P.)	17-85%	14-93%	11-91%	8-80%	9-90%	8-80%	8-80%	5-100%	4-80%	86	G
YMCA - Koraput (Orissa)	9-45%	5-33%	5-41%	3-30%	4-40%	3-30%	3-30%	2-40%	1-20%	35	P
YMCA - Mullanki (TN)	18-90%	12-80%	10-83%	7-70%	8-80%	7-70%	8-80%	6-75%	4-80%	80	G
Madras YMCA Boys town	14-70%	10-66%	8-66%	6-60%	6-60%	6-60%	6-60%	6-120%	4-80%	85	AA
Vimmarasu Asso.(T.N.)	15-75%	12-80%	9-75%	7-70%	7-70%	6-60%	7-70%	5-100%	3-60%	71	AA
SUMTA (A.P.)	14-70%	10-66%	8-66%	5-50%	6-60%	6-60%	5-50%	4-80%	3-60%	61	AA
Social Ser.Centre(A.P.)	15-75%	12-80%	9-75%	6-60%	7-70%	7-70%	7-70%	4-80%	3-60%	70	AA
STNBA (Manipur)	12-60%	10-66%	8-66%	5-50%	6-60%	5-50%	5-50%	3-60%	2-40%	65	A
YMCA - Tamhril (Mizo)	12-60%	11-73%	7-58%	5-50%	5-50%	5-50%	4-40%	4-80%	3-60%	56	A
YMCA - Lungdai (Mizo)	8-40%	4-26%	4-33%	3-30%	3-30%	3-30%	3-30%	2-40%	1-20%	31	P
YMCA - Zemabawk	13-65%	10-66%	8-66%	5-50%	5-50%	6-60%	4-40%	5-100%	3-60%	59	A
YMCA - S.Hlimen (Mizo)	8-40%	8-53%	5-41%	4-40%	4-40%	3-30%	4-40%	3-60%	1-20%	40	P
YMCA Moolachel (TN)	18-90%	13-86%	11-91%	7-70%	7-70%	6-60%	7-70%	7-140%	4-80%	80	G
Christian School(Naga)	11-55%	8-53%	6-50%	5-50%	5-50%	5-50%	4-40%	5-100%	2-40%	51	A
1.94 PCC Centre (T.N.)	15-75%	11-73%	8-66%	6-50%	6-60%	6-60%	5-50%	5-100%	2-40%	64	AA
YMCA - Patna (Bihar)	6-30%	6-40%	5-41%	6-60%	3-30%	4-40%	4-40%	2-40%	1-20%	37	P
The Salvation Army (Mizo)	13-65%	12-80%	8-66%	6-60%	6-60%	6-60%	6-60%	6-120%	1-20%	58	A
The Meth. Church (Raj)	8-40%	4-26%	6-50%	3-30%	3-30%	3-30%	3-30%	2-40%	1-20%	33	P
1.93 Mysore Rural Devt. (Karn.)	13-65%	12-80%	8-66%	6-60%	6-60%	6-60%	7-70%	6-120%	3-60%	67	AA

Below 50% - Poor
50 - 60% - Average
60 - 75% - Above Average
75 Above - Good

P - 6
A - 6
AA - 8
G - 5
25

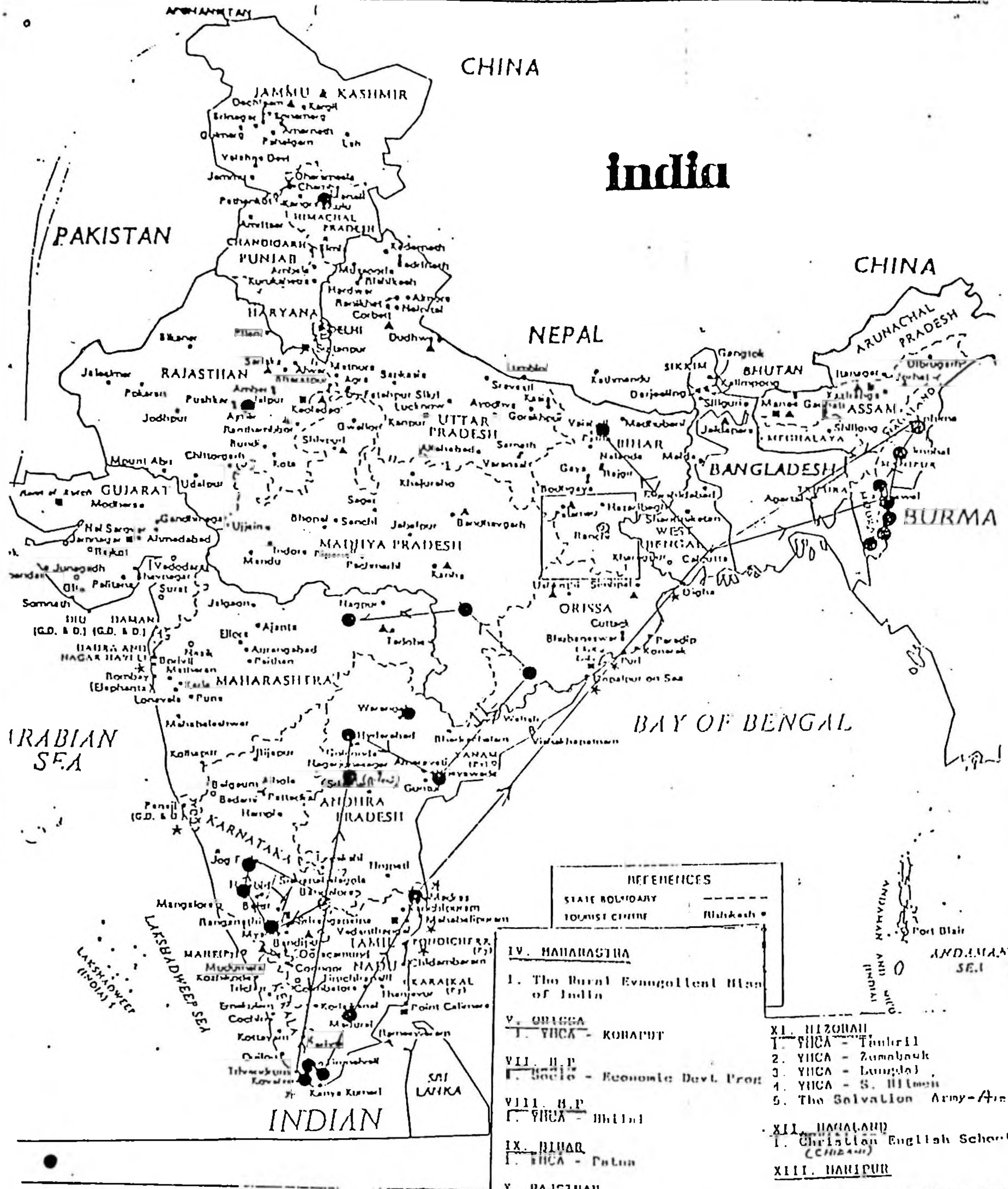
CSCD PROJECT'S ANALATEMENT 1993 & 1994/

1993

SLNO	NAME OF PROJECTS	No. P	B77	3 AN	No. B	No.de	BCG	DPT/OPV1	DPT/OPV2	DPT/OPV3	Mea	Vit	Boos	FP - T
		23	23	22	12	—	12	8	10	10	7	—	10	3/24
1	Socio Economic Devet.	153	153	153	106	2	180	135/145	135/134	156/139	148	111	156/156	340/15
2	Rural Evangelical Mission													
3	YMCA - Bhilai	17	17	4	2	—	11	4/7	5/6	3/5	—	5	8/6	8/—
4	YMCA - Bhadravathi	210	120	120	204	2	44	97/67	97/97	97/67	35	158	97/67	67/7
5	YMCA - Davangeri	177	129	128	122	3	244	209/205	168/168	133/138	110	200	109/109	89/42
6	YMCA - Narayanguda	127	84	176	67	6	59	37/37	50/50	53/53	19	59	—	141/90
7	Adoni Area Rural Devt.	92	5	15	58	—	29	36/36	30/30	—	—	—	—	5/13
8	YMCA - Korraput	34	34	8	17	—	12	12/12	6/6	—	—	—	—	—
9	YMCA - Mullankinavilai	93	63	49	49	1	49	38/34	36/42	36/38	49	67	27/57	28/7
	Madras YMCA Boys town	150	100	100	140	1	145	150	150	—	—	150	—	12/35
	Mysore Rural Devt.proj	140	175	36	136	—	91	92/92	78/78	72/72	40	214	15/15	—
	Vinnarasu Association	152	139	135	29	8	73	72/43	55/39	62/41	45	86	73/35	32/80
	SAMATA	33	26	26	76	3	20	15/15	17/17	26/28	132	—	188	89/65
	Social service society	42	42	42	16	—	16	35/35	32/32	30/30	65	97	120/18	131/102
	STNBA	68	—	—	—	—	27	28	16	8	16	—	45	—
	YMCA - Tambil	28	28	28	12	—	—	20/20	5/5	6/8	—	14	—	—
	YMCA - Lungdai	54	52	56	15	—	91	211/211	90/90	65/65	52	105	65/—	142/18
	YMCA - Zemabawk	110	62	56	64	—	164	106/37	134/35	294/49	133	50	114/51	2901/60
	YMCA - S. Hlimen	50	42	—	44	2	68	65/65	49/43	43/46	53	69	41/41	71/3
	YMCA - Moolachel	57	37	44	35	—	33	32/27	26/23	21/21	3	—	—	23
	Christian English school	68	66	52	74	5	68	58	57	47	59	77	—	69/13
	YMCA - PATNA	—	—	—	—	—	—	—	—	—	—	—	—	—
	Pankajam Carlin M. Centre	126	114	114	104	—	—	—		— —	15	—	—	—
	The Salvation Army - Aizwa	88	49	64	6	—	48	64/64	113/64	63/61	35	17	27/28	54/17
	The Methodist Church - Mad	—	—	—	—	—	—	—	—	—	—	—	—	—

CSCD - 1995 Services Details

SL No	Name of the project	DOSP	Total Pr	TT	ANC	BIRTH	DEATH	BCG	OPV/DPT1	DPT/OPV2	DPT/OPV3	BOOST	MEA	VIT A	FLY PL	Ad
1	Socio - Eco Devt.	1.1.93				No Reports in 1995										
2	Rural Evang. Mission	- do -	69	63	41	124	-	147	130/336	131/127	147/132	138/138	110	212	220/	
3	YMCA - Bhilai	- do -	41	37	—	45	1	46	41/27	31/32	30/31	34/49	33	38	28/-	
4	YMCA - Bhadravathi	- do -	98	34	98	59	3	42	21/21	18/18	15/15	11/11	10	61	64/	
5	YMCA - Davangere	- do -	70	59	59	66	1	46	54/54	39/39	29/29	10/10	22	150	—/8	
6	YMCA - Narayangdua	- do -	27	22	21	22	—	22	22/22	20/20	20/20	28/28	36	16	25/8	
7	Aconi area Rural Devt	- do -														
8	YMCA - Koraput	- do -	31	31	4	67	-	-	—	—	—	—	-	—	—	-
9	YMCA - Mullankinavila	- do -	170	175	134	141	5	123	112/164	111/154	113/160	152/	295	280	129/	
10	Madras YMCA Boys town	- do -	90	37	—	12	—	57	48	48	—	—	-	81	—	-
11	Mysore Rural Devt	- do -	118	120	36	118	—	81	91/91	79/79	68/68	33/33	57	406	219/	
12	Vimarasu Assoc.	- do -	48	51	23	48	—	70	70/60	51/56	61/55	65/73	68	77	20/22	
13	SAMATA	- do -	91	73	78	70	5	100	73/73	77/77	79/79	120/120	89	67	127/	
14	Social Service Centre	- do -	147	111	97	65	—	73	158/158	126/126	151/151	225/	202	242	96/	
15	ITNBA	1.4.93	9	23	16	16	2	33	35/27	—	—	—	22	—	—	
16	YMCA - Tenkril	- do -	53	74	74	64	2	46	74/74	67/67	60/60	49	68	85	141/	
17	YMCA - Lungdai	- do -					No Reports 95									
18	YMCA - Demabawk	- do -	2		7	7	9	—	—	—	—	—	—	—	-	
19	YMCA - S. Hlimen	- do -		—			No Reports 95									
20	YMCA - Mualachel	- do -	58	41	46	46	—	25	28/28	26/26	25/25	—	18	—	—	22 30
21	Christian English Sch	- do -	58	59	53	67	3	59	63	64	64	35	60	79	45/2	20
22	S.D.O Health Centre	1.4.94	25	15	15	30	—	—	—	—	—	—	—	—	—	
23	YMCA - Patna	1.1.94					No Reports									
24	Salvation Army	1.1.94	92	51	69	6	—	53	67/67	115/115	67/30	30/29	30	27	54/17	8
25	Salvation Army	1.1.94					Reports									



I. ANDRA PRADESH

1. Adoni Area Rural Developmet Initiative Project -
2. YMCA - Narayanguda
3. GAMATA - Mylavaram
4. Social Service Centre - Nacenkal

II. TAMIL NADU

1. YMCA - Mullankina vilai
2. Vinnarasu Association of India - Alantarapari
3. Madras YMCA Boys Town
4. YMCA - Moolachel
5. Pankajam Carolin Clark Health Centre - Madurai

III. KARNATAKA

1. YMCA - DAVANGERE
2. YMCA - Bhadravathi
3. Mysore Rural Development

IV. MAHARASTRA

1. The Rural Evangelical Miss of India

V. ORISSA

1. YMCA - KORAPUT

VII. M.P

1. Socio - Economic Devt. Prog

VIII. M.P

1. YMCA - Bhilai

IX. BIHAR

1. YMCA - Patna

X. RAJSTHAN

1. The Methodist Church Madar

XI. MIZORAM

1. YMCA - Tawlril
2. YMCA - Zumabuak
3. YMCA - Lungdai
4. YMCA - S. Hlimen
5. The Salvation Army - Aie

XII. NAGALAND

1. Christian English School (CHIBANI)

XIII. MANIPUR

1. South Thankul Nagal Bapt Association - STNBA (SHIRIPOK)

APPENDIX 'C'
DETAILS OF PEOPLE MET DURING FIELD VISITS

A - YMCA Board members/Others related to project - not directly implementing CSCD project.
B - CSCD Project Executive members - CEOs and PMs
C - CHVs employed part/full time to implement CSCD project
D - Other health professionals connected or not to CSCD
E - Pregnant women and mothers affected by CSCD project
F - Other village persons not connected to CSCD
G - CMAI's classification based on monitoring and self-administered questionnaire.
H - Re-classification considering field realities and processes evolved.

Sl.No	Name	A	B	C	D	E	F	G	H
1	Mysore Rur Dev.	-	1	2	-	20	5	AA	G
2	YMCA Bhadravati	5	1	3	4	10	5	AA	AA
3	YMCA Davangere	4	1	3	5	20	5	G	AA
4	AARDIP Adoni	4	2	2	2	15	10	G	G
5	YMCA Hyd'bad	-	2	-	-	-	-	G	G
6	SAMATA Vijwda	3	1	12	-	25	50	AA	A
7	YMCA Koraput	-	2	-	-	20	15	P	P
8	YMCA Bhilai	4	1	2	1	5	10	P	A
9	REM Mahar.	1	1	5	2	8	10	AA	G
10	P.C.Centre Madurai	-	2	9	-	10	6	AA	AA
11	YMCA Mlnkvli KK	-	1	3	-	5	7	G	G
12	YMCA Moolchl KK	3	1	5	-	-	6	G	G
13	Vinnarasu Assn	-	1	12	-	6	4	AA	G
14	YMCA Madras	-	2	4	-	10	5	AA	G
15	YMCA Tanhril	-	1	4	-	4	8	A	G
16	YMCA S.Hlimen	4	1	-	-	-	-	P	P
17	YMCA Zemabawk	5	2	2	-	5	8	A	AA
18	Salvation Army	1	2	2	-	1	1	A	P
19	YMCA Lungdai	-	1	2	-	3	5	P	P
20	STNBA Manipur	-	2	2	1	7	12	A	AA
21	CES Chizami	26	1	-	2	10	15	A	AA
22	YMCA Patna	6	2	2	3	3	5	P	P
	Total :	66	31	76	19	187	192	-	-

Total No. of people met : 571

<u>CMAI's classification</u>:
Good - 5; AA - 7; Average - 5; Poor - 5.

<u>Reclassification after review</u>:
Good - 9; AA - 6; Average - 2; Poor - 5.

Classification remains unchanged in - 9.
Classification upgraded in - 10.
Classification downgraded in - 3

REVIEW OF ACTIVITIES FOR CSCD - FIELD OBSERVATIONS

1) PROGRAMME OFFICER:

The CMAI considers CSCD project an important component in promoting the Community Health approach to make Primary Health Care a part of peoples' activity. The CSCD project is under the Community Health Department of CMAI, with a Programme Officer taking all responsibility for the functioning of the 25 micro-projects across the country. The Programme Officer independently handles all problems of the micro-projects, from funding, to training and liaison to monitoring and advisory services.

The Programme Officer is supported with advice from the Community Health Department during their regular staff meetings, when the status, problems etc. of the projects are highlighted and discussed. Implementation processes receive prominence during such meetings, with a global perspective of the CSCD projects. The Programme Officer works out details suitable to individual micro-projects.

The present incumbent CSCD Programme Officer came in as the selection of projects had been completed. He has been involved in

- visits to projects for on-site assessments;
- conducting training programs for project holders and staff as per their needs;
- receiving reports/returns form projects as part of the monitoring process, including advise; and,
- handling fund-related and administrative problems of the projects.

The needed liaison networking, correspondence and documentation for the CMAI in this project activity are also attended to by the Programe Officer.

As part of the Community Health Department of CMAI, he is also involved in other Community Health related activities, co-operating with colleagues of the department.

The above processes have been educative and capability-building in nature for the Programme Officer providing a range of perspectives in Community Health from the micro-projects. The distribution of the microprojects across the country have helped cross-fertilization of ideas and initiatives from varied situations unique to each project/location, yet useful somewhere else. The programme officer not being a medical professional has helped promote community perspectives well, though a handicap at tackling medically oriented project initiatives is noticed. He has effectively made use of medical expertise at local levels, which, to an extent has 'medicalized' some projects, detracting from the Community Health/Primary Health Care approach viusalized by CMAI.

2. MICRO-PROJECTS:

The CSCD micro-projects have already been tried and tested in an initial round evaluated in 1991 as mentioned earlier.

The locations for micro-project work have been well chosen in areas of dire need and lack of access to health care.

The training programs, curriculum and resources for training have been well selected and organised. The mix of groups trained, locations for training and frequency have been well planned, to help the evolving micro-project, with adequate attention given to the Community Health volunteers, Project Managers and Chief Executive Officers roles.

During field visits, the following observations were common to all micro-projects.

a) A request for further training programs to help them go beyond CSCD, to make CSCD sustainable.

b) A request to help micro-projects identify other development needs in their area which could mesh with CSCD and Community Health perspectives.

c) to help the micro-projects in conducting training programs locally, in regional language, for a larger number to their project personnel.

Language facility and communication in English has been seen as a major problem by micro-projects.

This was observed during field-visits, when the micro-projects have not been able to effectively communicate their work and involvement through reports/returns, though adequate provision for the same has been made.

A major implementing group have been the YMCAs, with 13 out of 25 micro-projects being held by YMCA. 4 of these YMCAs are well established, 2 are yet to be affiliated to the National Council of YMCAs, and most have only CSCD as a project in health.

The YMCAs being similar in terms of administration, relationship to the National Council of YMCA, and overall perspectives in terms of the YMCA movement, the following have been observed to affect the CSCD processes implemented by them.

- a) The YMCAs being governed by a Board of members, who are otherwise employed and involved in numerous other activities, CSCD is just one of the initiatives, dependant on a full-time Project Manager. They are handicapped when a change of P.Ms occurs, especially when it is the transfer of a YMCA trained secretary for project implementation.

- b) Frequent changes in the elected Board, and annual changes as seen in the Mizoram projects changes the CEO of the CSCD project as well.

- c) A frank opinion expressed by the President of a YMCA was - "We are all men here, and the CSCD related to women and children. We take time to really understand and work to be effective in these circumstances". This lacuna has been obviated in YMCA Patna, where women members are also on the YMCA Board.

- d) The newly established YMCAs have yet to make an impact in other areas of work, to support CSCD effectively. They do find CSCD as a good initiative towards social and community relevance of their work, and are happy to be 'different' in their perspectives.

- e) The YMCA projects are also caught in the dilemma of catering to some needs of their own membership, while promoting a social concern like CSCD, which may entail entirely different sets of activities.

I. PROCESSES INITIATED AT CMAI HEADQUARTERS

1. Evolving the Child Survival Child Development project as a Community Health oriented initiative, focussing on Mothers and Children, for the most needy areas of the country.

2. Developing this idea through trial, testing and evaluation during an earlier phase between 1988 to 1991. This includes a manual, methods of recording and reporting, and information for technical support in a simplified format for implementors.

3. Selection of suitable implementing agencies (at 25 locations across the country) that are non-hospital based Christian/Social Service organisations.

4. Appointing a Programme Officer (P.O.) at CMAI headquarters vested with full responsibility for all aspects of the project.

5. Providing adequate backing to Programme Officer in resource mobilization, training, networking and liaison for implementation of the project.

6. Monitoring of the technical aspects of project activity through the Programme Officer's reports at staff meetings with the Community Health Department team of CMAI. The administrative, and finance aspects being monitored by the concerned departments at CMAI headquarters.

7. Developing of an internal monitoring and advisory system through
   - regular monthly reports/returns from micro-projects
   - evolving a self-administered questionnaire for the Chief Executive Officers (CEOs) and Project Managers (PMs) of the implementing agencies, referred to as micro-projects of the CSCD program.

II. PROCESSES BETWEEN CMAI-HQs and CSCD micro-projects

1. Training programs for the CEOs, PMs and Community Health Volunteers (CHVs) for
   - Orientation to the CSCD project philosophy, Primary Health Care concepts and Community Health approaches;
   - Methodology for need-assessment and steps to meet the needs of the people of the area for CSCD; and
   - Reports, returns, monitoring of the projects, including technical, managerial and financial aspects.

   (Details of training programs - numbers, locations, who attended, curriculum and resource persons in Appendix-B)

2. Visits of the Programme Officer from CMAI-HQs for monitoring/liaison/advisory purposes; and

3. Monthly reports/returns, as well as the Internal monitoring exercise through a self-administrative questionnaire. (Refer Appendix-B)

Observations/Comments:

(1) The Programme Officer of CSCD program at CMAI-HQs is primarily responsible for all these processes and consequent activities.

The extensive travel needs of the Programme Officer for visits, organisation and implementation of training programs, etc., keep the Programme Officer in a constant shuttle between desk and field. It leads to a fairly rigid 'planning' of activity.

The 25 micro-projects being distributed across the country and being located in areas of difficult access, personal contact between the micro-project implementors and the Programme Officer average once or twice a year. The contact between micro-project holders is lesser, despite proximity at a regional level.

Reports, returns and other correspondence are subject to postal delays and also contribute to accumulation and hold-up at the 'desk' at HQs.

These factors detract from the ability of the Programme Officer to address the important and long-term CSCD needs as opposed to the immediate and urgent administrative and financial matters.

(2) The training programs are excellent in concept, design, content and execution - as reported by the micro-project implementors.

The much needed renewal, reiteration and help at field level to translate these ideas to practice are slow in coming - since the micro-projects look forward to these from the CMAI.

A positive effect of this has been the looking for and finding local medical resources to help them. The other side of the coin is a 'medicalization' of the CSCD interventions being the local medical/health personnel who are not familiar with Primary Health Care and Community Health approaches.

III PROCESSES AT THE CSCD micro-projects

1. Appointment of CEO, PM and CHVs for the CSCD project.
2. Implementation of CSCD project, including registration, reports, returns and monitoring & providing services to the Community, especially mother and children
3. Integration with Non-CSCD functions of the implementors.
4. Sustainability efforts.

Observations/Comments:

1. The CEOs, PMs and CHVs were appointed as per CMAI's guidelines (ref. CMAI manual for CSCD) when the projects started.

   A majority (13 out of 25) microproject implementors being YMCAs, some common features affecting CSCD functions noticed were,

   - the secretaries trained and appointed by the National Council of YMCAs were the Project Managers of CSCD. Their withdrawal for further training or postings elsewhere seriously hampered CSCD's functions.
   - non-affiliation to the National Council of two YMCAs (S.Hlimen and Lungdai YMCAs) reduced fund and support availability to supplement CSCD work.
   - changes in the YMCA Board locally affected the CSCD program, since CEOs changed and needed to be re-oriented. The CSCD program is for 3 years, while these changes occur annually, or once in two years.
   - the YMCAs being membership organisations, some activities needed to be designed for them at the urban area - not necessarily helpful/supportive to CSCD activity.
   - the Board of YMCA being the controllling authority, bureaucratic delays and shifts in priorities depending on YMCA needs affected CSCD functions.
   - the members of the YMCA Boards being busy, were involved more in the high-profile 'medical' activity rather than field/community-based work, which is left to the CHVs and PMS. This naturally shifts the focus of interest of these 'employees' towards medicalization of CSCD efforts.

2. The process of Registration of mothers, children and filing of reports and returns has been well understood by all and takes place adequately for maintenance of CSCD activity.

   The personal contact between people and members of the implementing organisation this generates is visibly the most effective component of the program.

This 'Direct contact' as mentioned in the activity profiles of each organisation seems to be the underlying reason why

- people recognise the CSCD effort and participate in CSCD activities;
- CHVs are under pressure to learn more about health and dissemination of information;

and - the implementing agency learns of people's needs and has to evolve methods of tackling them.

Conversely, the lack of popularity of mass communication methods both among people and the organisations can ve understood in this context.

Health as it emerges is an intensely personal and family activity, best addressed by direct contact with the clientiele. Apart from a real need, the 'medicalization' of programs as commented on at several places, could be attributed to the personal and direct contact provided there.

3. In agencies where community organisation already exists as a basic strategy for other programs, the CSCD efforts are being integrated easily. Also, the number of CHVs have been reduced in most organisations to 2 or 3 from the original 5 appointed for reasons of
   - ease and familiarity of CSCD implementation
   - weeding out of those CHVs who are ineffective, and
   - difficulties in payment for a larger number, since CMAI funds do not support salaries of CHVs.

The need for atleast one full-time worker to ensure CSCD program effectivity is felt by all organisations, lasting for full 3 years of the program. This is acutely felt when such persons leave the job mid-way for various reasons and also when continuity of program is disrupted whenever part-time CHVs shift to other jobs. This is a recurrent theme when the ups and downs of the CSCD micro-projects are studied.

During discussions at various micro-projects, the methodology of integrating CSCD goals with other development activity in the area is not yet clear to the implementors, since they still perceive CSCD as a separate activity requiring Medical/Health professionals. Many organisations, especially YMCAs have activity which is membership related, and away from project location to enable integration. Also, focussing on specific groups, like orphans, vocational trainees, etc., makes integration difficult.

This 'Direct contact' as mentioned in the activity profiles of each organisation seems to be the underlying reason why

- people recognise the CSCD effort and participate in CSCD activities;
- CHVs are under pressure to learn more about health and dissemination of information;

and - the implementing agency learns of people's needs and has to evolve methods of tackling them.

Conversely, the lack of popularity of mass communication methods both among people and the organisations can ve understood in this context.

Health as it emerges is an intensely personal and family activity, best addressed by direct contact with the clientiele. Apart from a real need, the 'medicalization' of programs as commented on at several places, could be attributed to the personal and direct contact provided there.

3. In agencies where community organisation already exists as a basic strategy for other programs, the CSCD efforts are being integrated easily. Also, the number of CHVs have been reduced in most organisations to 2 or 3 from the original 5 appointed for reasons of
   - ease and familiarity of CSCD implementation
   - weeding out of those CHVs who are ineffective, and
   - difficulties in payment for a larger number, since CMAI funds do not support salaries of CHVs.

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4. Sustainability;

The sustainability of CSCD activity beyond the 3 years planned is related to integration into other non-CSCD activity, which is yet to occur in most agencies.

A systematic, continuously developing CSCD project activity over two years could lend itself to implementing a withdrawal and handing over phase during the third year, making it sustainable.

The practical aspects of ups and downs in CSCD functioning at micro-project level added to lag periods due to postal, bureaucratic, fund-flow and information flow problems has made this a difficult ideal to reach.

On the field, the actual conditions observed are,
- there is adequate information (knowledge) dissemination, with attitudinal and practice changes lagging behind and needing the facilitatory activity of CSCD personnel.
- Adequate levels of community organisation to be able to hand over the CSCD activity to people is yet to emerge in almost all places, except two viz., Vinnarasu Association at Kanyakumari and AARDIP at Adoni, A.P.
- an emerging need of the Community to be able to handle common/minor ailments and ability to recognise serious illnesses at peoples' level itself without complete dependence on medical aid from outside.
(Utilization of safe herbal/home remedies knowledge already available with the community, but marginalized due to a dependant attitude on Western medicine has been brought to the notice of executives/CHVs of the micro-projects during discussions with them. Also, the need to transfer demystified medical information on why diseases occur/what first-aid or immediate help is needed, etc. has been discussed).

- the areas selected for CSCD implementation being the most needy in all aspects, more inputs in the following areas are needed before sustainability can become a reality -

a) Social and economic programs to fulfil basic needs of the community viz: employment, food security, safe water and housing;
b) nutrition education/supplementation appropriate to local conditions and needs; and
c) General education and awareness to overcome gender, class/caste, cultural and other traditional biases hindering development. Also, bringing into reach of these people, various programs from the Government and Voluntary agencies addressing these and for other development purposes.

Considering these, the requests from most agencies to continue the CSCD support to them for at least a year or two more is justified. A planned strategy to effect withdrawal over a period of time is not yet a part of the micro-project thinking.

An oft-repeated question by the review team while talking to people was - "We hear the CHVs are doing good work with you. We would like to take them to areas where there is more need. What do you feel?" The peoples' reply was very telling - "We need them for a year or two more - may be you could take them away then. We could help others too, after that!"

IV. PROCESSES seen AMONG PEOPLE met at CSCD micro-project areas

1. Those related to CSCD projects.
2. Those related to non-CSCD/other initiatives.
3. Independent processes conducive to positive Community Health.

1.a) The registration of mothers and children, regular follow-up and education for CSCD needs has
- created an awareness of their life situation and that improvements can be made by themselves, with Government and other voluntary agency help.
- focussed their concerns on the needs of women and children in the community.
- made sense locally of the Government mass-media efforts on Mother and Child Health, Immunization, ORS, Family Planning/Welfare, etc.

These, and most importantly the idea that other people are concerned about them has brought in a feeling of being a part of the National mainstream, and not a neglected/ignored population.

-b) The frequent contacts with friendly CHVs has also helped them voice concerns about other health matters which they feel important, like -
- tackling of minor/common health problems at their level itself
- avenues that can be explored for low-cost medical care from surrounding areas, and
- promotive, preventive and rehabilitative measures related to water-supply and sanitation, nutrition and hygiene, care of the elderly and disabled, schooling and non-formal education, etc.

-c) The community have been enabled to understand the need for participation in health related activity overcoming caste/class and other social barriers.

The communities being organised for other purposes on political, social, ethnic, religious lines, do not yet feel the need for Community Organisation for Health, though they favour participation if/when others organise for the same.

2) It is only a few agencies that have well established Community development initiatives, with community organisation. Some micro-projects as at Adoni, Bhadravathi and Vinnarasu Association Kanya Kumari, have communities organised for various reasons, ranging from Survival imperatives, to political and statutory needs. Most of these are related to obtaining of resource benefits from the Government and other Voluntary Agencies, though not averse and able to tackle internal conflicts, evolve common goals and lead to combined action. They have histories of more than five to six years. Integration of CSCD activity into this framework has been smooth and easy.

   Community organisation for development and health (also CSCD) initiated at organisations in the past two to three years are yet nascent and will need time to mature, since people still view these efforts as the initiatives of the voluntary agencies concerned, and not their own. Developing a sense of 'OWNERSHIP', as seen by the Hyderabad YMCA seems to be the stumbling block.

3) People are upgrading 'Health" to a higher priority among their basic needs and are willing to invest in it as a resource for better life conditions. This is manifested in the following
   - seeking and participating in health initiatives by the government and voluntary organisations;
   - exploring low-cost, self-help and appropriate interventions to tackle morbidity;
   - developing an awareness of their rights and responsibilities as consumers of the health industry.
   - looking at health implications of occupation, education, environmental degradation and development; and,
   - expressing concern in various ways for those marginalized in terms of health, like the aged, disabled, children and women.

STRENGTHS / WEAKNESSES / RECOMMENDATIONS

A. AT CMAI HEADQUARTERS

STRENGTHS:

1) A well conceived, planned, monitored and evaluated Health project addressing the most-needy, for implementation through non-hospital based organisations with simplified, demystified methodology providing them adequate technical support.

2) Well selected (development oriented) implementing agencies, given appropriate training to bring Health work into their ambit.

3) Low-cost, minimal and appropriate documentation, and ability to establish direct contact with people are the projects' highlights.

4) Non-medical Program Officer vested with full responsibility for all aspects of the project, supported by the Community Health Department of CMAI.

5) Transfer of ability to identify and initiate Health Action beyond project needs and in directions appropriate to local area.

WEAKNESSES:

1) Scattered distribution of micro-projects across the country, varied nature of populations addressed and problems of communication with them makes for a fairly rigid, centralized planning to meet their needs. Hence, responses to immediate/urgent needs and flexibility to suit micro-projects evolution becomes difficult for a Programme Officer.

2) Extensive and tiring travel needs for training, monitoring and follow-up of the Program Officer and Project holders makes for less contact than optimum between these persons - a key to evolving appropriate solutions to emerging situations.

3) Medical and Public Health initiatives to suit the differing and evolving natures of each micro-project (though not part of the project, yet affecting it) need technical support from the CMAI HQs (eg. in endemic areas of Malaria, Kala-azar, etc., and drought-prone or water-logged areas)

RECOMMENDATIONS:

1) Decentralized training, monitoring and follow-up facilitation through regional CMAI membership adequately trained for project needs. Regional language usage will make them more appropriate to peoples' needs.

2) Clustering of micro-projects and developing of adequate regional networking for them.

3) Public Health advisory visits for technical support by Publilc Health/Medical personnel from or nominated by CMAI HQs, familiar with project goals.

4) Extending of support for a total period of 5 to 6 years to help projects:
   - get over problems of understanding & implementation as they need to work at the peoples' pace.
   - develop and implement a strategy for sustainibility among people.
   - support other health action initiated by micro-projects to shift local needs and problems.

The present 3 year phase could be a mid-point to determine what support the micro-projects need and taking appropriate action, to go beyond CSCD.

B. AT THE MICRO-PROJECTS

STRENGTHS:

1) Recognizing Health work as a socially-relevant initiative bringing the organisations into closer and direct contact with people and their needs.

2) Ability to demystify and innovate simple methods of spreading health awareness among the poor and needy.

3) Understanding and utilizing the available Government and Voluntary agency initiatives in Health in local needs, with a good coverage in Immunization, Family Welfare and Maternal and Child Health achieved.

WEAKNESSES:

1) Dependance on local medical personnel for tackling minor illnesses and endemic disease problems, who 'medicalize' interventions, making them 'clinic'-based, rather than Community-based.

2) Difficulty in mobilizing resources for peoples' felt-needs beyond CSCD, like Balwadis, supplementary nutrition for children and mothers, etc.

3) Difficulty in liaison and networking with Govt. agencies and between regional CSCD/other Volag activity, and looking towards CMAI for the same.

4) Paucity of motivated staff, staff turnover and other staff related problems due to low honoraria offered and dependence on training on CMAI mainly.

5) Giving inadequate thought and action to make the project sustainable as a people's activity, and finding ways and means of addressing their immediate and emerging health needs beyond CSCD.

6) Dependence on CMAI to sort out all issues which emerge out of CSCD activity.

RECOMMENDATIONS:

1) Evolve ways and means of tackling common/minor disease problems using traditional/local/herbal knowledge already available with people.

2) Utilize peoples' participation emerging as outcome of the project towards making it a peoples' activity which is sustainable.

3) Moving away from the 'medical' and 'curative' solutions which are high-profile to preventive and promotive initiatives which strike at the causes of health problems.

4) Network actively with Government and Local Voluntary agency towards combined action for Health.

5) Integrate Health into all other development activity in their work, from Non-formal Education to Income-generation, and not keep them compartmentalized as separate activities.

APPENDIX 'D' : INDIVIDUAL REPORTS OF 22 CSCD MICROPROJECTS

CSCD MICRO PROJECT I

1. Details of the Project

a. Mysore Rural Development Project - Karnataka
Date of starting project - 1.1.1993.

b. This project covers 6 Villages, approximately 25 km from Mysore City,a population of 6000 mostly SC and ST, with 75% below poverty line.They are Daily wages labour, Rural -agriculture, and urban - construction work.The levels of literacy are low and health conditions poor.There is one PHU for medical needs in the area,and No other voluntary agencies.

c. The CEO has implemented a CSCD project earlier in a Tribal area at Periyapatna. Now, he has selected a nearer area with similar problems for better implementation.
The difficulties he has faced are due to - new area, recruitment of Local Health Volunteers and Fund-flow problems.

Interviewed: 1 CEO, 2 CHVs, 20 Mothers, 5 youth.

2. CSCD Activities

a. Registration of Mothers and Children, Follow up as per CSCD guidelines being done,ensuring good direct contact with them.

b. Special efforts have been made to overcome Caste/Class differences through education. Utilization of all services from PHC, including an Ayurvedic Dispensary is promoted.The credibility of staff is good with people,who participate well in CSCD activity.

c. Record-keeping is adequate and reporting is regular.
CHVs are from local area and familiar with people.
Utilization of Growth-monitoring cards for education of mothers needs to be promoted.

3. Non-CSCD Activities

a. Non-Formal Education of mothers directly helpful to CSCD activities.
Dispensary for minor ailments and Medical camps helpful to the community, utilizing Government Medical personnel.
Balwadis supported by CMAI for a period of one year started as a logical extension of the CSCD effort.This was handed over to the Government, with people paying for the Teacher employed.

b. Overcoming of Class/Caste differences in area through special efforts in all contacts of staff with people, despite separate Anganwadis run by Government for different castes.
Community participation in project activities good due to direct contact with people.
Community Organisation still in nascent stage, with the Mahila Mandals recently formed (2 months) and not yet active.

4. Relationships / Liaison

a. With Government -good -as mentioned above with the Health Services. Their credibility and liaison with Social Welfare Department/ICDS also very good.
b. Networking with Voluntary agencies outside area - yet to start. Help of Church related organisations - Diocese, CTVT, etc. is being taken.No other Voluntary agencies work in the area.
c. Community not yet ready to take over responsibility for Health.

5. Discussions/Suggestions during review team visit

a. The morbidity due to minor ailments is still high, despite dispensary and PHC utilization.They are mainly, seasonal Respiratory, / G.I./ Skin diseases.
To explore local/herbal medicine initiatives as an enabling/ empowering process.

b. Focus on Community Organisation - to be able to hand over to people - the work being done by the project.

c. Consider organisation of youth and employment generation for them to tackle economic problems.

d. To focus on nutrition education.

e. Potential areas of development include
- School Health
- Adolescent/youth education - especially girls.
- Womens' Health.

f. CEO in process of planning for Integrated development work in larger area of 31 villages with Diocesan and CTVT help. To consider all the above to add to experience already gained.

g. To utilize mass-education methods and Government Health Education resources as well as Voluntary agencies with expertise outside the area.

6. Summary of Processes

a. CSCD activities systematic and with adequate understanding, well organised and documented, good community participation.

b. Good liaison with Government agencies in health, social welfare and ICDS (Child development).

c. Logical extension of CSCD into Pre-school. Anganwadi started and handed over to Government.

d. Community Organisation - Mahila Mandals just beginning - not yet established/active.

e. Require about 2 years to hand over activities to Government or people.

CSCD Micro Project II

1. Details of the Project

a. Y.M.C.A. Bhadravathi.
Date of starting project 1.1.1993.

b. Work in two urban slum areas in Bhadravathi - Vellore Shed and Zinc line, covering a population of approximately 5000.A majority live on Daily-wages and areas like -Domestic labour/construction work/ factory labour/petty business, vegetable vending, etc. The literacy and socio economic levels are poor. The Zinc-line community is well organised, being a large S.C. settlement.

c. This is a newly established YMCA, affiliated to the National council.CSCD is their first project and their well- trained Project Manager left after initiating this project. A new Project Manager has been appointed recently - not yet well oriented. They have shifted from Fishermens colony to Vellore- Shed slum, finding a greater need here.

e.Interviewed- YMCA Board members-6; CHVs-3; + 1 TBA,
Doctors/Nirmala Hospital Staff-3,Mothers/People-15.

2. CSCD Activities:

a. Registration of Mothers,Children as per CSCD guidelines being done. Immunization and follow-up adequate,though Documentation not adequate/regular.

b. Weekly dispensary (Health Camp!) facility at each of the locations (Wednesday and Thursday) with doctor from Nirmala Hospital and private doctor - FREE OF COST.

Zinc line Community have provided a place and are constructing a new room for medical activities as community contribution.

People have adequate information/practice of immunization, ANC and PNC. They are well backed by Nirmala Hospital (Catholic Hospital) for hospital based facilities. This has led to Medical orientation of activity with Preventive and PHC Orientation minimal.

YMCA Board members cite Medical activity being used as an entry point for CSCD activity.

c. Records/Reports - not well planned/executed due to leaving of Project Manager and new person not yet well oriented. YMCA Board Members are also not well oriented to this activity.

d. CMAI Classification - Above average.

3. Non CSCD Activities

- NFE for women(is being assisted by CMAI),and Tailoring activity for girls, - Not connected/related to CSCD activity.
- Seminars/Symposia for youth during vacations on issues of topical interest - separate from CSCD activity.

4. Relationship /Liaison:

a. No liaison with Government agencies formally. CHVs/Organisation helped in Pulse Polio campaign with good success.

b. Good liaison with Nirmala Hospital and a Private doctor for medical activity. They are able to obtain free/concessional and necessary help for needy people of area. TBA in Vellore shed also helpful in CSCD activity, as a volunteer.

c. Well organised community already at Zinc lane. Liaison with them and obtaining of place/new room built freely as community contribution to YMCA - CSCD activity.

Community participation good at both areas due to CHVs enthusiastic/committed activity. They have good contact with community and are well accepted.

YMCA Board members not deeply involved due to their own employment needs and need proper orientation.

5. Discussions during review team visit:

   - Staff orientation to Preventive and Primary Health care concepts.
   - Introduction of Alternatives/Home remedies for tackling minor ailments.
   - Education for Girl Child/Women on Health.
   - Socio-economic development activities, especially for youth and their involvement in health.
   - Shifting from 'Medical' orientation to handing over activity to people/peoples' organisations.

SUMMARY

1. CSCD activities good. Participation good, Recording inadequate.
2. Newly established YMCA therefore few other activities helpful to CSCD.
3. Good relations for medical needs with Voluntary agencies hospitals, Nil with Government.
4. Selected one area with good Community Organisation - have to utilize full potential for handing over health to people.

CSCD Micro Project III

1. Details of the Project:

   a. Y.M.C.A. Davangere.
   Date of starting project 1.1.1993.

   b. The selected population is Rural - 6 villages - with approximate population 3,500 plus. Access by road is difficult; the population poor in socio-economic and health terms, involved in agricultural labour in dry/irrigated areas. Selection is need based.

   c. This is the first project of this newly established YMCA, affiliated to National Council.In addition they are operating in urban slum area of 800 population, where Tailoring and NFE Activities are conducted for women.They have attempted liaison with Government for socio-economic programmes with no success.
   They had established a FREE Clinic at a village, which was recently closed due to local political factors.

e. Met 4 Board members,1 CEO/Medical team - 2 doctors/3 CHVs/2 AWWs/1 Government Health Inspector/20 mothers and 5 others.

2. CSCD Activities:

a.Registering of mothers/children as per CSCD guidelines with good follow-up. Contact regular and good.Records and Reports exemplary and simplfied/systematic.

b.Good rapport of CHVs with community. Awareness levels of people good. Activity restricted to CSCD project.
Activity of camps/clinics/dispensary medically oriented and clinic recently stopped.
Have not been able to influence Anganwadi activity in Kuruba locality. Good Liaison with upper classes of village who permit CSCD activity with understanding of peoples' needs, despite local politics.

c.Well running CSCD with good recording, especially growth monitoring, immunization, etc.

3. Non-CSCD Activities:

a. Tailoring/NFE in urban area not related to CSCD activity in rural community. Nil other activity.

b. Attempted Income Generation Programmes of Government for rural areas, with inadequate success.

4. Relationship/Liaison

a. Government Services: utilize Government Health Education and Immunization services well for CSCD programme.

b. Voluntary Agencies: Utilize advise and services of Doctors of Medical College for running of CSCD programme, especially of Community Health Department. Hence able to have systematic and well documented programme. CHVs also well trained.

c. - Good level of awareness among people on CSCD, due to a good direct contact and follow-up.
- Good liaison with members of different class/caste groups.
- CHVs well-trained/enthusiastic/effective.
- YMCA board members unable to devote more time required for the programme due to personal work commitments.
- 'Medical' approach is strong. Involvement mainly in Clinic approach to Preventive care. Mass education and Community Organisation to be promoted.

5. Discussions

a) To focus on Community Organisation of Village Health Committees/Youth groups/Mahila mandals etc.to enable local decision making process.
b) Alternative systems/Herbal medicines for minor ailment treatment.
c) Utilization of Government and other NGOs as resources for development activities in area.

6. Summary

a) Newly established YMCA with separate activity at Urban level, not linked to CSCD program in rural area.
b) Good rapport of CHVs, with community. Participation and awareness in community of CSCD activity good.
c) Excellent, systematic, simplified documentation of academic standards, with involvement of Community Health Professionals from Medical College.
d) Local problems have restricted utilization of Government programs,free medical clinic and such welfare measures in the villages.
e) Community Organisation, Minor-ailment tackling with local resources/herbal medicine.

CSCD MICRO-PROJECT IV

1. Details of Project
   a) Adoni Area Rural Development Initiatives Program.(AARDIP) Date of starting program - 1.1.1993.
   b) This project covers - 4 villages, around 25 kms from Adoni town,a chronic drought affected area,with a Poverty ridden/SC and ST population of landless labour -approx. 1900 families/8000+population.
   c) Started as Integrated Development project for poverty alleviation. Have been tapping Governmental and other programs as available. Linking up with other NGOs and programs in district to build a good network of peoples' organisations towards a peoples' movement.
   d) CEO/PM; 2 CHVs, 2 Animators, 2 ANMS, 2 Activitists, Others 25, met.

2. C.S.C.D. Activities
   a) As per CSCD guidelines - Registration of Mothers/Children, and Direct H.E./Immunization through Government.NFE for mothers for Integration into non-CSCD activities.

b) Awareness of Mother & Child Health needs among CHV's and mothers good. Activist approach to obtaining Health needs from PHCs, to prevent alcoholism, obtain drinking water, etc. Heightened health awareness beyond CSCD, despite low levels of literacy in area.
Measures taken by community to facilitate safe home deliveries and care, since far away from PHCs and sub-centres.
c) Records adedquate for program. Reports/Returns regular.
d) CMAI classification - Good.

3. Non-CSCD Activities
a) Community-Organisation for participatory decision making and taking up of issues like water,alcoholism,dowry and child marriages, women's rights, etc. This is well utilized to help CSCD.
Small savings in Mahila Sanghas to help community in small enterprises (loans for) etc. DWACRA scheme of Govermnemt being tapped for same (eg. Tea-shop of member).
Obtaining of land pattas and Government housing scheme for the village. Road improvement in village.
All non-CSCD activities well related to CSCD work, bringing in good co-operation and participation from people.

4. Relationship/Liaison
a) Obtaining immunization services from Government and help in ANC. Most deliveries at home, since hospital over 25 Kms. off, but people availing hospital services for first and problem deliveries.

b) Nil other NGOs working in same area. Hence,no direct liaison. Networking with other NGOs on issues of the taluk and District. AARDIP established leading role and has good credibility/track record as a network leader.

5. Discussions

a) To enhance Nutrition education program, since malnutrition very common.
b) To pursue Anganwadi/Balwadi program in area for Supplementary nutrition for growing children with pre-school education.
c) To pursue school facilities for children, since literacy levels low. To link this with NFE efforts.
d) To promote utilization of peoples' health resources like tribal/herbal medicine for minor ailments and other traditional/cultural practices which promote health.

6. Summary

a) Project wholistic in approach for overall development in well selected area where people are still struggling for survival.
b) CSCD well received and integrated and part of other development activity.
c) Community Organisation and participation - good, with leadership in networking of NGOs in the district.
d) Poverty and related problems of nutrition/ education being tackled - needs a long time despite good organisation and participation, due to lack of needed resources.
e) To initiate measures to put Peoples's health in people's hands by promoting traditions/cultures conducive to health.

CSCD Micro project V

1. Details of the project
   a) YMCA Narayanaguda Development and Social concerns department
      Hyderabad, Andhra Pradesh.
      Date of starting project - 1.1.1993.

   b) This project covers 8 villages as part of a larger set of 24 villages.

      Did not visit villages due to local YMCA problems & 2 CHVs having shifted to other jobs. Work stagnant for past 2 months.
      I had visited these villages during the 1991 evaluation, and Programme Officer CMAI twice in past 2 years.

   c) This is a part of YMCA's plans for Comprehensive Sustainable Rural Development near Secuderabad in 24 villages taken up on criteria of backwardness. They are in 3 sets of 8 villages each,with work shifted to the next set every 2 years. The 2nd phase of the program is nearing completion. Fund flow and internal problems of YMCA have been interfering with project.
   d) CEO/PM - Mr. Boneventure

2. CSCD Activities
   a) CEO has utilized learning from earlier project. A major approach is through schools and school children in educating the community.

The project has established Mahila Sanghas, where Training & Education have been given importance. NFE, Tailoring, Kitchen gardens, Legal education for women and socio-economic programs.
They have also initiated herbal-medicine use for minor ailment management.

b) Special efforts have been made to build a sense of "OWNERSHIP" among people to make the development efforts sustainable. They have been transferring experience from working with urban poor and street children to rural area, effectively.
c) Records/Reports adequate.
d) CMAI's classification - GOOD.

3. Non-CSCD Activities

a) Savings schemes in Mahila mandals and obtaining of DWCRA support.
b) Interactive seminars on National Integration, Superstitions and Social ills, Legal issues of poor and women,etc.and celebration of events like Environment day, World Health Day, etc. at village centres. Each-one-teach-one programs for literacy,Vocational training for youth, Rotation Chick, Baby show and other such innovative programmes etc.

4. Relationships/liaison:
a) Good relationship with Government Health Services/PHC for immunization, maternity and Health Education Services. Also, liaison with other Government agencies/programs in Integrated development efforts.
b) Networking for combined action and solidarity with other voluntary agencies on issues concerning poor.

Discussions

- to enable networking at peoples' level for transfer of knowledge and processes.
- to consolidate herbal medicine initiative- to tackle all minor ailments in area.
- to involve volunteers from other systems of medicine in rural development work.
- to help spread their experience and understanding to other fledgling voluntary agencies in need.

CSCD Microproject VI

1. Details of Project
   a) Society for Ameliorating Mass and Tribal Action.
      - SAMATA, Vijayawada.
      Date of starting project - 1.1.1993.
   b) The project covers 10 villages in Mylavaram and A.Konduru mandals of Krishna district, approx. 40 km. from Vijayawada.
      The former, with SC population and latter with tribal Lambadi population, totalling approximately 8000.
   c) This Voluntary agency started 7 years back in well identified area of great need.
      CSCD is their only project in area at present, with no other activity for health/development. Work related to fund flow.
      Activity stopped since Dec '95 as CSCD project ended.
   d) Met CEO/PM - 1; CHVs - 12; People-75.

2. CSCD Activities:
   a) As per CSCD guidelines, in registering and follow-up.
   b) CSCD messages have reached people, though practice is inadequate.The CHVs employed are all male. Hence, contact with mothers for proper ANC/PNC not satisfactory.
      Most ANC/Deliveries are at Government PHC facility 30 km away.
      People incurring heavy medical expenses in hands of private practitioners
      Kalajathas with CHVs done earlier to spread CSCD message.
      Co-operative effort in Pulse polio very effective.
      Their efforts have been mainly to try to create awareness among people.
   c) Records/Reports adequate - maintained upto Dec '95 only.
   d) CMAI Classification - Above Average.

3. Non CSCD Activities:
   - Thrift programs and Mahila mandals have just been initiated.
   - No other activities in area of development - to help CSCD.
   - Land patta and housing schemes of Government - an awareness being initiated.

4. Relationship/Liaison:
   a) Co-operating with Government in Health care programs.
   b) No other Volags in area.

5. Discussions
   a) To take up other development activities, including employment generation for youth.
   b) Strengthen self care capabilities of Community with herbal medicine.
   c) To organise Community - towards handing over to people and focus on social problems.

CSCD Microproject VII

1. Details of Project:
   - YMCA - Koraput - Orissa

   - Four villages - 25 kms. and over from Koraput. Tribal population with high illiteracy levels and working as agricultural labour at low wages. Villages cut off from main road and Koraput for 4 months in a year due to flooding and bad access roads. Considered poorest areas of Koraput district which Prime Minister has also visited - no improvement despite such attention. Now, Koraput district (as large as Kerala) has recently been divided into 4 districts. Hence, improvement in Government activity in recent past.
     YMCA started in 1989, affiliated in 1993. Nil other projects in hand, except CSCD. CEO is LIC officer and busy. Homoeopathic doctor has joined the team and is helping in conducting clinics so far. No replacement found as yet to YMCA project officer who left after starting the project.

     - Met CEO, PM (Homoeo Doctor) and about 35 people, target and non-target population.

2. CSCD Activities:
   - as per CSCD guidelines. Unable to cope up with work due to lack of permanent staff.
   - Immunization inadequate due to PHC being far off (> 25 kms.)
   - Deliveries at home or Koraput - which is nearer and easier to access by bus/road.
   - People illiterate/unemployed. Alcoholism rampant, and festivals celebrated for prolonged periods.
   - Anganwadi/Primary school not attended - badly running. Govt. building new premises for school.
   - Homoeo Doctor conducts regular clinics and immunisation.

3. Non-CSCD Activities:
   - Government housing program (Indira Awas Yojana started recently.)
   - NFE for adults - started recently.
   - Food for work programs on road building.
     None of these integrated with CSCD activities.
     Nil programs by YMCA.

4. Relationships/Liaison:
   - With government agencies - improving with recent break up of Koraput district into 4 for easier administration. Government Health Services marginally touching village.
   - Nil other Volags in area. Networking etc. with others in Orissa not done.

5. Discussions:
   - Tribal medicine becoming extinct. To revive the same and promote herbal medicine for minor ailments which are rampant.
   - To consider appointing a full-time worker to be able to do regular work.
   - to start other activities relevant to local needs and likely to provide employment for youth, like carpentry, traditional crafts, etc.
   - to make more frequent contact and conduct mass education programs on health.
   - to network with other NGOs and Government to fulfill identified needs of the people.

5. Summary

Newly established YMCA has chosen area of work where real need is present. Permanent trained YMCA person needed to continue work in a regular manner. Improving life and living conditions of people should be prime focus, with tackling of minor ailments with local resources, and making people more health conscious. Starting of development programs and tackling social problems like alcoholism needed. With improving Government administrative reach, better networking with Government and other Volags will help.

CSCD Microproject VIII

1. Details of the Project:
   - YMCA Bhilai
   - Rural - Covering 4 village areas with approximately 3000 population. This village has been adopted by Bhilai Steel Plant (BSP) for Education and Medical support and is a 'model' village in Durg district with unanimously elected Sarpanch who is enthusiastic and active. Villages clean with no class/caste conflicts.
   - Earlier villages selected were dropped due to political interference problems. Also, Project Managers have changed twice during the project period. New incumbent is still getting a grip of the situation. Peculiar nature of Bhilai - always "outsiders".

- 4 YMCA Board members/1Project Manager/1 Doctor/4 village leaders and 1 teacher/2 Village level workers/10 others.

2. CSCD Activities:
   - as per CSCD guidelines. Adequate.
   - Medicalized approach due to BSP support for medical camps. Good NFE for women by Eswari Bai - a motivated woman of the village who has got national recognition and TV coverage. Government programs for immunizations/ORS/etc, well supported by BSP specialist camps spreading awareness through their nurses and students. No TB. Leprosy 30 pts. under treatment. Malaria rampant.
   - Records/Reports good/adequate.
   - CMAI - internal monitoring status - POOR.

3. Non-CSCD Activities:
   - Nil in village area. Those at HQ - more relevant to its membership and urban ethos.
   - Indira Awas Yojana, Jawahar Rozgar Yojana, Rajiv Gandhi library for neo-literates are Government programs well utilized by active Sarpanch. Integration of CSCD activities into these not explored.
   - BSP support to building of school well utilized for medical programs/camps of specialists - EYE/ENT/F.P., etc. Enthusiastic school teacher available for help.

4. Relationships/Liaison:
   - With Government agencies/programs good due to standing of BSP and Sarpanch's initiatives.
   - Nil other Volags in area. Networking with others not yet initiated- need not felt.
     BSP is the biggest Volag, since it has adopted the village. YMCA members being employees of BSP, the relationship is good.

5. Discussions:
   - School health program to become child-to-child and Child-to-community Health program - to be explored.
   - Introduction and promotion of Herbal medicine for common/minor ailments to be explored.
   - To network with MPVHA.
   - To start other development oriented programs with Diocesian support.
   - To explore Anganwadi/Balwadi as logical extension of CSCD program - Eswari Bai has already volunteered for same.

Summary

Bhilai YMCA's CSCD program is going on well despite change in Project Managers - due to BSP's medical support and adoption of 'model village' for its activities.
Approach being 'medicalized', avenues of school, anganwadi and NFE programs available to project for, shifting to preventive, promotive and 'Health' approach.
Initiatives to evolve methods for handling over health activity to people needed.

CSCD Microproject IX

1. Details of the Project
   a) The Rural Evangelical Mission of India
      Daryapur, Amaravathi - Maharashtra.
   b) Rural, covering population of approximately 8000 across 10 villages. People tribal, scheduled castes and landless labour, 10 to 20 km. from Daryapur. One village recognised as model village. Good Governmental health facilities which are being utilized adequately in recent past. Literacy 60% for male and 40% for female, with a good degree of awareness of health.
   c) Related to fund flow. Nil other funding/other projects of REMI. Depend on available Government programs and their utilization.
   d) CMAI links through PO's visit/Training programs/Reports & Returns.
   e) 1 CEO/1 Pastor/5 CHVs/2 ANMs + 18 local people.

2. CSCD Activities
   - as per CSCD guidelilnes.
   - Awareness of CSCD activities good. Reach of Government facilities for mother and child - good.
   - Occassional Health camps and co-operation with Government Eye & F.P. camps.
   - Local Dais trained at CMAI and doing well in home deliveries.

   CEO is Homoeo Doctor, his wife is ANM and another Ayurvedic doctor employed.
   Records/Reports - adequate.
   CMAI's internal evaluation status - Above Average.

3. Non-CSCD Activities:
   - NFE for women and informal Women's groups meeting on contemporary health issues.
   - Health of Adolescents, Vocational training opportunities, employment opportunities - publicised.

- Government programs on Smokeless chulhas, latrines, water supply programs promoted.
- Balwadis for pre-school children being run.

Principal approach through creating awareness, co-operating with Government programs and maximizing utilization of available programs.

Utilized all training opportunities for different people each time from NIPCCD, FARMS INDIA, CMAI etc, creating a large base of persons aware of Community needs.

4. Relationship/Liaison:
   - Good - with Government services - Health and Development.
   - Nil other Volags in area, but utilizing training facilities wherever possible. Good relationship with PHC and its staff.
   - Have not interfered with/influenced local realities, yet co-operative with all bodies on health matters. Good relationship with Panchayati Raj and utilization of facilities.

5. Discussions
   a) To encourage/promote local herbal remedies to help people tackle minor illness/ailments by themselves.
   b) To organise community to take over CSCD activity for sustainability
   c) To liaise with/utilize other NGO programs in development.
   d) Frequent visits by the CEO/PM to the target area.

Summary

A well chosen rural community for project. Utilizing all available Governmental programs in Health and Development. Approach principally through creating awareness and maximizing utilization of available programs, doing well in CSCD program, and need to take steps to hand over same to people towards sustainability.

CSCD Microproject X

1. Details of project
   a) Pankajam Caroline Clark Health Centre - Madurai.
   b)c). Seven rural areas, covering approximately 7,500 population off Madurai town. The centre is well known for over 85 years for its work dedicated to the poor in various rural areas around Madurai.
   These areas now taken up are new, with SC, ST and tribal population with low levels of literacy and awareness.

They are daily wages labour in agriculture, construction work and domestic work. Tuberculosis, Anaemia, Malnutrition and Skin diseases are common. The approach is 'medical' through a mobile weekly clinic in addition to training of Dais and CHVs. An orphanage and adoption facility for rejected female infants is a unique on-going activity of need in this area. Supported by CSI and Diocese of Madurai and Ramanad in its activity.

d) CEO; PM; Doctor; 9 CHVs; 10 Mothers; 6 others.

2. CSCD Activities:
- as per CSCD guidelines/adequate.
- NFE for women.
- Good communication through CHVs on womens' issues and CSCD programs through charts (self-generated); Songs and street-theatre. Focus on girl child due to female infanticide prevalence in this area.
- Medicalized approach for health needs through weekly clinics. Trained Dais deliver mostly at home.
- Free medication for common illness like scabies, diarrhoeas, ARTIs, Tuberculosis and Leprosy prevalent, with medication help being provided from other funds of Diocese, and donated medicines.
- Orphanage and adoption facility for female infants.

Records/Reports adequate.
CMAI's classification - ABOVE AVERAGE.

3. Non-CSCD Activities
- Orphanage and Adoption centre cited above.
- Creating awareness on Womens' issues/Girl child.
- Utilization of Government services on Housing, Water supply and Immunization.
- Balwadi for pre-school children - started with CSCD help and now shifted to other funding sources.

Nil other direct development activities in area of social/economic problems; Employment; Youth etc.

4. Relationship/Liaison
- With government Services mainly on immunization, and housing/water
- With other church related Volags. of Diocese, CSI.

5. Discussions:
- to encourage/promote self-help with herbal/local resoruces for minor ailment management and wean off clinical approach.
- to promote community organisation for handing over activity to Community.

- to tackle social/economic/employment problems through other Volags/approaches to get to roots of health problems.
- to identify and promote other Government aid programs available/relevant to needs of people.

6. Summary

A well established and recognized Volag with 'medical' approach to social, economic problems. Doing well in areas of CSCD and female infant/Girl child issues. Communicating well, and having good rapport with Community. Need to evolve methods of shifting responsibililty to people and enabling/empowering them to utilize available/local resources to tackle own problems.

CSCD Microproject XI

1. Details
   - YMCA - Mullankinavilai - Kanyakumari Dt.
   - A well-established YMCA (since 1977) have taken up Nattalam village in Killiyoor Block with approximate population of 5000. The literacy level is about 58%, though health awareness is equally lacking in both literate and illiterate population.
   - The YMCA has been working in areas of NFE for adults; Environment, Water and sanitation programs; Pre-school education, Youth talent promotion and summer schools; in addition to savings, socio-economic and income generation programs in areas of spinning, tailoring, handicrafts, fibre units and loan schemes. Youth are trained in type-writing and leadership. All these are implemented through an organized form of Village Development Committee. The CSCD program is a welcome activity to their community Health program where liaison with Government is the mainstay. Help to rehabilitate widows is also undertaken. All these are supported by the Community and other funders, with self-generated funds.
   - CEO/PM; 3 CHVs; 5 mothers; 2 widows; 5 others.

2. CSCD Activities:
   - as per CSCD guidelines. Systematic and well-organised through Community Health approach with 1 CHVs for approx. 500 population.
   - Components of CSCD organized as part of Community Health approach, utilizing only Government Services avaialable in area, and facilitating PHC activity with co-operation. Direct contact with people and utilization of Village Development committee for support ensures good coverage.
   - Activities - EXCELLENT. Records/reports: GOOD.
   - CMAI's classification - GOOD.

3. Non-CSCD Activities:
   - NFE of adults, youth, pre-school children.
   - IGPs and loan/savings schemes.
   - Creating awareness of Environment, Water & Sanitation as already listed above.
   - Widow rehabilitation & tackling of social problems.
   - Medicalization of activity with camps and medications for ailments.
   - Logical extension of Child Development activities - Day Care Centre.

4. Relationships/Liaison:
   - With Govt. - good on health/medical issues and maximal utilization of services.
   - With other voluntary agencies - in networking on issues relevant to area.

5. Discussions
   - to explore herbal medicine/local resources in tackling minor/common ailments and enable people to take care of own health.
   - to integrate CSCD activity into all other programs to make it sustainable.
   - to promote nutrition education and Kitchen gardens for both nutrition and herbal medicine.
   - to reduce dependency on Western medicine and 'medical'solutions to health problems with "Education for Health".

Summary

A well established YMCA with good credibility in areas of socio-economic problem tackling and creating awareness in all segments of population through specific programs. Community Organisation and participation good. Needs to be handled over CSCD responsibility along with integration into other activities to make it sustainable.

CSCD Micro-project XII

1. Details of Project
   - YMCA - Moolachal, Thuckalay.
   - Rural - 6 villages under Vilavoor town panchayat covering 10,000 plus population. 80% of these landless labour below poverty line. The YMCA has been running free Medical clinics weekly and EYE/Dental camps 6 monthly. Veterinary help for livestock , loans and Poultry vaccination are undertaken. Help to deserving school students as fees, uniforms and other expenses; encouragement too, in form of prizes for best students are other activities.
   - 3 YMCA Board members/CEO & PM/5 CHVs/ 6 others.

2. CSCD activities
   - as per CSCD guidelines.
   - CHVs had additional/continued training by Neyyoor Hospital apart from CMAI's training.
   - Doctor from Neyyoor Hospital conducts clinics/ camps.
   - No Infant Mortality in past 1 year.
   - Medicalization of approach with Clinic base.

   Records/Reports - GOOD.
   CMAI's classification - GOOD.

3. Non-CSCD Activities:
   - Embroidery centre provides employment and generates funds too.
   - Tailoring training for girls/women.
   - Creche for children (30) focussing on most needy with pre-school teaching and feeding of 3 meals/day undertaken. Looking for donors, since need is for more than double the present strength.
   - YMCA involved in Primary English Medium school construction on own land.

4. Relationships/Liaison:
   ~ Government - good for immunization activity.
   - other socio-economic programs from Govt. to be tapped.
   ~ Voluntary organisations
   - KNH Hospital is functioning nearby.
   - Network on local issues when needed.
   - Utilize Neyyoor Hospital for all medical needs & training needs.

5. Discussions
   - To explore herbal medicine to enable taking care of minor ailments by people themselves.
   - To explore possibilities of supporting creche through Government help/other Volag help.
   - To organize Community to take over health care.
   - To reduce 'medical' approach and shift to 'community' approach.

6. Summary

   Well established YMCA with good credibility includes CSCD along with socio-economic income generating and education activity. Utilizing Govt. resources and Volag. Hospital resources for medical needs of well identified population. Need to shift to community organisation and exploring local resources towards sustainability.

CSCD Microproject XIII

1. Details of Project
   - Vinnarasu Association - Marthandam - K.K. Dist. TN.
   - Rural, covering 12 wards of entire Panchayat of Kappiyarai, which is one of the 8 village areas covered by this organisation. Started work in these villages in 1973 and registered in 1984 as an Ecumenical Christian Movement for Human Development. Have a holistic approach to development working through small groups of 30 families each, called 'Neighbourhood groups', with a leader. Activities include
   - Leadership training; Help to poor students; Womens' programs for self-help; Community based health care; and, Inter Faith dialogue for peace.
   - CEO/PM, 12 CHVs, 10 others.

2. CSCD Activities:
   As per CSCD guidelines. Well organised and executed as part of Community Health program.
   - CHVs trained by CMAI, and also by TNVHA as lay first-aiders (LFAs)
   - CSCD well understood and well integrated into program.
   - Use herbal and alternative systems as part of program, though dependant on Govt. health services.
   - Approach through education creating awareness and mobilizing for group action.
   - Records/Reports - GOOD.
   - CMAI's classification - Above Average.

3. Non-CSCD Activities
   - Tailoring for girls/women; non-formal education at regular group meetings; Credit-unions for savings.
   - Creating awareness and utilizing all available Governmental programs in area related to health and development.

4. Relationship/Liaison
   - Good relationship with Government for Health Services. Able to utilize and co-operate with same.
   - Nil other NGOs in area. Network with other NGOs and TNVHA on broader issues of the area.

   Have been gradually developing the concept of 'neighbourhood committees' and able to hand over most activities to Community for discussion, decision-making and implementation, through this simple method of Community organisation.

5. Discussions:
   - To strengthen herbal medicine/other self-help methods in the area of health and minor-ailment management.
   - To evolve methods of tackling Bronchial Asthma in a wholistic manner, since it is a major problem in Kanyakumari Dt.

Summary:

A well organised Volag. with the idea of putting health in peoples' hands through a wholistic approach to Development and working through small groups of people - Neighbourhood groups - consisting of 30 families each.

Approach through creatilng awareness and promoting necessary action for Community needs. Need to give needed help/inputs to make health a self-sustainable effort of the people.

CSCD Microproject XIV

1. Details:
   a) YMCA - Madras - Boys town.
   b) Peri-urban/rural area off Madras, covering two Panchayat union areas with population of over 5000. Well established Volag. working with Orphanage, Vocational training centre and School. They have experience of working with CSCD program in adjacent areas earlier.
      - CEO/PM; 1 Doctor; 4 CHVs; 5 pregnant women; 5 mothers; 5 others.

2. CSCD Activities:
   - as per CSCD guidelines. CHvs are visiting area regularly and have good rapport with people.
   - Conduct NFE in addition to Health Education during direct contact with mothers at home. Community participation enthusiastic.
   - Approach medicalized and clinic based due to availability of Gynaecologist as Doctor in clinic. Well backed by VHS services for deliveries/immunization and liaison with nearby Catholic Hospital.
   - Records/Reports and returns adequate - well maintained.
   - CMAI's classification : Above Average.

3. Non-CSCD Activities:
   - NFE for adults mentioned above.
   - Vocational tralining, Orphanage and Formal School.
   - Not integrated into CSCD activities.

   Have developed good rapport with surrounding Community and good credibility for CSCD activity.

4. Relationship/Liaison:
   - With govt. agencies for immunization and F.P. services. Others related to Non-CSCD activity.
   - With Volags like VHS and nearby Catholic Hospital for Medical needs.

5. Discussion
   - Alternative medicine/Herbal medicine avaialble with CHVs and Community - not being utilized. To promote self-reliance in minor ailment management.
   - To proceed from vertical/compartmentalized medical care towards demystification and Community Health approach.
   - To evolve methods of handing over health care to communities.
   - School health programmes.

6. Summary:
   A well established volag with good rapport with community and doing effective CSCD program. Need to shift from 'Medical' to 'Community' approach, with enabling dimensions for self-help and eventual handing over to Community.

CSCD Microproject XV

1. Details:
   a) The Salvation Army - Aizawl - Mizoram.
   b)c)A well known and well established organisation focussing on the poor in its activities. They are involved in Community Health activities through Community Health Action Network (CHAN) with key themes of Care, Counselling, Training and Hope.
   The project works in four phases, I - Samaritan House for female sex workers; II - Family counselling centre; III - Mobile Health unit providing free medical care; and IV - Vocational training for rehabilitation. Find need for medical personnel to be involved in CSCD and Health Education programs. Extensive activity in other areas has affected CSCD work.
   - IPM/CEO1/NFE teacher1;2CHVs;1Mother;1 other.
   - The CSCD financial assistance being small, the interest and attention is minimal.

2. CSCD Activities:
   - Initiated well, but ran into problems with trained CHVs not able to function well, migratory population in taken up area of work and rapid urbanization of Aizawl town, bringing Government Health Services closer to area.

- CHV upgraded to PM and handed over project - is unable to manage due to lack of medical knowledge.
- Plan to shift area of work to 2 other needy areas and recruit 2 new CHVs with nursing background.
- Records/Reports adequate.
- CMAI's classification Average.

3. Non-CSCD Activities:
   - In areas of rehabilitation, counselling and vocational training. Not integrated with CSCD activity.
   - Professionalization and vertical approach to problems seen, hence expect CSCD also to be handled by health professionals.

4. Relationship/Liaison:
   - Good, with Govt. due to credibility and standing. Able to garner support for activities.
   - No co-operation/networking with other Volags, mainly since NIL other Volags in area, and Volag concept is new to them.

5. Discussion:
   - High literacy levels in area needs more written/printed material for use.
   - Changing/dynamic nature of population in Aizawl area points to taking up more interior and rural areas for work.

6. Summary:

A well recognised Volag involved in multiple Community level activities in vertical, compartmentalized manner. High level of professionalization occuring, with problems of implemnetation being impeded by paucity of same in CSCD area. Feel need for written material, shift of location of work and recruitment of professionals.

CSCD Microproject XVI

1. Details of project:
   a) YMCA - Tanhril - Aizawl district, Mizoram.
   b) West of Aizawl, well connect by road to the city, approx. 45 mts. distance by road. Covers population of approx. 3000, scattered in the hilly terrain, with local mud-roads and pathways for access.
   YMCA in centre of town in a rented building used as a centre for most community activities. People are all tribal/Christian, involved in agricultural activity and domestic animal rearing. Literacy levels more than 90% with Primary, Middle and High Schools in Tanhril. Most houses made of bamboo and thatch, with just enough water from a reservoir at higher level of hills. Nil industry in area, except for petty shops conducting business for daily needs.

c) YMCA recently establlished, and recognized by National Council of YMCAs.
d) Met CEO/PM, 4 CHVs, 4 mothers and 8 others.

2. CSCD Activities:

a) As per CSCD guidelines, registering and follow-up of mothers and children being done regularly.
b) Deliveries conducted at nearby Health sub-centre or by ANM at home. Adequate ANC and PNC.
Good Health Education activity from Health Department, the CEO being from same department.
H.E. posters in Mizo language seen in most houses on Mother and Child care, Breast-feeding, ORS, etc. Innovative exercise seen in this area, is boards painted with CSCD messages at highly visible locations on village roads.
c) Records, reports adequate.
d) CMAI's classification - AVERAGE.

3. Non-CSCD Activities:

- N.F.E. program being utilized for CSCD promotion and other community needs, since literacy levels are high. YMCA helps as centre for marriages and other social activities.
- Weaving centre for women being supported by YMCA to help in socio-economic development.
- Medical camps with Government & Pvt. Doctors for general disease problems in area. IDD well tackled with iodized salt being available and used in village.
- Local type of pit-latrine available at all houses, built by community, and has helped in good reduction of worm-infestation among people of the village.
- People using herbal medicine to limited extent. Common problems in area - Diarrhoeas and Respiratory tract infections.

4. Relationship/Liaison:

a) Good relationship with Govt. Health services, with nearby health centre, and CEO himself being from H.E. department. He also is available to help people during medical emergencies and other medical needs. Liaison and work with VDP, HLIM etc., good - in community building activities.
b) Nil other Volags in area. Networking with volags outside the area not done.
c) Medicalized approach to problems due to high need in this area. Water supply and sanitation being given due prominence with community involved in evolving local solutions - eg. pit latrines. People noticed that mosquito menace and rampant malaria is also due to pit latrines.

5. Discussions:

People already using herbal medicine - to promote use for common/minor ailments in area and reduce dependence on medicines.

Respiratory problems could be tackled better by promoting chimneys in kitchens and smokeless chulhas.

Anaemia and nutrition problems to be highlighted to help in bettering health status.

Programmes for Youth and their opportunity for skill training.

6. Summary

Newly established YMCA that has taken up CSCD work enthusiastically and extended into other areas of health needs. With high literacy, education and creating awareness is the main line of approach, with innovative methods of communication. Constant availability and creating facility for social activities beyond CSCD and health has firmly established the credibility of this organization for sustainable development work in the area.

CSCD Microproject XVII

1. Details of project

a) YMCA -Zemabawk, Aizawl District, Mizoram.

b)c)Peri-urban/rural area north-east of Aizawl city, with newly established YMCA (1991) affiliated to National Council of YMCAs.

Cover a population of approximately 3000, scattered in hilly terrain around the YMCA centre - 90%ST population. Land donated to YMCA by one of its members, but no building as yet. Office runs from premises of one of the Board members. CSCD is the only project run by the YMCA at present.

reports/returns. adequate.

d) 1 CEO/PM; 5 YMCA Board members; 2 CHVs; 5 Mothers; 8 others.

2. CSCD Activities:

a) Following CSCD guidelines for registering/follow-up of mothers and children.

b) Awareness of CSCD good among people as YMCA-CMAI initiative. Utilization of Government services, for ANC, Maternity and PNC, with immunization. Dependence on same for disease problems in area. H.E. efforts well received.

c) Reports/returns maintained, with delays due to change-over of YMCA Board members, including PM/CEO of CSCD every year. CHV's part of YMCA network, also change.

d) CMAI's classification - AVERAGE.

3. Non-CSCD Activities:

a) NFE - not functioning as such, due to high literacy in the area. Being used to create awareness of health.

Nil other projects/activities. One YMCA Board member is having a private enterprise of Silkworm rearing, silk reeling and thread-making. He provides employment for a no. of women in the area. Planning to innovate on weaving for local needs to meet marketing needs. ~~Another~~ Another runs private school and is a member of political group.

4. Relationship/Liaison:

a) Good with government Health Services, especially in Primary Health Care.

b) Nil other Volags in area. YMCA members are also part of other local organisations like VDA, HMIP. etc., and influence better working of YMCA along with them.

c) Local shawl/clothing unit run by a member, providing employment to local people.

5. Discussions:

a) To promote/utilize herbal medicine form locally available herbs and knowledge to prevent dependence on hospital medicine.

b) To enhance activity in H.E. on issues like Anaemia, nutrition, safe water, iodized-salt etc., to help health efforts.

c) To train CHVs regularly for CSCD/other health activity to meet people's needs.

6. Summary

Newly established YMCA (1991) with CSCD being the only project activity. Good liaison and utilization of government Health Services. Suffering delays in documentation due to changing of YMCA Board every year and consequent disruption of activity. Need to develop self-reliance and sustenance measures for health activity.

CSCD Microproject XVIII

1. Details:

a) YMCA - South Hlimen - Aizawl District.

b) Rural area South of Aizawl city, connected by road - approx. 45 mts. away. People scattered in hills around area. Nil industrial activity. Population agriculturists - doing Jhum cultivation. Very similar in characteristics recorded in other rural projects of Mizoram.

The CSCD project team and YMCA board members were not available during the evaluation team's visit to S.Hlimen. Hence, visits/meetings with CHVs, people, mothers and children was not possible.

Five members of the YMCA Board visited us at the hotel the same night after receiving the message that we had visited their location. The following is from talks with them:

YMCA South Hlimen is a newly established YMCA (1991) which has not yet been affiliated to the National Council of YMCAs.

Regarding CSCD, they informed us that

- All records/reports are being maintained, and had been sent to YMCA Shillong for onward transmission (CMAI-CSCD to follow up).
- They plan to conduct CSCD activities, even if YMCA support for CHVs salaries was not available, since they found CSCD helpful.
- They are able to get all women delivered at the Government Hospital facility. All children have been receiving immunization services from same, and the results have been satisfactory.
- Their liaison with Government Health Department has also brought about 3 Medical camps in the past year to help the people.
- Regarding NFE, they said that all the target non-literate persons having migrated out for socio-economic reasons, they find only a literate population left!
- CMAI classification - POOR.

CSCD Microproject XIX

1. Details
   a) YMCA Lungdai - Aizawl district - Mizoram.
   b) A newly established YMCA (1991) yet to be affiliated to the National Council of YMCAs. No prior experience with any projects. CSCD taken up to help service ideas focussed on Mother and Child.

      Population covered - mostly scheduled tribes - approx. 3,500 people scattered in the hills. The literacy level is about 50% and nearest Government Health Centre is over 25 kms. away.
   c) The CEO/PM is the Headmaster of a School and busy with own assignments. CHV's find the training and work useful to them as well as people, but do not find adequate support from YMCA.

The existing peoples' organisations like VDP (Village Defence Party), HLIM (Women's group organised by Government) and political parties are serving most needs of people. The CEO/PM who is a YMCA Board member expressed a frank opinion of the people, that one more organisation like YMCA is not needed in the area and hence is non-functional.

d) CMAI links through POs visits/Training programs/Reports & Returns.

e) PM/CEO, CHVs, 3 Mothers, 5 others.

2. CSCD Activities:

a) Registration and follow-up of mothers and children not being done adequately, since there is no full-timer to take responsibility for same. The evaluation team met a young girl educated at Bangalore, who was willling to do the same. We introduced her to the YMCA team.

b) - ANC, Maternity and PNC awareness present among people due to Government Health efforts and CSCD efforts which are not regular/consistent.
- Immunization of children being done through Government functionaries.
- Awareness of IDD not yet adequate. So also, regarding Water, Sanitation, Disease problems, and nutrition.

c) Records/Reports not maintained.

d) CMAI's classification - POOR.

3. Non-CSCD Activities:

NIL.

4. Relationship/Liaison:

a) Adequate with Government Health services to serve CSCD needs. Other health and socio-economic problems - nil addressed.

b) Other Vol.ags. like VDP, HLIM etc. in area appear to be strongly politically connected and interfering with YMCA and CSCD functioning.

5. Discussions

a) To revive CSCD work with literate girls/women of area - one of whom was identified by evaluation team.

b) To continue CSCD even if as non-YMCA project. To consider any other liaison with CMAI if possible.

c) The CHVs were very enthusiastic about further training, which had already helped them in CSCD work earlier. To sponsor suitable volunteers for CMAI training programs for North-East India.

6. Summary

- Newly established YMCA - not affililated as yet to National Council due to (?) local problems. CSCD program useful, but inadequate reports/records due to non-availability of full-time worker and paid CHVs. People and CHVs found the CSCD useful, but hampered by lack of initiative/support from YMCA.

CSCD Microproject XX

1. Details
   a) South Tangkhul Naga Baptist Association (STNBA)
   b) This is an Association of 75 self-supporting village clusters working for spiritual and socio-economic development of the villages since 1959, covering a population of approx. 17,000 people. The villages are in Ukhurl district of Manipur at Indo-Burma border in hilly areas. Villages are on hilltops, consisting of 20 to 40 houses with fair-weather roads for transport. The main occupation is agriculture, with dependence on Jhum cultivation and the monsoon. The literacy and socio-economic conditions are poor. Medical facilities -only Govt. sub-centres which function erratically and far away for most of the people.
   c) Education is an important need-based activity of STNBA, with a school (upto High School) and boarding facility at Irong, Yaripok, catering to 550 students. The CSCD project has been taken up in remote villages, covering about 4000 population, 80 kms, away from Irong, the HQ. 4 CHVs manage this activity and find immunization reach from the Govt. very difficult. Supervision is also difficult for reasons of distance and access. NFE is conducted for women in areas surrounding Irong, as a separate activity. Local tribal problems between Kukis and Nagas restricts continuous activity through the year.
   d) Met 1 PM/1 CEO/2 CHVs/7 mothers and 12 others.

2. CSCD Activities:
   - Initiated as per CSCD guidelines, with registration of mothers/children and follow-up.
     CHVs complained of irregularity of immunization activity by Govt. health centres, and consequent difficulties. Attempts at immunization through voluntary agencies through medical camps being done to supplement Govt. work. Awareness of nutrition, sanitation and diarrhoea management adequate, but influenced by socio-economic conditions of people.

- Reports/Records adequate. Clarifications about utility were done during the visit, since new PM and CEO have taken over CSCD work.
- Considering shifting of CSCD activity to nearby areas which have equal need and advantage of conducting of NFE for adults in the same area.
- CMAI's classification : AVERAGE.

3. Non-CSCD Activities:
   - Education both schools and NFE as listed above.
   - Community Organisation and Development, Socio-economic activities related to agriculture - horticulture, poultry, piggery, cardamom plantations etc. and vocational training. CSCD and Health Education not being incorporated into these programs.

4. Relationships/Liaison
   a) Good with Government in Health and Development areas, though erratic and limited nature of services due to local and political problems does not address peoples' needs adequately.
   b) Nil other Vol.ags. in area. We visited Manipur VHA and liased with Mr. Kuber Singh - the Secretary -for transfer of material in local language for H.E.

5. Discussions
   a) To shift CSCD to villages nearer to HQ in areas of similar need for better monitoring and implementation.
   b) To continue CSCD activity in earlier distant villages and secure adequate support locally, since it is useful and appreciated by people. ie., continue CHVs in old area and train new ones for nearer villages.
   c) To incorporate Alternative/Herbal medicine for minor/common illnesses to enable people to take care of themselves.
   d) To strengthen nutrition education and on Hygiene and sanitation in surrounding areas.
   e) To start school health program, evolve Child-to-child program and progress to Child-to-Community program for health, since education upto High School is a major activity of the organisation.

CSCD Microproject XXI

1. Details:
   a) Christian English School, Chizami, Nagaland.
   b)c)Chizami is a large village settlement surrounded by smaller villages, 5 hours by road from the Capital city of Kohima, located in Phek district, bordering Burma and Manipur in hilly terrain. The population is about 11,000, mainly agricultural labour in conditions of poverty and low literacy. Chizami English School has grown over past years into a high school. It is located in the basement floor of the Baptist Church, with a good support from the people in its running. Teachers from various parts of the country are employed here, and they are involved in Community development activity - one of the schools with a social concern. A nearby Government sub-centre caters to immunization and minor medical needs of the Community, though the services are limited. A majority of deliveries occur at home by Traditional Birth Attendants, with assistance from the Government nurse in case of problems. A school and dispensary run by a Catholic organisation also provides some health services. Hygiene and Sanitation are poor, with water-supply being catered for at a Community level.
   d) CMAI links through PO's visit/Training programs/Reports & Returns + Earlier CSCD project.
   e) PM/CEO, 26 Church elders, 12 Mothers & children, 1 local nurse, 1 TBA, 25 others.

2. CSCD ACtivities:
   a) - As per CSCD guidelines, Registration & follow-up of mothers and children.
      - CSCD messages passed through church activities, NFE groups for women and direct contact.
   b) Good understanding of CSCD. Community being organised by church, gives good participation in health work - controlled by church elders.
   c) Records/Reports adequate.
   d) CMAI's internal evaluation classification - AVERAGE.

3. Non-CSCD Activities:
   - Mainly revolve around education and creating awareness through school, church and NFE. Have direct relation to CSCD activity.
   - People hold the church and the school in high esteem. Hence, have good rapport in all activities either spiritual, educational or service. School teacher involved in running a school dispensary which also caters to health/disease needs of the Community.

4. Relationship/Liaison
   - Good with Government Health Services for medical care, immunization and Health Education.
   - Liaison with Catholic School and dispensary for health problems of the people which can be tackled by them.

5. Discussions
   a) To initiate and foster use of herbal medicine knowledge of Community for minor/common ailment management.
   b) To initiate school health programs, which can evolve into child-to-child and child-to-community programs later.
   c) Organise youth wing of organisation to clean up the water-storage tank, since the incidence of water-borne diarrhoeal disease will increase with onset of monsoon.
   d) Create awareness of community to needs of pre-school child, Adolescents and elderly for a rounded-off Community Health program.

CSCD Microproject XXII

1. Details
   a) YMCA Patna - Bihar
   b)c)Newly established YMCA (1991) affiliated to the National Council of YMCAs. The YMCA Board is unique with female members on the Executive, and have a YMCA trained secretary for implementing project CSCD. An earlier selected rural area, 25 km. away has been given up due to logistics of transport and supervision. A new area in peri-urban fringe of Patna (4 kms from City) which is a Harijan settlement has been taken up since the beginning of this year. This area has no medical/health care facility working, nor any Vol.ags. in area. A medical approach with a weekly clinic, Doctor, 2 Nurses, etc. has been initiated to gain a foothold for health work. A volunteer social worker, Mr. Ravi Shankar, who has single-handedly made literate the children and elders, is helping the project. The co-operation of the Sarpanch and a local lady CHV are also available.
   d) 1 CEO/1 PM/6 YMCA Board members/1 Doctor, 2 Nurses,2 CHVs, 3 Mothers and 5 others.

2. CSCD Activities:
   - Registration and follow-up of ANC,PNC mothers and children has been initiated and needs to be completed.
   - Good rapport with Community through the local CHVs, active use of medical support for CSCD activities by people in addition to minor ailment management.
   - Records/Reports - initiated well/adequate.
   - CMAI classification - POOR.

3. Non-CSCD Activities:
   - Nil initiated directly by YMCA. Supporting the NFE work of Mr. Ravishankar through provision of books, etc. Utilization of Hygiene and Sanitation efforts of this volunteer to spread health messages.
   - Co-operation with this volunteer and support of Panchayat through Sarpanch auger well for a comprehensive Community Health approach.

4. Relationship/liaison
   - With government Health Services for immunization and problems of maternity.
   - With civic authorities for water and sanitation.
     Nil other Vol.ags. in area. Networking with other volags/fedérations like VHA Bihar and DEVNET discussed.

5. Discussions
   a) To emphasize preventive and promotive activities even at clinic.
   b) To shift from 'Medical' to 'Community' approaches in tackling health problems.
   c) To initiate Child-to-Community programs from nearby schools.
   d) To train and strengthen skills of local CHVs towards Community Health approaches for Primary Health Care.
   e) To liase with Bihar VHA and DEVNET (a group of youngsters involved in Education activity in Bihar) for new approaches to foster Community Health and Development in selected area.