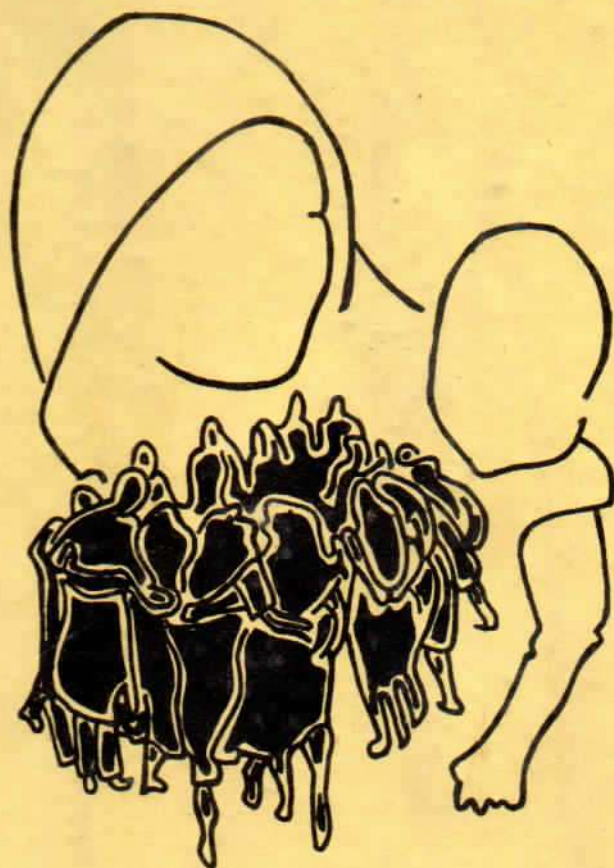


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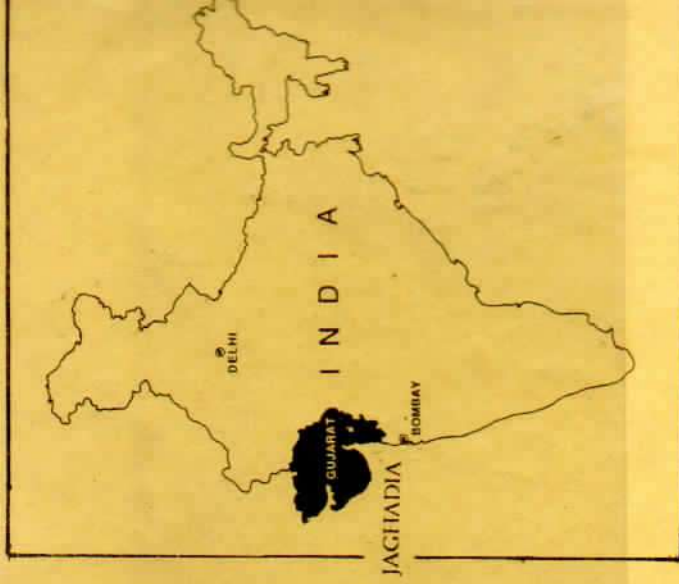
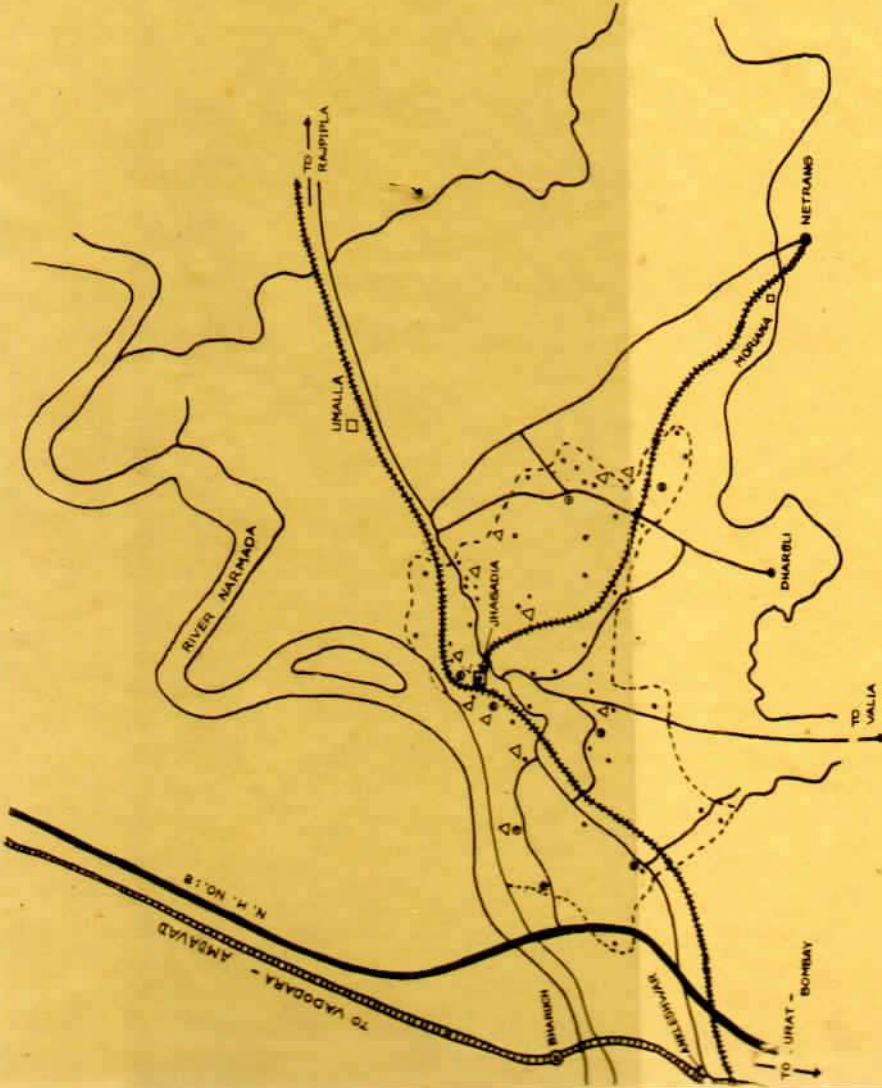
# VOLUNTARY EFFORT IN COMMUNITY HEALTH

Review  
of  
the Community Health Project  
of SEWA - Rural



Renu Khanna  
N. R. Mehta  
Anil Bhatt

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PROJECT AREA  
 COMMUNITY HEALTH PROJECT  
 SEWA - RURAL

- PROJECT VILLAGE.
- ⊙ HEALTH SUB CENTRES.
- PRIMARY HEALTH CENTRE.
- △ VILLAGE SURVEYED IN THIS STUDY.
- AREA COVERED BY DOTTED LINE REPRESENTING THE PROJECT AREA.

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Review  
of  
the Community Health Project  
of SEWA - Rural

Renu Khanna  
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August 1991

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VOLUNTARY EFFORT  
BY  
COMMUNITY HEALTH

The funding support of Bank of Baroda in the publication of this report is gratefully acknowledged.

Grateful acknowledgements are due to USAID/Government of India and IIM-Ahmedabad for sharing the cost of this study.

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(SEWA-Rural), Jhagadia, District Bharuch, Gujarat, India.

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Designed and produced by Editorial Services Division, Shishu Milap,  
Baroda for SEWA-Rural, Jhagadia.

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## FOREWORD

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The community health project at SEWA-Rural completes nine years of work on October 2 this year. It has been a rich and interesting experience, and each member of our team has emerged wiser, and the community, we hope, healthier. We have never adequately documented our experiences, and it was with a sense of expectant excitement that we took on the job of getting our work reviewed.

The primary objective of this review has of course been to understand how and what we could have done better. We hope that our future course of action will show that this objective has been largely realized. The other important objective has been to share these lessons with others like us, who have bravely set out to explore the unfamiliar path of running a community health project. We offer this report to them with an expectation that they may enlighten us on aspects that we must have missed. Among others who may find this report interesting and useful would be policy makers in the government and in the voluntary sector; academics, especially those who are concerned with the realities of community health work; other activists who closely follow the fortunes of such voluntary efforts; and donor agencies. We invite every serious reader to send us comments and suggestions; we shall value such contributions.

The process of this review began in April 1989, and has taken much longer than we would have liked it to. A number of factors have contributed to this delay. Importantly, we now realize with retrospective wisdom, that we were too ambitious in defining the scope of the review; it has almost reached the size of a comprehensive evaluation, which it is not. We cannot help feeling that it might have been wiser to restrict ourselves to certain specific activities of the community health project; it would have been less unwieldy. We now also believe that a comprehensive review of this kind could have been put off by a few more years.

None of this should, however, detract from the immense value of this review for our work. It has been an intensively participatory process and we have benefitted from every day we spent after it. The predominant feeling at the end of it all perhaps is that a systematic review of one's own work is at once essential and helpful, painful and exhausting. Paradoxically, it is refreshing as well. Although at the outset many had questioned the 'participatory' nature of the review, preferring a more 'unbiased, external' evaluation, we now know it

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could not, and should not, have been otherwise. The major part of the work, however, was organized and carried out by an external team of reviewers, which comprised Ms. Renu Khanna, of SAHAJ, Society for Health Alternatives, Baroda; Prof. N.R. Mehta, formerly Professor and Head, Department of Preventive and Social Medicine, and Ex-Dean, Medical College, Surat; and Prof. Anil Bhatt, Chairman, Public Systems Group, Indian Institute of Management, Ahmedabad. Needless to say, their contribution has been invaluable; we doubt if we would have looked so closely at ourselves but for their encouragement. We look forward to their continuing guidance and help.

Finally, we are grateful to the Editorial Services Division of Shishu Milap, Baroda, for help in the production of this report; the Centre for Regional Management Studies of IIM - Ahmedabad for funding the study; and the Bank of Baroda for funding the publication of this report.

August 1991  
Jhagadia, Gujarat  
India

Anil Desai  
for  
SEWA-Rural Team

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## PREFACE

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After almost eighteen months of protracted meetings among ourselves, with the CHP team and other members of SEWA-Rural, after several community meetings, and intensive field work that also included a survey, and after wading through several data and documents, we are happy to present this review of the Community Health Project of SEWA-Rural.

This review was undertaken by us with the hope that it would be a process of education for all concerned. This expectation has been greatly fulfilled.

The process of review was sought to be participatory. It was intensively so. It took more time, sometime led to heated discussions and eye-opening feedback but altogether it has turned out to be a tremendously educative and rewarding experience.

It is rare that findings or recommendations of such studies get directly and immediately implemented. But SEWA-Rural has already started implementing several of our recommendations. Nothing could be more satisfying for an external review team than to see its work (particularly when most such studies get contemptuously dismissed as being academic) bearing fruits so directly and so soon. It is also a tribute to the earnestness and sincerity of the SEWA-Rural team.

At a larger level, we do hope that this would be of use to a range of community health practitioners.

Practically every one in SEWA-Rural's CHP team has helped us in this work. They are too numerous to be acknowledged individually. But we acknowledge with gratitude the tremendous effort put in by Dr. S.Sridhar in making this report possible. Among others, Devendra, Girish and Akshay among the CHP team deserve our special thanks. Dr. Pankaj Shah, Dr. Lata Desai and Dr. Anil Desai of SEWA Rural were always there for us to bank upon.

Finally, we would like to thank the Centre for Regional Management Studies (CRMS) of Indian Institute of Management, Ahmedabad, who shared along with SEWA-Rural the cost of this study.

Renu Khanna  
N.R.Mehta  
Anil Bhatt

March 1991

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## ABBREVIATIONS USED IN THE REPORT

ABER	Annual Blood Examination Rate
ANC	Antenatal Care
ANM	Auxilliary Nurse Midwife [ = FI IW ]
API	Annual Parasite Incidence
AWW	Anganwadi Worker
CAPART	Council for Advancement of People's Action and Rural Technology
CDPO	Child Development Project Officer
CH	Community Health
CHP	Community Health Project
CHV	Community Health Volunteer [ = VI IW ]
CP	Community Participation
CSM	Corn Soya Milk
CuT	Copper-T (an Intra Uterine Device)
DDO	District Development Officer
DHO	District Health Officer
DWCRA	Development of Women and Children in Rural Areas
FI IW	Female Health Worker [ = MPI IW (Female); ANM
FP	Family Planning
GO	Governmental Organization
GOI	Government Of India
GTK	Gramin Tekniki Kendra
HE	Health Education
HNE	Health and Nutrition Education
ICDS	Integrated Child Development Scheme
KAP	Knowledge Attitude Practice
MCH	Maternal (or Mother) and Child Health

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MMR	Maternal Mortality Rate
MO	Medical Officer
MPHW	Multipurpose Health Worker (Male)
MTP	Medical Termination of Pregnancy
NGO	Non-Governmental Organization
NNMR	Neonatal Mortality Rate
NREP	National Rural Employment Programme
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
OTC	Opinion leaders' Training Camps
PHC	Primary Health Centre/Primary Health Care
PNC	Postnatal Care
PNMR	Perinatal Mortality Rate
RMO	Resident Medical Officer
SEWA-Rural	Society for Education Welfare and Action - Rural
SR	SEWA-Rural
SSC	Secondary School Certificate
TBA	Traditional Birth Attendant [Trained Dai]
TT	(Inj.) Tetanus Toxoid
USAID	United States Agency for International Development
VHC	Village Health Committee
VHW	Village Health Worker [ = CHV ]
VOP	Voluntary Organizations Project

## Part I

### INTRODUCTION : SEWA-RURAL, CHP AND THE REVIEW

# CHAPTER 1

## THE ORGANIZATION AND THE CHP

### A BRIEF HISTORY

#### Beginnings

More than two decades ago, a few of SEWA-Rural's founding members enrolled as students in some of Gujarat's colleges. They shared a common inspiration, mainly a deep-rooted conviction that all life is for serving the people and that one's profession is a good means to that end, and possibly one of the best. As they went through their studies and their subsequent professional work, the shared initial inspiration drew them closer to a common bond. Some of them went abroad for further specialization, but unlike many aspiring Indian students who go with an intention to settle overseas, their main aim was to return to India, and having acquired appropriate professional knowledge as well as some resource base, to start some action to serve the rural masses.

To a generation of Indians born around the time of independence, much of the commitment of the earlier generation to serve the country and its needy people, had become a shared vision. The enthusiasm with which these professionals decided to work for a larger and worthwhile cause of social service was a refreshing contrast. It was also infectious. Soon, many more individuals with education and experience in diverse fields of specialization decided to join the group. Drawing their inspiration from the life and teachings of Mahatma Gandhi, Swami Vivekananda and Shri Ramakrishna, this group of motivated and sensitive individuals sought to create an institution which would enable them to use their knowledge and skills for the benefit of the rural underprivileged. The result was SEWA-Rural (Society for Education, Welfare and Action - Rural) which was founded in May 1980 to provide assistance to the socio-economically depressed rural population of Jhagadia, a subdivision in South Gujarat. Jhagadia is primarily a tribal and agricultural area with 60 percent of its population landless labourers.

Large portions of this chapter are adapted from the issue on SEWA-Rural in the 'Anubhav' series published by Ford Foundation, 1989.

Taking their cue further from Vivekananda's and Gandhiji's beliefs that India resides in its villages and that no meaningful development is possible until the rural masses of India are well educated, well fed and well cared for, SEWA-Rural committed itself to integrated development encompassing activities in the fields of health, women's development, self-employment, and above all 'man-making and character building education.'

The founding group was particularly sensitive to the need to involve people in their own development. Its starting premise was that comprehensive development occurs only through community participation and that a participative ethos can be inculcated through the community's involvement, motivation, and consciousness.

A necessary complement to SEWA-Rural's community development effort is their own attitude to service of the community. The operative tenet underlying all work at SEWA-Rural has been that 'individuals develop by serving others.' Taken in that sense, service rewards and elevates not only the served but also the server. It is this convergence of enlightened self-interest with altruism that affords SEWA-Rural its very special organizational culture.

### **Emphasis on Health**

Although the founding group was convinced that integrated development was their overall organizational goal, for practical reasons (most of the original group were doctors), a deliberate decision was taken to start the project with curative health services which the group believed should precede and form an integral part of preventive health services.

'Curative health enjoys high visibility,' according to Dr. Anil Desai, SEWA-Rural's Managing Trustee and Project Director. 'An important preface to acceptance by a community is how well you are able to tend and cure the sick.'

Having decided that health would be a curtain raiser, the founder members were in no hurry, however, to commence the health project without adequate groundwork. This included scouting around for an existing option in the area where SEWA-Rural intended to work. 'We needed to save time and to conserve our limited resources,' according to Dr. Lata Desai, a trustee and wife of Dr. Anil Desai and Co-Director. 'Having selected Jhagadia as the project's location, we were on the look out for an existing setup with considerable potential. The Kasturba Maternity Home run by a local charitable trust in Jhagadia was godsent.' Appreciative of their ideals, the trust known as the K.M.A. Society decided to entrust the

management of Kasturba Home to SEWA-Rural. The maternity home was converted into a fully equipped 40 bed hospital in October 1980. It had four full time doctors, six consulting doctors, facilities for X-ray, a laboratory and an operation theatre. The number of doctors later increased, and at the time of writing, the hospital has full time services of a general surgeon, an ophthalmologist, a pediatrician, an anesthetist and a gynecologist. The facilities include an intensive care unit, ultrasonography, and microsurgical equipment for the eye department.

All through this transformation, however, the emphasis was less on physical renovation and more on provision of service. Resources to fund the facilities were raised through loans, donations from well wishers and personal savings of the founder members. Hospital charges were deliberately kept low (lower than at comparable hospitals) so as to reduce the economic burden on an already impoverished rural population.

The impact of the maternity home, reconstituted as a curative care centre having linkages with sophisticated urban centers for rarer cases, was compelling. As intended, it helped SEWA-Rural to establish its presence and credibility. In a relatively short period, the agency was able to elicit considerable acceptance and support from the community. Earlier, other than for normal deliveries, Jhagadia's patients had to trek to distant urban centres for health care which meant additional hardship for those who could ill afford the costs of health care in the first place. This major strain on people's time and resources was now averted by SEWA-Rural providing diagnostic as well as therapeutic medical care at the doorsteps of the residents of the villages.

The response of the people to such a well-founded medical facility situated in their midst was overwhelming. The utilization rate of the facilities offered at the Kasturba Hospital jumped significantly in the months to follow. SEWA-Rural decided to render services free to those who were very poor but to charge others some nominal amounts for the care they received.

The decision to work in the villages had been taken years earlier, and in 1982 the circumstances seemed favourable to 'step beyond the hospital walls.' Health work was started in 10 villages, built around a mobile dispensary. Almost simultaneously a semi-official liaison with the state government began, and by the next year (1983) the government had placed all the three kinds of village level health functionaries, CHVs, AWWs and TBAs, under the direct technical and administrative control of SEWA-Rural.

### **How the Government Came in**

Soon SEWA-Rural found itself on the threshold of a unique situation. When it applied for financial assistance from the GOI/VOP/USAID scheme in 1983, the issue of duplication of services under USAID funds came up (USAID was already funding the government health services in Bharuch district). The one logical way to resolve the issue was for the government to remove all government functionaries from the project area and hand over its total health care responsibility to SEWA-Rural. Incredibly, the government was positively inclined and it was left to SEWA-Rural to choose which way to go. After much deliberation within the group, the organization agreed to take over this responsibility and a historic agreement was reached. Never before had such an arrangement been worked out between a voluntary agency and the Government of Gujarat, and perhaps, it was a first of its kind in India.

Under this agreement, the government agreed to finance the entire Primary Health Care services in SEWA-Rural's project area. These services were to be run on the same pattern as that in the Government, but managed wholly by SEWA-Rural. SEWA-Rural would be required to fulfill the same targets in various health services which the government fixed from time to time. While SEWA-Rural was free to recruit its own workers, the criteria for their recruitment would be the same as that in the government, with some exceptions. However, SEWA-Rural had the independence to provide whatever extra training it decided that the workers required, and to employ and utilize extra staff at its own cost, with some degree of independence in implementing the given programmes. Besides, SEWA-Rural's Community Health Project (CHP) would be recognized for posting government functionaries on deputation whenever such an arrangement would be mutually agreeable.

Obviously, the organizers were quite aware of the potential pitfalls of such a system. They decided still to go along mainly on the argument that no kind of organisation could match the government in its reach and potential for reproducibility, and that if substantial meaningful services were indeed to be given over an extended period of time this would be very difficult to achieve without public funds. Also, they could see that this was an opportunity to establish credibility for the voluntary sector, and at the same time, to try and effectively implement the envisaged health programme of the government.

The agreement was to conduct this experiment for a period of five years starting April 1984, and then review the whole matter. The documents concerning this agreement are

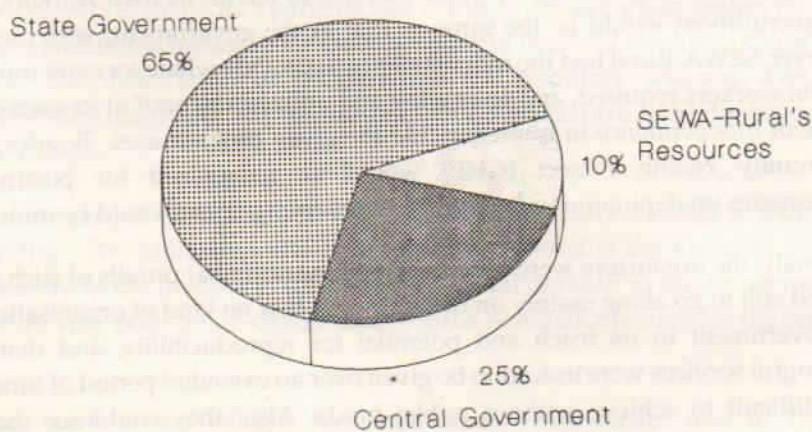


reproduced in Annexure 5, and Annexure 4 lists the objectives of the CHP as envisaged at the outset.

### Funds and Finance

The running of the community health project requires considerable funds. In addition to actual health work in the villages, expenditure is also incurred in subsidizing hospital services for needy patients from the project villages, who constitute 20-25 percent of all patients coming to the hospital.

The major monetary requirement is, as expected, towards recurring expenses including salaries, cost of medicines, transportation, etc. The non-recurring expenditure includes building construction at the head quarters and the villages, equipment, furniture etc.



Total Annual Budget: Approx. Rs.20,00,000

Fig. 1.1: Sources of Funds for the CHP

Altogether, the CHP has spent Rs. 1.25 crores over the years, including Rs. 84 lakhs as recurring expenditure for PHC, ICDS, family planning incentives, field studies and training; this amounted to Rs. 32 per capita per year for 1988-89. The year-wise details are given in Annexure 6.

Where do the funds to meet this expenditure come from? As shown in Figure 1.1, the bulk comes from the government: two-thirds from the District Panchayat and State Government, and most of the remaining from USAID grants through Government of India. Each year around 10 percent remains to be raised by the organization from its own sources.

This funding from the government has been possible, obviously because of the close linkages with the government, especially the taking up of total health care responsibility for the project area. In fact, one of the major reasons behind taking this step was the firm belief of the organizers that expecting self-sufficiency of the community in health financing is a utopian dream, and that public money is the only answer to finance such activities.

#### **OTHER ACTIVITIES AND PROGRAMMES**

An overview of the various activities of the organization is presented in Annexure 1. In addition to health activities, SEWA-Rural is involved in an income generating scheme for women, papad making, in three villages for around six years now. The scheme has had its share of teething troubles, but has now stabilized. Among other developmental activities for women, are savings and credit cooperatives running in three villages, and a programme for enhancing women's awareness. A social forestry programme involving tribal women on a cooperative basis had to be abandoned after a couple of years due to the government's refusal to give forest land to SEWA-Rural for development.

From the beginning, it has been the goal of the organization to contribute substantially to the education of the underprivileged.

One major thrust in this direction is the Gramin Tekniki Kendra (GTK). This is a novel experiment in holistic development of village youth, especially of the less privileged classes, for educational and economic betterment of villages. At the new campus of GTK at Gumandev, 3 km from Jhagadia, technical skills are imparted to students for various trades

which may lead to other dependent employment (fitting, welding, etc.) or to self-employment (masonry, pottery, etc.) or either (carpentry, motor mechanic, etc.). In addition, emphasis is laid on personality, character and responsibility building, and the training is conducted with the active participation of the family of the student. Over the years, the reputation of the students of GTK has grown, and now almost all of them get absorbed in industries. The close collaboration of voluntary organization, government and industry is a unique feature of this venture. In addition to technical training, GTK is also involved in issues related to low cost construction, appropriate technology, and energy and development.

Coaching classes for school going boys and girls of weaker sections are conducted regularly and many students avail of this facility. This will hopefully reduce the dropout rate in schools.

In addition to other community health programmes, the organization is making a beginning in environmental sanitation. Sanitary latrines are being promoted, and seem to be popular. For those with cattle, household biogas plants are being offered at a subsidy in some villages. Other similar programmes are poised to take off.

## **ABOUT THIS REVIEW**

### **OBJECTIVES**

SEWA-Rural decided on the following objectives for this study:

To provide an opportunity for the concerned members of the organization to reflect on their work of the previous five years by considering the objectives, strategies and methods on the basis of which the project was started; by reviewing the process of implementation; and by assessing the achievements at the end of the five years.

To find out from the target community by helping them articulate their perception of the role and function and services provided by SEWA-Rural; and their further expectations from SEWA-Rural.

To decide the future course of action and directions of work on the basis of the reflection and findings mentioned in the above two objectives.

To provide the staff an opportunity to design and conduct a systematic and sound review.

To disseminate the experience of SEWA-Rural to other interested individuals and organizations for purposes of sharing and learning.

### **PROCESS**

Some persons in SEWA-Rural were of the opinion that a 'participatory method' should be followed; a process through which the CHP staff members would be facilitated to assess their own work. The idea was that the CHP staff, instead of being passive recipients of a report from external reviewers, be involved in a process that would be of a great learning value to them. This principle of a participatory evaluation was sought to be extended somewhat by seeking feedback about the CHP from the community of beneficiaries.

With this view, SEWA-Rural organized a workshop in February 1989 inviting about 25 persons from all over India with experience in evaluation of health and development

programmes ( see Annexure 8 for some details of this workshop ). A series of meetings were also held with different groups of staff members including village level workers to help them articulate what they thought should be part of the review and how the review ought to be carried out. After the workshop and these meetings, the terms of reference and scope of the review were concretized. It was decided to adopt both epidemiological techniques employed in health sciences and also a case-study approach of social anthropology. Public health being a management area, enough weightage was also to be given to techniques used in management studies. The review team was constituted to include expertise from these three disciplines.

### METHODOLOGY

It was decided that the review would be done through : a sample survey covering health aspects; a KAP study of a sample of the mothers already surveyed in 1984; analysis of data from the existing records; a study of organizational systems and processes; and an analysis of perceptions of the community, SEWA-Rural staff, and government personnel.

It was also decided that, even though the staff would be involved at all stages of the review process, once the data was fully analyzed, the findings would be fed back to all the staff.

Though this review mainly concentrates on the five years (1984-1989) of SEWA-Rural's USAID-funded CHP, at places it touches on the events of the period since then to the time of writing of this report, so as to either update the information, or else to illustrate a point better.

Operationally, the following methods were adopted during the review for data collection.

#### Health Survey

Inspite of known limitations of such surveys in evaluation, it was felt that a health survey was essential. A pretested proforma (Annexure 9) was designed to collect demographic, sociological and health status data. Information collected included treatment-seeking behaviour, knowledge regarding health services provided by SEWA-Rural, people's

knowledge about roles of various categories of workers, community participation, opinion regarding SEWA-Rural and quality of its services, particularly mother and child health, people's expectations and complaints regarding the organization and its services. Utilization of MCH services was enquired in greater detail on a specially designed proforma (Annexure 9). Physical examination for nutritional deficiencies of people, particularly children, was performed, and their weights taken.

**Sampling :** There are 10 subcentres of CHP of SEWA-Rural each covering three to five villages. It was decided to take one village from each subcentre so as to get a representative sample. There are certain differences in the demographic and socio-economic profile of each subcentre area with respect to the caste, religion, occupation, availability of services and access to transportation. The villages were selected randomly. Every alternate house ( that is, 50 percent of households) in each village was included in the sample. The first house was drawn randomly (either even or odd) and subsequently even or odd households were included in the sample. If any house was closed, the house following immediately was included. The numbering of the households was according to the registers maintained by the male health workers.

Ten graduate investigators, who were trained intensively prior to the survey by the review team, and SEWA-Rural doctors, carried out the survey. They were assisted in the physical examination by interneer doctors of two medical colleges. Supervision was provided by the CHP doctors and a member of the study team. Information was collected from the mother or grandmother or any other elder female member of the family. SEWA-Rural field staff assisted in the survey by accompanying the field investigators so that rapport could be established. They also helped in interpreting the tribal dialect. The survey, including the training for it, was completed in three months. The sample survey which was conducted in 10 villages revealed the following profile of the population covered under the project area.

**Demographic Profile :** Table 2.1 shows that there are about four percent more males as compared to females (sex ratio 927). This slightly lower ratio would be expected in a tribal area.

Table 2.1 : Sex Composition of Surveyed Population

Sex	Freq	Percent	Cum.Percent
Female	1387	48.1	48.1
Male	1497	51.9	100.0
Total	2884	100.0	

Scheduled tribes form approximately 60 percent of the sampled population ( Table 2.2 ) while Muslims constitute about 11 percent of the population. However, the entire Muslim population is concentrated in one village, Kapalsadi. There are four exclusively scheduled tribe villages. Other backward communities who form about 15 percent reside mostly in four villages. This tendency for specific communities to concentrate in certain areas is a demographic characteristic which has considerable significance in determining health planning and delivery services as health behaviour is considerably affected by caste situation in the community.

Table 2.2 : Caste Breakup of Surveyed Population

Caste	Freq	Percent	Cum.Percent
Muslim	336	11.7	11.7
Tribal <sup>1</sup>	1781	61.8	73.4
Backward <sup>2</sup>	545	18.9	92.3
Higher <sup>3</sup>	222	7.7	100.0
Total	2884	100.0	

<sup>1</sup>Tribal includes Christians

<sup>2</sup>Backward classes include Harijans and other backward classes

<sup>3</sup>Higher class Hindus include Rajputs, Patels, etc.

**Education :** Table 2.3 shows that 38 percent of the people are uneducated. A high rate of illiteracy is a national feature, but the level here is higher as compared to some Hindi heartland states. Only 4 percent of population has education higher than the secondary level. Overall, 65 percent males and 35 percent females are literate.

Table 2.3 : Levels of Education in the Surveyed Population

Education	Freq	Percent
Illiterate	1107	38.4
Upto Std.4	560	19.4
Std.5 to SSC	618	21.4
SSC pass or more	115	4.0
Anganwadi <sup>1</sup>	324	11.2
Information NA	160	5.6
Total	2884	100.0

<sup>1</sup> under six-year-olds NA: Not Available

**Occupation :** More than 40 percent of the population was engaged as farm labourers, household workers, daily wage earners or petty traders (Table 2.4). It was also found that thirty percent of females are engaged as housewives. Around 16 percent of the population consists of school going children. One noteworthy finding was that almost equal number of girls and boys, are attending school.

### KAP Study

SEWA-Rural had carried out a KAP survey of the mothers in some villages of the CHP in 1984. Some of these villages appeared in the ten sample villages of the current survey (1989-90). It was felt that a repeat KAP survey of these mothers after five years would bring out the changes in the knowledge, attitude and practices. The same old proforma used in



1984 (Annexure 10) for a particular mother was used in the repeat survey and the findings recorded in a different colour. Changes were classified as 'improved', 'declined' and 'status quo' for each question in the proforma.

Table 2.4 : Occupation-wise Breakup of the Surveyed Population

Occupation	Freq.	Percent
Labourers <sup>1</sup>	846	42.3
Jobs / Skilled workers <sup>2</sup>	257	12.9
Own farm / cattle <sup>3</sup>	182	9.1
Unemployed/Handicapped	118	5.9
Own domestic work <sup>4</sup>	595	29.8
Total <sup>5</sup>	1998 <sup>6</sup>	100.0

<sup>1</sup>Includes farm labour, domestic labour, casual labour and small business.

<sup>2</sup>Includes secure jobs like government, at the mines, etc. and craftsmen like blacksmiths, masons, tailors, and diamond polishers.

<sup>3</sup>Those living off their own land or cattle : not doing any labour.

<sup>4</sup>Includes only females.

<sup>5</sup>Including minors who are gainfully employed : excludes those minors who are not so recorded.

<sup>6</sup>Adult population

#### Data from Existing Records

SEWA-Rural had from 1982 established a data record system in CHP. Birth and death registration and recording systems were fairly elaborately developed. The ICDS has had its own monitoring system which was further simplified by SEWA-Rural. SEWA-Rural is also required to send to the government periodic progress reports on family planning, ICDS, OTC (Opinion leaders' Training Camps) etc. Reports are also prepared for advisory committee meetings. Annual reports are regularly published. Various health indicators are worked out from these data every year. These are tabulated year-wise to measure changes (Annexure 7).

However, it was found during the review process that the data collection system had some weaknesses, lapses and faults. These are discussed in detail later in their respective chapters. Some of the data were corrected by the study team through field visits, discussions with field staff and cross checking with other records. This experience (of rectification) has been exploited by SEWA-Rural to subsequently train their workers in proper record-keeping. Some improvements have already been introduced, thus fulfilling one important objective of the review process, namely feedback and learning.

### Organizational Systems<sup>1</sup> and Process<sup>2</sup>

The data for this part of the study was largely gathered through a study of existing records and documents, interviews with various persons ( staff members, managers, trustees, village level workers and meetings with various groups of staff members). Certain exercises and tools for data gathering and analysis were designed as the work progressed through different stages ( see for example the chapter on organizational systems ). The review team members had also drawn insights from observing at close quarters the processes in the organization over a period of 15 months during 1989-90. Also, two members of the team have been associated with SEWA-Rural in an advisory capacity since almost the beginning of the CHP.

### Perceptions of the Community and Staff

Community perceptions were gathered through focus group discussions that were held at ten places in eight villages . Staff perceptions were gathered through personal interviews with about 27 of the community health project staff. Also, an organizational climate questionnaire (Annexure 11) was administered to 29 CHP staff. An open-ended questionnaire (Annexure 12) was given to about 75 village level workers. Both these questionnaires were designed with the input from field supervisors and medical officers.

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<sup>1</sup>Systems such as divisions within the organization, its management subsystems recruitment, supervision, monitoring, reporting, etc.

<sup>2</sup>Processes include norms, conventions, rules that guide people within the organization

## LIMITATIONS

While conducting this study the review team faced certain difficulties arising from some peculiarities of the situation. These are discussed in detail in the Introductory Note to Part III, and may be summarized as under :

1. While the work of the CHP began in October 1982, and to some extent the government collaboration began soon thereafter, the actual period under scrutiny begins 18 months later, in April 1984. Beginning at this point is therefore necessarily artificial since the work of the CHP was already 18 months old by then.
2. The problems associated with progressively enlarging the project area: The work of the CHP started in 10 villages in 1982. In April 1984, when the period of review begins, 10 more villages were included (which effectively came under SEWA-Rural's control in September 1984). Two years later around September 1986, the population again nearly doubled with the inclusion of 19 more villages (Annexure 7). Thus, viewed from March 1989, roughly half the population had been served for about two years and a half, a further quarter for four years and a half and the remaining for around six years and a half.  
This makes it impossible to determine a satisfactory baseline for comparison. The varying base population also makes overall assessment of change in various demographic indices almost meaningless, and at best, difficult to interpret. Even for data on service utilization, there is much difficulty in interpretation, particularly for a transitional year like 1986, where the number of villages covered doubled right in the middle of the year as new villages were handed over only in September. Hence it would be not proper to assess the work done in the newer villages in the remaining half of 1986-87.
3. The absence of a control population: Theoretically, some of these difficulties might have been overcome by comparing SEWA-Rural's CHP programme against a neighboring control population. This was not done, because it was deemed logistically not feasible, and also not necessary: the period of five years was thought to be far too short to make such a comparison meaningful.

## Part II

# ORGANIZATION : PROCESS AND SYSTEMS

An attempt is made to understand the organizational culture of SEWA-Rural through the study of three aspects: the stated values and philosophy of the organization, the leadership styles of some of its key persons, and finally, the decision making processes in the organization.

Although this study is limited to the review of the CHP, these three aspects of the organization are being described because they have a direct bearing on the CHP.

#### VALUES AND PHILOSOPHY

SEWA-Rural's emphasis on values and operationalization of these values forms an important aspect of its character. There is often a stubborn, uncompromising stance adopted when these values are threatened, a stance that is often criticised even by well-wishers who otherwise have the 'good' of the organization at heart. However, the leaders of SEWA-Rural believe that these threats to their values are to be considered as tests and as opportunities for strengthening the institution. In confronting these situations and standing by their values, although in the short run they face turbulence and struggle, in the long run the organization apparently emerges stronger.

The fact that SEWA-Rural has been, by and large, successful in practising these values, especially in the context of working with the government, is noteworthy. One has to view this also in the light of the cynical reception given to groups professing these values in the current Indian socio-political milieu. More importantly, SEWA-Rural's experience is a lesson, small in itself, but significant in the context of voluntary organizations, that in order to achieve goals in real life, one need not compromise with values like truth and integrity. Another notable feature of SEWA-Rural's value orientation is its ease of interpretation coupled with a determination of getting on with the task. There is a marked absence of ideological or reductionist hairsplitting, about theory and praxis, that often leads to paralysis in the delivery of concrete services among many activist groups. This determination of

getting on with the task is perhaps carried to an extreme sometimes. There have been some instances of programmes being launched without adequate and necessary preparation. A case at hand is the starting of the Training Centre at SEWA-Rural. Instead of waiting till a suitable person was recruited to handle the responsibility of such a centre, several of the existing doctors and core group members spent considerable person hours in learning the nuts and bolts of developing a training programme. In SEWA-Rural, the large scale, organization wide acceptance of value interpretations (in routine as well as in crisis situations) is aided by the persuasive charisma of some members of the core group. The internalization of these interpretations, however, varies from person to person in SEWA-Rural, but, by and large, the resulting situation has not been dysfunctional.

### Guiding Principles

What, then, are some of the guiding principles of SEWA-Rural's value orientation? In contrast to the values of empowerment and conscientisation of some other contemporary voluntary agencies, service to the poor and emphasis on the spiritual essence of human beings are some of the major guiding principles followed by SEWA-Rural. The interpretation of these principles are often ascribed to the witness of the lives of Ramakrishna Paramahansa, Vivekananda and Mahatma Gandhi. The emphasis of these epochal figures of Indian society on the *Daridranarayana* (seeing God in the poor and the distressed) and on 'man-making' are often cited by the core group as major sources of inspiration. 'Man-making' appears to be interpreted in SEWA-Rural as a striving for perfection of each and every human being in more than one sphere. All tasks and challenges in SEWA-Rural are therefore viewed in the light of this ultimate quest. The essential spirituality of SEWA-Rural's project is reflected, ideally, in work being viewed as prayerful worship. A close corollary of this world view is one in which SEWA-Rural's core group views temporal successes and failures as part of a divine plan, a world view which could be essentially healing and strength-giving to carry on with the task at hand.

### Some Examples

Prominent among the values dear to SEWA-Rural are *honesty and integrity* at whatever cost. As an example, people in SEWA-Rural are fond of citing the incident about the three year old child who was mistakenly dispensed a wrong drug. The error was discovered by her

parents after some skin burns occurred near the mouth. The parents considered taking legal action fearing that SEWA-Rural would not admit their mistake. SEWA-Rural however, informed the parents and all concerned that the highest authority in the institution was responsible for the error no matter at what point within SEWA-Rural it originated. The concerned staff at all levels too took the responsibility for their mistake. Everything possible was done to remedy the situation for the child, who is well now.

A further example of the operationalization of this value for integrity is in the relationship with the government. SEWA-Rural is regularly required to submit the data of its performance and achievements in several government fora. Earlier, SEWA-Rural's reports with their lower target achievements were frequently questioned or scoffed at. However, now SEWA-Rural has been able to establish with no uncertainty that its data is authentic and uninflated, unlike that produced by most of the government agencies. The situation now is that SEWA-Rural's figures are accepted without question in government circles.

Achieving and maintaining high standards in their *quality of work* and in terms of the services provided at the village level, is another value of SEWA-Rural. Particularly in the CHP work this comes out strongly. A supportive factor for this may lie in the personality of the person who has been in charge of this programme from the time of its inception. If there is one characteristic that may be called the hallmark of the community health physician, it is his thoroughness and attention to detail. The improvement in the quality of work is achieved through constant collective and individual introspection and reviews: strategies and methodologies are reworked thereafter.

The extreme importance that SEWA-Rural attaches to good quality of work is illustrated in its attitude towards long term financial stability. Policy makers at SEWA-Rural believe that if the organization were to have financial security for more than a certain period of time, there would be a danger of the organization becoming complacent and lax. They feel that as a way of keeping the organization on its toes, fund raising activities for operational expenses should be undertaken each year : at the least, for the sake of showing the donors, the quality of work would be maintained, a rather indirect way of ensuring that a certain standard of work is maintained. The amount of time and energy spent by the key persons in this particular fund raising activity each year could surely be put to other better uses. Mechanisms for safeguarding against complacency and ensuring continued good standards in the quality of work done could be designed, and put into practice without fear of compromise.

Yet another value upheld by SEWA-Rural is *equality of all patients* and no dispensation of special favours to anyone. There used to be pressures by several community leaders to get preferential treatment at SEWA-Rural. Much to their chagrin, they have learnt that everyone who comes to the hospital has to take their turn in the queue, whether he/she be the local rich person, or the politician or even a staff member.

Many local leaders who have been supportive of the SEWA-Rural efforts, have at times assumed that as a gesture of reciprocating their goodwill, the organization would let them use its facilities like the duplicating machine, or a hall for meetings, etc., free of charge; or that they and their family members would get special attention, preference or favour over others. The organization's stand that these are public resources and not for the personal use of any one individual, or for purposes unrelated to the organization's stated objectives, have not been appreciated by many. In fact, sometimes, there have been adverse reactions which have resulted in creating strained relationships with the community.

An example that would fall in the same category is that of 'recommendations' for local candidates applying for jobs at SEWA-Rural. The local power-brokers and 'big shots' who used to earlier confidently recommend their candidates to SEWA-Rural, have now come to realize that their recommendation may, in fact, work as disqualifiers for candidates who otherwise would stand a good chance of being selected by the organization. All the above are examples, whereby, while upholding its own values, SEWA-Rural is attempting to educate its own staff and the larger community about more ethical and egalitarian ways of functioning. The task, however, is extremely difficult. Getting work done through 'sifarish' or 'personal relationships' is so much a part of the Indian psyche that the SEWA-Rural kind of ethos and 'professionalism' tend to look so alien, that although the community has now come to 'accept' the organization's way of functioning, even if unwillingly, one wonders whether they would ever be able to appreciate it at all.

*High standards of sexual morality* is another value which is regarded as absolutely critical in SEWA-Rural. This value has also been severely put to test in the last seven years. So rigid and uncompromising is the organization's stand on the maintenance of high moral conduct that the decision makers had little hesitation in asking some important persons to resign from SEWA-Rural when found guilty of violating this value. In all these cases, the decisions were extremely painful. The concerned individuals were highly respected within and outside SEWA-Rural. There was a natural hesitation in openly discussing these incidents. In many of these cases, there were at least two underlying considerations : (i) the particular



relationships were seen as exploitative of women, negating the value of liberating women from their unequal positions in society, and, (ii) sexual relationships outside the institution of marriage are simply not done.

Related to the above, as already mentioned, is the *value for women and their situation* in today's world. In operational matters decisions are taken keeping their special problems in perspective. In one incident where the male staff member was asked to leave the organization, the woman was treated with far greater sympathy and support by key persons at SEWA-Rural. The problems of women staff members working in the field are considered with greater sympathy with some of the male staff members resenting the unequal treatment. Frequent demurrals are to be heard in this regard. However, like elsewhere in the country where women field workers are working in the villages, SEWA-Rural has not yet found any solutions in terms of viable mechanisms, to their special problems.

Notwithstanding all the above, the underlying attitude of most people in the organization towards women appears to be one of patronage and condescension : good intentioned welfare approaches to women appear to be followed, approaches that reflect a lack of appreciation of the gender issues at work in micro situations as well as in society at large. Instances of the above would include the way the improved chulha programme was taken up by SEWA-Rural as also the way aspects of the community health programme concerning women (for example, the family planning and MCH programmes) have been executed. These programmes have been carried out without much critical consciousness of women's status in society and the factors affecting their status. The current debate and thinking going on in the women's health movement in India has left SEWA-Rural largely unaffected.

#### **Percolation of Values**

The main mechanism for the percolation and dissemination of the organizational values down the hierarchy seems to be to treat each conflict situation as opportunity for education. The situation is discussed and analysed with the staff so that they understand the different aspects. In many of these situations, the staff are asked that if they were to take a decision and action, what would they do. Responses that uphold the organization's values are reinforced whether they be actually rooted in conviction or not.

Department heads are encouraged to do the same : to use every possible opportunity for illustrating the values on which SEWA- Rural works to their staff. For example, it is almost a daily occurrence for work to spill over and beyond office hours in the evenings. Heads and senior members put in extra time regularly without expectation of financial compensation; the other staff are thus encouraged to follow suit, and by and large a culture of not shutting shop till the day's work is done has been well imbibed at all levels. Similarly, the pro-poor thrust is given a concrete shape by unequivocal stands taken by senior members every day while taking policy and operational decisions, which make it amply clear that the poorer, downtrodden people are VIPs and are to be treated as such. But with all this, as mentioned earlier, the process of understanding and internalization is very slow. Many of the staff members are extremely attracted by the noble ideals. But when it comes to implementation of these ideals, at the personal level, there is often an understandable struggle which results in frequent lapses and deviations. A vivid example of the inner struggle that many of the staff members have is related to the salary structure of the CHP in comparison to what their counterparts in the government get. SEWA-Rural has a policy of giving the CHP staff around 20 percent lesser than what they would get if they were employed by the government. While the staff members understand the reasoning behind this policy, to maintain parity in salaries all through SEWA-Rural, they are not able to accept the 'loss' that they personally incur.

#### **Outcome of Value Orientation**

This kind of value orientation and a conscious operationalization of the value system has led to several interesting outcomes and trends in SEWA-Rural. It has led to persons with similar values being attracted to SEWA-Rural and joining the organization. This is very clearly illustrated by the example of the number of doctors, who could choose to be anywhere else in the country (or the world for that matter) who approach the organization and express an interest in joining it. This experience of SEWA-Rural is in marked contrast to many other rural voluntary health organizations, who just cannot attract doctors. These are doctors who have the desire to 'serve' or for whom the fellowship of other serious professionally competent colleagues is important. For some the prayerful atmosphere and the spiritual quest is the attraction. There is an element of safety which this atmosphere offers, the safety coming due to the ability of the value system to evoke the catholicity and tolerance of the best of humanist religious traditions, a tradition in which the uninitiated,

the neophyte, the seeker, the believer and sometimes even the doubting Thomas and the sceptic have their respective spaces to operate in relative freedom. At its best, this comes out as a form of gentle cooption, task and task efficiency is stressed, and differences underplayed.

However, the question does nag certain others whether it could be that SEWA-Rural attracts only those type of people who like to be 'good' and in a 'good' organization, rather than those who have deep interest in, and insight into the political issues related to community health work.

The emphasis on spirituality and making it an organizational, as opposed to a personal value has led to some problems, too, within SEWA-Rural. Some of the staff members have not grasped the essential difference between 'spirituality and 'religion', the latter especially when viewed as ritualistic cant. It does happen often that, some persons who initially join the organization for the sake of a 'job' and who initially do not have any great aspirations or higher goals for themselves, develop a commitment to the philosophy and the values espoused by SEWA-Rural. This is true of several of the young middle level field staff members, whose need at their current stage of life is for the security of any gainful employment but having joined SEWA-Rural have developed the commitment and dedication. At least four (of the six middle level field staff interviewed) of them volunteered that even if they were to get government jobs, they would prefer to remain at SEWA-Rural.

Yet another notable outcome of the spiritual and value orientation of SEWA-Rural seems to be its effect on the styles of interpersonal conflict resolution and team building. Having super-ordinate goals like 'service' and development of all human beings and appealing to their higher ideals, helps in sublimating or reducing personal power struggles and intergroup frictions. Team building is certainly made easier when people share similar values and have a commitment to a common goal.

Many of the personnel management practices are influenced by the above mentioned values. Persons are seen as a 'whole', having a spiritual dimension in addition to the physical, mental and emotional growth in all.

In conclusion, it may be mentioned that some of the words and phrases that best describe the ethos of SEWA-Rural are:

- strong pro-poor thrust; deep sense of commitment to values;
- yet practical; down to earth; conscious of getting on with the task;
- building on commonalities;
- non-confronting;
- conscious about receiving and giving recognition to good work done; and
- shy, introverted with respect to larger systems.

### LEADERSHIP STYLES

The observations about leadership styles are based on years of association of the study team members with the key persons at SEWA-Rural. Personal communication at various points of time with these persons also forms a basis of this analysis. Moreover, semi-structured interviews with the staff and the organizational climate questionnaire have provided some insight as to how the staff perceive the leaders.

Leadership styles will have to be looked at throughout the organizational hierarchy, right from the level of the Board of Trustees, to the executive and implementing levels of SEWA-Rural including the CHP project staff.

#### Delegation

The most notable feature of the Board of Trustees is how a group of persons competent and capable in their own right, have delegated complete authority to one Managing Trustee while trying to maintain strong links, accountability and their own involvement. This is in contrast to a number of voluntary agencies in India today, where either the trustees function merely as rubber stamps fulfilling statutory roles or else there are frequent conflicts and power struggles, probably a result of unclear roles or unfulfilled power needs. Most SEWA-Rural trustees contribute in certain specific areas and thereby play a supportive role to the Managing Trustee. There appears to be a clear understanding (and acceptance of the fact) that while the Managing Trustee and his team will consult the trustees and get their opinions on a variety of decisions and also report to them in the monthly meetings, in times of crisis however, the decision of the Managing Trustee shall be final and binding.

### Team Work

At the operational level of SEWA-Rural, the Managing Trustee, who is also the Director of CHP, the Co-Director and the community health physician (also trustees) function very closely together, so closely in fact that they are often perceived as one by many of the junior level community health project staff whom we talked to. There are surely differences in individual styles and in the sources of power and influence that they exercise. For instance, the Director's influence appears to come from his personal example and conduct. Several of the staff members hold him up as a source of inspiration and he seems to be a role model with a style of leadership that tends to evoke the following descriptors: pragmatic, balanced, definitive, decisive and humanistic. Competent value-based administration and management is stressed. In contrast to a 'benevolent paternalistic' leader, his focus is as much the care and nurturance of the employees as that of the organization itself. Loyalty to the organization's task and values is demanded and obtained. While in the early years of SEWA-Rural's growth, the Director spent his time equally between surgery and maintaining and developing the organization, now his principal function seems to be monitoring progress, fire fighting or managing crisis situations as well as communicating and sharing with as many persons as possible, the vision and philosophy with which SEWA-Rural was started. He also considers it his responsibility to launch new projects, to think through with others on issues concerning expansion and growth.

While the Director appears to be conscious of a larger leadership role that is being demanded of him and that he can possibly play, he seems to be torn between his personal need for greater solitude and prayer and the organization's need for maintenance, consolidation and further development.

The Co-Director (who as mentioned earlier is the wife of the Director) functions very closely with the Director and the community health physician. She is a paediatrician and has a good insight into the problems of community health. She has been especially interested in the MCH and ICDS aspects of the outreach work and lately has been putting her energies into the women's programme.

The community health physician, as a part of the trio has his own unique style. He is more comfortable with the 'task' rather than the 'people' aspect of management. Planning and execution of the work down to the last fine detail is his forte.

With the Director as the pivot, the other two team members support him with their strengths: the community health physician with his knowledge of community health and his thoroughness and attention to fine detail and the Co-Director with her sympathetic attitude towards the women staff members who are the majority (60 percent of the total). This accent of focussing on people's strengths rather than dwelling upon their weaknesses is a feature that is seen repeatedly at other levels of the organization also.

A related aspect of the leadership style that is appreciated by the staff is the fact that if there is any failure, no one person is blamed for it. Collective responsibility is assumed in a spirit of 'let's learn from this.' One of the staff members gave an example of the Women's Health Camp at Simadhra. Only six women out of a total population of more than a hundred eligible women attended the camp. The blame was not ascribed to any individual field worker but in a collective review, each person involved in the effort analyzed his/her own role and gave suggestions for how improvements could be brought about in the future. Good work done, is brought to the notice of senior persons and duly recognized. This is borne out by the fact that about 68 percent of the respondents of the organizational climate questionnaire feel that credit and appreciation is given for innovative work done in SEWA-Rural (Q. 23, Annexure 11).

The value based leadership style has a direct effect on team functioning especially in the event of crisis. A number of persons in the personal interviews, and while responding to the organizational climate questionnaire, remarked that they have experienced team spirit and team functioning in SEWA-Rural. Again it is the value based approach and appealing to a person's nobler or higher self that is used in conflict resolution. The staff say that generally things are worked out by mutual consent, by emphasis on the commonalities rather than as the differences.

#### Community Contact

These leaders although one step removed from the CHP, do have an influence on the staff of the CHP. Some of the older staff members who have grown with the organization, regret the growth of SEWA-Rural in terms of the increase in size. This growth, they say, has brought a distance between them and the leaders who were earlier far more accessible and approachable. Not only do they miss the socio-emotional support that was present earlier, but they also appear to miss the attention that these people gave to the task in the field earlier.

The Co-Director and the community health physician who used to frequently go out in the field and thereby monitor the work and guide the staff, now no longer have the time to do so. The Co-Director herself feels the lack of a meaningful contact with the community and the staff but cannot seem to manage her time better to fit in, what is to her, a source of spiritual inspiration.

This team, which appears to be otherwise strong and cohesive seems to be lacking in one other crucial element: a person who is close enough and sensitive enough to the CHP staff so as to feel their collective emotional pulse and sustain their interest and motivation in their work, a person who is excited about community health and relates to the community by helping infuse a sense of creativity and excitement in the field staff who are often drained and exhausted by the sheer hardships and frustrations of field work. This gap however, has been recent.

In one piece of feedback that the CHP staff offered, the systems and methods of working of the CHP were found to be too person centred: each of the three incharges of the CHP during the last year (1989) had his/her own way of doing things. The result was that during this turbulent year, 1989, the staff had to adjust to many frequent changes in the methods of work and in what was expected of them. Not much can really be done in the face of the unexpected and unavoidable changes that occurred in the CHP during the year. Also it is inevitable, and to some extent desirable, that each new person entering a job will bring her/his own unique influences to bear. However, the organization does need to be conscious of a need for some continuity, and minimum disruption, because of changes in personnel.

Clearly the key people at SEWA-Rural have succeeded to a large extent in providing a role model for the staff, but one point that has to be emphasized is the need for the leaders to maintain some degree of regular and direct contact with the community. This is necessary for several reasons: one, it is a source of insight and feedback on which many decisions and policies of the future of SEWA-Rural can be based and two, leaders who maintain a contact with the community are a role model for the other staff. They demonstrate a value for sensitivity to the nuances of the community. On the positive side, the sense of collective responsibility and accountability being nurtured at SEWA-Rural is notable.

## DECISION MAKING

In this section, we seek to answer questions like : who makes decisions at SEWA-Rural? how are decisions made? what do people at SEWA-Rural feel about decision making processes? The decision making processes at the CHP of SEWA-Rural are a function of many factors : of the historical evolution of SEWA-Rural, the values held dear by the organization, and the personalities and leadership styles of the key persons at SEWA-Rural.

### Who makes Decisions at SEWA-Rural?

The forums of decision making have not yet been formalized at SEWA-Rural. They are largely as they were when the organization was small and growing. Earlier however (till 1985) all decisions, major and minor, were made by the Managing Trustee, the Co-Director, the community health physician and after 1985, when the community health physician took greater responsibility for the CHP, most CHP decisions were taken by him after consulting the co-director and sometimes the Managing Trustee. It appears that two of the trustees have also been consistently involved in the planning of major decisions, even those of the CHP. Most of the matters thus, are decided upon in an informal way though preceded by prolonged discussions and then reported in the meetings of the trustees and sometimes ratified therein. Sometimes however important decisions fail to get ratified even in this forum. Discussions with several persons all along the organizational hierarchy revealed that the following forums (or groups) are involved in one way or another in the decision making processes : the meetings of the trustees : the Advisory/Evaluation Committee;

- the 'core' group or the 'management; the coordinating committee and the planning group;
- the triad of the Director, the Co-Director, the community health physician;
- the supervisors of the CHP; and
- the Director.

A review of the minutes of the trustee meetings reveals very little. Bare resolutions are recorded, very little of the discussions and processes of the meetings is recorded in the minutes or for that matter anywhere. The Managing Trustee admits that recording history



in writing is a weakness of SEWA-Rural. Apart from the necessary project proposals and reports very little else gets written down.

From the point of view of assessing the historical evolution of the institution, it may be useful for SEWA-Rural to begin noting some salient aspects of decisions affecting the organisation. The Advisory/Evaluation Committee, although largely advisory in nature, as its name suggests, also plays some decision making role. Many technical and managerial matters concerning the CHP are brought to the Advisory Committee which acts as a sounding board and helps in the finalizing of several decisions. Some decisions, for example, in the very first meeting the decision to fire a CHV, and later the decision to expand the CHP to new villages, were actually taken in the Advisory Committee meetings.

However, the groups that play the most significant role in decision making at SEWA-Rural (decisions which have a bearing on CHP too) appear to be the 'core group' and the 'management'. Often these two terms appear to be used interchangeably to indicate the same group. However, on deeper study, there appears to be a fine distinction between the two.

Although all staff members freely use the above terms, no one seems to be quite sure of exactly how many and who are the members of the core group and management group. According to the Director, the core group is an informal group; a broad criteria for finding entry into the core group is: persons working in key positions in SEWA-Rural and having the same philosophy and having demonstrated a sense of loyalty to the organization. Generally, people who find entry into this inner circle come in after being observed for four or five years after they join SEWA-Rural for evidence of having internalized the organisation's value system.

Six persons, the Director, the Co-Director, the community health physician, the administrator, a medical officer and the coordinator, appear to be the nucleus of the core group. Everyone whom the review team talked to, including these persons themselves, has a clear understanding that the individuals referred above belong to the core group. Apart from these six names, three or four other names are mentioned in connection with the term 'core group'. This implies that the six persons (who are mostly heads of departments) certainly have a say in almost all the major decisions taken at SEWA-Rural. The others who are in the outer circle of the core group are sounded out for their opinions for many of the decisions. The core group appears to function as an informal policy making and vital decision making group.

The term 'management' also appears to be equally nebulous in connotation. According to the staff, management seems to include the Director, the Co-Director, the community health physician and the coordinator. According to the planners, 'management' is synonymous with the coordinating committee. It is interesting to note that the two trustees who are part of intense discussions in most decisions, are not perceived by the staff as being members of the core group or management. This may be because all their interactions with the Managing Trustee take place behind the scenes.

The coordinating committee is a formal body comprising of heads of all departments (about 9 to 10 persons), including the RMO, GTK incharge, etc., and is involved in discussions for many new programmes. In an attempt to develop a second line of decision makers in the organisation, a 'planning group' was constituted that includes all the coordinating committee members except the Director and the Co-Director. This group was entrusted with the task of deciding whether SEWA-Rural should start a formal training centre. The group was also supposed to prepare proposals for any new programmes at SEWA-Rural and take decisions on these. However, after that first decision on the training centre, this group has not really taken off.

Many of the decisions related to the CHP are taken by the medical officer, the community health physician and the Co-Director. The decisions about rationalizing the salary scales of the CHP staff and about promotions of the staff are taken by these three persons. The supervisors are not involved directly although their feedback is obtained. The decisions about staff transfer and reallocation of responsibility also seem to be taken by these three in consultation with the supervisor and the field level staff.

Most operational decisions of the CHP are taken by the field level supervisors. Some examples of these kinds of decisions are: evaluation of the FHWs and MPHWs, allocation of villages among the different workers, planning activities for the community participation days, scheduling the visits of the mobile dispensaries to the various villages, deciding the timings for the subcentre meetings, etc.

However, no matter how all these different level of decisions are taken it would be appropriate to say that in certain cases the decisions are made by none other than the Director himself. In a crisis situation, as for example, the sanctity of the basic values of SEWA-Rural being threatened, the right to make the final decision is assumed by the Director. There have been also situations when the Director has not agreed with a particular decision but has gone

along with it because the other members of the group have strongly supported a particular point. A case at point would be the decision about whether SEWA-Rural should accept the responsibility and assume the status of a PHC. Two of the trustees strongly felt that in continuation of the principle of 'GO-NGO collaboration' and to establish SEWA-Rural as an example of a replicable model, the PHC should be taken. The co-director and the community health physician felt that the previous five-year experience of working with the government had been positive: SEWA-Rural had learnt to manage the tensions implicit in the relationship with the government. Despite his deeply felt reservations, the Managing Trustee went along with the decision.

The other aspect about the above decision has been that the key persons in SEWA-Rural now feel that the options were never seriously considered even as alternative modes of functioning were not thought about. Becoming a PHC was assumed to be a natural next stage.

What however of community involvement? Even in decisions directly related to the work of CHP, community involvement seems to be nil. Community representatives are not consulted for any decisions, whether they be decisions related to charges at the mobile dispensaries, or be it about the frequency of the mobile dispensary visits or about the of field level staff from one village to another.

#### **Perceptions about Decision Making Processes**

Many of the staff members feel that most major decisions concerning the organization are taken together, or discussed first, and then taken and then shared among the staff. As one of the senior staff members put it, decision making processes in SEWA-Rural reflect 'guided democracy': no one person takes any decisions nor is there absolute democracy, if such a state were possible.

Several staff members mentioned the 'goshti' as a very valuable forum for expressing their opinions. Every Thursday evening the Managing Trustee would have an 'open hour' when staff members would be free to discuss any topic that they wished to with the Managing Trustee.

The organizational climate questionnaire (Annexure 11) administered to 29 staff members of the CHP contained one question (Q. 11) on the decision making processes as applicable to individuals at their own level: To what extent do you feel that the employees here are allowed to make decisions to solve their problems without checking them with their supervisors at each stage of the work?

The responses were as under (all figures in percentages):

To a very great extent	17.2
To a great extent	10.3
To some extent	24.1
To a little extent	37.9
Not at all	10.3

More than 48 percent of the respondents felt that problem solving and decision making autonomy was not available to them at their own levels. This was reinforced by the responses in the semi-structured personal interviews with the staff too. Two of the field level supervisors stated that, 'Absolutely minor decisions are left to the middle level staff; most of the decisions are taken at the top level. We cannot implement a new system that we think is good, until we have convinced the top level.' Another supervisor stated that, 'Decentralization works on paper, if there are problems at our level we are not left to tackle them. Decisions are taken over us. For instance, once an MPHWH working under me was sick and I gave him some table work to do. However, the MO incharge of the CHP saw him in the office and went and marked him absent.'

### Conclusion

To conclude this discussion on the decision making processes at SEWA-Rural, the effort towards creating or strengthening a second line of decision makers should be lauded. Perhaps staff members need some more clarity on the forums which are entrusted with the task of making different categories of decisions. This need of the staff members should be responded to.

Another aspect of SEWA-Rural which needs some comment is the practice of testing people and then if they conform to the established norms and values, rewarding them by letting them enter the 'inner' circle or the core group. The practice in our opinion should be reverse: true openness would be reflected in a situation where each person would be treated as a part of the inner circle until he or she demonstrates his/her inability to function as a part of this group.

Having discussed the issue of decision making extensively, the external review team is of the opinion that often because of a lack of clarity of decision making structures and also perhaps because of individual styles, decisions bounce between different individuals and different levels and are taken after considerable delays. Another aspect concerned with decision making at SEWA-Rural relates to too many key people getting involved in relatively routine or unimportant matters.

What this implies is that perhaps as the organization is growing in size and in the complexity of its functions, there is a need for greater clarity and formality in decision making structures and processes.

This chapter deals with some of the more functional organizational aspects and systems: aspects like organizational structure and staffing; systems like job descriptions and performance appraisal, communication, coordination, monitoring, supervision and training.

### ORGANIZATIONAL STRUCTURE

Figure 4.1 shows an organization structure of SEWA-Rural. The organization chart of the community health project is shown in Figure 4.2.

In the community health project a process of decentralization has taken place. Since 1986, 10 subcentres have been created each with a subcentre incharge who is either a male supervisor, or a female supervisor, or an anganwadi supervisor. This person is supposed to be fully responsible for his/her area and for all the field staff working therein. This responsibility is in addition to his or her responsibility of supervising some MPHWs, or FHWs, or AWWs, as the case may be. Decentralization seems to have helped in creating a suitable climate for the planning and implementation of the various activities, as well as in delegation and monitoring and guiding of various staff members.

The Advisory/Evaluation Committee is a unique feature of the community health project. This was set up with the inception of the community health project in 1982. However when the USAID project started, the Advisory Committee was changed at the behest of the Zilla Parishad to the Advisory/Evaluation Committee. This was instituted when the experiment of the government handing over an entire area to the voluntary agency started.

The Advisory Committee has as its members some government functionaries (for example the DDO, DHO, Regional Deputy Director of Health Services), the key persons at SEWA-Rural (for example the Managing Trustee who is also the Director of community health project, the community health physician), and some specialists and experts in the

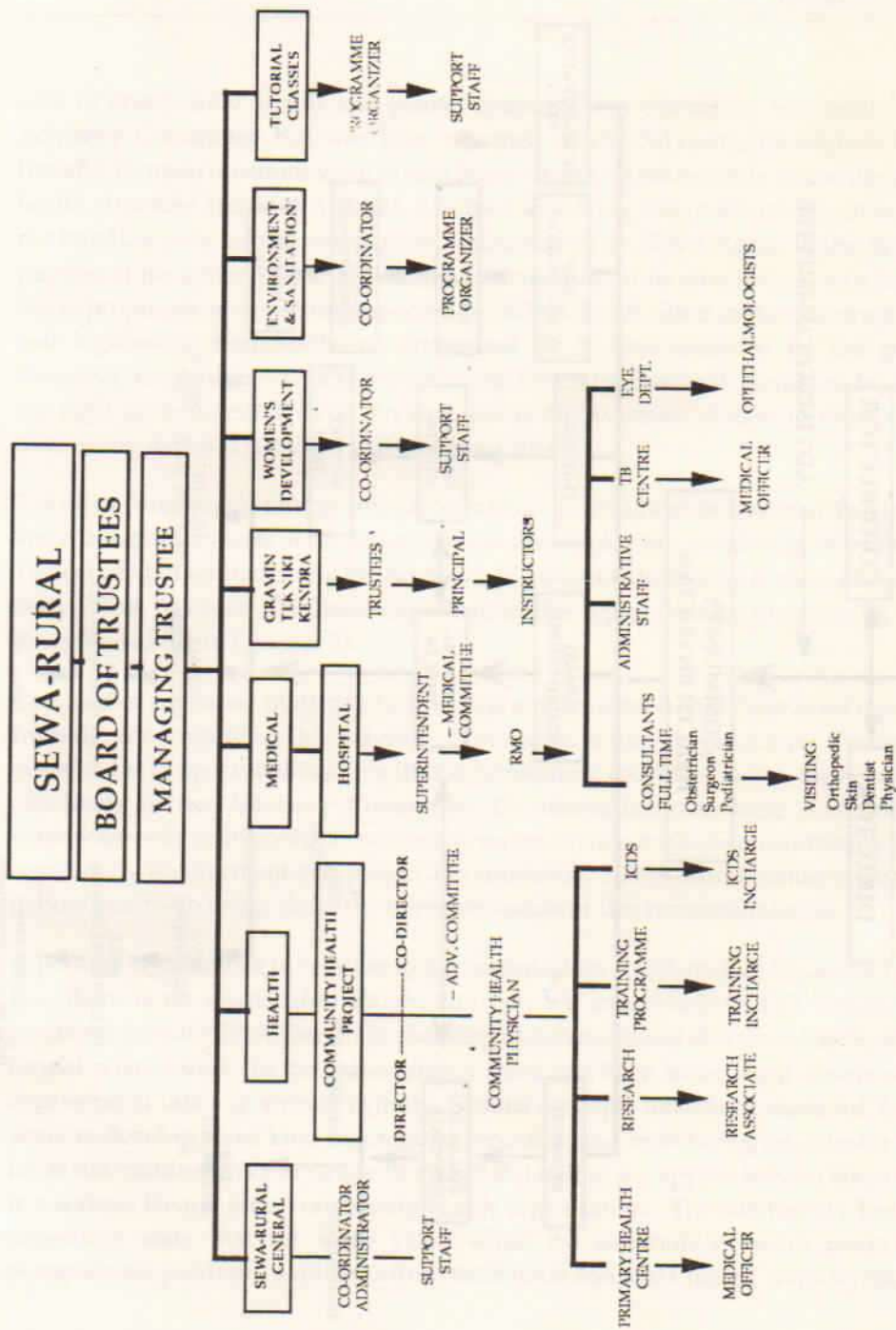


Fig. 4.1 : Organization Chart of SEWA-Rural

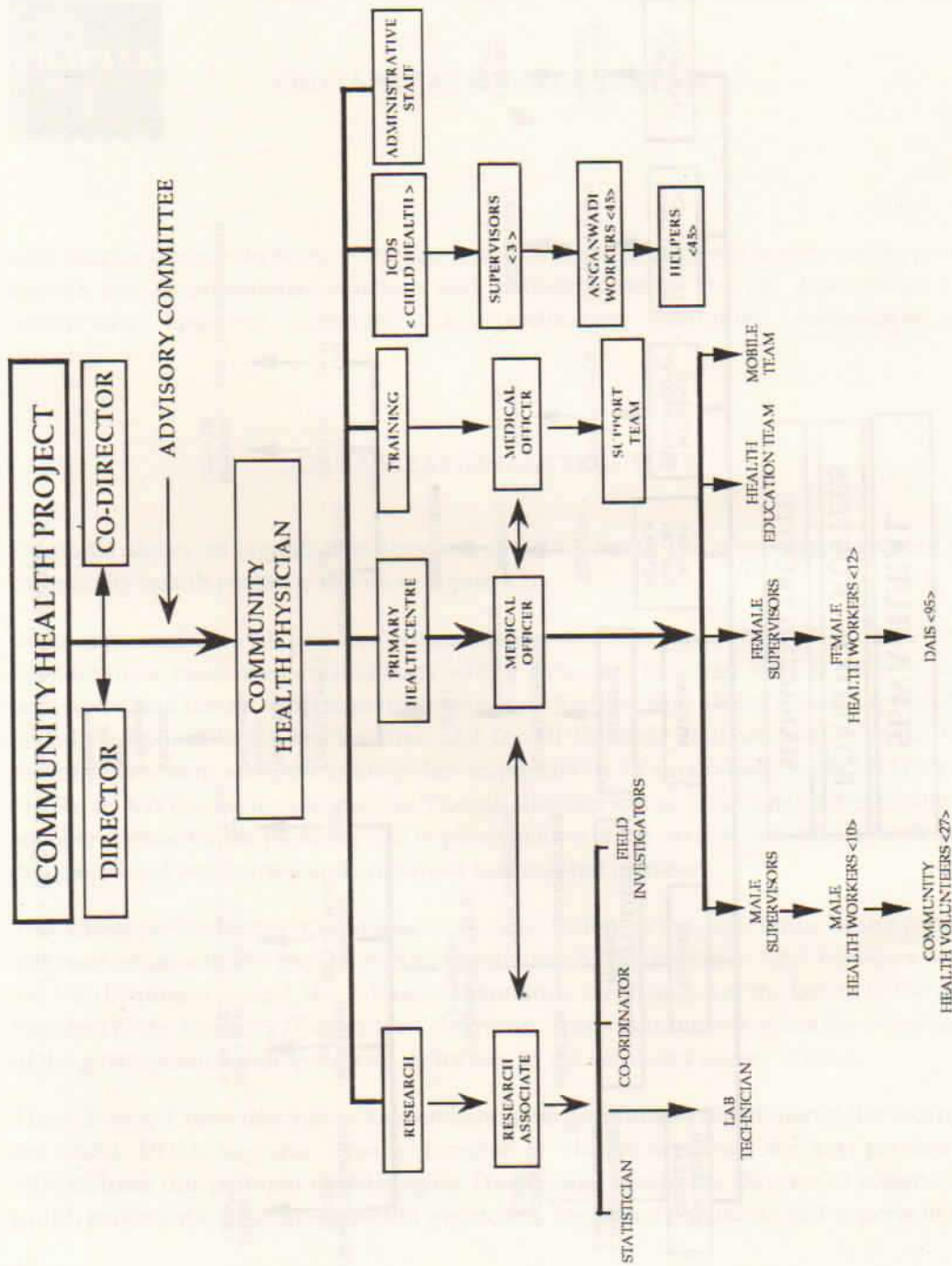


Fig. 4.2: Organization Chart of CHP



area of community health and public systems. This committee was earlier called the Advisory Committee but was later renamed as the Advisory/Evaluation Committee. Initially, its main functions were to help bring about a coordination between the government health structure and SEWA-Rural. It helped in solving the problems which accompanied the handing over by the government functionaries to SEWA-Rural. It also helped in the passing of the action plans. This committee, because of its structure, gave a legitimacy to many proposals or suggestions mooted by SEWA-Rural. Since in the government circles it had legitimacy, suggestions recommended by it were accepted by the government. However, some of the matters recommended even by this body could not be accepted by the rigid government system. An example is the recommendation to change the policy concerning the food supplied to the anganwadis.

The other functions of this committee have been : to act as a sounding board on the technical and managerial aspects of the programme as also to play the 'watch dog' or evaluatory role. To a certain but limited extent the Advisory/Evaluation committee is also a decision making body ( This has been discussed elsewhere in this report. See for instance, the section on decision making in Chapter 3).

One lacuna which we think can be filled up in the future is that there is no representation from the community on this Advisory Committee. It may be good, over a period of a few years, to build up a relationship with the community members so that they can participate effectively in the Advisory Committee. Or alternatively, to have a second advisory committee comprising only of community representatives which can ultimately lead to both community involvement and project accountability. SEWA-Rural planners are at a loss as to how exactly to bring about the implementation of this recommendation.

A point of significance in relation to the organization structure (see Figures 4.1 and 4.2) is that there is no relationship shown between the anganwadi (ICDS) structure and the paediatricians at SEWA-Rural. On checking out it was found that there has been indeed no formal relationship. In the earlier stages, there had been some input which waned with expansion of other spheres of activity. Serious attempts have been made for the past few years to develop some kind of a regular reporting and monitoring relationship especially for at risk children in PEM Grade III and IV but it does not appear to have taken roots. This is a serious lacuna for a community health organisation. The community health project organizers state that for some years while the community health project received postgraduate paediatrics students from the Baroda Medical College, considerable attention

was paid to the ICDS and child care aspects of the work. During these years there was a mutually supportive relationship between the academic institutions and the voluntary agency.

### STAFFING

SEWA-Rural has had regular contact with 167 village level workers and out of these 68 percent are Adivasis. This roughly corresponds to the demographic data of Bharuch district. Only 10 percent of the village level workers are high caste Hindus (Table 4.1).

#### Village Level Workers

At the village level, there are five kinds of health workers: community health volunteers (CHVs), dais (TBAs), the MCH workers and anganwadi workers (AWWs) and helpers. The last named have a role limited to fetching children from homes to the anganwadi, and looking after their feeding and cleanliness under supervision of the AWWs. The other four are dealt with in detail below. SEWA-Rural makes special efforts to enhance the standing of these workers in the community, and to maintain their dignity and self-esteem by emphasising their closeness to the people and stressing the important nature of their work.

In selecting the CHVs and AWWs, the organization informally sounds the community repeatedly for suitable candidates. The criteria, mostly suggested by the government are followed to whatever extent possible. These are : the person should belong to the same village, should represent the larger or the weaker community (or caste), be preferably functionally literate, willing to work in the community, and be acceptable to the community. Destitutes or widows meeting these requirements would be preferred. After suitable candidates have been identified, supervisory staff, and if necessary, doctors visit the village specifically for the purpose of confirming suitability before the final choice is made. However it is not a regular practice to routinely and formally involve the entire community in the process.

Table 4.1 : Caste Breakup of Village Level Workers

	High caste Hindus	Adivasis	OBCs <sup>1</sup>	Muslims	Harijans	Total
CHV	08	14	08	0	0	30
Dai	0	78	13	01	01	93
AWW	09	22	09	02	02	44
Total	17	114	30	03	03	167
(Percent)	(10.2)	(68.2)	(18.0)	(1.8)	(1.8)	(100.0)

<sup>1</sup> Other Backward Classes

### CHVs

When the community health project began, the existing government CHVs were handed over to SEWA-Rural and SEWA-Rural weeded out the unsatisfactory ones. SEWA-Rural's experience has shown, and the present study corroborates that among villagers, the CHV's post still has limited status. Very few women come forward to work as CHVs. The stipend of Rs.50 per month is just too low for the time and energy required to sincerely carry out all the functions of the CHV (although SEWA-Rural's CHVs make about Rs.80 per month on an average, with the incentives that they get). However, for the amount they get, they do a fair variety of work. They treat minor ailments, and refer patients requiring further care. They have the power to recommend free treatment at the hospital for the patients they identify as non-affording, and in general function as a liaison between the hospital and the community. They are a part of the malaria control programme. They record and report births and deaths, and are responsible for chlorination of wells. They attend all mobile unit visits to their villages, as well as all special health education sessions or meetings. Long after the government stopped supplying drugs to the CHVs, SEWA-Rural continued to supply these from its own resources.

Once selected, they are provided training by the MPHVs and the MO for a minimum of 48 days (as stipulated by the government) spread out over a period of six months. Thereafter, their training is carried out on an ongoing basis. No training plan, or their contents, were however available for review.

### **Dais**

The traditional dais working in the project villages are trained for thirty days (with intervals in between) by female supervisors, MOs and other community health project staff.

Even now in the 39 project villages, there are nine dais who are still conducting deliveries without being trained. The reasons why they did not come for the training were because they were either too old and hard of hearing and short of sight, or because attending 30 days of training at a time (on even spread out) was too difficult for them. On the other hand, there are some dais (33 out of 90) who have received the training at SEWA-Rural but are not conducting deliveries regularly.

The dais are paid Rs. 4 for each delivery that they conduct. A recommendation has been made by SEWA-Rural to the government for an increase in the CHV's and dai's payments.

### **Anganwadi Workers**

The selection of AWWs is along the lines described above, but involves in addition, a formal interview by the community health physician, the Co-Director of community health project and the CDPO. The selected AWWs are sent for a three month government training programme.

### **MCH Workers**

Because of the difficulties with FHWs, SEWA-Rural has been experimenting with a new cadre of village level workers who are provided training on maternal and child health. Twenty seven such workers are working at the time of writing this report (May 1990).

### **Female Health Workers**

When the community health project began in 1982, a hospital nurse was shifted to the community health project. Three FHWs came to SEWA-Rural on deputation from the government. But since the last six years, local girls who have passed tenth class are selected

and sent for the government training, lasting 18 months. After one year's training, they come back to SEWA-Rural for their six month field experience. Out of the 19 girls trained till March 1990 eight have left after paying the bond of Rs. 3000 (now the bond is Rs. 5000). They have joined the government where they get higher salaries. Generally, filling up the sanctioned posts of the FHWs is a problem. FHWs are also not able to do all that is expected of them. They have problems of moving around in the distant villages, of staying at the subcentres, and then face pressures from their husbands and children.

### Male Multipurpose Health Workers

Just as in the government, men recruited for these positions are required to go through the sanitary inspectors' training. There seems to be a plentiful supply of MPHWs: in response to advertisements for one or two posts, more than 70 applications have come in the past. Several rounds of interviews have been held to select the required number. The MPHWs are taken on three month probation and then if found satisfactory, their employment order is renewed for one year. They are made permanent only after this period, if found satisfactory. The MPHWs are being increasingly given the responsibility of liaising with the community for other activities in the villages, for example promotion of gobar gas plants, latrines, etc. This may be good from the point of view of job enrichment of the MPHWs who used to earlier complain of frustration at repeatedly talking about immunisation and weaning of children in the villages. The organizers believe that as far as is possible, there should be a common worker for various kinds of work; this kind of integration would benefit both the community and the institution.

### Supervisors

The FHWs and MPHWs are now being promoted to be supervisors. Earlier, persons with qualifications of MSW (Master of Social Work) were appointed as supervisors. Unlike in the government, where a criterion for promotion to the post of supervisor is five years of service, SEWA-Rural promotes them to the supervisor's position even if they have not completed five years. The supervisors are not provided any special training to orient them to their new responsibilities. Most supervisors state that they recall what their supervisors used to do when they themselves were MPHWs or FHWs and emulate those who supervised them at that time. An exercise (see the section of job descriptions) conducted with all levels

of staff revealed very little difference between the field activities of a field worker and the supervisor, although the supervisors do fulfill the important function of planning and organizing the activities in their subcentres. Two newly promoted supervisors were sent for middle level supervisory training for six weeks to a community health training institute in Maharashtra. They state that they have benefitted from this training now they have come to know of the scientific principles of supervision and how to supervise and monitor the work and performance of their subordinates.

### Anganwadi Supervisors

These are women, usually graduates who are given on the job orientation to their role and responsibilities. Since they are functioning within the government framework, they often face rejection and ridicule from the government functionaries because they have not received any government training (although the male and female supervisors too have not received any government training, they did not articulate this problem, maybe for reasons discussed later). No formal external training programme for anganwadi supervisors has been found satisfactory for SEWA-Rural's needs. The on the job training appears to be adequate although for the sake of their self-confidence, it is important that this training be complemented by a structured training programme either internal or external that is suited to their total job requirements, namely, health and preschool education, by qualified and competent trainers.

The ICDS programme at SEWA-Rural seems to have more problems than the community health project when it comes to functioning within the government's frame of reference. The reason for this appears to be that while the problems with the district health department can be easily ironed out with the help of the Advisory/Evaluation committee, the ICDS is a part of a different department and the coordination and liaison is not so easy. A major problem that occurred soon after SEWA-Rural took over the 20 anganwadis was related to supervision of these anganwadis. The ICDS government supervisors started supervisory visits to the anganwadis without going through the SEWA-Rural community health project structure. Ultimately the problem could be resolved and SEWA-Rural succeeded in convincing the ICDS structure at the district level to leave the supervision to them.

As mentioned elsewhere in the report, although SEWA-Rural has to adhere to the policies laid out by the government, the community health project has been able to maintain some

differences in its day to day functioning. In the government system for example, there is seldom any coordination between various categories of the village level functionaries, that is, the dais, the CHVs and the AWWs. In SEWA-Rural's community health project on the other hand, there are two fora in which these three village level persons get together. In the government structure, the relation of the MO with the MPHWs and FHWs is restricted mainly to reprimanding them or finding faults with them. The monthly meetings of PHC staff are largely used for criticising the field workers about their family planning targets. In SEWA-Rural, a major responsibility of the MO is helping solve problems of the field workers, provide them new inputs, and guiding and supporting them.

An important point that needs to be mentioned is that the community health department of SEWA-Rural has four main functions (Figure 4.2): primary health care, ICDS, training and research. The number of staff, especially field level workers and supervisors, appear to be very inadequate to carry out all these functions. Apart from two extra supervisors, the field work related to research also falls into the ambit of the 10 MPHWs and 10 FHWs. The community health physician himself admits that their field staff are involved in multifarious activities including, non-health activities.

The end result of this shortstaffing is that deadlines for various time bound projects cannot be kept. This is true for also the higher levels in the community health department. The community health physician has so many responsibilities, not only in the field of health, but also in other important organizational matters. He is involved in so many activities that things do not move without his availability. In this light, the organisation's attempts at decentralization and delegation are helpful. These need to be further reinforced also at the higher levels.

Another important aspect which is related to staffing and the contents of the community health programme is the presence of three Ayurvedic doctors at SEWA-Rural; two are medical officers in the community health project and one is incharge of the special TB clinic and the community health OPD. With these rich resources and given the fact that SEWA-Rural is situated in a predominantly tribal area and has a funded research unit, it is disappointing that the organization has not given attention to the important task of validation (or otherwise) of some important tribal medicines and traditional practices in health. Even a systematic documentation would be of considerable medical-anthropological value.

### UNDERSTANDING OF JOB CONTENT

In 1986, SEWA-Rural undertook an exercise of writing job descriptions for most of the positions in the community health project. Although the community health project is patterned on the government lines, the job descriptions were written to suit SEWA-Rural's own needs. A noteworthy feature of the contents of these written job descriptions is that the function of guidance and support to the subordinates is well emphasized. But most of these job descriptions are incomplete in content. For example, the job description for the medical officer does not contain any mention of the main responsibilities and functions of the MO. The job description contains only a perfunctory list of duties that the MO is expected to carry out. Another example is the supervisor's job description: the supervisor's is a key position in the community health project but the contents of the job description are not detailed enough nor clear enough to reflect the supervisor's importance.

Another significant fact related to job descriptions is that although these written job descriptions are present in the organization's files, they have not been given to the staff members. Staff are told about their responsibilities and duties only verbally. Whenever their responsibilities are changed, this too is communicated to them by word of mouth either during staff meetings or personally. Despite this, the majority of the staff members have, by and large, satisfactory understanding of their work. While these job descriptions deal with specific duties and activities that each functionary is supposed to do, they do not deal with the 'role' that they are supposed to perform within the larger objective of the community health.

During the current review, an exercise was done with the staff in order to find out

- (a) how well each person understands his/her own job, main responsibilities, duties, etc.
- (b) whether the supervisors and the subordinates have a basic, common understanding of the latter's job.



*DETAILS OF EXERCISE ON JOB DESCRIPTIONS*

- 1. Two medical officers individually wrote out what they thought were their job descriptions.*
- 2. A male supervisor and a female supervisor and the two medical officers individually wrote the supervisor's job descriptions.*
- 3. One female supervisor and one MCH supervisor and seven FHWs individually wrote out what they thought was the job description of the FHW.*
- 4. A male supervisor and nine MPHWS each wrote what they thought was the job description of the MPHWS.*
- 5. The ICDS incharge and two anganwadi supervisors wrote what they thought were the job descriptions of the anganwadi supervisor.*
- 6. Two anganwadis supervisors individually wrote the job descriptions of anganwadis workers.*
- 7. The ICDS incharge wrote his job description.*

The latter is important because the supervisors are supposed to evaluate the subordinate's performance and if the supervisors expect something different from the subordinates than what the latter understand to be their responsibilities, major problems can arise in the organization (see box above for details of the exercise).

The exercise revealed the following broad trends :

- (a) Greater clarity existed about the field worker's jobs (MPHWS and FHWs), both among these workers and their supervisors (see box below). The reason for this may be

that their jobs are the most structured in the community health project. They have detailed registers that they have to fill out as a part of their monthly reports. These registers probably work as concrete guidelines for the tasks that they are to perform.

#### UNDERSTANDING OF FEMALE HEALTH WORKER'S JOB

*Two female supervisors and seven FHWs participated in this exercise.*

- (i) Two supervisors had quite a good understanding of FHW's responsibilities (80 percent common points).*
- (ii) Seven FHWs demonstrated good understanding of their jobs.*
- (iii) The only major notable point is that only one of the two supervisors and two of the seven FHWs mentioned about running a weekly clinic at the subcentre.*
- (iv) Only one person (a supervisor) mentioned that she is expected to be called by the dai if a delivery is about to occur in the subcentre/village where the FHW resides.*
- (v) Followup of TB patients is mentioned by only three out of these nine persons.*

#### UNDERSTANDING OF MALE MULTIPURPOSE WORKER'S JOB

*One supervisor and nine MPHWS participated in the exercise.*

- (i) The supervisor's and five MPHWS understanding of responsibilities and duties of the MPHWS match to a large extent - these six persons have written points which are common to the extent of 70 percent to 80 percent.*
- (ii) The writeups of four MPHWS indicate a less than satisfactory understanding of their responsibilities.*

- (b) The anganwadi incharge and the two supervisors also seem to have a good understanding of the various levels in the ICDS programme (see box below). This is despite the fact that no structured or formal training has been provided either to the ICDS incharge or the two supervisors.

**UNDERSTANDING OF THE ANGANWADI SUPERVISOR'S JOB**

*On reading through the job descriptions of anganwadi supervisors written by the ICDS incharge and two anganwadi supervisors, it was found:*

- (i) the general level of awareness of their responsibilities and duties is quite good although somewhat lesser than what their incharge understands their duties and responsibilities to be.*
- (ii) one supervisor was rather more concerned about the maintenance of records especially the growth chart of underfives. She overlooked mentioning the community contact aspect of her job. Also did not mention that the three-monthly evaluation of the anganwadi or the training of anganwadi workers are part of her job responsibilities.*
- (iii) the ICDS incharge expects each supervisor to meet him daily for between half to one hour for planning the next day's field visits or reporting what happened that day in the village. The anganwadi supervisors have not mentioned this aspect of their work in their writeup.*
- (iv) the understanding of the new anganwadi supervisor about her responsibilities corresponds more closely with the expectations of her supervisor than the older supervisor. This implies that older anganwadi supervisors may require regular re-orientation to their jobs and their responsibilities.*
- (v) the two anganwadi supervisors also do not have a completely uniform understanding of the anganwadi worker's responsibilities. The older supervisor mentioned many more functions of the anganwadi worker - this may be a reflection of her longer experience.*
- (vi) the ICDS incharge wrote detailed notes on his own responsibilities and duties. He wrote an additional piece on the problem of the ICDS programme and his own suggestions. His writeup indicates a good understanding of his job.*

- c) The writeups of the supervisors and one of the medical officers on the job description were the weakest: they were very general and not specific enough (see box below). This was rather surprising. Each supervisor also performs the job of the subcentre incharge, but none of the people participating in the exercise mentioned this aspect of their jobs at all.

To clarify further whether there was any significant difference in the work that the supervisors and the middle level workers were doing, a second exercise was given to them. In this, each person was asked to write down what they had done during the last field visit and during the last time they went out with the mobile dispensary. This exercise, too, revealed that there is virtually no difference in the work done by the supervisors and the field workers in the field. The supervisor's job of monitoring certain critical features of the work in the field does not seem to get done. They do seem to be doing an admirable job planning and organizing the activities in their subcentre/village during their weekly meetings but do not appear to have an adequate understanding of how they can play an effective monitoring role in the field.

#### **UNDERSTANDING OF THE JOBS OF SUPERVISORY LEVEL STAFF**

*Two medical officers and one male supervisor participated in this exercise.*

- (i) One medical officer answered very generally.*
- (ii) The field supervisor also wrote about his responsibilities and duties in a very general way. His understanding of his role as a support and guiding force for his subordinates, was seen as the main content of his job.*
- (iii) The female supervisor wrote about how the supervisors should relate with their field workers. In the second part, she described her duties to a limited extent - the duties which relate to checking the FHW's records and registers, how the FHW gives antenatal care, how her community contact is, etc.*

Although all the supervisors and the MOs who participated in this exercise emphasized the guidance and supervision aspects of the supervisor's job, no one seems to know what the critical features are that need to be supervised or exactly how to supervise them.

Based on the observations listed in this section, to help further improve the work of the community health project staff, the following steps may prove to be useful :

- each staff member be facilitated to write up his/her job description in detail. This exercise will help in internalizing the role, responsibilities and the duties which each person has to do;
- the supervisors be required to help in finalizing the job descriptions. This will help them to become familiar with the job content of the field workers and indicate exactly what they are supposed to supervise. They can then evolve the standards and checklists of certain critical factors for supervision and monitoring;
- the supervisor's job descriptions need to indicate the role and responsibilities of these persons in addition to the duties that they are supposed to perform;
- the health educator's job descriptions needs to include aspects like development of health education materials (see also the section on health education);
- the subcentre incharge should have their responsibilities and duties also laid out in their job descriptions;
- once the job descriptions that are evolved according to the methodology listed above are finalized, each person could be given a copy of a job description. She/he can be informed that this is a standard against which her/his annual performance review shall take place.

#### PERFORMANCE APPRAISAL SYSTEMS

Annual performance appraisals are done in a systematic and formal manner only for the middle level field staff, that is, the MPHWs and the FHWs. The appraisal system consists of

- (i) A written test mainly on the technical aspects of the field worker's job
- (ii) Target achievements
- (iii) Qualitative aspects of the job assessed during the field survey

- (iv) Maintenance of records and registers and
- (v) Feedback of the doctors and supervisors.

The appraisal is done generally by the supervisor, the MO and the community health physician, after each person does his/her own evaluation. On the basis of these annual evaluations, decisions about promotions and increased responsibilities are made. Another method of rewarding 'good' workers is to give their opinions greater weightage during decision making discussions.

As an extension to our recommendations listed in the previous section, we suggest that the performance appraisal be done for all the community health staff including the community health physician and the medical officers. As mentioned earlier, the performance appraisal should be linked to job descriptions. A small committee of the community health project staff should be entrusted with the task of developing an appraisal system. This will help to break the fear that most staff members have about performance evaluation. Also the appraisal system should have the perspective of helping individuals in the organization to develop personally and professionally. Identification of training and development needs should be an essential outcome of each appraisal. Also self and peer evaluation should be built into the system as these generally work as motivating and team building processes. It may be a good idea also to involve the community in evaluating functionaries.

#### COMMUNICATION AND COORDINATION SYSTEMS

The communication and coordination systems are painstakingly designed by SEWA-Rural and are thorough. The 'chit' system which is the focus of many jokes among the SEWA-Rural staff does serve its purpose of quick and clear communication.

##### Meetings

The community health project has a neatly laid out time table of meetings. Observation of some of the community health project meetings (subcentre meetings, Thursday staff meetings, etc.) indicates that by and large the staff at all levels conduct these meetings admirably. The meetings are orderly and follow predetermined agenda. Their effectiveness

can be further increased if the communication was not so top down and one way. The supervisors (or whoever is conducting the meeting) are so anxious that the communications from the 'headquarters' be understood by all those present that they frequently repeat themselves and seldom give an opportunity for unstructured communication during meetings. Or even if this does occur, the supervisors do not pay sufficient attention to this thereby missing opportunities for important feedback. With the clearly laid out structure and lines of communication, SEWA-Rural's community health project has a tremendous potential of becoming even more responsive to the community needs if sensitivity is built up at all levels to upward communication.

### **Reports, Records and Registers**

The community health project at SEWA-Rural gives an impression of being overburdened with paper, paper that is not kept systematically. During the current review one encountered several times thick files of documents and proformas which were mostly undated and not kept in a way which is conducive to study. Often important data and files could not be located.

A cursory study of the system of registers and records of the community health project indicates that it can be streamlined to avoid duplication and yet yield information. Some attempt at streamlining has been made in the recent past but it has not succeeded in yielding vital information. The maintenance of a data appears to be a problem; for example, the data on deaths although fed in by the field workers, has not been entered into the central records. Also the links between the ANC and PNC records and the birth registers could not be established.

A small working group needs to be constituted to redesign the entire information system of the community health project. With the availability of a computer on the campus, data storage and retrieval should become a fairly easy and efficient operation. With a research centre attached to the organisation, this becomes all the more imperative.

An integral part of the redesigned system should be a set of critical reports which can help each level of staff in identifying deviations from established norms and taking immediate corrective actions. Also all records should be placed in the charge of one person who would also have the responsibility of following up gaps in the data flowing in from the field.

### Monitoring and Supervision

Monitoring of the work of the village level workers is done through the subcentre meetings, by scrutiny of the staff records and reports and through the field visits of MPH, FHW and the supervisors. The FHW and the MPH is supposed to visit each village once a week or two weeks. The supervisors are supposed to visit each worker (FHW or MPH) twice in a month. Each AWW is also visited on an average twice in a month - either by the AW supervisors or the AW incharge and the doctor accompanying the mobile dispensary. The mobile dispensary is supposed to go to each village on an average once in a month. During the mobile dispensary's visit, the doctor is supposed to meet the AWW and the CHV and the dais if possible. He/she is supposed to see the records, see the high risk children and non-compliant TB cases (apart from the curative work).

The Thursday staff meetings at the SEWA-Rural campus also have a monitoring element built into them, especially the mortality conference serves this purpose. The community health project has recently developed some proformas to help all levels of field staff plan out their visits, some of the staff do appear to be using these proformas.

Some major points that need to be mentioned in the area of monitoring and supervision are:

- (i) By and large supervision is considered as a way of guiding subordinates and helping them in solving their problems rather than as a way of policing over subordinates.
- (ii) No checklists or standard procedures seem to have been developed which will help each level in deciding what are some of the essential features of the work that need to be monitored and how to monitor them. (The anganwadi supervisors do have a standard form that they are supposed to fill out during a visit to the anganwadi). Each level in the community health project hierarchy needs to develop a set of critical indicators that will help in monitoring the performance and quality of work done in the community health project.
- (iii) Persons who are supervising the work should be involved in the training of subordinates in some measure.
- (iv) As mentioned above, the supervisors have not received any structured training. They are not aware of the principles of monitoring and supervision, exactly why they should monitor certain aspects of their subordinates' work or how this should be done.



## TRAINING

SEWA-Rural has relied heavily on its own internal training for various categories of staff. Much of the training has been provided on the job following a common sense approach. It has not been accompanied by structured or systematic exercises like a long term training needs assessment, and predetermination of training objectives or of expected outcomes. The current training processes have therefore left gaps in properly preparing people for various roles.

Within the organization, one commonly comes across persons being promoted or recruited without being adequately prepared for their responsibilities. They are expected to learn by watching their superiors. There is, no doubt, a tremendous emphasis placed on the 'guidance and support' functions of each individual's job but by way of structured on the job training, there is very little in SEWA-Rural.

For a long time, the organization resisted sending people out for training. Early experiences of sending people for government training were disappointing. As a result, perhaps, the organization rejected all external training. Recently the organization seems to have decided on a 'glasnost' of sorts. More and more people are being sent out for training programmes, and exposure tours to other organizations. But how much of what they are learning is really incorporated into the organization's functioning, remains a question.

With a fullfledged training centre on the cards, hopefully all the above lacunae will get filled. As mentioned in the section on performance reviews, annual reviews of all staff members need to be done. These will help in assessing the training needs of each individual. A master training plan for each year can be drawn up based on this, in which there is a proper balance of internal and external training. The training of individuals should focus on knowledge and skills required for carrying out their job responsibilities and also on their personal growth and development.

All staff members need to be provided some input on training so that they can become effective trainers at their own levels. A core group of staff members, persons with special aptitude and interest to provoke thinking in others, should be developed so that they can effectively accomplish the task of training the staff members each year.

## CONCLUSION

In concluding this discussion on the organizational systems in the community health project, we perhaps need to highlight that most of the systems are followed, although 'informally' and without much structure and consistency. The approach seems to be one of trial and error which has advantages as well as disadvantages. The resistance to systematizing processes like evolving job descriptions and performance appraisal still continues. The essentially humanistic approach towards personnel development (which seems to be instinctive and intrinsic to SEWA-Rural) would reap greater benefits if complemented with some personnel management systems.

The other aspect which needs to be thought through relates to the staffing pattern. The community health project has been dissatisfied with its experience of following the government staffing pattern.

Middle level workers who are mainly responsible for health, and are essentially health workers do take up some non-health work as well. Though there are some field workers in non-health service activities like research, the staffing ratio definitely needs to be increased if field workers and supervisors are to continue to be involved in such other activities.

SEWA-Rural has a number of workers at village level and their potential has been adequately exploited wherever the work taken up by the organization demanded. They have been involved in developmental roles which would help build the capacity of the community and would also enable them to widen the scope of their activities to help develop SEWA-Rural's non-health activities like social forestry, biogas, latrine and women's credit and savings programmes. These activities however, do not cover all villages.

The Advisory/Evaluation Committee monitors and guides the activities of the community health project. It meets regularly twice a year and performs an important ongoing 'watchdog' function. The monitoring of the day to day activities by the community health physician is also a religiously regular feature, one without which smooth and efficient functioning would have been impossible.

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**CHAPTER  
5****ORGANIZATIONAL CLIMATE, MOTIVATING  
FACTORS AND PERCEPTIONS**

In this chapter, we discuss the results of an organizational climate questionnaire that was administered to 29 CHP staff members, motivating factors at work, and perceptions of village level workers.

**ORGANIZATIONAL CLIMATE**

A questionnaire was administered to 29 CHP staff members. Semi-structured interviews with a cross section of the staff gave some indication of the significant issues which would be included in the organizational climate questionnaire. A tool designed by Pareek, Rao and Pestonjee was adapted to suit the CHP needs (see their *Behavioural Processes in Organisations*, Oxford/IBH Co., New Delhi, 1981). Two questions on values in the organization were added. The questionnaire was translated into Gujarati, tested and finalized. The staff members were told to indicate their responses without discussion with colleagues; they could remain anonymous if they wished.

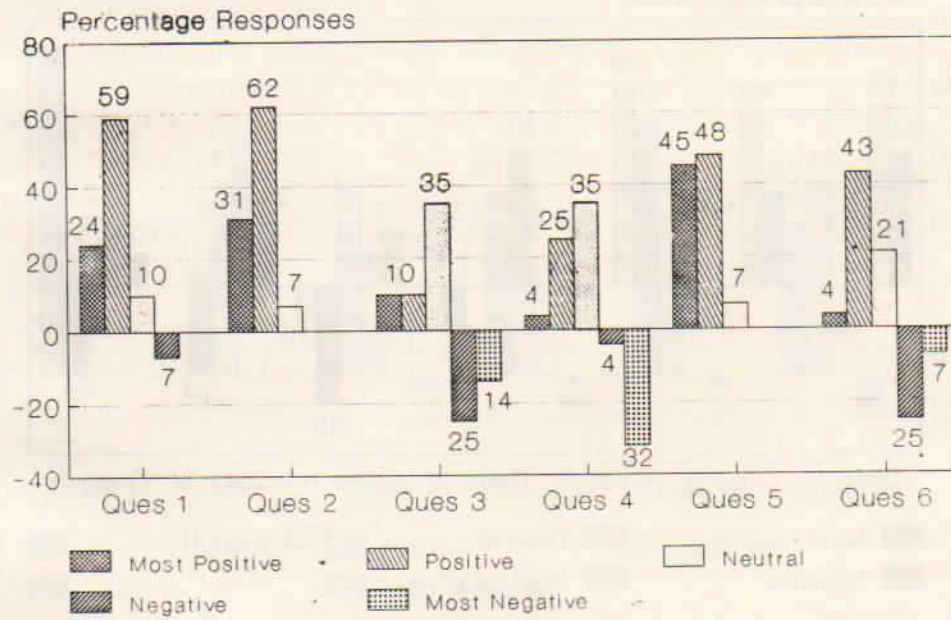
The analysis is classified according to categories of staff and then summarized for each question. More detailed presentation of the responses is given in the table in Annexure 11. A summary presentation of the findings is shown graphically in Figure 5.1 to 5.4 below.

The scores have been tabulated such that all histograms above the abscissa (or x-axis) indicate extent of 'positive' responses and those below indicate 'negative' responses. All the graphical portrayals are cumulative and not staff category wise. For detailed analysis, the reader is urged to study the tabular responses (Annexure 11).

There are several possible ways of interpreting the graphs. The sample was approximately stratified with respect to various categories of staff. Cumulatively viewed, the general response to various questions having a bearing on the overall organizational climate, has been positive.

Let us consider first the outstandingly 'positive' scoring responses. Except Qs.3,4,6,11,13 and 17 all others come under this category.

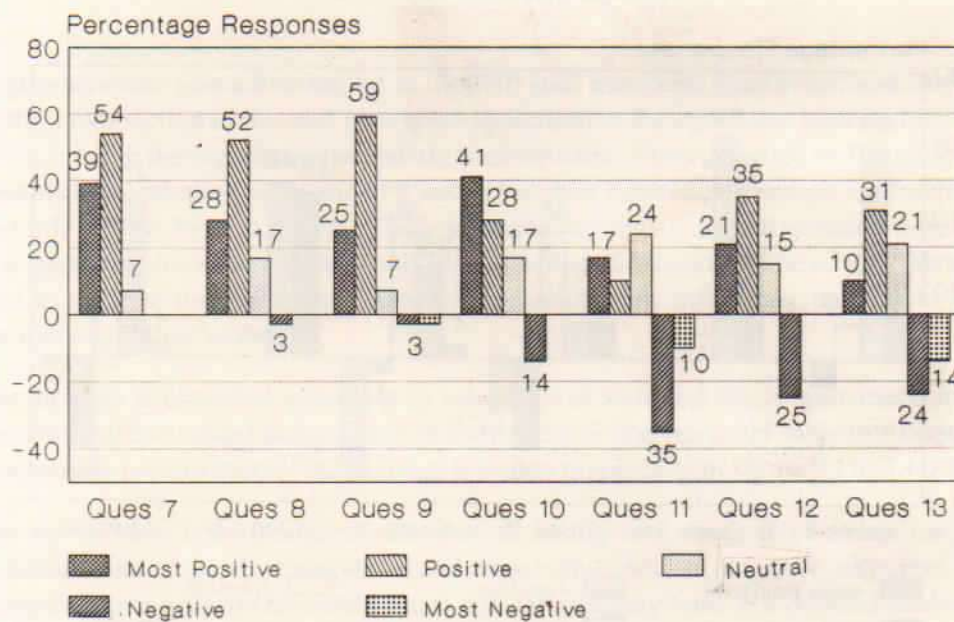
For instance, let us take Q.5. about 93 percent of the respondents either agree, or strongly agree, that SEWA-Rural is better than other similar organizations to work in the country. This should be gratifying to any organization. It is to be examined however that how many have actual experience of working in other similar organizations or even in any other organization.



Data from Annexure 11

Fig. 5.1 : Organizational Climate Questionnaire Responses

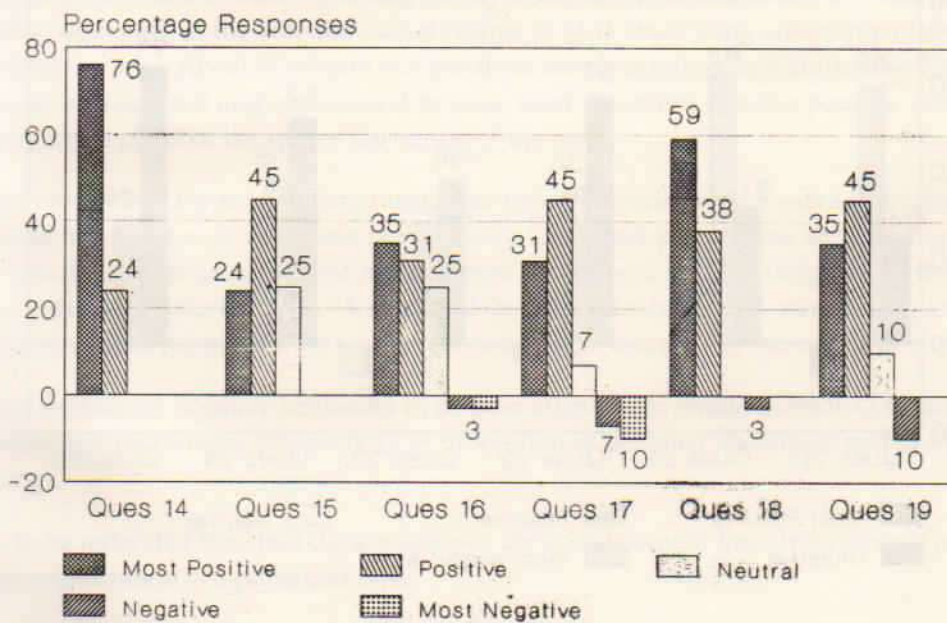
A similar percentage (93 percent) of the respondents feel that supervisors and knowledgeable colleagues take pains to a considerable extent/great extent to help an employee of SEWA-Rural to learn more about his/her job. This too speaks well of the work atmosphere and peer and supervisory support (see Q.5. and Q.9). Again 93 percent of the respondents to the questionnaire feel that correct information about one's work, duties, etc., is received to a considerable/great extent (see Q.7). This corresponds to our observation made earlier that while written job descriptions are sketchily done, oral communication about work expectations seem to be fairly well understood.



Data from Annexure 11

Fig. 5.2 : Organizational Climate Questionnaire Responses

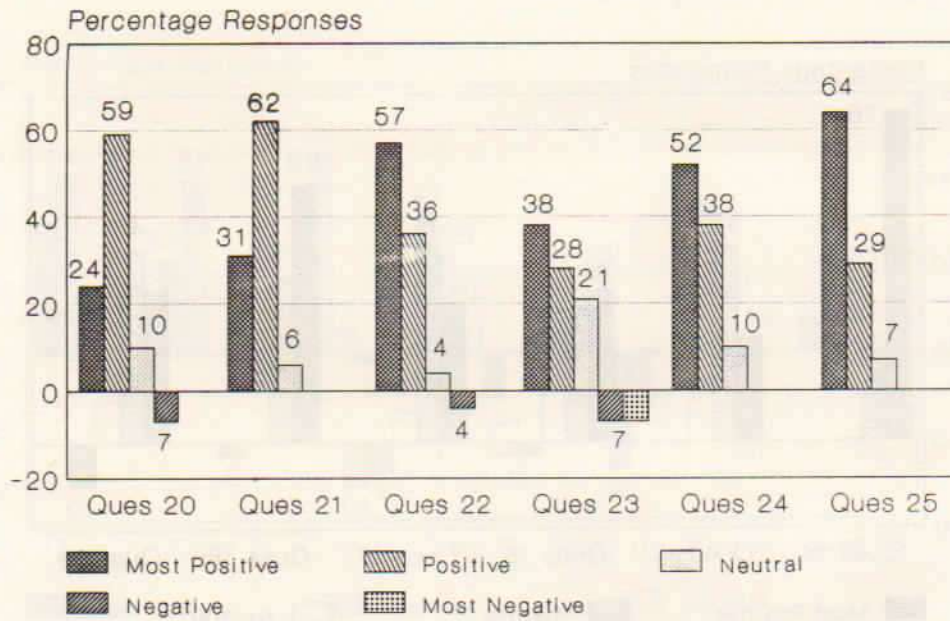
The response to Q.14, reflecting the workers' understanding of excellence at work, is particularly notable. Almost 99 percent of the respondents feel that shoddy work will not be tolerated by the 'management' and all work has to be done well. Of course, standards of work and of particular tasks are absolute or relative. In matters of scientific content, what constitutes work well done (for instance, the aseptic process of delivery), there cannot be ambivalence and one can have fairly well-defined and unambiguous standards of good work. In matters of community organization, people's participation etc., 'work well done', or the standards for it, tend to be those set by leaders and core group members in SEWA-Rural. These may in turn tend to reflect the confusion of those at the top as discussed in the chapter on community participation.



Data from Annexure 11

Fig. 5.3 : Organizational Climate Questionnaire Responses

Other notable positively oriented responses are Q.21, 22, 24 and 25 (all averaging about 90 percent) approximately reflecting work fulfilment, team spirit at work, esteem of one's work with respect to the organization, and the practice of ideals proposed by SEWA-Rural respectively. In fact in Q.21 (work fulfilment), Q.24 (esteem of one's work) and Q.25 (practice of ideals) there are no 'negative' responses.



Data from Annexure 11

Fig. 5.4: Organizational Climate Questionnaire Responses



### **Negative and Neutral Responses**

In the light of this background, let us examine some of the responses which have a prominent 'neutral' or 'negative' connotation. One such is Q.3 ( How often do you feel that an employee's career is harmed in the organization?). About 38 percent have responded 'sometimes', and about 20 percent 'usually/almost always' together constituting 58 percent. This can be seen as either a schizoid response or as another facet of existing reality, the reality of a possible subgroup intensely distrustful of the management and capable of creating a wave of dissent and resentment.

In Q.6, about 32 percent of the respondents either agree/strongly agree that there is not enough time to think about improving quality of work, and consequently feel bound by the routine demands of the job. Somewhat related is Q.11 (indicating autonomy of decision making at work ). About 48 percent feel that there simply is not enough autonomy. This may have to be discussed and explained if in some work situations of some persons, not much autonomy is possible because of the nature of the work.

Notwithstanding the recent salary raise at the time this questionnaire was administered, 37 percent felt that rarely, or almost never, salary raises and promotions are based on valid reasons. It is quite possible that this segment could have skewed (negatively) the other responses too. Similarly (Q.12), 25 percent of the respondents feel that 'most employees look upon the jobs of people at their level as one that can be taken away from them at any time.'

Other significant negative responses to be paid attention to would include Q.16 (advance information on changes planned), Q.19 (resolution of personal hostilities) and Q.4 (target setting).

It is to be reiterated here that these responses are at one point in time, indicative of a mood of an organization at a particular time.

One can view the totality of these responses as 'good' but only at the risk of ignoring some people do not feel good about the organization. Who are these people and why do they not feel good?.

On the other hand, one can view the responses as no cause for serious alarm, which is probably the case at hand.

### A Caveat

A caveat is in order at this juncture. Such questionnaires are a one point response in time and the responses are likely to be skewed either by a positive/negative experience just before the administration of the questionnaire or by an expectation of such an experience immediately after. In this case, the questionnaire was administered not long after a much sought salary raise for everybody.

Ideally then, such questionnaire ought to be compared with responses at two or three different points in time. In the time that has elapsed between the date of administration of this questionnaire (May 1989) and the date of writing of this report (May 1990), SEWA-Rural staff have witnessed at least a couple of major uncomfortable happenings that they would now probably respond differently.

### MOTIVATING FACTORS AT SEWA-RURAL

Several people, government officials, visitors and others who work closely with SEWA-Rural, have remarked on the high degree of commitment and dedication among the SEWA-Rural staff. One of the main reasons for SEWA-Rural's success in terms of achievement of objectives is thought to be these high degrees of commitment and dedication. A study of the factors that motivate the staff is important especially in the context of the question of replicability of the experiment in which the government has handed over to an NGO an entire area for the delivery of the primary health care services. What motivates the staff of SEWA-Rural? Can other organizations learn anything from SEWA-Rural's example which can help them to infuse their workers with a greater sense of commitment?

In the following section, we will attempt to list what appear to us as some important motivating factors in SEWA-Rural.

These factors can be divided into two broad categories : the first classically called the 'hygiene' factors and the second 'motivators'.

### **Hygiene Factors**

Salaries deserve the foremost mention when we discuss this category. SEWA-Rural has placed itself in an awkward position as far as the salary structure of CHP is concerned. Several projects are being implemented in SEWA-Rural: the CHP, the hospital, Grameen Tekniki Kendra, women's papad programme, etc. Each has a different source of funding. Some projects are funded wholly or partly by government funds, some by donations from aid agencies and some by private donations. Because of the policy makers' desire to keep parity in the salaries all through the organization as far as possible, the salaries of the CHP staff are pegged about 20 percent lower than their government counterparts. The policy makers state that because SEWA-Rural salaries are pegged lower than the government's the organization avails of only 80 to 90 percent of the total grant available to it. As expected, the CHP staff members find this ridiculous and resent this practice. They feel that the organization should accept all the funds and keep the salaries of the staff on par with the government norms. This way, they say, the already motivated staff would be even more motivated.

The salary structure was an even bigger source of discontent till May 1989. However, in May 1989, SEWA-Rural did a major review of salaries, which was by and large found acceptable by the majority of the staff members. However, the point that they do not get the government salaries although they work much harder than their government counterparts still continues to rankle many.

Accommodation on the campus is provided to some of the CHP staff. For others who cannot be provided houses on the campus, the salaries are adjusted. Facility of a common mess on payment system is available on the campus for those who do not want to cook their own food.

The employees have formed their own cooperative society for consumables. Periodically, especially for festivals, the society procures special items at wholesale prices and sells them to the employees at these reduced prices. There is also a credit society which gives loans at low rates of interest.

Another reason mentioned by some of the staff members, which helped them to decide on whether they wanted to join SEWA-Rural or not was the fact that the organization takes pains to find a suitable job for the spouse too.

### Motivators

Several factors appear to motivate the staff to give off their best. The most notable among these, is the example provided by the Managing Trustee and the Co-Director. Many CHP staff members mentioned in the course of personal interviews that they have been inspired by the commitment and dedication of these two persons to the cause of the poor and the oppressed. The very philosophy and the values of SEWA-Rural and its actualization in practice is a force which drives many of the staff members to 'get ahead' with the task.

The spiritual atmosphere in SEWA-Rural kept alive through the celebration of religious occasions, regular discourses by different swamis, daily evening prayers at the temple on the campus, appears to appeal to many of the staff members, even those who profess to be atheists. Of course, there are contradictions generic to the focus on these spiritual aspects that sometimes lead to organizational crises. These have been discussed in the chapter on organizational culture.

There are others for whom opportunities to learn and grow are very important. In SEWA-Rural there are avenues for those with initiative and willingness to shoulder increasing responsibilities; learning opportunities are built into the work, weekly meetings of all the field staff have a training component. The interns and other doctors are supposed to provide input on a new topic. More and more staff are being sent for training programmes outside the organization. Staff members mentioned how the special talents of individuals are spotted and given opportunities to flower, even in extracurricular activities. Several staff members mentioned that they have felt the support of their superiors when they were new at their jobs. For many who were coming from other organizations, government as well as other NGOs, this experience of guidance and interest in their work, was a pleasant surprise. However, as pointed out earlier in the section on training, the provision of these learning opportunities are not located within a framework of a long term assessment of the training needs of the organization. Thus a lot of these good intentioned efforts result at best in suboptimal utilization of what people have learnt during these training programme and/or visits.

Many of the staff have not only felt guidance and support at work, but also in their personal lives. Two persons mentioned that they were given personal loans when they had financial crises. In several instances during the review, senior SEWA-Rural staff were observed having counselling sessions with the younger staff members who needed help in clarifying certain

aspects of their personal lives. The distinction between the 'work life' and 'personal life' of people working at SEWA-Rural, often times appears to become blurred although now perhaps with the increase in staff the personnel practices may tend to become more formalized. This is in contrast to that of the government system where neither work nor people's personal lives get any positive attention.

Another aspect of SEWA-Rural which many of the CHP staff seem to appreciate is the 'extracurricular' activities: the sports facilities and the annual sports tournaments, the cultural festivals, the annual day celebrations, the annual staff picnic. In these activities not only the staff but also their family members participate. Many of the specially talented persons working in SEWA-Rural appreciate these fora for the expression of their creativity. Some other staff members mentioned that these activities are an excellent means of dissolving the hierarchy that exists at work: people at all levels relate freely with each other in these activities.

Feedback mechanisms like the 'goshti', a suggestion box placed in each department, the fortnightly 'ventilating' sessions started by the previous MO incharge of the CHP, are some other efforts to create an atmosphere of openness in the organization and to maintain a high level of morale.

#### **'Dissatisfiers'**

A factor which seems to irritate many staff members are the communication styles in the organization; on the one hand, some of the superiors are too brusque and unyielding; and on the other, some others are too sweet but are perceived as not genuinely so.

Many of the field staff expressed that at times they feel extremely frustrated. They felt caught between the pressures from the top to do better in terms of target achievement and towards greater involvement of the community, and the non-responsiveness from the community who think that to get the services is their prerogative and right. These field staff seriously question their job content and feel that beyond a given point the organizational structure and system within which the CHP functions, any incremental improvements would be marginal compared to the efforts that they put in. Although most staff members work with a high degree of commitment and motivation, this 'dissatisfier' needs to be seriously looked into.

### Conclusion

The picture that emerges in trying to understand what motivates people in SEWA-Rural seems to be mixed. The interest shown by superiors in the work and lives of those subordinate in the hierarchy; the learning opportunities that are actively sought to be created; and the emphasis on larger ideals and higher goal-these seem to contribute positively to invoking dedication in people at SEWA-Rural. The stress on the quality of work, and the example set by at least two of the core group members, appears to elicit a commitment to task. While the commitment to task forms the core aspect of people's motivation, many SEWA-Rural workers appear to be also inspired over a period of time by the philosophical and spiritual ideals propagated by the core group at SEWA-Rural. In contrast to the FHWs and other middle level employees, the village level workers (AWWs, dais, CHVs, MCH workers) appear to view their work as essentially a service ('seva') to their fellow village persons and not as much as a 'job' with promotional avenues and benefits (The perceptions of village level workers are discussed below).

Yet, it has to be mentioned that unless SEWA-Rural keeps pace in some meaningful manner with the inflationary pressures in the economy, and tries to promote some semblance of parity with the government salary and benefit structure, especially now after assuming the status of a PHC, many CHP staff will find it hard put to continue in SEWA-Rural on the basis of inspiration alone. This has been borne out to some extent by the fact that as of the time of writing this report (May 1990), the CHP has witnessed a mass exodus of FHWs (four of the existing eight have left). It may be interesting to note the feelings of those who have left.

### PERCEPTIONS OF VILLAGE LEVEL WORKERS

An open ended questionnaire (Annexure 12) was administered to the village level workers in seven out of the ten subcentres. Responses were obtained from 25 dais out of a total of 59 in these seven subcentres, 26 anganwadi workers out of 34, and 15 out of 24 CHVs. The answers of dais were noted down, while the AWWs and CHVs wrote the answers themselves.

### Perceptions of Dais

The following section describes the perceptions of dais about their work and about SEWA-Rural.

#### *What motivates dais?*

Most of the dais like doing their work. This was expressed in different words. One dai stated, 'After each delivery, I am thankful for the opportunity to care for a woman in labour.' About 15 out of the 22 dais who responded, said that theirs was 'dharam nu kaam,' God's work, through their work, many children are saved, they do 'seva' for the poor people who would otherwise have to spend money for safe deliveries in hospitals. A number of dais mentioned that they liked learning and doing new things, like using the delivery pack that SEWA-Rural provides for each pregnant woman. Only five out of the 22 dais who responded mentioned money as a motivating factor for their work; for most others this factor appeared to be marginal. For one dai the flexibility of working hours and work load was an important motivating factor for continuing to do this work.

#### *Do they think their work is important?*

The dais think that their work is important both for SEWA-Rural and for their village community. For SEWA-Rural, the dais are important because their work directly helps SEWA-Rural to achieve its objectives, the nurse is often inaccessible and it is the dais who conduct safe deliveries in the villages. As a result of their work, fewer children die in the villages now. They think that their relationship with SEWA-Rural is especially important for 'bad cases'; they can take these women to SEWA-Rural when necessary. One dai stated that even 'bad cases' from the neighboring villages (which do not come in SEWA-Rural's project area) seek her help in getting referred to SEWA-Rural. Three of the dais talked specifically about their role as health educators and counsellors for pregnant women; they tell the women to take iron and folic acid tablets regularly and also give them relevant nutritional advice. One dai remarked, 'If any pregnant woman in the village has any questions, she comes to me.'

#### *What do the village people think about their work?*

The dais think that their village community has rather a mixed opinion about them. On the one hand, they respect the dais for their valuable services to pregnant women. They want

their help when they want to be accompanied to SEWA-Rural either for a family planning operation or when the pregnant women needs referral services. Many dais think they are regarded as important representatives of the village. They are especially invited for weddings and other social functions. On the other hand, many dais feel, that they are resented because they get some money from SEWA-Rural. People think that the dais are 'paid workers,' and that it is their 'duty' to help the women of the villages. Their biggest problem in relating to the village folk arises when they 'motivate' eligible couples for family planning. People say that, 'You have nothing else to do ('tu navari chhe'), that is why you go around doing this work.'

This fact of receiving some remuneration from SEWA-Rural has unfortunately led to an ironical situation, the traditional village support system for the dais has collapsed now. Earlier the dais were compensated for their services by giving them grain, clothes and some money for each delivery. The village people like to believe that now the dais have become salaried employees of the 'sarkar' (government). The people readily accept all their services (in fact, according to some dais, some richer families demand more) but have however become tightfisted when it comes to appreciation of their services by way of material compensation. In reality however, SEWA-Rural's policy of paying Rs.4 for each delivery and Rs.2 for each immunisation session attended (as compared to the government's practice of paying only Rs.3 per delivery) does not really add up to much for each dai.

There are signs that this is happening in organizations with respect to other systems, a fact of which the organization needs to be vigilant.

#### *Difficulties faced by dais*

The above factor of material compensation features prominently whenever the dais talk about their difficulties. They are unhappy that their recognition either by the government or by SEWA-Rural has resulted in people thinking that they are adequately compensated and do not need any compensation from them. In fact, four of the dais interviewed clearly mentioned that they are feeling the pinch (of not enough money). One mentioned that if she forgets to get the signature from the family on the delivery pack slip after she conducts a delivery she does not get paid by SEWA-Rural. One other person mentioned that the motivation incentive for a family planning case was given to someone else in the village while it was she who 'motivated' the couple. These may be small issues as far as an organization is concerned but personally for the dais they are very significant issues. They



reflect an erosion of the old social support systems in a village economy where each person with a vocation had a place of honour and esteem. With recognition coming from external sources and the ingression of status symbols of modern medical technology -- the delivery box, the aseptic delivery pack -- the spontaneous give and take of the older system has largely been replaced by an attitude of only 'take' from the dais.

Other major difficulties mentioned by the dais were: convincing the pregnant women to get the TT injections, to make her take iron folic acid tablets, to get physical examination done, etc. Persuading the people to get their children immunised was also a major problem. One dai talked about how she referred a difficult case to the hospital, and the new born child came back to the village and died. The family was very dissatisfied with this and she never heard the end of it. These sort of situations also arise occasionally. In such situations, the field staff make it a point to visit the aggrieved party and explain why the dai took certain decisions and how she was not at fault.

There are also difficulties directly related to the nature of the dais' work: having to go for deliveries at all odd times of the day and the night, during all seasons, often rushing with the patient to the hospital, and at times remaining without food for long -- all these hardships without extra compensation. These difficulties were mentioned by five of the twenty two dais interviewed.

SEWA-Rural's meetings are another problem area for some of the dais. Some said that the venue is too far for them, they waste the entire day just because of the distance. Some others said that the money that they are paid for attending the meetings is not worth their time and labour.

However, nine of the 22 dais interviewed, stated that they had no problems or difficulties in their work.

#### *Dais on the impact of SEWA-Rural's work*

*Direct results* : Some of the direct results of SEWA-Rural's involvement in their villages, according to the dais were :

- illnesses have decreased
- availability of medicines has decreased the death rate
- less abortions, less polio, less antenatal and postnatal complications

earlier there was no easily accessible hospital, now because of the facility of the ambulance, patients can be taken to SEWA-Rural.

*Enhanced Awareness* : As a result of SEWA-Rural's work in their villages superstitions have reduced and people have learnt to go to the hospital. Earlier measles and jaundice were regarded as 'maharaj padharya' (visitation of the spirits) but now people have become aware that these are diseases that can be treated. Earlier dais used kitchen knives for cutting the cord at the time of delivery, now they use the delivery pack provided by SEWA-Rural. People used to call home private practitioners and pay 'double fees' to them, now this is reduced.

Indirect effects of SEWA-Rural's involvement : According to the dais :

- earlier people had to go to Rajpardi (a nearby town) and pay for treatment there, now they get free treatment at the village and can save their work day and get 'majoori' (daily wage) also;
- healthier children and improvement in health status has resulted in less 'klesh' (family tensions);
- economic help and support to village people is now available.

*What do village people feel about SEWA-Rural?*

According to the dais, the people in their villages appreciate SEWA-Rural for the :

- mobile dispensary visits
- ANC help including the iron folic acid tablets
- the facility of calling the ambulance
- 'picture shows' (health education) at night
- 'nashto' and immunisation for children.

*Expectations from SEWA-Rural of dais*

Since the availability of water is major problem in most of the villages in the area, many of the dais (12 to be exact ) wish that SEWA-Rural could help them tackle this problem. One dai said, 'We can get our drinking water by digging holes and collecting a handful but our animals have no drinking water.' Another expectation from SEWA-Rural is that the organization should help in the area of income generation: either by starting papad making

programmes, or social forestry and seeds distribution or any other. There are also demands like helping to replace the roof of the village 'balmandir' which had blown away, or to build a hospital in the village. A few dais (4) had no specific opinion ('I am not literate so what can I say?').

### **Perceptions of AWWs and CHVs**

#### *What motivates them?*

Most of the women who responded expressed that they liked and enjoyed their work. Many regard it as an important service. One AWW said that she does this work because she loves children and another woman stated that she does this work because she feels that she should do something for her village. Among the factors which motivate these village level workers are : service to the community, vision of a good future for the children, liking for the work, opportunities for learning and personal development. As in the case of the dais, only two women mentioned money as a motivation for their work.

#### *Is their work important?*

They see their role as an important link between SEWA-Rural and the community: one woman stated that she provides the organization with important feedback each month, and SEWA-Rural bases its programmes and policies on this kind of information. Another woman expressed that SEWA-Rural needs the help of the AWWs and CHVs to establish contact with the villagers for its village level activities; specifically one woman mentioned that she is needed to bring the family planning cases to SEWA-Rural. Another said, 'I inform SEWA-Rural about all the births and deaths in my village; this information is important for SEWA- Rural.'

They feel that their work is important for the villages too. One CHV said, 'Earlier people had to go to the hospital, now I provide relief in the village itself.' The CHVs think that they do an important service to their villages: by providing medicines (one CHV stated that the adivasis in her village who go out for work, can now take medicines from her in the evenings), by chlorinating wells and by being the link for referral services. One woman stated, 'People need my help for ringing up SEWA-Rural.' Two women stated that they are approached for not just health problems but their advice and help is sought for any problem in the village.

The anganwadi workers (AWWs) believe that their work is important for the villagers because they look after the physical development of the children - growth monitoring, giving Vitamin A, immunisations and supplementary food to the children. They also help in the social development of the children: helping them to develop good habits and good character. In turn the children effect changes in their families when they go home and sing the songs that they have learnt in the anganwadi or talk about the new things that they have learnt . The anganwadi workers feel that their work also provides solace to the parents who go out for work when they realize that their children are well taken care of for at least three hours a day.

*What do people in the village think about their work?*

As in the case of the dais, the CHVs and the AWWs too face a mixed reaction from the village community. Many people are happy when their children learn new things at the anganwadi. One AWW stated, " People consider me as their children (sic). Some people are satisfied with the medicines. Others say, 'With your medicines, my boils do not go away,' or, 'For everything, fever, headache, etc., you give the same tablet.' "

When the CHV runs out of medicines, people abuse her. One CHV believes that the people have tremendous faith in her healing hands and appreciate her very much. Some other people in the village believe that the CHV and the AWW works only for the money that they are paid by SEWA-Rural and are not really interested in doing their work.

*Difficulties faced by the AWWs and CHVs*

The main difficulties that the anganwadi workers face in their work appear to be centered around the children's attendance at the anganwadi; either the children come late, or some children do not come at all, or children come irregularly. The anganwadi helper has to go twice or thrice to fetch the children. One AWW from Fulwadi stated, 'The village handpump is near our anganwadi. When their mothers come to fetch water, the children run away with them.' Another AWW feels that parents do not send their children to the anganwadi because the children get diarrhoea after eating the food. Children also run away when large groups of visitors or officials and doctors come to visit the anganwadi.

Space for the anganwadi seems to be another problem mentioned by the anganwadi workers. In at least two cases, the anganwadis are running in the anganwadi helpers' homes and this is not found to be very convenient.

Maintaining the records and registers was a problem mentioned by a few AWWs; they also stated that their superiors help them with these. The CHVs have problems because of stock outs and short supplies of medicines. People resent being given 'simple' medicines by CHVs and want multidrug therapy even for routine complaints like cough and cold. There does not seem to have been systematic effort at educating the community in this regard.

Another class of difficulties that both the AWWs face is related to the community's resistance to taking immunisation, chlorinated water, iron and folic acid tablets and weighing in pregnancy. When repeatedly pursued for this purpose, some people react with unfavorable comments about the workers themselves: that they are 'navari' (free), and are hounding them only because their salary is at stake, etc.

*What do the people say about SEWA-Rural?*

As reported by the AWWs and CHVs, village people's opinions about SEWA-Rural are mixed, something that is not unexpected. The health services are apparently appreciated by the people. The village level workers say that the availability of medicines, the visits of the mobile dispensary, and the ANC for pregnant women are the most appreciated by the village community. In two of the seven subcentres, the village level workers mentioned that earlier when government was involved, the health services were not as good as when SEWA-Rural started coming to their villages.

The negative opinions arise because of SEWA-Rural's policy of not providing absolutely free services: this is resented by the people. Many feel that the organisation takes funds from funding agencies and also charges them. On the other hand, another section of villagers believes that because SEWA-Rural provides cheap services, their quality of care must be suspect.

People also have a poor opinion of services at the SEWA-Rural hospital; they resent the long waiting time and complain that the hospital staff do not treat them well. One person said, 'Earlier people used to appreciate SEWA-Rural. Now they are disappointed because only one kind of medicine is given by SEWA-Rural and no injections are given. Also the staff do not talk properly when they come to the village.'

People also appreciate SEWA-Rural's Gramin Tekniki Kendra, the handpump installation programme, the savings and papad making programmes.

*Expectations from SEWA-Rural*

Most of the expectations of the AWWs and the CHVs from SEWA-Rural relate to building more and deeper contact with the villagers. For example, the seven workers of Padvania subcentre said :

SEWA- Rural should

- conduct more meetings in the villages
- conduct more mahila meetings to give them information
- improve relationship with villagers
- get to know the difficulties of the villages
- give more information to the CHV
- send 'nurseben'

Five of the Limodra women workers echoed the above ('do gram shibirs, prabhat pheris'). Seven of the Govali subcentre workers said, 'SEWA-Rural staff should give more attention to people's feelings' and 'meetings should be held regularly and senior staff should attend the same.' The women workers of Ratanpor felt that, 'Behaviour of SEWA-Rural should be such as to increase the trust and cooperation of the people. Once the people are won over, in turn the people would hold meetings in the villages...' 'Repeat visits, try to understand our problems and help with our work ...', etc., were some of the other expectations voiced by the Ratanpor workers. A second category of expectations related to improving existing services or starting new programmes. Improvement of food in the anganwadi featured heavily in this category. Changes in the anganwadi timings were also suggested.

Provision of gobar gas plants, latrines and bathrooms, handpumps, starting anganwadis in villages where there are none, starting savings programmes and income generation programmes for women were among other demands that the AWWs and CHVs had of SEWA-Rural.

## **Conclusion**

In summary, when one looks at the perceptions of these worker categories, namely, the dais and the AWWs/CHVs, one sees certain common trends and some difficulties.

The village level workers seem to derive inspiration from the immediacy and relevance of their work. They see themselves appropriately as vital links to the preventive and promotive aspects of community health while monetary compensation for the work done is important for most of these women workers, it does not seem to be a primary motivator. More important is the feeling of self-esteem, self-worth and recognition by the others that the performance of a socially useful task generates.

As is natural, these workers do face a range of difficulties. The difficulties are related both to the content of specific tasks as much as to the changing interface caused by the new expectations, external recognition and the introduction of a modern medical system in an otherwise traditional rural society.

On the whole, the services offered by the village level workers on behalf of SEWA-Rural are appreciated by the inhabitants of the project villages. The complaints regarding the referral hospital, the anganwadis, and the frequency of the mobile dispensary visits, need to be carefully looked into.

The need to deepen community level relationships, as expressed by the AWWs and CHVs is a matter that needs consideration, a feeling that has been also echoed by many field workers like the MPHWS and supervisors. Also considered important by the village level workers is SEWA-Rural's help in income generation efforts and provision of safe drinking water.

## INTRODUCTORY NOTE TO PART III

There are some facts, largely of an explanatory nature, that run common to many of the chapters in Part III. They serve mainly to put in correct perspective various aspects described hereafter. They have been brought together into these notes for two reasons. Firstly, they deserve repeated mention at many places in these chapters, but such repetition would have rendered the text less readable. Secondly, some of these facts have had an important, sometimes overbearing, influence on the CHP's policies and programmes, and are mentioned here at the outset, so that the reader may view the chapters in the light of these facts. (The reader may find it necessary to refer back to these notes when reading through the text.)

1. In order to interpret better the information given in these chapters, it is necessary to fully understand the manner in which the CHP project area expanded to its present size. The community health project became functional in 10 villages in October 1982. The period reviewed in this document began from April 1984, when the CHP was already 18 months old, and when the USAID funded the project and the collaboration with the government began. Later in the same year (September 1984), the CHP gained effective control over health programmes in 11 more villages (thus totalling 21 villages covering a population of around 18,000). Again, in September 1986, it took over 18 more villages. SEWA-Rural was thus working in around 39 villages<sup>1</sup> with a total population of 34,000 when the period of the contracted project came to an end in March 1989. In September 1989, Jhagadia village, with a population of around 9000, and which had not so far been a part of the project area (although the headquarters of SEWA-Rural are situated here), was also taken up, and the CHP came to be recognized as a Primary Health Centre (equivalent to the primary health centres of the government). These changes are depicted in Table A.

Thus, the project has been growing at regular intervals, even during the period under review.

<sup>1</sup>Here villages mean administrative units as defined by the village panchayat. The number of hamlets would be many more. Thus, 40 villages are to be found in around 60 geographically distinct units, hamlets and all.



Table A : Growth of the CHP Project Area

	Oct 1982 -Sep 1984	Oct 1984 -Sep 1986	Oct 1986 -Sep 1989	Oct 1989 onwards(PHC)
Villages covered	10	21	39	40
Population covered(approx.)	10000	18000	34000	43000

- One immediate consequence of such relatively frequent increases in population covered has been the impossibility of being able to determine a satisfactory baseline for comparing the achievements, particularly since uniform baseline data have not been collected for each fresh batch of villages taken up. One baseline survey was conducted in May 1982 in the original 10 villages, and this data has been used in some tables for comparison. In other tables, the inservice data of these 10 villages for 1983-84 has been utilized as baseline. It was not until late 1984, however, that the full complement of SEWA-Rural's workers were in charge in the villages; there could thus have been incompleteness in the recording of health-related events before that. It must be mentioned here that, and as the reader will notice, the sharpest changes in figures of data - both as related to service utilization, as well as mortality rates - have occurred in most cases in the very first year after the respective baseline (one of the above mentioned), the change thereafter being either relatively gradual, or minimal. This is in spite of the covered population virtually doubling twice over during the five years reviewed: once in late 1984 and again in late 1986. An explanation, particularly in the case of mortality rates, could probably lie in that the chosen baseline data is not a true representation of baseline health status of all the 40 villages.
- Mortality rates are also plagued by the well known problem of inadequate base population on which to determine the rates. This is true not only of those mortality rates which depend on a certain number of births that is neonatal, perinatal, infant and maternal), but also those where the deaths in absolute numbers are few (for example

deaths in 1-6 year old children, maternal deaths). Since the population has been changing frequently, a pretest comparison of deaths in absolute numbers is also not possible. Thus, one finds considerable fluctuation in rates, even though the changes in absolute numbers may be small, and clear patterns are difficult to identify.

4. The inherent inaccuracy in a verbal postmortem determination of cause of death in the field is well known all the world over. SEWA-Rural's system of recording causes of death in the field is faced with similar problems. The causes of death mentioned in the following chapters must therefore be interpreted with caution.
5. As mentioned in Chapter 2, the major focus of this review has been the processes, as they led to achievements, rather than the achievements themselves. Much of the information on the programmes were gathered over a prolonged period of time, complemented by discussions with various levels of personnel in the organization, and by whatever documentation was available. The figures mentioned in various tables in these chapters have been largely obtained from already analyzed inservice data (exceptions are mentioned in the text). By and large, no attempt has been made to obtain and reanalyze raw data for the purpose of this review. Almost all figures related to coverage of services (for example, antenatal, intranatal, postnatal, family planning methods, vaccination), and all figures for birth and death rates, fall into this category.
6. As has been mentioned in earlier chapters, the major consideration for collaborating with the government was to avoid duplication of services and to utilize public funds for a public cause to the extent possible. When SEWA-Rural undertook total health care responsibility of the project area from the government, it was not without anticipating the problems that it was taking upon itself, and the organizers were mentally and otherwise prepared to deal with these problems. What they probably had not fully anticipated was the amount of human effort required to run the various programmes to a level of satisfaction, while functioning within the constrained framework of the government set up. Although SEWA-Rural is better endowed than many other voluntary agencies (or for that matter, the government's rural health services) in terms of the number of doctors and related professionals, it had also chosen to run a hospital, as well as various non-health activities (see Chapter 1 and Annexure 1). As a result it soon learnt to prioritize utilization of its manpower and other resources. It then has been concentrating more on certain aspects of the CHP, like maternal health, intranatal care, ICDS and vaccination, as a matter of choice, and on certain others like family planning

because it has to fulfill certain obligations (in terms of target achievement) to the government. It has been forced to give lesser energies to control of communicable diseases, school health and environmental sanitation, much to its own disappointment. Whatever its priority, each activity has, nevertheless, demanded some minimal time and effort. This has led to a dilution and overstretching of available resources. Strained as it was against such a situation, SEWA-Rural has not always been able to give the intensive creative input that is required into many of its programmes. Several activities therefore, often run at bare maintenance levels.

7. Another factor consuming large chunks of time of all levels of personnel has been the almost distinctive activity of recording and reporting. Although SEWA-Rural has made some attempts to simplify recording procedures, this continues to be a major burden, sapping both time and energy. This is largely a direct consequence of being responsible to the government, but partly the result of an inner compulsion of the organization to be accurate in recording and reporting.
8. One aspect of the work of the CHP encompassing all the activities mentioned in the chapters in this part is the conscious efforts at teambuilding and team work. Although each category of worker has her/his defined role and defined share of work, there is apparent overlap, mainly because the functions are planned to be mutually complementary. Thus, for instance, activities like vaccination and family planning are carried out with various middle and village level workers working as a team, rather than as individuals. The village level workers, including dais, CHVs and AWWs, function mainly to motivate the identified beneficiaries, while the middle level workers, both male and female providing guidance and technical support, and where required, directly interact with the people. Similarly, while activities like maternal care are considered the 'area' of FHWs, it is common to find the male middle level worker chipping in to visit a pregnant woman here or refer another to the hospital and to give iron tablets to those whom the FHW could not cover during her routine visits. Likewise, the FHW is active in both malaria and tuberculosis work to some extent, areas traditionally considered the prerogative of the male workers. The process works vertically as well, with supervisors often doubling as male or female multipurpose workers. All this has been consciously introduced into the system with the aim of building a closely knit, interdependent team. Thus it would be artificial to ascribe the credit or otherwise of the achievements in various areas to one level or category of workers.

(Note written by the members of the CHIP team.)

## MATERNAL AND PERINATAL CARE

Maternal and newborn care services are considered together because, apart from being conceptually a continuum, even the provision of these services is difficult to separate. These services conventionally form the core of any primary health care programme, the main reason being the relative vulnerability of these groups in the population.

Over the last half century, extensive experience has helped evolution of maternal and child health services into fairly standardized packages with well-defined units of activity and objectives for achievement. The programme prescribed by the government is, in these terms quite comprehensive and within the limitations of available knowledge, well-planned. While generally following this programme, SEWA-Rural has introduced modifications and innovations at various points, mainly choosing to emphasize certain aspects more than others and has evolved strategies for effective delivery of health services.

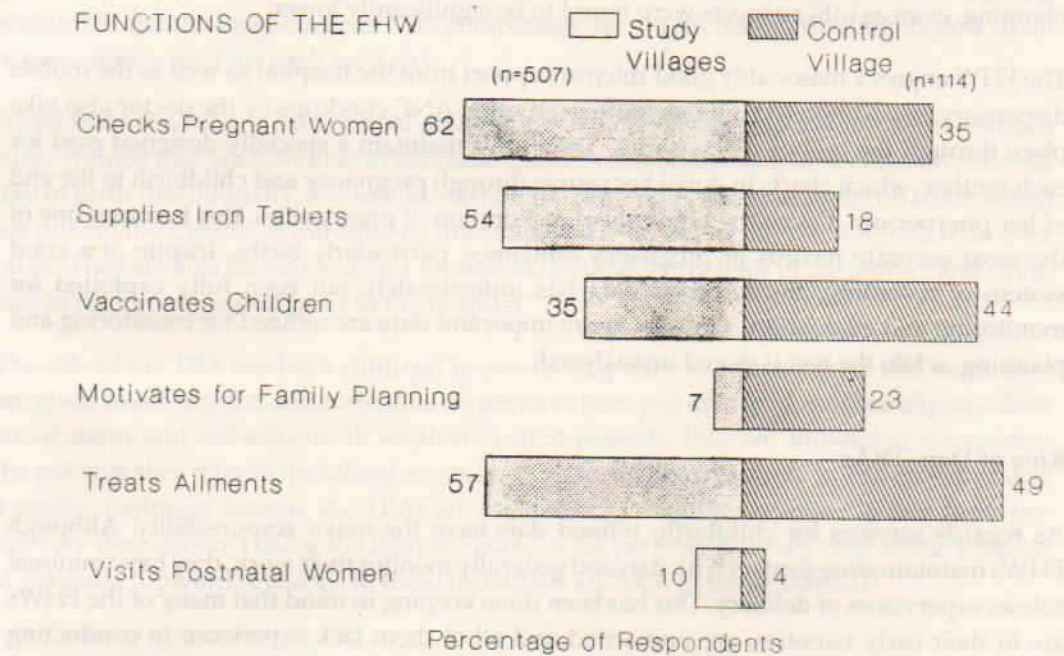
**Role of FHW/ANM**

The middle level female worker (or ANM) remains the backbone of antenatal and postnatal services in the PHC. In addition she is also responsible for a considerable proportion of family planning and immunization services. The survey for this review showed that as many as around 98 percent of women in project villages were aware that a nurse visits the village (Table 6.1), while in the same time period only 61 percent knew about the FHW in Jhagadia village, a taluka headquarters still under the care of the nearest government PHC).

Table 6.1: Awareness about the FHW

	Survey villages		Jhagadia village	
	Number	Percent	Number	Percent
Total respondents	519	100.0	186	100.0
Knew that the FHW visits village	507	97.7	114	61.3
Knew the FHW's name	266	51.3	72	38.7

When asked to list the functions of the FHW, most were able to recall the more visible functions of the antenatal period: visits and distribution of iron tablets, in addition to treatment of minor ailments (Figure 6.1). Remarkably, in contrast to the image of an ANM



(Note to Figure 6.1: Respondent women were asked to enlist the functions without being prompted and while interpreting these data one must bear in mind the limitations of the women in reciting such lists. The valid inference one may draw from this kind of data is that the recalled functions were the more striking ones from the respondents' perspective.)

Fig. 6.1 : Awareness of Functions of FHW

as seen elsewhere, very few (less than 7 percent) seem to associate her with family planning. This reflects well on the relative emphasis placed on MCH with respect to family planning. As reported elsewhere in this review, family planning has not been neglected either.

Also, people's awareness of her curative role is appreciably high (around 60 percent). While popular awareness in Jhagadia village about the FHW's curative role and of her role in vaccination was almost equally high, a greater proportion associated her with family planning, even as other aspects were found to be significantly lower.

The FHW enjoys a reasonably good referral support from the hospital as well as the mobile dispensary. In addition to high risk mothers, routine ANC checkups by the doctor also take place through the mobile dispensaries. The FHWs maintain a specially designed card for each mother which charts in detail her course through pregnancy and childbirth to the end of her puerperium. Given the high rate of registration of pregnancies, this becomes one of the most accurate records of pregnancy outcomes, particularly births. In spite of a good system of recording, the recorded data has unfortunately not been fully exploited for monitoring and evaluation. Only the more important data are utilized for monitoring and planning, while the rest is stored unanalyzed.

#### **Role of Dais/TBAs**

As regards services for childbirth, trained dais have the major responsibility. Although FHWs maintain close contact with dais and generally monitor their work, they have minimal role as supervisors of delivery. This has been done keeping in mind that many of the FHWs are in their early twenties, are unmarried and all of them lack experience in conducting deliveries. As a result, they do not have much acceptance in the community as birth attendants. However FHWs are supposed to attend the confinements that they have easy access to and when time permits. In practice, they have hardly been able to do this.

A remarkable aspect of intranatal care has been the process of involvement of traditional midwives in the health services. Starting with an intense reorientation of dais in the project villages in 1984, a high proportion of deliveries were attended by trained dais by 1985, and the figure has been almost steady since then (Figure 6.4).

Dais are highly independent minded, well-entrenched, respected old women in these villages, and it required a high degree of identification of the trainers with them and their

society before a reasonable level of competence in safe midwifery could be achieved. Their illiteracy, their routine occupation in agricultural labour, the cultural barriers and capacity to change were major problems. These were overcome to an extent by training them in short, non-demanding sessions, using a lot of visual and verbal teaching, to the exclusion of written material. These sessions would be spaced, giving them adequate time to attend to other routine work. The training was conducted by medical officers and supervisory level staff of the CHP. Continuing education was and is ensured through periodic training sessions at the the Jhagadia centre. To compensate for wages lost on training days, a small honorarium is paid for each such day.

Apart from conducting safe normal deliveries, the dais play an important role in newborn care. Trained dais are now able to persuade mothers to start nursing their children from the day of birth (traditionally, this would start on the third day), to avoid prelactal feeds which are potentially capable of introducing infection, and to get their children weighed soon after birth. They are also trained to detect immediate postnatal problems in the mother and child, and to refer complicated cases to the hospital.

The role of the TBA has been confined to conducting normal deliveries; for this work they are given much respect, and conscious efforts have been put in to enhance their dignity, their social status and self-esteem. To whatever extent possible, they are allowed to accompany the patients they refer in the labour room, and to assist where required. In addition, through a nearly foolproof system, the TBAs are assured of getting the incentive of Rs.4 for every delivery they conduct using the delivery pack, or for patients that they refer to the hospital at Jhagadia (upward revisions in these incentives are soon to be introduced).

### **The Delivery Pack**

One special input of SEWA-Rural deserves to be mentioned. Over and above the dai kits given to TBAs, each pregnant woman in her third trimester is given a special presterilized, disposable 'delivery pack' which the TBA uses at childbirth. This pack consists of a razor blade fashioned into a knife for cutting the umbilical cord, strands of coloured thread for tying the cord, powder for making antiseptic solution and some cotton and gauze, all packed in a polythene sheet, which serves as a mackintosh at childbirth. This pack is assembled at SEWA-Rural, sealed in plastic covers and thereafter large batches of these packs are sterilized by gamma irradiation at Bombay. The pack has been widely appreciated by

the TBAs, mothers and outsiders alike, and the Government of Gujarat has tried to adopt this as an innovative programme. The organization receives demands from voluntary agencies all over India for the pack, only some of which it has been able to meet. The pack has been undergoing improvisation as more and more experience is gained, and some of the modifications, like introducing coloured thread, have directly followed after suggestions from the TBAs.

The organizers believe that the major purpose it serves is by becoming a tangible symbol for the TBA and the community of the need to maintain cleanliness and safety at childbirth and immediately thereafter. And its use serves as an indicator of the quality of attendance at childbirth. For instance, a study conducted in 1986-87 showed that 57 percent of TBAs have made 'satisfactory' use of the delivery pack (dissertation of Dr. Rajesh Mehta, Department of Preventive and Social Medicine, Medical college, Surat).

One possible direct consequence of the propagation of the pack has been a considerable increase in the awareness of the women about the hazards of unclean childbirth and need for using the correct methods (Table 6.2).

Table 6.2: Awareness of Clean Birth Delivery Methods, 1984-89

Aspect	Total interviewed	Showing improvement		Showing no change		Showing decline	
		No.	Percent	No.	Percent	No.	Percent
Correctness of instrument to use for severing cord at birth	203	94	39.8	84	41.4	25	10.5
Awareness that the instrument be clean	180	50	23.9	73	40.6	57	27.0
Cord care after birth	126	56	43.7	52	41.3	18	14.3



An appreciable aspect of the delivery of all maternal and child health services is the conscious integration of the functions of the male and female middle level workers. This has helped to fill to an extent the lacunae outlined earlier in the functioning of the FHW. At times, the male worker has been seen to maintain singlehandedly essential MCH services in the absence of FHWs. This is also typical of the general team approach that characterizes much of SEWA-Rural's community health services.

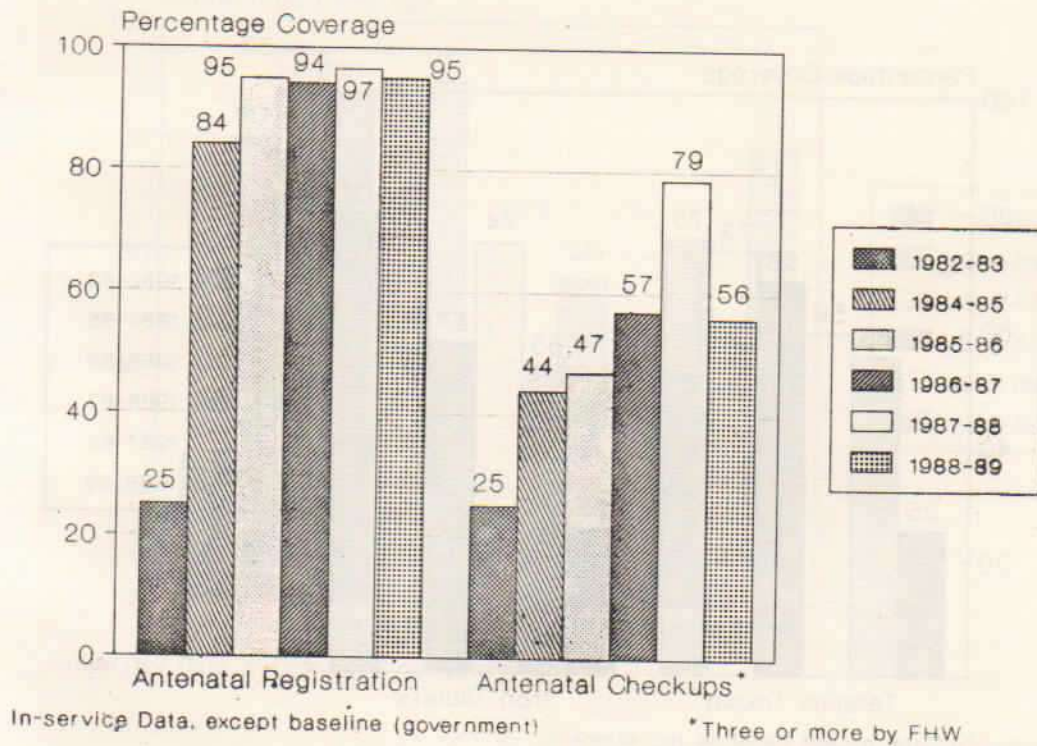
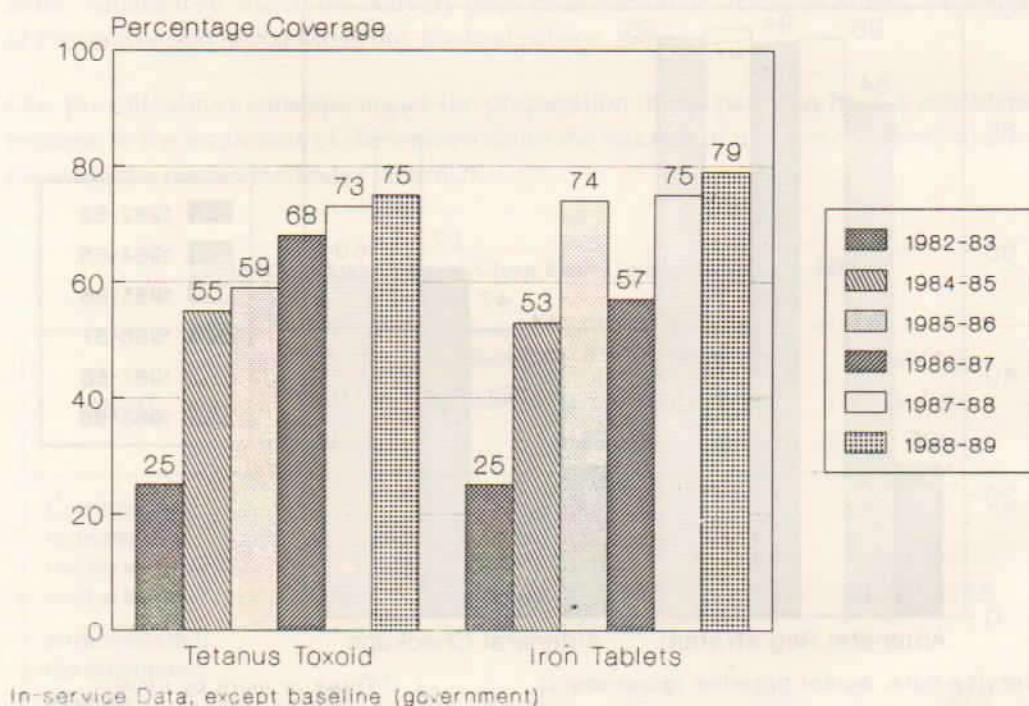


Fig. 6.2 : Proportion of Women covered by Antenatal Registration and Antenatal Checkups

**Coverage of Maternal Services**

As regards maternal care services rendered, inservice data indicate that the general trend has been one of a steady rise, reaching high rates of coverage (Figures 6.2 to 6.4). Antenatal services begin with recognition of pregnancy at the earliest possible and registering the same. This requires a religiously regular monthly followup of all eligible couples in the population. That this is happening is borne out by the higher proportion of pregnant women registered (Figure 6.2).



**Fig. 6.3 : Coverage of Pregnant Women with Tetanus Toxoid and Iron Tablets**

The delivery of specific services (tetanus toxoid and iron tablets) too, is quite high (Figure 6.3), in contrast to the modest coverage of checkups of pregnant women (Figure 6.2). This could be related to the greater time and motivation, and lack of appropriate place, required to conduct a thorough examination of a pregnant lady as compared to that required to give some tablets or an injection.

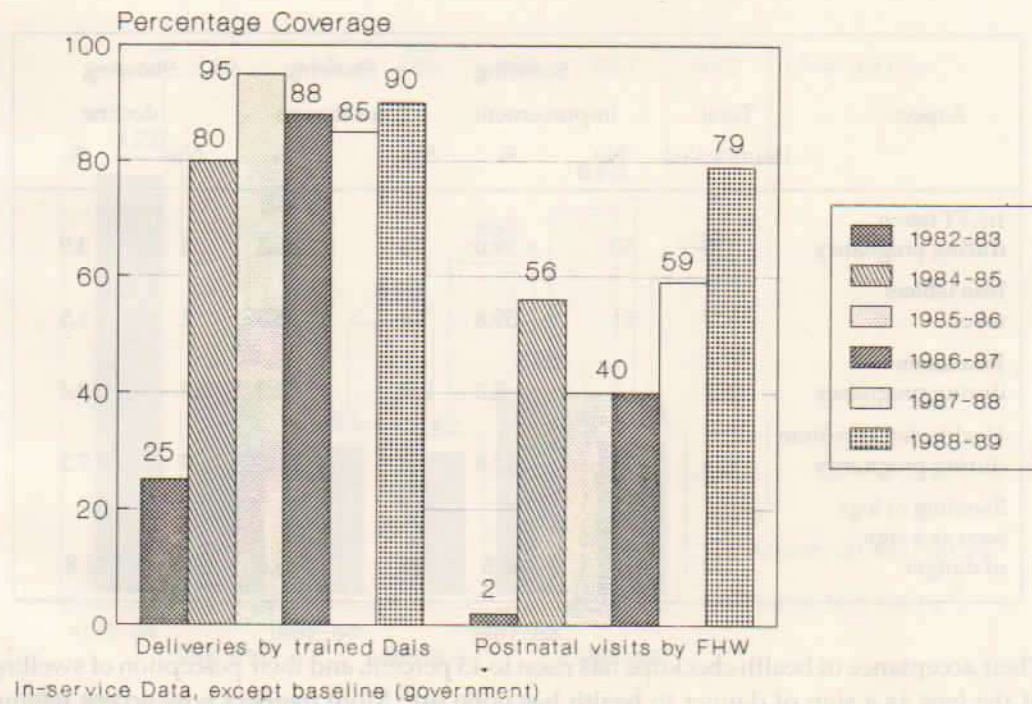


Fig. 6.4: Proportion of Deliveries by Trained Dais; Proportion of Postnatal Women visited three or more times by FHW

There is scope for improvement, however. For instance, tetanus toxoid, which was earlier carried door to door by the FHW, was later restricted to availability at mobile clinics and at subcentres, and during vaccine camps, with a view to prevent people becoming dependent on the system. One cannot help feeling that had the original policy been maintained, it may have considerably enhanced the coverage of pregnant women with tetanus toxoid.

A KAP survey (see Chapter 2 describing methods of evaluation) showed that practices and awareness in mothers about various aspects of antenatal care has also increased (Table 6.3)

Table 6.3 : Difference in KAP, 1984-1989; Antenatal care

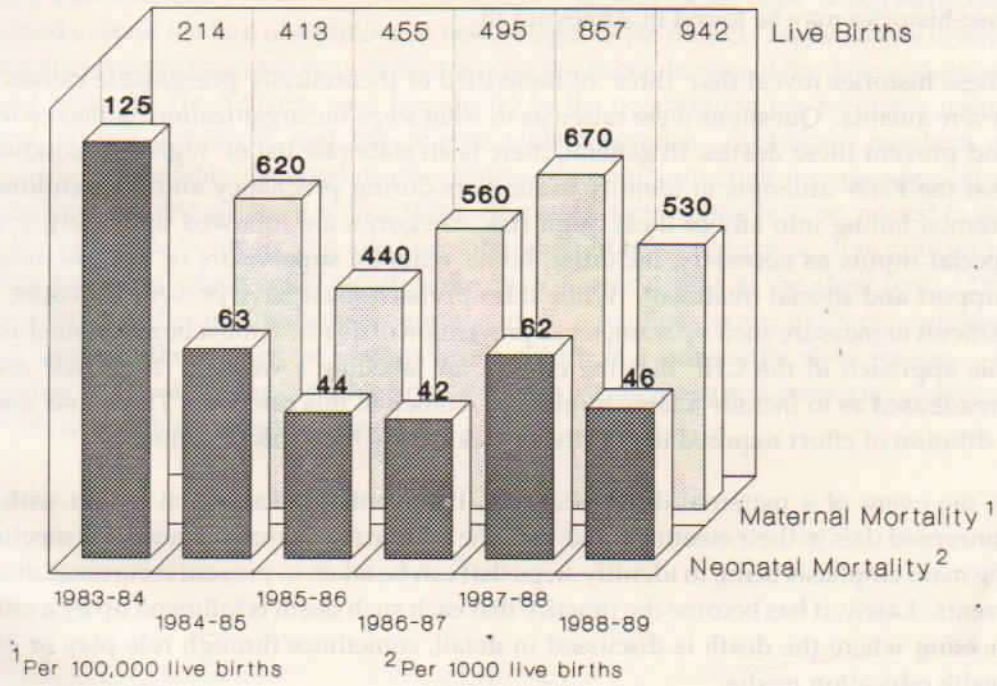
Aspect	Total interviewed	Showing improvement		Showing no change		Showing decline	
		No.	%	No.	%	No.	%
Inj.TT taken during pregnancy	128	50	39.0	72	56.3	5	3.9
Iron tablets taken	127	51	39.8	74	58.3	2	1.5
Rest taken during pregnancy	127	3	2.3	107	84.3	17	13.4
Health checkup done during pregnancy	128	55	42.9	64	50.0	9	7.2
Swelling of legs seen as a sign of danger	232	110	46.6	94	40.5	28	11.8

Their acceptance of health checkups has risen to 43 percent, and their perception of swelling of the legs as a sign of danger to health has gone up. More mothers now accept tetanus toxoid and iron tablets.

The coverage of postnatal services (Figure 6.4) has risen remarkably, particularly in the last year, from a situation when it was almost absent. However, it is difficult to obtain details of these services, since recording is not always complete, and analyzed data are not available.

**Maternal Mortality**

One important indicator that any MCH program would hope to alter is the maternal mortality rate. To an extent, neonatal mortality is a function of adequate antenatal care as well. These two rates are presented in Figure 6.5.



**Fig. 6.5: Patterns of Maternal and Neonatal Mortality.**

It is obvious that maternal mortality has remained essentially constant over the years, and after an initial fall, neonatal mortality rate too seems to have stabilized.

The causes of neonatal deaths are discussed in the chapter on child health services. As expected, low birth weight, including prematurity, and infection account for most of these deaths.

As regards maternal mortality, it shows a plateau at around 5-6 deaths per 1000 live births. In order to develop a better understanding of this, detailed case-histories of the maternal deaths of the last year (1988-89) were obtained from a combination of available records and notes and recollections of health workers. Brief summaries of five such case-histories may be found in Annexure 13.

These histories reveal that three of them died of theoretically preventable causes like severe anemia. Questions were raised as to what steps the organization had taken to try and prevent these deaths. In general, there is an elaborate list of 'high risk' conditions that the FHW attempts to identify in mothers during pregnancy and after childbirth. Women falling into any of these 'high risk' categories are followed up closely, giving special inputs as necessary, including home visits by supervisors or doctors, referral support and special treatment. While this approach must have prevented deaths, it is difficult to measure such a parameter as prevention of death. It must be mentioned about this approach in the CHP that the criteria for labelling a woman 'high risk' are so broadbased as to include a large number of women in this category. This could lead to a dilution of effort required to effectively tackle truly high risk situations.

In the event of a maternal death occurring, the event is discussed at length with the concerned dais in their meetings, and with the middle level workers in weekly meetings, the main emphasis being to identify steps that can be taken to prevent recurrence of such events. Lately, it has become the practice that each such death is followed up by a village meeting where the death is discussed in detail, sometimes through role play or other health education media.

Looking at the case-histories of the maternal deaths of 1988-89, one finds that two out of the five refused to come to the hospital for treatment inspite of persuasion. Two others died in places beyond the project area, in the homes of the women's parents where they had gone specifically for their confinement as is the traditional practice. One woman

died one week after returning home from intensive treatment in the hospital. Details were not available.

### Conclusion

In sum, it is clear that the importance of maternal and child services has been well-emphasized, both within the organization and in the community, even with respect to family planning - a welcome development. People are well aware of the FHW and her functions, and women's KAP have shown distinct improvement over the period of the project. This is reflected in the high levels coverage of most of the services, which have been sustained even in the face of additions of new villages to the project. Major factors behind these achievements appear to be ongoing training, the strengthening of the dais, and strong referral support. The delivery pack introduced by the organization has become a useful symbol of safe childbirth, and has proved widely popular. Significant numbers of potentially preventable maternal deaths continue to occur, although the organization is making considerable efforts to reduce them. The major factors appear to be related to the inability of people in timely and adequate utilization of referral services. It is difficult to identify measures which could significantly reduce these deaths in the short term. The answer probably lies in simultaneous improvement in multiple factors like socioeconomic status, among other things, at various levels, which is a necessarily slow process. A tightening and streamlining of the high risk approach may help as also a greater involvement of FHWs in childbirth wherever possible.

The health status of children in SEWA-Rural's project villages has shown a change for the better. Areas which have been decisively affected include the near-eradication of measles deaths in the project villages by means of effective coverage with the vaccine, and a similar dramatic fall in the prevalence of symptomatic vitamin A deficiency. Child mortality has fallen to a level around half that of Gujarat state.

### Integration of ICDS

Integrated Child Development Services (ICDS) is the one scheme in the government health system which is generally known to be a success to considerable extent. It is also the scheme on which the government has been most keen to collaborate with voluntary agencies. ICDS also happens to be the best monitored government welfare scheme and one which has been the subject of exceptionally extensive research compared to other health activities.

The main thrust of ICDS is the health and development of pre-school children and their mothers. Among its listed major activities are provision, through nurseries called anganwadis, of supplementary nutrition to preschool children and pregnant and lactating women, preschool education, growth monitoring, health and nutrition education to mothers, immunization, treatment of minor ailments and regular health checkups of the beneficiaries. Since it is a prized scheme whose benefits are believed to be tangible, immense welfare resources are being poured into the scheme and is monitored closely by the state and central governments. This entails an extensive and often cumbersome reporting system.

SEWA-Rural took over the first six anganwadis in 1983-84 and has since increased to 44, covering all but a few hamlets of its project villages. In terms of design there is very little difference between the government's scheme and SEWA-Rural's ICDS. An anganwadi worker in each village assisted by a 'helper' from the same village conducts village level activities. She is supervised by an anganwadi supervisor based in Jhagadia. These supervisors report to a CDPO substitute at the headquarters in Jhagadia (since there is no CDPO post sanctioned for SEWA-Rural). There are differences, however, in the



qualifications and training of these supervisory level staff. None of them have been sent for the formal training given by the government. The CDPO substitute is a postgraduate without any formal social science background, and without formal training. Like the supervisors, he has learnt the tricks of the trade on the job. The main reason for this antipathy towards formal government training stems from an earlier disappointing experience that the organization had in the training of one anganwadi supervisor. The organizers are, however, willing to give it another try.

At the same time, the organization has attempted to introduce various operational modifications within the system. Most importantly, there is a close linkage between the staff and activities of the community health project and the ICDS, especially made possible since they are under one roof (for all practical purposes, these two are not distinct). This eliminates the otherwise inevitable friction between the PHC and the ICDS functionaries as happens in a government system. Along with this, SEWA-Rural has modified the recording and reporting system so as to make it less cumbersome, to avoid duplication, and most importantly, to make it easier to generate correct figures. For instance, the recommended system has two separate cards for recording growth monitoring efforts and for recording medical checkups. These have been combined into one card at SEWA-Rural. However, scrutiny of this system reveals that for some reason, it does not seem to be working well. Apparently, in the process of simplification, generation of important data has suffered.

Also, towards similar ends, certain activities have been realistically rescheduled. For instance, children are weighed three monthly instead of every month. Health checkups of all children are done twice a year, but not necessarily by a doctor.

An important and successful experiment made at SEWA-Rural was the replacement of CSM (corn-soya milk) powder, supplied by CARE, with indigenous food for supplementary feeding, without compromising on the nutritional quality. Attempts were also made to introduce iron rich indigenous food (wheat flour and fenugreek leaves mixed into a high fat sweet dish - 'sukhdi') for pregnant and lactating women. As mentioned elsewhere, these gained popularity while they lasted. The indigenous food was supplied for a total period of three and a half years, from April 1985 to October 1988; they had to be abandoned due to inability on the part of government to support it financially.

Table 7.1 : Coverage of Services under the ICDS

	1985-86	1986-87	1987-88	1988-89
<i>Pregnant Women</i>				
Total Target*	360	580	580	580
Registered	80	331	300	302
	22.2(%)	57.0(%)	51.7(%)	52.0(%)
Actually utilising services	42	243	247	235
	11.6(%)	41.8(%)	42.0(%)	41.0(%)
<i>Lactating Women</i>				
Total Target*	240	384	384	384
Registered	229	344	348	330
	95.0(%)	89.5(%)	90.6(%)	85.0(%)
Actually utilising services	91	270	295	297
	37.9(%)	70.3(%)	76.8(%)	77.3(%)
<i>Underthrees</i>				
Total Target*	1200	1950	1950	1950
Registered	172	1709	1704	1604
	97.6(%)	87.6(%)	87.4(%)	82.2(%)
Actually utilising services	576	1284	1433	1393
	48.0(%)	66.4(%)	73.3(%)	71.4(%)
<i>Three To Six Years</i>				
Total Target*	1500	2400	2400	2400
Registered	1194	1764	1902	1952
	79.6(%)	73.5(%)	79.2(%)	81.3(%)
Actually utilising services	681	1469	1683	1756
	45.4(%)	61.2(%)	70.1(%)	73.1(%)

\*Estimates based on population, fertility rates and birth rates

### Coverage of ICDS

In evaluating the programme, the aspect of utilization of services is easier to gauge, and shows visible improvement over time (Table 7.1). Over 80 percent of eligible children and lactating mothers are shown to be registered by anganwadis. The proportion of antenatal mothers registered is lesser which may be due to their being covered mainly by the FHWs. The figures for the proportion actually availing services have risen steadily over the years.

Table 7.2: Awareness about Anganwadi Workers (AWWs)

	<i>Survey villages</i>		<i>Jhagadia village</i>	
	Number	Percent	Number	Percent
Total respondents	511	100.0	165	100.0
Knew there is an AWW in the village	496	97.1	98	59.4
Knew the AWW's name	436	85.3	30	18.2

The community is also well aware of the presence and functions of the anganwadi worker (Tables 7.2 and 7.3).

Less than 20 percent mentioned one of her jobs to be weighing of children, and very few mentioned immunization or treatment of minor ailments. While the latter are probably perceived to be functions of the FHW, the former may be related to weighing being done only at the anganwadi, that is, less visibly.

While the services of ICDS thus seem to be satisfactorily utilized, the other aspect under evaluation, that is, impact, becomes difficult to gauge. Given the objectives and activities under ICDS, major areas where impact should be visible are the level of undernutrition (protein-energy-malnutrition) among children where a reduction would be expected within a few years of work; the level of mortality among infants and children, which is a relatively more tenuous area; and preschool education, which should reduce school dropout.

Table 7.3 : Awareness about AWW's Work

Function	Survey villages		Jhagadia village	
	Number recalling function (n=496)	Percent	Number function recalling (n=98)	Percent
Teaching children	456	91.9	69	70.4
Makes children play	197	39.7	17	17.3
Feeds children	371	74.8	33	33.7
Weighs children	88	17.7	2	2.0
Vaccination of children	35	7.1	0	0
Treats minor ailments	43	8.7	1	1.0
Recalling any function	484	97.6	77	78.6

### Malnutrition and Child Health

It is general community health wisdom that the proportion of children, who are severely undernourished (that is less than 60 percent of the expected weight for age), is a reliable measure of the general quality of services provided. Over the years, SEWA-Rural has made several serious attempts to help malnourished children improve their nutritional status, including regular monitoring, checkups by doctors and intensive health and nutrition education. As recorded in SEWA-Rural (Table 7.4), the baseline level of severe undernutrition was 15 percent (of all undersix children) with an impressive decline to a level of five percent by 1989.

Table 7.4 : Levels of Severe Childhood Undernutrition

	1982 (baseline)	1984 -85	1985 -86	1986 -87	1988 -89	May 1989 survey data
Total Children (0-6 years)	1760	1783	2863	2675	4123	-
Children weighed	180 (10.2)	545 (30.6)	1760 (61.5)	1674 (62.6)	3823 (92.7)	244
Severely undernourished	29 (16.1)	65 (12.0)	270 (15.3)	256 (15.3)	193 (5.0)	28 (11.5)

N.B: 1) Reliable data for 1983-84 and 1987-88 are not available.

2) Figures in parentheses are percentages.

However, the survey conducted as part of the current evaluation seems to tell a different story. The survey covered a random sample of 50 percent of families from 10 project villages, of which nine had anganwadis. In this sample, the proportion of severely undernourished children is found to be 11.5 percent, against a proportion of 5.0 percent in these villages as per anganwadi records. This discrepancy between the evaluation figures and those reported by the anganwadi raised several doubts and the organisation is investigating the matter. Preliminary inquiries reveal errors at various levels: in calibration of weighing scales, in weighing children, in plotting their weights and recording grades of nutrition. Also, there is considerable variation between anganwadis. It may be mentioned at this point that one of the supervisors could not detect grossly erroneous growth charts as faulty when questioned by a member of the evaluation team. It should also be mentioned that some inter-observer variation between those who weighed children during the evaluation survey may contribute in small part to the errors. Such discrepancies are usually due to missing out children who do not come to anganwadis, that is, the underthrees, the truly poor and underprivileged, the really malnourished, etc. Checking with records reveals that none of these factors seem to be true in this case.

It is therefore difficult to accept the reliability of even the figure of 15 percent baseline severe undernutrition. It would be hazardous to estimate the precise extent of decline of malnutrition, though there can be little doubt that it has declined.

Importantly, all this shows that there is much room for improvement in terms of better training of supervisors in supervision, serious cross checking and verification of growth monitoring efforts of anganwadi workers, and a greater input from concerned doctors in overseeing the whole process

### Impact on Mortality Rates

To judge the impact in most of the mortality rates is also somewhat difficult, and the simple reasons for this are: (a) the base population being small, the deaths in absolute numbers are small, and small changes in numbers of deaths cause apparently wide fluctuations in rates; and (b) the health programme has been functioning for only a few years.

Table 7.5 : Child Mortality Patterns

	1983-84	1984-85	1985-86	1986-87	1987-88	1988-89
Child mortality <sup>1</sup>	20 (12.8)	21 (8.0)	10 (4.3)	11 (2.4)	24 (5.3)	31 (6.8)

<sup>1</sup>calculated per corresponding child (1-6 year) population

The pattern in mortality rates over the years has been shown in Figure 7.1 and Table 7.5. After an initial fall, most of the rates have stabilized. The infant, neonatal and perinatal rates have come down and remained at par with the national and state averages, while these mortality rates are in line with the HFA targets. The childhood mortality rate after gradual reduction over the years is around 5-7 per 1000 corresponding child population. This mortality picture is less than half as compared to state and national averages, while it compares well with HFA targets. This would indicate a good level of child care services.

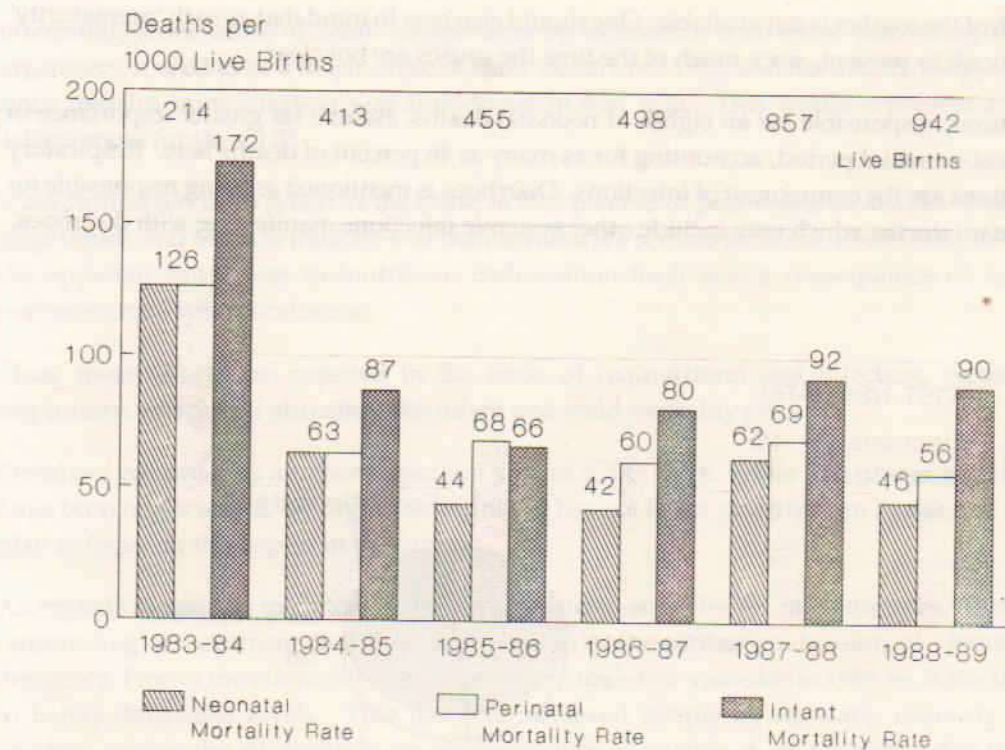


Fig. 7.1 : Perinatal, Neonatal and Infant Mortality Rates

### Causes of Mortality in Children

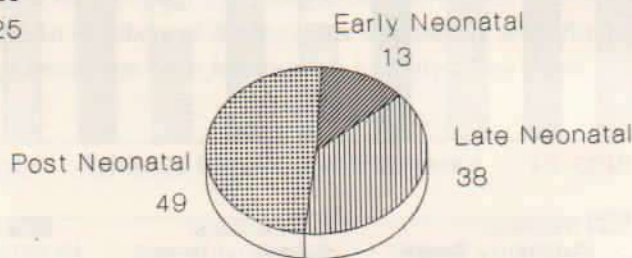
A look at the leading causes of deaths among infants in the last one year reveals (Figure 7.2) that of the 84 infant deaths recorded, 43 (51 percent) died within four weeks of birth, a majority of them (that is 22, or, more than a quarter of all infant deaths) of low birth weight. While this doubtless points to some maternal ill health, it is difficult to say whether these deaths could have been prevented, especially since complete information about the state of

health of the mother is not available. One should also bear in mind that as such 'prematurity' is difficult to prevent, since much of the time the causes are not clear.

Infections, responsible for an eighth of neonatal deaths, assume far greater importance in the post-neonatal period, accounting for as many as 46 percent of deaths here. Respiratory infections are the commonest of infections. Diarrhoea is mentioned as being responsible for six infant deaths which may include other systemic infections manifesting with diarrhoea.

POST NEONATAL

Infections	46
Malnutrition	29
Others	25



NEONATAL

Low Birth Weight	51
Infections	16
Others	33

Inservice data for the year 1988-89  
 Total Infant Deaths = 84  
 Figures in percentages

Fig. 7.2: Causes of Infant Deaths



Interestingly, one cause of death conspicuous by its absence is measles. According to the organizers, it used to be a major cause of child death until 1985, and has all but disappeared since measles immunization was introduced in that year. This would represent a true achievement for the CHP.

Malnutrition has been stated as the cause of 29.3 percent of post-neonatal deaths. This is a large figure, and tends to indicate that malnutrition is a serious problem. In one case, though the apparent cause was malnutrition, malnutrition itself was a consequence of severe non-infectious systemic disease.

Thus, more efforts are required in the areas of malnutrition and infection, especially respiratory, which will also affect the infant and child mortality rates.

Preschool education is another important area of ICDS work. While this cannot be said to have been neglected, as the organizers admit, it has got lesser priority than health and they plan to focus on this aspect in the future.

As regards morbidity in children, figures are hard to come by for most diseases. But one outstanding achievement that deserves mention is the virtual eradication of vitamin A deficiency. From a prevalence of over 30 percent in undersix-year olds in 1985-86, it has fallen to barely detectable levels. This has been achieved simply by regularly ensuring that children receive the six monthly prophylactic dose of vitamin A, as recommended in the ICDS programme, an example of how sincere implementation of a simple measure can bring about palpable changes in certain health situations.

Besides vitamin A deficiency, the perception of the community and the doctors alike has been a decrease in general of child morbidity as well. This is probable considering the strong curative component at the hospital, and the visible positive effects of measles vaccination and vitamin A distribution (both of which are known to reduce morbidity from respiratory and gastrointestinal infections).

## VACCINATION

Vaccination is one of the best established areas of work in maternal and child health. The universal immunization programme as adopted by India aims at completing primary

immunization against six major childhood infections: tuberculosis, poliomyelitis, diphtheria, pertussis (whooping cough), tetanus and measles before a child is fully one year old, in addition to immunizing all pregnant mothers against tetanus.

SEWA-Rural's approach with respect to vaccination has been professional, blending with a good understanding of the community's perceptions on the matter. Right from the beginning, planning has been meticulous, training rigorous and accompanied by tremendous efforts at creating awareness in the community. For instance, for nearly 18 months after starting community health work in the initial 10 villages, vaccination was deliberately not performed due to the prevailing fear of injections in the community. As rapport and awareness were built up, the introduction of vaccination became a smoother process. At the outset, the major task was to clear the accumulated backlog of potential vaccinees and for this, mass vaccination programmes were taken up with a camp approach, where for four consecutive months each year, large teams of workers would cover each village in painstaking detail. At such camps upwards of 100 children would be covered in a session, depending on the size of the village. As the backlog diminished, the emphasis gradually shifted to covering mainly fresh candidates for vaccination.

Today, vaccination has become a matter of monthly routine, with a team comprising of a couple of workers vaccinating a handful of children each month in a village, mostly infants. It is planned, implemented and supervised almost fully by male and female supervisors, with doctors giving only occasional guidance and troubleshooting as required. Vaccination reactions and side effects are low (0-3 incised abscesses/year in whole population) and promptly managed by followup teams which visit almost each vaccinated child in the week following vaccination.

The acceptance of vaccination by the community seems to be truly high and is reflected in the progressive increase in coverage from less than 10 percent to almost 70 percent in the initial years and the high plateau that has been maintained (Table 7.6) over the last three years.

In addition to the above mentioned factors, there are others worth mentioning which have contributed to this remarkable success. Vaccine schedules, once planned and announced, are kept up most of the time at almost any cost. Though the supply of vaccines to this organization comes from the government, any shortfall or delay is met by ad hoc purchases from the market, so as not to upset schedules. The sterilizing of all vaccine related equipment

takes place centrally, and is the responsibility of one or two person, thus ensuring quality. Vehicle support is provided to each team going for vaccination, either four wheelers or two wheelers. Even today, the attempt is to reach villages at a time convenient to the villagers, even if it were for just a handful of routine vaccinees.

The true test of effectiveness of a vaccination programme would be whether morbidity and mortality due to vaccine preventable diseases in the community has fallen significantly since vaccination was begun. In the absence of reliable baseline morbidity data it is very difficult to comment conclusively on this. But with respect to at least one vaccine, namely measles, it may be said that its introduction has made apparently substantial change. Epidemics of measles have not occurred in project villages for the four years since introduction of measles vaccine in spite of being rampant in many areas of the state (before 1985, project villages had witnessed severe epidemic measles repeatedly). Also, no child mortality due to measles has since been reported from project villages.

Table 7.6 : Vaccination Coverage

	1983-84 or 1982-83	1984-85	1985-86	1986-87	1987-88	1988-89
BCG	33	69	84	93	93	96
Polio	9	36	49	67	76	89
DTP	7	44	57	62	70	79
Measles	NA	NA	40	76	77	73

All figures are as percentage of total eligible.  
NA : Not available

Table 7.7: KAP regarding Vaccination, 1984-89

Aspect interviewed	Total No.	Showing improvement		Showing no change		Showing decline	
		%	No.	%	No.	%	No.
Which diseases are vaccine preventable?	236	63	26.9	162	68.6	11	4.6
Mode of administration of polio vaccine?	236	54	22.8	159	67.4	23	9.7
Harm caused by vaccine to children?	236	37	15.9	175	74.2	24	10.1

A greater proportion of mothers accept that vaccines are harmless, and seem to have knowledge about the method of administering polio vaccine (Table 7.7).

The coverage of Tetanus Toxoid in pregnant mothers is around 75 percent and is discussed in the chapter on maternal care services.

### Conclusion

In conclusion, the health status of children has indeed shown a change for the better, though not as much as one would have hoped. Areas which have been decisively affected include the near-eradication of measles deaths, and a dramatic fall in the prevalence of symptomatic vitamin A deficiency.

The persistently high perinatal mortality (in spite of a strong emphasis on dais) and a moderately high rate of malnutrition (which has fallen less than expected) should provide pointers to areas requiring deeper investigation and more effective intervention. One way of achieving even limited results could be by shifting emphasis from three to six year olds to undertwos. This will require a reorientation of policy and programmes, but the effort is

likely to be worthwhile. Preschool education needs a more creative, innovative approach, and unless it can be given higher priority, this is unlikely to happen.

On the positive side, SEWA-Rural has made useful contributions in demonstrating the feasibility and popularity of indigenous foods for anganwadis. It would be desirable for the government to finance such experimental efforts of voluntary agencies. There is also much to be learnt from the close integration of ICDS with other community health services which has been made possible at SEWA-Rural.

The vaccination programme at SEWA-Rural's CHP serves as a model to demonstrate how such a programme can be organized and carried out. It has evolved from a heavily time and effort intensive door to door campaign to a low key centralized programme having practically no backlog left uncovered. Its success has been remarkable, and coverage is substantial despite addition of fresh villages every few years. The major factors contributing to this success seem to be thorough planning, minute detailing, close monitoring and followup, all leading to a very low rate of complications.

## **FAMILY PLANNING**

The CHP at SEWA-Rural is active in family planning not quite by choice. Like many other voluntary health organizations, the organizers at SEWA-Rural recognize the problem of population as important, but not paramount, not necessarily having a higher priority than all other health activities, and certainly not to be dealt with in the manner in which the government health services do. The organizers at SEWA-Rural believe that better quality of health and family planning services, and intense educational efforts should form the basis of an effective family planning programme, and would have preferred to adopt a different approach, one that would produce surer, albeit slower results. But since family planning forms an integral part of PHC services, SEWA-Rural acts under pressure from the government, and is making efforts to put in whatever required to make the programme work better.

### **Reasons for Better Acceptance**

Indeed, to an extent, it has been able get the programme to function a lot better. For one thing, the overbearing importance family planning otherwise gets has been substantially reduced. A very conscious, though not always successful, effort is made to ensure that family planning does not unduly impinge on other activities. That this has been successful can be seen (Figure 6.1) from the image the FHW carries with the people, she is identified much more closely with maternal care services, than with family planning.

Secondly, the health workers work as a team, rather than as individuals. The middle level workers support and encourage village level workers to do much of the work of convincing and motivating people. The work thus becomes the burden of village level workers than that of middle level workers. This is made easier by incentives for motivating people to accept family planning methods going to village level workers, rather than middle level workers.

Thirdly, efforts are made to pace the family planning work as evenly as possible over the year so as to minimize the otherwise inevitable rush in the last quarter to meet targets.

Besides all this, a fixed day each week is marked out for sterilization operations at the hospital. This day is publicized widely, making it simple for patients to get operated on the day of their choice, and to plan for the same. Also, this way, large camps and the attendant mess are avoided. However, traditionally and culturally, family planning activities generally pick up only in the latter half of the year.

Fourthly, criteria for sterilization are strictly followed, even at the cost of losing a potential candidate to 'rival' family planning camps. For instance, sterilization is not performed if the level of hemoglobin is below 7 grams percent, if urine shows significant abnormalities, or if certain medical conditions exist which contraindicate surgery. In other words, the 'rejection' rate of patients from sterilization at SEWA-Rural is quite high compared to other organizations. Over the last three years 69 patients have been rejected on such grounds at the hospital. In order to minimize this, patients are screened more carefully in the field according to the laid down norms at the time of motivation itself, thus also avoiding unfruitful hospital trips for patients. Over a period of time, the community seems to have appreciated this as people even from non-project villages often seem to prefer sterilization at SEWA-Rural rather than at other centres.

#### **Quality of Sterilization**

After sterilization each patient is followed regularly by the health workers, and serious efforts are made to minimize complications. In the event of a problem occurring, prompt attention and care are provided.

Over the years there have been six known failures out of all the sterilization operations performed so far on 1144 patients of project villages at the hospital at SEWA-Rural, giving a failure rate of 0.52 percent.

All this has made family planning more acceptable for the workers and the patients alike, and this is reflected in consistently high (usually greater than or equal to 100 percent) target achievement for sterilisation (Table 8.1).

The efficacy of this is also visible in the birth rate which has been maintained at around 2.7 percent.

Table 8.1 : Target Achievement in Various Family Planning Methods

		1984-85	1985-86	1986-87	1987-88	1988-89
<i>Tubectomies</i>	Target	282	180	287	267	263
	Achievement	126 (45.0)	216 (120.0)	292 (102.0)	350 (131.0)	333 (126.0)
<i>CuT Placements</i>	Target	125	152	373	257	269
	Achievement	33 (26.0)	65 (42.7)	60 (16.0)	62 (24.1)	67 (25.0)

The quality of sterilization work is fairly good, as can be seen from Table 8.2. For instance in the year 1987-88, as many as 43 percent of sterilizations were performed on women with two or fewer children giving a mean of 2.7 children per sterilized woman in the project area.

Table 8.2 : Number of Surviving Children at Sterilization

No. of children	1984-85	1985-86	1986-87	1987-88	1988-89
Two or less	20 (29.9)	37 (31.4)	81 (37.9)	105 (43.4)	93 (36.2)
Three	35 (52.2)	65 (55.1)	98 (45.8)	98 (40.5)	127 (44.4)
Four or more	12 (17.9)	16 (13.6)	35 (16.4)	39 (16.1)	37 (14.4)
Total Sterilized	67 (100)	118 (100)	214 (100)	242 (100)	257 (100)

Figures in parentheses are percentages



### Spacing Awareness and Couple Protection Rate

The couple protection rate is around 60 percent, mostly accounted for by sterilization alone (Table 8.3). Even among sterilized couples, tubectomies far outnumber vasectomies, a picture no different from elsewhere in the country. This points to a near-exclusion of non-terminal methods, a surprising finding in an organization that believes in education as an important means of getting people to utilize services.

Table 8.3 : Contribution of Various Methods to Couple Protection Rate

Method	1984-85	1985-86	1986-87	1987-88	1988-89
Total eligible couples	2983	2671	4521	5274	5960
Protected by sterilization	1580 (53.0)	1479 (55.4)	2689 (59.5)	2644 (50.1)	3382 (56.8)
CuT	14 (0.5)	- -	35 (0.8)	62 (1.2)	67 (1.1)
Oral pills	34 (1.1)	86 (3.2)	175 (3.9)	75 (1.4)	66 (1.1)
Nirodh (Condom)	18 (0.6)	- -	- -	420 (8.0)	168 (2.8)
Total couples protected	1646	1565	2899	3201	3683
Couple protection rate (%)	55.2	58.6	64.1	60.7	61.8

Figures in parentheses are percentages, indicating proportional contribution of that method.

Indeed, the KAP survey showed a fair degree of awareness about spacing, intrauterine devices, and even oral pills among women of reproductive age which indicate good educational efforts (Tables 8.4 and 8.5).

Table 8.4 : Awareness about Spacing among Women of Reproductive Age

Question asked	Total respondents	Preferred Interval		
		1 yr	2 yr	Other
When should the second child be born after the first?	376 (100%)	23 (6.1%)	207 (55.1%)	146 (38.8%)

Table 8.5 : Ability to Recognize Spacing Devices among Women of Reproductive Age

Total Respondents	Proportion recognizing CuT	Proportion recognizing Oral Pills
377	131 (34.7%)	114 (30.2%)

The organizers consider that they may not have tried hard enough, and that whatever they have tried has not worked out well. But obviously, some degree of disinterest, fear of side effects of Copper T and dearth of formal education on part of the community must at least partly be responsible for this dismal picture. Also, there is that important factor of the FHWs being discouraged by the organizers from inserting Cu T in the field, in the belief that adverse effects and complications resulting from this could vitiate work in other areas.

Similarly, although abortions conducted by unqualified personnel in the area are quite common, MTP does not seem to have been encouraged at the hospital by SEWA-Rural. The organizers explain that this is in part due to sensitivities of individual gynecologists who have worked at the hospital, and in part an ethical tradition handed down over the years; but they are now making efforts to liberalize this.

### Conclusion

In summary, though family planning has never been high on the list of priorities of SEWA-Rural, because of SEWA-Rural's accountability to the government for fulfilling targets, family planning has still demanded and received more attention than have other areas (like environmental sanitation) which have correspondingly been accorded a low priority by the organization. While the organizers are not too happy about this, it has resulted in good work being done in sterilization, the factors contributing to which have been discussed in detail above. The most outstanding of these would seem to be the high quality of hospital services and the team approach to field work.

The awareness in people about spacing methods is fair, though less than desirable. In spite of this, these methods barely contribute to the otherwise moderately high couple protection rate. Similarly, vasectomy too is hardly accepted by people. The organization would do well to closely examine the underlying reasons for this picture, so that appropriate efforts for achieving some concrete results can be put in.

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## COMMUNICABLE DISEASES

### MALARIA

Ever since it was discovered that attempts to eradicate malaria from India are, at the present juncture, at best ambitious dreams, the efforts have been directed at containing the spread of disease by mosquito control measures and effective drug therapy to patients, aimed at killing sexual forms of the malarial parasite which are responsible for transmission of the disease.

To achieve the latter purpose, the approach has been to examine the blood of all patients with fever for the presence of the organism and to give appropriate drugs to all those found to be harbouring them. To be effective, this entails collection of blood smears from all possible cases of malaria-like fever in the community in door to door screening (the proportion over a year being called the annual blood examination rate or ABER). The proportion of smears showing the presence of malarial parasite is the annual parasite incidence (API) and reflects, if ABER is good, the patterns of incidence of malaria, including type of malaria, in the community. This in turn would reflect on the efficacy of the various malaria control measures instituted.

In the project area of SEWA-Rural, smear collection activity, as reflected by ABER seems to be done quite enthusiastically (Table 9.1).

The same enthusiasm is seen in the fact that the recommended mass survey of a community neighbourhood is actually performed regularly when plasmodium falciparum, the dangerous type of the parasite, is detected in the blood of a patient. This is particularly gratifying because this type of malaria is showing an increasing trend, not only in SEWA-Rural's project villages (Table 9.1) but all over Gujarat. This rising API till 1988 probably reflects the true worsening of the situation as seen elsewhere in the state as well. Persons exhibiting these organisms in the blood are treated in time with a full course of chloroquine, followed by primaquine to prevent spread of the disease.

Table 9.1 : Malaria Work in Project Villages

	1984-85	1985-86	1986-87	1987-88	1988-89
Total population	18768	19116	34474	35090	35706
Total slides collected	3009	4466	8237	12057	8452
ABER (%)	16.0	23.4	23.9	34.4	23.7
Total positive slides	130	296	893	1288	584
API (per 1000 pop.)	6.9	15.5	26.0	36.7	16.4
<i>P. vivax</i> infections	125	260	694	1056	262
<i>P. falciparum</i> infections	5	36	199	232	322

The value of this work would be better appreciated when compared to surrounding areas in the district where ABER is low (10 to 12 percent) and API very high (greater than 50).

Another indicator of severity of the problems would be mortality due to malaria. While some deaths from project villages have been attributed to malaria, not a single smear positive case has died. Conclusive interpretation of cause of death is difficult.

The concerned workers are also equally active in assisting anti-malarial insecticide spraying teams. They accompany these teams, and utilize their personal rapport with the community to enhance acceptance. Around 89 percent of all households interviewed reported that they do get houses sprayed, a remarkably high figure. One potential lacuna here would be that people would avoid getting their kitchens sprayed, a common tendency that should be checked.

Some questions were asked in the survey about symptoms in malaria and about the insecticide spray. While most (75 percent) mentioned fever and rigors as symptoms, other symptoms were less frequently mentioned (Table 9.2).

Table 9.2 : Awareness about Malaria Symptoms

Symptom	Proportion mentioning this symptom	
	No.	Percent (n=522)
Fever	425	81.4
Rigors	372	71.3
Alternate day fever	67	12.8
Sweating	19	3.6
Vomiting	92	17.6
Malaise, bodyache	266	51.0

Insecticide sprays were perceived by many as being useful against fleas, bed bugs and even flies, but most recognized that it was primarily to control mosquitoes (Table 9.3).

Table 9.3 : Perceived Uses of Insecticide Spray (DDT)

'Useful against...'	No.	Percent (n=522)
Mosquitoes	400	76.6
Fleas, bedbugs	308	59.0
Other insects/pests	103	19.7
Ineffective	38	7.3

The major credit for the good work in malaria should go to the multipurpose male worker [MPHW (M)].

A word about mosquito control measures. Except for sprays and occasional spurts of other methods of vector control, the organization has not made systematic and sustained efforts in this direction right from planning level (for instance, measures to control breeding places

and biological methods to limit breeding), as the organizers readily admit. For truly effective control, such measures will have to be more seriously instituted.

### TUBERCULOSIS

A TB centre is attached to SEWA-Rural's hospital at Jhagadia, which caters to patients of tuberculosis who come from various parts of the district, and even beyond. The centre enjoys popularity particularly among those who come from afar. The centre generally follows the same principles as the national TB control programme, and is attached to the district tuberculosis centre to the extent of obtaining drugs from the centre for sputum-positive patients belonging to Bharuch district. For patients from outside Bharuch district or for non-sputum positive patients, SEWA-Rural gets funds from a Bombay based trust. Patients of tuberculosis from SEWA-Rural's project villages also get their monthly supply of drugs from this TB centre, where they form a fraction of all patients of tuberculosis attending the centre, around 10-12 percent (Table 9.4). The proportion of patients from non-project villages treated at the TB centre is increasing progressively.

**Table 9.4 : Patients Detected and Treated at SEWA-Rural's TB Center**

	Detected till March 1989	Detected in 1988-89
All villages	3035	773
Project villages	679 (22.4 %)	75 (9.7 %)

The main objectives of any TB control programme are to achieve as complete as possible case detection and then to ensure case holding until cure. This remains true of SEWA-Rural's TB control component as well. The middle level workers (particularly male workers) are expected to keep a tag of all patients of tuberculosis in the villages they cover, and to attempt

to enhance case detection mainly through contact tracing and collection of sputum for examination at the laboratory at Jhagadia. They are also expected to motivate patient to regularly attend the centre at Jhagadia for collecting their drugs. Any children suspected of contact with sputum positive patients are also encouraged to visit the hospital for a checkup and Mantoux test. Children with suspected lymphadenitis are also referred.

In turn, the TB centre maintains a tag on TB patients under treatment and sends them postal reminders when they fail to turn up by a given date. An attempt is made to track down such defaulters of project villages through the concerned middle level workers. This is usually a function of the referral system referred to later.

While all this has been planned, in reality, the TB programme suffers somewhat, mainly due to it being a relatively 'peripheral', less emphasized component of the CHP. Thus, right from the beginning, case detection in the project villages has been low. For a period of around two years, when the mobile dispensary services were frequent, case holding was strengthened by delivering drugs to patients through the mobile dispensary at their villages. Earlier, there was a policy of reimbursing the transport expenditure of patients. Both have since been stopped. The frequency of the mobile dispensary is much reduced and its role is under going changes, making it impractical to combine delivery of TB drugs with it. The travelling allowance was stopped mainly due to the high cost that it entailed.

However, in a recent study on lost patients conducted by SEWA-Rural, it was found that these were at best minor reasons for patients getting lost to followup: the major reasons cited by patients were their 'feeling' better after a couple of months of treatment as also side effects of the drugs (Table 9.5).

The detection of tuberculosis in the project villages has been around 3.28 for 1000 population per year. While this is fairly good, falling within the 2.5 to 5 per 1000 range expected in India, the records show no evidence of any backlog being cleared before this steady state was achieved. This would probably mean that there are still quite a few patients who are undetected. This could partly be explained by the social stigma that still prevents patients from making public their disease, and partly by patients going directly to private practitioners. But to an extent that is difficult to define, it seems to be due to a less than enthusiastic drive by SEWA-Rural for detecting new cases.



Table 9.5 : Reasons given by 'Lost' Patients for Stopping Treatment

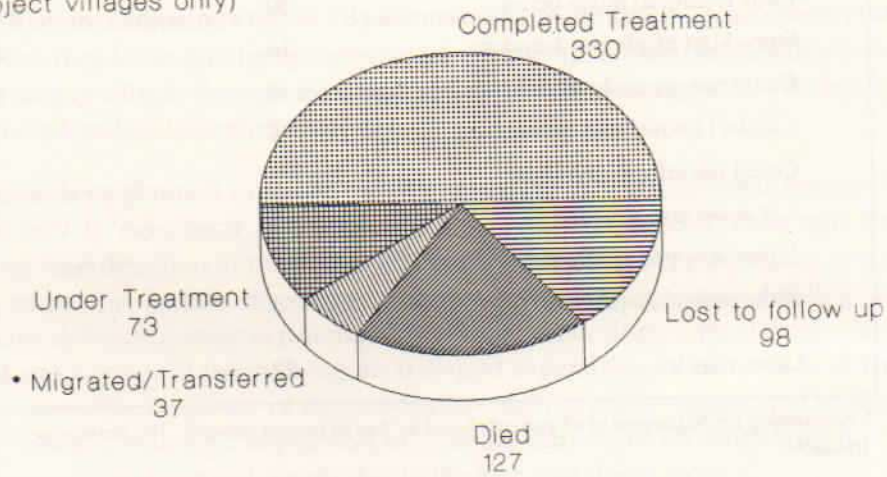
Reason given	No.	Percent (n=78)*
I was feeling so much better...'	30	38.5
Some kind of adverse reaction	16	20.5
Could not get away from work...'	9	11.5
'...didn't know I had to continue'	6	7.7
Could not afford travel cost	5	6.4
'...it is too far...'	3	3.9
'...they stopped giving medicines at the mobile dispensary...'	2	2.6
Other reasons	27	34.6

\* Accounting for 50 percent of all patients listed as 'lost' in project villages. The remaining were not traceable.

The evidence for this comes from two indirect sources. Some male middle level workers who were questioned about this expressed the view that TB work was not a priority area of CHP work, and so does not feature prominently in their planning of their field work. In fact, some of them thought even doctors were not paying much attention to TB work. While this may not be wholly true, it does reflect the relatively lower priority that TB gets, especially when it forms a part of a much wider ranging community health programme. Secondly, the rate of sputum collections from the field is low. In one village, only 57 collections had been made as against a target of 156; of these, only one was positive. The picture for most villages is similar. The low rate of field detection of TB, though, is no different from what obtains in most other parts of the country. The organizers believe that it is unrealistic to expect fulfillment of target sputum collections in the field.

Case holding is however good with 59.5 percent of the detected patients having completed treatment since the CHP began functioning in 1982 (Figure 9.1). When calculated over the period of one year only, it was found that of all patients detected from these villages between April 1988 and March 1989, nearly 40 percent had completed treatment by end of March 1990.

Data from TB Center, 1982-90  
 Total Patients Detected : 665  
 (Project villages only)



• Includes patients who stopped treatment under medical advice

$$\begin{aligned}
 \text{Case holding} &= \frac{\text{No. of patients having completed treatment} \times 100}{(\text{Total detected} - (\text{Under treatment} + \text{Migrated, etc.}))} \\
 &= \frac{330 \times 100}{(665 - (73 + 37))} \\
 &= 59.5\%
 \end{aligned}$$

The rate of case holding indicates a good followup and educational efforts by the field staff in the villages.

Fig. 9.1 : Case holding in Project Villages.

### Conclusion

As regards malaria, the awareness of people about malaria is high with enthusiastic slide collections and followup by middle level workers contributing to a well organized programme. It would undoubtedly become effective if equal attention could be given to controlling the breeding of mosquitoes; this would not be too much to expect, considering the public health importance malaria has assumed of late.

In tuberculosis, the work is less visible, and one gets the impression that it has not been accorded adequate priority. If case detection could be improved, for which there is clearly room, even maintenance of the fairly high current rate of case holding should ensure an adequate control of tuberculosis in the area.

## CHAPTER 10

# SCHOOL HEALTH AND ENVIROMENTAL SANITATION

### SCHOOL HEALTH

School health services are considered an integral part of the PHC that covers the area where the school is situated. The potential of this component for promotive and educational efforts is great, but in practice this remains one of the neglected parts of the PHC services.

Well aware of all this, SEWA-Rural decided from the outset that, given all the rest of the PHC work, it would not be able to spare enough time or manpower to conduct fullscale school health services, and hence that it would cover this area mainly to fulfil its duty as a part of overall PHC activities.

Accordingly, the main input by SEWA-Rural has been an annual examination of the school children by a doctor, which includes anthropometric measurements and rapid clinical survey of children for presence of disease. Children of appropriate age are then vaccinated according to recommendations from the government. Any child found to have some health problem is either given primary treatment if possible, or asked to visit the hospital at Jhagadia for further investigations. A list of children requiring further followup is given to the teachers, who are then expected to guide the children and the parents accordingly. There being no regular planned followup of such referred children, little information is available on what happens of them, an area which can probably be improved easily without too much effort.

Some efforts have been made over the years to involve children in schools for various health educational programmes in villages, apparently with some success. During the day when a health checkup is conducted, the health supervisors and middle level workers in the team engage the children on various aspects of health, making the day a little different and special for the children. In this manner, all schools (about 50 in number) in the project villages are covered regularly once a year. This is scheduled according to the availability of adequate manpower (for example, when intern doctors are posted). However, little of this has been documented or systematically pursued.

All said and done, the major component that needs to be strengthened in the school health programme is the creative aspect of utilizing the tremendous potential children have as agents of change, whether in health, or otherwise. For instance, such well established ideas as 'child-to-child' need to be explored for feasibility and utility in the area.

#### ENVIRONMENTAL SANITATION

Though SEWA-Rural has stated improvement of sanitary conditions among its USAID project objectives, their achievement in this area is little. Economic constraints and lack of people's enthusiasm for such programmes are stated as the main reasons by the organisers. However, some efforts were made in this direction. Knowing fully well the uselessness of occasional chlorination, CHV and other workers were trained in chlorination of well water and domestic chlorination with tablets. When chlorination procedure was checked in the field, it was found to be faulty and different cadres of workers used different procedures. Differences were in details. Chlorination was done only weekly, people objected to taste of chlorine in water and after lots of persuasion, were motivated into consuming this water.

SEWA-Rural undertook repair of tubewells during years of scarcity to relieve water shortage. It is now a regular program. Cleaning and repair of dug wells is sporadically carried out by involving people in the activity. But enthusiasm of people and workers is limited.

SEWA-Rural has been promoting smokeless cookstoves and gobar gas plants and a few families have adopted the latter innovation. An attempt was made to introduce smokeless cookstoves in a big way, a few years ago. More than 300 cookstoves were built, but most cookstoves are now defunct.

Malaria is rampant in this area. SEWA-Rural is promoting breeding and extension of Guppi *Gambusia* fish which feed on mosquito larva. However it is not a systematic and regular programme

As late as the year 1990 SEWA-Rural started a campaign to propagate construction of sanitary latrines. Three types of latrines with different costs are offered to families. These latrines are subsidized by the government under different schemes. The response is

encouraging but several years of efforts will be needed to cover even 50 percent of the families. At present less than 10 percent of the families have latrines. In some irrigated villages hookworm infestation is very common among agricultural labourers because of the practice of open air defecation.

Though there is piped water supply in some villages there is no provision of sullage disposal. Disposal of human excreta and refuse is a big problem. Culex mosquitoes are a nuisance and in plenty. House flies are other regular seasonal problems. These problems need solution but SEWA-Rural has yet to attend them.

## **BIRTHS AND DEATHS : RECORDS**

For any community health programme having comprehensive objectives as in the case of SEWA-Rural's CHP, maintenance of reliable records of births and deaths becomes a must. They form an important basis of evaluation of the long term impact of the programme. It has been mentioned elsewhere that five years is too short a time in which to expect a health programme to drastically affect figures of births and deaths; hence the need to keep this principle in mind while evaluating such figures. But this argument does not in any way dilute the need for meticulousness in maintenance of such records.

The system at SEWA-Rural for recording births and deaths has been undergoing a slow evolution, and is as yet imperfect. At the beginning, CHVs were given postcards in addition to registers, through which to inform the centre about any birth or death occurring in their village within a specified period of days. This postal information would be logged onto a register kept for that purpose at the Jhagadia office. The middle level workers would confirm this information during their routine field visits and update the register. Births would be also noted along with details about the child birth in the records maintained by the female middle level workers. A combination of these records and the records in the register gave a complete and fairly reliable picture of the births occurring in project area.

For recording deaths, separate forms are filled in for each event leading to death, and causes of death, and these forms are filed together. Attempts are made by doctors to visit the family of each deceased where deemed necessary, as for example in the case of maternal or infant death. In addition, a separate register is maintained at the centre to log deaths. Keeping in mind the nature of work of male and female workers, the female worker is given the responsibility of keeping track of preschool deaths and maternal deaths, while the male middle level worker is responsible for other adult deaths. With the introduction of decentralization in terms of separate subcentre level meetings, another avenue of cross checking the birth and deaths date was introduced. In these meetings, all village level functionaries including AWW, CHV and dai attend, as also the concerned male and female workers, the anganwadi supervisor and the male and female supervisors. This tended to reduce the importance of the routine field visits of the middle level workers and of the post cards sent in by CHVs. When the male CHVs were removed by the government, the number

of CHVs in the project villages was significantly reduced, thus making this postcard based information grossly incomplete in coverage.

### **Problems**

At present the same multiple system of gathering information is in force, and with a lot of coordinated effort it is possible to obtain a near complete list of deaths and births. The major problem is that there are multiple sources of information, none of which has final authority; and there is no effort to systematically maintain one central list of birth and deaths, though there is a central register. The organisers consider the records maintained by female worker as most complete even if supplemented by other sources. An examination of the register at the central level indicates the lack of united effort. Information is some times grossly incomplete, and entries are inordinately delayed.

However, it must be mentioned that no gross discrepancy could be detected in the number of births and deaths as reported by the organisation. These figures, got by collection from various sources mentioned above, agreed well with the data obtained by the survey of the sample villages. This only means that apparently, data collection is sincere, but the system of record maintenance is poor.

The interpretation of data thus collected and analysed is even more difficult. The relatively small and changing base population, and unreliable baseline data are mainly responsible for this difficulty. This is particularly true for indices that demand a large base population, like infant and maternal mortality rates.

The crude birth rate has not declined significantly since the programme began (Table 11.1) nor has the crude death rate. High levels of target achievement of permanent sterilization of women may partly explain the maintenance of relatively low birth rate.

It would be a safe assumption that the low initial birth rates are due to under-reporting.



Table 11.1 : Crude Birth and Death Rates

	1983-84	1984-85	1985-86	1986-87	1987-88	1988-89
Total population**	11678	18768	19116	19463*	35090	35706
Total births	224	426	475	525	879	963
Crude birth Rate	19.2	22.7	24.8	27.1	25.1	27.0
Crude death Rate	12.0	8.6	8.0	7.0	7.9	12.5

\*For the year 1986-87, population for only 20 villages has been considered, since the rest of the villages were taken up into the project area late during the year.

\*\*Estimates on basis of 1981 census figures.

The more age-specific mortality rates are discussed elsewhere in the report.

In conclusion, the basic system of collecting data seems to be quite accurate, but needs improvement, particularly in the maintenance of one central register for births and deaths. The figures obtained are not at present fully utilized for planning action in the field, something which can be readily done without much effort. This can be facilitated if the work of maintaining these records is regularly overseen by a specified senior member of the team, and if incoming data is sifted for 'dirt' and relevant data identified and separated from the very outset.

## Part IV

### ISSUES IN INTERFACING

OBJECTIVES

Most voluntary agencies believe that it is not possible to work meaningfully with the government in achieving anything, even at a task concerned with the provision of services which is the least controversial. Persons from the voluntary sector generally have a fear of initiating any action with the government because they believe that they will get entangled in the bureaucracy and politics of government's functioning. Moreover, voluntary agencies also shy away from collaborating with the government because they are afraid that they may lose their autonomy and independence both in their functioning and in playing the larger role of being a critique of the system. They are also afraid that fellow organizations may consider them as having got coopted and become part of the establishment. SEWA-Rural on the contrary sought to prove that it is possible to work with the government in achieving a common goal, but a strong commitment and a carefully formulated strategy are necessary.

This experiment of collaboration with the government is perhaps the single most important characteristic of SEWA-Rural. Through this experiment, SEWA-Rural has been handed over 40 villages by the government and has the entire responsibility for the delivery of primary health care services in these villages. Government resources have been made available to SEWA-Rural to implement government's health schemes in these forty villages, the choice of methodologies being left to SEWA-Rural.

What was SEWA-Rural seeking to achieve when it decided on this collaboration ?

The objectives, as they evolved over the years of intense discussion and debate among the SEWA-Rural planners were :

- (i) *To prevent the duplication of resources and input into a given geographical area.*

The government health system and SEWA-Rural's work had the same objectives. Instead of creating a situation of competition and conflict and duplication of manpower

and physical facilities, SEWA-Rural thought that it was better to work with the government in achieving the goals of primary health care.

- (ii) *To put the government's resources, which after all things considered are people's resources, to the best use.*

There is universal acceptance of the fact that the government is not able to use its resources in the most efficient and effective manner possible; there are leakages and suboptimal functioning which result in wastage and misuse of resources. With SEWA-Rural tapping the government funds, it was taking proactive action in trying to prevent, or at least considerably reduce, this wastage.

- (iii) *To reduce for themselves, the burden of collecting donations.*

Voluntary agencies are dependent on donors and funding agencies for funds for carrying out their activities. Undertaking the task of implementing government's schemes would result in an assured sum of money flowing into the organization.

- (iv) *To demonstrate to other voluntary agencies that it is possible to work with the government.*

#### **Specifics of the Collaboration**

The relationship with the government went through three phases. In the first phase (1982-1983), at the initiative of SEWA-Rural, only the village level health functionaries in 10 villages were placed under the technical and administrative jurisdiction of SEWA-Rural. In the subsequent years (1984-1989), Government of India along with USAID's VOP accepted the proposal of SEWA-Rural for an expansion to 39 villages with 35000 population. The Government of Gujarat placed the responsibility of total health care services of these 39 villages in the hands of SEWA-Rural while giving financial assistance to cover middle level workers and supervisors as well. SEWA-Rural selected the village level personnel that they wanted to retain. Some field workers came on deputation to SEWA-Rural and gradually the organization took on the entire responsibility of recruiting, training and dispensing with the services of the personnel working in these villages. USAID provided funds for the recurring and non-recurring expenditure of headquarters as well as construction costs of health posts in the villages. The government provided the recurring and non-recurring costs for village and middle level staff.

An Advisory/Evaluation Committee set up for the purposes of advising and guiding the work of the CHP also helped in smooth coordination and problem solving between the government structure and the voluntary agency. A list of the members of this committee is appended in Annexure 3.

All the above arrangements were accompanied by appropriate government resolutions and official orders from the state and district levels (Annexure 5).

### ACHIEVEMENTS AND RESULTS

The results of this collaboration have been lauded by one and all. In fact in recognition of the fact that an NGO and the government collaborated for the first time on such a scale, SEWA-Rural was conferred the first Sasakawa Health Award by WHO in 1985.

#### Changes in Government Norms

There is little doubt that SEWA-Rural has been able to make an impact at the government level. It has helped create an openness among the government functionaries to the idea that it is worth encouraging voluntary agencies and that there are voluntary agencies who are sincere and competent. On the basis of its experience with SEWA-Rural, the state government has deviated considerably from its normal way of relating with voluntary agencies. It has decided to

- hand over PHCs to other voluntary agencies
- hand over ICDS blocks to voluntary agencies
- recognize voluntary agencies as places where interns can be posted
- become more flexible in norms; for example, the authority of hiring and firing and training personnel is also being handed over to voluntary organizations now. Another example of flexibility in norms is the change in

the policy concerning certain technical health matters, for instance the cholera vaccine<sup>1</sup>

accept/recognize the government bond for doctors who work in other trust hospitals<sup>2</sup>

### Spread of Innovations

Some of the other innovative measures that SEWA-Rural's CHP introduced as a part of its service delivery system have been accepted by the state government for implementation in other districts. The delivery pack devised by SEWA-Rural was introduced in two other districts on an experimental basis. After this trial, the state government plans to implement this all over Gujarat. SEWA-Rural was also asked to review the entire reporting and records system and suggest changes to the state government.

UNICEF through Government of Gujarat has requested SEWA-Rural to undertake the entire training programme for the dais in the district.

### Other Spinoff Effects

There is a common feeling that because of SEWA-Rural's work, the functioning of the government health system in the surrounding areas has also become better. More supervisory visits are now being made to the anganwadis. The MPHWS too seem to feel a pressure to work better.

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<sup>1</sup>The government's policy is that when there is an outbreak of gastroenteritis in the community, cholera vaccine should be immediately administered. According to the text books, this practice is of no use. Once when there was an outbreak of cholera, SEWA-Rural decided not to administer the vaccine. After prolonged discussions with the DHO, SEWA-Rural was not forced to follow the dotted line.

<sup>2</sup>Doctors graduating out of any government medical college in Gujarat state are bonded with the government to work in a rural area for a period of two years. Working at SEWA-Rural is considered by the government to be equivalent to execution of the bond. This becomes an important attraction for a fresh doctor.

SEWA-Rural is expected to participate in the monthly meeting of all the Medical Officers of the District Health Office. The effect of SEWA-Rural's participation in meetings has been good in many ways: because of the sharing of SEWA-Rural's experiences, many of the MOs and the DHOs have also developed a different perspective about various aspects of community health especially about the family planning and immunisation targets. The DHOs have started taking SEWA-Rural's primary health care related questions to state level meetings which in turn has generated some rethinking of issues at that level.

In meetings with the Regional Deputy Director and the Health Secretary, the DHO now urges the SEWA-Rural representative to raise the common issues of which he too feels the strain. He feels that SEWA-Rural's voice will be heard better rather than his.

SEWA-Rural's honesty and correctness in action has also got due recognition. The top bureaucracy of the state, it is reputed, often depends more on SEWA-Rural's health data rather than those generated by their own staff.

#### **Positive Effects of Collaboration**

What has this relationship with the government meant for SEWA-Rural in terms of its values? This is a question asked by several interested observers. Has this relationship with the government with its emphasis on targets and their achievement, meant that SEWA-Rural has had to compromise on its principles? No, assert SEWA-Rural policy makers. In fact their values for honesty and standing up for what they believe in have been further strengthened. Despite rigorous pressure by the government to achieve certain targets, SEWA-Rural has been able to stand firm. Achievements of targets through education, awareness generation and community involvement rather than pressure and coercion continues to be the organization's principle.

Because of the collaboration with the government in the health sector and resultant increase in credibility, several non-health activities of SEWA-Rural have also been supported by the government. Funding has been received from CAPART for the Gramin Tekniki Kendra, DW CRA has supported the women's programme and the NREP funds have been received for the social forestry programme.

### **Factors that Helped**

Let us examine a few other factors that have contributed to making this collaboration a success.

First and foremost is the setting where this experiment was to take place. Gujarat is one of the few states of India where voluntary efforts and voluntarism have been for long part of the politics of the state. The dairy cooperative movement experience is an example of this kind. Also at the time when initial thinking about the collaboration in SEWA-Rural was going on, there were present in the state bureaucracy (for example, the Directorate of Health and Family Welfare, the state secretariat and the district level officials), persons who had an image of being exceptionally risk taking and bold. There seems to have emerged at the time, a group of people, who saw the task of making the experiment a success as their own personal challenge. Ownership of this effort gave them probably a will and motivation that could make the collaboration a reality.

The operational strength on SEWA-Rural's part was, among other things, that they had on their Board of Trustees a man who had an intimate knowledge and experience of the government functioning at all levels. He formed a very effective bridge between the voluntary agency and the government structure. Secondly, unlike the general experience of government where they find voluntary agencies hypercritical, in SEWA-Rural they found a set of people with an understanding of the constraints and difficulties that government faced. This was continuously communicated and reflected in SEWA-Rural's interaction with the government. Thirdly, SEWA-Rural related to the government bureaucracy not as a nameless and faceless entity but it sought out sympathetic persons and related to them as persons appealing to their 'good' sense. Also, tilting the balance in SEWA-Rural's favour was the visible commitment, perseverance and competence for the task that they had undertaken, aided by the fact that the founders of SEWA-Rural were seen to have chosen the harder path of settling in a rural area giving up their long sojourn in America. Their religious-spiritual mores, their non-confrontationist, non-agitational methods and their moderate rather than radical stance, were perhaps more palatable and much less threatening to the political and administrative establishment.

The broad strategies that were evolved by key government functionaries and SEWA-Rural were centred around not threatening existing power structures. For example, through a series of meetings and discussions, with all levels of state health functionaries, a conducive



climate was sought to be created and the seed of the idea of the GO-NGO collaboration was planted. It was the district level officials, who could have been potential adversaries, who actually mooted the idea of handing over the health care delivery services for the area to the voluntary agency. The resistance that was put up by the Zilla Panchayat and the taluka level officials was broken through non-confrontational methods.

Another aspect of the strategy that was adopted especially by the government functionaries who operate within the framework of their rather rigid structures was to find solutions within the rules. Government officials who the review team spoke to, admit that with a little bit of creativity, perseverance and a genuine desire to make things happen, this kind of reinterpretation of the rules is not difficult.

Additionally, a factor that does seem to have contributed to the success was the realization on both sides that this success would mean that both the volag and the government structure need to be willing to acknowledge each other's contribution and share the resulting credit.

### Tensions And Constraints<sup>1</sup>

Perhaps among the biggest constraints of the collaboration with the government, according to a senior SEWA-Rural core group member, has been that the community health programme got stereotyped. The government pattern was closely followed and an innovative and imaginative approach to primary health care got short shrift. Integrated development approach in the villages could not be attempted, because of the pressure of targets, and an integrated role of the workers also could not be developed.

Another effect of the preoccupation with targets was that a relationship of equality would not be built with the community: the field workers mentioned that initially they had to use tremendous persuasion to bring people for immunisation. The community perhaps sensed that it was the workers' and SEWA-Rural's need to relate with them. SEWA-Rural thus failed to establish a relationship of collaboration on collective goals with the community. The workers' stated that yet another effect of the target orientation was that they often felt so burdened that they lost sight of the 'seva' aspect of their work.

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<sup>1</sup> The discussions in this section are based on the opinions voiced by the persons working at different levels in the hierarchy of CIIP and some senior government officials who have been associated with SEWA-Rural.

Another category of problems that are a part of this relationship with the government is the lengthy reports that need to be produced, often unrealistically fast. Especially the ICDS staff of SEWA-Rural are very dissatisfied with the system of reporting and recording that is stipulated by the ICDS. An anganwadi supervisor states that the work guidelines are not clear to the (local level) government functionaries themselves. They ask for too many reports, many of them are duplicates. The reports are sent back and forth very often because according to the local taluka level ICDS authorities, they are not filled correctly. Many of the anganwadi workers struggle for many months before they are able to master their work of record keeping and reporting.

Delays in correspondence, delays in fund disbursement, and delays in equipment distribution are another set of problems which cause impediments in SEWA-Rural's work. A classic example of this was when no food was distributed through the anganwadis for one week because there was no supply from the government.

There is universal acknowledgement however of the fact that the CHP has always received support and encouragement from the higher level government officials. The officers at the level of DDO and above have come to understand that SEWA-Rural's motives are sincere. In fact, some of the district level officers have put their own positions in jeopardy so as to create space for SEWA-Rural's functioning. The district officers have been able to strike a balance between their own lower level staff, SEWA-Rural's needs and aspirations and the expectations of their seniors in the hierarchy. It is however, the lower level staff in the state and district offices who create problems. Earlier there was lack of flexibility and resentment on the part of these persons. Now, this has lessened because the lower staff have realized that both SEWA-Rural and the higher officers mean business and that it is no use putting up a resistance. However, the staff of the neighboring PHCs resent that their work is being unfavourably compared with SEWA-Rural's field workers who are held up as an example by their superiors.

Within SEWA-Rural, the relationship with the government has resulted in a few tensions as far as personnel management is concerned. Firstly, the organization, has had to face the constant pressure of the voiced or unvoiced demands of the workers that their salaries should be on par with the government scales, especially since they work harder than their government counterparts. Secondly, some of the workers resent the voluntary agency's tighter monitoring and control system; being made accountable is also not very acceptable

to them. Many of them, 22 at the time of the review, have left SEWA-Rural and sought government jobs.

Now with SEWA-Rural assuming the status of the PHC, it is expected that the tensions with the staff will become greater because they will demand all the benefits that go along with government jobs: bonus, public holidays, fewer working hours, lesser supervision. There will be a greater tendency to push SEWA-Rural to be like the government.

As far as the relationship with the community is concerned, SEWA-Rural's policy of charging nominally for services provided at the base hospital are causing a problem. As mentioned elsewhere in the report that the community has been demanding free services. Now that SEWA-Rural has assumed the status of a PHC, the pressure has become stronger because all PHCs are supposed to provide free services.

#### GOVERNMENT COLLABORATION IN RETROSPECT

The reviewers asked SEWA-Rural planners what they thought of the government collaboration in retrospect. Would they have done anything differently? Why? The responses were revealing and would be perhaps of some use to other voluntary agencies who are contemplating similar collaboration with the government.

Retrospectively, SEWA-Rural planners now feel that they would have negotiated with the government to undertake only specific activities which they think are especially important from the community health point of view, or in which they are specially interested, rather than health care in toto. They point out the MCH and school health programmes as examples. Further, in these programmes they would have set their own objectives and targets and defined their own strategy. For instance, medical checkups of school children are of marginal interest to SEWA-Rural while this is a prescribed government programme. More in keeping with their intrinsic philosophy of 'man-making and character building' is the aspect of education and increasing health awareness of school children. This finds no mention in the government pattern, or at least is not given high priority.

Another point of negotiation with the government should have been the size of the geographical area of SEWA-Rural's undertaking. Instead of accepting the villages en bloc,

SEWA-Rural planners now feel that they should have right from the beginning worked only in those villages where the people were relatively more responsive and motivated. They would have been able to build a relationship of equality rather than the present relationship of 'givers' and 'receivers.'

A third area of negotiation should have been to seek flexibility in grant utilization. Instead of being rigidly tied to the allocations under different account heads, SEWA-Rural organizers should have preferred an agreement with the government that they would have the discretion to reallocate different account heads, and use the total available budget in ways that they thought were best.

SEWA-Rural should also have pressed for relaxations in the personnel recruitment criteria. After having gone through the situation of a number of field workers leaving to join government service, SEWA-Rural is of the opinion that the way to tackle this problem is to recruit people who would not be accepted by the government; recruiting persons without the government stipulated qualifications but providing them the requisite training and experience would have to some extent solved the problem for SEWA-Rural.

Yet another lesson that the organization has learnt over the years is that the strategy for long term development ought to be perhaps to strengthen the village level workers rather than middle level field workers employed by the organization. Both the above points are directly related to the freedom to design their own staffing pattern, within the given budget. SEWA-Rural feels that it is probably better to have proportionately more village level workers in relation to the middle level workers than in the government's prescribed pattern.

Another learning that SEWA-Rural has had is that preventive and promotive health care services, even if charged for nominally, to the extent that the community can afford, will never be sustainable without some external funding (either from the government or some other source). Their conclusion is that government funding has to be sought to bridge the gap but as remarked before with the freedom to use it in ways that the organization thinks are the best.

More importantly, the whole idea behind such a collaboration should be for a voluntary organization to experiment and innovate, rather than to accept the straitjacket of the government's programme design, its organizational design, its administrative arrangements and its annual targets. SEWA-Rural should have the freedom to develop the

programme in its own way and then achieve the desired objectives of the programme rather than the targets within a given time frame of five to seven years. This way, it would not have become a mere substitute delivery system for the government which it largely is today, though a better one.

### Feedback of Key Government Functionaries

All the government persons whom the review team spoke to were very positive about their experience with SEWA-Rural. They were impressed by the commitment to task and sincerity of purpose of all SEWA-Rural functionaries, right from the top to the field worker level. One of the district level persons went so far as to say that his experience with SEWA-Rural was 'exceptional' and that his own experiences with other voluntary agencies were 'pathetic.' Most of the other voluntary agencies that he was relating with were using their voluntary work as a front for either making money or creating niches for their political purpose.

The other point that was mentioned by them was the multisectoral approach that SEWA-Rural has. While this pays rich dividends for the health work as other primary needs of the community are addressed, if the other activities are not carried out with the same degree of competence, they can boomerang on the health sector.

SEWA-Rural's strategy of intensive educational campaigns before pressing for acceptance of services (like immunisation, family planning methods, etc.) was also lauded. The DHO stated that he believed in the authenticity of SEWA-Rural's work; he did not feel the need to supervise their work and their statistics as closely as those of the other PHCs under his jurisdiction.

Some of the problems that the district officials have faced have been due to their unique position of being sandwiched within the two wheels of the proverbial grinding stone. On the one hand is SEWA-Rural with its demands for flexibility and space for experimentation reinforced by their own personal conviction that SEWA-Rural's point of view is the correct one. On the other hand is the rigidity of the government structure and the system within which they operate. They are accountable to their higher levels for certain tasks that just have to be done in their areas regardless. Then, there are problems due to pressures of local level political leaders. While government functionaries do not seem to have many qualms about giving in to these pressures, SEWA-Rural refuses to yield either in giving

appointments to nominees of the political leaders or giving them preferential treatment for the hospital and other services.

Delays in the receipt of funds and/or supplies of either food commodities, medicines, etc., from the concerned government agencies also cause problems to them because SEWA-Rural makes demands. They feel that they have to try and solve these problems by temporary diversion and reallocation of the necessary items from other sources.

Some of the government persons because of their attitude of helpfulness to SEWA-Rural are not appreciated by others in their departments. They are perceived as 'pro SEWA-Rural.' The lower level staff resent the special treatment meted out to SEWA-Rural.

#### Future Action Required

On the basis of talking to government functionaries, it appears that certain proactive steps need to be taken to build on this experiment of a GO-NGO collaboration. Now that SEWA-Rural has established its credibility both with the state and central government levels, the organization needs to draw up a systematic plan or a blueprint on the issues in the larger health policy, that it can help change. SEWA-Rural can negotiate for formal recognition of their field area as experimentation and demonstration ground for community health issues. On the basis of their experience, they can press for changes, in the content of policies and programmes related to health. For instance, one issue where a programme content change would be beneficial is the use of indigenous foods in the anganwadis. SEWA-Rural's beneficiaries are vociferous that they want the indigenous rice and 'moong dal' to be distributed through the anganwadis instead of the utterly alien bulgar wheat CSM powder.

Another example of the government throwing out the baby with the bath water is the issue of the community health workers. Government of India has decided to abolish this scheme because the government's planners felt that the scheme has proved to be ineffective; however, much of the ineffectiveness has been the result of faulty implementation rather than faults in the CHV concept itself. SEWA-Rural's experience with the CHVs has been positive but they have had to withdraw the CHVs because of the government's change in policy. The government needs to have a policy of greater flexibility and allow organizations who have positive experiences with the CHVs, to continue using them.

Yet another area where SEWA-Rural's experience can provide valuable data to the policy makers is in the area of finances and financial planning. SEWA-Rural's experience shows that in addition to government's sanctioned budget, additional financial resources were, and are, required to do the primary health care work according to government's own pattern.<sup>1</sup> This data needs to be fed back to the government planners and changes in budgetary allocations pressed for. Nearer home, the information on the innovations that SEWA-Rural has introduced in its area should not just be limited to the district level monthly meetings. Mechanisms need to be created whereby these changes are reported in the state level meetings. Probably SEWA-Rural's representation is required on certain state level bodies which are decision making and not just advisory in nature.

There is thus a case also for setting up a separate policy action unit in SEWA-Rural with the explicit objective of using its experience in the field for pressing state wide, if not nation wide, changes in policies and programmes. Such a unit should also perform the function of raising awareness about common issues facing everybody concerned with the poor people's health and acting as a social audit body of public health programmes. A mere replication or enlargement in terms of scale and size of work, while useful in itself, is a tremendous opportunity wasted for macrolevel impact.

SEWA-Rural has so far fought shy of providing a critique of the governmental system, of being a change agent to the government and attempting to educate it, either in terms of policies or implementing mechanisms and procedures. Even when its own work is adversely affected because of government policies, as in the case of the abolition of CHVs or nutritious food for the anganwadi, SEWA-Rural has made only feeble protests. This may be because SEWA-Rural has either not developed the inclination and capability to think in broader and macro terms or because it has strategically thought it prudent not to rock the boat. Whatever may be the case, the larger impact and benefits of this experimental collaboration would remain very limited unless the learning and changing process gets legitimized by both sides.

It is of course very likely that this experiment of collaboration would not be continued to be perceived as a success if the organization did adopt a more activist stance with respect to government programmes and policies. It could well be that government finds SEWA-Rural as a 'good' partner, because of SEWA-Rural's relatively low profile approach

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<sup>1</sup>See Priti Dave's report, sponsored by the Ford Foundation, on financial aspects of SEWA-Rural.

and soft critique of the government. Maybe it is this possibility of losing its popularity with the government that holds back SEWA-Rural.

This of course raises the question whether this is the only kind of collaboration possible with the state, implementing under the broad framework of the government's given policies and administrative arrangements and not stepping beyond the specified boundaries that would mean questioning fundamental structures of the state's health system. Certainly, SEWA-Rural's relatively problem solving nature, even if non-confrontationist and non-agitational, with a humanist religious world view than radical political rhetoric, seems to be more acceptable to the government.

In conclusion, perhaps we need to reiterate that this successful partnership needs to be built upon further. Forums and mechanisms need to be created whereby SEWA-Rural can feed in its experiences to the policy makers and help evolve suitable policies and effective implementation systems for primary health care. SEWA-Rural should also prepare itself to share its experience of working with the government with other voluntary agencies and help them design ways and means which can make their task easier. More importantly, SEWA-Rural and the concerned government functionaries can think of ways to streamline implementation of health policies and programmes, notwithstanding all the weaknesses of the system. It must be mentioned that some degree of involvement of the organization in the formulation of certain health related policies and programmes is already occurring at district, state and national levels.

Despite an overall positive approach to this arrangement by both partners, some well known irritants persist. Most importantly, selection of health functionaries continues to be governed by government rules, and SEWA-Rural is increasingly facing the danger of staff migrating to government jobs, which for various reasons are more attractive. A high turnover of staff can prove disastrous to a voluntary venture. Again, there is virtually no flexibility for the organization to choose its own broad health policy and strategy, although within a given programme there is considerable elbow room for innovations in the delivery systems. Finally, SEWA-Rural is in no way immune from the pressure for achievement of targets fixed by the government, whether in family planning or any other programme. In all probability, it will be these irritants, or their absence, that will determine the ongoing success of the partnership.



## CHAPTER 13

### COMMUNITY PERCEPTIONS

An important part of this study was to find out what the CHP beneficiaries thought of the CHP services and staff, and their expectations from SEWA-Rural. It was decided that this would be done through a sample survey and secondly through unstructured meetings with various groups in the villages.

#### SAMPLE SURVEY

The details of the population as found by the sample survey are described in Chapter 2. In brief, they reveal a community comprised largely of tribals, with around 35 percent of the population being literate, and over 40 percent being casual, usually agricultural, labourers.

Considering the background of the beneficiary community it would be interesting to look into their perceptions of and expectations of SEWA-Rural.

#### Perceptions and Expectations

As seen in Table 13.1, medical care, supplementary food and village healthpost are the only three developments recognized by the public as activities contributing to change in their villages (and in that order). Other non-health activities like social forestry, technical school, papad making and women's savings mandal are hardly mentioned by people (see also Chapter 5, especially the section on perceptions of village level workers). These activities were introduced late and not in all the villages. That is probably the reason that they are not recognized and appreciated by the people. As these activities are part of the primary health programme, SEWA-Rural may also review the performance of non-health activities with a view to strengthening them further.

Table 13.1 : Impression of SEWA-Rural's Overall Impact

Impression	Number	Percent
It has made no difference	31	6.0
Sick get treatment	453	88.1
They explain better	74	4.4
We got a health post	130	25.3
Children get food at AW	249	48.4
We got a forestry program	12	2.3
We got a savings scheme	6	1.2
They give technical training	6	1.2
Papad program	0	0.0
Miscellaneous	159	30.9
Total	514*	100.0

\* 514 out of 523 interviewees answered this question

As seen above, people identify SEWA-Rural with health and medical care. When asked what they expect SEWA-Rural to do for them, they came out with other non-health demands (Table 13.2). However, demands for nurseries and/or anganwadis were most common as some of the villages or areas in the village do not have any anganwadis. The next and almost equally common demand was for a regular source of water. In summer months in some of the villages there is an acute shortage of water particularly in the drought years. Seventy eight percent of the respondents wanted SEWA-Rural to provide free medical care and a similar number wished the health and medical services would be more regular. Though about 10 percent wanted SEWA-Rural to create more employment opportunity, very few wanted a home industry or handicraft. Notably, there was practically no demand for more school rooms or educational facilities.

Table 13.2 : People's Expectations from SEWA-Rural

Expectation	* Freq.	Percent
Develop water sources	237	49.5
Generate employment	45	9.4
Build school rooms	12	2.5
Put up cottage industries	9	1.9
Make Latrines	39	8.1
Give free treatment	32	6.7
Provide (more?) regular services	47	9.8
Miscellaneous	321	67.0

\* n=479

### Treatment Seeking Behaviour

Table 13.3 describes the treatment seeking behaviour. When ill, 50 percent of the respondents seek treatment from practising doctors of allopathy, ayurveda or mixed systems at Jhagadia or Rajpardi; 30 percent employ household remedies, herbal cures or witch craft. Only a little more than 10 percent have availed of the medical care facilities provided by SEWA-Rural. These facilities include the hospital, mobile dispensary and treatment provided by various categories of middle level field staff (it does not include treatment provided by village level workers). It is only when the illness persists despite initial treatment that a substantial number of people prefer to avail of SEWA-Rural's services. People's overwhelming preference for practising doctors in spite of a wide network of health workers in all the villages, a referral system consisting of a mobile dispensary and services of well qualified and specialist doctors, need examination. This problem is recognized by SEWA-Rural. People's views were enquired into and they will be discussed below.

Table 13.3 : Treatment Seeking Preferences

Options	First time		If still not well <sup>1</sup>	
	Freq	Percent	Freq	Percent
Home remedies	172	33.0	-	-
Traditional healers	8	1.5	-	-
Nurse (FHW)	8	1.5	-	-
Mobile dispensary	9	1.7	-	-
SEWA-Rural hospital	48	9.2	195	37.6
Ankleshwar/Bharuch <sup>2</sup>	6	1.2	86	16.7
Others <sup>3</sup>	260	49.9	206	39.7
Nowhere	10	1.9	31	6.0
Total	521	100.0	518	100.0

<sup>1</sup>Three respondents did not answer this question.

<sup>2</sup>Includes mainly private doctors; also, government hospitals in these towns.

<sup>3</sup>Includes mainly, private doctors in Jhagadia and in some larger villages nearby; also, the local government referral hospital.

### VILLAGE MEETINGS

The field supervisors, community health physician and members of the study team decided that around 10 villages (25 percent approximately) should be sufficient to gather data through meetings. In the initial exercise, 12 villages were selected on the following basis:

- \* Cooperative and resistant
- \* Tribal and mixed
- \* Where the CHP work had been going on since the beginning and villages which were recently taken up.
- \* Villages where SEWA-Rural's involvement was only through the CHP and villages where SEWA-Rural was doing other work too, e.g., social forestry, women's awareness camps, or papad making.

- \* Remote villages (that is, about 15 kms away and difficult to reach in terms of accessibility) as well as villages close to Jhagadia.
- \* Preference to villages other than those included in the sample survey; this would increase the sample size for obtaining villager's perceptions.

(See Table 13.4 below for a listing of the villages according to criteria for selection. Out of the initial list of 12 villages, finally nine meetings were conducted in eight of these villages in 1989.)

Table 13.4 : Criteria For Selection of Villages

Name of Village	Cooperative(c) or Resistant(r)	Tribal(t) or Mixed(m)	Old [1984](o) or Recent [1986](r)	Only health(h) activity or non-health also(n)	Remote(r) or Near(n)	Included in Sample Survey(s) or Not surveyed(n)
1. Sardarpura	c	m	o	h	r	n
2. Ratanpor Bhiwado	c	t	o	n	n	n
3. Bhimpore	c	t	o	h	r	n
4. Karad	r	m	o	h	n	n
5. Kapalsadi	r	m	o	h	r	s
6. Maljipara	c	t	r	h	n	n
7. Govali	c	m	r	h	r	s
8. Limodra	r	m	o	h	n	n
9. Vakhatpara	c	t	o	h	n	n
10. Mulad	c	m	r	h	r	n
11. Kharia	c	t	o	n	r	n
12. Amalzar	c	t	r	h	n	n

Before each meeting, the field supervisor and external team members together reviewed the information on the village (for example, the time the CHP has been working in the village, which other SEWA-Rural activities were going on, the physical, demographic and political features, etc.). This kind of preparation helped decide the kind of questions that needed to be asked during the meeting. Present during the meetings were at least one member of the

external team and the field supervisor. It was decided that the MPH and the FHW for the particular village would not be present for the meeting so as to give village persons greater freedom to provide feedback on the performance of these workers. The field supervisor, it was felt, should be present as an observer for two reasons: (a) to introduce the external member and provide legitimacy to the meeting and (b) to immediately implement any followup action or minor changes that may be required on the basis of the feedback and that which was within his/her power. The major points that emerged during these meetings are presented below in an informal style.

### **Findings from the Village Meetings**

#### *Health Awareness*

The village meetings revealed that there was a general awareness about the different aspects of the community health activities of SEWA-Rural among the people who attended the meetings. The people also knew who their village level health functionaries were and also recognized the field staff of SEWA-Rural. Only one out of the nine village meetings (Karad) revealed very low knowledge about SEWA-Rural's village health activities and about the health functionaries. This village is known to be a 'resistant' village and people may not be interested in finding out about SEWA-Rural and may, in fact, be shunning SEWA-Rural staff's overtures.

Health consciousness appears to have increased in most villages since SEWA-Rural started its work in them. The women of Govali mentioned that it was only after their contact with SEWA-Rural they came to know that there are specialists for different diseases, earlier they used to think that one doctor could treat all illnesses.

In almost all the village meetings, the people were aware of the names of the various vaccines given under SEWA-Rural's immunisation programme. However, the disease that each vaccine protects against was generally not known. In two meetings, people mentioned that pregnant women on their own initiative now ask for TT.

People demonstrated an awareness of the benefits of starting weaning at six months. Also in most of the meetings people demonstrated an awareness of giving ORS to children with diarrhoea. However, most people thought that ORS was a treatment for diarrhoea rather

than an important measure for prevention of dehydration; they complained that the frequency of stools does not decrease even after they give the ORT.

#### *Impact*

Among the other changes that have taken place in their villages after SEWA-Rural started its CHP programme were, according to the people:

- \* a decrease in the incidence of tetanus, polio, TB and measles among children (in six of the nine village meetings this was mentioned). Earlier there used to be major outbreaks of measles and scabies, now there are very few of these.
- \* deaths among small children have decreased (this was mentioned in four village meetings).
- \* weights of small children are better because of improved nutritional practices and because of the supplementary food available at the anganwadi.
- \* anganwadis help the village children by looking after their physical and developmental needs.
- \* common diseases are now treated in the village itself since medicines are available.
- \* referral services are available at SEWA-Rural. If a serious patient requires an ambulance, it can be called from SEWA-Rural.
- \* safer deliveries as a benefit of SEWA-Rural's work was mentioned in many of the village meetings. People mentioned that now safe delivery packs were used, earlier kitchen knives or sickles were commonly used and women and babies used to die of tetanus.
- \* At that time no one knew about tetanus and that the cause of deaths was tetanus but now with their newly acquired knowledge, they presume that it must have been tetanus.

#### *Problem Areas*

People do not appreciate the reduction in the frequency of the mobile dispensary. They would like the mobile dispensary to go more often. Apart from the reason of pure convenience, people in atleast two village meetings mentioned that at the mobile dispensary, they are treated free, whereas every time they visit the hospital they are required to pay for the services.

The issue of payment is a major bone of contention that the villagers have with SEWA-Rural (or 'leva-Rural', the taking organization). SEWA-Rural has recently changed its policy. Earlier patients from project villages were given all medicines free. Now patients who need medicines not available from the hospital dispensary, have to purchase them from a drug store on SEWA-Rural campus. People have not yet been able to overcome their resentment over this change despite repeated and patient explanations by the field staff about the financial situation at SEWA-Rural.

People have another complaint about the services at SEWA-Rural: they feel that they are not taken care of well. In Bhimpore this was expressed very strongly. In the community, they are literally pandered to by the field staff whereas when they come to the hospital they are just one of the many patients, warranting no special treatment. In almost all the village meetings, very strong feelings were expressed at the treatment meted out to them at the

#### OF ANGANWADI FOOD

*Another complaint which came up commonly at almost all the village meetings was against the food provided at the anganwadis. People categorically said that pregnant and lactating women do not like to take this food. Also the children do not eat it since it is raw and uncooked and gives them diarrhoea. The CSM powder 'mutthia' is generally fed to the birds and dogs as the children walk back home from the anganwadi. People at the meetings also said that despite repeated complaints to the anganwadi workers, no change has taken place. This, to our mind is a classic example of how centralized planning of the government is utterly dysfunctional and yields results in contradiction to their aims and objectives. The donated CSM powder is provided free to the anganwadis but is rejected by the beneficiaries in contrast to the local foods, for example, rice and 'moong dal khichri', or 'choorma' which the children and the parents really appreciate (when SEWA-Rural took over the anganwadis from the government, CSM powder was given for the nutritional needs of the children and pregnant and lactating women. At SEWA-Rural's instance, the government agreed to make a policy change and allow the voluntary agency to use local foods in the anganwadis. After a couple of years, the government felt that the indigenous foods proved to be expensive and reverted back to the donated foreign CSM powder).*



hospital. People complained more about having to wait, being treated equally rather than preferentially. Thus their complaint is not against any kind of ill-treatment but lack of special and preferential treatment.

In two of the village meetings (Govali and Limodra), it was mentioned that the anganwadis were too far for their children to walk to and the helper did not come to take the children. The Limodra women stated that the anganwadi of Sukavna was closer for their children and they wished that their children would be allowed to attend this anganwadi.

Another feature of SEWA-Rural's philosophy which is a source of dissatisfaction among villagers is the attempt towards rational therapy. People want quick relief and demand injections, this was articulated in about three or four of the village meetings. In Limodra, the women said that if they went to SEWA-Rural, they had to pay only Rs.10 to Rs.15 for the treatment, in contrast to calling home the private practitioner to whom they had to pay Rs.30. But the private practitioner gives injections and the patient gets well in two days in comparison to the SEWA-Rural's slower treatment, which takes 15 days.

In some other meetings, we were told that the CHVs should be given medicines to stop diarrhoea, and to treat coughs and colds. A greater number of medicines in larger quantities to be given to the CHVs was another demand.

The low payment to the CHVs was another point which came up in repeated village meetings. In Kapalsadi, when the older CHV died, no one was ready to take up the responsibility because they felt that the payment is too low, in relation to the responsibilities and demands on the CHV. In the Limodra meeting a clever and articulate woman who had resigned from her post as the CHV was present. She felt that an honorarium of Rs. 50 was just not sufficient for her to support her four children and herself. The work was quite demanding, she was required to spend 10 to 12 days in a month with the village people if she were to take her responsibilities seriously. She found that she could not go for her daily wage labour, so for reasons of economic compulsions, she had resigned although she asserted that she enjoyed the work and was keenly interested in it.

Many villages appear to be looking upto SEWA-Rural for help in organizing themselves for developmental activities other than health. The Village Health Committee (VHC) of Sardarpura, the women of Ratanpor Bhilwado and the youth of Bhimpore expressed the same need in different words. The organizing efforts need to be directed towards collective

action for water and electricity and income generating schemes. The Kapalsadi Muslim women would like to have regular meetings with the SEWA-Rural women staff where they can discuss and learn new things.

The village people look to SEWA-Rural for help in training their illiterate and/or unemployed youth so that some avenues for earning open up for them.

### Conclusion

One of the ways in which the CHP's efforts in providing primary health care services to the 40 project villages can be evaluated is through people's perceptions.

Through the nine village meetings that were conducted, the review team found that generally people were highly satisfied by the availability of health services. There was an appreciation expressed about the regularity of the visits of the middle level field workers and the mobile dispensary; the efficiency and sincerity of the SEWA-Rural team was universally acclaimed. In all the village meetings, appreciative mention was made about the easier access to the referral services when required, as also of improved services provided by the village level functionaries, especially the dais and the anganwadi workers.

There was a general perception that especially among children there was an improvement of the health status. There appeared to be moderately high awareness about the causes of health and ill health. For example, people appeared to know about the importance of pure drinking water and ways of making it pure, about the importance of safe delivery practices, immunisation and nutritional supplements during pregnancy.

Motivation towards action by the people was not really high. The unwillingness to accept the responsibility or to initiate action seems to be for two reasons: one, they think that it is SEWA-Rural's need and duty to provide these services and the organization should continue to do so, and secondly, the village groups seem to lack a confidence that they can manage their affairs on their own. Often, people seem to have a clear analysis of their village problems and what needs to be done about their water situation; but they feel it is better and safe that SEWA-Rural take a lead and help them to organize themselves to solve their problems. Perhaps because of past failures in drawing their village people together, the local leaders would like initial support from the external agency.

The village meetings revealed quite a mixed bag of *subjective attitudes towards SEWA-Rural*. While generally there was a mood of appreciation of the organization, there were one or two sore points: the issue of payment for referral services at SEWA-Rural raised resentment. The reduction in the frequency of the mobile dispensary visits was not appreciated. It seems that at whichever point SEWA-Rural challenges the status quo of the dependency of the community on the organization, there is a backlash of negative reaction. People are appreciative and grateful as long as the CHP and SEWA-Rural continue to play the traditional role of providers. They are not so appreciative when the organization takes steps to move away from this position and to decrease this dependency.

Village people, as revealed through these meetings do appear to have sufficient trust and faith in SEWA-Rural that they would like a relationship with the organization other than the existing one limited to their health needs. The spectrum of what SEWA-Rural can do with the village communities ranges from periodic awareness generating meetings with women to organizing village groups for collective action to meet their felt needs (e.g. drinking water, road and transport facilities, electricity, etc.) to helping in income-generating activities and providing employment opportunities. Thus several expectations for SEWA-Rural's increased role in their villages were voiced by the people during these meetings.

This chapter discusses the concept of community participation as understood and practised by the community health project at SEWA- Rural. The organization's own assessment of how much community participation it has been able to generate is explored, some possible reasons for the perceived performance in this area are listed, and what the organization has learnt about community participation is discussed. The types of community participation that the CHP has been actually successful in generating are enumerated as also some of the mechanisms used for generating participation. The chapter ends with a conclusion in the form of some suggestions for future action.

To begin with let us look at a cross section of staff opinion about community participation (CP) in SEWA-Rural.

- \* 'If the selection of anganwadi workers and community health workers is an indication of community participation, yes, CP is present. Otherwise, the people are receivers and the CHP are givers.'
- \* 'Health is not a priority of the people so there is a limit to their degree of participation.'
- \* 'We are so concerned about the community and preoccupied with what we know and what we think is good for them, that we do not pause to discover or understand the reasons for their not accepting our advice.'
- \* 'There is need to increase community participation. We get too involved in our routine tasks and do not give much attention to this aspect.'
- \* 'Community participation is very low or negligible. Many of us do not know what it is.'
- \* 'People should run the programme. They should be involved in planning and execution. Village Health Workers (VHWs) should be accountable to the VHCs and the VHCs should pay them.'
- \* 'There are several examples of community participation :

land for the health post has been donated free of charge by the participants and private people, in all villages where health posts are constructed.

in Kharia, the entire village forfeited one day's 'mazdoori' to clean out the village well. SEWA-Rural supplied the material.

repairs to the health posts are done largely through the people's contribution.

the cooperative society in Uchedia gave money for a big vessel for their anganwadi.'

The above is a sample of what the staff members have to say about community participation in the CHP's work.

### ORGANIZATION'S ASSESSMENT AND FEELINGS

The issue of community participation in the CHP of SEWA-Rural seems to have become a complex of a strong need to generate community participation at one level and ambivalence and cynicism at another level. This has led to halfhearted attempts, anxiety and at times defensiveness. This seems to be pervasive at all levels of the organization. While on the one hand they apologetically state that community participation is very low, on the other hand, they remark that community participation is community health is just not possible, at least beyond a point. Community participation as a concept in all its hues and shapes does not seem to be clearly understood by many in the organization, or at least there does not seem to exist a common understanding of exactly what the CHP at SEWA-Rural is aiming at when they talk about 'community participation.'

#### Relationship with the Community

Discussions with the staff members on community participation revealed that the issue of 'relationship with the community' needs to be explored in all its dimensions before community participation can be discussed. The two are inextricably linked. The nature of

relationship with the community is a major determinant of the quality of community participation.

Several people working in the CHP feel that the efforts of their seven years of work has at best succeeded in making people passive recipients of their services. If the immunisation team comes around to their doorstep, most people will get the vaccines administered. Although this is quite an improvement from the initial years when mothers and children used to run away as soon as they saw the team approach the village, it is still a far cry from the dream of the CHP staff of the mother demanding immunisation for her child on schedule.

Most middle level field staff have started questioning SEWA-Rural's objectives of 'providing health care at the doorstep.' They think that this objective makes the community dependent on them. As one field worker put it, 'We have given people food to eat, not taught them to eat themselves.' Their repeated visits to the villages only for health purposes have resulted in the devaluation of their roles in the eyes of the community: their repetitive health messages as much as their repetitive appearances are now taken for granted.

While most people appreciate and or accept the services of the CHP, there are a few, the educated and richer ones, who do not care for the CHP services at all. They have other choices to fall back upon when they fall ill they prefer to go to the private practitioners<sup>1</sup>. Most of these people do not like the rational therapy approach and the more conservative treatment that SEWA-Rural provides and prefer to get injections which they feel give them faster relief. Some of these people also have no qualms about paying the private practitioners a fat fee but grudge paying SEWA-Rural the cost of the treatment (which is about 25 percent of what the private doctors charge) and sarcastically refer to the organization as 'leva-Rural' (the study by Ford Foundation has shown that treatment is the third most highly subsidized item in SEWA-Rural).

All this is just as well because SEWA-Rural is quite conscious that its target community is the poorer and the socially disadvantaged and not the better off sections of the village population.

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<sup>1</sup>SEWA-Rural's research on women's health has shown that when ill, 27 percent of them go to private practitioners, and 22 percent to one of SEWA-Rural's facilities.

Through the sample survey, an attempt was made to find out people's perceptions about their role in SEWA-Rural's CHP (Table 14.1). Around 42 percent of the respondents said that they had not involved themselves in the community health programme. About 37 percent said they had provided information to SEWA-Rural workers. Only 15.3 percent really helped SEWA-Rural by providing place, food, labour, shelter and food to workers and assisted in special programmes. About an equal number more (16.6 percent) helped during relatively routine activities like vaccination, mobile unit visits, gram shibir and health education. This lack of participation by the people and their less than desirable level of perception about their and SEWA-Rural's mutual roles is one of the disquieting features of the CHP.

Table 14.1 : People's Perception about their Role

Role Assumed	Number	Percent
Material help provided in terms of food, shelter, labour to anganwadi or health workers	80	15.3
Helped in routine CHP activities only (excludes material help) <sup>1</sup>	84	16.6
Provided at least information when asked <sup>2</sup>	195	37.3
Provided any other kind of help (not specified) <sup>2</sup>	138	26.4
Never helped SEWA-Rural in any manner	218	41.2

<sup>1</sup>Includes help provided during vaccination, health education, mobile clinics and gram shibirs.

<sup>2</sup>Both categories include some of those who helped in any of the first two categories.

### Reasons For Inadequate Participation

Most of the staff members feel that while their personal relationship with large segments of the village community is cordial, the community regards them as 'paid employees' of an

organization whose objective is to serve them. On the whole, the community members do not feel any sense of 'ownership' or of belonging to SEWA-Rural's CHP. The objectives of the CHP are not close to their hearts. In other words, health is not a primary need of the people and thus their involvement and participation in the programme is weak. Another reason why the community does not get actively involved may be because the community members are not involved formally in decision making or planning and reviewing of the CHP. Although an advisory/evaluation committee exists and contains members who are part of the government health structure, and some are external experts, the community is not represented at all on this body. There is another body, related to the management of the hospital and the community's need, wherein there are four members nominated from the community. In addition, a formal meeting is organized each year of representatives of various non-government bodies: cooperatives, banks, other voluntary agencies, and leading citizens of the village are invited to discuss the activities of SEWA-Rural, including hospital services and the CHP. Here, the needs, difficulties and expectations of people are discussed and suggestions sought. Limitations of the organization are discussed in the light of these, and changes in programmes and policies are made wherever appropriate. Over and above these, there are three to four occasions during the year when, as part of celebration of some event, the public has an opportunity to air its grievances. Besides, it is frequently made clear to people that suggestions and complaints shall be encouraged. In spite of all these interactions, the involvement of the community rarely goes beyond involvement in the implementation of some specific activities.

When SEWA-Rural started its work in the villages, it restricted its involvement to health because this is where the expertise of the key people lay. However, this was far removed from the major preoccupations of the people which were mainly employment, wages and drinking water. Probably another reason for not being proactive in community participation was that the CHP's key functionaries were feeling their way in community health. Quite understandably they were preoccupied with establishing certain standards of technical perfection and rendering quality services than getting involved in the nebulous and murky process of 'community participation.' Probably, also in terms of inclination and competence at that time no one was present in the community health team who had a special flair or passion for eliciting community participation or for that matter even interpreting the concept. None had any insight in social structures and processes or the experience of working with people who did not belong to their own class and culture. In the recruitment, training and the job content of the other field staff also little attention was paid to this aspect



of the work. In spite of these constraints, as mentioned earlier, considerable efforts were put in to elicit community participation.

Another reason, and according to SEWA-Rural organizers, the primary reason, why historically SEWA-Rural started off with a disadvantage as far as community participation was concerned, was because of the fact of SEWA-Rural's collaboration with the government. This meant that SEWA-Rural could not freely choose the villages that they wanted to work in: they had to take the non-cooperative or contiguous resistant villages along with the cooperative and welcoming ones. Also, government collaboration meant being subject to certain pressures for achievement of targets which in turn was an indirect pressure to sacrifice the goal of community participation. Because of the pressure of targets, SEWA-Rural could not negotiate and bargain with the people; people became passive recipients of services that SEWA-Rural felt compelled to provide in order to meet the targets.

Finally, the architects of the CHP, Lataben, Pankaj Shah and Anil Desai, admit that they started off with very high expectations of how they wanted the community to participate. Their vision of community participation was one of the community organizing itself to demanding and receiving better health services. The community would do all the ground work and SEWA-Rural's role would be limited to giving technical advice. The programme would be the community's with SEWA-Rural playing the facilitative and consultative role.

#### EXPERIENCE AND LEARNING

However, experience of the last seven years has been rather educative as far as community participation is concerned. The main initiators of the CHP have realized that their initial expectations of the community taking total responsibility for the CHP was rather unrealistic. Given the extent of poverty and deprivation in the area, the people, especially the adivasis who are SEWA-Rural's target community, are hardly going to be able to devote themselves to organizing and managing a health programme; their struggle for survival is arduous enough. Only when a certain basic level of need, chief amongst them being secure and minimum level of wages, is satisfied can people be expected to take the initiative to organize developmental programmes like health and education for themselves.

Wherever SEWA-Rural has started work in relation to people's stated needs (for example in Simadhra and Ratanpor Bhilwado) the relationships with large proportion of the village population has by and large become very good. SEWA-Rural's social forestry programme in these villages has provided daily wages to the village women and close to their homes at that. They do not have the anxiety of leaving behind their small children and going out of the village for wage labour.

In Ratanpor Bhilwado, yet another thing the people, especially the women, really appreciate is the hand pump that SEWA-Rural installed in the middle of one falia. Admittedly, the handpump was primarily for providing water for the nursery of forest saplings, but the village people could get water for their domestic use from the handpump. Earlier the women used to get the water from a well which is on the outskirts of the village. During the recent three year drought, the water supply from the well was very sparse. The women had to wake up 3 to 4 am to get their water (during the early morning hours, the well would have slightly better supply). In both these villages, the task of the CHP field staff has become apparently much easier. Says Ashok, the field supervisor, 'People in these villages are totally involved in the CHP's programme; immunisation and family planning which are generally tough areas of work, are no problem here. All the children are immunised in these villages. People gather within half an hour when we go on our immunisation visits, unlike other villages where we have to coax and cajole mothers and children to get their shots.' Thus the well known wisdom that wherever contact with the community has increased and more comprehensive work in relation to people's needs and problems has been initiated, their involvement in the health programme has been greater.

The maintenance of handpumps is a major problem, especially since this is not looked after by the concerned government to any level of satisfaction. With passing time, it came to be recognized as an important felt need of the community and a programme was taken up to tackle this problem even though it had not been originally so planned in the CHP. A team skilled in repair of handpumps, operating under the technical guidance of the GTK (the technical training school run by SEWA-Rural), has been built up. The field staff of the CHP identify the location of handpumps broken down and inform this team which then visits the place and conducts repairs. In contrast to almost all other services of the CHP, this repair is undertaken only when the community makes a certain specified payment for the service. Thus far, there has been no undue problem in getting the community to come forward and avail of this service on payment.

Some of the factors that have affected community participation in SEWA-Rural's experience have been village interrelationships and caste factors. In homogeneous or single community villages, it is far easier to elicit people's cooperation. In mixed caste villages, especially where Rajputs or Patidars and Adivasis, are living together, efforts at getting their involvement have not been much successful. For example, in a couple of villages where the population is of mixed caste, and the AWW belongs to the higher caste, tribal children attend anganwadis less readily, affecting the attendance significantly.

The caste of the field workers has also had some bearing on the relationship with the community and therefore the level of community participation. One scheduled caste MPHWS felt that he has received less cooperation from the village people because of his caste. He says that he has faced this problem in mixed caste villages and not in tribal villages. His feelings about the caste being a problem is echoed by another scheduled caste MPHWS as well.

Organizational factors like transfers of the field workers and supervisors have had their own role to play as far as building rapport and relationship with the community is concerned. The staff feel whenever they have succeeded in establishing their credibility and rapport with the people, they have to move to new villages again. (This however, can be employed as a positive strategy for improving community contact. When field workers are good, they can do the task of creating rapport on behalf of SEWA-Rural and move on to other villages to do the same and leave other people to build on their efforts)<sup>1</sup>.

### Examples Of Community Participation

However, to the study team as outsiders, the situation regarding community's involvement does seem to be better than what is perceived by the staff. The entire spectrum of possible community participation ranges from a situation where the community either rejects or tolerates the services provided by the organization through various levels of increasing interest and participation to an 'ideal' situation of the community being self-reliant and empowered.

<sup>1</sup>The coordinators of the CHP did not agree that the fieldworkers had been frequently reshuffled. This point was probably articulated by the field staff because at the time this study was being conducted, the CHP went through a major reorganization, and the staff were facing temporary problems in adjusting to their new areas of work.

A small example of the community taking initiative to solve their problems was in the replacement of an anganwadi helper. The husband of the anganwadi helper of Khadoli was an alcoholic. He had sold away some anganwadi articles to raise money for his alcohol. The people became very upset by this and with their active help the concerned helper was replaced. Selection of the location of the health posts has been another decision that most village communities took. This involved multiple extensive visits by the CHP staff to the villages involving substantial interactions. This caused the construction of the health posts to be delayed considerably more than what was planned, but this was considered worthwhile since it ensured deeper involvement of the community.

Instances of contribution of time and labour by volunteers from the village communities are many. An important example is of the involvement of women in the health programme: dais and the voluntary MCH workers are the most striking examples. In spite of very meagre compensation for their efforts, they continue to be agents of better health services.

SEWA-Rural has been conducting many diagnostic health camps in the villages. The people help in the entire management of these camps, they arrange for and erect tents, inform village people, offer hospitality. 'Shram Dan' for certain village needs, cleaning the well, cleaning the village lanes, making a kitchen garden near the well or a platform for washing clothes, are other examples of people contributing their time and labour. Many a time, it is the village people themselves (and not the CHP field worker) who suggest that these things need to be done. The role of the field worker then is to organize the efforts and material required.

During epidemics of jaundice and cholera, village people on their own take the responsibility for the treatment of the water: they advise each other and their neighbors and provide relevant health education. Collecting people for meeting or for immunisations is done by village women themselves, rather than by village level health functionaries or CHP field staff going house to house to collect the people. This was mentioned with respect to atleast two villages, Junapora and Ratanpor Bhilwado.

Contributions of land, money and articles by the village people for their health needs have also been significant. In all the project villages where health posts are constructed, the land for the health posts has been contributed by the Panchayat or other private landowners from the villages. The repair and maintenance of the health posts are done to a large extent with money contributed by the people. Repairs of the broken down handpumps are done, as

mentioned earlier, only when people contribute their share of the maintenance costs (at present Rs.50 when no major part replacements are required).

### MECHANISMS FOR GENERATING COMMUNITY PARTICIPATION

#### Village Health Committee

One way of generating community participation was through the formation of Village Health Committees (VHCs). The role of the VHCs was foreseen to be one of implementing and monitoring the outreach and referral services. Also to evaluate these and give feedback on them. VHCs were set up in eight villages. The VHCs were generally constituted with persons who had taken some initiative and helped the CHP in its initial work. Also formal local leaders like the sarpanch and the police patel were part of the VHCs, as also village level health functionaries like AWWs, dais and CHVs and members of mahila mandals or youth clubs. When the project started the CHP staff used to have regular monthly meetings with the committees.

However, as time went by and other pressing tasks came up, the staff got diverted. The meetings became infrequent, the staff had trouble in sustaining the interest of committee members and a creative and meaningful ongoing role for the VHCs could not be evolved. Another reason perhaps why the VHCs failed to get established was because the responsibilities were not clear. At one level, a core group member initiated these VHCs; somewhere along the line the field staff were supposed to take them over, without being suitably equipped with the skills and/or knowledge for handling their concerns. The situation now is that most of the VHCs exist only in name. Most have not met at all during the last one year(1988-89).

#### Falia Meetings and Mahila Meetings

For one year (in 1988) weekly meetings were held in a village of each subcentre. These were termed as 'falia' or 'mahila' meetings. In these meetings, health education according to pre-determined topics based on the need of the community and the local health situation as communicated by the concerned field staff was provided to the group present.

The field staff expressed rather mixed opinions about these meetings. On the one hand, they felt, that while there was initially a good attendance and interest by the women, the weekly meetings became quite a burden for the field supervisors and field workers. During peak agricultural seasons, gathering the women together became a time consuming task. And then the women would want to go away after half an hour.

When the falia meetings were initiated, the vision was that in time, the village level functionaries and the MPHw and FHW would conduct these. But the process could not reach its logical conclusion; the idea of these meetings was abandoned before the village level functionaries could be adequately prepared for the task.

Due to the nature of SEWA-Rural's work, mainly in MCH, and due to the extent of contact with the village women, an opportunity exists of harnessing women power with a little bit of effort; this can be tremendous in itself. The village level functionaries can become powerful forces in organizing the women so that they become aware of their health rights and can influence not only SEWA-Rural but also the local government bodies in meeting their health and other needs.

#### **Mahila Mandals and Yuvak Mandals**

These local village level forums do not seem to have been adequately used by the CHP to obtain community involvement. The Mahila Mandals, formal, as well as informal, exist in 15 of SEWA-Rural's 40 project villages. Their main purpose or activity seems to be to get together periodically and sing 'bhajans.' The Yuvak Mandals in most villages are a forum for organizing sports and games. Many of the village volunteers working with SEWA-Rural are a part of these Yuvak Mandals but again as a group, SEWA-Rural has not worked with them in preparing them to define problems and enabling them to take the initiative to solve them.

#### **Gram Shibirs**

Another programme that was started at one time with a view to increase contact with the community and thereby elicit community involvement was camps of about two or three days in the villages. SEWA-Rural staff would go and live in the villages with the people and

participate for this short time in the daily routine of their lives. This would help them increase their understanding of the community's problems, and also give the people a chance to get to know SEWA-Rural functionaries at closer quarters.

About five such shibirs (camps) were organized. The general feeling among the staff is that they were good and exciting. They provided an opportunity for close community rapport as the team spent whole days not bothered by routine work. The villagers, in groups or as individuals got involved in various activities like village and well cleaning, 'rallies' of school children spreading health messages, cultural and educational programmes in the evenings, competitions for healthy babies, clean houses, etc. The activities were selected on the basis of deliberations with the community about its perceived health problems. However, whenever it was planned to involve large numbers of the general public, difficulties arose in motivating people and left the staff dejected. But as a whole these shibirs have provided rich learning and reflective experience to the field staff.

### The CP Days

Every Wednesday is supposed to be the 'minor' CP Day and first Saturday of the month, the 'major' CP Day. On Wednesdays, the field staff are supposed to conduct village meetings (the *falia* or *mahila* meetings mentioned above) during their working hours. On the major CP Day all the CHP staff go to about three or four villages in teams (the staff of three subcentres go to one village belonging to a subcentre). In each of the villages covered, there are about three teams each of at least two persons doing various activities like:

- \* health education in schools
- \* women's meetings
- \* organizing people to clean their surroundings
- \* activities with children
- \* eliciting contribution and planning with the village people for various activities like inauguration of the health post
- \* arranging of a health camp, etc.

After one such 'major' CP Day the staff got together to evaluate the day's happenings. One salient point that was raised in the meeting was how worthwhile was it to spend all the time and energy of the CHP staff members in the CP Day activities when majority of the village people are away on wage labour during the day.

The CP Day activities themselves seem to be contrary to the larger goals of community participation; once again the CHP staff are carrying out set tasks: giving health education, conducting women's meetings, doing activities with children, etc., and perhaps reinforcing the dependency syndrome. Efforts to have the community articulate its concerns, and take relevant initiatives in relation to these concerns do not seem to be present. Empowerment of the community as the ultimate goal of community participation seems to have been missed in the chase of symbolic 'community participation.'

Another point that needs to be discussed is the rather mechanical and segmented way in which 'community participation' is regarded: a day is kept aside for 'CP activities' rather than finding ways of integrating community involvement in the day to day work of the CHP.

### CONCLUSION

In conclusion, what needs to be definitely lauded is the tremendous amount of effort put into increasing the community's contribution to the programme. The achievement in obtaining land from villages for construction of healthposts, and the involvement of people to the extent of a village making payment for a common handpump are examples of the success of these efforts. Many other examples of a lesser level of participation have also been quoted. Reflection and search are continually on to find viable ways of getting people to participate: the ideas of the gram shibirs and CP Days are a product of this reflection and search. However, what seems to be missing, is a coherence and harmony in the understanding of the concept of community participation in its various dimensions. Different people in the organization seem to have a different understanding of community participation. This is indicated by the following examples.



The CHP incharge states, 'My revised vision of community participation in SEWA-Rural's context includes the following elements:

- (i) awareness among people, especially among the weakest and most disadvantaged in a particular village, of the health services available through SEWA-Rural or the government;
- (ii) their efforts to utilise these services;
- (iii) if the services that are supposed to be available, do not reach them or are not of quality, they should demand them and make themselves heard;
- (iv) if community members are not able to avail of the services for either financial or social reasons, the community should mobilize and motivate the patient and support him/her to avail of them.'

According to a core group member of SEWA-Rural, 'Ultimately people should run the health programme; they should be involved in the planning and execution. Village Health Committees should monitor the programme; CHV and other village level functionaries should be accountable to these committees. The VHCs should pay the CHVs.'

In the view of the organizers, the major hurdle to more intensive and imaginative efforts for achieving community participation are the ills attendant upon working so closely with the government. It should also be stressed that SEWA-Rural by and large still works on health in isolation, a situation hardly conducive to large scale participation by the community.

An exercise of collective reflection seems to be therefore required to thrash out the following questions:

- \* Why does SEWA-Rural at all aspire for community participation? Is it because it is a fashionable concept being mouthed by development theorists? Or is it because SEWA-Rural believes in the ultimate empowerment and self-reliance of the people that it is working for?
- \* What can be the specific goals of SEWA-Rural's community participation efforts?
- \* In order to achieve these goals, which types of community involvement should SEWA-Rural foster?

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- \* What specific strategies can SEWA-Rural employ to achieve goals of community participation? How can the activities be integrated and not piecemeal?
  - \* What does SEWA-Rural need to do to organize itself to achieve goals of community participation? What new approaches and activities does it need to take on? What ones does it need to give up?

A number of small and not so small mediating structures, processes and programmatic innovations mark various aspects of the CHP. They have evolved over the years as a creative response of the team to situations that demanded more than the run of the mill solutions. By their nature, most of these responses have mediated the interface between the organization and its programmes on one hand, and the people in the villages on the other. As with most innovations, these have had varying measures of success. Some, like the mobile dispensary, served well till a point of time when they became redundant and were either withdrawn or considerably modified. Some, no doubt, never quite took off and were soon forgotten. Some, like the delivery pack and the systems of monitoring, have stood the test of time and have become more talked about features of the organization. Though it has not been possible to critically review all such efforts, and though several of them have been dealt with in varying detail elsewhere in this report, this chapter attempts to look at them together.

The first activity at SEWA-Rural was the hospital at Jhagadia. The hospital had been functioning for around two years when the community health project was born, and had helped to build up a credibility for the SEWA-Rural team among the villages around Jhagadia. Among the first visible activities of the CHP was the mobile dispensary, followed by recruitment of various kinds of health workers. Around these, a referral system evolved, and continues to evolve.

#### MOBILE UNIT

The mobile dispensary initially functioned as a first level of curative care in the original 10 project villages. It attracted large numbers of patients and it would visit each village once a week, with a team consisting of a doctor, a nurse and a compounder. Efforts were made to ensure that these visits take place at a time and place convenient to the people. These

visits helped build up contacts and faith among the villagers, and to develop a better understanding of the community among members of the SEWA-Rural team.

As health workers began to be employed, the role of the mobile dispensary expanded to include field monitoring of their work, firstly of village level functionaries, and later of middle level workers. The curative function continued, but over a period of time there was a perceptible decline in the numbers of patients availing its services, especially after the curative role of village and middle level workers was strengthened. This aspect became further diluted when the project area doubled in 1984 and again in 1986 forcing a decrease in the frequency of visits. With this, the role of the middle cadre also became more prominent, and they came to be an integral part of the mobile unit, whose role was gradually transformed to one of mainly monitoring and supervision of the work of the middle and village (CHVs, AWWs and dais) cadres. At present, in addition to minimal curative care, the mobile unit also handles partly the examination of pregnant and lactating mothers and of high risk mothers and children, anganwadi and school medical checkups, followup of TB patients, field training of various cadres of workers, health education, etc. Various doctors, including those who come to SEWA-Rural on a temporary basis have run this unit from time to time, and this frequent change of personnel has further undermined its credibility as a curative unit.

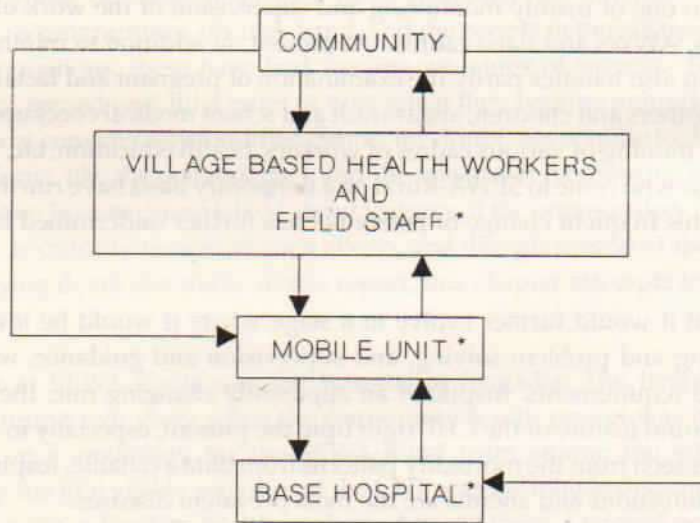
It appears that it would further evolve to a stage where it would be involved mainly in troubleshooting and problem solving, and supervision and guidance, with its schedules based on field requirements. In spite of an apparently changing role, the mobile unit has remained a central feature of the CHP right upto the present, especially in terms day to day field work. As seen from the morbidity patterns from data available, respiratory infections, malaria, skin infections and anemia are the most prevalent diseases.

### REFERRAL SYSTEM

Originally, the referral system was introduced to support the CHP outreach services, and has grown in complexity over the years. At the outset it helped basically to try to ensure that patients in project villages who were in need of hospital services did not remain deprived of them for reasons that were easily remediable. It grew in scope, and its evolution is a story of the efforts to coordinate field health activities, and hospital services (Figure 15.1).

As seen from records, of the hospital patients, around 25 percent (approx. 1000 per year) and 20 percent of outdoor patients (approx. 10000 per year) come from project villages. Of these, over 60 percent have contacted one or other health worker prior to the hospital visit.

The patients referred to the hospital from the project villages have become a class by themselves, and can be distinguished from the non-project patients by their expecting and



\*Recording and reporting \*

Fig . 15.1 : Referral System

demanding extra care at the hospital, something the hospital staff do not always appreciate. A separate OPD cell for these patients of project villages was a natural consequence, where they could be given a patient hearing and more health education. It also helped concentrate on feedback from the field. Payment of fees became a critical issue as the expectation of these patients was often to be treated free of charge. This too could be better handled by the separate cell. After going home, these patients have an opportunity to air their grievances about the hospital when they are visited by the field staff. This is fed back to the hospital and while it does tend to heighten the tensions between the hospital and CHP, it acts as a social audit, helping the former improve its services.

Patients are referred from the field by means of a referral slip given to the patient by the health worker, wherein the worker also indicates whether the patient needs free care. After the patient is seen this slip goes back to the workers with a mention of the diagnosis and treatment advised. This system still has loopholes, but helps improve the credibility for the field staff, who are perceived by the people to be an important link to the hospital.

#### HEALTH EDUCATION

Health education has been recognized as important from the outset, and has by itself become a major activity of the CHP. Considerable efforts and resources have been spent on this activity, which has consequently become quite visible.

Over the years, a large amount of audiovisual educational material and tools has been accumulated at SEWA-Rural in the form of slides, posters, flashcards, flipcharts, puppets, film projectors, video cassettes, etc. and probably form one of the larger such collections among voluntary health service agencies. In addition to material which can be used directly for health education of the people, a lot of material for training various cadres of workers, from doctors to village level workers, has accumulated. With some imagination most of this material can be and has been adapted for health education. Over and above material acquired from elsewhere, some have been developed at SEWA-Rural. For instance, a series of roller boards were designed and produced for local use in dai training. They graphically describe the various steps to be followed in conducting a safe delivery. These have proved popular, and other dai training centres, including medical colleges in Baroda and Ahmedabad, have purchased sets of these roller boards. Similar roller boards depicting

issues related to women's health have also been produced. The CHP team has also prepared scripts in vernacular for some of the slide shows, and these are quite popular. The puppetry team by and large produces its own hand puppets, and has developed its own skills of script writing. Some pictorial cards for MCH have also been locally produced.

Hand in hand with the building up of health education material, the personnel in CHP have been given training in the process of health education. Major workshops were organized for the middle level workers and supervisors at CHP to sharpen communication skills. These were conducted by experts in the field and topics included training on one to one communication, dynamics of group meetings and communication with larger groups and how to understand, motivate and mobilise oneself and others. Specific attention was paid to the use of various media, particularly puppetry, flannel charts and flip books. Some input was also provided for local preparation of the health education material. Ongoing efforts are being made to remain in touch with all these, by allocating time in the weekly meetings at the headquarters to practise health education methods. Special training was provided to some of the middle cadre at the CHP, and a puppetry team was built up. This training was given at special centres in Ahmedabad and Karjat. After this, the team has developed puppet shows on a variety of themes including vaccination, malaria, family planning, women's developmental activities, environmental sanitation, high risk children and mothers, etc. Recently some efforts have been made to build a team of youth from nearby villages to perform puppet shows on an ongoing basis. These have met with limited success. Another colorful and highly successful effort has been the development of role plays and street plays on some specific themes, notably measles and conduct of safe delivery. While the latter has been largely used as a training tool, the former was used extensively when measles vaccine was first introduced in 1985 in the villages, with apparent success. These media involve all levels of workers, are flexible and provide room for much spontaneous innovation. They are also great entertainers and draw large crowds. The measles street play often skillfully used a slide show in the course of the play to push the point home.

The routine health education effort in the CHP, however, uses these special media and methods infrequently. Mostly, it is conducted on a one to one basis by individual field workers of all levels, sometimes with the help of flip books/flash cards. A two member team of health educator and audiovisual operator who look after maintenance of all the health education material, and are skilled in communicating to villagers, do regular health education work with assistance from other middle level workers. These consist of slide shows, film shows and other such media being used for health education in villages, mostly

during the evenings, with the health education team accompanying the mobile unit or proceeding independently. A variety of topics are dealt with at these sessions, with the effort being to address the major current illness in the community. In addition, the health education team, along with one or two doctors, conducts health education sessions in the evenings once each week in the hospital campus for the benefit of hospital patients. Street level meetings are planned in the event of a major health problem occurring, for instance an epidemic or a maternal death. In the initial years, when vaccination had not yet stabilized, massive health education inputs were given before each vaccination session. These gradually became redundant as coverage improved, and were withdrawn. Exhibitions were also held at various times covering specific themes, like women's health problems.

No systematic effort has been made to evaluate these extensive efforts. However, a study was conducted on nutrition education as dissertation work of a postgraduate student of pediatrics in 1986-87. This involved reemphasizing the health and nutrition education (HNE) component of the FHWs' job, specifically for infant feeding, and studying the impact on KAP of mothers, as also various sociocultural determinants of such change. While the study did reveal some interesting and useful details of the process of health education, the CHP has unfortunately not been able to follow it up.

One important point that needs to be mentioned relates to the process of health education at SEWA-Rural. This reviewer observed multiple 'health education sessions' of different kinds, and was struck by the tendency among all those imparting education, doctors, supervisors, field workers and the health educator included, to deliver a volley of information and a series of 'shoulds' and 'should nots.' The result is that the 'receivers' appear to get overwhelmed and nod their heads in agreement to whatever is being said. There appears to be little attempt to evolve responses from the receivers, to understand their frames of reference and to address these with sensitivity.

In conclusion, the extensive efforts at collecting and utilizing health education material at SEWA-Rural deserves to be lauded. Equally gratifying are the training input which have no doubt helped the workers develop skills in communication and use of media like puppetry and street plays. The attempts being made to integrate these efforts into the mainstream of CHP work would probably bear greater fruit if an ongoing impact assessment can be carried out. A position paper on health education needs to be prepared: this could include philosophy, approach and methodology of health education. This needs to be



widely discussed by all those involved in health care delivery work so that there is uniform understanding of what is being attempted through the health education efforts.

#### DEVELOPMENT AND MANAGEMENT OF HUMAN RESOURCES

One of the distinguishing features of SEWA-Rural, as has been observed earlier, has been its emphasis on certain values. What is remarkable about SEWA-Rural however, and particularly the community health project, is the consistent and tireless effort to ensure that these values and ethics percolate to all members of the organization. Messages conveying these ideals are sought to be given, at almost every opportunity, by various ways: personal example, quotes from the lives and sayings of saints and great men and women, analysis of events and decisions, and a matching system of rewards and disincentives. This is done at work, at meetings in training sessions and in casual interactions. The effort is always to keep the poor at the centre of the focus, and to remind each other that this must not, at any cost, be sacrificed. At the same time, the dignity of work of whatever kind is emphasized, as also the virtues of team work. Responsibilities are shared, and especially with major mistakes, there is a public expression of the fact that every one in the hierarchy, including the head of the organization, are responsible. On the other hand, a job well done is publicly commended, while emphasizing that it would not have been possible without contributions from all members of the team. An attempt is made to retain a 'family' atmosphere inspite of a growing organization.

The exposure to these values begins from the moment a person joins the organization. Remarkably, even after about a decade of starting the organization, this explicit faith in, and enthusiasm for, these values and ideas continues unabated.

While expecting a high level of commitment, the needs of individual development are also looked into. Wherever possible, individuals are encouraged to 'move up the ladder,' by acquiring new skills and making efforts to develop themselves in other ways. One outstanding example of the several in this category is a boy who started as a helper in the operation theatre, wound his way through many jobs and is now being groomed to be a computer programmer. In the process he also became a graduate. Higher posts are also not exclusive: recently, the head of the community health project became a trustee of the organization. Members who cannot aspire for posts higher in the hierarchy, are encouraged

in other ways: those who perform well, and demonstrate leadership qualities become supervisors; some of the more competent dais have been involved in training workers from other organizations, and a couple of them have even addressed national meetings on perinatology.

The other more mundane aspects of training get similar attention. Training programmes are usually designed to fit into the daily routines of the workers, particularly when village level workers are involved. Training is imparted in short sessions, and is repeated at frequent intervals. Methods more likely to get the message across, like the case study approach, and role play, are frequently used with active participation of trainees. More experienced workers are roped in to train novices. Effective communication is stressed.

Almost all categories of staff are from time to time exposed to workshops conducted by experts in communication, interpersonal relationships, and individual and team development. Professionals are encouraged to update their skills through participation in conferences, other peer group gatherings and weekly academic meetings.

Efforts are made to ensure a high level of participation of workers in decision making at various levels, though, as has been mentioned elsewhere, some workers have reservations about this. At the field level as well, monitoring of the work of the field workers is performed with the approach of helping the field workers do better, rather than using the stick.

#### PROGRAMMATIC INNOVATIONS

Some of the many innovations within programmes, including development of small appropriate technologies are described here.

##### **Delivery Pack**

In addition to training dais to conduct safe deliveries and provide appropriate newborn care, one of the important inputs in SEWA-Rural has been the development of a delivery pack to facilitate the process of safe childbirth. The pack contains the essential consumables required by the childbirth assistant, including a piece of razor blade fashioned into knife to

cut the cord, some string for tying the cord, an antiseptic powder and some cotton and pads, all wrapped in a polyethylene sheet that doubles as a mackintosh. It is sterilized by gamma irradiation in large batches at Bombay, although this is probably not absolutely necessary.

The pack took birth when a need was felt for some instruments sufficiently clean to be used in the process of childbirth, and when it was realised that there was no immediate prospect of getting people to consistently provide for themselves this level of cleanliness.

The form and contents of the pack continue to evolve, mainly on basis of feedback on its utility in the field. For instance the white string originally provided was not easily distinguishable from the white cotton swabs and gauze, especially in the dark interiors of the rooms where childbirth occurs in villages. The dais suggested that the color of the string be changed to red, and this change was incorporated. Similarly other components were also modified over time. It was also clear over the years that the major purpose it served was as a symbol of a certain scientific process of technique and cleanliness to be adopted during childbirth by dais, rather than its antiseptic value.

#### **Pictorial Records**

The CHP has experimented with pictorial records of health services in several settings. The home based road-to-health chart for children and the home based antenatal and postnatal services record cards are examples of this. A variety of easily understood pictorial symbols depict a number of services to be taken, like checkups, vaccination, diet advice, and iron tablets. The likely complications during pregnancy and delivery are also depicted, along with advice for action to be taken when something goes wrong. Records kept by illiterate village level workers are designed, with the use of pictures, in a manner that makes it easier for the workers to get a literate family member to help in their maintenance.

#### **Records and Reports**

One of the most cumbersome aspects of the work of a health worker, especially in the government health system, is the multitude of records to be maintained, and reports to be generated. While it has not been possible for the CHP to do away with almost any of the reports, a number of modifications have been made in records and registers that facilitate

function of the workers, and eliminate duplication as far as possible. For instance, growth charts of children, which are maintained at the anganwadis are designed to incorporate health checkup records as well, and are made so as to be easy to store.

#### **Use of Postcards for Communication**

Effective use has been made of the simple postcard for a variety of communication purposes: reminders for workers to come for meetings or other functions to the headquarters, and for patients to come to the hospital for followup. In the case of the dais this has additional value: for them, the regular receipt of a postcard is a status symbol, and a reinforcement of their credibility.

#### **Infantometer**

One critical input for accurately identifying malnourished children requiring immediate attention is measurement of height. To do this reliably in the field, an infantometer (an instrument to measure height) was developed, and produced in a small number. It was light weight, rugged and accurate. After calibration and standardization among workers, it was used extensively and successfully in a research study on impact of nutrition education. However, measurement of height could not be incorporated into the services regularly, and the instrument has been temporarily shelved.

#### **Monitoring of Meetings**

One programmatic innovation has been the CHP team's attempts to rigorously stick to a detailed schedule of meetings to monitor the many details of running a community health programmes. What distinguishes such meetings from meetings conducted by the government health system is that meetings actually take place and the agenda as mentioned is transacted. However, the reviewers of this report have observed elsewhere that there is scope for improvement of these meetings in terms of more upward communication, and greater responsiveness to field level feedback (see Chapter 4).

EMERGING CONCEPTS AND CONCLUDING NOTES

Part V

CONCLUSION

**CHAPTER  
16**

**EMERGING CONCERNS : A CONCLUDING NOTE**

This review focusses on the period between 1984 and 1989. During this period SEWA-Rural had the total responsibility of delivering primary health care services to the villages under its project area. The main objective of the review has been to systematically reflect on the strengths and shortcomings of the project, and help SEWA-Rural, as well as other interested organizations and individuals learn from what must be in many ways a unique experience, unique in terms of the comprehensive nature of the health coverage, and the total management of a government health structure by a voluntary agency.

**Changes in Health Indicators**

The period of the project may be too short a time in which to expect substantial impact on the health status as such of the community. The approach in this study has been to analyze both the processes and the outcomes. Let us begin by briefly looking at some of the indicators of health, particularly those mentioned by the organization in its project objectives. The tables on the following page give a summary of the changes in the health indicators over the five year period. Health service utilization targets for HFA 2000 have by and large been already achieved. In the case of many of the vital indicators too, HFA targets for 1990 have been achieved, notably the birth rate, infant mortality rate, couple protection rate, and under five mortality rate, among others. Maternal and perinatal mortality rates remain somewhat higher as compared to HFA targets, though only maternal mortality is higher than comparable rates for Gujarat State. Measles has virtually ceased to be a killer in the project area and vitamin A deficiency in children has been controlled. Neonatal tetanus is now rare as is severe childhood tuberculosis. Severe childhood malnutrition has declined, though modestly. Tuberculosis case detection is less than satisfactory, while case holding is fairly high. Malaria continues to be a problem, though possibly lesser than elsewhere in the country. Definitive figures for morbidity are not available to enable firm statements about most other infectious diseases. Fertility control is satisfactory, with a moderately high couple protection rate and relatively stable and low birth rate. However, non-terminal methods of

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birth control are virtually not complied with. Effective referral care utilizing a well equipped and staffed base hospital has been established at a cost the community can afford. Data collection is accurate, with most events under scrutiny being captured. However, retrieval of past records poses problems due to unsatisfactory cataloguing and storage.

Table 16.1 : Vital Statistics

	Baseline 1982-84	Present Status S      G./I. (1987-1989)		HFA Targets	
		1990	2000		
Crude Birth Rate (CBR)	35.6 <sup>G</sup>	27.0	29.6 <sup>G</sup>	27.0	21.0
Crude Death Rate (CDR)	12.7 <sup>G</sup>	8.0	9.9 <sup>G</sup>	10.4	9.0
Maternal Mortality Rate	3.1 <sup>G</sup>	5.0	5.0 <sup>G</sup>	2.3	<2
Neonatal Mortality Rate	121.8 <sup>S</sup>	45.7	63.6 <sup>I</sup>	NA	NA
Perinatal Mortality Rate	126.2 <sup>S</sup>	56.0	61.6 <sup>I</sup>	NA	30-35
Infant Mortality Rate	172.0 <sup>S</sup>	89.2	104.0	87	<60
Pre-school Mortality Rate (1-5 yr.)	12.8 <sup>S</sup>	6.8	NA	15-20	10
Childhood Mortality Rate (0-4 yr.)	32.0 <sup>S</sup>	21.0	40.9 <sup>G</sup>	NA	NA
Couple Protection Rate (%)	36.9 <sup>G</sup>	61.8	42.7 <sup>G</sup>	42	60
Severely undernourished children (%)	16.1 <sup>S</sup>	11.5	NA	NA	NA

S : SEWA-Rural    I : Govt. of India    G : Govt. of Gujarat    NA : Not Available

There is evidence to demonstrate an increase in the general level of health awareness in the community over the years. Some programmes for socio-economic upliftment have been launched and efforts at environmental sanitation have been just initiated.

Handpumps in villages are maintained by a special team, thus helping provision of safe water. However community participation in most health programmes is at best modest, and self-reliance of the community even in a limited sense remains elusive.

Table 16.2: Service Utilization

	Baseline 1982-84	Present Status		HFA Targets	
		S (1987-1989)	G/I	1990	2000
<i>MATERNAL CARE</i>					
Ever-registered	25.0 <sup>G</sup>	95.0	NA	80	100
3 or more visits by FHW	25.0 <sup>G</sup>	56.0	NA	80	100
Inj. Tetanus toxoid	25.0 <sup>G</sup>	75.0	58 <sup>I</sup>	100	100
Childbirths attended by trained personnel	25.0 <sup>G</sup>	90.0	NA	80	100
Postnatal checkup within 7 days of birth by FHW	1.0 <sup>S</sup>	79.0	NA	NA	NA
<i>VACCINATION COVERAGE</i>					
BCG	33 <sup>S</sup>	95	46 <sup>I</sup>	85	85
Polio	9 <sup>S</sup>	89	50 <sup>I</sup>	85	85
DPT	7 <sup>S</sup>	79	58 <sup>I</sup>	85	85
Measles		73	17 <sup>I</sup>	85	85

S: SEWA-Rural I: Govt. of India G: Govt. of Gujarat NA: Not Available

### Programmatic Changes

When SEWA-Rural began its community health work through its hospital and outreach services in the early eighties, it was one among many voluntary agencies to do so, close on the heels of the Alma Ata declaration of WHO in 1978 calling for a fresh zeal to achieve Health for All by 2000 A.D. In the decade since then, SEWA-Rural has striven to provide a package of health services through the conventional three-tier health delivery system in a defined geographical area in lieu of the government. It has endeavoured to innovate within this system. Besides various programmatic innovations, the major thrust has been in its way of motivating and managing its cadres of workers. The remarkable extent of team work in



the organization gives an indication of the healthy work environment that prevails. As has emerged from this study, the achievements in terms of health improvement have been significant. They serve as an indicator of what can possibly be achieved in other rural areas through the existing pattern of health delivery, with adequate extra input and innovations of the kind made possible at SEWA-Rural.

### **Critical Concerns**

Two issues of critical concern arise. Firstly, what lessons does this experience carry for people and institutions beyond SEWA-Rural? What is the relevance of this experience to the wider world of Primary Health Care? Secondly, what can one infer about the desirability and success of the unique feature of a voluntary agency working closely with the government; specifically, about a voluntary agency working closely with the government?

While trying to reflect on these concerns, one must grant the possibility that some reforms may take a longer period to show impact. Nevertheless, while there has been some justification in the excuse that the package does not work within the government due to inherent problems of implementation, the same can hardly be said of SEWA-Rural. This in turn raises some doubts about the adequacy of the currently defined package of health services as provided by the Primary Health Centres. Indeed, their needs to be a closer scrutiny of efficiency of the contents of the programmes as planned, and it is not irrelevant to ponder here over the question where these programmes would work better even if given more time and resources.

### **Reprioritization**

A growing realization within the organization has been, in fact, that in spite of the best efforts, it is extremely difficult to implement the programmes fully as prescribed within the existing resources of the primary health centre, as envisaged in the government health system. Secondly, the organizers also feel that the programmes are not optimally prioritized, with relatively less relevant programmes like guinea worm surveys and school health checkups and family planning, the way they are being planned and executed in the government, taking up a lot of working time of the workers; and this even after efforts to minimize time allocation to such programmes.

These two factors are inter-related and probably partly responsible for the programme's inability to make further dent on vital indicators. This would call for a careful review of activities expected to be carried out with the resources provided, and equally importantly, a review of the relative priorities of the various programmes. One way of doing this could be by identifying two or three critical programmes, like maternal care and child care, having universal applicability and importance, which all primary health centre would be expected to conduct uniformly. For the rest of the programmes, the PHCs could be asked to plan time and resource allocation on the basis of local relevance, and modify programme content accordingly. A possible immediate step in this direction could be reprioritizing programmes at the reporting level, which is the most effective tool for monitoring activities. By de-emphasizing reporting of less relevant programmes, some elbow room can be provided to the PHC to concentrate on more important areas.

All programmes at SEWA-Rural related to maternal and child health have high levels of service utilization. Simple reprioritization of programmes therefore is unlikely to push these up significantly higher, especially since, in any order of priorities MCH is going to be at the top. It would be unwise to assume that the present package can still produce better results in the context of an effective implementing agency like SEWA-Rural. Factors related to basic socioeconomic variables may well be major determinants of further improvement in the health status, and would call for interventions beyond the scope of 'health services.' At the same time, one needs to search deeper even into 'pure' health aspects of programmes like antenatal, intranatal and postnatal care, to search for possible critical inputs which one may have overlooked thus far. To an extent this distinction between 'pure' health and 'non-health' is semantic and arbitrary, and can be misleading. Exploring these areas seems to be the immediate challenge, and could produce some answers.

### **Qualified Success**

The other issue of concern is the one of voluntary agencies participating in a government programme. What could be the possible argument for such joint efforts? If there be any it should be the search for fresh, alternative, innovative approaches unshackled by old ideas and structures, so that the programme may improve and the receivers of the service may benefit.

As it happens, SEWA-Rural's experience has been an almost lone 'success' among a series of NGO-government collaborations that have misfired, especially in the health sector. Undoubtedly, the Government of Gujarat does get its fair share of credit in making this collaboration a success. However, it is necessary to be careful in drawing generalizations about such collaborative efforts based only on this study, and it should be enlightening to go in depth into other such experiences as well.

SEWA-Rural's success in its collaboration with the government however is a qualified one. There is a feeling in the organization that it has not been able to concentrate upon important areas in its health care efforts largely due to having to adjust to the routine demands of the government on less relevant and poorly prioritized issues. Can there be an alternative model for such a collaboration, one that recognizes the wisdom and need for greater autonomy and flexibility for the voluntary organization? If the value of such voluntary efforts is indeed recognized, what prevents the government from funding them with fewer administrative and mechanistic controls while ensuring accountability?

Given its objectives, SEWA-Rural has at least two courses of action open: expand its scope of activities geographically to more villages, or to continue to innovate in terms of programme effectiveness and try to come up with solutions with greater replicability. The prevailing mood in the organization seems to favour the latter.

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## A POSTSCRIPT

*Several changes have occurred in the CHP over the last two years, and the process of the review has had substantial influence on these changes. Some of these are listed here.*

*One critical problem the organization faced in recent times was migration of trained ANMs to government jobs. This was compounded by the fact that ANMs were of from far off places and tended to want to work nearer their homes. Local candidates often did not meet the formal qualifications required to become ANMs and so could not be recruited. Now, the organization has been able to persuade the government to relax the recruitment criteria for selection of candidates, thus ameliorating the problem to a considerable extent.*

*Another major irritant marring the NGO-government relationship has been the issue of an excess of, unnecessary and duplicate, reports demanded by the health department, imposing considerable avoidable load on various levels of workers. The state government has recently agreed to allow SEWA-Rural to introduce in its project area a new Management Information System on an experimental basis. This system is designed to make reporting more relevant and meaningful. Duplication has been virtually eliminated. The major time saving is at the level of collation of reports of individual workers, and indirectly, on the relative priorities of various activities.*

*This is combined with a degree of reprioritisation of programmes. For instance, malaria, a major health problem, has got a fresh thrust especially in the area of vector control. The whole system of recording and documenting deaths and causes of death has been modified, with special thrust on maternal, and infant mortality. In fact, the process of review gave a new impetus to the data collection-storage-retrieval process. Storage and retrieval have been substantially improved, and the data is being utilized regularly for purposes of monitoring and planning of community health project activity.*

*The drive against maternal morbidity and mortality has gained momentum with introduction of new programmes to tackle adolescent and young women's health, and by a revamping of the high risk approach towards pregnant and lactating women: fewer women, but women at truly high risk are being identified for special attention. Some of the problems of supervision and monitoring are being rectified, and emphasis on the theoretical aspects (as opposed to task-specific) in training of health workers is increasing, to give them a broader framework for understanding their roles and jobs.*

ANNEXURE

TABLE OF CONTENTS

# Part VI

## ANNEXURES

## OVERVIEW OF ACTIVITIES OF SEWA-RURAL

Founded in October 1980 in Jhagadia, a rural tribal block, with the objective of overall development through an integrated approach encompassing various activities like health, education, income generation and women's development (see box below for details).

### ACTIVITIES AT A GLANCE

#### (1) HEALTH

*Hospital* : 70 bed hospital with all major specialities and catering to more than 600 villages.

*Community Health Project (1982)* : Provision of comprehensive primary health care to enblock area of 45,000 population in 41 villages.

*ICDS (1983)* : Package of services including supplementary nutrition, preschool education and growth monitoring for children under six years of age.

*Health & Medical Research Centre (1989)* : Conducting field operational research studies with particular emphasis on the health delivery systems.

*Environmental Sanitation (1989)* : Maintenance of handpumps and promotion of sanitary latrines, biogas plants, etc.

*Training Centre (1990)* : Conducting formal and nonformal training courses in the areas of health and rural development for different categories of workers from voluntary agencies, academic institutions as well as the government.

#### (2) EDUCATION

*Gramin Tekniki Kendra (1986)* : A technical training school for village youth.

*Coaching Classes (1987)* for school children of weaker sections.

#### (3) WOMEN'S DEVELOPMENT

*Income generating activities (1986)* : Papad making.

*Savings and credit programmes (1987)* along with awareness generation activities involving rural and tribal woman.

### Financial Sources

The organisation has spent more than Rs.3 crores in the last 10 years. The yearly expenditure at present is around Rs. 75 lakhs. Besides grants from the Government of Gujarat and the Government of India, a large number of individuals, business houses and institutions, both indigenous and foreign continuously help SEWA-Rural. Funding agencies that helped include Oxfam, USAID, Ford Foundation, Community Aid Abroad, Holdeen India Fund, and Share and Care Foundation.

The staffing structure is indicated below.

### Staffing Structure

Board of Trustees : 8

Advisory committees separately for hospital, community health project and technical training centre.

<i>FULL TIME STAFF</i>		
TOTAL	:	33
Doctors	:	13
Technical Staff	:	92
Administrative Staff	:	14
Supporting Staff	:	16
<i>VOLUNTEERS</i>		
TOTAL	:	240
Community Health Volunteers	:	51
Anganwadi Workers	:	47
Traditional Birth Attendants	:	95
Helpers	:	47

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## ANNEXURE 2

### TRUSTEES OF SEWA-RURAL

Dr. Anil Desai, M.S. General Surgery, D.A.B.S. (USA),  
Managing Trustee, SEWA-Rural, Jhagadia.

Dr. Lata Desai, M.D. Pediatrics, D.Ped., D.A.B.P. & F.A.A.P.(USA),  
SEWA-Rural, Jhagadia.

Dr. Dilip Desai, Ph.D. Chemistry (USA),  
SEWA-Rural, Jhagadia.

Dr. Pratima Desai, Ph.D. Higher Education (USA),  
Development Officer, M.S. University, Baroda.

Mr. Arvind Desai, M.Sc. Chemistry,  
Valsad.

Dr. Bhupen Trivedi, Ph.D. Chemistry (USA),  
Technical Director, Electro Printers,  
Nandesari, Baroda.

Mr. D.A. Anandpura, B.A. Economics,  
Director, UPL; President, Ankleshwar Industries  
Association, GIDC, Ankleshwar.

Dr. Pankaj Shah, M.D. Community Medicine,  
SEWA-Rural, Jhagadia.



## THE ADVISORY /EVALUATION COMMITTEE

1. Dr. N.R.Mehta	Retired Professor of Preventive and Social Medicine, and Ex-Dean, Medical College,	Surat
2. Dr. Anil Bhatt	Chairperson, Public Systems Group Indian Institute of Management	Ahmedabad
3. Father Jerry Fernandes	Formerly, Secretary Gujarat Voluntary Health Association,	Ahmedabad
4. Ex-Officio	District Development Officer District Panchayat	Bharuch
5. Dr.J.B.Shah	Regional Deputy Director, Health and Family Welfare	Gandhinagar
6. Ex-Officio	District Health Officer, District Panchayat	Bharuch
7. Mr.Bankim Sheth	Coordinator, SEWA-Rural	Jhagadia
8. Dr.Pankaj Shah	Community Health Physician, CHP, SEWA-Rural	Jhagadia
9. Dr.Lata Desai	Co-Director, CHP, SEWA-Rural	Jhagadia
10. Dr.Anil Desai	Director, CHP, SEWA-Rural	Jhagadia

### GOALS AND PURPOSES OF CHP

*(Excerpts from the project proposal submitted to USAID/VOP in 1982-83)*

(The) Objective of proposed project (Comprehensive Rural Health Programme, Phase II) is to provide community health care to the rural tribal population with an emphasis on children and women. The project further envisages a stage when the community will be self-reliant for the preventive and promotive aspect of health care such that eventually only curative services are provided by professionals. The project aims to achieve in the project area (the targets of) WHO's Alma-Ata Declaration of Health for All by 2000 AD to which India is also a signatory.

Towards this goal, we shall plan our services with following objectives :

#### Long term Objectives

1. Health awareness in community.
2. Making community self-reliant to take care of minor ailments.
3. Effective maternal and child health services which will reduce infant mortality rate; maternal mortality rate; malnutrition of children under six; and reduction in morbidity like diarrhoea, anemia, upper respiratory tract infection, worm infestation, tuberculosis, etc.
4. Control of communicable diseases like tuberculosis, malaria, etc.
5. Proper approach and application to reduce fertility rate.
6. Practical service oriented research studies to improve and develop new systems and health strategies, e.g., strengthening of peripheral health workers, non-terminal methods to reduce fertility rate, motivation and better coordination of various level of health personnel, etc..
7. Better quality and low cost of referral services.
8. Improvement on the environmental, sanitation and hygienic conditions
9. Health activities will provide basis for generating other socio-economic development activities in due course.

As mentioned earlier, SEWA-Rural's Health Programme (Phase I) consisting of community hospital and outreach services in ten villages is being implemented with above objectives in mind. The present proposal (Phase II) seeks to strengthen and expand these services by achieving the following.

**Short term Purposes**

1. Increase the number of villages from 10 to 35.
2. Enlarge the 35 bed hospital facility to 50 beds to accommodate (expected) additional referral, particularly infections, maternal disease, malnutrition, etc., due to expanded coverage.
3. To create a centre for coordinating the three-tier activities on a continuous basis.
4. Intensive and continuous educational programme for all levels of health workers (dais, MPHs and MPII supervisors) with help of appropriate technical aids and field experience.
5. To avoid duplication with the Zilla Panchayat and state government health services.\*
6. Intensive drive for control of TB.
7. Effective health education of the community and community participation and involvement towards preventive and promotive health care.
8. Better monitoring of our community health work by efficient data collection, organization, analysis and retrieval.
9. Provision of safe water supply and proper waste disposal methods.

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\* Though this has been mentioned as an objective, this clause actually describes the process involved.

## GOVERNMENT RESOLUTIONS

Given below are relevant extracts from resolutions and orders passed by the Government of Gujarat at various stages of the collaboration of the organization and the government.

- a) *SEWA-Rural,  
Management of certain villages of Jhagadia  
taluka of Bharuch district for providing specific health services.*

Government Resolution No. MIS-1084-917-B, April 24, 1984

The Society for Education, Welfare and Action-Rural is a voluntary agency providing assistance to the marginal income families of certain villages of Jhagadia taluka. To complement the diagnostic and curative services being provided by it through Kasturba Maternity Hospital taken on lease by them for this purpose, this Society (SEWA-Rural) has initiated community based outreach services after conducting intensive survey of the above area to identify health problems. For this purpose it has submitted a project called Community Health Project which has been approved for financial assistance under the participation by the Government of India, Ministry of Health and Family Welfare (VOP-Section). The Jilla Panchayat, Bharuch, in the year 1982 had initially entrusted 10 villages of the Jhagadia taluka to the organization for this project.

1. Limodra 2. Karad 3. Ranipura 4. Uchedia 5. Nanasanja 6. Motasanja 7. Selod 8. Vanthewad  
9. Kapalsadi 10. Vaghpura

The above organization having successfully provided rural health services at village level in these villages the Jilla Panchayat, Bharuch, has proposed to hand over another 10 villages for providing the aforesaid rural health services which are as under.

1. Fulwadi 2. Bhimpur 3. Untia 4. Kharchi 5. Sardarpura 6. Ratanpor 7. Pora 8. Simadhra 9. Khadoli  
10. Kharia

The Jilla Panchayat will hand over the amount of grant-in-aid received from Government for services to these 20 villages (i.e. for pay and allowances, medicine, equipment, building, etc.) together with the village level staff consisting of village health workers, anganwadi workers, helpers, trained dais, female and male multipurpose health workers working at these villages to SEWA-Rural.

The aforesaid staff will be on deputation to SEWA-Rural and under its supervisory control and will be governed by the guidelines/conditions outlined in the resolution passed by the Jilla Panchayat, Broach no.119 dated 30-06-85 with the modification that even though the staff will be on deputation to SEWA-Rural and will be under the supervisory control of it, the final administrative control will remain with the Jilla Panchayat and Govt. and the organization will not be able to terminate their services or take disciplinary action against these employees.

Annexure 5

Government is further pleased to direct that, the Director of Health Services shall pay a visit to this organization during the course of his normal duties and see the work done by the SEWA-Rural. The state will also closely involve itself in the implementation of the project and also carry out appraisal and evaluation on periodical basis.

This order will come in effect from 01-04-84.

(sd/-) Deputy Secretary to Government, Health & Family Welfare Department, Government of Gujarat.

- b) SEWA-Rural,  
management of certain villages of Jhagadia  
taluka of Bharuch district for providing specific health services. Corrigendum.
- (i) The paragraphs of G.R. H & FWD No. MIS-1084-917-B dated April 24, 1984 should be numbered as 1, 2, 3, 4, and 5.

(ii) For the existing paragraph 4 the following paragraph should be substituted.

The aforesaid staff (except that consisting of village health workers, anganwadi workers, helpers and trained dais) will on deputation to SEWA-Rural and would be under its supervisory control and will be governed by the guidelines/conditions outlined in the Resolution passed by the village panchayat, Bharuch no. 119 dated 30-06-83 letter No. DP/734/USAID/86 dated 22-02-1984.

It is further stipulated that those Government Servants who are not willing to work on deputation with SEWA-Rural can be transferred and absorbed in other equivalent posts in other areas of the district/state. It is also further stipulated that in such a contingency the SEWA-Rural tenure basis for the period of present arrangement which is for 5 years with effect from the date of the aforesaid Government Resolution dated 24-04-1984 and such recruitment made by the SEWA-Rural will be on the condition that such recruited persons will not have any claim to get absorbed in government service except through the Gujarat Public Service Commission for other regular procedure of recruitment.

It is also further stipulated that for such staff as recruited by SEWA-Rural subject to above conditions, the Jilla Panchayat will give grant-in-aid for their remuneration for the duration of the project. It is also stipulated that voluntary village workers at village level excepted above are placed under the direct control of the SEWA-Rural and are, therefore, not on deputation like the other staff consisting of Female and Male Multipurpose Health Workers and Supervisors working at the villages in charge of the SEWA-Rural.

(iii) In paragraph 3 in line no. 6 after the words "and male multipurpose workers" the words "and supervisors" should be added.

By order and in the name of the Government of Gujarat.

(sd/-) Deputy Secretary to the Govt. of Gujarat, Health & Family, Welfare Department.

- c) (From the original in Gujarati)  
Entrusting Rural Health & Medical Services to a Voluntary Organization,  
SEWA-Rural, Jhagadia, district Bharuch

Resolution No. MIS-1084-2265/867-B, June 10, 1986.

## References

- (1). Health & Family Welfare Dept. Resolution No. MIS/1084/917/B, dated 24-4-84.
- (2). Health & Family Welfare Dept. Corrigendum No. MIS-1084/917/B, dated 2-6-84.

## Resolution

- (1) As mentioned in the reference 1 & 2, SEWA-Rural, Jhagadia was entrusted the responsibility of providing health services to following 10 villages of Jhagadia Taluka in Bharuch District as per the resolutions No. MIS-1084-917 dated 24-4-84 and corrigendum No. MIS-1084-917-B dated 2-6-1984.

(1) Fulwadi (2) Bhimpor (3) Untia (4) Kharchi (5) Sardarpura (6) Ratanpor (7) Pora (8) Kharia (9) Khadoli (10) Simadhra

- (2) Entrusting 19 villages (as enlisted under) of Jhagadia Taluka of Bharuch District to SEWA-Rural, Jhagadia for providing health and medical services was under consideration with the Government. After due considerations 19 villages (as enlisted under) of Jhagadia Taluka of Bharuch District are entrusted to SEWA-Rural, Jhagadia for providing health services.

(1) Kharchi Bhilwado (2) Govali (3) Mulad (4) Naugama (5) Boridra (6) Amod (7) Bhuri (8) Maljipara (9) Malipipar (10) Damlai (11) Kunvarpara (12) Andharkachhla (13) Gundecha (14) Padwania (15) Amalzar (16) Jajpor (17) Anadhra (18) Malpor (19) Dholakuva

The other conditions will be as per reference No. 1 and 2 (Corrigendum). In the name of and by the order of Government of Gujarat.

(sd/-) Deputy Secretary, Health & Family Welfare Department.

d) (From the original in Gujarati)

Entrusting management of Primary Health Center to SEWA-Rural, Jhagadia.

Resolution No. PIC/1087/8096/88 GH. Dated February 14, 1989.

## References

- (1) Health & Family Welfare Dept. Resolution No. MIS/1084/17/B, dated 24/4/84.
- (2) Health & Family Welfare Dept. Resolution No. MIS/1084/2265/86/B/ dated 10/6/86.
- (3) Health & Family Welfare Dept. Resolution No. BUS/1087/257/6-B/dated 15-7-87.
- (4) Health & Family Welfare Dept. Resolution No. BUD/1087/2571/B. dated 13/1/88.

- (5) District Development Officer, Bharuch Letter No. J.P./J.A/Development 2458-59 dated 5/11/88.

#### Introduction

As given in Reference No. 1 dated 24/4/84, the order was given about providing health services of 30 villages by SEWA-Rural. As given in Reference No. 2 This Dept. had given order dated 10/6/86, about health services of additional 19 villages to be provided by SEWA-Rural. As per above Reference No. 3 this dept., by order dated 15/7/87 has sanctioned necessary personnel & equipments etc. for 30 Primary Health Centers in tribal area. As per above Reference No. 4 this dept., by order dated 13/1/88, has sanctioned 14 primary health centers in tribal area. Out of these fourteen one primary health center has been sanctioned at Jhagadia. The organization, SEWA-Rural, has proposed that SEWA-Rural be entrusted the management of the said PHC. As per Reference No. 5 District Development Officer, Bharuch has sent a proposal to entrust the management of Primary Health Center at Jhagadia to SEWA-Rural. The above proposals of SEWA-Rural and District Development Officer were under the consideration of Govt.

#### Resolution

After due consideration the management of Primary Health Center at Jhagadia is entrusted to SEWA-Rural under the following conditions.

- (1) At first stage the management of Primary Health Center at Jhagadia is entrusted to SEWA-Rural for 10 years
- (2) Govt. will provide grant to the organization to arrange Primary Health Center from Dt.1-4.89.
- (3) District panchayat, Bharuch will take over the management of this primary health centre if the organization either does not want to manage the primary health center or discontinue this activity.
- (4) The organization can accept employees from District Panchayat on deputation. If the organization wants to recruit the employees by its own selection process the organization will be able to do it by following whenever possible, Recruitment Resolution of the concerned vacancy of either Govt. or District panchayat.
- (5) When the organization discontinues the activity in future Govt. will consider absorbing the employees, who were appointed by the organization, provided they satisfy the necessary recruitment criteria like age limit, education qualification, experience at the time of their appointment.
- (6) When the organization discontinues the activity, the employees appointed by the organization, who do not fulfill the recruitment criteria will be absorbed by the organization in their other activities after due consideration. If not then they will be relieved from the service and this matter is to be brought to the notice of such employees by the organization.
- (7) When the organization wants to appoint the employee by following their own criteria the organization is required to have either District Health Officer or District Development Officer in the selection committee and the appointment has to be given in his presence.
- (8) It is not possible to sanction the post of driver as it does not fall into the pattern of primary health center. But if the organization has the facility of vehicle, the organization can create the post of driver for its use on its own cost.

- (9) These resolutions code passed following the approval of dept. of General Administration, panchayat and Rural Housing.

In the name of and by the order of the Governor.

(sd/-) Deputy Secretary, Health & Family Welfare Dept.

(e) (From the original in Gujarati).

*Entrusting Health & Medical Services to a Voluntary Organization,*

*SI.WA-Rural, Jhagadia, Dist. Bharuch.*

Resolution No. PRCH/1084/590/89/B. Dated April 13, 1989.

#### References

1. Health & Family Welfare Dept. Resolution No. MIS/1084/917/B, Dated 24/4/84.
2. Health & Family Welfare Dept. Corrigendum No. MIS-1084/917/B Dated 2/6/84.
3. Health & Family Welfare Dept. Resolution No. MIS/1084/2265(86)B, Dated 10/6/86.
4. District Development Officer Bharuch Letter No. J.P./J.A/Development 323 & 324 Dated 3/2/89.

#### Resolution

1. As given in above references No.1 & 3, by this dept. resolutions, SEWA-Rural, Jhagadia was entrusted the responsibility of providing health services to 30 villages, as per attached list, for first stage of 5 years.
2. SEWA-Rural organization having provided good services to the said villages, as given in the list, achieved SASAKAWA award for the best health performance. It was under consideration of Govt. following District Development Officer's proposal to enable SEWA- Rural to continue to provide health services for 10 more years. After due consideration the continuation of provision of health services by SEWA-Rural, to 39 villages with an additional two more villages, is here by sanctioned.

The other conditions will be as per reference No 1 and 2 (corrigendum). In the name of & by the order of Governor of Gujarat.

(sd/-) Section Officer, Health & Family Welfare Dept.



## EXPENDITURE BY THE CHP

	1982-83	1983-84	1984-85	1985-86	1986-87	1987-88	1988-89	1989-90	Total
Recurring	80,066	1,67,175	3,00,242	8,26,178	13,42,467	17,91,490	19,53,442	19,76,731	84,37,791
Non-Recurring	81,276	61,057	2,16,460	8,96,463	6,87,127	11,22,621	5,00,330	4,72,238	40,37,372
Total	1,61,342	2,28,232	5,16,702	17,22,641	20,29,594	29,14,111	24,53,572	24,48,969	1,24,75,163

Figures in rupees

Out of the total expenditure of about Rs. 1.25 crores for the Community Health Project in the last eight years, the contribution from central government was 34.40%, that of state/district government was 30% ;the foreign donor agencies contributed 8.64% while contribution from other individual and institutional donors was 27.6%. The present recurring expenditure is about Rs. 20 lakhs, which includes cost involved in supplementary nutrition and the cost of incentive schemes associated with various activities like family planning.

The activities under CHIP include primary health care, ICDS, field studies and training.

## YEAR-WISE CHANGES IN HEALTH INDICATORS

## (A) Indicators of Health Service Utilization

	1983-84 or 1982-83	1984-85	1985-86	1986-87	1987-88	1988-89
Total Population	11678	18768	19116	19463	35090	35706
Total Pregnancies	224	426	475	525	879	1002

## Antenatal

Ever - registered	179 (79.9%)	358 (84.1%)	451 (94.9%)	494 (94.1%)	851 (96.8%)	952 (95.0%)
3 or more checkups by FHW	56 (25.0%)	187 (43.9%)	223 (47.0%)	299 (57.0%)	691 (78.6%)	560 (56.0%)
Inj. Tetanus toxoid	56 (25.0%)	232 (54.5%)	280 (59.0%)	357 (68.0%)	645 (73.4%)	752 (75.1%)
Iron tablets distribution	103 (46%)	266 (62.5%)	352 (74.1%)	299 (57.0%)	688 (78.3%)	792 (79.0%)

## Postnatal

3 or more visits by FHW #	42 (1.8%)	37 (55.6%)	190 (40.0%)	210 (40.0%)	520 (59.2%)	792 (79.0%)
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\* Figures from inservice records

### Vaccination Coverage

BCG	33	69	84	93	93	95
Polio	9	36	49	67	76	89
DPT	44	57	62	70	79	-
Measles	NA	NA	40	76	77	73

### (B) Vital Indicators

	1983-84 or 1982-83	1984-85	1985-86	1986-87	1987-88	1988-89
Total births.....	224	426	475	525	879	963
Live births.....	214	413	455	498	857	942
Crude Birth Rate.....	19.2	22.7	24.8	27.1	25.1	27.0
Crude Death Rate.....	12.0	8.6	8.0	7.0	7.9	12.5
Maternal mortality .....	3	2	3	6	5	-
Neonatal mortality .....	NA	(6.2)	(4.4)	(5.6)	(6.7)	(5.3)
Infant mortality.....	27	26	20	21	53	43
Perinatal mortality.....	(126.2)	(62.9)	(44.0)	(42.2)	(61.8)	(45.7)
Child mortality.....	37	36	30	40	79	84
Childbirths attended by trained personnel(% ).....	(172.9)	(87.2)	(65.9)	(80.3)	(92.2)	(89.2)
Severely undernourished children(% ).....	27	26	31	30	59	53
Couple protection rate (% ).....	(126.2)	(63.0)	(68.1)	(60.2)	(68.8)	(56.3)
	20	21	10	11	24	31
	(12.8)	(8.0)	(4.3)	(2.4)	(5.3)	(6.8)
Severely undernourished children(% ).....	16.1	12.0	15.3	15.3	5.0	11.5
Couple protection rate (% ).....	55.2	58.6	64.1	60.7	61.8	

\* Figures from inservice records

## REPORT OF THE PREREVIEW WORKSHOP

Described below is a brief report of the consultation workshop held by SEWA-Rural at Kevadia, near Jhagadia, on March 11 and 12, 1989, to discuss the design and format of the current review. Participants were select invitees with experience and knowledge of community health practice and research (for a list of participants, see Appendix at the end of this annexure).

After a brief introduction about the organization and about the broad goals of the workshop by Dr. Anil Desai, Managing Trustee, a detailed presentation was made on the activities, innovative features, achievements and limitations of the community health project of SEWA-Rural.

### Objectives of Evaluation and Workshop

After break, the groups reconvened with Dr. Anil Bhatt as moderator. Dr. Pankaj Shah, the community health physician, briefly introduced the topic of evaluation: why the evaluation, objectives of evaluation and objectives of the workshop.

Participants invited were from various fields having expertise in different areas for this workshop. The organizers of the workshop felt that the comments, guidance and suggestions of the participants would help SEWA-Rural in adequately and critically evaluating the CIIP by reviewing the list of parameters and prioritizing these as well as refining the methodology for the evaluation according to the parameters so listed. Further, it was thought that the group members could provide ongoing support to SEWA-Rural in its future work.

The workshop thus would serve the purpose of sharing and learning from the experiences of a larger group even as the workshop would serve the purpose of initiating the process of appropriate networking for similar such efforts.

In the discussion that followed participants questioned the need for a conventional evaluation based on standard parameters. Broadly, two views emerged.

Some participants strongly felt that information on much of the standard parameters were already available and there was no point in reevaluating these. Rather, SEWA-Rural was an experiment and hence efforts should be put into finding out how its views have developed/evolved/changed with time and experience, and what its concepts were regarding other related issues as of now. Secondly, rather than sorting out achievements and failures in cold figures, one should evaluate whether SEWA-Rural's interventions have empowered people.

At this point a need was expressed of clarifying further what broad underlying goals SEWA-Rural had set itself at the beginning as to what its vision and mission were.

Other participants were of the opinion that the objectives of CIIP had already been amply clarified and there were concrete parameters already defined. The task was to decide how to go about it. These conflicts were rearticulated by various members in different terms.

Finally the group broke for lunch with the understanding that it would reconvene to enlist broad parameters and if necessary divide into groups for discussions. In the post-lunch session Dr. Pankaj Shah presented what were in his view certain broad areas of the evaluation.

After considerable discussion, two groups were ultimately formed and guidelines and tasks for discussion by each group were decided. What follows is a brief report of the outcome of discussions of each group.

#### Report of Group 1

The areas identified for discussion by this group were: various health care services, health education and the health information system.

1. Sources of data and method of data collection : Although everyone felt that an independent survey should, theoretically, be ideal, it was agreed that it was neither feasible nor desirable to evaluate all parameters. Past experience of SEWA-Rural had shown that such independent third party surveys produced data that was substantially of inferior quality as compared to inservice data. Beside, the massive effort that would have to be put in for such a survey may not, even if feasible, produce commensurate results. There was a consensus that since the inservice data, and the recording seemed reasonably accurate, wherever appropriate these records could be utilized. Thus it was necessary to delineate parameters which could/should be evaluated with the help of records, surveys or other methods.
2. The baseline data for comparison could prove a tricky question, since villages were taken in three phases in 1982-84 and again in 1986. Only government data were available at the time of the 1982 baseline survey. After much discussion, it was decided that the data collected at the time of taking villages in 1982 and 1984 could be taken as baseline and it could be safely presumed that the status of the second batch of villages (that is of 1984) was the same in 1982 as found by the 1984 survey. Thus before/after comparisons could be done. Comparison with control villages from non-project areas had already been hinted at as probably not feasible in the discussion during the previous sessions.
3. While assessing in terms of achievement of targets, it was sought to be reminded that setting of targets was empirical. Thereafter, the group decided to enlist possible parameters for evaluation and the method of collecting data for the same. A list was accordingly drawn up..

#### Report of Group 2

The mandate of this group was to look into how the organizational and management aspects of the community health project could be studied from the point of view of the goals of the evaluation. The group suggested that the following aspects be studied.

*Decision making*

Five to ten 'out of the ordinary' decisions taken during the last five years relating to the CIIP be recalled by the members of the core group. ('Out of the ordinary': those that generated a great amount of enthusiasm or conflict). The decision making processes would then need to be analyzed from the point of view of: who was involved in decision making; at what stage of the decision was person involved; what was the role of each person in the decision making process; decisions taken for which level, and so on.

It was felt that the study of the decisions would also reveal certain aspects of the leadership development and processes of decentralization in the organization.

*Leadership Development*

It was suggested that the founding members be asked to spell out what their understanding of leadership was: what kind of leaders did they set out to create? Interviews with some of the now senior staff would reveal the process of leadership development.

*Organizational Values*

Certain values seem to set SEWA-Rural apart from other organizations: What are these values? What is their root? How are these transmitted to the staff members and others? What is the process of internalization of these values? How are they practised and at what levels?

Related to values is the concept of *man-making*; how is this understood by the various levels of staff members? To what extent does it inspire persons at various levels within the organizational hierarchy?

SEWA-Rural's strong roots in *spirituality* also need to be examined. What is the effect of the spiritual ethos on the morale of the persons working in the organization? How are management styles influenced by the spiritual leanings of the core team?

*Organizational Processes*

SEWA-Rural representatives described some of the organizational processes related to salaries, systems of reward and punishment, and so on. It was felt that these need to be studied further to find out how they effect the morale and motivation levels of the staff. Also one needs to find out whether there are any inbuilt mechanisms to identify 'murmurs' in the organization, and the need to find out what are the critical levels of 'murmurs' and what is done to handle the dissatisfaction once it rises above critical levels.

*Values about Financial Management and Funds*

It was suggested that the review process would need to find out how SEWA-Rural decision makers view specific purpose funds; are inter-fund transfers accepted? What are the norms regarding economy and expenditure, say, for travel on organization's work, for staff development, etc?

*Review, Reporting and Communication Systems*

What are they? How effective are these systems? What are the problems at various levels? What are people's suggestions of how this can be overcome?

The methodology suggested for looking into most of these areas was indepth, personal interviews as well as group sessions with concerned persons for some of the issues.

#### *Government Collaboration*

Members spent most of the time discussing the generic aspects of voluntary organizations and health organizations at that. The discussion would probably have continued much longer as most participants were extremely interested in this topic. A good study of the organizational aspects of SEWA-Rural would be extremely useful from the point of view of validating the theories (if there were any) of such organizations.

Several concerns of participants could not be discussed adequately because of shortage of time. However members dwelt at length on the issue of GO-NGO-collaboration, a feature that admittedly stood out with respect to the community health project of SEWA-Rural.

In addition to reviewing the mechanisms of the collaboration, it was felt that it may be useful to recall the original objectives of the collaboration: Did SEWA-Rural decide to work with the government to show how an NGO could do the government work more effectively? Or was the original objective to avoid duplication of services in the area? Whatever be the original objectives, the achievement needs to be assessed. One needs to examine what else has happened in the process.

Also, one needs to ask what has been the effect of the collaboration on SEWA-Rural's values? What kinds of policies and decisions did it lead to?

It was mentioned that a substantive study based on a concrete experience of the GO-NGO collaboration had not really been done although several papers discussing various points of view have been surfacing in the recent past. A review of SEWA-Rural's experience would therefore be valuable.

#### *Plenary Session*

The presentation of the above points in the plenary session elicited a series of interesting reactions. Some people wondered whether attempting all these was feasible: did we have requisite skills and the time to do in depth, personal interviews?

A few others were of the opinion that we were attempting an evaluation of the community health program and not of the management of the organization. Some others remarked that since we had set out to see whether SEWA-Rural's work was qualitatively different from the government's we did need to look into what makes SEWA-Rural different from the government. For this, a study of the organizational factors was necessary.

However, all agreed that these aspects were tricky, needed unusual openness on the part of the organization even as it needed appropriate expertise to evaluate; these however were to be taken only as suggestions. SEWA-Rural could think things over and take a choice of what, out all this, it would find most useful and feasible to do.

#### **Potential Areas/Parameters of Evaluation/Review**

Some kind of consensual conclusion as to what were the potential parameters and areas of the evaluation/review was sought to be arrived at as an outcome of the consultation workshop :

- (1) Objectives of CIIP, goals planned and achieved.
- (2) Examination of health areas/services as suggested above :  
achievements, process, quantitative/qualitative indicators, strategy, methodology, vital statistics, target achievement, training methodology, etc.
- (3) Community aspects: participation, perception, knowledge, attitude, practice and awareness.
- (4) Organization, methodology and strategy: structure, decision making, communication, leadership development, decentralization, monitoring and supervision, training and development, health information systems.

- (5) Relationship with other agencies/networking/boundaries; NGO-GO collaboration: mechanism, achievement, constraints; academic linkages with universities, training schools, other voluntary agencies, sharing and learning.
- (6) Management of financial resources: cost benefit, cost effectiveness.
- (7) Larger issues: relationship with other developmental activities, future direction, ideology/philosophy/approach.



## List of Participants of the Workshop

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9. *Dr. Anil Bhatt,*  
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11. *Dr. Anil Desai, 12. Dr. Lata Desai, 13. Dr. Pankaj Shah (Community Health Physician),*
14. *Dr. Mukesh Dave (Medical Officer), 15. Dr. Rajesh Mehta (Community Health Physician), 16. Dr. S. Sridhar (Paediatrician)*  
SEWA-Rural, JI IAGADIA, Dt. Bharuch 393110. (for 11 To 16).
17. *Mr. Binoy Acharya,*  
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18. *Dr. Amala Rao,*  
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19. *Dr. V.M. Shah*  
Training Incharge, Rural Health and Training Center, At & Post: Padra., Dt. Baroda.
20. *Dr. Vibha Shah*  
Baroda Citizens' Council, Baroda 390002.

## EVALUATION SURVEY QUESTIONNAIRE

(Please note that these questions are to be filled up by the interviewer.)

## Part A : General Information

VILLAGE :	FALIA (STREET) :	FORM NO. :	SERIAL NO. :
HEAD OF HOUSEHOLD :			HOUSE NO. :
RELIGION :	1. Muslim	2. Christian	3. Tribal
		4. Baxipanch	5. Harijan
			6. Upper class Hindu

Sr. No.	Name	How related to head of house	Date of Birth	Age (yrs)	Sex	Education	Occupation	Physical Examination	Remarks
1									
2									
3									Lameness/Anemia/Bitof's/Illness Treatment Wt.(kg) N.blind. last mth. source (0-6 yrs)

Staying in village since (1)&lt;1 yr. (2)&gt;1 yr. Deaths in household over last 1 yr.:

Name :

Age :

Date of Death :

Marriages over last 1 yr. Y / N

Births over last 1 yr. Y / N ( If yes, please fill part D)

Is anyone pregnant at present? Y / N ( If yes, please fill part C)

Name of Interviewer :

Date of Interview :

**Part B: KAP Questions**

1. Does a FHW (nurse) come to your village? Yes / No
2. If yes, what is her name? True / False
3. What work does she do?  
(1) Examination of antenatal women (2) Visits postnatal women (3) Gives tablets to pregnant women  
(4) Gives injections of tetanus (5) Immunizes children (6) Motivates women to undergo tubectomy operations  
(7) Treatment of minor ailments (8) Health education
4. Is there an anganwadi worker in your village? Yes / No
5. If yes, what is her name? True / False
6. What work does an anganwadi worker do?  
(1) Teaches (2) Plays with children (3) Gives food (4) Weighs (5) Does home visit (6) Gives treatment of diseases
7. What is her name? True / False
8. Why do you send your children to anganwadi?  
(1) Because food is given (2) Because they get to play (3) Because songs are sung (4) Because they teach  
(5) Because children can be taken care of (6) Because we (mother/father) can go for work (7) Instead of roaming about it is better if they go there
9. Who is the anganwadi helper? True / False
10. What all does she do?  
(1) Takes children to anganwadi (2) Brings them back from anganwadi (3) Keeps the children clean  
(4) Gives food to the children (5) Cooks food
11. Who is the dai (TBA) in your village (street)? True / False
12. What work does she do?  
(1) Conducts delivery (2) Gives bath to the child till the 6th day (3) Explains to get examined by nurse (FHW)/doctor (4) Gives iron-FA tablets (5) Explains women about tubectomy operation (6) Others
13. By giving vaccines what all diseases do not occur?  
(1) TB (2) Measles (3) Polio (4) Tetanus  
(5) Whooping cough (6) Others
14. What do you do at first when someone falls ill in the house?  
(1) Home remedies (2) Traditional healers (3) Nurse (FHW) (4) Mobile (5) SEWA-Rural  
(6) Ankleshwar/Bharuch (7) Others (8) Nothing
15. If not cured by this then what do you do?  
(1) Go to Ankleshwar (2) Bharuch (3) SEWA-Rural (4) Others (5) Nothing
16. Who is your Community Health Volunteer? True / False

17. What work does she/he do?  
(1) Chlorination of water (2) Takes blood smear in case of fever (3) Treatment of minor ailments (4) Explains cases of operations (5) Keeps information about births/deaths (6) Others
18. If a child is suffering from diarrhoea in your house then what do you do?  
What should be done if the child has got diarrhoea?  
(1) Stop giving food (2) Give water to drink (3) Show to traditional healers (4) Get medicines from health worker (5) Give salt-sugar solution (6) Take the child to hospital (7) Nothing (8) Others
19. After one child when should the 2nd child be born?  
(1) 1 year (2) 2 years (3) 3 years (4) 4 years (5) 5 years
20. What should be done for spacing of children?  
(1) Nothing (2) Copper-T (3) Nirodh (4) Ora Ipills (5) Herbal drugs (6) Others
21. What is this (Copper-T)? True / False
22. What has been the impact of SEWA-Rural's work in your village?  
(1) Nothing (2) Treatment of sick (3) Feel good when they explain (4) Health post (5) Children get food (6) Social forestry (7) Savings (8) Vocational training of youths (9) Papad (10) Others
23. What help have you rendered in the work of SEWA-Rural?  
(1) (Given) Place / food / labour for anganwadi (2) I helped in immunizing children (3) I helped in gram shibir (4) Helped at the time of mobile dispensary (5) I helped at the time of health education (6) Give information to health worker (7) Food and shelter for the health worker (8) I help at the time of special functions (9) Others
24. What else should SEWA-Rural do in your village?  
(1) Should develop sources of water (2) Should create jobs for employment (3) Should make rooms in schools (4) Weaving (5) Should make latrines (6) Should give free treatment in hospital (7) Regular health services should be available (8) Others
25. What all problems do you face when you go for getting medicines at SEWA-Rural hospital?  
(1) (They) Do not give injections (2) (They) Get blood urine examined (3) (They) Take lot of money (4) (It) Takes lot of time (5) (They) Admit (6) (They) Keep on explaining (7) (They) Create doubts (8) Others
26. Can a patient of minor ailments get well without injections? Yes / No
27. Last year did you get all parts of your house sprayed with DDT? Yes / No
28. What is the difference caused by it (DDT)?  
(1) Mosquitoes decrease (2) Fleas/Bugs decrease (3) Rodents decrease (4) Others
29. What are the symptoms of malaria?  
(1) Fever (2) Chills (3) Bodyache (4) Sweating (5) Fever on alternate days (6) Amount of blood decreases (7) Vomitting (8) Loss of appetite (9) Others
30. Who is the malaria doctor in your village? True / False

31. What work does he do?  
(1) Gives drugs to cases of fever (2) Takes blood smears of fever cases (3) Puts powder in wells (4) Explains to cases of operations (5) Explains to cases of TB (6) Gives treatment to sick (7) Refers critically ill
32. By taking what in food can the blood remain red?  
(1) Green leafy vegetables (2) Jaggery
33. Do you have a latrine in your house? Yes / No  
If 'No' then,
34. Do you feel the necessity of building a latrine? Yes / No
35. What all diseases can occur by drinking dirty water?  
(1) Diarrhoea (2) Dysentery (3) Jaundice (4) Cholera (5) Typhoid (6) Polio (7) Others
36. What should be done for purifying water?  
(1) Straining (2) Sedimentation (3) Boiling (4) Putting powder (chlorine) (5) Use handpump water for drinking (6) Keep wells covered (7) Cleaning wells (8) Put a tortoise (9) Put stones in the well (10) Others
37. Does a mobile dispensary visit your village? Yes / No

**Part C : Antenatal Form**

Project village / Non-Project village

Name of the Pregnant mother :

Did the nurse come (during the pregnancy)? Yes / No

- |                                                                                                                                           | Month   |   |                       |   |   |   |   |
|-------------------------------------------------------------------------------------------------------------------------------------------|---------|---|-----------------------|---|---|---|---|
| 1. When did she come first?                                                                                                               | 1       | 2 | 3                     | 4 | 5 | 6 | 7 |
| 2. When did she come last ?                                                                                                               | 1       | 2 | 3                     | 4 | 5 | 6 | 7 |
| 3. Iron-FA tablets : Given how many times?                                                                                                | 0 1 2 3 |   |                       |   |   |   |   |
| Do you take the tablets? Yes / No                                                                                                         |         |   |                       |   |   |   |   |
| Do you have tablets of present? Yes / No                                                                                                  |         |   |                       |   |   |   |   |
| 4. How many injections of tetanus have you taken? 0 / 1 / 2 / 3 / Booster<br>(Ask the following question only where anganwadi is present) |         |   |                       |   |   |   |   |
| 5. Do you get food from anganwadi? Yes / No                                                                                               |         |   |                       |   |   |   |   |
| 6. How many times have you received food in the last three days? 0 / 1 / 2 / 3 /                                                          |         |   |                       |   |   |   |   |
| (Fill up the following only if they have been provided by a nurse)                                                                        |         |   |                       |   |   |   |   |
| Blood examination                                                                                                                         | Y       | N | Weight                | Y | N |   |   |
| Urine examination                                                                                                                         | Y       | N | Blood pressure        | Y | N |   |   |
| Abdominal examination                                                                                                                     | Y       | N | Examination by doctor | Y | N |   |   |

Is edema present?	Y	N	Referred?	Y	N
Delivery pack given?	Y	N	given given?		

**Part D: Delivery Form**

(To be filled up only if the delivery has taken place in the last year.)

Project / Non-Project

Mother's name :

Place of delivery : Home / Hospital / SEWA-Rural / Referral / Other Hospital

Date / Month of delivery :

Delivery conducted by : (1) Relatives (2) Dai (3) Nurse (4) Doctor/ Other

Result of Delivery : Live / Dead

1. Iron-FA tablets : Received / Not received  
 : If received how many times? 1 / 2 / 3

2. After how many days of delivery did the nurse visit? 15 days / more

3. After delivery does one get/ did you get food from the anganwadi? Yes / No

4. Did you get food in the last 3 days? Yes / No

5. If yes, how many times? 0 / 1 / 2 / 3

6. After delivery did you get iron tablets? Yes / No

7. Breast feeding started on which day? 1 / 2 / 3/

8. Family Planning accepted : Y / N

9. What method? : Operation / Copper T / Nirodh / Oral pills

Name of  
 Date of  
 Education  
 Pregnancy  
 1. Did yo  
 2. Which  
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 3. Did yo  
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 For st  
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 6. Why n  
 7. Who in  
 Mother  
 8. Did yo  
 Taken  
 9. Did yo  
 10. Why sh  
 11. Does s  
 12. If this w  
 Call the  
 13. Did yo  
 14. Should  
 15. Do you  
 16. Did yo  
 17. If no, w

## KAP QUESTIONNAIRE (1984)

Name of Woman (Interviewed) \_\_\_\_\_ Age: \_\_\_\_\_ Village: \_\_\_\_\_ Falia: \_\_\_\_\_  
 Date of Interview: \_\_\_\_\_ Total children \_\_\_\_\_ Under six children \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Total \_\_\_\_\_  
 Education : \_\_\_\_\_ Occupation : \_\_\_\_\_ Elders: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

*Pregnancy*

1. Did you get yourself vaccinated during pregnancy? Yes / No
2. Which vaccine is given during pregnancy?  
Tetanus / Others / Do Not Know
3. Did you taken any tablets during pregnancy? Yes / No
4. Which tablets are given during pregnancy?  
'For strength' / Others / Do Not Know
5. Was there any food that you particularly avoided during pregnancy? (specify)
6. Why not (that is, why avoided)?
7. Who informed you that such food was to be avoided during pregnancy?  
Mother / Mother-in-law / Self / Others
8. Did you take complete rest or did you continue to work till the end during pregnancy?  
Taken complete rest / Continued to work
9. Did you get swelling on your feet during pregnancy? Yes / No
10. Why should such swelling occur? What do you believe? (specify)
11. Does such swelling harm the mother or child? Yes / No
12. If this were to occur, what would you do?  
Call the dai / Call the FHW / Go to doctor or hospital / Do nothing
13. Did you have night blindness during pregnancy? Yes / No
14. Should one get checked up regularly by doctor/nurse during pregnancy? Yes / No
15. Do you know the benefits of such checkups? (specify)
16. Did you have checkup(s) during your last pregnancy? Yes / No
17. If no, why not? (specify)

*Delivery*

18. Who conducted your last delivery?  
Dai / Nurse or Doctor / Relatives / Others
19. Does FHIW conduct delivery in your village? Yes / No
20. With what instrument should the cord be cut?  
Scissors / Knife / Sickle / Others Why? (specify)
21. If this instrument has not been cleaned properly, would it harm the child?  
Yes / No / Do Not Know If yes, what happens? (specify)
22. (If applicable) Why did you not get your delivery conducted by the FHIW? (specify)
23. After childbirth, which particular foods do you avoid? For how long? (specify)
24. Why do you avoid? (specify)

*Care of Child after Birth*

25. Should colostrum be given to the child? Yes / No Why? (specify)
26. How many days after birth did you initiate breast feeding?  
First / Second / Third day
27. What do you apply to the stump after the umbilical cord falls off?  
Ash / Sindur / Powder / Others Why? (specify)
28. When did you start giving other milk to child?  
At 6 months / 1 year / 2 years
29. When did your child start eating all kinds of food? (specify)

*Anganwadi*

30. Are you aware of balmandir / balwadi / anganwadi? Yes / No
31. If yes, what are the benefits of sending child there?  
Gets food / Gets education / Do Not Know / Others
32. Does your child go to the anganwadi now? Yes / No
33. If not, why not? (specify)
34. Should the child be weighed regularly? Yes / No Why? (specify)
35. Reasons for not giving any weaning foods? (specify)

*Vaccination*

36. Are you aware that smallpox does not occur any more? Yes / No
37. Are you aware of the reason for this? Yes / No / Do Not Know
38. Can you tell the reason? (specify)
39. Are you aware that vaccines prevent disease? Yes / No

40. What c
- (41 to 44 sam
45. Of th
46. How
47. Do vac
48. What
49. Consid
- vaccin
50. Have
51. If yes,
52. In the
53. Are yo
54. If yes,
- Treatment
55. When
- At ho
56. Does
57. How
58. If yes,
59. If a ch
60. Would
61. Can
62. How
63. The
64. What
- Family
65. How
66. Why
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98. How
99. How
100. How



40. What does this child suffer from (picture to be shown)? (specify)  
(41 to 44 same as 40)
45. Of the above, which are vaccine preventable? (specify)
46. How is polio vaccine administered? Injected / Oral / Other
47. Do vaccines cause harm to children? Yes / No
48. What harm? (specify)
49. Considering that children can get fever after vaccine, would you or would you not get your child vaccinated? Yes / No
50. Have you ever got your child vaccinated? Yes / No
51. If yes, what vaccine? When? BCG / DPT / Polio
52. In the future, are you planning to get your children fully vaccinated? Yes / No
53. Are you aware that at present some one comes to your village to give vaccinations? Yes / No
54. If yes, who comes? Nurse / Others / Do Not Know

*Treatment*

55. When someone at home is sick, where do you first seek treatment?  
At home / CI IV / Govt. Doctor / Pvt. Doctor / Others
56. Does the CI IV give curative treatment in your village? Yes / No
57. Have you ever taken treatment from him / her? Yes / No
58. If yes, for what? (specify)
59. If a child gets diarrhoea at home, what do you do? (specify)
60. Would you stop feeding the child at such times? Yes / No
61. Can one give ORT to such children? Yes / No
62. I have you ever given this? Yes / No
63. I has your child ever got 'Ratva'? Yes / No
64. What is 'Ratva'? What happens in this condition? (specify)

*Family Planning*

65. How many children would you like to have? (specify)
66. Why this number? What benefits do you see in this? (specify)
67. What should be the minimum spacing between children?
68. What can one do to prolong this spacing? (Use) Nirodh / Oral Pills / IUD / Others
69. What is this (IUD)? Where is it placed? In the uterus / Elsewhere / Do Not Know.
70. What is this (oral pills)? Oral Pill / Others / Do Not Know  
How frequently is it to be taken?
71. Have you ever used any of these methods? Yes / No

Name of interviewer :

Date of interview :

## ORGANIZATIONAL CLIMATE QUESTIONNAIRE

QUESTIONS	OPTIONS	TOTAL					OTHERS DOCTORS				
		PERCENT- AGE	FIW (N=6)	MPHW (N=6)	AW SUP. (N=4)	VISORS (N=7)	PERCENT- AGE	FIW (N=2)	MPHW (N=2)	AW SUP. (N=2)	VISORS (N=2)
1 How many of the employees in SEWA-Rural get the opportunity to do their work in a better way?	1. Almost all	24.1	4	2	0	0	1	0	0	0	0
	2. Most	58.6	2	3	4	1	5	2	2	2	2
	3. Some	10.3	0	0	0	2	1	0	0	0	0
	4. Very few	6.8	0	1	0	1	0	0	0	0	0
	5. Almost none	0.0	0	0	0	0	0	0	0	0	0
2 To what extent do the supervisors and other knowledgeable colleagues take pains to help an employee of SEWA-Rural who wants to learn more about his/her job?	1. To a great extent	31.0	2	3	0	2	2	0	0	0	0
	2. Considerable extent	62.1	3	3	4	1	5	2	2	2	2
	3. Some extent	6.8	1	0	0	1	0	0	0	0	0
	4. Little extent	0.0	0	0	0	0	0	0	0	0	0
	5. Not at all	0.0	0	0	0	0	0	0	0	0	0
3 How often do you feel that an employee's career is harmed in the organization?	1. Almost always	10.3	0	1	0	0	2	0	0	0	0
	2. Usually	10.3	1	0	0	0	0	0	0	2	2
	3. Sometimes	37.9	2	2	4	2	1	0	0	0	0
	4. Rarely	27.6	2	1	0	1	4	0	0	0	0
	5. Almost never	13.8	1	2	0	1	0	0	0	0	0

QUESTIONS	OPTIONS	TOTAL PERCENT-AGE	FWH (N=6)	MPH/AW (N=6)	SUPERVISORS (N=7)	OTHERS DOCTORS (N=2)
4 How are the targets set in this organization?	1. Orders issued, no opportunity to raise questions or give comments	3.6	0	0	0	1
	2. Orders issued, explained, opportunity given to ask questions	25.0	1	1	2	0
	3. Orders drawn up, discussed with subordinates sometimes, modified before being issued	35.7	3	3	1	1
	4. Specific alternative objectives drawn up by supervisors, subordinates asked to discuss and choose the one they prefer	3.6	0	0	0	0
	5. Problems presented to involved persons, objectives set up by subordinates and supervisors jointly by group participation / discussion	32.1	2	2	1	2
5 How much do you agree with the statement that this organization is better than other similar organizations in the country to work in?	1. Strongly agree	44.8	3	3	0	4
	2. Agree	48.2	2	2	4	3
	3. Neither agree nor disagree	6.9	1	1	0	0

QUESTIONS	OPTIONS	TOTAL PERCENT-AGE					MPIW/LW		SUPER VISORS		OTHERS DOCTORS	
		(N=6)	(N=6)	(N=7)	(N=2)	(N=4)	(N=6)	(N=7)	(N=2)	(N=4)	(N=7)	(N=2)
4. Disagree	5. Strongly disagree	0.0	0	0	0	0	0	0	0	0	0	0
		0.0	0	0	0	0	0	0	0	0	0	0
6. Somebody says, 'There is so much work to do here every day that I have to do it somehow, and I do not have the time to think about how the quality of the work can be 'improved.' How much would you agree with the statement?	1. Strongly disagree	3.6	0	1	0	0	0	0	0	0	0	
	2. Disagree	42.9	1	1	2	1	5	2				
	3. Neither agree nor disagree	20.7	1	0	1	3	1	0				
	4. Agree	25.0	2	4	1	0	0	0				
	5. Strongly agree	7.1	1	0	0	0	1	0				
7. To what extent do you receive correct information about your work, duties, etc.?	1. Not at all	0.0	0	0	0	0	0	0				
	2. To a very little extent	0.0	0	0	0	0	0	0				
	3. To some extent	7.1	0	0	0	1	1	0				
	4. To a considerable extent	53.6	1	2	3	2	5	2				
	5. To a very great extent	39.3	5	3	1	1	1	1				
8. There is a general feeling here that grievance of the employees are handled properly. To what extent do you agree with this statement?	1. Strongly agree	27.6	2	2	1	1	1	1				
	2. Agree	51.7	2	4	2	1	5	1				
	3. Neither agree nor disagree	17.2	2	0	1	1	1	0				
	4. Disagree	3.4	0	0	0	1	0	0				
	5. Strongly disagree	0.0	0	0	0	0	0	0				

QUESTIONS	OPTIONS	TOTAL PERCENT-AGE	FHW (N=6)	MFIHW (N=6)	AW (N=4)	SUPERVISORS (N=7)	OTHERS (N=2)	DOCTORS (N=2)
9 To what extent do people in your department encourage one another in work?	1. Not at all	3.4	0	1	0	0	0	0
	2. To a little extent	3.4	1	0	0	0	0	0
	3. To some extent	6.8	1	0	0	1	0	0
	4. To a considerable extent	58.6	2	4	3	3	4	1
	5. To a very great extent	27.6	2	1	1	0	3	1
10 Is the organization receptive to new ideas?	1. Never receptive	0.0	0	0	0	0	0	0
	2. Sometimes receptive	13.8	1	1	1	1	0	0
	3. Often receptive	17.2	2	1	2	0	0	0
	4. Almost always receptive	27.6	2	1	1	2	1	1
	5. Always receptive	41.4	1	3	0	1	6	1
11. To what extent do you feel that the employees here are allowed to make decisions to solve their problems without checking them with their superiors at each stage of the work?	1. A very great extent	17.2	1	1	1	1	1	0
	2. A great extent	10.3	0	0	0	0	1	2
	3. Some extent	24.1	2	1	3	1	0	0
	4. A little extent	37.9	3	3	0	1	4	0
	5. Not at all	10.3	0	1	0	1	1	0
12 Is there a general feeling amongst the employees of your level that anybody can be removed from his/her job at any time?	1. Almost all employees	0.0	0	0	0	0	0	0
	2. Most employees	25.5	0	2	1	3	1	0
	3. Some employees	17.9	2	1	1	0	0	1
	4. Few employees	35.7	1	2	1	0	5	1
	5. No employees	21.4	2	1	1	1	1	0

QUESTIONS	OPTIONS	TOTAL PERCENT-AGE	FHW (N=6)		MPH/AW (N=6)		SUPERVISORS (N=7)		OTHERS DOCTORS (N=2)	
			FHW	PERCENT-AGE	MPH/AW	PERCENT-AGE	SUPERVISORS	PERCENT-AGE	OTHERS DOCTORS	PERCENT-AGE
13 How often are the rewards (such as raise in salary and promotion) given strictly on the basis of valid reasons?	1. Almost always	10.3	0	0	1	16.7	1	14.3	1	50
	2. Usually	31.0	1	16.7	2	33.3	3	42.9	1	50
	3. Sometimes	20.7	1	16.7	2	33.3	1	14.3	1	50
	4. Rarely	24.1	1	16.7	3	50	2	28.6	0	0
	5. Almost never	13.8	3	50	0	0	0	0	0	0
14 'In order to stay here, one just cannot perform work somehow, but work has to be well done.' To what extent do you agree with it?	1. Strongly agree	75.9	5	75.9	3	50	4	57.1	5	100
	2. Agree	24.1	1	16.7	1	16.7	2	28.6	2	100
	3. Neither agree nor disagree	0.0	0	0	0	0	0	0	0	0
	4. Disagree	0.0	0	0	0	0	0	0	0	0
	5. Strongly disagree	0.0	0	0	0	0	0	0	0	0
15 To what extent are people in the higher levels aware of the problems at lower levels in this organization?	1. Not at all	0.0	0	0	0	0	0	0	0	0
	2. Very little extent	6.9	0	0	0	0	1	14.3	0	0
	3. Some extent	24.1	1	16.7	2	33.3	2	28.6	0	0
	4. A considerable extent	44.8	2	33.3	3	50	1	14.3	5	100
	5. A very great extent	24.1	3	50	1	16.7	1	14.3	1	50
16 How often do you have advance information of any changes which are planned?	1. Almost always	34.5	3	50	1	16.7	3	42.9	2	100
	2. Usually	31.0	0	0	3	50	2	28.6	2	100
	3. Sometimes	27.6	2	33.3	2	33.3	0	0	2	100
	4. Rarely	3.4	0	0	0	0	1	14.3	0	0
	5. Almost never	3.4	1	16.7	0	0	0	0	0	0

QUESTIONS	OPTIONS	TOTAL PERCENT-AGE	FHW (N=6)	MPHAW (N=6)	SUP. VISORS (N=7)	OTHERS DOCTORS (N=2)
17 Are discussions at meetings in this organization free and open?	1. No, very guarded and defensive	10.3	2	1	0	0
	2. Quite guarded and defensive	6.9	1	1	0	0
	3. Slightly defensive	6.9	0	0	1	0
	4. Quite free and open	44.8	2	3	3	2
	5. Very free and open	31.0	1	1	0	2
18 Which of the following best describes the manner in which problems between departments are generally resolved?	1. Problems worked out at level where they appear, through mutual effort/understanding	58.6	4	4	3	2
	2. Problems appealed to a higher authority in the organization, usually resolved there	37.9	2	1	1	2
	3. Problems appealed to a higher authority in the organization, not usually resolved there	0.0	0	0	0	0
	4. Little is done, they work themselves out with time	3.4	0	1	0	0
	5. Little is done, they continue to exist.	0.0	0	0	0	0

QUESTIONS	OPTIONS	TOTAL PERCENT-AGE	FIW (N=6)	MPI/WAW (N=6)	SUPERVISORS (N=7)	OTHERS DOCTORS (N=2)
19 How often is it true that personal hostilities are usually resolved as quickly as possible?	1. Almost never	0.0	0	0	0	0
	2. Rarely	10.3	1	1	0	1
	3. Sometimes	10.3	1	1	0	0
	4. Usually	44.8	1	2	3	2
	5. Almost always	34.5	3	2	0	0
20 How much do you think your organization has interest in the welfare of the employees?	1. Not at all interested	0.0	0	0	0	0
	2. Not very much interested	6.8	0	1	1	0
	3. In certain ways interested	10.4	0	2	1	0
	4. Somewhat interested	58.6	3	2	3	6
	5. Very much interested	24.1	3	1	0	1
21 Do you agree that in this organization the capabilities of its employees are fully utilized?	1. Strongly agree	31.0	1	2	1	3
	2. Agree	62.1	5	4	3	3
	3. Neither agree nor disagree	6.4	0	0	1	0
	4. Disagree	0.0	0	0	0	0
	5. Strongly disagree	0.0	0	0	0	0
22 Do the employees here work with a team spirit?	1. Team spirit does not exist at all	0.0	0	0	0	0
	2. Exists in few members	3.6	0	1	0	0
	3. Exists in quite a few members	3.6	0	0	1	0



QUESTIONS	OPTIONS	TOTAL PERCENT-AGE	FHW (N=6)	MPHAW (N=6)	SUP. VISORS (N=7)	OTHERS (N=2)	DOCTORS (N=2)
4. Exists in many members		35.7	2	2	1	3	2
	5. Exists in almost all members	57.1	3	3	3	4	0
23 How often does a person in this organization receive credit and appreciation if he finds out a different way of doing things which nobody has ever done before?	1. Almost always	37.9	3	1	2	1	4
	2. Usually	27.6	1	2	1	2	0
	3. Sometimes	20.7	0	3	1	0	2
	4. Rarely	6.9	0	0	0	1	1
	5. Almost never	6.9	2	0	0	0	0
24 How much is your job important in this organization?	1. Very much	51.7	3	4	2	2	3
	2. Much	37.9	3	1	2	2	3
	3. Somewhat	10.3	0	1	0	0	1
	4. Little	0.0	0	0	0	0	0
	5. Not at all	0.0	0	0	0	0	0
25 In the activities of SEWA-Rural which ideals have been utilized?(One or more than one can be ticked.)	1. Social service-	-	5	6	3	4	7
	2. Scientific approach-	-	2	6	4	4	4
	3. Spiritual outlook-	-	2	5	4	4	4
	4. Individual development-	-	3	4	2	2	3
	5. More emphasis on working and developing together in a group-	-	2	3	3	3	6

QUESTIONS	OPTIONS	TOTAL PERCENT-AGE	FHW (N=6)	MPIW (N=6)	AW (N=4)	SUPERVISORS (N=7)	OTHERS DOCTORS (N=2)
6. Rather than members it is the quality of work which is important			5	4	3	4	2
26 To what extent are the above mentioned ideals followed?	1. Almost always	64.3	4	4	1	3	6
	2. Mostly	28.6	1	1	2	1	2
	3. To some extent	7.1	0	1	1	0	0
	4. Rarely	0.0	0	0	0	0	0
	5. Never	0.0	0	0	0	0	0

QUESTIONNAIRE GIVEN TO VILLAGE LEVEL WORKERS

- (1) What do you think about your work?
- (2) What problems and difficulties do you face in your work? Has the staff of SEWA-Rural made any efforts to solve your problems?
- (3) Do you think your work is important for SEWA-Rural? If yes, then how?
- (4) Do you believe that your work is important for the people?
- (5) What, according to you are the five main problems faced by the villagers?
- (6) What do the people of the village think about you?
- (7) Do the people of the village help you in your work? If yes, in which work? How? Explain with examples.
- (8) What is the opinion of villagers about SEWA-Rural?
- (9) Has your village benefitted by the activities of SEWA-Rural? If yes, what are these benefits?
- (10) Why do you do this work?
- (11) What should be done to increase the importance of SEWA-Rural's work in your villages?

## SOME CASE HISTORIES OF MATERNAL DEATHS:1988-89

## CASE HISTORY 1

Mother's Name : Diwaliben Balubhai Vasawa

Village : Utiya

Age : 40 years

Death : Utiya

Date of Delivery : 27-6-88

Illiterate,tribal,labourer

Date of Death : 30-6-88

Obstetric History : 1 F 10 year a/w

G4 P1 Abo; 2nd full term delivery baby died 2 months; 3rd full term baby died 18 months

## ANTENATAL HISTORY

Registration is done in 4th month of pregnancy

Tab Iron Folic acid started in 4th month; total Iron tab taken: 210 (from card)

Inj. TT booster dose was given; 1 lb% not done; urine not done; height: 143 cm

Medical checkup by FI IW: 3 times (3 visits) and referred to SEWA- Rural; patient was referred to SEWA-Rural, Jhagadia for severe anaemia and also advised TBA to bring her to hospital.

High risk : Bad obstetric history severe anaemia edema (pedal)?

Availability of mother : being labourer mother was not available in some visits. She was going for her work in early morning and coming back in the evening.

## INTRANATAL HISTORY

Delivery : preterm / at home

TBA : trained and delivery pack used

Baby : alive/female

Birth wt : 900 gm.

No other complication during labour

**POSTNATAL HISTORY**

Severe anaemia after pregnancy could not walk also, could not feed her baby, always lying down only.

Date of delivery : 27-6-88

Date of death of mother : 30-6-88

Mother died on day three

**PNC Visit**

Death visit taken on 9-7-1988.

(Exact date not written in card but mother's death is noted in PNC first visit and child is at risk is noted. Child also died on 27th day of her life.)

**Steps taken after death**

1. Death visit is done by FIIW with supervisor on 9-7-88
2. Second time with doctor - 21-7-88
3. Third time with doctor with pediatrician on 21-7-88 (for child mainly).
4. Falia meeting is done in the village; explained about death and causes of it.
5. With leaders in the village: meeting done and explained about death and causes of it.
6. Extra efforts to save baby was also done but old grand father and mother refused to bring child to hospital and lastly child without mother also died.

**Causes of Maternal Death**

Severe anaemia PNC death; after death during visit it was found that 120 tab of Iron were in her house.

**CASE HISTORY 2**

Name : Vanitaben Madyabhai Vasawa      Age : 17 years      Education : 3 Standard

Tribal : labourer      Date of Delivery : 16-10-88      Date of Death : 16-11-88      Village : Motasanza

**OBSTETRIC HISTORY**

G1 Po Abo (Primi)

**ANTENATAL HISTORY**

Registration in 2nd month of pregnancy; Tab Iron Folic started at 4th month; Total Iron taken (ANC): 270

Inj.TT : 2      FIIW Visits : 2

SEWA-Rural hospital admission - twice B.T. given

Home visit by internee doctor done.

High risk : As severe anaemia FIIW had advised hospital delivery; all family members informed about it.

**INTRANATAL HISTORY**

Preterm delivery

Delivery conducted by relative (mother); - Chord cutting done by TBA using delivery pack; Baby (M) : alive;

Birth wt.: less(?)

**POSTNATAL HISTORY**

Visit on the same day by FHW; mothers poor condition; noted tab Iron started; fever and cough; so advised to go to hospital; doctor's visit done; referred to hospital but patient did not come; all medicines sent at home but not doing well; at last died on 16-11-88.

Death visit on 20-11-88; after one week doctor visited.

Cause of death: severe anaemia with LRT 2 postnatal death.

**CASE HISTORY 3**

Name : Sarita Balu Beahar Patel      Age : 22 years Education : Class 8      Farmer : non-tribal

Date of death : 9-1-89      Village : Gowali      Death : At Kasturba Hospital      Date of delivery : 8-1-89

**OBSTETRIC HISTORY**

G2 P0 AG0

During first delivery baby died after 1 hour.

High risk noted : as bad obstetric history

Antenatal : care taken

TT : 2

Iron : Regular

Patient delivered stillbirth in Kasturba Hospital. First news not given to mother, but someone told her baby died and she went in shock and died on the same day in hospital.

Patient from non-project village; death due to shock in hospital.

**CASE HISTORY 4**

Name : Gitaben Thakorbbhai Patanwadia      Age : 22 years illiterate      Labourer : non-tribal

Death in : non-project village      Date of Death : 14-11-88      Obsteric History      G1 P0 AG0 (Primi)  
ANC : Inj. TT taken; Iron Tab taken regularly; noted as anaemia; for delivery she went to ('piyar') father's place

**INTRANATAL HISTORY**

Delivery conducted by untrained TBA; kalla done; baby stillbirth; Postpartum haemorrhage present.

As hospital far from village, could not be taken to hospital; mother died after 1 hour of delivery.

Postnatal death.

Death visit : 17-11-88      On CP Day : Patanwadia falia meeting done and explained about death of Gitaben.

Talked with TBA's from Gowali about this incident.

<sup>1</sup>Death in non-project village; postnatal death due to PPH.

**CASE HISTORY 1**

Name : Ganga Sivali

Village : Gowali

**OBSTETRIC HISTORY**

G1 P1 AG0

**ANTI-NATAL HISTORY**

Antenatal care taken in

**INTRANATAL HISTORY**

Delivery at Sivali

Referred to hospital; patient died as

Falia meeting in

<sup>1</sup>Postnatal death; severe

**CASE HISTORY 2**

Name

Age

Date of Delivery

Date of Death

**OBSTETRIC HISTORY**

Registration in 2nd trimester

Iron tab : 210 taken; Inj. TT

**POSTNATAL HISTORY**

Four visits by FHW : 15-11-88

18-8-88 : Iron taken 150 tabs; AKT completed on 25-8-88.

Relapse : on 25-9-88 in medical camp available.

Date of delivery : 12-7-88

Death on : 26-12-88 (not taken)

**CASE HISTORY 5**

Name : Ganga Baylal Vasawa

Age : 25 years Illiterate, tribal

Village : Cowali

Date of Death : 11-10-88

**OBSTETRIC HISTORY**

2 P1 Ago 1 F/alive

**ANTENATAL HISTORY**

Antenatal care taken; Inj. TT covered; Iron FA taken; anaemia - noted during antenatal period.

**INTRANATAL HISTORY**

Delivery at Selod ('piyar') by trained TBA; PPH; preterm delivery (8th month); baby stillbirth.

Admitted to hospital : Admitted at SEWA-Rural hospital; 2 B.T. given after discharge from hospital; after 1 week patient died as vomiting and anaemia still present.

Family meeting in Vasawa talia done by FI IW and MI IW and explained people about death and cause of death.

Cause of death: postnatal death; severe anaemia with PPH.

**CASE HISTORY 6**

Name

: Pankiben Umedbhai Vasawa

Age

: 25 years Illiterate, tribal, labourer

Date of Delivery

: 12-7-88

Date of Death

: 26-12-88 at village Limodra (Father's place)

**OBSTETRIC HISTORY**

Registration in 2nd trimester

Iron tab : 210 taken; Inj. TT : taken; Visits by FI IW : 3

**ANTENATAL HISTORY**

Regular visits by FI IW : 15-7-88; 22-7-88: mother and child normal;

8-88 : Iron taken 150 tab; Pankiben was having pulmonary Koch's; detected on 24-12-86 and AKT started; AKT completed on 25-3-88.

Collapse : on 25-9-88 is noted on card; further history of hospital admission; no further record of restarting AKT is available.

Date of delivery : 12-7-88

Cause of death : 26-12-88 (not taken as maternal death).

**HEALTH FACILITIES AVAILABLE TO THE PROJECT POPULATION**

Jhagadia is one of the talukas (blocks) of Bharuch district. Health services in rural areas are provided by Primary Health Centres (PHCs) and referral-level hospitals, under the administrative control of the district panchayat. In addition, some private health facilities are also available.

When SEWA-Rural began its work in 1982, there were two PHCs in the entire block : one at Umalla, about 20 km from Jhagadia, and the other at Moriyana, 35 km away. At present, there are six PHCs, at Avidha, Dharoli, Panetha, and Jhagadia in addition to the other two. The PHC at Jhagadia, which is under the administrative control of SEWA-Rural, is the largest, covering a population of 45,000. The others serve populations varying from 20,000 to 35,000.

The curative services commonly availed of by the people of the project area include :

- The Kasturba Hospital at SEWA-Rural, Jhagadia , a 70 bed general hospital functioning since 1980.
- The government CHC at Jhagadia, a 30 bed general hospital functioning since 1985.
- The recently upgraded PHC at Umalla.
- The Civil Hospital, Rajpipla (45 km from Jhagadia), a 30 bed general hospital.
- Vijay Prasuti Gruh, Rajpipla, a private trust hospital offering mainly obstetric services.
- The Municipal Hospital and Jayaben Modi (Trust) Hospital, both general hospitals, at Ankleshwar, and (District) Civil Hospital and Sevashram (Trust) Hospital, Bharuch, both around 20 km away.
- An Ayurvedic hospital at Netrang, 30 km from Jhagadia.
- Around 10 private clinics run by qualified doctors in and adjacent to the project area, and a number of such others in Netrang, Ankleshwar and Bharuch.
- An unspecified number of local healers in every village.

It must be mentioned that for the entire district east of Ankleshwar and Bharuch, the only modern indoor facilities available are at Rajpipla and Jhagadia.



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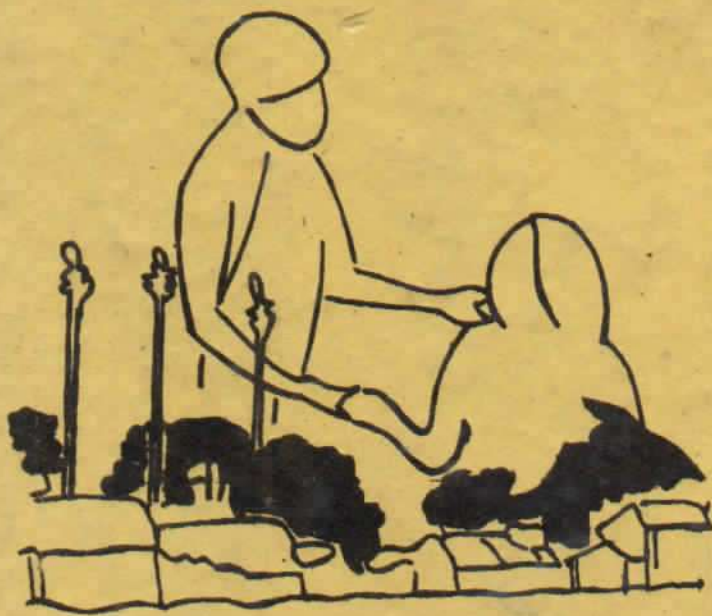
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