WORLD HEALTH
ORGANIZATION

REGIONAL OFFICE FOR
SOUTH EAST ASIA

New Delhi

WHO/UNICEF JOINT COMMITTEE ON HEALTH POLICY

PRIMARY HEALTH CARE

THE COMMUNITY HEALTH DEVELOPMENT PROJECT OF THE KOTTAR SOCIAL SERVICE SOCIETY NAGERCOIL TAMIL NADU INDIA

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Muttom Tamil Nadu: India, September 1976
W.H.O. (SEARO), New Delhi:

"..... due to congested social environments morality is very low; a sense of justice, forgiveness, love for the neighbour and self-abnegation are pearls to be searched among strong currents of jealousy, superstitution, lack of self-control, and other evils like promiscuity and drinking"

KSSS's Discussion of A. Selik's "Tamil Family Life and Values" K.S.S.S Annual Report 1972.

".... Development is not primarily a matter of Economic Growth. It is a complex process of human progress in which man must be able to assume the responsibility of making his own decisions. This means a transformation in the mentality of a population which has for centuries regarded the events of life as problems they could not tackle. It also means the transformation of certain social structure very profoundly linked with the culture, whether secular or religious....."

F. Houtart and G. Lemercinier

"A Social Analysis"
KSSS/University of Louvain 1974.

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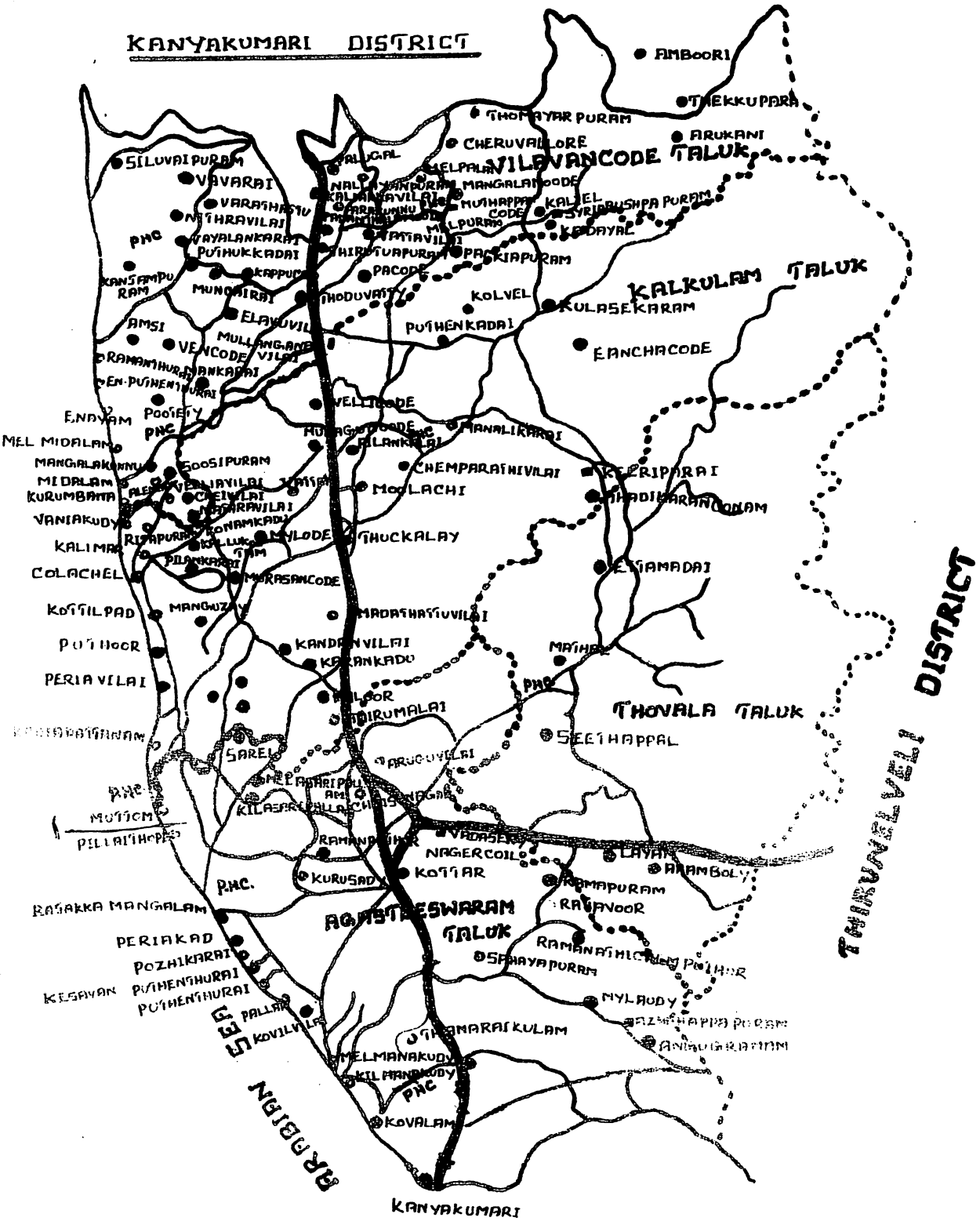

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GULF OF MANNAR

K.S.S.S

COMMUNITY HEALTH CENTRES

IN 126 VILLAGES

SECTION II

SUMMARY ACCOUNT OF THE PROJECT/PROGRAMME

1. The Community Health Development Project (CHDP) of the Kottar Social Service Society did not get under way until 1971. Its conception grew from the experience amassed over the proceeding two decades during which a multitude of community based projects were initiated and carried through. These projects were largely concerned with creating economic opportunity among the poorest section of the District, in Agriculture, in Fishing, and in cottage type Industry. Under the spur of a study made in 1971* the Society decided to emphasis its attempts to bring about major change along the lines of a growing philosophy of 'conscientization' with its concepts of 'awareness', 'contradictions' and 'liberations'. One of the directions selected for this emphasis was related to the plight of women in the society; the conditions under which they lived; and particularly the burden they carred as mothers, related to lack of health of themselves and their children.

At the same time a feeding programme for poor families, sponsored by the Catholic Relief Services (through which USAID provided resources) was being operated by K.S.S.S. based on some of the local hospitals and dispensaries. A desire for a change in C.R.S. policy brought about the suggestion that the food be used as an incentive for a more far-reaching programme.

These two developments, the realisation of a more fundamental approach and the new direction, and the C.R.S. policy change were

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* F. Houtart & G. Lemarcinier "A Social Analysis of the Social Action of the Christian Churches in Kanyakumari District". Centre de Recherche: Socio-Religieuses Univesite Catholique de Louvain 1975.

crystallized by the K.S.S.S. in their plans to provide a Community Health Development Programme.

1971 was a preparatory year and the centres began to function in 1972. The enclosed map indicates the growth of centres through out the District of Kanyakumari in 1972, 1973, 1974, currently (mid-1976) there are 126 such centres serving 43,000 families-approximately 20% of the total District population. All these families pay a small sum regularly. The centres are directed to mothers and under-fives. Attendance at the centres, impressively, is in the region of a consistent 90% of all those due to attend on the regularly appointed days. The centres are staffed by a mobile team of Staff Nurses, Health workers, Health Guides, Health Educators and four Volunteers from each village. The atmosphere of 'sorority' among the team members is striking.

This year (1976) a new departure has taken place with the begining of permanent centres in 6 villages. These are slightly different in organization from the mobile centres, and have been designated "Health-cooperatives"; they are to be family oriented, and include the men more deliberately. It is intended that these be the pattern of future consolidation and expansion.

It should be restated that these centres are out-growths of the preceeding twenty years of community-based activity, begining with the organisation of the Palmyra Climbers at Parakunnu, to the present strugggles and conflicts surrounding attempts to assist the fishermen to break out of the debilitating grip of money-lenders and merchants, and of their own limitations, in order to determine their own lives more satisfyingly through the promotion of 'Sangams' (K.S.S.S. inspired co-operatives).

2. It is difficult to concretise the impact of these projects. However in relation to the primary health centres the imputs and overall impression convince one of the major contribution that is bound to be made to standards of health through pre-natal and post-natal care, immunisations, nutrition, sanitation and health habits, and the early detection and referral of the diseased. The delivery of such service to this poor section of the community until now has been miserable. Similarly the amount of employment generated and the financial improvement of the poorer section of some of the communities is again without doubt - although an exact and conclusive expression of this is not available to us. There can be little question that the results obtained to date are directly related to the particular projects, although there are indirect plusses and some minusses.

It might be mentioned here that critics, although generous in their appraisal of what they call the ameliorative activity of the K.S.S.S., have raised fundamental questions regarding whether the underlying social structure, which they see as the cause of poverty and social injustice, has yet been satisfactorily tackled. K.S.S.S. accepts the necessity for such an objective and believes it has made some inroads on such problems, and is resolved to renew and seek fresh expression of its efforts in this direction.

3. K.S.S.S. is both the creation and instrument for development of a few outstanding personalities within the Diocesan structure of the Catholic church (dating back in this part of India 400 years).

Increasingly it would seem that a natural paternalism has been giving way to a variety, in degree and quality, of community participation.

In respect of the Community Health Centres, 'communities' must deliberately request them; be able to provide a minimum of accommodation; provide four unmarried girl volunteers each time the centre functions; and the families must pay a registration fee and a regular monthly fee. The mothers also determine how some funds are to be used for environmental sanitation in their particular village. Most of the other projects have a co-operatives base. Parish priests and Sisters play an important leadership role but all kinds of leadership are also in the hands of non-church people and increasingly new ways are being found to involve individuals and groups in the identification of need, decision making, development and maintenance of activities. It would seem, however, that this is a pains-taking and very slow process and is not yet to the full satisfaction of K.S.S.S.

4. The initial interest was on a specific group in a particular village: twenty-four years later there is a multitude of projects; a perspective that covers the district of 1-1/4 million people; and an umbrella organisation, (K.S.S.S.) which attracts considerable international resources . Interest has undoubtedly been growing.

5. Care seems to have been taken to make the communities self-assisting through contributions, fees, revolving funds for loans, etc. etc.. However addressing as the project does many of the poorest, assistance has come from outside in terms of grants-in-aid for training, vehicles, credits, and foods. Technical help has also been available, especially in the mechanisation and boat-building activities of the Fishing Project.

6. Activity has clearly spread from village-based projects to a variety of District-wide efforts. There are indications that in the field of health, government may well have been influenced in its programme. It is of significance to note that the interest of the WHO/UNICEF study team in K.S.S.S. has activated government in what may prove to be a most positive and considerable response.

SECTION III

DETAILED DESCRIPTION OF THE COMMUNITY

A. Demographic Characteristics

1. According to 1971 census the total population of Kanyakumari District is 12,22,549 comprising 6,19,884 males and 6,02,665 females. The density of the population is 726 per Km. About 50% of the population is less than 20 years old.

2. Though it is a part of Tamil Nadu administratively there are many customs, socio-economic and geophysical likenesses with the adjoining Kerala State. The language itself has borrowed much of the vocabulary from Malayalam, the local language of Kerala. The great majority of the population (10,18,144) live in rural areas as against 204,045 in urban areas.

3. The number of Revenue villages in this District are 81 and the hamlets are 1,144.

Agriculture is the main occupation and 53% of the population are engaged in this occupation. Fishing and marketing are other important occupations.

4. The population comprises 6,94,522 Hindus, 4,75,611 Christians and 52,357 Muslims. In villages the population varies from 300 to 5,000.

5. Usually the communities are clustered in the coastal areas due to lack of enough space and tend to be dispersed in the interior areas where the people are engaged in agriculture and having plantations. The latter type is particularly found in the interior taluk of Vilavankodu and Kalkulam adjoining Kerala State.

B. Cultural Characteristics

1. The religious composition in the coastal villages is usually

homogenous comprising Christians. The religious composition tends to be heterogenous towards the interior areas.

2. The heterogenous population comprise the Roman Catholics C.S.I., Lutherians, and Salvation Army, and in the interior villages, where agriculture is the main occupation Nadars (both Hindus and Christians) Nairs, Muslims and Harijans live in the same locality.

C. Social Characteristics

1. In the coastal areas joint families are quite common whereas in the interior villages where agriculture is the main occupation, more nuclear families are found.

2. There is a pronounced caste system rather than social class.

3. Factions among fisher folks and Nadars are commonly seen and occasionally among Muslims and fisherfolks. One such instance took place in June 1972 where there was a major clash between the Bharather of Fisherfolk community residing in Cape Comorin and Nadar community from a near-by village.

4. Men are mostly engaged in agriculture, fishing, palm tapping etc.

5. Women usually take care of children, cooking, assisting husbands in agricultural work and engaging in netmaking, fish marketing (fisherfolk) and household duties whereas decision making are usually made by adults of both sexes.

6. The parish priest plays an important role in decision making among the Roman Catholic community. Usually committees are organised and conducted periodically among each caste group. Any decision made

by a particular caste group, is through consensus in the committee. Matters related to the general Community Welfare are decided by the local panchayat which includes elected member representatives of dominant political groups.

D. Local Communication Patterns.

1. Church gatherings are usually utilized for religious purposes occasionally for announcing and motivating people to utilize the health the other welfare activities carried out in their community and motivating parents to send their children to schools. Meetings of political nature are quite common at the time of general elections.

2. People, irrespective of their religion and having leaning to a particular political ideology attend these meetings. Church gatherings are attended by both the sexes, usually women in larger numbers, whereas in the case of political gatherings mostly by men.

3. Caste plays a dominant role in political elections and as such serves as a binding force among the same caste groups. Since persons belonging to different caste groups having a common political ideology come together, the need for maintaining unity irrespective of caste or creed is being stressed. These political meetings usually serve as forums for explaining to the people regarding their achievements in community. welfare activities if it is the ruling party and the opposite parties utilize it for explaining the lapses and problems unsolved in order to gain confidence and support for the elections.

4. The district has a well developed net work of roads, national highways, state highways and panchayat union roads and the frequency of public transport lying on these roads varies from every 5 to 20

minutes on main high ways one to two hours to interior villages. Most of the transport facilities have been nationalised. The proposed rail road connecting this District to Thirunelveli (T.N.) and Trivandrum (Kerala) has already been taken up and this is expected to be completed within a couple of years. The nearest air-port to this place is at Trivandrum which is about 60 Km. from Nager-coil the Dt. Head Quarters and is mostly utilized by foreign tourists, business people and high ranking Govt. officials.

5. Postal system is available in almost all the villages. Tele-graph facilities are available only in towns and villages where subpost offices are located. Telephone facilities are found in selected towns and in big institutions. There are 227 post offices distributed all over the district. The Telegraph offices are located in 67 places. There are 67 Telephone offices in the whole district. Postal services are one of the main sources in the formal communication.

6. Periodicals (weeklies and monthlies) are published locally both in English and in Tamil languages. These local periodicals are in greater circulation in villages, whereas dailies both English and local language published outside the district are also available. The English dailies are in greater circulation in towns. Libraries in villages are quite common where local dailies and periodicals are also available. There are 61 libraries and 179 reading rooms through-out the district. The literacy rate of this District is high (58.1) as compared with the National literacy rate of 29.35.

7 & 8. Radios are quite common in the areas and about 26,293 Radio receivers were in use at the end of March 1975. Film songs, news, programme for the villagers are very popular.

9. There are 24 market places in this Dt., and important of them are Vadaseri (twice a week), Monday Market, Friday Market, Thoduvetti and Kaliyakavilai. In these market days the market prices rate is fixed. The publicity department utilize the market days for informing health and family planning campaigns through exhibitions,stalls and information centres.

10. Rotary and Lions clubs are functioning in the Dt. Head Quarters and are mainly for the elites. The Rotary and Lions conduct free eye and dental camps and help in the organisation and conduct of family planning campaigns. They are also adopting villages for providing community welfare services as a sequel to the 20 Point Programme launched by the Central Government. Men clubs like "Grama Munnetra Sangam" (Village Improvement club), Film Fan Association like "M.G.R. and Sivaji" Mandrum have small libraries and conduct oratorical competitions. Caste clubs like "Nadar Mahajana Sangam", "Bharather Munnetra Sangam", Women's club like Mother Sangam etc. are also functioning.

E. Socio-cultural Characteristics that Influences the Health situation

1. People in these communities tend to classify diseases into those that can and should be cured by physicians and those to be treated by indigenous healers. Cases like Mental diseases, evil eyes, eruptions, infantile diarrhoea, simple bone fracture, cramps etc. are usually taken to local healers.

2. Western or allopathic medicine are resorted to in cases involving surgery and those which could not be cured by the indigenous systems of medicine. The preference for allopathic system is more due to the anti-

biotic which give a quicker results than other indigenous medicines. The common belief is that Western system of medicine is costlier than the indigenous medicines. Any thing given free is looked upon with a certain amount of suspicion in its quality and there is the usual belief that the free medicine available through the governmental agencies is of a poor quality.

3. Smallpox, chickenpox, measles etc., are considered as causes due to the wrath of Godess and hence do not come forward to take vaccination as a preventivemeasure. However, there is a noticeable change in the acceptance of immunization against smallpox due to the well organised maternal and child health services and health education. Christians belonging to Pentecost church and Mulims during fasting period do not take any medicine and they believe that the diseases could be cured through prayers to God. Running water is considered pure and hence do not consider it necessary to boil it for drinking purposes. The services of untrained dais are usually preferred because of their availability locally, experienced in conducting safe deliveries; and they also provide services like giving bath to the child etc. It is believed that there must be a certain amount of round worms in the stomach for digestion. So they do not want to take medicine to expell the worms fully.

In some parts, they burn the navel with hot iron rod when their children get fever and convulsion.

Pregnant mothers have their deliveries attended to by 'quacks' due to fear of removal of uterus if they go to hospitals. These quacks usually use rusty and unsterilized knife for cutting the umbilical cord.

Some mothers do not take bath when their children are having fever.

4. People believe that nutrition has an impact on health but they are not quite clear regarding the nutritive values of different types of foods and their relationship in the causation and prevention of diseases.

5. Certain types of foods are believed to cause heat and certain cold to the system. For (e.g.) pappaya fruit is not taken by pregnant mothers as they believe its extreme heat will result in abortion. Milk, ghee, onion are supposed to cool the system. Infants are fed only with liquid food till about six months mainly by cows milk and on breast milk.

6. Usually "kanji" (porridge) is prepared from Ragi or green-gram flour as a supplement to milk. After six months semisolid food (mashed tapioca or rice) is given till they are able to digest solid food. Usually there is no specially prepared food for children.

7. Cleanliness of body and clothes and absence of disease is considered as "health".

8. Cleanliness is closely associated to health and the usual saying that "cleanliness gives food" is quite common in this community. People keep neem leaves at the entrance of their houses when there is a case of smallpox and chicken pox. This helps in warning others not to frequent that particular house. If any death occurred due to cholera and small pox people won't attend the funeral due to fear of infection, and the person is usually cremated along with his clothes. It is cusotmary to remove the slippers and wash feet before entering the house. This helps in the prevention of any external infection. The

house is swept daily twice or thrice, and the floors are washed twice a week. During important festivals like Pongal and Deepavali houses are white washed.

9. Religious beliefs have basis in health practices for e.g. taking bath daily, washing hands and feet before taking meals, white washing the houses and cleaning the environment during festivals. During cases of small pox infection, isolation of patients, restriction of outsiders entering the house and hanging of neem leaves at the entrance are favourable for health promotion and can be activily encouraged.

F. Political Characteristics

1. Local leaders come into power through high economic status and social influence. This usually lends itself to political leadership

2. They are elected through adult franchice. The members and president of the panchayat are elected by the local people and stay for a term of 5 years.

3. There is no special leaders for different kinds of community needs and all the need are supposed to be met by the local panchayat or at the Panchayat Union level.

4. The constitution allows freedom to various political parties to carry out political campaigns provided it is not determental to the national interests. In case of political activities threatening the national interests, the centre takes control of the administration of the state through declaration of emergency. Leadership among Roman Catholics is mostly vested among the parish priest who is more an ascribed leader and their appointment and tenure of office is determined

by concerned diocese. The local political organisation is integrated with state and national system through election of a member for the State Legislature from each constituency and one member for every six constituencies for the Parliament at the Central level.

5. In case of factionalism among communities, usually the District Government Officials and some times Religious leaders (parish priest) help in bringing about amicability among the rival groups.

6. Local affairs are managed by the village panchayat which is an elected body. The panchayat meets once a month and transacts the local routine activities. The decision is done by the concensus of its members through discussion.

7. The panchayat president presides over the monthly meetings of the panchayat.

8. In case of religious matters concerning the local community usually the parish priest or religious heads presides over the meeting. The teachers do not seem to have marked influence among communities except among the school children since usually they are not the local residents.

9. The male village level worker (Gram sevak) is engaged mainly in agriculture and Development activities. The female village level worker (Gram sevika) carry out women welfare activities such as tailoring, kitchen gardening, home keeping etc. There are health workers engaged in programmes like malaria, small pox, and family planning, vital statistics registration. There is an Auxillary Nurse Midwife who attend to the Maternal and child health activities and family planning. The village officers are incharge of collecting revenue from the land and also issue community certificates.

G. Resources/Economic Characteristics

1. In general, it can be said that the District has great promise, for there is a balance in its resources, human and otherwise. The main natural resources available in the area are, paddy, coconuts palmyra, banana, rubber coffee, cashewnut, sea products, tapioca and minerals.

These natural resources that are available in this community contribute to the local economy by means of

a. Coconut for coir industry, oil extraction

b. Tapioca for flour mills

c. Rubber for rubber based small scale industries

d. Cashewnut for cashewnut factories which exceeds 100 factories in this Dt.

e. Paddy for food.

Palmyrah and coconut fibre, fish, coconut, jaggery, rubber, tamarind, cashewnut, sugar, pulses and cereals are exported and there-by improve the local economy. The extent of land available (according to 1974-75 report) for various purposes are as follows: 2,3

Forests	1,25,396 (acres)
Barren and uncultivable land	14,880
Land put to non-agricultural use	55,621
Cultivable waste land	3,094
Miscellaneous crops	1,886
Fallow lands	1,918
Area cultivated	2,08,877
Permanent grazing land	568
Total	4,12,240

2. Every bit of cultivable land is brought under cultivation. Rice fields comprise 38%, cash crops (rubber etc.) 24%, tapioca 13% vegetables and grains 12% coconut plantation 8% and fruit garden 5%. The extent of available farming land varies from 5 cents to 15 acres per family. 75% of the land owners have a holding of less than half an acre. The Government have imposed a ceiling for 15 acres (standard acres) per each family. The District can be divided broadly into four regions; a) The hilly region along the easter border of the district with chain of mountains. In this region the main crop is rubber, tea and coffee. The forest is rich in timber and bamboos. b) The plateau region has several hillocks and areas of red soil. The main cultivation is tapioca. c) The valley region lying between the mountain and the coastal sandy soil. In terrain are paddy, coconut and plantain cultivation. d) In this coastal sandy belt, coconut groves flurish in places where fresh water is available.

3. The general quality of the land is clay loam, sand, sandy loam, red soil. Clay loam is suited for paddy, sand and sandy loam for coconut, red loam for hill crops like pepper, clove, cardomom etc. paddy, coconut and rubber. Red soil is suited for mangoes, coconut, and ground nut.

4. The local resources of water supply are tanks, open wells tube wells, channal irrigation, taps etc. Channel irrigation and tanks are used for paddy cultivation. Coconut and other plantation crops mainly depend on rain fall. The irrigation system in this district are Kothaiyar irrigation which irrigates about 60,000 acres; Neyyar dam about 50,000 acres. Chittrar dam irrigating about 17,000 acres.

5. Mostly trees are grown in forest areas which are used for lumber, charcoal etc. Teak trees, pineapple, banana and mangoes are also grown. Some special plants like cardomom, pepper, tea, rubber and palm are also grown. In forest area Vinca species are cultivated for medical purposes and it is also a commercial crop.

6. Mineral resources like Zircon, Rutile, Monazite, Illiminite, etc. are available.

7. This District is famous for tourism. Tourists both nationals and outside visit the important places in Kanyakumari District. They are Kanyakumari temple, Vivekananda rock memorial, Gandhi memorial in Cape Comorin, Ulakkai falls, Thiruparappu falls, Muttom sea shore, Colachel harbour, Padmanapapuram Palace and Museum, Vattakottai etc. It is not only a tourist place but also has its own historical importance.

8. The important occupational groups are Agriculturists, palmyra climbers, fisherman, masons, carpenters, midwives, bone setters, indigenous medical practitioners.

9. Seva Sangams (Social Service clubs), Mary Senai are examples of traditional mechanisms for community work and have been engaging themselves in cleaning public wells, helping patients, road maintenance in case of erosion, removing drain blockages, during heavy rains etc.

10. The basic sources of family income are coconut, paddy, palm juice and sea products. Some are engaged in net making, and others as agricultural labourers.

11. The basic crops grown in and by the community is paddy wherever irrigation facilities are available. During summer season pulses

are grown in the paddy fields. Tapioca (a variety of tuber) is grown in dry lands and hill slopes.

12. Cattles and goats are reared by the community in their houses. Some have sheep also and are utilized more for providing manure to the fields, pigs are also reared in some house for providing pork. Poultry on a small scale is kept in most of the houses.

13. The principle sources of wages employment are through factories such as mineral, timber factories, textile mills, agriculture and fishing operations.

14. The sources of cash income in this community are through paddy, coconut, tapioca, sea products, palmyra rubber, tea and cashewnuts.

15. There is no reliable data available regarding the distribution of income for the entire district. However a study conducted by the Planning forum of Hindu College, Nagercoil in 1973 reveal as follows[6].

Income	Number and percentage	
Below Rs. 100/- per month	72	30
101-200	82	34.2
201-500	59	24.6
501 and above	27	11.2
Total	240	100.0

16. The money supply is not even,and fluctuates according to different seasons. In post harvest season they tend to spend money lavishly. But in preharvest season they get loan from money lenders and wait till the expected harvest season. The fisherfolk get substantial money after a good catch and the money received is spent extravagantly

and no saving is being done. This naturally makes them to go to money lenders for loans. The lack of finance does have significant effect on their food habits.

17. Persons having large land holdings usually let out on lease to tenants who should give about 2000 kgms. of paddy for one acre of land. The average size of family holdings will be about half an acre and common ownership for rubber and tea estates.

H. Basic Health Data

1. The current crude birth rate in the community is:

Current crude birth rate : 25.0

Current birth rate in 1965: 28.8 (as registered. But there is under registration).

2. The crude death rate in the community is:

Current crude death rate: 8.7

Crude death rate in 1965: 9.5 (as registered. But there is under registration)

3. The current infant mortality rate is:

Current infant mortality rate: 63.5

Infant mortality rate in 1965: 74 (as registered. But there is under registration)

4. The most common diseases being treated in hospitals or clinics in the area are:

P.U.O. Anaemia, Dysentery and diarrhoea, Scabies, U.R.I. Helminthic infections.

5. The ten most common causes of death in children aged five to fifteen years in 1975 are:

Cause of death in Age Group 5 .. 15 (1974):

1. Acute Gastro Enteritis
2. Bronchopneumonia

3. Cardio respiratory failure
4. Diptheria
5. Meningitis
6. Enteric fever
7. Accidents
8. Tetanus

6. The 10 main causes of childhood mortality, e.g. 0..5 years are:

Cause of death 0..5 years (1974)

1. Prematurity
2. Asphyxia meonatorum
3. Acute Gastro Enteritis
4. Encephalitis
5. Meningitis
6. Pnenumonia
7. Tetanus
8. Enteric fever

Source: Hospital and Clinic Records.

7. There are pronounced environmentally linked health hazards.

8. Malnutrition is a major problem in the area,

More than 50% of children are malnourished. Accurate data are not available and it has to be surveyed.

9. The basis of the daily diet of the majority of the community is:

Major diet: Topiaco, Rice, Fish, Wheat.

10. Children are usually breastfed upto ten months to two years.

11. Solid foods are introduced after one year.

12. First foods, in addition to mother's milk, usually given to infants are:

Cow's and Buffalo's milk, Topiaco or Ragi kanji.

13. Foods usually given to children after weaning are:

Rice, Topiaco, Vegetables.

14. Foods which are not considered appropriate under certain circumstances, e.g. during pregnancy and lactation, in early childhood, during diseases, usually consumed by the population are:

During pregnancy and lactation

Eggs, Pappaya fruit, Mango fruits, Jack fruits are not considered appropriate.

During childhood and disease

Spices, Fish, Mutton.

15. The usual diet is:

Nutritionally inadequate for 0..5 age group

(No studies made however)

I. Education data

1. The different kinds of schools available to the community are: a. Primary schools (364), b. Middle schools(21), c. High schools (110), d. Colleges (12) and other educational institutions (22). Teacher training schools, Single teacher school (5), Blind school (1) and Training schools (2). It has been observed that the majority of schools are academically oriented and very few other agricultural related curricula.

2. The average years of schooling children receive is 11 years.

3. Facilities and opportunities for higher education both technical and non-technical are available within the district and also outside. Industrial training schools are located within the district. Facilities for those who want to take up Medical, Engineering and Law courses are available in the neighbouring districts.

4. 92% of the school age children are regularly attending the school.

5. The estimated level of literacy among the males according to 1971 census is 64.12% for males and 62.14 for females.

J. Nature and Extent of Community Involvement

1. In the Health activities participating families numbers 43,000 and these attend regularly, pay regularly and arrive at the Centres on the appointed days to the extent of more than 90% of all those registered. Volunteers continue to come forward to assist the Centre and for training.

The various co-operatives continue to function, more than 1000 workers each day work on the irrigation and land developing programme, and 1350 girls attend the net making.

2. Every time themothers with their children attend the Centres, groups of 20-25 receive instruction in Health Education matters. The volunteers serve the clinic regularly for at least a year and places are eagerly sought for the training courses, in order for them to be able to move on to become Health Workers and Health Guides. A major objective of these training courses is not merely to serve at the Centres, but to give a "preparation for life". When a girl marries it is not possible for her to continue in these mobile services, but it is deliberately planned by the programme that they will become exemplary wives and mothers, so raising the standards of health, welfare and living of their villages.

3. In the health programme families contribute a bi-annual registration fee and a bi-monthly fee also. This is collected at each attendance. The contribution has been determined by the project, arrived at through discussion with the community. The fees meet all the running costs and medications of the Centres (but not the foods, training, or purchase of vehicles.).

In the co-operatives, payment is made against loans and credits; a system of compulsory savings exists (a percentage of the catch by the fisherman, a percentage of the pay by the net-makers; 50% of the palmyra juice from the tappers.) Labour is provided on the irrigation project, and materials like stone are contributed for retaining walls, etc. Money and materials are contributed for physical facilities.

4. The "political endorsement" is to be seen only at the project level where collaborative activity takes place. (See the Channel Irrigation Project.) Otherwise there is no political involvement, nor are there any general fund-raising activities.

5. Some examples:

a) All the 43,000 families contribute money to the Health programme. There are 481 Volunteers contributing time.

b) In the Health Project 43,000 families (38,600 with income below Rs.150), perhaps totaling 75% of eligible families of the low income group with children under 5, are involved.

In the Palmyra Tappers Co-operative virtually 95% of those who could join (all within a radius of two miles belong) participate (total: 250).

In the Channel Irrigation Project help is given when it is requested. There are new areas served every six months. Of 1000 workers per day, 300-400 are more or less permanent (perhaps 10,000 different workers in all). Of Landowners, 75% have been involved so far, and 100% will be involved by the time 10 years will have elapsed.

In the Fisheries Project, out of 28 villages only 6 have started sangams so far (perhaps 25-50 families in each village). This presents about 10% of the population.

In the Fisherman Women Welfare, (Netmakers) 18 out of 28 villages on the coast (in 14 centres) are involved, with 1350 girls (perhaps 50% of unmarried girls) participating.

6.

K.S.S.S. Board of Directors	90%
K.S.S.S. General Body	50%
K.S.S.S. Executive	90%
Projects	
Palmyra Tappers Board General Body	90%
General Body	75%
Channel Irrigation	
(Members) Village Meetings	50%
Fishermen Sangams	
Members	75%
Health	
Members	92-94%
Net Makers	
Members (Daily)	90%
Production/Education Meetings	

7. There is an effective administration of projects. All projects are oriented to important activities for the participants, such as employment, and related to the way they make a living (palmyra climbers, fishermen net makers, etc...) The Health Centres distribute well-appreciated food and service.

8. The Sangams and co-operatives are an example of new types of organizations which have come into being as a result of the programme. The savings schemes and training programmes are others. The K.S.S.S. as a constituted District-level organisation is central to all the developments and grew from the proliferation and increasing scale of the programme.

9. The projects seem to be well supported over time.

SECTION IV

DETAILED DESCRIPTION OF INFRASTRUCTURE: SUPPORT TO COMMUNITY-BASED PROGRAMMES

A. Non-Health Personnel

1. K.S.S.S. is an integral part of the Catholic Diocesan structure and the main community work (identifying need, support etc.) relies in most part on, the activity and skills of the Priests and Sisters in each Parish.

There are 90 Parishes in the District and a total of 120 Priests and 400 sisters (the Sisters are largely working in schools).

Arising from the parish work there are various "pious groups", such as Catholic Action (SODALITIES, LEGION OF MARY, FAMILY LIFE MOVEMENT etc.), which in a general way direct attention to identifying "Community Needs" and attempt various support and promotion of development.

K.S.S.S. itself is under the Trusteeship of the Bishop of Kottar, a general body of 30 members and a Board of Directors consisting of a President and 6 members. The Executive staff consists of a Director (Fr. James) and 6 Project Directors with District Responsibilities for Training, Technical (Fisheries etc.), Women Development, Food for Work, etc. In addition, there are Project Directors for village-focused projects.

K.S.S.S. employs 12 Community Development Organisers; 6 of these are linked with the Fishery Sangams (cooperatives) and 6 with Agriculture (Farmers clubs, etc.) and Community Health.

There is of course the Panchayat structure which is the Government organization. (Panchayat has Block Development offices now called Panchayat Commissioners and these have mainly an Agriculture Extension background.) Although this is quite separate from the K.S.S.S. endeavours

it turns out that 2 Priests are the Presidents of their local Panchayats. Cooperation takes place between the organizations at the project implementation level (e.g. the Parakunna Canal digging activity.).

2. The population for which each worker is "responsible" differs with the task.

Roughly 90 Parishes comprise a Catholic population of 250,000 which averages say 2,500 but as the community interest of the Priest apparently extends beyond the Catholics, it can also be calculated as being five times that amount (Catholics comprise one-fifth of the population). The Sangam workers are in touch with villages of 3000 - 6000 persons. The organisation of the worker is through the Diocesan and K.S.S.S. structure. In the case of K.S.S.S. the General Body meets 4 times a year, the Board of Directors and Executive staff formally meet every 15 days. The day-to-day work is administered by the Executive Director and his Project Directors.

The K.S.S.S. operates three mini buses, eight motor cycles, and one car.

3. The Parish Priests have no formal Community Development Training, but over 24 years the work of Fr. James and K.S.S.S. has engaged the interest of the Priests, they follow K.S.S.S. activity closely and some seek to emulate the skills exhibited by the K.S.S.S. staff. (Fr. James himself began as a Parish Priest). Eight of the 12 Community Development officers were sent for training to the Indian Social Institute, Bangalore for periods of 3 months).

Recruitment (in the words of the informants) is on "a personal basis". "They have to be people who know their own community and wish to return there and dedicate their own lives." "The proper selection is most important; without committment ... nothing can succeed."

4. There seems to be little doubt that the Community Development workers have contributed to the rousing of "awareness" of members of the community and have successfully promoted and organised action projects. Each of these projects can be shown to have raised the living standards and well being of at least some members of the communities.

A lively debate continues to be in progress, however, as to whether "success" is to be measured in such term as individual or small group improvement of living conditions, or whether "success" can only be claimed where the fundamental structural causes of poverty, social injustice and exploitation of one group by another have been tackled and made inroads upon. The familiar welfare objectives of raising the standards of living, etc. must certainly have been in the minds of the initiators of activity twenty odd years ago, but they have argued since that where such progress has been made there are often real signs of improved community "spirit". They cite such examples as the decrease in group tension and a growth in mutual trust and willingness to cooperate. It is also of interest to note that the advocates of this position (the community workers concerned) have increasingly adopted, the language (jargon?) of "conscientization."

From our superficial observation of the situation here we are inclined to the opinion that the terminology is rather more revolutionary and abrasive than the activity. There certainly seems to be a

hesitation to push openly the conflict and confrontation elements of the conscientization position as we understand it. Those (in the main, persons some what removed from day to day concern with the programme) who have aruged the fundamentalist (WEBERIAN?) case for the making over of the social structure say that efforts to-date have been mainly alleviating activities and have helped the present situation to continue, or at worst have even reinforced it, in the face of the "contradictions" which would ordinarily have resulted in the downfall and replacement of the social strucuture. It is not for us to judge the merits of these arguments but it is noteworthy (as we have already remarked) that the vocabulary being used is increasingly strident and that the persons concerned have in the main welcomed and given serious attention to the "criticism". They say too that in recent times their efforts have tried to incorporate the views expressed by their critics (e.g. they say that the Primary Health Care programme has become more "family-oriented" and they point to the marked change of roles among some men and women that is an outcome of their 'liberating' projects for women generally). The Sangam efforts are also potentially explosive and may break the old system in time. A much more participatory emphasis has been adopted.

5. The problems associated with these programmes are numerous. This is to be expected, but we are told that such problems have spurred rethinking, renewed efforts, and although tackled perhaps on a crisis to crisis basis, has contributed to the dynamism and innovativeness of the workers. However some of the 'principal problems' might be directly stated as follows:

a) Occasional failure of commercial skills in securing adequate marketing and distribution systems for products.

b) Unexpected economic events such as the dramatic increase in the price of oil making it too expensive to use equipment such as a sugar refining plant and out-board boat engines.

c) Failure of the prawn catch, which has a high economic yield.

d) Mistrust of official cooperatives generally, due to earlier failures and misappropriations.

e) Chronic conditions of poverty and indebtedness which result both in an inability to raise capital and poor habits of debt repayment.

f) Chronic deprivation resulting in spending "sprees" when money is available and on special occasions, to the detriment of a sound sense of budgeting.

g) High incidence of community factionalism in a highly caste-conscious society.

h) Quarrelsomeness and distust within communities (eg. sabotaging of boats, destruction of nets etc.).

i) Suspicion of the motives of those who take leadership roles.

Lack of clear perception by the leaders themselves of the processes of the community and their appropriate relations to it.

j) The control exercised by money lenders and land owners over subsistence level communities and their open opposition to organisations.

k) Lack of, experience among the community of a sense of independence, a sense of cause and effect, ability to alter their own conditions,

ability for leader ship or constructive participation, of honest and effective administrative practice etc.

1) Some doubts as whether religious leaders should become involved in social development projects and especially in politically significant activities, etc. etc....

B. Health Personnel

INFORMATION SUPPLIED BY

	K.S.S.S.	Govt. (District Health Department)
1.	The following are the health personnel available:	
a.	Physicians	
	Nil	320
b.	Nurses	
	16 R.N.R.N. (Registered nurse and Registered midwife)	218
c.	Nurse-midwives	
	2 A.N.M. (Auxillary Nurse midwife)	146
d.	Pharmasist	
	6 R.M.P. (Registered medical practionar with three months Intensive training in Community health, Community development midwifery and home management.)	51
e.	Paramedical personnel:	
	16 Health guides (Secondary education certificate with one year intensive residential training on community health, community development, home management and mother child care.)	665 (Leprosy, P.H.Cs, Private Hospitals, Voluntary agencies)
	16 Health guides (Secondary education certificate with one year intensive residential training on community health, community development, home management and mother and child care.)	

K.S.S.S.	Govt. (District Health Department)
16 Health guides (Secondary education certificate with 3 to 5 years experience in hospital work. Four months residental training on community health, community development, home management and mother and child care and mid-wifery.)	
42 Health educators (academic graduates with three months intensive training on community health, community development, home gardening.)	
64 Health workers (Secondary education certificate with five months intensive training on community health, home management, and mother and child care after one year of field experience as voluntary extension workers.)	
6 Home science Diploma holders.	
4 Community Development and Child care diploma holder.	
10 Inservice trainees.	
17 Stipendary inservice trainees	
199 (will be undergoing training)	

2. Where are they located:

a.	In the training centres (Muttom and Thirumalai for trainina and field supervision)	11
b.	In the villages	148
c.	Presently undergoing training at Muttom	28
d.	Presently undergoing training at Thirumalai	12
	Total	199

Government: Headquarters: Kottar Taluk Headquarters Hospital: Boothapondi, Kottaram, Kuzhithurai and Padmanabhapuram at Thuckalai.

International Cancer Institute; Neyyoor.

Primary Health Centres: Agasteeswaram, Chenbagaramanputhur, Rajaakamangalam Thurai, Karunkal, Kuttakuzhi, Kothanallur, Muttom, Edaicode and Arudesam.

	K.S.S.S.	Govt. (District Health Department) T.B. Hospital: Asaripallam. Govt. Dispensaries: Kottaram, Thengapattanam, Thoothoor, Aramboly, Ganapathipuram, Kulasekaram Azhakappapuram. Mission Hospital: Neyyoor, R.S. Mission Hospital, Leprosy Hospital Thuckalai, C.S.I. Mission Hospital, Marthandam. Ayurvedic Hospital: Asramam, Thiruppathisaram Private Hospital: 25 .. 30
3.	Nil	There are traditional midwives/birth attendants who have received additional medically-approved training and upgrading. 210 traditional Dais: Trained for a period of three months in seven Primary Health Centres namely Agasteeswaram, Chenbagaramanputhur, Muttom, Rajackamangalam Thurai, Arudesam Edaicode and Karinkal. Kit box provided, but not replenished.
4.	Nil	Traditional Practitioners are present in this District. But they are not recognised by the National Health Authorities.

5. The "contents" of the Care Provided by the people identified above are:

a.	Drugs and medicaments	The "contents" of the Care provided by the people identified above .
b.	Facilities-Clinic room with minimum facilities for conducting health education and ante-natal check-up and	Aurvedic, Siddha, Homeopatic practioners and quacks who use modern medicine are in existance

K.S.S.S.	Govt. (District Health Department)
care of other first aid and minor ailments is the responsibility of local leadership of the community.	in this District. They render curative services, but not preventive or promotive health services. These practitioners are usually trained indigenously without undergoing any regular training course in the Medical Colleges. Besides using their special medicines, they also use modern medicine such as pencillin, tetracycline etc.
c. Equipment	

6. Other Health Care and related roles:

a. Comprehensive Health Education. (Food and nutrition, hygiene, sanitation etc.)	Nil
b. Home Visiting	
c. Home Gardening.	
d. Sanitation.	
e. Nursery schools.	
f. Common fund for providing environmental sanitation in the village. (25 ps. scheme) Refer annual report 1974.	
7. These activities were started from the beginning of the Project one by one from 1971.	N/A

8. There are problems associated with the retention of these people in health roles:

Retention of the people. The training of these Paramedical workers is first of all a personal training for life and their employment in a project ends with their marriage, as they stay cannot continue to stay in the team living in the villages after their marriage. This offers new chances for other girls to be trained. Those who married are expected to continue to be useful in the village where they are settled. The original group of Staff Nurses have been 'brain drained to more lucrative posts in Hospitals	There are problems associated with the retention of these people in health roles. As the Government is stepping up the health facilities, and as more number of professional doctors, from Medical Colleges are released, they face acute competition. Some of them take up other profession if they do not earn further livelihood ade adequately.

K.S.S.S.	Govt. (District Health Department)
and Abroad (Arab Countries). However the current 16 Staff Nurses (3 are lay nurses) are a stable group.	
9. Problems exist with respect to supplies for these people:	
a. Drugs and medicines for preventive care are supplied by the project for the registered members. According to availability of funds medicines for preventive purposes are available, and usually have been well budgetted for.	Problems exist with respect to supplies for these people.
b. Supervision: The training staff is each asked to go one day in a week to supervise and follow up the workers in the villages. To begin with there were difficulties but it is now a built-in part of the training and service programme. Training staff are directly linked to the supervisory process.	They acquire medicine directly from the Medical shops from their own funds and they deliver services to the people of payment. There is no supervision or training provided by Government.
c. Training: A latent problem is that to date there has been no need to formally obtain government approval of the training as it is geared to social family welfare and staff nurses handle the health care. But K.S.S.S. would welcome Govt. providing technical support so as to meet the very highest standards from the medical point of view. There was an early problem of placing workers to serve before the training programme was ready for them. This led to a reluctance to revert to trainee status. However this was soon ironed out by not appointing any one to serve before training commenced.	
There is a minor problem of conveying to workers the concept of training as truly a life-long (certainly a service-long) process. There is a tendency to think that	

K.S.S.S.	Govt. (District Health Department)
at the end of a course one is completely and finally trained. The current system however is overcoming these difficulties.	
d. The vans are available in the project to take the staff to the remote villages of the district and to take the staff for field supervision. But clearly the cost of vans, maintenance in difficult terrain and soaring oil costs are real and continuing problems.	
10. Financial Problems: The only financial problem which the project is facing for the time being is the cost of purchase of vehicles which cannot be met by the contribution of the people and also the major portion of training expenses has to be met by grants from abroad.	Since they function as private Medical practitioners on commercial scale, there is no financial problems related to Government.
C. <u>Physical facilities</u>:	
1. Types of treatment facilities:	Allopathy and Ayurvedic Refer section IV-B-2
a. First-aid and symptomatic treatments - K.S.S.S. clinics primary health centres Govt. hospitals Vountary dispensaries and hospitals Private practitionars.	
b. Major ailments and minor surgery Govt. Dt. hospital, Private hospitals.	
c. Infectious diseases - T.B. Leprosy, Cancer Govt. and Voluntary specialised hospitals	
2.	Hospitals: Government Hospitals 25 Mission Hospitals) 25-30 Private Agency) Ayurvedic Hospital 2 Hospitals Beds: Govt. Hospital 745 Mission Hospitals) 1750 Private Agency)

K.S.S.S.	Govt. (District Health Department)
3. Location a. K.S.S.S. centres are located in 126 centres in the rural remote places of the Dt. b. Primary Health Centre are situated in the area of each panchayat union. Govt. hospitals are situated in the main villages of each taluk. (4taluks in the Dt.). The voluntary and private hospitals are situated in important rural centres. Private hospitals are concentrated in Nagercoil town No. of clinics, a) K.S.S.S. is conducting 126 preventive Centres in different centres in the Dt. providing preventive care and first-aid 43,000 families in the Dt. b) Voluntary dispensaries. c) Private dispensaries. d) Govt. dispensaries.	Clinics are available and are located: Refer section IV-B-2
4. Sources of Financing. K.S.S.S. preventive centres financed by local contribution.	Particulars about initial investment recurrent costs labour in kind are not available.

D. <u>Health Care Services</u>

1. <u>Immunization</u>

a. D.P.T. & T.T. is carried out regularly through the C.H.D.S. in the district according to the availability of vaccine. K.S.S.S. centres are utilised by the staff of the P.H.C. to meet the children and provide immunization. b. B.C.G. vaccine is provided by a special team of health workers under District tuberculosis officer. Some of the staff of the K.S.S.S. have been trained by the Govt. staff to utilise B.C.G. vaccine in the villages.	Immunization: D.P.T. 9,825 children 0-5 years Polio Not available in Govt. Hospitals B.C.G. 70,965 (all below 20 years) Smallpox: Primary Vaccination: 34,991 Re vaccination: 1,95,767

K.S.S.S.	Govt. (District Health Department)
c. Measeles vaccines are not available in the country.	
d. Polio vaccine is obtained by K.S.S.S. from private firm from Bombay which imports them from Russia, so far 10,000 children have been immunised in the clinics.	
e. Cholera, Small pox, vaccines are utilised during epidermy.	

2. It is expected that the total 43,000 families will be covered for all immunization,to date 10,000 have been covered. The total is expected to be reached within 18 months (Smallpox everyone has already been covered.).

a. Safe water supply. Except for drought condition which has been prevalent this year in most of the villages of the district, sufficient and safe water supply is provided through wells over head tanks hand pumps and open drinking wells.	Safe water supply is available in urban areas. Only 25% of the rural areas receive safe water supply. Rest of the villages have been provided with wells, which are not protected. Sanitation: Condition is very poor Vector control: No control measures.
b. Adequate sanitation is not provided in most of the rural areas of the district 99% of the houses in rural areas are not provided with latrines. No proper facilities are provided for environmental sanitation like soak pit and waste pit and drainage is not adequate in most of the villages.	
c. Vector control - The Government has practically eradicated epidermis of Malaria. Cholera and Small pox epidermis are under immediate control.	
3. Assistant to mothers during pregnancy. K.S.S.S. provide ante-natal and post-natal care to the mothers attending the clinics and during home visits. Timely advice is given to refer difficult cases to the hospitals. 95% of the deliveries are conducted at home by traditional helpers and many women are frightened to go to the Govt. hospitals for fear of compulsory sterilisation.	Assistance to mothers during pregnancy. Antenatal and Post-natal work are done by the Health Visitors and Auxiliary nurse Mid-wives. But the work is not satisfactory.

	K.S.S.S.	Govt. (District Health Department)
4.	Health and nutritional education is systematically provided in K.S.S.S. Clinics by health workers who conduct 20-30 minutes health talk to groups of 20 mothers who attend twice a month, the clinic in the villages. The following subjects are covered. Nutritional Class and demonstration, Home Management, Home Gardening, Personal and environmental hygiene, Child Care, First Aid, Food habits These classes are implemented and followed up during the home visits by the health workers.	Health and Nutritional education. Health and Nutritional education is expected to be given by Health Visitors and Auxillary Nurse Midwives, but the work is poor.
5.	Simple Medical Care a. Worm infestation b. Under malnutrition c. Cough and Fevers d. Scabies e. Diarrhoea f. Sore eyes	Available at the sub-centre, but not utilised properly by Maternity Assistants in the sub-centre.
6.	First-aid Minor cuts, and burns.	First aid and emergency treatment Available at the Primary Health Centre level.
7.	Drugs are supplied for treatment.	Drugs for treatment or prophylaxis. Sufficient drugs are not available for treatment and prophylaxis.
8.	Facilities for referral of serious conditions. Primary Health centres Government and private hospitals are available in the main centres of the district.	Government Headquarters Hospitals and Neyyeer Hospital are available for referral services. But there are no organised referral services.

K.S.S.S.	Govt. (District Health Department)
9. Other services	
A number of ayurvedic and native physicians are available in the district and it is some times difficult to identify those who are proficient and those who are cheats.	Other voluntary agencies, Kottar Social Service Society, Kanyakumari Social Service Society, Mission Hospitals, Salvation army also render the basic Health needs.
E. Utilisation	
1. Problems:	Problems have been identified in the normal utilization of these services offered.
a. Primary Health Centre are identified with family planning and are after avoided for that reason.	Poor utilisation of health services, provided by the Government Hospitals in rural areas. In urban areas, the utilisation for major illnesses is satisfactory.
b. The socio-economic poor section of the population cannot afford the competent services offered by voluntary and private hospitals.	
2. Economically poor section of the population utilises more the services offered by K.S.S.S. in the villages while the better off can avail themselves with hospital care.	No particular groups use the services more than others.
3. Kottar Social Service Society has opened its centres where-ever the request from the community was the strongest and therefore these centres are located closer to the low income groups. Distance from clinics is not a major obstacle to utilise its facilities provided it is at a walking distance.	Are services located closer to some particular groups within the community than to others, and is distance from services soon as a major obstacle to utilization?
	No major obstacles is provided by distance of location from services.

F. Other Health-related Services Available

1. The health programmes described in this study are direct outgrowths of the general developmental activities of K.S.S.S. (and the efforts proceeding its formal constitution in 1963) which go back over 20 years. Some of the more important of these activities with varying kinds and degree of community participation are as follows:

Date of starting	Name of Project	Place	Purpose
1954	Palmyra Co-operative Society	Parakunnu	Joint effort of Palmyra climbers to improve their working and living condition.
1962	Palm Mortgage Scheme	Parakunnu	Joint effort of Palmyra Climbers to become quasi owners of palm trees.
1964	Palm Sugar Plant	Parakunnu	Technical improvement for manufacturing crystallised sugar from palm juice. (Eventually this input was not utilised economically due to the increase of juice and non-availability of light fuel oil).
1965	Palm fibre unit	Parakunnu	Joint effort of women to get employment by preparing palm fibre for making brushes in India and abroad.
1965	Saw-Mill-cum-Brush unit	Parakunnu	Small unit to manufacture brushes and furniture.
1967	Mechanisation of catamarams (fishing crafts)	Muttom	First attempt to improve the fishing condition of local fishermen by providing imported out board engines. The attempt was technically successful but failed due to the lack of preparation and participation from the fishermen.
1967	Nylon Net manufacturing centre	Cape, Muttom and extension to 11 other coastal villages.	Organisation of women's labour to provide new fishing nets made of nylon and to prevent exploitation of their labour.
1967	Land reclamation and housing scheme	Muttom	First attempt to interest fisherman in agriculture and settle them at some distance from the shore.
1968	Channel Irrigation Project.	Parakunnu with extension to Vilavancode and Kalkulam Taluks.	Joint effort to organise the local communities to dig feeder canals and terrace the land of marginal farmers.

Date of starting	Name of Project	Place	Purpose
1969	Fertilizer depot.	Parakunnu	Supply of fertilizer to farmers on cash and on credit basis.
1971	Resettlement of Fishermen	Midalam, Kurumbanai Puthenthurai Pattanam	Housing scheme for fishermen who have lost their houses by sea erosion and Creation of revolving fund for housing.
1972	Potters Sangam	Thirumalai	Organisation by the potters into a co-operative to liberate themselves from the hands of the money lenders and organise their work on joint pattern.
1973	Young Fisherman Sangams	Manakudy Enayam and other coastal villages	Organisation of the young fishermen by process of self awareness and common action for marketing fish; saving and improving their occupation.
1973	Boat Building Training Centre	Muttom	Provides technical training to young boys of the fishing community for building fibre glass boats for the Sangams.
1974	25 Paise Scheme	Kanyakumari District	To conscientise the mothers of the lower social economic status in the Dt. in a joint effort for improving the environmental health conditions and give them the power of decision in fixing the priorities.
1975	Handicraft Training Centre	Thirumalai	To organise the young women of the locality to provide them with training and production in handicraft and adult education.

Only some of these outlines are described here :-

The Palmyra Climbers Project has been described in 1969 as follows:

"So far very little has been done to save the palmyra climbers from their miserable condition. The work, restricted to one particular community consists in climbing to the top of palm tree to extract from the stem a few drops of liquor which is not allowed to ferment, thanks to the addition of calcium in the form of fresh lime collected from sea shells. Further climbing during six months in a year, thirty to forty palmyra trees a day requires a tremendous amount of physical strength. Most of them are too poor to be the owners of the palm

trees; they are too poor to get those palm trees in an annual rent and they have to climb on a Varam system which means that 50% of the palm juice collected has to be handed over to the owner of the tree.

The tapper's wife will be seen taking away the palm juice from the bottom of the trees to her house where she will sit for four or five hours in front of an open fire to evaporate the 85% of water and concentrate the juice into a blackrock of sugar called jaggery.

The children of the climbers will be seen from 4. O'clock in the morning on the road leading to the forest 10 miles away where they will collect a load of fire wood which will be used to boil the juice. There is no question of schooling for them. This is in short the situation of the climbers' family in many villages in the Kanyakumari District.

In 1954 an attempt was made to study and implement a comprehensive approach to the development of a climbers' village at Parakunnu. Palm-gur Co-operative Society was registered which has now 360 members and a share capital of Rs.9,699 and a business of 1-1/2 lakhs of rupees was turned during the year 1968-69. In discussions, and common action a number of initiatives were taken.

a) By a palm-mortgage scheme, about sixty tappers have become practically tree owners of 1000 palm trees. A loan of Rs.20,000/- had been secured from the Government for the Scheme and Rs.11,000/- has already been applied to Misereor for the same purpose.

b) Instead of producing jaggery which was on a very low price because of its low preservation capacity, attempts were made to manufacture crystallized white sugar out of palm juice. At first pedal driven centrifugal machines were used to seperate the sugar from the molasses. Then the Khadi and Village Industry came from the Central Government and installed at their own cost a one-third ton palm sugar plant in the land placed at their disposal by the Parakunnu Co-operative Society. MISEREOR cam forward in 1964 with a grant of Rs.32,420/- and the loan of Rs.32,700/- (of which Rs.17,884/- is still due).

Crystallized white palm sugar was extracted and the return of sugar was only 7 kilos (per 100 litres of palm juice). A lot of loss was due to the burning of sugar and immersion due to direct contact with heat in the first process of deliming. The plant was not upto the mark and improvement was found necessary. Secoure Catholique of France provided the imported equipment required, a Kestner evaporator, and CAFOD gave the boiler which was bought, at Bombay. CAFOD gave also a pump and overhead tank for the existing well. During the year 1969-70 the new sugar plant will be inaugurated. In 68-69 the Co-operative Society has worked with a net profit of Rs.4,205.76 ps after having distributed a bonus equal to one month's income to each of the tappers engaged in the palm-mortgage system.

c) The sugar plant at Parakunnu will provide work and better income to a great number of palmyra climbers, but at the same time it throws out of employment an equal number of women who were boiling the palm juice to manufacture jaggery at home. The palmyra tree gave the answer to the problem. The young palmyra during the first fifteen years does not produce juice but its branches provide a very precious fibre which is exported all over the world for manufacturing hard rough brushes. MISEREOR provided with a grant of Rs.7,000/- in 1965, and Rs.3,704/- in 1968, and a loan of Rs.26,000/- of which Rs.16,250/- is still due. Sixty girls are employed continuously and bring a turnover of Rs.1,23,000/- annually. In the next compound, under the Madras State Corporative Movement, 50 men are engaged in the final process of dyeing the fibre, baling it and despatching by lorry to Tuticorin harbour for export to places like Copenhagen, Hamburg, Antwerp, Liverpool, London, Montreal, New York and son.

d) Palmyra fibre produced at Parakunnu is sent all over the world to manufacture brushes. Why not have brushes made for India also? It was a natural development in the process of providing employment for a number of boys and girls who had studied in Secondary Education, and were idling at home. For manufacturing brushes, wood work is required. Thereafter a small unit with a number of machines for working the wood, was started; rotative saw planer, lathe, drilling and trimming machines were provided and brushes made of palmyra fibres, coco fibres, bristle nylon came out and were despatched to mills and important shops in the South. Another section provided furniture for the local needs; another section still provides wooden equipment for housing (doors and windows, roofing and wooden electrical equipments). After a few years of hard beginning it is now self-supporting."*

The report summed up:

"The evaluation of the works started in this palmyra climbers village at Parakunnu, is quite interesting to see the natural development in action; one improvement creating new problems which bring with them new solutions; another interesting aspect is that each and every step taken was the result of a common discussion with the people and except for the impetus and financial assistance the whole work was executed by the people themselves. There is really a new life in this village."**

The Vilavancode Channel Irrigation Project has been described as follows:

"Government has provided the Vilavancode Taluk with a network of channels called the Neyyar Irrigation Scheme. 9,000 acres of land

*Kotton Social Service Annual Report 1968-1969 page 11-13.

**Ibid page 14.

have to be irrigated by this system. But after fifteen years of its existence, 2,000 acres only have been reclaimed for paddy cultivation.

The reasons were:

1. Small feeder channels had to be dug in private properties to bring the water upto the dry lands to be converted into paddy fields.
2. Most of the land being on the slope area they have to be levelled at great cost.
3. As most of the land holders possess small areas below fifty cents, they are not able to secure the loans provided by Government.

To help these poor small farmers the project had been started. It provides them with labour to level the lands under Food for Work, with the difference that the labour has to be repaid in small instalments after each crop. This scheme provides also the farmers, on a loan basis, with implements for levelling and cultivation, seeds and fertilizers and pumpsets for lift irrigation. A tractor rental service is also provided under this scheme."

"The amount received back from the farmers on the loan granted has to be utilised as a revolving fund for the continuation of the scheme during the following years."

The report sums up:

"So far a total of 8 miles of small feeder channels have been dug in a dozen places.

This scheme is welcomed by all. Poor people get work. Small farmers get their lands fit for paddy cultivation, without having to spend anything of their own. Government sees the benefit, the channel reaching finally the people. The great risk taken by the K.S.S.S. was the repayment of the loan. So far the confidence placed in the poor farmers has been well placed and loans have been repaid without necessitating any legal means."*

The Fisherman's Sangam Project has been described as follows:

"The socio-economic conditions of the fishermen community of Kanyakumari District presents a bleak picture against the background of the developments made by other communities in the same district. The tale of woe begins right from the nature of their occupation. As it is subject to the fluctuating fortunes of seasons, which are becoming more and more unpredictable, their condition very often

*Kottar Social Service Society Annual Report 1968-69, pages 4-6.

borders on the fringes of economic instability and social insecurity, bringing in their wake misery, poverty and desperation. The situation is further aggravated by the unscrupulous exploitation of the fishermen by the money-lenders and merchants. On top of these, their primitive method of fishing which brings poor catches ashore, renders saving impossible, leading to economic stagnation and periodic starvation. Although the older generation is reconciled to this situation, it is heartening to see that the younger generation is beginning to realise the gravity of the situation, but is perplexed at their inability to find the way to solve this problem. So far there was no constructive proposal for a planned approach to help the fishermen to liberate themselves. The Govt. sponsored Co-operative Societies proved to be a blighting touch and have fallen into disrepute. Here the KSSS tried to be of help.

Formation of young fishermen sangams:

At first, the KSSS proposed the idea of forming a cooperative sangam for young fishermen. Their reaction was one of scepticism and indifference. It was mainly due to their sad experience with the Government sponsored Cooperative Societies. However, KSSS was confident that proper education on cooperative ways of action would definitely dispel their diffidence on cooperative societies and convince them that it was the only way out to achieve the goal of human liberation. In fact the correctness of this approach of educating the fishermen in the techniques of cooperatives is vindicated by the willingness of young fishermen of Kurumbanai, Manakudy and Pillaithope to organise Young fishermen Sangams.

The Young fishermen Sangam will operate in two stages. In the first stage, marketing and pawning schemes will be introduced and in the second stage mechanised boats.

Marketing and Pawning scheme:

The first step in the process of liberating the fishermen is to free them from exploitation of the money-lenders. As they lack the sense of saving they become an easy prey to money-lenders, who levy an exorbitant interest, particularly during the off-seasons. There are two ways through which a man can get loans from the money-lenders. In one case they get loans by surrendering to them the right of selling their fish. This is a kind of slavery and the following explanation will show how the fishermen are exploited in this manner.

Usually a fisherman gets a loan of Rs.100/- to 150/-. The usual interest is 3% per month and Rs.36% per year. If the loan is taken for prawn nets, the money-lender, who is usually the auctioner, takes 5% by way of interest and also a commission of 6%. Recent statistics show that the money-lender cum merchant gets for the 3 months season

an interest of 98% to 125% in a year. Moreover, once a loan is taken from such a money lender, the fisherman is obliged to sell his fish exclusively to him; of course the price is fixed in an arbitrary manner. This deprives him selling of his fish at a higher price in the open market."

"In the second case, the fishermen can get money by pawning either gold or fishing implements. If the pawned article is gdd, the interest is 36% per year and for fishing implements, it is 72%. Besides, pawning involves the risk of loosing the pawned articles if he fails to redeem them within the stipulated period.

The primary aim of the Sangam is, therefore, to liberate the fishermen from the hands of the money-lenders by introducing marketing and pawning. The scheme works as follows.

Marketing: The Sangam will appoint one or two salesmen, who has some experience in marketing. He will be responsible for selling the fish from the members and collecting the money from merchants. Marketing will be done partly on cash payment and partly on credit. When the fish is sold the salesman gives a receipt to the fishermen showing the price of the fish. On presentation of the receipt, the Society, after deducting 5%, gives the amount. Out of the 5%, 3% is retained to meet the administrative expenses and 2% for compulsory saving in the name of the fishermen.

Pawning: Under this scheme the members can pawn gold or fishing equipments at 5% interest per year. The period for redeeming the article is nine months for fishing equipments and one year for gold. During this period 10% of the duty catch is taken towards the repayment of the debts.

Mechanisation programme:

While modern technology has made great inroads in almost all the industries including the fishing industry in other parts of our country, it has not made its impact on this area. Even if the people are ready to be benefited by its use, its cost is beyond their purse. In view of this critical situation, the KSSS is intending to help poor fishermen by organising them and encouraging them to collect within a period of 6 months to one year, a share capital of 500/- per member, which is well within the range of poor fishermen. Once the members complete their payment of share capital, order for purchase of boats will be placed. Five members will be working in the boat for a period of one or two months, each in turn, until a sufficient number of boats are bought for the Sangam. The total income from a boat will be divided as follows:

35% will go to the crew, while 30% for the payment of loan, 20% for the fuel and the maintenance, 10% for the general fund , 2% for saving in the name of the crew members and 3% for administrative expenses. The general fund will be utilised for the purchase of more boats."*

In 1971 there is an evaluative comment "The main objectives of the I Phase have been successfully achieved. Fishermen are fully convinced that the mechanisation of the Catamarams brings in a substantial increase in their catches. As they are very clever fishing skill, they will slowly find out new methods and new means for improving their catch with the help of mechanisation.

The project has not been able to change their traditional mentality which is to spend immediately all the money they gain and try to avoid repaying the loan! On these two aspects the project has been partially a failure. Only under threat and compulsion 1/3 of the amount due for repayment has been collected. Although objectively it is a partial failure, knowing the character of the fishermen, subjectively it is a success to have been able to collect so much !"**

In 1974 Annual Report sum up:

"100 catamarans were mechanised at Muttom with 18 HP Evinrude outboard engines powered by petrol and kerosene. Although these engines were given as free gift to the fishermen of Muttom, an amount of Rs.1,200/- has to be collected from each fisherman towards the custom duty. The mechanisation of catamarans has proved successful technically and economically viable provided the fishermen are assured to get the fish, mainly prawns. Unfortunately for many reasons, the catch of prawns on the off-shore has been very poor. 37 fishermen have taken their outboard engines to the Eastern coast south of Tuticorin where they have been found very successful. Now that the cost of petrol has considerably gone up the extension of the scheme is becoming more and more difficult. Thus the first stage of mechanisation has opened the mind of fishermen towards the purchase of bigger boats which can go for off-shore and deep sea fishing. Different types of hulls were experimented during these five years.

a. A 21' plywood surf-crossing boat has been built in India with a plan from FAO. It was motorised by o.b. engine and later by 11 HP Kirlosker marine diesel engine.

b. Six 21' wooden Doris boats were received from Senator Ckairaux of France. These boats are excellent for beach landing, thanks to their flat bottom and their retractable propeller. One such boat was built in India and is plying with Ruston diesel engine.

c. One small craft made of ferro-cement was constructed on an experimental basis and has awakened the attention of fishermen.

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*Kottar Social Service Society Annual Report 1974 pages 8-12

**KSSS A Statistical Study 1971, page 4

It has been the first step towards construction of a 54' F.C. trawler in collaboration with the Fisheries Department of Tamil Nadu, which will be used a mother ship to tow catamarans to the Wadge bank, 30 miles south of Cape Comorin.

d. Four 15' Fibre glass dingies were built at Coimbatore and have proved the advantage of reinforced fibre glass boat construction.

The problem of marketing fish was thoroughly studied and different minor experiments were tried.

Preservation of lobsters and prawns has been studied and eventual starting of deep freezing with plate contact freezer has been proposed.

A boat building yard of the construction of hulls made of plywood fibre glass and ferro-cement was established and the service of a qualified technician has been secured from abroad.

One batch of 7 graduates have completed the first training in fibre glass boat construction and 4, 24' boats have been completed. One technician of the Department of Fisheries has been deputed to KSSS and has been sent to Canada for five months training in advanced technology of Ferro cement boat construction.

Besides the activities suggested in the plan of operatinn, the following additional works of development for the welfare of fishermen were implemented.

The High School at Muttom conducts a job oriented course, imparting to the students, besides academic education, an additional training in fishing technology which keeps the students in touch with the sea."

Fisherman Women Welfare

The Girls net making project has been described under the heading of "Liberation of Women" as follows:

"In the coastal villages, while men are busy fishing, women and girls idle away their time in their houses gossping and fighting. To provide them occupation and a social status in the society, nylon net making centres were opened in 11 villages of Kanyakumari district.

Instead of purchasing nets from abroad, KSSS thought it wise to familiarise the fishermen with nylon nets manufactured in their own village out of the twine made in India. Permission was obtained from the department of Fisheries to get the twine directly from the Garware company in Bombay.

In order to avoid the temptation for the fishermen to sell in the black market the twine which they receive from the co-operative Society and in order to fight against the exploitation of women's labour in manufacturing nets, two centres were started where girls were taught the techniques of manufacturing nylon net. A part of their wages is paid in cash and the rest in kind (American food under food for work.)

Misereor came forward with funds for purchase of twine.

From 1971 the number of centres has been growing up to 13 centres with a total of 1200 girls fully engaged in manufacturing nets.

Since the beginning of these centres, each girl working there was urged to open a personal Bank Account. As a result the amount of savings stands as high as Rs.79,596/-. The nationalised Banks are coming forward to supply loans to the fishermen for purchase of catamarans and nets. The savings of the girls stand as guarantee for the loan taken by their fathers and brothers. It is interesting to know that the moral pressure exercised by these girls on the family has been such that the repayment of loans is remarkably regular. In the villages where the loan scheme was launched an amount of Rs.49,950/- has been issued as loans."

The report adds a postscript which illustrate well the one thing leading to another process under the heading "Problems and hopes".

"The energy crisis has affected severely the supply of lactane, raw material required for making nylon and the company of Bombay which has the monopoly of manufacturing it, has decided to stop production of medium and big size twines and has increased considerably the rate of the twine which is still manufactured. In spite of the increase of rates, the fishermen are willing to buy. Is there any hope for the future?

There is a ray of hope in finding a substitute to replace the nylon twines made of HDPE (High Density Polyethylene) which is available in India. Two companies are manufacturing the material BDEP, the cost of which is much lower than that of nylon. A dozen of small industries are manufacturing twine from HDEP for making ropes and thick twines for trawlers. We have contacted these manufacturers with the request to provide us samples of twine of small thickness for trials; if the trials are successful, we intend not only to purchase this twine but eventually to manufacture it ourselves."*

The Community Health Development Project (CHDP) operates as follows:

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*Kottar Social Service Society Annual Report 1974, page 20-22

Mothers are given registration cards and decide for themselves which day of the week and time of the day is most convenient for them. (The clinics are arranged accordingly). A group of 20-25 mothers with their children assemble at the appointed time.*

They are then given health education "talks" by a trained health educator, (nutrition, the best use of the Catholic Relief Service foods, balanced diet, hygiene, personal and baby care, cleaning and arranging of the house, sanitation etc.). The talks are accompanied by demonstrations. (We observed a rather didactic approach in these talks but some participatory discussion took place.)

The health talk is followed by a medical check up of the mother and children by the Staff Nurse and individual attention and advice is given. The child's weight is recorded on special growth charts. Where necessary, a simple range of medicines are dispensed; an immunisation programme is implemented; and vitamin capsules are distributed. At this juncture again the nutritional side of the programme is emphasised by the staff and efforts again made to encourage the mothers to make the best use of the food to be distributed for the full benefit of the child.

The supplementary food, calculated as a 15 days supply, is then given to each family. Two or sometimes three of the following foods are available.

1 lb. of milk powder
1-1/2lb. of W.S.B. (Wheat/Soy, blend precooked and prepared with mineral and vitamin fortification)
1 lb. of bulgur wheat
1/2 lb. of oil.

The equivalent cash value is between 5 and 8 Rs. per month. per family. (It is clear that this food is an incentive for the families to attend the centre and is much appreciated).

The mothers pay regularly:

The registration fee (for each 6 months)	1 Rs.
Health Centre fee (per visit, twice each month for a mother and a child)	45 paise
Health Centre fee for pregnant mothers (the mother with no child under five yet per visit twice each month)	25 paise

*An impressive regularity is achieved; well above 90% of those expected keep the appointment.

In 1974 the annual budget for 36,800 registered families was given as:

RECEIPTS

Registration fee at Rs.1/- for 6 months for 36,800 beneficiaries	Rs. 73,600
Clinical fee for 36,800 families at 90 P./month	Rs. 3,88,800
Clinical fee for 800 pregnant mothers at 50 P./month	Rs. 4,800
Total	Rs. 4,67,200

Expenditures

Pay of staff - administrative staff, doctor, 21 teams of nurses and health workers, drivers, watchmen	Rs. 2, 36,880
Renumeration to voluntary village extension workers on clinical days	40,300
Purchase of Medicines	1, 08,000
Travelling Allowances and maintenance of vehicles	28,800
Stationary	24,000
Training expenses	24,000
Unforseen expenses	5,200
	Rs. 4, 67,200

There is a follow up programme of regular Home Visits to evaluate how the mothers implement the programme, "to remind them and then help them to do so". The Visitors stress especially the need for bringing clean containers for storing and preserving food. They try to see how far the food is being given to the children and give practical demonstrations in the home.

One observer has summarised*: It is too early to have any big changes or results, but where the mothers in the beginning were only concerned on receiving the food mostly to have for a few days a good meal for the whole family, would hardly listen to what we wanted to tell them and even were tempted to sell the milk for a few Rs. to

*K.S.S.S. Annual Report 1974, page 4.
Survey Report of Midalam (Conducted by S.T. Hindu College Sociology students.)

what we wanted to tell them and even were tempted to sell the milk for a few Rs. to buy some local foodstuffs, there is certainly already more interest in the educational part of the clinic, the care for the children--they some time come more clean, bringing proper containers for the food commodities--in many cases the health condition of the children is improving and we hope that with perservering and united efforts this Health/Nutrition programme may serve the people to its full aim for better, healthier and happier families."

This pattern was improved upon and has been described as follows:

"After three years' experience, it was found out that the programme was having its own limitations; it touches only the mother and child and not the whole family. Health instructions about hygiene and sanitation cannot be put into practice unless drinking water facilities, latrines, drainage are provided in the village. Consequently the second phase of the project was launched.*

The 25 paise scheme

Quite an original idea is the 25 paise scheme by which 36,800 families, beneficiaries of the Community Health Programme, contribute 25 paise each, once a fortnight on the clinic day to a common fund for health development in the district. The amount so collected is divided every month in 6 parts which are given to 6 villages selected by lucky-dip. At the initial stage it is envisaged as a self-help project to provide drinking water facilities, latrines, drainage etc. in the villages. This self-help community development programme has attracted the attention and appreciation of many an agency in the social field. This CHDP programme proposes to widen its scope of activities to extend to:

Hygiene and sanitation
Health education
Food production and balanced diet.

The objectives of the programme are:

a) to awaken in the mothers a sense of leadership and responsibility
b) to create in the village community a sense of self-reliance in improving the conditions required for sanitation and health
c) to train the villagers to take decisions in setting up priorities for developmental schemes at village level
d) to encourage food production and balanced nutrition.

*Kottar Social Service Society Annual Report 1974, page 5-6

There has been an even further development in the project.

In the current year it has become possible to establish 6 centres on a permanent basis. (i.e. no longer mobile). They are designated 'Health Co-operatives'. The centre is equipped and staffed every day on a regular basis and to meet the expenditure for the equipment etc. The families pay 25 paise more for this improved service.

2. The activities described above are clearly not evenly distributed or characteristic of the entire population.

The variations are considerable and are due to a whole range of factors:

a) The projects listed are related to the different economic activities in the area, such as Palmyra Tapping, Fishing, Pottery making and in the case of Agriculture where a major irrigation channel was being constructed, offering opportunity to utilize and extend it locally.

b) The recognition of local possibilities for viable projects. This recognition is said to be the recognition by the "community". However, it includes the important element of the recognition, enterprise, initiative promotion and persuasion of the local parish priest and leader where he conceives of himself both as of the community, and of his role as including leadership of this developmental kind. In fact to begin with (and to a lesser extent today) there was strong clerical and lay opposition to the priest actively engaging in such matters.

c) The response of the community to the "recognition" described above (b).

This responsiveness has differed from community to community. (K.S.S.S. insists that projects must be expressed as a need and the community must request help in these matters). The articulation of these needs and requests differs from place to place.

d) There is an element of projects "catching on" either because of geographical proximity or of the enthusiasm and drive of individual persons who have different patterns of mobility. Examples of these are the irrigation project, and net making for the women.

e) K.S.S.S. say that they are particularly concerned with the poorest sections of the community. This poverty is determined by such factors as occupations (e.g.) fishermen, palmyra tappers, caste and sex (women).

f) Although both by inclination, policy and formal constitution K.S.S.S. operates "irrespective of race, community, caste or creed," and in practice this is seen to be the case there is possibly an element of concentration on the Catholics of the area. This is inevitable in terms of preselection for a number of reasons - (i) The fisher-folk, who are amongst the poorest, most exploited, least community-development oriented, and least 'future' oriented population in the District, are for historical reasons 100% Catholics. (ii) The Parish Priest, often the motivator of developments, tends to lead his flock; the Catholic are in the first instance most accessible to him and his leadership is recognised by them at an earlier stage. (iii) Physical facilities (e.g. churches, orphanages, convents) and staff* are largely Catholic. However this "natural" Catholic identification which probably initially predisposes to Catholic participation clearly spreads out actively to other groups and there is no suggestion of exclusiveness.

Discussion has taken place as to whether more Catholics are served and involved in these projects than others but there are no conclusive figures. This itself in perhaps significant in that no distinction between one creed or another appears on the records; (Thus the register of 43,000 families on the Health Programme has no religious reference). The indications are that whatever the percentage of the community served who are Catholic, their over-representation, if there is one, is due to the concentration of Catholios on the coasts; the existence of the institutions; and the historical origins of the particular programme. (A rough accounting was made at the time of our visit - see Appendix)

3. There is indeed a very strong training programme for the community-based health workers. Health workers are of five categories (i) Staff Nurses (ii) Health Workers (iii) Health Guides (iv) Health Educators (v) Voluntary Extension workers.

These workers all provide service in the Health Centre according to competence, as health educators, first aiders home visitors, nutritional advisers (kitchen garden), distributors of supplementary foods and some carefully selected medications, attendants and midwives at births, instructors in prenatal and postnatal care which includes the 'natural' methods of family planning. Originally the staff nurses were hired from the hospitals, but this stage did not last. Now the 16 staff nurses who are

*Nursing and the care of the sick in not easily taken up by Hindu girls there is a strong element of 'pollution' involved in such activity.

trained according to the standards recognised by Government of India are appointed because of their commitment to this type of village programme.

It is the requirement for setting up the Village Centres (currently 126 of them) that the community provide a minimum of accommodation and four volunteers (unmarried girls with a minimum of SSLC - 11 years schooling) on a regular basis.

These volunteers are given a three-day orientation and thereafter regular week-end courses (this week-end pattern is giving way to three periods of a week over the period of each year). They serve a kind of informal apprenticeship in assisting the health workers and in preparing themselves for their own family life. The Health Workers undergo a five-month training course with one month full-time field work (see syllabus in appendix). After a period of service the Social Health workers can undergo a five-month training and one-month field work to become Health Guides. (see syllabus in appendix).

There is another group of Health Guides who come with a background training either as R.M.P. (Registered Medical Practitioners) - a three to five year training programme, or as Hospital Aides who have three to five years experience working under the supervision of doctors. These are given a three month intensive course by K.S.S.S. plus one months field work before qualifying as Health Guides.

The Health Educators (30 are serving in the field, at the Centres, schools, and with the Net Makers, Fibre Worker etc.) are drawn from graduates (most of whom have remained unemployed after graduation) some have had a period as volunteers. They receive four months' training which include one month of field work. Most come from the villages where K.S.S.S. operates Centres. They make informal application and are invited 30-40 at a time to an'orientation course.' Here selection takes place. They receive Board and lodging and a small amount of pocket money.

During service, workers meet regularly for supervision each week at K.S.S.S. Headquarters, and various inservice training components are introduced at these weekly gatherings.

4. There are no specific programmes for administrative methods except as a component of the five months training, although administrative activities are conducted by the workers who keep the Centre's accounts, and these are vigorously supervised by K.S.S.S.

5. The original group of Health Workers included girls who had been brought up in the organization's orphanages. However, now exclusive selection is made from the volunteers who have proved suitable and "dedicated" to the work over the period of a year or so of their volunteer service. These volunteers come from the villages themselves. It is, however, policy that once accepted for training the girls will serve in villages other than their own.

6. The Health Workers receive board and lodging but they are expected to contribute Rs.10/- a month for 5 months. The second stage of training "Health Guides", do not contribute but receive board and lodging and a small pocket money allowance. Funds are administered through K.S.S.S., Grants-in-aid for training are received from Misereor, and Oxfam provides funds for training Health Educators.

7. There is a training staff of 21. Each staff member spends at least one day a week in the field. The training takes place at a special training centre at Muttom, at K.S.S.S. Thirumalai, and in the villages.

8. The K.S.S.S. training staffs have developed a curriculum and much of the training material seems to have been semi-indigenously produced. One set of guides and slides, however, derives from the Institute of Child Health.

Guilford Street, London, U.K. (David Morley). Consequent upon our visit to the project K.S.S.S. has invited State Government to review the training programme and offer advice for improvement. Charts, posters, flannel-graphs are used from the Christian Medical College, Vellore, Tamilnadu, and also from the Voluntary Health Association, New Delhi, and the Public Health Department, Tamilnadu. Socio-drama is an element in the teaching methodology.

G. Extra Community Financial and Technical Support

1. Most of the extra-community financial assistance comes from international organisations. Indeed the formal constitution and registration of K.S.S.S. in 1963 was largely determined by the need to establish the legal requirement to set up a charitable trust in order to negotiate loans, receive foreign aid and so forth. Among the organisations contributing to K.S.S.S. are:

a) Catholic Relief Services (U.S. Catholic Bishop Conference) through which US Aid also contributes. They give assistance in kind, such as food, and also funds which have been especially utilised for the Channel Building Irrigation project, land reclamation, housing and the construction under way of a 54' ferro-cement trawler.

b) Misereor has provided loans for boats and the sugar plant and makes grants to the training programme. Contributes also for the allowances paid to the community organisers (supplied one van also).

c) Oxfam made a grant for a van, on the condition that K.S.S.S. contribute to a depreciation fund. They give subsidies to the 25-paise scheme for environmental sanitation projects (contributing Rs.1,000/- to six villages each month, who have saved Rs.3,000/-). They provide too for the training and allowances for health educators for a period of 3 years.

d) Catholic Lenten Campaign (Entraide et Fraternite), Belgium:

Makes grants to short course training such as the 3-months course at the I.S.I. Bangalore where K.S.S.S. sends C.D. workers, and the training programmes for volunteers. Allowances are given to training centre staff. The short course Health Guide training is also supported. They have also been prominent in the Fisheries project.

e) Government of Tamil Nadu. Relations with Health Department are informal and good. Government provides some of the vaccine used in the Health Centres of K.S.S.S.

Consequent upon our visit to K.S.S.S. (and the formal arrangement that the Assistant Director of Health Services (P.H.C.) joined our team,) definite proposals have been made that the Government will consider providing a considerable and regular supply of vaccines and vitamins for under fives and may match the communities' contribution to the Health Programme (Rs.600,000/-) to a considerable extent.

2. Government has provided technical inputs mainly in those projects where K.S.S. has helped in the implementation of Government or Panchayat inspired projects (for example, the irrigation channel building and the agricultural activities associated with the projects.) Also, involved are the Department of Fisheries in the construction of the large ferro-cement trawlers. The international organisations detailed above have provided considerable technical inputs especially in the Fisheries Project, such as boat building and training.

Catholic Organisations have provided advices on matters such as Family Planning.

There has been no formal link between Government and K.S.S.S. regarding the Health Programme. However, again consequent upon our visit, Government has been requested to assist in the teaching at the Training Centre and to work out collaborative programmes with their medical staff and K.S.S.S. facilities, for school Health Programmes and a referral system.

3. No. The Government does provide a system of Primary Health Centre manned by trained personnel. There are many problems regarding these centre which Government frankly acknowledges. K.S.S.S. has a cordial relationship with these centre but no systematic relationship has yet been worked out between the welfare, preventive oriented Centres of K.S.S.S. and those of Government. As described above, our visit has led to an examination of a mutually supporting system of relationship.

4. Government material assistance to community based activities is ordinarily through Government departments or through Panchayat structure. The exceptions to those in relation to K.S.S.S. have been outlined above.

5. To generalise about this is difficult but there are numerous examples which have lead to us hearing comments such as "Highly competent technicians have proved to be social failures." 'They did not know how to live among the people". Of course we have been told of some who have made excellent relationship with the community, but these seems to be exceptional and when found are highly prized.

6. Flip charts, flannel-graphs, slides posters and demonstrations are used and socio-drama is one of the techniques.

It seems that local drama is dying out and being increasingly replaced by the cinema. Government makes use of documentaries and the radio. K.S.S.S. workers seen to have a wide repertoire of songs and some a talent for dancing of the story-telling kind. We have not heard whether these talents have been

deliberately put to use in the projects, other than perhaps as good-will entertainment. We noticed too that many churches have a loud-(very)-speaker system which provided music for the villagers and we wonder if these are used directly for the projects.

H. Extra-Community Communication System

1. English, Tamil and Malayalam dailies published outside the district are available. The estimated circulation of English dailies is 4100, Tamil dailies 22,000, and Malayalam dailies 65. Periodicals (weekly fortnightly and monthly) are also available and the estimated circulation of English periodicals is 725 and Tamil 23,700.

2. Regional and national, international radio programmes are available in the community through private and public radio receivers. The programmes broadcast in the local language (Tamil and Malayalam) and in English are heard by the local population. The kind of programmes available are varied such as News, film songs, devotional songs, special programmes for mothers, college and school students, villagers programmes, drama etc., etc. News, film songs, are very popular and is heard by all. Special programme are heard only by a selected audience depending upon their field of interest. Film songs broadcast from Ceylon is very popular in this area and is usually heard by every one.

3. Permanent cinema theatres are to be found in towns and touring type in rural areas. This is very popular and very well attended by the local population.

4. Extra-community government messages and informations are made available to the community through Panchayats, newspapers, radios, wall posters and field publicity organisations.

5. The messages and information are given to the public in general through mass media and in addition to the community leaders by visiting government officials during panchayat and other important meetings.

6. Seasonal migration is common in this area. The Nadar community (palm tappers) migrate to other districts during March-September. Similarly the fisher folk migrate during January to May to places like Kerala, Rameswaram etc., where they expeet a better catch of fishes. The agricultural labour class migrate to other places in the district during harvest season.

7. This type of migration is temporary and lasts till the season is over.

8. The seasonal migration is only moderate.

9. The urban migrants usually send money to their aged parents and families living in rural areas. They usually take up to modern practices and serve as an example setter for others in the community.

10. Significant number of community members attend secondary schools and universities both within and outside the district. They serve as a diffusing agent in communicating urban modernity to their family members and among their peer groups.

11. The residents of the community usually visit places of pilgrimage and also intra-community weddings and meeting of people during these occasions serve as one of the important communication mechanisms.

SECTION V

DESCRIPTION AND ANALYSIS OF THE PROCESS OF COMMUNITY INVOLVEMENT IN THE ACTIVITIES BEING DESCRIBED (CASE STUDY)

A. The Initial Events

1. There seems little doubt that a major 'triggering' of community action in the first case can be associated with the arrival of Father James in the Parakunnu area twenty four years ago. He says he was particularly interested in the social condition of his parishioners and was resolved to find ways to improve the lot of the poorest. At that time he identified the palmyra climbers as the ones being most in need.

This was a large group of landless low-caste Hindus whose living, at the best of times miserable, precarious, and at the mercy of the palmyra tree owners, was from 1947 threatened by followers of Gandhi, some of the most zealous of whom fought against the 'evils of alcohol'. With the enactment of the prohibition laws not only did the work eventually become illegal, but in 1947 there was a determination to cut down the trees themselves.

Fr. James eventually enlisted the help of the Khadi and Village Industries Commission (itself a Gandhian movement) to examine the plight of these 'person'. Presumably the unforeseen additional burden visited upon these very poor persons by the very philosophy and movement which, generally speaking, aimed to succoor them, must have added the weight of logic to his appeal.

The bringing together of the palmyra climbers to focus upon and consciously consider their condition in order to explore the possibilities for action, the historical forces at work through the Church in the person of radicals like Fr. James, and the independence movement with its Gandhian philosophy in the shape of the Khadi Village Industries, all conspired to

bring about a multitude of events and actions which created this project and those which followed. The spreading of projects and the creation of K.S.S.S. to operate a whole range of projects at the District level grew from this project. But each project has a history of its own and combining the projects into the terminology 'programme' suggests a uniformity which is not present.*
The triggering of the CHDP came about in this fashion:-

The Community Health Centres (C.P.H.D.) sprang from a feeding programme which K.S.S.S. operated at local hospitals and dispensaries. It served about 1,000 families. This was as part of a Maternal and Child Welfare input sponsored by the Catholic Relief Society. The C.R.S. were seeking to use their food more constructively than in a straightforward gift. Sister Lieve meanwhile had been much concerned with the plight of women and girls. A programme to provide girls with paid employment, education, and an opportunity for saving (with the objective of raising their status and relieving their acute dependence on family and dowry marriage)had been launched as an offshoot of the projects for the fishermen. This was the net-making described elsewhere.

Sister Lieve had observed that the hospitals and medical services seemed to provide for the individual sick and did little for the community to improve health conditions in a social sense. A combination of C.R.S.'s wish for a policy shift and Sister Lieve's concerns gave rise to the concept of Community Health Centres. The idea was discussed with the Parish priests who in turn discussed the matter with the community through the Parish Pastoral Councils. Interest was quickly aroused. Communities who wished to be involved in the implementation of this programme had to: make formal application to K.S.S.S.; provide minimal physical facilities; (often the church or church buildings) make a survey of those who wished to register and those eligible for supplementary foods (i.e. families with incomes less than 150 Rs. per month);

*See footnote on p.~~3~~ 4.

agree to the financial contribution expected from each registered member; and provide for volunteers (unmarried girls of S.S.L.C. level) to assist the centres regularly at each session.

Annually there is a village level festival at which the "pious groups" report their yearly activity. At this time the part that these groups play in relation to the Health Centres is reported upon.*

2. The condition of the palmyra climbers was clearly a subject of concern - but for the community? The community constitutes (especially in India) many variously defined groups, so perhaps it cannot be said that it was a very 'visible' subject of concern for many, other than those clearly effected, and they, being the poorest and of low caste, could not really have been initially a high priority concern of anyone. We see however that those, like the Gandhians, who could be expected to be concerned, may not have been aware or were at first unable to demonstrate practical concern at the local level. (For this movement was national and as far as we know had no effective Parakunnu-based organisation to bring its influence to bear.) The immediate answer to this question (VA.2.) is 'No'. However it seems that latent (or background (?) dispersed (?)) - concern became crystallised by the person who articulated the concern (Fr. James, the Parish Priest), and this focussed whatever discussion there might have been.

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* At present there seems no mechanism for K.S.S.S. to report in turn to each village regarding its Health Centre activities. The annual report of K.S.S.S. is a District level review and is not formally presented to the villagers-nor would they find direct accounts of their local centre in it. One of the responses to questions about this was that until recently all the centres were served by mobile teams which would have made village by village reporting difficult. With the emergence of the new "Health Co-operatives" (6 to date) it will become possible to set up a reporting-back system. K.S.S.S. thought that this might well be a useful community involving activity.

This catalytic function, sensitive to what forces are at work; embedded in a set of values regarding social justice; and with special concern for those least able to articulate their condition would seem to be a vital talent/ skill of a community development worker.**

3. Before action took place there was a period of about two years of 'idea germination' (This is a kind of activity in its own right).

4. The initial stimulus for the Parakannu project(s) was clearly the person of Fr. James himself. He was the parish priest.

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* FOOTNOTE(1)

Perhaps this is the place to make a comment related to the conceptual framework provided as a guide by the WHO/UNICEF study organisers? This particular K.S.S.S. programme does not have one clearly defined line of development stage by stage. It is possible to follow the development of this first palmyra climbers project step by step, but in due course one begins to see the 'spores' emanating from this beginning, appearing (seemingly spontaneously?) elsewhere in the district. Partially this is because slow but profound social forces have been at work over centuries 'preparing the soil' for such actions, and partially because there are diffusion processes at work though people like Fr. James so that these in geographic proximity begin (sometimes unknowingly) to generate hope and to emulate his work. A direct line of development may be too neat an explanation to seek. Nevertheless it is possible to trace Fr. James' passage from project to project and how (among others) he was joined by Sister Lieve whose work began with concern for the girls and women of the Kanyakumari coastal area; how K.S.S.S. was created and its activities expanded to a district level; and how it became increasingly diverse in programme; how international assistance was attracted; how development was crystallised by the Louvain study of 1971-1974; and one can then begin to see how and why in a relatively short time it has been possible to establish a health programme in no less than 126 villages with a registered paid-up membership of 43 000 families, which already constitutes 20% of the district population.

** The intriguing thing is that much of this is not always at the level of intellectual consciousness, but is essential nevertheless, and presumably might be conveyed and even systematically taught? Certainly this is an area for much work if community development workers are to be recruited and trained on a systematic basis.

5. That Fr. James utilised the traditional base of leadership associated with the Church is apparent, but he represents a radical and minority element within the Church and was a departure from the traditional conceptualization of the role of priest and leader. That the influence of Catholic theology and philosophy work upon Fr. James is without doubt, that he has interpreted these in a 'community development' manner is very much his own contribution. To an extent then his community action role was from, his point of view, informal. It is likely however that the people see his role as firmly exbedded in his formal leadership role. Even so, there are some within and outside the Church who at their various levels of sophistication argue what should and should not be the priests development role.

6. The palmyra climbers were particularly under pressure economically and socially and it may well be that in the immediate post-independence period something of the spirit of social change echoed in response to the efforts that Fr. James had embarked upon. It may also be that the Church, seen as 'rich and powerful', provided protection, hope, and know-how, in contacting authority and in navigating through the inevitable local conflicts.

7. Activity began to crystallize when the Khadi and Village Industries Commission was brought into the picture at Parakunnu. They had developed nationally a philosophy, an organisation, and technical skills to promote village industries.

8. The reason for intervention was the request for help addressed to an organisation that had grown out of the religio-political philosophy of Gandhi.

9. The Khadi Commission seems to have reinforced the thinking emerging in Parakunnu and provided technical advice and assistance.

10. The Khadi Commission helped in the establishment of a palm sugar plant (which was an alternate product to alcoholic toddy from palmyra) and in setting up cottage-type industry for the use of palm fibre, such as the manufacture of brushes. They sent some of the villagers for training. Clearly the palmyra tappers were motivated towards economic gain but the expectation of aid must have been general rather than the 'spring' of action.

B. Project Development

1. Perhaps the best way to get at the processes, advances and shortfall of the community involvement is to take the first of the projects (Parakunnu Palmyra Tappers) as an example. It represents the great variety of succeeding projects which, although they have very different features, nevertheless seem to produce and come up against similar community involvement elements.

We have described the role of Fr. James as the 'trigger' in terms of assessing the needs of the village and selecting the plight of the poorest-the palmyra tappers - as a priority group. His selection of this priority was influenced not only by his predisposition, but also by the informal discussions he had with his parishioners and by the troubles and comments that they brought to him. This kind of dialogue between the tappers and Fr. James gave expression to their needs, which he took up and articulated. During the course of informal meetings in the evenings gradually the idea of a co-operative was introduced. The notion of a co-operative for the palmyra tappers had to overcome at least two hurdles. First was the nature of the palmyra tappers' situation, in which all they had was the crude strength of their labour; second was the general disrepute, that

co-operation had previously earned in the poor peoples' mind as being instruments of the relatively well-to-do and a temptation for the officials to wield power and to misappropriate funds.

However, eventually more formal meetings took place and elections were arranged for seats on a 'Board of Directors'. These elections apparently were approached very seriously and a real campaign was fought within the village.

Characteristically Fr. James was elected as the President of the co-operative. At the time he thought it 'wise' to take this office as the people concerned, quarrelsome and mistrustful, 'needed a symbol of unity'. The parish priest has a whole range of different leadership functions and for the most part is given the benefit of the doubt that he is a relatively neutral figure. This kind of trust is of course constantly reassessed by the villagers in the unfolding of time and events. It is said that village people can 'smell out' those they trust. One element of this is related to the common atmosphere of family feuds. The Catholic priest has no wife and children and the conflicts, tensions, accusations, and counter-accusations surrounding marriage obligations do not therefore involve him personally. However it is remarked that where, as is often the case, the parish priest is a local man, his blood brothers and sisters are watched carefully to see whether they are the recipients of pastoral privilege.

Fr. James gradually has come to see this turning to the priest for leaderships in so many matters - especially in the community development projects - as a sign of weakness in the community and in the process of development itself (especially since the embracing of the concepts of

'conscientization'*). However the palmyra tappers have continued to refuse to stand for the office of President because 'they could not trust their own'. 'They seem to need a symbolic leader who represents a unity which they do not have themselves'. 'They can work together but cannot fully trust each other'. '... a profound mistrust... a presence is required....'. 'They seem puzzled by altruistic motivation'.

Fr. James seems to have tried to step down from his position in the co-operative but no tapper was prepared to step forward. When Fr. James left the parish he was "forced" to continue as President for some more years and then was succeeded by the next priest. However there has been over the years a just detectable shift in this impasse -- it eventually became possible for a 'Committee of Presidents' to emerge and a different chairman presided for each meeting, but this did not last long. The priest remains the one to sign documents. It has been suggested that he is just a 'signing machine', but he also chairs the meetings.

Fr. James sums this up sadly as '... development has not reached the core of the people ... without a positive presence beyond their internal dissensions...' progress does not seem possible. 'Theoritically, we have not succeeded... but that seems to be the way life is...'

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* It is felt now that the whole community has to progress by a process of self-awareness without allowing the gap between the privileged section of the community and the rest of the population to go on widening. Previously it was thought that helping a few individuals to come up would create a new leadership for the improvement of the whole community. Experience has proved that most of the social activities to help the poor have finally resulted in the rich becoming richer and the poor becoming poorer. As a consequence of this startling discovery, the impact of the social structure on development appears to be a dominant factor. The first step towards development, then, will be, to lead men to liberate themselves from the oppressive structures in society. "Kottar Social Service Society Annual Report 1974, pg. 1".

On the coast among the fisherfolk the dissension seem to be even more chronic and organisation of the 'Sangams' sometimes bring about acute situations which become the occasinn for violence.* Sabotage of boats and destruction of nets take place. Murder in the coastal villages is not unfamiliar. In one place the Sangam split between the eastern and the western ends of the village. There seemed to be no confidence that if the fishermen were merely to become boat owners in their own right-having been helped to free themselves from the traditional exploitation - they would not quite readily move to become exploiters in turn. The Sangam and the Community Development Organiser works against this tendency.

Given this background, it is probably even more difficult to distribute leadership roles away from the traditional leadership persons.

These fishing villagers are, it will be remembered, 100% Catholic and one observer commenting on the role of the parish prients says:

"The intimate connection between the social and religious activities makes the priest in the coastal villages as the most powerful man, his power resting upon many different roles. He is the spiritual leader of the village by performing and administering the religious functions. The priest is also the official representative of the Roman _Catholic Church and in the Diocese he has to collect and care for the Church funds and maintain the church building and himself with the funds so collected. The priest is the manager of the village (high) school, he appoints & directs the school operations & collects teachers' salary from the Govt. and pays them. In some villages the Priest is also the president of the Village Panchayat, the democratic governing agency at the village level.

* One observer says 'There seems to be an accepted location for a battle-ground between factions -- the church yard! '

As Panchayat President, he has to care for the village welfare, and solve its problem, which in turn means that he must handle the funds which the Panchayat decides to collect towards implementing its schemes. He makes many decisions on allocations and is responsible for getting work done and for paying for it. Another important role of the priest is settlement of disputes within the village. In many villages the priest serves the role of a banker, enabling the fishermen to save a portion of their income. From this incomplete list of priestly duties and roles in the village, it is obvious that there is a tremendous concentration of power in his hands and this may be an obstacle for the natural growth of leadership among the people of the village".*

However it is said that, on the coast, "over the centuries the priests seem to have made no great impact on the forces of unity in the community". This distresses them and in practice "they have retreated from developmental activity". They approve of the Sangams but are keeping very much away from having anything directly to do with them. Still, alternate leadership has not yet emerged.

A slightly more positive case is that of the Channel Irrigation Project. This project emerged from the frustration produced by the fact that ten years after the building of a government main channel (in some places 90 feet deep) only one third of the prospective area was being irrigated. Problems of the mosaic of small tenures and lack of capital for the work made progress appear impossible. However, in time a host of workers, upward of 1000 a day, were organised and 15 supervisors emerged from their own ranks. Here too, one feature was the collaboration with the Panchayats who were expected to officially approve each sub-unit of work and endorse expenditure

* K.S.S.S. Annual Report 1972, page 25-26.

of funds. These tasks, it is said, "gave importance to the Panchayat..." The point here seems to be that the community is showing some ability to function autonomously* to the extent that the supervisors have taken hold, (they meet every Wednesday under K.S.S.S. project auspices) and the Panchayat have a formal function in this large-scale development.

There is a further consideration to be made. In recent years the Panchayat has formally been designated as the political power and structure from which the administration of many activities stems and is implemented. It might be expected that the Panchayat structure, based on a democratic ideology, would become the people's institution for managing their own affairs. Non-government organisations might then become initiators and demonstrators of projects and programmes, which, if they became sufficiently wide in coverage and importance, would find a natural and useful process at work for the community to take them over either directly or in close association with the Panchayat.

However, this is said not to be likely in the foreseeable future. Apparently the general mistrust of the people, one for the other, is manifest not merely also, but especially, in the political realm. It is argued by some that the Panchayat structure is not in tune "with the South", the implication being that what is appropriate to the North and promulgated by the Central Government. is not necessarily the practical or desirable pattern for the South. Further it is said that the Panchayat structure has been incorporated into the traditional power structure, so perpetuating the very social injustice and lack of representation that it was designed to change; that the political parties are bitterly opposed to each other and appear to

*One comment has been "... the priest is a local man, is he or is he not the community also"?

seek power and priviledge rather than promote unity and devise acceptable (if alternate) programmes that ordinary people see as relevant to their situation and which give them a choice; (a point that the reasons given for the present national" state of emergency" would seem to endorse). Whatever the merits of this argument there does seem to be evidence to support the statement that "... at the political level there is an indifference... the political field as it is represented now remains naturally reserved to the favoured groups who in that way monopolise both the possession of goods and power".*

The decision to give Community Health Development Programme priority is as we have seen derived from two mainstreams. The first is that the K.S.S.S were becoming dissatisfied with the care provided at the hospitals and dispensaries where they operated a feeding programme of relief for poor families. Sister Lieve says she was struck by the emphasis on curative medicine and the little that was done to reach out to the backward areas (along the coast and in the area of the Parakunnu projects). It occurred to K.S.S.S. that a preventive service was necessary and might be possible. At first this was attempted through the hospital and dispensaries but it eventually seemed necessary to launch out separatly. Secondly the Catholic Relief Service expressed the desire for a change of policy away from straight relief giving, with the relief foods being used in more constructive developmental ways.

K.S.S.S. welcomed this C.R.S. thinking and responded by planning and launching the (CHDP) programme.

In late 1971 an exploratory visit was made to the Voluntary Health Association of India (in New Delhi) to study their experience with Community Health.

* F. Houtart and G. Lemercinier. "A Social Analysis" University Catholique de Louvain. 1975. page 129.

2. Discussions took place with the Board of Directors of K.S.S.S. and the parish leaders. Questions arose regarding the need to alter a straightforward relief programme and the need to change the direction of the existing programme. K.S.S.S. kept on meeting people, arguing and persuading, getting surveys carried out, registering families and starting Centres. Public Nutrition demonstrations were undertaken. 'Sometimes people did not come, then they would come in a rush'.

3. The parishes found it easier and more satisfying just to give relief and seemed not in favour of the priorities or plans. However the reputation of the leaders of K.S.S.S. was a decisive factor in an agreement 'to leave it in their hands.'

4. The community at large reflected the misgivings of the parish leaders; - "It is easier to give food"; "What can young unmarried girls tell us that we don't know"? "In fact the difficulties were not resolved at this point, but K.S.S.S. were allowed to have their way.

Comments from K.S.S.S. leaders is of interest here. "Few were for us - many against". "Development is not in the minds of the community - but must start in the minds of a few". "Man of himself is not committed unless you see the other as your brother". "This requires "AWARENESS". "But in the past five years it is changing."

Difficulties still exist, K.S.S.S. says, especially the slow acceptance of medical professionals regarding the importance and priority of preventive rural community care in contrast to disease-oriented urban high-powered institutions. (During our visit one government primary health care village doctor sought from his superior a transfer to the district hospital. "I am not using and I am losing all I have been taught", he said." I want to continue my professional growth to learn and practice more surgery -- as a doctor should.")

5. Once the project was launched, many meetings - singly and as a group - took place between members of the Board of Directors and the village people. Although the Centres cannot be said to be in the beginning a wish of the community, there was a rush of enthusiasm. Girls were collected and given short orientation courses. There was a waning in interest when it was seen that hard work and slow progress was what was being offered but in time it became apparent that girls were getting an educational opportunity and being provided with employment. "It took three years to make real friends". "It was also, as with the net-makers, difficult to get acceptance that women's labour should be paid for."

In time more and more parishes demanded centres and a continuous stream of volunteers came forward. They are "the link with the community," "the messengers", "they value the education", "discover their personalities," "crystallising into awareness," "and look forward to becoming full-timers."

6. The organisational mechanism was obstensibly the existing K.S.S.S. Despite the opposition they seem to have worked as an organisation and impressed with their determination, "principles", "clear vision", and the demonstration of their having a "new fixed policy" (especially in respect of the food). Soon the community "accepted it", seemingly with enthusiasm. "The experience of previous K.S.S.S. projects led to the confidence of others - "TRUST".

7. a) In a sense 'local' resources were available in terms of the existing feeding programme (though this was donated extra-local.) A minimum staff and running costs budget was worked out and a bi-annual and bi-monthly payment system was designed to make the project self-supporting in these maintenance respects.

Volunteers came forward in large numbers. Money and materials comes from the community to supplement the "25 paise scheme" for environmental health. Activities and labour were contributed too for the construction of simple facilities (40-60%).

b) Extra locally, we have listed the International Organisations (IV G.1.). From these have come technical aid, cash and kind. A very small number of physicians have helped. The Staff Nurses have been trained outside but are paid by K.S.S.S. Medicines so far have not been donated, but it is hoped that government with follow through on a proposal formulated at the time of the WHO/UNICEF visit. Community Development workers are trained at the Indian Social Institute, Bangalore. Trainees are supported by extra-local resources.*

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*See Financial Report (Appendix)

C. Division of Responsibilities

1. The roles and responsibilities were determined by the Board of Directors of the K.S.S.S. This Board has the recognition of the formal leaders and is thought to act "wisely".

2. The conflicts were not around the matter of apportioning responsibility but were struggles about concepts - conceptions of what the movement should be doing and concepts regarding the definition and meaning of health. Visits to the communities by the whole Board, and singly, for discussion, led to the rapid expansion of Centres.

3. Conflicts in relation to projects like the fishermens Sangams certainly arise because of the shift they bring in the wielding of economic power in the community.

The major conflict (other than those discussed earlier) in relation to Community Health Centre was around an early insistence that different Centres (or times) be set aside for different castes. This was vigorously resisted by K.S.S.S. and their insistence has prevailed.

4. Reconciliations are on-going. Meetings, dialogue and discussions are the medium. K.S.S.S. people "keep coming" and all reinforce each other in the approach and concept of their programme.

5. There have been many week-end orientation courses, discussions and use of visual aids. Each community where a centre is being proposed receives "1000's of pamphlets written in simple local language" explaining and promoting the project.

D. The Outcome of the Project

1. The Parakannu project continued along the lines of developing employment and improving conditions for the village people. In the main this was through the spin-offs into village agricultural-based cottage-type industry. A major change was noted, however, when the opportunity came for the village to link up with a large government-constructed irrigation dam. It became possible for Parakunnu to organise a very large work force to construct truly spectacular feeder channels and to terrace large tracts of land, which has appreciably improved agricultural production both in quality and quantity. However it cannot really be said that this chain reaction was what was originally planned. Rather, it was a process of once something having been started, one thing led to another.

The Health Centre project has continued with minor improvements over the four years.

2. Clearly the original project expanded into many more or less related projects and these in turn led to quite different projects elsewhere being undertaken with a growing sense of confidence.

The Health Centres expanded rapidly.

3. In the light of what has been explained above it will be understood that a whole range of modifications, adaptations, innovations and quite new departures have had to be improvised according to the particular activity and particular project. A most significant organisational development was the raising of these diverse activities to the level of an 'umbrella' organisation and administration at a District level with the formal creation of K.S.S.S. in 1963. A conceptional change has been described in (V B.).

4. Arising from this original project all the subsequent activity has incorporated different degrees and quality of community action. These are numerous and the main ones are summarised in Section IV F.1.

5. The programmes seem to have been steadily supported. Once or twice the sangams have run into trouble (e.g. the splitting of a village Sangam into two separate organisations) but the problems have not been ones to endanger continuity.

6. New occupational groups have emerged because of the programme. Health Workers, Health Guides, Health Educators, boat builders, boat mechanics, well diggers, sluice builders etc. etc.

7. Generally responsibility has stayed with the same group of people.

8. A rotating type of responsibility is thought to be desirable but this has not been achieved.

E. Pre-existing Community Characteristics Favouring the Project

A major factor in the success of the project(s) is the background and infrastructure provided by a long-standing Catholic Church. Despite differences of view within the Church regarding the role of the priesthood in connection with the emphasis and expression to be given to social development as distinguished from spiritual guidance, the existence of a network of parishes and physical facilities such as churches and convents have provided a foundatinn for the projects.

The Diocese provides a means of communication, a tradition of disciplined and sound organisation, and accommodation especially for the housing and protection of a large group of unmarried girls (several hundred in the Health Centre programme) in a society where unaccompanied girls cannot easily move from place to place. This element of 'sorority' is a very important factor in the programme. Some very positive factors are the relative ease and frequency of travel possibilities within the District; the widespread electrification of the villages, and a very high literacy rate.

The personality of the initiators of these projects such as Fr. James and Sister Lieve, has also been decisive; they have attracted many other devoted workers, and also have shown a skill in organisation and in educational endeavours.

In a society which is very mistrustful of motives, suspicious of the powerful, and used to misappropriation of resources, the honesty and openess of the approach to these projects has been salutary.

These conditions of trust had to be earned and the informants stress the essential requirement of "having to live with the people". The two leading persons in these projects, both "foreigners", have served in Kanyakumari District for nearly a quarter of a century.

The projects through the medium of K.S.S.S., because of their position in the wider social structure, have been able to attract both a wide range of and considerable resources from international organisations.

The one-project-leading-to-another pattern of development, has both gained repute amongst the people of the District and given the initiators experience and confidence in launching increasingly ambitious programme.

The projects have tried to address themselves to obvious needs in the community: improvement of conditions, opportunity for employment among the poorest, and the nutrition and health requirements.

F. Pre-existing Community Characteristics Threatening the Project

It is of interest to note that all the factors enumerated is this question (V.F. a) -h) have been very present in these projects.

Only g) gives pause for thought. We have already discussed the view that perhaps these projects have favoured the Catholic or Christian communities, but we concluded that this view could not be strongly substantiated The main area for examination would concern the relation of the projects overall to the political and administrative structure of governments.

On the implementation level relations with Government organisation are good and getting better, it would seem. We do not know what local government and political groups think of these projects, but the element of "pet-project" would not seem too predominant. However there are important theoretical and practical questions involved here. Should not community involvement in projects ideally move to increasing decision-making at the grass roots level? And shouldn't this spirit and the skills involved begin to express themselves in positive political organisation, policy formulation and programmes?

The evidence in that these especially poor people involved with the K.S.S.S. projects see themselves as totally unrelated to the political structure and organisation. It is these areas, that they believe are the domain of the priviledged and it seems not to occur to them that they can be, and have anything, to be represented.

Perhaps it is this politico - priveledged group who have failed to become involved. This lack of major political processes growing within and around the programme has serious implications.

It is a debatable question as to what, from the political perspective can be said presently to be "really in the community interest". Which community, we may well ask?

This question is certainly at the heart of the discussion by critics of K.S.S.S. as well as a matter which exercises K.S.S.S. itself.

Question F (i) - "How they were overcome?" The response must be that they have not been overcome -- they are constantly being worked at step-by-step, crisis by crisis. Gains are being made all the time by the daily work and attitude of the project workers and through decision within the community but fundamentally the old processes are still at work along with the new.

G. Impressions

1. There are special circumstances both of infrastructure and personalities and the length of time (over twenty years), the projects took to turn community health centre efforts. The basic characteristics of the community seem to have been particularly difficult and it is likely that there are more positive social and cultural conditions elsewhere which would lend themselves better to development. By and large the planning of the projects seems to have been sound and the implementation carefully and painstakingly well organised and carried out.

There are unusual circumstances in this project both of a plus and a minus quality. Certainly the infrastructure based on the 400 years of convertion and the work of missionaries is unusual but cannot altogether be seen on the plus side, as we have discussed earlier. The fact is that infrastructure is necessary for any major planning and although this particular kind of infrastructure is not likely to be replicable, in other places structures will be found - operationally sound government structures for example - which can be adapted to community development processes.

There has been the input of large amounts of outside money and technical aid. The food inputs are a feature to be considered.

The supplementary food programme is undoubtedly an incentive for poor families to attend the Centres. The food in financial terms is worth between five to eight rupees a month (according to supplies) which is a real contribution to families whose income is less than 150 Rs. per month.

Currently 38 600 of the 43 000 families receive this supplement each month, which over the period of a year amounts to a very high total cost. Could such a programme be replicated elsewhere? There are a number of ways of looking at this:-

Firstly there has to be a source for the food, and funds to purchase it. Some will argue that programmes should be self-sufficient and ought not to incur these costs. However it is well known that it is very difficult to operate and devise nutrition programmes for children below school age, who are or should be the crucial and prime target group. This K.S.S.S. programme clearly hits this target and goes to great pains to ensure that the under-fives are in fact the main beneficiaries.* Where a nutrition programme is desirable, (and among these very poor families with poor nutrition possibilities, it is,) it is unreasonable in the first case to expect this to be an element of self-sufficiency. In the first case is an important qualification for it is possible that in order to get Primary Health Centres successfully started and to institutionalize the habit of attending in the community, some such attractive incentive is required. At what point this kind of input could be phased out is a matter for socio-technical consideration. Hopefully, the families will keep coming eventually even if the food is not contributed; (at K.S.S.S. it is said that this is probable - and some already do). Perhaps there is some parallel in the "free gift", "introductory offer" and "advertising" used in the commercial world for promoting the public's continuing use of brands or services?.

Such supplementary foods can be seen as a 'pump-priming' device for getting community action started, especially amongst the poor, deprived, and distrustful. The dependency element must of course be carefully watched.

The matter of outside technical and financial aid does pose serious questions of replicability. However, it can be argued that social and innovative projects should and do attract aid and in this sense the better and

*54 000 under fives attend the Centres.

sounder the programme the more such assistance may become available.* It may be the case that injections of capital and aid, international, national, or otherwise are prerequisities to getting major programmes started. Planning should of course be crystal-clear regarding how much, what for, and how long, to achieve what objectives, and how in the long run the programmes will become self-sustaining and part of normal budgeting.

The 'personality' input again raises important questions. It may be that a special kind of pioneering dedication is required to get things started and a sufficient time must elapse for these important (rare?) persons to immerse themselves and "live with the people". How long and how intensively should be a matter of exploration and experiment. Much will be determined by the strength and quality of political or other inspirational forces actually alive within the community, and the kinds of people who will come forward and be given an opportunity to serve. Clearly quality of relationships and the genesis of processes for development must take time and have a natural growth. This is why a 'model for planning' should not merely look primarily to providing in the first instance for large scale programmes, but allow for quality, experience, demonstration, for trust to grow, for processes to move from the personal to institutionalisation, and for teams of initiators to know, and be excited by, and committed to what they are doing. Perhaps this is one of the major lessons to be learned from this particular programme. Expansion, innovation and sophistication will follow.

Of the three aspects -- social, political, and economic - it would seem that the political is the most unpromising area in this project, as an example for others. Socially there are many difficulties and the community

*The international organisations supporting K.S.S.S. projects have a world-wide clientele and in this sense (within the limitations of those agencies) such aid is replicable elsewhere. See for example the writex up on CRS "The Examiner" Bombay, 28 August 1976.

participation in the broader areas of decision making needs to have much more work expended upon it. However, the social conditions are difficult ones, and the projects have undergone a shift in the thinking about this area of participation. Perhaps the really meaningful breakthrough is yet to come, and there are as yet only elements of replicability, rather than a full scale model. Perhaps governments can use private organisations such as these from place to place, but sooner or later they will have to adopt nation wide programmes and processes.

Economically the programme is an interesting one, with a whole range of community participatory elements in repayment of capital inputs, and in contributory schemes as in the Health Centre projects. Given the hurdle of acquiring "pump-priming' finance discussed above, there does seem to be a fair degree of replicability in the economics of this programme. Perhaps a serious cost-benefit analysis would be informative.

The speed with which a quality primary health centre programme has spread to 126 villages and a fair proportion of the community is, as we have indicated, built much upon the wide range of projects which preceeded it. This probably provides a vital clue to replicability. Health programmes would seem to need a broad-based community involvement in many related programmes if health is to find its proper place both in planning and in peoples' well-being.

"..... a dilemma, because to initiate projects some initiatives must be taken, and most of the time they cannot be initiated by the people themselves. One can discuss the whole "philosophy" of such projects and even think that more radical political solutions are only able to give a real answer. But in the present social and political situation, the problem is to be aware of the moment when a new orientation has to be taken."

F. Houtart and G. Lemercinier
ibid.

Appendix 1

1. Name of the centre: KSSS Community Health Development Project,
P.B.No. 17,
Nagercoil-629001.

2. Percentage of registered families according to religion:

	Coastal villages.	(%)	Interior villages	(%)	Total	(%)
1. Christian	6,231	84%	12,908	45%	19,139	53%
2. Hindus	1,074	15%	15,610	54%	16,684	46%
3. Muslims	89	1%	368	1%	457	1%
	7,394	100%	28,886	100%	36,280	100%

3. Availability of other medical/health facilities interior covered by centres in two mile radius:

See list attached.

4. Activities other than health in the centres:

a. Family kitchen garden in every centre.

b. Sanitation programme by private latrines.

c. Construction of community centres.

d. Construction of drinking water wells, public facility for bathing, drainage.

e. Employment and adult education to 1,350 girls manufacturing nylon nets in 14 centres along the coast.

f. Conducting nursery schools with 1,500 children in 30 centres.

g. Organisation of young fishermen sangam in 6 coastal villages.

h. Organising farmers for digging 18 miles of irrigation feeder canals and terracing 1,500 acres of land for paddy cultivation in 40 centres.

5. Map of the district with centres:

Already forwarded.

127 124 134 141 150 134 135 113 18

Date: 9.9.1976.

Appendix 2

KOTTAR SOCIAL SERVICE SOCIETY.

COMMUNITY HEALTH DEVELOPMENT PROJECT.

--:0:--

Availability of other Medical/Health facilities in the area covered by Centres in 2 Miles radius.

Team No.	Teams	Vil. No.	Villages Attached	Total No. of Fam.	Government Hospital	P.H.C.	Valuntary Hospital or Dispensory	Private Hospital or Dispensory
I.	Nagercoil	1	Ramanputhoor	470	1	-	1	10
		2	Kurusady	355	1	-	1	10
		3	Aruguvilai	220	1	-	1	20
		4	Vadasery	127	1	-	2	20
		5	Christumager	499	1	-	1	20
		6	[illegible]	[illegible]	1	-	1	20
II.	Kottar	6	Kottar	365	1	-	1	20
		7	Sarol-Puthoor	200	-	-	-	-
		8	Manavilai	240	-	-	-	1
		9	Sasal	178	-	-	-	1
		10	Sahayapuram	252	-	-	-	2
		11	Mylaudy	260	-	-	-	1
		12	Ashappapuram	257	1	-	-	1
		13	Anjugramam	343	-	-	-	2
III.	Karonsadu	14	Alengilai	413	-	-	-	-
		15	Kizh-Asaripallam	152	-	-	-	-
		16	Peruvilai	204	-	-	-	1
		17	Mel-Asaripallam	130	-	-	-	1
		18	Aloor	299	-	-	-	-
		19	Karonsadu	436	-	-	-	-
IV.	Kanyakumari	20	Kottaram	196	1	1	-	2
		21	Thamaraikulam	199	-	1	-	-
		22	Kil-Manakudy	148	-	1	-	-
		23	Aromboly	240	-	-	-	2
		24	Layam	121	-	-	-	2
		25	Kovalam	289	1	1	-	-
		26	Kanyakumari	541	1	-	-	-
V.	Manakudy	27	Ramanathichanpu.	162	-	-	-	1
		28	Rajavoor	128	-	-	-	-
		29	Ramapuram	122	-	-	-	-
		30	Ritapuram	268	1	-	1	-
		31	Mel-Manakudy	323	-	-	-	-
		32	Kovilvilai	154	1	-	-	1
		33	Pallam	274	-	-	1	-
VI.	RAJAKAMANGALAM	34	Keeriparai	115	-	-	-	-
		35	Thadikarankonam	221	-	-	-	-
		36	Ettamadai	241	-	-	-	-
		37	Mathal	170	1	-	-	3
		38	Seethapal	157	1	-	-	-
		39	Rajakkamangalam	366	-	1	-	-
		40	Periasadu	99	-	1	-	-
		41	Polikarai	64	-	-	-	-
		42	Nos.Puthenthurai	81	-	-	-	-
		43	Puthenthurai	100	-	-	-	-
VII.	Mutton	44	Kadiapattanam	354	-	1	-	2
		45	Chinnavilai	197	-	-	-	2
		46	Mutton	388	-	1	-	-
		47	Annandivilai	366	1	1	-	2
		48	Periavilai	218	-	-	-	2
		49	Pilaithope	331	2	1	-	1

Team No.	Teams	Vil. No.	Villages Attached	Total No. of Reg. Fam.	Govt. Hosp.	P.H.C.	Valun. Hosp. or Dispen.	Private Hosp. or Dispen.
VIII.	Colachel	50	Kottolpadu	154	1	-	1	2
		51	Midalam	322	-	-	-	-
		52	Mangalakunnu	330	-	-	-	-
		53	Kalimak	545	1	-	1	2
		54	Colachel	445	1	-	1	2
IX.	Alonchy	55	Puthoor	235	-	-	1	-
		56	Kodimunai	405	-	-	-	1
		57	Vanikudy	321	-	-	-	-
		58	Soosaipuram	176	-	1	-	1
		59	Kurumbanai	376	-	-	-	-
		60	Alonsy	412	-	-	-	1
X.	Karingal	61	Vellavilai	168	-	1	1	-
		62	Karingal	711	-	1	1	-
		63	Mathiravilai	428	-	-	-	-
		64	Peottotty	342	-	-	-	-
		65						
XI.	Palliady	65	Palliady	864	-	-	-	2
		66	Mullangnavilai	549	-	-	1	-
		67	Elavuvilai	398	-	-	-	-
XII.	Mulagumoodu	68	Plankarai	215	1	-	-	2
		69	Mulagumoodu	671	-	-	1	1
		70	Vellicode	408	-	-	-	-
		71	Manali	250	1	-	-	4
		72	Thuckalai	379	1	-	-	5
XIII.	Vattam	73	Muramanoode	571	-	-	1	4
		74	Mylodu	334	-	-	1	-
		75	Konamoodu	307	1	-	-	-
		76	Kallukuttom	123	-	-	-	-
		77	Vattam	411	-	-	-	1
XIV.	Manalikarai	78	Manalikarai	1021	-	-	1	1
		79	Madathattuvilai	748	-	-	1	-
		80	Chovilai	174	-	-	-	-
XV.	Chembarathivilai	81	Chembarathivilai	537	-	1	-	-
		82	Plankalai	441	-	-	-	2
		83	Theduvatty	210	1	-	1	4
		84	Cheruvalloor	364	-	-	1	-
		85	Thomayarpuram	275	-	-	1	-
XVI.	Puthenkadai	86	Kolvel	345	-	-	-	-
		87	Puthenkadai	577	-	-	-	1
		88	Voncode	410	-	-	-	-
		89	Anai	243	-	-	-	-
		90	Kapisadu	428	-	-	-	-
XVII.	Kulasekaram	91	Panchoncode	239	-	-	-	-
		92	Kulasekaram	670	1	-	1	2
		93	Syriapushpapuram	174	-	-	-	-
		94	Kadayal	305	-	-	-	-
		95	Thiruthuvapuram	367	1	-	1	4
XVIII.	Amboori	96	Amboori	462	-	-	1	-
		97	Arukani	147	-	-	-	-
		98	Thekkupurai	222	-	-	-	-
	Silguaipuram	99	Silguaipuram	823	-	-	-	-

Team No.	Team	Vil. No.	Villages Attached	Total No.of Reg.Fam.	Govt. Hosp.	P.H.C.	Valun. Hosp.or Dispen.	Private Hosp. or Dispen.
XIX.	NITHIRAVILAI	100	Melpuram	235	-	1	-	-
		101	Vattavilai	407	-	1	-	-
		102	Pusodu	326	-	-	-	-
		103	Nithravilai	568	-	-	-	-
		104	Ranjampuram	319	-	-	-	1
XX.	Manjalamoodu	105	Kaliel	173	-	-	-	-
		106	Panchiapuram	662	1	-	-	2
		107	Muthapanoodu	260	-	-	1	-
		108	Manjalamoodu	478	-	-	1	-
XXI.	Padanthalamoodu	109	Palugal	463	1	-	-	-
		110	Nallayanpuram	575	-	-	-	-
		111	Padanthalamoodu	467	1	-	-	2
		112	Kulukkavilai	505	1	-	-	3
XXII.	Munchirai	113	Mankarai	207	-	-	-	-
		114	Munchirai	340	-	-	-	1
		115	Puthukadai	378	1	-	-	2
		116	Vavarai	341	-	-	-	-
		117	Vayalankarai	211	-	-	-	-
		118	Varathattu	313	-	-	-	-
Health Co-operative:								
		119	Kandarvilai	662	-	-	-	2
		120	Mangushy	660	-	-	-	2
		121	Enayam	556	-	-	-	-
		122	Em.Puthenthurai	397	1	-	-	-
		123	Ramanthurai/ Pattanam	410	1	-	-	-
		124	Parakuru	628	-	1	-	-
		125	Melpalai	805	-	1	-	-
		126	Thirumalai	287	-	-	-	-

Appendix 5

N.S.S.S. SOCIAL TRAINING CENTRE, MUTTOM

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31-3-1976.

Figures for the previous year Rs.		EXPENDITURE	Rs. P.	Rs. P.
13,197	To	Allowances		14,152.50
1,724	"	Travelling Expenses		1,185.15
320	"	Taxes for building		320.40
2,440	"	Training Expenses		8,038.26
--	"	Stationery		836.76
--	"	Teaching Aids		62.02
--	*	Audit Fee		400.00
	"	VEHICLE EXPENSES:		
5,277		Diesel & Oil	5,273.04	
7,491		Servicing and maintenance of Van	3,045.08	
215		Rates and Taxes	202.00	
616		Insurance	524.10	
				9,044.22
	"	Loss on sale of Van		9,212.00
	"	BOARDING AND LODGING EXPENSES:		
79,104		Food Stuffs and Grinding charges	1,03,216.44	
2,560		Firewood & Fuel	3,807.68	
2,021		Utensils	1,213.17	
948		Current Charges	1,583.30	
1,406		Repairs to Electric Fittings ~~of buildings~~	230.15	
1,560		~~Garden expenses~~ Repairs and maintenance of buildings	1,741.75	
310		Garden Expenses	511.61	
2,170		Wages to Watchman	2,235.50	
--		Subscription to Periodicals	232.35	
130		Miscellaneous Expenses	139.25	
				1,14,911.24
15,123	"	Depreciation		7,496.00
1,36,612				1,69,658.55

		INCOME:	
15,600	By	Misereor Grant	25,000.00
--	"	Oxfam Grant	9,000.00
--	"	Belgium Grant	3,000.00
--	"	Contribution from MSSS Community Health Development Project	30,488.17
36,463			
730	"	Donation and Gift	10,546.69
54,908	"	Mess Fee from Staff	80,714.35
3,340	"	Trainee's Contribution	847.50
342	"	Interest	400.05
298	"	Nursery Fee	61.62
313	"	Income from kitchen garden	175.50
276	"	Sale of Note Books	54.21
24,342	"	Excess of Expenditure over Income	4,370.46
1,36,612			1,69,658.55

VIDE OUR REPORT ATTACHED
sd/-
FRANK & CO.
CHARTERED ACCOUNTANTS.

NAGERCOIL,
17-8-1976.

(seal)

/ True Copy /

Appendix 6

K.S.S.S. COMMUNITY HEALTH DEVELOPMENT PROJECT, MUTTOM.

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDING 31-3-1975.

E X P E N D I T U R E:

		Rs.P.
To Opening Stock: Medicine	....	16,430.51
" Medicine	...	1,11,533.22
" Allowance to Staff	...	1,95,[illegible].85
" Clinical Expenses	...	3,2[illegible].90
" Petrol, Disel and Oil	...	5,329.41
" Repairs and Maintenance of Van	...	8,104.71
"Re-pairs and Maintenance of Building.		551.30
" Rates & Taxes	...	582.67
" Insurance	...	1,667.50
" Training Expenses	...	---
" Printing & Stationery	...	15,477.31
" Teaching Aid	...	132.00
" Travelling Expenses	...	4,057.11
" Books & Periodicals	...	350.15
" Postage, Telegrams and Telephones	...	350.05
" Current Charges	...	433.95
" General Expenses	...	83.65
" Depreciation	...	11,997.24
" Contribution to KSSS Social Training Centre		36,462.71
" Excess of Income over Expenditure, transferred to Capital Fund.	...	---
	Total:	4,12,501.24

I N C O M E :

By Gifts	...	5,770.60
" Registration Fees	...	61,114.39
" Clinical and Medical Fee	...	2,98,999.96
" Interest	...	1,153.62
" Miscellaneous Receipts	...	523.75
" Closing Stock of Medicine	...	20,648.54
" Excess of Expenditure over Income..		24,290.38
	Total:	4,12,501.24

VIDE OUR REPORT ATTACHED.

(Sd/-)
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CHARTERED ACCOUNTANTS.

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Appendix 7 25 PAISE SCHEME

KOTTAR SOCIAL SERVICE SOCIETY

COMMUNITY HEALTH DEVELOPMENT PROJECT (25 paise scheme)

STATEMENT OF ACCOUNTS

INCOME:

No.	Details	Amount
		Rs. P.
1.	Pool of fund from local contribution	2,33,000.00
2.	Contingencies	8,750.44
3.	Oxfam grant	2,22,800.73
4.	Contribution from CHDP for Van depreciation	7,000.00
	Total:	4,71,551.17

EXPENDITURE:

1.	Gr ants issued to centres	2,13,000.00
2.	Oxfam grant issued to villages	67,000.00
3.	Purchase of Oxfam van	70,093.98
4.	Oxfam grant for nursery equipment	19,308.82
5.	Pay of Agricultural Instructor	5,065.60
6.	Health educators tranining expenses	9,000.00
7.	- do - Allowances	9,900.00
8.	School kitchen garden	640.14
9.	Family kitchen garden	3,096.86
10.	Deposit for van depreciation	7,000.00
	Total:	4,04,105.40
	Closing Balance:	64,445.77
	Grand Total:	4,71,551.71

K.S.S.S. TRAINING CENTRE, MUTTOM.

FIVE MONTHS INTENSIVE TRAINING FOR COMMUNITY HEALTH GUIDES.

S.No.	Subject	Periods	Staff
I.	Anatomy and	22	Self-teaching by assignments, guided by Dr.Anne Victoria, B.Sc.,M.B.B.S.
II.	Physiology		- do -
III.	Diseases affecting each system and management.	69	- do -
IV.	Pharmocology	19	- do -
V.	Community Health	19	- do -
VI.	Sex education, Family Planning, Veneral diseases	5	- do -
VII.	Obstetrics	17	Miss. Britto, Staff Nurse.
VIII.	Gynaecology	6	Staff Nurse, Staff Nurse.
IX.	Hygiene	15	-do-
X.	Immunisation	3	-do-
XI.	Child care	16	Sr.Sebastina, Staff Nurse.
XII.	Infectious diseases	15	- do -
XIII.	First Aid	8	- do -
XIV.	Microbiology	5	- do -
XV.	Nursing Procedures	17	- do -
XVI.	Field work	28 days	All the 3 staff
XVII.	Symposiums, Tutorials	34 Hrs.	All the 3 staff
XVIII.	Social Life	15	Sr.Christy B.A.BT. I.S.I. Trained.
XIX.	Community Development	15	Mr.Lucas,B.A. I.S.I.Trained.
XX.	Nutrition	10	Miss.Nesam,Homescience Dip. I.S.I. Trained.
XXI.	Home Management	10	- do -

1. Anatomy of various systems in the body.

11. Physiology of various systems.

111. Diseases affecting each system and management:

1) Eyes
2) Ears
3) Digestive system
4) Respiratory system
5) Circulatory system
6) Lymphatic system
7) Urinary system
8) Endocrine glands
9) Nervous system
10) Burns and scalds
11) Shock

IV. Pharmocology.

V. Community Health.

VI. Sex education, Family Planning and Veneral Diseases.

VII. Obstetrics.

1) Anatomy
2) Physiology of pregnancy
3) Mechanism of labour
4) Abnormal presentations
5) Conducting normal delivery
6) Care of the new-born.

VIII. Gynaecology

IX. Hygiene

1) Personal hygiene
2) Environmental hygiene
3) Air and ventilation
4) Santary disposal of excreta

X. Immunisation

XI. Child care

XII. Infectious diseases

XIII. First aid.

XIV. Microbiology

XV. Nursing procedures.

XVI. Field work: Visits to:

a) Primary health centre - Muttom.
b) Catherine Booth Hospital - Nagercoil.
c) T.B. Sanatorium - Asaripallam.
d) Leprosy hospital - Udayarvilai.
e) Cancer hospital
f) Manjalamoodu - For attending home deliveries.

XVII. Symposiums, Tutorials, Cultural activities.

XVIII. Social life:

1) Beauty of womanhood
2) Beauty of Motherhood
3) Beauty of Home
4) Social Training of children

XIX. Community development:

1) Leadership qualities in our village women.
2) Techniques of mass education.

XX. ~~Home Management~~ Nutrition:

1) Advanced study of low-cost balanced diet.
2) Practicals

XXI. Home Management:

1) Budgetting
2) Home decoration
3) Flower arrangement.

• • • • • • • • • •

I. ANATOMY OF	and	II. PHYSIOLOGY OF
1. Eyes		Sight
2. Ears		Hearing
3. Tooth.		
4. Respiratory System		Respiration
5. Circulatory system		Blood circulation
6. Lymphatic system		Lymph circulation
7. Digestive system		Digestion
8. Nervous system		Nervous system
9. Urinary system		Kidneys
10. Reproductive system		Menstration
11. Endocrine system		Hormones
12. Skin		Skin
13. Life - cycles of:		
a) Hook worm		
b) Round worm		
c) Tape worm		
d) Thread worm		
e) Guinea worm		
f) Mosquitoes		
g) Flies		

III. DISEASES AFFECTING EACH SYSTEM AND MANAGEMENT- Dr. Anne.

1. Eyes:
   a) Effects of Vitamin 'A' deficiency.
   b) Conjunctivitis.
   c) Contract.
   d) Injuries
2. Ears:
   a) Foreign body in the ear.
   b) Otitis media
3. Digestive system:
   a) Diseases of the mouth.
   b) Diseases of the oesophagus.
   c) Diseases of the stomach - Ulcers, Tumours.
   d) Diseases of the small intestines.
   e) Diseases of the Large intestines.
   f) Diseases of the Liver.
   g) Diseases of the Gall bladder.
   h) Diseases of the Rectum and Anal canal.
   i) Diarroeas and Dysenteries.
   j) Common beliefs about indegestion
   k) Symptomatic diagnosis of deseases of digestive system.
4. Respiratory System:
   a) Asthma.
   b) Bronchitis.
   c) Pneumonias.
   d) Tuberculosis.
   e) Lung abscesses.
   d) Foreign body in the respiratory tract.
5. Circulatory system:
   a) Congenital heart diseases.
   b) Anaemias.
   c) Hypertension.
   d) Sudden attacks of faints.
6. Lymphatic system:
   a) Defensive mechanisms of the body - Lymph nodes.
   b) Filariasis.
7. Urinary system:
   a) Infections of the urinary tract.
   b) Other diseases of the urinary tract.
8. Endocrine Glands:
   a) Diseases of the thyroid and the Parathyroids.
   b) Diseases of the Pituitary and Adrenal glands.
   c) Diseases of the Pncreas - Diabetes mellitus and incipides.

9. Nervous system:
   a) Injuries to the Nervous system.
   b) General paralysis.
   c) Meningitis.
   d) Poliomyelitis.
10. Burns and scalds.
11. Shock.

* * * * * * * *

111. PHARMOCOLOGY.

1. Action of drugs.
2. Vitamins.
3. Enzymes.
4. Antihistamines in allergy.
5. Analgesics and antispasmodics.
6. Rationale behind treatment of common illnesses like:
   a) Common colds and head aches.
   b) Diarrhoeas and dysenteries.
   c) Asthma & Oesinophilia.
   d) Skin diseases.
7. Antibiotics.
8. Side effects of drugs.

V. COMMUNITY HEALTH.

1. Definition of health and Community health.
2. Home or an institute as an unit of community health.
3. Comprehensive healthcare.
4. Spread of diseases with special reference to Kanyakumari District.
5. Screening of children in under-five clinics:
   a) Routine check-up, height & weight and their significance.
   b) Signs and symptoms of malnutrition.
   c) Diseases of vitamin deficiency.
   d) Early diagnosis of leprosy.
   e) Management of leprosy.
   f) Early diagnosis of Tuberculosis in children.
   g) Diseases of ear, nose and throat.
   h) Respiratory infections.

VI. Sex education, Family Planning and Veneral diseases.

* * * * * * * * * * * * * * * * *

VII. OBSTETRICS. Miss.Britto.

1) Anatomy of female genital organs.
2) Structural importance of female pelvis.
3) Physiology of pregnancy.
4) Ear ly diagnosis of pregnancy.
5) Antenatal checkup.
6) Preantal care.
7) Pathology of pregnancy:
   a. Abortions; b. Ectopic gestation; c. Vesicular moles; d. Hypermesis; e. Hydramnios; f. pre-eclamptic toxaemia and toxaemia; g. anti partum haemorrhage.
8) Mechanism of normal labour.
9) Management of normal labour.
10) Complications during labour - Post partum haemorrhage - Retention of Placenta.
11) Abnormal presentations and lies.
12) Normal puerperium.
13) Complications during puerperium.
14) Care of the new-born.

VIII. GYNAECOLOGY.

1) Infertility.
2) Leucorrhoea.
3) Prolapse of the uterus.
4) Tumours in the female genital tract.

* * * * * * * * *

IX. HYGIENE.

1) Personal hygiene:
   a. care of the clothes.
   b. Care of the Hair and nails.
   c. Care of the Ears,nose and mouth.
   d. Care of the eyes - injuries and infections.
   e. Rest,sleep,exercises and posture.
   f. Bath and skin care.
   g. Formation of good habits.
   h. Food habits and food hygiene.
2) Environmental hygiene:
   a. Drinking water.
   b. Cleanliness of house, class room and school.
   c. Cleanliness of ~~xxx~~ Road and other common places.
   d. Disposal of excreta, sputum, urine etc.
   e. Disposal of other wastages.
   f. Sanitary latrines.
3) Air and ventilation.
4) Occupational hazards.

X. IMMUNISATION.

1) Introduction - aim of immunisation.
2) Mantaux, B.C.G. and T.A.B.
3) D.P.T., Cholera, Small pox and A.T.S. and Tetanus toxoid.

XI. CHILD CARE.

1) Daily care:
   a. Bath and skin care.
   b. Breast feeding and artificial feedings.
   c. Toilet training.
   d. Conditions necessary for normal development of children.
2) Problems of the new-born:
   a. Premature babies.
   b. Feeding problems.
   c. Birth injuries.
   d. Neonatal jaundice and tettanus.
   e. Infections of the new-born - Thrush, Umbilical infections, Ophthalmia neonatorum.
   f. Surgical emergencies in the new-born - Imperforated anus, Congenital pyloric stenosis.
3) Milestones and early detection of abnormalities in development.
4) Common illness among children:
   a. Colics and crying spells.
   b. Constipation, diarrhoeas and dysteneries and vomiting.
   c. High fevers, convulsions and epilepsies.
   d. SSurgical emergencies in infants - Intussusception, Volvulus
   e. Common accidents with children - household poisonsings.
   f. Household medicine chest.

XII. INFECTIOUS DISEASES. Sr.Sebastina.

1) Introduction.
2) Mumps and Measles.
3) Chicken pox and small pox.
4) Diphtheria.
5) Whooping cough.
6) Tetanus.
7) Poliomyelitis.
8) Cholera.
9) Diarrhoeas and dysenteries.
10) Typhoid fever.
11) Influenza.
12) Worm infestations.

XIII. FIRST AID.

1) Introduction.
2) Haemorrhages, wounds, bandages.
3) Drowning - Artificial respiration.
4) Burns and scalds.
5) Foreign body --- in the eyes, ears and nose.
6) Dogbite and Rabies.
7) Common accidents, with poisons.

XIV. MICROBIOLOGY.

1) Conditions for the growth of micro-organisms.
2) Classification of microbes and diseases caused by them.
3) Resistance to antibiotics.

XV. NURSING PROCEDURES.

1) Professional ethics.
2) Preparation of home for the ill.
3) Care of the bed-ridden patients, pediculosis and management.
4) Taking temperature, pulse, blood pressure and respiration.
5) Enemata.
6) Hot and cold applications.
7) Inhalations.
8) Management of colds and rigors.
9) Techniques of disinfection.
10) Techniques of sterilisation.

XVI. FIELD WORK.

*1) Visits to:
a) Primary health centre - Mutton.
b) Catherine Booth Hospital - Nagercoil.
c) T.B. Sanatorium - Asaripallam.
d) Leprosy Hospital - Udayarvilai.
e) Cancer hospital - Neyyoor.
f) Manjalamoodu - for attending home delivery.

XVII. Symposiums - once a fortnight to encourage communication and pannel discussion among the students.

Tutorials - once a fortnight for closer understanding between the staff and students in small groups.
- for inernal assessment of students.

Cultural Activities - to encourage the students to develop all their potentialities in teaching the village people.

XVIII. SOCIAL LIFE:

1. Beauty of womanhood.
2. Beauty of motherhood.
3. Beauty of Home.
4. Social Training of children.

XIX. COMMUNITY DEVELOPMENT:

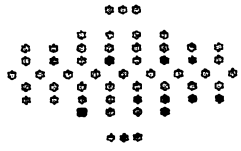
1. Leadership qualities in our village women.
2. Techniques of mass education.

XX. NUTRITION:

1. Advanced study of low-cost balanced diet.
2. Practicals.

XXI. HOME MANAGEMENT:

1. Budgeting.
2. Home decoration.
3. Flower arrangement.



Appendix 9

Kottar Social Service Society - Training Centre,

Muttom

Five months intensive training for health workers

Fifth Batch

S.No.	Subjects		Periods	Instructor
1.	Home Management	-	20	Mary Pushpa Bai
2.	Nutrition - Theory	-	20	"
	Practical	-	40	"
3.	Needle work	-	20	"
4.	Sex-education and family welfare	-	20	Sr. Josea
5.	Mother and Child care	-	30	Jegatha
6.	First aid and Home Nursing		20	Sr. Josea
7.	Public health and Hygiene	-	40	"
8.	Social Life	-	20	Sr. Christy
9.	Socio-economic problems in India	-	20	Lucas
10.	Community development	-	40	"
11.	Home gardening	-	20	Verghese
12.	Book-keeping	-	20	Sr. Christy
13.	Worship	-	20	Fr. Venantius.
			350	

Kottar Social Service Society - Training Centre, Katton.

Five months training for community health workers

I **Home Management**

1. Introduction to the subject
2. Organisation of a house
3. Duties and responsibilities of home-making
4. Budgeting and saving
5. House cleaning
6. Home decoration
7. Laundry

II **Nutrition**

1. Understanding basic food and nutrition
2. Planning and a balanced diet
3. Preparation of food
4. Diet for special groups

III **Needle work**

1. Differnet kinds of stiches and seams
2. Mending and darning
3. Embriodery
4. Machinge sewing
5. Taking measurements and cutting

IV Sex Education and Marriage Guidance

V Mother and child care

VI First-aid and Home nursing

VII Public Health and Hygiene

1. Definition of health and community health
2. Comprehensive health care
3. Environmental Hygiene
4. Health education

VIII Social life

IX Socio-economic problem in India

X Social Docterine of the Church

XI **Sociology and Social work**

1. Community Development
2. Co-operatives
3. Leadership
4. Extension work

XII **Home Gardening**

1. Introduction
2. Growing vegetables for home use
3. Kinds of manures and fertilizers
4. Classification of pesticides

XIII Book-keeping and Accounting

XIV Worship

Kottar Social Service Society - Training Centre, Kottar

Syllabus

I **Home Management** :

1. Introduction to the subject
   a. What is the home
   b. Difference between a house and home
   c. What is home management
2. Organisation of a house
   a. House site
   b. Planning of a house
   c. Arrangemant of rooms
3. Duties and responsibilities of Home-making
   a. Qualification of a home maker
   b. Different aspects of managing a home
4. Budgeting and saving
   a. Definition of a budget
   b. Importance of a budget
   c. Various steps in household budgeting
   d. Importance of saving.
5. House cleaning
   Daily - Weekly - Seasonal
6. Home decorating
   a. Colour scheme
   b. Colour combination
   c. Flower arrangement (Natural and Artificial)
   d. Framing and Hanging of Pictrues
7. Laundry
   a. Clothing and its care
   b. Washing of clothes and ironing
   c. Removing of stains

ii **Nutrition** :

1. Understanding basic food and Nutrition
   a. Introduction to the subject
   b. Classification of food groups
   c. Six food nutrition:

Corbohydrates	-	Minerals
Protein	-	Vitamins
Fat	-	Water

Practical work :

Preparation of Corbohydrates food, fired rice, lime rice, Preparation of protein rich food, dhall kodu, fish in banana leaves, gram fish curry, groundnut milk, eggless sponge cake.

Preparation of food rich in vitamins and minerals: drumstick leaves ponda, greens koottu, Sproutedgram salad, fruit salad, carrots halva, mango fulff.

2. **Planning a balanced Diet** :
   a. Definition
   b. Importance of a well balanced diet
   c. Basic four food groups

Cereals Milk and milk products
Flesh food stufis of pulses
Fruits and vegetables

d. Diet score card
e. Unbalanced - balanced diet - Cost relationship.

Practical work: - Preperation of low cost well balanced
Diet: - Tapioca with dhal, drumstick leaves, vegetable uppuma

3. Preperation of food:

a. purpose of cooking
b. effects of cooking
c. different kinds of cooking
d. serving meals

How to avoid wastage of food:

a. whpile buying
b. while preparing
c. while eating
d. while storing

Food preservation

4. Diet for special groups:

Pregnancy and lactation
Infancy and childhood
Invalids
Oldage

Practical work

Preperation of liquids diets

III. Needle work

a. Differmntkinds of stiches and seams
b. Mending and darning
c. Embmidary
d. Machine sewing
e. Taking measurements and cutting

IV. Sex education and Marriage Guidance:

Preperation : Answering a questionare to discover the attitude towards life, love and sex. - Group expectation
A set of slides - 110 slides - Love is life
Each session is followed by group dicussions and exercises

1. Session : - "God's creation and Beauty "
slide 1-36
2. Session : - Theme : man and animals - Themarvel and the intricasies of HUMAN BODY - Slide 37-50
3. Session :- Thes Theme; Growth or Maturity - Physical
- Emotional
- Social
Infantile Love tranforming into Adult love
- Slides; 51-73
4. Psychology of boys and girls
slides 74-82
5. Session : - Theme - Womanhood and motherhood
slides 83 - 101
6. Ultimated love
Slides 102-110
7 & 8. Sessions:- Veneral diseases - Prevention and management

V. Mother and child care:
a. Before birth : proper food, rest, exercises; peaceful environment, preparation for the baby
b. During birth: taking care of the new born baby
c. After birth : bathing feedingnad handling the new born food and clothing up to one year
d. Growth : pysical diet, physical developement
social : games
spiritual : formation of good habits, relation with God.
e. Common illnesses of children -signs and symptoms, management.
f. Common ailments among children and their treatment; Eye, ear and stomach trouble, colds and coughs, whooping coughs Teaching Prickly heat and scabbies and and mumps.

VI. First and Home Nursing:
a. Instruction on simple remedies
b. Minor accidents in daily life : cuts, nose bleeding, sprains burns
c. Drawning - Artificial respiration
d. Fractures
e. Poisonous bites
f. Nursing a patient at home.
- Patient's surroundings
- Care against noise, glare and unclealiness
g. Nursing an invalid
h. Taking care of a patient suffering from : Typhoid, malaria, small pox diarrhoea, dysentry, skin diseases.

VII. Public Health and hygiene:
1. Definition of Health by W.H.O. andwhile health or "Community Health".
2. Home or an institution as the unit of community health.
3. Definition of "comprehensive Health care".
a. Prevention of diseases.
b. Early diagnosis and adequate treatment.
c. Prevention of disabilities.
d. Rehabilitation.
4. Development of Diseases process with special reference to the diseases most prevalent in Tamil Nadu.
5. "Environment" and it's effects on "community Health".
6. Insect Vectors and their control.
7. Occupational Hazards and their prevention.
8. Role of preventive medicine in "Community Holist Health".
9. Health Education.
10. The Immunisation Scheme.
11. The impact of Tradition on our community health projects.
12. Nutrine in our community - Diseases of Malnutrition.
13. Community development in relation to health.
14. Water.
- Sources of water supply.
- Impurities in the water.
- Prevention of Pollution.
- Purification of water.
- Water - borne diseases.
15. Food :
- Food hygiene
- Food poisoning, its prevention.

- Food adulteration.
- Allergy.

16. Air and Ventilation:
    - Air pollution and its prevention.
    - Air-born diseases.
17. School Health and school health programme.
18. How to organise a Community Health programme.

VIII. Social Life :

a. Politeness, honesty, justice and other qualities.
b. Communication.
c. Interpersonal relationship.
d. Community building.
e. Spirit of service,
f. Welcoming and entertraining guests.
g. Cultural activites.

IX. Socio-Economic Problems in India:

a. General analysis of Indian situation.
b. Production and distribution pattern.
c. Trend in population growth.
d. Technology and Industrial development.
e. Poverty.
f. Political system in India.

X. Social Doctrine of the church:
a. Relegion and development.
b. Labour - Justice
c. Expolitation - Liberation.

XI. Sociology and Social work:

1. Community Development:
   a. Introduction and definition.
   b. Philosophy and principles of community development
   c. Religion and developement.
2. Co-operative:
   a. Philosophy and principles of co-operatives.
   b. Different types of co-operatives:
      - Consumers co-operatives
      - Marketing co-operatives
      - Credit and service co-operatives
   c. How to organise co-operatives
   d. Laws relating to co-operatives.
   e. Co-opentives education.
3. Leadership:
   a. Definition
   b. Types of leadership.
   c. Qualities of leader.
4. Extension work:
   a. Introduction .
   b. Basic principles.
   c. Explanation about community health programme.
      - Health Education.
      Importance of Home visits.
   d. Field problems.

XII. Home Gardening:

1. General introduction.
2. Growing vegetables for home use.
   a. Planning for garden.
   b. Location.
   c. Soil testing.
   d. Preparation of soil.
   e. Selection of seeds.
3. Kinds of manures and fertilizers.
4. Classification of pesticides.

XIII. Book-keeping and Accounting:

a. Single entry systems.
b. Day - book - Ledger - Statement of receipts and disbursements.
c. Preparing balance sheet - Profit and loss statement.

XIV. Worship :

In the content of Indian Spirituality and culture.

Appendix 10 244 ~~23~~

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K.S.S.S. TRAINING CENTRE, MUTTOM.

THREE MONTHS INTENSIVE TRAINING FOR HEALTH EDUCATORS [redacted].

S.No	Subject	Periods	Staff
I	Community Development	60	Mr. Lucas B.Sc. I.S.I. Trained Miss.Rosammal P.U.C., I.S.I. Tr.
II	Techniques of conducting Classes	20	Sr. Christy B.Sc. B.T. I.S.I. Tr.
III	Agriculture and home gardening	60	Agriculturist.
IV	Nutrition Education	40	Miss. Nesam B.Sc. I.S.I. Trained.
V	Health and hygiene in schools	50	Dr. Anne Victoria B.Sc. M.B.B.S. Sr. Sebastina R.N.R.M. Miss. Britto R.N.R.M.

K.S.S.S. TRAINING CENTRE, MUTTOM.

THREE MONTHS INTENSIVE TRAINING FOR HEALTH EDUCATORS IN PRIMARY SCHOOLS

I. COMMUNITY DEVELOPMENT:

a. Goal and methods of development
b. Analysis of Indian Situation
c. Programme planning to meet people's needs
d. Mass Education
e. Community Organisation
f. Leadership

II. TECHNIQUES OF CONDUCTING CLASSES:

a. Importance of organised teaching
b. Five basic factors
c. Steps in conducting a class
d. Model class
e. Practical teaching in Kudiapattanam and Muttom Schools

III. AGRICULTURE AND HOME GARDENING:

a. Introduction to the subject
b. Importance of vegetable garden
c. Planning the kitchen garden
d. Factors necessary
e. Climate

IV. NUTRITION EDUCATION:

a. Introduction to the subject
b. Food and its relation to health
c. Meal planning for pre-school children
d. Food economy
e. How to teach nutrition in schools
f. Methods suitable for nutrition education

V. HEALTH AND HYGIENE IN SCHOOLS:

a. Personal Hygiene
b. Environmental hygiene
c. Immunisation
d. Infectious diseases
e. First Aid
f. Screening of School Children

I. COMMUNITY DEVELOPMENT:

A. Goal and methods of development:
- Its concept and content
- Towards Socio - Economic transformation

B. Analysis of Indian Situation:
- The facts of the Indian Situation
- India - a political profile

C. PROgramme planning to meet People's need:
- Natural role of planning
- Some guides to planning
- A concept of needs

D. MASS EDUCATION:
- Present education in India
- Education and development
- Techniques of Mass Education

E. Community Organisation:
- Techniques of approach
- Methods of organisation
- Relationship between home and school leadership

F. Leadership:
- Leaders and group methods
- Concept of leadership
- Identifing local leadership
- Methods and leadership training
- Group discussion
- The Socio - Drama

II. TECHNIQUES OF CONDUCTING CLASSES:

A. Importance of organised teaching:

B. Five basic factors:
- Teaching instructor
- Learner or trainee
- Subject - matter
- Teaching material and equipment
- Physical facilities.

C. Steps in conducting class:
- The warming up or preparation step
- The presentation step
- Subject - matter
- The application step
- The testing or check up

D. Model class:

E. Practical teaching in Kadimpattanam and Mattom Schools.

III. AGRICULTURE AND GARDENING:

A. Introduction to the subject:

B. Importance of vegetable garden:

C. Planning the kitchen garden: Location

D. Factors necessary:
- Final plan
- Soil, fertilisor, seeds, irrigation, pesticides
- Germination of seeds and replanting
- Manures andfertilisers
- Maintaining the garden

E. Climate:
- Winter vegetables
- Hot vegetables
- Monsoon vegetables

IV. NUTRITION EDUCATION:

A. Introduction to the subject:
- Food and total development
- Food as the basis of life-Physical and mental
- Classification of different food groups

B. Food and its relation to health:
- Carbohydrates and fats (energy yielding foods)
- Accurance in nature, classification and characteristics, function in the body-chief food sources.
- Proteins (Body building foods)
- Accurance in nature, basic structures. Functions in the body, Quality of animal, plant and mixed proteins recommended allowances, Chief food sources, effects of protein defficiency on the body.
- Minerals and vitamins (Protective foods)
- Minerals - accurance in nature, Functions in building and maintaining bones, teeth and blood.
- Vitamins - Definition, brief history and discovery classification, general function in the body, recommended allowances, food sources.
- Practicals - preparation of low cost well balanced diet. eg. Tapioca with dhal and drumstick leaves.
- Vegetable uppuma
- Vegetable pulao

C. Meal planning for pre-school children:
- Practicals:- preparation of meals for primary school children

D. Food economy:
- Economic food purchasing and preparation
- Minimising nutrient losses on processing, storage and preparation, Factors affecting food habits, food believes in India.

E. How to teach nutrition in schools:
- Advantage of teaching nutrition to school children
- General goals of nutrition education in schools
- Sample survey in food habits
- What are the reasons for the poorstate of child nutrition in the country.

F. Methods suitable for nutrition education

V. HEALTH AND HYGIENE IN SCHOOLS:

A. Personall hygiene:

- Care of clothes
- Care of hair and nails
- Care of ears, nose, mouth
- Care of eyes, injury, infection
- Rest, sleep, exercises, posture
- Bath and skin care
- Scabies
- Necessity of foot wear
- Food habit and food hygiene
- Formation of good habits.

B. Environmental hygiene:

- Drinking water
- Cleanliness of class-room and school
- Cleanliness of home
- Cleanliness of road and common places
- Disposal of excreta stool, urine, sputum
- Disposal of other wantages.

C. Immunisation:

- Introduction - aim of immunisation
- B.C.G., Mantoux, T.A.B.
- D.P.T., Cholera, Small-pox, A.T.S.

D. Infections Diseases:

- Introduction
- Mumps and measles
- Smallpox and chickenpox
- Diptheria
- Whooping cough
- Tetanus
- Polimyelitis
- Malaria
- Typhoid fever
- Cholera
- Diarrhoeas and dysentry
- Wearms - Hook worm, round worm, thread worm, tape worm and guinea worm

E. First Aid:

- Introduction - aimof first aid
- Wounds and haemorrhages, Burns and scalds
- Bandages, Artificial respiration - drowning
- Foreign body in the eye, nose and ears
- Dog bite and rabies
- Common accidents with poison
- Management

F. Screening of school children:

- Routine check up - height, weight
- Symptoms of malnutrition
- Diseases of vitamin deficiencies
- Early diagnosis of tuberculosis in children
- Diseases of ear, nose
- Diseases of throat
- Respiratory infection.

Appendix II

KOTTAR SOCIAL SERVICE SOCIETY.

TRAINING CENTRE - THIRUMALAI.

--:C:--

INTENSIVE INSERVICE TRAINING IN COMMUNITY DEVELOPMENT AND HEALTH CARE.

SYLLABUS.

Sl.No.	Subject		No.of Periods.	Staff
1.	Community Development (C.H.D.P.)	...	30	Sam Florence.
2.	Social Life	...	12	Dr. Christy
3.	Family life and Sex Education	...	18	L. Padmavathy
4.	Obstetrics	...	48	"
5.	Gynecology	...	8	"
6.	Child Care	...	18	"
7.	Hygiene and Community Health	...	18	M. Jegatha
8.	Nursing Procedures	...	12	"
9.	First aid and Home Nursing	...	6	"
10.	Infectious diseases	...	18	"
11.	Microbiology	...	12	"
12.	Family Planning - Natural Family Planning		12	L. Padmavathy
13.	Venereal disease	...	4	"
14.	Home Management	...	12	N. Ponnamma
15.	Nutrition - Home Gardening	...	12	"
	Total	...	240.	

I. **Community Development:-**

a - **Socio - Economic Problems in India:**

1 - General analysis of Indian situation.

2 - Trend in Population growth.

3.- Poverty.

4 - Exploitation and Liberation.

b. **Community Development:**

1 - Goal and methods of development.

2 - Mass Education.

3 - Community Organisation.

4 - Leader-ship

c **Community Health Development Project.:-**

1 - Different approaches to health care.

Community Health Care.

- Hospital and dispensary care.

2 - Definition of health

3 Prevention is better than cure.

4. A rural Community Health Programme with Health Centre.

5 - 25 Paise Scheme.

II. **Social Life:-**

1 - Spirit of Service

2 - Community Life.

3 - Some rules on politeness.

4 - Interpersonal relationship.

5 - Beauty of Woman-hood.

6 - Beauty of Mother-hood.

III. **Family Life and Sex Education:**

1 - Love and happiness.

a - The nature of conjugal love

b - Love's Maturing.

c - Love's reward.

2 - Know yourself and your partner.

a - Physical aspect (Health, appearance, Age, Masculinity and Feminity).

b - Intellectual aspect (Intellectual equality, judgement, professional competance Social Class).

c - Moral aspect (Affection, Temperance, purity, Loyalty).

d - Religious aspect (spirit of faith and piety, ideal).

3 - **Conjugal love.**

a - Love, human love, true and false conjugal love.

b - Conjugal love and happiness.

4 - **Engagement.**

a - Nature and purpose of engagement.

b - Preparation for Marriage (Religious practice, Question of Children, Question of family budget).

....3

5 - Masculine and Feminine Psychology.

a - Temperaments and tendencies.

b - Man and woman's vocation

c - Pysical aspect.

d - Intellectual aspect.

e - Emotional aspect.

6 - The spirituality of marriage.

a - Marriage seen through God's eyes.

b - Faithfulness.

7 - Masculine and Feminine Anatomy and Physiology.

a - The female sex organs.

b - The male sex organs.

c - The role of personal and Social purity.

d - Venerial disease.

8 - Marriage Life:

a - Relations between husband and wife.

b - Conception and Pregnancy.

c - Birth.

d - Lactation.

9.- General Hygiene and Sex hygiene.

a - Basic Principles.

b - Individual Hygiene.

c - Conjugal Hygiene.

10 - <u>Rights and duties of Married Life</u>.

a - What is permitted.

b - What is forbidden.

c - Fidelity and chastity.

IV. <u>Obstetrics</u>:-

1 - Anatomy and female genital organs.

2 - Structural importance of female pelvis.

3 - Physiology of Pregnancy.

4 - Early diagnosis of Pregnancy.

5 - Antenatal Check up.

6 - Prenatal Care.

7 - Pathology and Pregnancy.

a - Abortions , b. Ectopic gestation, c. Vesicular mole.

d - Hyperemesis gravidarum, e. Hydramnios,

f - Pre-Eclamptic toxaemia.

g - Antepartum haemorrhage.

8 - Mechanism of normal labour.

9 - Management of normal labour.

10 - Complications during labour - post partum haemorrhage, retention of Placenta.

11 - Abnormal puerperium.

12 - Normal puerperium.

13 - Complications during puerperium.

V. Gynecology:-

1 - Infertility.

2 - Leucorrhoea.

3 - Prolapse of the uterus.

4 - Tumours in the female genital tract.

VI. Child Care:

a.- Daily Care.

1 - Bath and skin care.

2 - Breast Feeding and Artifical Feeding.

3 - Toilet Training.

4 - Conditions necessary for normal development of Children.

b - Common illness among children:

1 - Colics and crying spells.

2 - Constipation, diarrhoea, dysteneries and Vomiting.

3 - High fever, convelsions, and epilepsie.

4 - Common accidents with children - house hold poisonings.

c - Problems of New born:

1 - Premature babies.

2 - Feeding Problems.

3 - Birth injuries.

4 - Neo-natal jaundice and tetanus.

5 - Infections of the new born: Thurst, umbilical infections apthalmic neonatorum.

6 - Surgical emergencies in the new born:

Imperforated anus - Congenital Pylloric Stenosis.

B. Milestone and Early Detection of Abnormalities in Development:

VII. Hygiene and Community Health:

a - Personal Hygiene.

1 - Care of the cloths.

2 - Care of the hair, nail, ear, nose and mouth.

3 - Bath and skin.

4 - Rest, sleep, Experience and Posture.

5 - Food habits and good hygiene.

b - Environmental hygiene.

1 - Drinking water.

2 - Cleanliness of the house.

3 - Disposal of excreta, sputum, urine etc.

4 - Disposal of other wastages.

5 - Air and ventilation.

VIII. Nursing Procedure:

1 - Profession ethics.

2 - Preparation of home for the ill.

3 - Inhalations.

4 - Techniques of disinfections.

5 - Techniques of sterilisation.

IX. First aid and Home Nursing:

1 - Introduction.

2 - Haemorrhages, wounds, bandages.

3 - Drowning - Artificial respiration.

4 - Burns and Scalds.

5 - Foreign body in the eyes, ears and nose.

6 - Dog-bits and Rabies.

7 - Common accidents with poions.

X. Infectious Diseases:-

1 - Diptheria

2 - Whooping cough.

3 - Poliomyelitis.

4 - Tetanus.

5 - Cholera.

6 - Typhoid fever.

XI. Microbiology:-

1 - Conditions for the growth of micro-organisms.

2 - Classification of microbes and diseases caused by them.

3 - Resistance to antibiotics.

XII. Family Planning - Natural Family Planning.

1 - Anatomy and Physiology of Reproductive system.

2 Responsible parent hood.

a - Planning a family.

b The problem of Over Population.

c - Birth Control and Natural Family Planning.

3 - The Ovulation method and Family Planning.

4 - The Cycle how to chart.

XIII. Venereal disease.

1 - The Mode of Transmission.
2 - Syphilis.
3 - Gonorrhea.

XIV. Home Management:

1 Introduction to the subject.
2 - Organisation of a house
3 - Duties and responsibilities of a home-maker.
4 Budget and Saving.
5 - Home decoration.

XV. Nutrition - Home Gardening.

A. THEORY.

1 - Understanding basic food and Nutrition.
2 - Food and its relation to health.
3 - Planning a balanced diet.
4 - Food Economy.
5 - Food storage and Food preservation.
6 - Diet for special groups.

B. PRACTICAL.

1 - Low cost well balanced diet.
a - Tapioca with dhal and drumstick leave.
b - Vegetable uppma with vegetable pulse.

2. Iron rich food - ragi preparations.

3. Preparation of CH_2O food.

4. Preparation of food rich in vitamins and minerals.

5. Preparation of liquid diet.

C. HOME GARDENING.

a - Theory:

1 - Benefits of home gardening.

2 - How to make a home garden.

3 - Method of cultivation and protection.

b - Practical.

Awareness of the people who are not the beneficiaries of K.S.S.S.

Manavalakurichi panchayat has been taken for study to know the awareness of the non-beneficiaries towards K.S.S.S. programme. In order to have an idea of the community the investigators went to meet the President of that panchayat Mr A.K. Sundaram Pillai. This panchayat has been selected as one of the best panchayats in India in 1973. A tone of pride sounded while telling this. This panchayat consists of population around 12,000. There are two High Schools one for girls - Government Girl's High School, and the other Babuji's Memorial Boy's High School, a management school. There is one primary school which has, the strength is about 9000. A part from this there are 3 'Balar Palli' i.e. nursary school. Regarding Medical facilities there is no Primary Health Centre within its reach. They have to attend Muttom P.H.C., 6 Kms from this place. But there is one private clinic 'Mary Hospital' in the midst of the locality.

Mother and child welfare activities:- Under this the 3 preprimary schools i.e. Balar pallies play a role. These nurseries are functioning for about 14 years. 120 beneficiaries, i.e. 40 pregnant and lactating mother, 40 children between the years 6 months to 2 years, and 40 children below 5 years are getting mid-day meals. CARE is providing Balgar, Balanar, C.S.M., and sorkan wheat. 3 paise per head is incurred by the panchayat per day. Twice in a month Dt. Welfare Officer, Mukyasevika and Gram sevikas are visiting and inspect the activities. The children are taught on cleanliness - to keep the hands and feet clean, their nails cut and to write down the alphabets. They are let to make clay models as an outlet of their expression. After midday meals they are made to sleep for an hour. Then in the afternoon they sing chorus rhymes. Then they are left for playing till 4 p.m. Regarding

mothers there is one Mother Sangam nearby the President's house. Weekly once Tailoring class is being conducted. But the girls used to come to class daily for practising. On that particular day (i.e.) on every Tuesday meetings are arranged, nutrition education is given. In High schools under craft class the girls learn stitching, basket making, net and mat making etc.

Health facilities from outside the community: When the investigator interviewed the people it is revealed that they are not aware of K.S.S.S. programme. It is due to its far off distance. Only in Chinnavalai K.S.S.S. conducts the clinic. They told that it is natural that people seek help from nearby medical source available. But on every Thursday - medical facility is availed from Neyyoor Mission Hospital. A paramedical personnel comes on every Thursday on cycle to distribute medicines, tablets, vitamines for minor ailments. It is also found out that social status plays an important role in seeking the help from other agencies. For (e.g.) to investigators were told that very poor people, (i.e.) of very low in economic status struggling even for daily living seek the help of missionaries aid. One woman frankly told that she won't be a beneficiary due to the fear that the church people may convert her to christianity. As far as Muslims concerned, ladies are not usually coming out of their house. So it is obvious that they are not aware of K.S.S.S.

When interviewed the educated people (i.e.) the teachers, the investigators came to know that though they have not heard of the K.S.S.S. programmes. After explaining in detail its activities they welcomed it. They expressed that they are ready to send Volunteers for K.S.S.S., so that they can have a clinic within their village or Panchayat.

A. Govindachari

Appendix 4.

1 DIOCESES

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Family Planning
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pre-nuptial inquiry.
nd Bishop S. Pimenta

ERNANDES

the death of Mgr. Ayres
rmel's, Bandra on Saturday
an operation. Mgr. Ayres
23rd in the Sacristy of Dabul
was packed to capacity with
and Mt. Carmel's. Over 60
Exequial Mass concelebrated by
and 14 priests. His Eminence
final absolution, delivered a short
h he said that Mgr. Ayres had died
his apostolate, when he was making
build a new church for Mt. Carmel's.
mentioned that for four years during the
es had shouldered the burden along with
Holy Name Parish, especially the Konkani
n a letter to him before his illness, Mgr.
ed forgiveness of all those whom he may have
t as he forgave those who may have hurt him.
obituary will appear next week. R.I.P.

CHARISMATIC MISSION

a preparation for the forthcoming National Charis-
atic Convention which will be held in October, there
ill be a Charismatic Mission conducted by Fr. James
D'Souza and Fr. Rufus Pereira at St. Michael's Church,
Mahim, from Saturday, 4th September to Friday, 10th
September, every evening except the 8th, from
7-00 p.m. to 9-00 p.m.

C.R.S. COMPLETES QUARTER CENTURY OF SERVICE

On July 9, 1976 Catholic Relief Services-USCC quietly celebrated the successful conclusion of 25 years of service in India.

It was on July 9, 1951, that Catholic Relief Services opened its first office in Madras. Since then CRS has grown to an organisation with six offices serving 1.2 million people each year. The headquarters are situated in New Delhi, with zonal offices in Bombay, Madras, Calcutta, Bangalore, Cochin and Delhi. Assistance is given to every State in India from these offices.

Catholic Relief Services-USCC is a private voluntary agency through which the Bishops of the Catholic Church of America, along with other private organisations and lay people collaborate to help the poor and needy of the world. Since its early beginnings in 1917 as the National Catholic War Council (NCWC) aimed at co-ordinating the service work of the Catholics during World War I, Catholic Relief Services-USSC, has helped the refugees, the war stricken and displaced persons, victims of disasters, emergencies and the poor of the world.

From the inception of Catholic Relief Services-USCC, in 1943, aid in the form of food and clothing, and medical supplies, have been provided to the tune of $ 2.82 million. By the end of 1975, Catholic Relief Services had provided supplies and services to 86 countries, to 14.5 million people, shipped over 669 million pounds of supplies, totalling US $ 226.54 million.

Catholic Relief Services-USCC India Programme is active in all States of India in helping the "poorest of the poor" to develop better lives through far ranging programmes. CRS-USCC works in co-operation with the various State Governments and agencies, the U.S. Embassy, U.S. AID and local Catholic and lay organizations to provide the needed supplies, foodstuffs, equipment and services.

The India Programme serves 1.2 million people of which 275,000 are assisted in the Bombay Zone of Maharashtra, Gujarat, Madhya Pradesh and parts of Andhra Pradesh, Nagar Haveli and Rajasthan. Over 220,838,000 pounds of foodstuffs were allotted through the India Programme of which 58.8 million pounds were meant for the Bombay Zone.

Projects under this programme included *FOOD FOR WORK*, helping villages and towns through socio-economic development schemes to better the living standards. Digging and deepening wells, building bunds, roads, irrigation schemes, dams, bridges, low cost houses, godowns, and medical facilities through work by the villagers for food are just a few ways in which CRS sought to develop the area.

Mother/Child Health Care: helps children aged 0-5 years, and pregnant mothers to develop nutritious feeding habits with selected foods, preparations and education. Medical attention and controlled weight development are important ingredients of this programme.

Child Feeding and *School Lunch Feeding* help children over 5 years to develop strong body and healthy mind through at least one good meal a day.

C.R.S. has other schemes for orphanages, training centres, hospitals, leprosy clinics, education of the poor, credit union, and technical consultancy service

that are funded and supported by donors and private organizations around the world, such as, the Australian Catholic Relief, Caritas-Austria, CAPOD, Help the Aged/U.K., Medico International, Germany and Switzerland, OXFAM/U.K. etc., in all 86 organizations in 19 countries. They all work in close co-ordination with Catholic Relief Services-USCC to help those who cannot help themselves.

The underlying philosophy of Catholic Relief Services is the Christain compassion and concern for the poor, regardless of race, creed, or political affiliation. "Catholic Relief Services accepts this mission in the belief that every human being is entitled to at least the minimum of material goods which will enable him or her to live in dignity".

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73 61 62 70 53 59 68 62 65
125 110 121 56 58 58
62 55 67 136 137 151 149 131
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1. name of the centre: KSSS Community health