

CONTENTS :

CHAPTER I

1.PROJECT NUMBER AND DETAILS

2.NEED AND SIGNIFICANCE OF BLOOD AND BLOOD DONATION

- National blood Policy
- WHO Guidelines and recommendations
- Blood Donation as Community Health Programme

3. Scenario in Kerala

4. Nature and Scope of Study

5. Review of Literature

6. Objectives

7. Methodology

Phase I

Phase II

CHAPTER II

Phase I

A Situational Analysis of Blood Banks in Thiruvananthapuram District:

Results of the study

Salient Findings

CHAPTER III

Phase II

Organisation and Implementation of voluntary blood donor programme in the Community by participatory approach

1. Introduction of the programme
2. Tools and techniques
3. Activities formulated and implemented
 - Training workshops for leaders of the programme
 - Assessment of Community through a participatory health survey
 - Ward wise action for building awareness on blood donation in the Community
4. Results in a nutshell

CHAPTER IV

DISCUSSION AND CONCLUSION

- 1. People,s participation in health oriented programmes**
- 2. Acceptance as an important principle in participation**
- 3. Role of researcher in Participatory programmes**
- 4. Side Bench technique**
- 5. Continuous interaction**
- 6. Monitoring an important tool for sustainability**
- 7. Case for institutionalisation of the programme**

ACKNOWLEDGEMENT

REFERENCES

NEED AND SIGNIFICANCE OF BLOOD AND BLOOD DONATION:

Blood is a vital life saving fluid, it is an everyday need in most hospitals dealing with surgical cases and in all cases where bleeding is anticipated .In cases of severe blood loss (more than 1000 ml) as in accident cases or in major surgeries the blood loss has to be substituted immediately . There is also need for transfusion in cases where there is deficiency of blood and its components(e.g.: anaemic cases need to be transfused with red blood cells , hypoproteinemia cases need plasma etc.) to keep the body functions normal. Blood has to be transfused periodically for bleeding disorders like thalasemia, hemophilia etc. At present the source of blood for transfusion are human beings themselves and this gives it ‘a unique’ status. A number of psychosocial factors are involved before a unit of blood reaches a patient. This involves people who have to become donors, it involves relatives of patients, organizers of blood donors, and in fact, it involves the society at large. It also involves the blood bank / blood transfusion services that take up the responsibility of collecting this valuable fluid and distributing it to patients. “Blood transfusion services have now become an integral part of health care system throughout the world. Provision of safe blood in an efficient, coordinated, cost-effective manner to all those who need it, is recognized as an essential function of health providers” (Uton Rafei, 1998).

Blood Transfusion Services (BTS) are institutions that are responsible for the collection and distribution of blood required for transfusions to patients. The goal of every BTS is to provide SAFE BLOOD for its patients. There are many technical factors that are to be considered before a unit of safe blood is provided. An additional constraint is that, this VITAL FLUID blood is of short supply and the demand always

overtakes availability. WHO has placed the demand at 7 units per hospital bed and 10-15 units per specialized services (KSBTS, 1994).

NATIONAL BLOOD POLICY

In 1992 the Supreme Court of India, asked the Govt. of India for its comments on a proposal for formulation of a national policy on blood transfusion and establishment of a national institute of blood banking and transfusion, to improve transfusion standards and blood bank operation. A division bench comprising of Chief Justice Mr.M.H.Kania ,had directed a public interest organisation “Common Cause” which had sought a ban on all unlicensed blood banks, to submit a scheme for improvement in blood transfusion system in the country. This served a focus of attention to ensure action for adequate and safe blood for patients. Blood Transfusion Service was managed by the EMR section of the Health Services of the country and due to many other basic health problems that had to be tackled; it did not receive the support and attention of the Government. However, the advent of the HIV epidemic caused a panic as the safety of blood supply was at stake, due to the lack of a standardised and organised set up. The entire responsibility of blood transfusion service was handed over to the National AIDS Control Organisation, as a Blood safety Programme in 1992. HIV testing, though important, is only a small facet of a blood transfusion service, but easy availability of funds was the justification. In January 1996, the Supreme Court of India directed the Government to set the house in order. In compliance with the directives, National and State Blood Transfusion Councils have been constituted as autonomous bodies for planning and management of blood transfusion service.

The basic mandates of these councils are as under:

- Formation of National Blood Policy
- Promotion of a Voluntary Blood Donor recruitment programme
- Development of well equipped nodal blood centres
- Strengthening of the enforcement mechanism of regulatory authorities
- Promotion of rational use of blood
- Human resources development through introduction of training programme

The progress after the Supreme Court judgement is rather slow and the Blood Transfusion Services continue as hospital based programmes under different managements and in very few places by the Red Cross and other NGOs. The Blood Transfusion Service in the country is yet to be optimally managed and still lies scattered.

WHO GUIDELINES AND RECOMMENDATIONS :

WHO has developed guidelines and recommendations for national policies and plans for the development of blood programmes. Resolution WHO 28.72 recognises the need for national blood transfusion services based on voluntary non-remunerated donations with protection for the donor and the recipient. In the guidelines for National Blood Programmes, it spells out among other technical issues “within the framework of the National policy, the blood programme should develop and maintain all the services required to provide safe and adequate supply of blood and blood products by:

- developing donation of blood from voluntary non-remunerated low risk donors who donate regularly .It is acknowledged that this will take time to be developed fully and should be started as soon as possible”.

Here we must note the importance given to promotion of voluntary blood donor programme, which is considered as foundation for any BTS. It is worth noting the

comments of Dr.Zarin Barucha, one of the leading Transfusion experts of the country.

There is a need to concentrate on the donor programmes in all the States of the country.

These programmes should target the potential donors and make them understand

- the need for blood
- the regular requirement of blood
- safety of blood supply
- safety of blood donors'

Blood Donation as Community Health Promotion Programme :

Blood Donation is a unique community programme, for here “blood” has to come from the people themselves. It is a self help, self supporting programme. It involves inconveniences and sacrifice by people for “mutual support”. The advantages and benefits have to be well understood and the need felt, before the people can adopt it. People have to become blood donors and help each other in times of need. A blood programme needs organisation if it has to serve its purpose. It also means heavy responsibility on part of the leaders who take up the programme. Commitment and integrity of leaders play an important part. Much is in stake for the local leaders, who have to keep their word to organise donors and help people, for it is a “life saving programme’, and leaders cannot falter in the moments of need. The stakes are rather high for people involving in the programme. It will a do or die situation for the leaders, once the programme gains momentum. Some characteristics of a good voluntary blood donation programme are:

- involves the community
- can induct the best available persons for a particular job

- helps in improving the quality of life
- uses manpower is a vital resource
- can work with minimum funds
- volunteers contribute according to their ability and skill
- there is place for everybody and anybody willing to work for the cause of the programme.

There are four fundamental requirements for such programmes:

Work
People
Organisation
Working place

The volunteers are individuals but they have to work together as team. Such an organised group always has a distinct character. Though individuals, their vision, their practices, their attitudes have a common feature. Though voluntary, the organisation cannot evade responsibility and commitment. It raises the expectations of the community. There are a number of challenges facing people who want to provide safe blood to the society. Long back, The Alma Ata conference had emphasised the importance of full and organised community participation and ultimate self reliance with individuals, families, and communities assuming more responsibility for their own health. The enabling concept when applied to health is to transfer of control of important resources in health, notably knowledge, skills, authority, and money to the community. Community action probably holds great potential with the emphasis on community projects, and development programmes, all of which should be under the control of the community itself. But there is a need for information, training and resources that can make it possible. It is a combination of educational, organisational, economic and environmental

support. The increasing focus on participation approach, involving the community, in health programmes is the behaviour that is greatly influenced by the environment in which people live. Community Organisation as a means of achieving healthier life styles among people, decreasing the morbidity and mortality has been reported by Blackburn (1983). Community Organisation is based on “Principle of Participation” (Green 1986), which states that large scale behavioral change requires the people heavily affected by a problem to be involved in defining it, planning and instituting steps to resolve the problem, and establishing structures to ensure that the desired change is maintained.” The ‘Principle of Ownership’ is closely related to the principle of participation. Ownership is that the local people must have a sense of responsibility for and control over programmes promoting change, so that they will continue to support it even after the initial organising effort. The community as a system includes individuals, sub systems and the inter relationship between them. Some important subsystems identified are political sector, economic, health, communication, education, religious, recreational, social welfare and voluntary and civic groups. From a systems perspective when one is affected there are adjustments or responses in the other parts of the system. However, it takes a long time to affect the entire system. Community intervention is one effective strategy for health promotion programmes.

SCENARIO IN KERALA :

The requirement for blood in the State in 1994 had been calculated at 3.5 lakhs annually as against 2 lakh units collected. The need for 2000 is anticipated to be about 5 lakh unit annually (KSBTS, 1994). It is like saying “water, water everywhere but not a drop to drink”!

Blood, for our Thiruvananthapuram based hospitals is available mainly from urban areas and by replacement donors brought by patients along with them from other parts of Kerala and other neighbouring states. The sub urban areas are yet to contribute to the main stream.. Moreover there is no concerted and concentrated organisation to take the responsibility, the blood donor programme is very poorly organised and lies scattered even in the city and almost absent in the peripheral areas, except for a few programmes here and there. Blood has been defined as a “drug”, but what makes it difficult is that blood unlike any of other drugs, is not manufactured in any commercial factory, but comes from a live human being, who has emotions and very much forms a part of the society, whose actions and reactions all affect his act of blood donation (he / she may decide to donate or not to donate due to a number of reasons). So also is the patient who has his own share of psycho-social problems (and frantic search for donors adds to their burden). Both of them have to be brought together and an interaction established, and encouraged so that the needy will be served with no harm to the person who serves the needy. This is a parameter of a healthy society.

Kerala takes a pride of place among other Indian States when health of its population is concerned. But we lag behind in the field of Voluntary Blood Donation. Like most states in India, there is a shortage of blood here also. Voluntary Blood Donation programmes are usually services provided by NGOs. In other states like West Bengal, where the voluntary blood donor programmes have achieved an international image. But in the Kerala scenario this type of NGO activity is absent, with the exception of a few groups here and there. Another reason why we have to take intensive efforts to organise our blood donation programmes is that, Transfusion

Transmitted Diseases are on the rise (eg. Hepatitis B, Hepatitis C, HIV etc.) and the nature of the infections is such that even if the collected units are fully tested for infections the units do not become foolproof. An example of this is the 'window period' in HIV infection. As the routine tests can detect only the antibodies to the virus, which develop only after a certain period after the exposure, to risk activities. The tests will not detect a donor donating at this stage of his infection. Voluntary Donors are preferred for they are not under any pressure to withhold information harmful to the patient. It will be better if we can make provisions for blood to be available from known, local sources, rather from unknown sources. It is here that such organised blood donor forums can come in handy for the community.

NATURE AND SCOPE OF THE STUDY:

It is time that there is up gradation of community services to serve this cause so that it will drastically bring down the problems faced by patients in this area. It is high time we make the people aware of this responsibility and the importance of becoming self sufficient in their blood needs. Therefore an action programme undertaken at Vilappil (Thiruvananthapuram) attempts to make a beginning in this area. The aim is to prepare the peripheral areas of Thiruvananthapuram for this challenge, so that there will be an expansion of the donor base already available, and also it will prevent people from relying on a donor base unknown to them. The programme also aims at a participatory approach to the intervention to ensure sustainability of the programme, so as to make it a model to other Panchayats also. Moreover it will be a programme of making the attempt to make available ,the existing resources and infrastructure(eg extending the available technical service of a blood transfusion service available in

Thiruvananthapuram) for the betterment of the community.

The study aims to examine the the scenario of blood transfusion service in one of the major districts of Kerala, that is the Thiruvananthapuram District, and also to take up an action oriented programme , in the periphery area of the District, to extend the blood donor base beyond the urban area. The idea is to build a model Panchayat Based Blood Donor Programme, by participatory approach, a model that is suited for similar communities, the idea is to create a self sustaining programme, develop its local resources including human resources so that, they can if needed cater to the need of other Panchayats. The claims may be tall at this stage but the investigator believes that much can be done, taking into consideration the high level of health consciousness among the people and the sound literacy base of the State. The Community intervention has been initiated adopting the ‘Principles of Community Organisation (CO)’ as its base for community intervention. “Community Organisation is a planned process to achieve a community to use its own social structures and any available resource (internal or external) to accomplish community goals, decided by community representatives and consistent with local values. Purposive social change interventions are organised by individuals, groups, or organisations from within the community to attain and then sustain community improvements and new opportunities”. The project proposes to go through the process of CO, community analysis, design initiation, implementation, maintenance and consolidation, dissemination and reassessment.

REVIEW OF LITERATURE :

Blood Transfusion is by and large a life saving procedure. Prevalence of diseases in increasing population has proportionately increased the requirement of blood, which could be met only by having sustained and planned approach from voluntary blood donation. Many hospitals in the country institute a blood replacement programme in an effort to overcome blood shortages and to avoid difficulties of recruiting voluntary blood donors by putting the onus of finding blood donors on patients The mistake is to look upon the blood transfusion services as an emergency need, whereas it is in fact, an organized voluntary social service (DGHS, 1990).

A potential blood donor must be sufficiently motivated to spend time in blood bank..... in spite of personal inconvenience. Donor psychology must be built on the premise of inherent human psychology of doing good to others without causing harm to oneself (DGHS, 1990).

Blood Transfusion is a complex science that links healthy blood donor with the ailing patient in quest of a new lease of life..... The first requirement is the blood donor. Only two out of a thousand people in India can think of donating blood. Dearth of donors prompted many people to trade in human misery to open commercial blood banks, engaged in buying and selling of blood (Anon, 1994).

Makroo and Raina (1996) indicated that the safe blood transfusion had gained special significance during recent years because of HIV infection Blood Donors were the third main source of HIV infection in the country.

Blood transfusion services in our country are still in its infancy. In India for a population of 900 million and a bed strength of little over half a million, blood needs met in relation to population per thousand are less than 10 donations per year (Jaisy Mathai and Ramankutty, 1996).

Rajagopalan and Pulimood (1998) from their studies on attitudes of medical and nursing students towards blood donation concluded that in a medically oriented population, donors and non-donors did not differ significantly ; however other social valuables might account for donor behaviour which needs to be investigated.

Blood transfusion services have now become an integral part of health care system through out the world. Provision of safe blood, in an efficient, coordinated, cost-effective manner to all those who need it, is recognised as an essential function of health providers (Uton Rafei, 1998).

At present over 3,50,000 bags of blood are required annually in West Bengal for treatment of accident victims, surgical patients, thallemic children, newborn babies and others. Of this 2,30,000 bottles are donated voluntarily. The consequences of the shortfall are perhaps best left to imagination. The only solution is to build up a strong base through the motivation, recruitment and retention of healthy, voluntary donors. It is no doubt, a mammoth task, but one, which must be done (Anon, 1998). High priority should be given to elimination of family / replacement and paid blood donor systems, which are associated with a significantly higher prevalence of transfusion transmitted infections. Voluntary non-remunerated blood donors (Anon, 1999).

Thompson (1993) made an elaborate investigation on blood donation behaviour and attitude of Hispanic residents of the lower Rio Grande for the purpose of developing promotional and education approaches to enhance donor participation.

Chiliaoutakis *et al* (1994) studies on blood donor behaviour in Greece indicated three factors as important regarding blood donation; Health related incentives for donor, structural incentives (organisation of blood donation, education, and management facilities) and creation of socio- economic incentives.

Leon *et al* (1998) made an in depth study in Venezuela on how to reduce the prevalence of HIV positive blood donors and enunciated that awareness, education and screening through questionnaire were important for making a true, voluntary, altruist blood donor.

Young (1998) had reported that personal contact with satisfied donor remains the single strongest factor for recruiting donors.

Loss and Sibinga (1998) had observed that among the most important reasons for not donating blood, is personal perception of the blood donor system and blood donation. Social surveys in general population could reveal in a great part of contemporary public perception of blood transfusion, blood donation and prejudices regarding giving blood, to guarantee safety and self-sufficiency of the blood supply.

A key feature of community-based action research is that it takes into account the impact of activities on the lives of people engaged in or subject to investigation. Its indent is not only to “get the job done”, but to ensure the well being of everyone involved. This notion runs contrary to many of the imperatives enshrined in

bureaucratic practices that make up much of our public life. We have come to accept the impersonal, mechanistic, and allegedly, objective procedures common to many health, education, and welfare services and business corporations as necessary evil. We endure hierarchical and authoritarian modes of organization and control despite the sense of frustration, powerlessness, and stress frequently felt by both practitioners and the client groups they serve (Stringer, 1996).

“Action research is undertaken by participants in social situations to improve their practices and their understanding of them. The method was designed to study social systems with an aim of changing them (i.e. to achieve certain goals). It is a community - based method. Community -based action research has frequently been employed in a wide range of settings, from hospitals and health clinics to clubs, factories and schools. The method is used by teachers, social workers, doctors, and nurses, community workers and so on in their local working environments in order to define needs and problems and behaviours by health professionals in an area, with the aim of developing appropriate treatment and preventive programmes (e.g. in relation to community health issues or health promotion projects).

The emphasis of action research today has shifted from its early emphasis on rational social engineering to a method of community or organizational development by awareness raising, empowerment (an ability to influence decision - making) and collaborative investigation between trained researchers, professionals (e.g. nurses and doctors) and lay people, with the help of designated mediators (facilitators)” (Bowling, 1997).

Action researchers do not treat participants as subjects but empower them to act on their own behalf as active participants in making changes. Hart and Bond (1995) selected seven criteria which distinguish different types of action research, and which together distinguish action research from other methods Action research : 1 is educative; 2 deals with individuals as members of social groups; 3 is problem-focused, context- specific and future - oriented; 4 involves a change intervention; 5 aims at improvement and involvement; 6 involves a cyclic process in which research, action and evaluation are inter linked; 7 is founded on a research relationship in which those involved are participants in the change process.

OBJECTIVES:

Phase I objective:

1. To make a situational analysis of Blood Transfusion Services in Thiruvananthapuram District

Phase II objective:

2. To augment voluntary blood donation in the peripheral area of Thiruvananthapuram city by making a Gram Panchayat self sufficient in its blood needs, through participatory approach.

METHODOLOGY :

Phase I

Exploratory research design was adopted for study of blood banks of Thiruvananthapuram District which allowed for broader insight into the research problem under study. The units of study consisted of four categories.

- Blood Bank Officers
- Patients and Relatives

- Surgeons / Medical Officers
- Drug Inspectors

A purposive sampling method was adopted for the study which aimed at population related to BTS. Formulation of interview schedule was done and pre-tested. A pilot study was also conducted before the actual data collection. Data collection was carried out by survey through interview schedules.

Phase II

The second objective was planned as an action programme. A qualitative research methodology was adopted for this objective. Action Research suggested by Stringer (1996) formed the basis, for this community intervention programme.

The stages are:

- ◆ Setting the stage.
- ◆ Looking
- ◆ Thinking
- ◆ Acting

Setting the Stage:

The need of having a panchayat based blood donor forum was presented to the Panchayat during December 1998, and time was given for the representatives and people to take a decision. The idea was presented by the Panchayat president Dr. Krishnan in the Grama panchayat meeting and acceptance was conveyed to the Principal Investigator/ facilitator, in January 1999. With the acceptance of the idea by the community, the first step of setting the stage was initiated.

In the beginning of the project it is essential to explain the objectives of the project, to ensure that they all know what, who how when, where of the project, its aims and events. Building a rapport was a must, to establish a positive climate of interaction and activity that all are involved in. The first such interaction was established on January 19,1999 at 3pm, at LP School at Peyad. It was presided by the Panchayat president, Vice president, Sri. Sasamalam Sasi (the identified key person in the Panchayat, this person needs special mention as he was the main character, the anchor of the programme in the Panchayat, he was a KANFED worker, he is the blood donor forum secretary of his office forum for the past ten years, a person interested in common good, and had the experience and genuine interest in such welfare work, moreover he had the motivation to spend all his leisure time for this programme), later on he was selected as the Co-ordinator of the programme in the panchayat, four ward members and other informal leaders occupied the dias. There was an open discussion and pros and cons of the programme were debated. An outline of the programme was thus formulated. The investigator was the representative of the Blood Transfusion Service that was to offer the technical support to the programme. It was important to arrange meetings with people and to maintain regular contact, in order that they feel continuously involved and feel some ownership of the project. Networking skills are essential. It is also important to find out from each person involved whom else he or she thinks should be contacted and included in discussion. The groups were encouraged to develop their own schedules giving a broad outline of the project. The resources available and what could be tapped was also an important part of the agenda. The Panchayat was motivated to take the responsibility from the very beginning and

publicity of the programme was handed over to them. The investigator took the role carefully to an observer / facilitator and planned from this stage itself, for “a good start” only could win the confidence of the community (eg. the timings of the scheduled meetings and programmes etc. so that it was convenient for people to attend programmes, and also for the institution to offer its services).

Looking :

The investigator with the help of research assistant gathered information, on the panchayat, geographical, social profile by documents, interviewing etc. .A rough structure was developed on the profile as a bench mark and a work plan was drawn for further activities. Inter-group meetings, focus groups meetings, where all people interested were held and agenda discussed. This was the second stage, which brought out the practicalities of the project and we all had to work hard to understand each other, for there was always doubts in the mind of the people about the real purpose of the programme. There were doubts that surely there was some selfish interests on the part of the people who have come forward with this programme etc. Then there were people who were only curious to know about the programme and not do anything for the programme (but they dropped out after sometime), there were people who expected financial gains. This was a stage where the investigator had to give the maximum information, clarify facts, and be alert to the response from the community.

Thinking :

The facilitator had to play an active role here, she had to make a work plan of activities from the discussions? and copies were distributed to the participants. These were again discussed and modified based on the needs and other conveniences of the

community. Group sessions were organised during training programmes to discuss the issues and negotiate their prospective, which were summarised and presented to other groups in a common session at the end. Follow -up activities are arranged, for example, to plan the next phase.

Acting:

This involved the reviewing of the plan and taking decision agreeing on the priorities. The next stage was the setting of goals, objectives and tasks on the basis of the priorities. This was followed by the implementation stage. The facilitator had to do continual reviewing of progress of the project. Monitoring and evaluation is an important part of this stage. Being a participatory approach project , the investigator had to always remind herself of the importance of inclusion:

‘Inclusion’ in action research involves

- * Maximisation of the involvement of all relevant individuals
- * Inclusion of all groups affected
- * Inclusion of all relevant issues - social, economic, cultural, and political rather than a focus on narrow administrative or political agendas
- * Ensuring cooperation with other groups, agencies, and organizations
- * Ensuring that all relevant groups benefit from activities"(Stringer 1996)

Though the above stages have been given as isolated steps, it was an almost Cyclic Experience for the Investigator. Each stage did not end itself but was a continuum of the other, and so the cycle went on.

‘Action research is a popular technique for attempting to achieve improvement in processes and critically analyzing events. It is a critical, self -reflective, bottom-up

and collaborative approach to enquiry that enabled people to take action to resolve identified problems. Action research involves a participatory and consensual approach towards investigating problems and developing plans to deal with them. Although it uses the methods of social science, it does not treat people as 'subjects' of study: the research process is presented to lay people and professionals in an accessible way, and undertakes the research in a way that is user-friendly. This has the potential of leading to solutions that are appropriate for local communities, and to local commitment to them” (Stringer 1996).

CHAPTER II

PHASE I

SITUATIONAL ANALYSIS OF BLOOD BANKS OF THIRUVANANTHAPURAM DISTRICT:

The objective of Phase I was to make a situational analysis of the blood banks in Thiruvananthapuram District, from the view point of the problems faced by patients and relatives in arranging for blood donors; the perception and opinion of blood bank officers, surgeons, medical officers in charge of hospitals on this issue; and the need for strengthening the community voluntary blood donor base, to make more voluntary blood donors available. An attempt was also made to study the profile of existing blood banks and hospitals without blood banks and how they meet their blood needs.

Data collection was carried out from the following sources :

- Blood bank officers of licensed blood banks
- Medical officers in charge of hospitals
- Medical officers/Surgeons directly in contact with transfusion cases
- Patients and relatives of cases needing blood Transfusion.
- Drug control Authority, the licensing authority for blood banks.

The results of the study are given under the following headings for easy comprehension:

1. A profile of Blood Banks in Trivandrum district. (Number of licensed Blood Banks, approximate number of units collected per year, type of donors, storage ,charging system, location of blood banks etc.)
2. Perception and opinion of Medical Officers and Surgeons on the issue.
3. Problems of patients and relatives in procuring blood donors, the average time taken to arrange for donors ,their problems their opinion and views on need for voluntary blood donor programmes.

4. Perception and opinion of Drugs Controlling Authority (as licensing authorities for blood banks) on the issue.

1.PROFILE OF BLOOD BANKS :

There are eleven Blood Banks (5 state govt., 1 central govt. & 5 private) licensed blood banks in the District (Table 1) . Fig 1 gives the map showing the location of blood banks in the district. A survey of all the blood banks was done and some of the general data obtained is given in Table 2 and 3. The study revealed the annual collection of, the number of blood units to be appx. 44,040 units in the District. The exact figures of demand for blood was not readily available, but there was unanimous agreement that there was shortage of voluntary blood donors.

2.Survey on Perception and opinion of Blood Bank Officers

. In the survey of Blood Bank Officers cent % agreed to the fact that arrangement of blood donors was a problem faced by patients, the majority of blood donors were from urban (city) area, and community should be educated and motivated to provide “safe blood” donors for itself. All of them have given “fear of blood donation” as the major cause for people not coming forward to donate blood voluntarily. The blood bank officers were also in consensus that the voluntary blood donation scene was not satisfactory (with 90% of blood coming from only replacement donors, that is donors arranged by patients).

Lack of organized effort to bring the voluntary blood donors together and to make them available when emergencies and necessity arises was another area of consensus by this group. To the question “Kindly enlist some specific problems faced by the blood bank in carrying out responsibility to the public”, the respondents had enlisted the following problems :

- Lack of staff

- Lack of generator, storing is affected (TQ hospital)
- Lack of proper management of detected test positive cases of blood donors
- Lack of providing minimum facilities for voluntary blood donors (eg : conveyance facility)
- Blood components preparation (Specifications of licensing authorities)
- Lack of “mobile unit” for collection of blood at the place of voluntary blood donors
- Lack of voluntary blood donor organization support especially during emergencies
- Lack of full financial support for conduct of donor motivation camps
- The paradox situation faced has also been brought forward, where due to lack of network among blood banks the resources cannot be shared.

Table 1: Profile of 11 licensed blood banks of Thiruvananthapuram District.

Name of blood bank	Status	STAFF PROFILE			No. of Blood donations per month appx.
		No. of doctors	No. of technicians	No. of Supporting Staff	
MEDICAL COLLEGE	STATE GOVT.	3	17	15	2000
GENERAL HOSP	”	1	1	3	30
W7C HOSP.	”	1	5	4	50
TALUK HOSP CHIRAYINKIL	”	1	1	2	15
RCC ##	AUTONOMOUS	2	4	2	500
SCTIMST ##	AUTONOMOUS	3	7	2	500
SUT HOSP	PVT ATTACHED TO HOSP.	1	4	2	200
PNM HOSP KATTAKADA	PVT ”	1	3	3	10
ST. JUDE’S MEDICAL CENTRE	PVT ”	1	2	2	35
SUPERIOR** BLOOD BANK	PVT	1	3	2	130
DR RAO’S** BLOOD BANK	PVT	1	2	3	200

** No transfusion facilities

Components separation facilities available

Table 2 Profile of area and storage capacity blood banks

Name of blood bank	Area of blood bank	Storage capacity units
MEDICAL COLLEGE	AS PER SPECIFICATION OF LICENSING	300
GENERAL HOSPITAL	”	70
W 8 C HOSPITAL	”	220
TALUK HOSPITAL CHIRAYINKIL	”	50
RCC	”	100
SCTIMST	”	300
SUT	”	50
PNM HOSPITAL	”	50
ST JUDE’S	”	25
SUPEROR BB	”	40
DR RAO’S BB	”	50

Table 3 Charges collected per unit of blood in blood banks

Name of blood bank	Charges per unit in rupees
MEDICAL COLLEGE	90.00 (only Pay ward Patients)
GENERAL HOSP.	150.00
W&C	200.00
TALUK	250.00
RCC	50.00 (Poor Patients.) 250.00 (Middle) 350.00 (Higher)
SCTIMST	(As surgery package based on Income)
SUT	500.00
PNM	500.00
ST. JUDE'S	500.00
SUPERIOR	550.00
DR. RAO'S	450.00

2. PERCEPTION AND OPINION OF MEDICAL OFFICERS AND SURGEONS:

The random survey was conducted in 39 hospitals with facilities for invasive or surgical interventions, among them 21 were in the private sector and 18 in the govt. sector (Table 4 and 5). The medical officers in charge of these institutions and medical officers dealing with patients in need of transfusion were chosen as respondents.

The medical officers responded that on an average 64.8% of patients faced problems in arranging for blood donors. Out of 58 medical officers 33 responded that they had come across cases paying for blood donors (56.8%). 86% of the medical officers have reported that *arrangement of blood donors by patients* was a serious problem to be studied (24 of the respondents have strongly agreed and 31 of respondents have agreed that “patients face a lot of problems in arranging for blood donors”).

Some other factors, of concern revealed by respondents of the study are :

- ❖ Hospitals without blood bank facilities have lot of problems in managing cases of RTA (road traffic accidents) especially cases at night.
- ❖ Even with other specialized service and facilities the absence of blood bank facilities, leads to cases to be referred to MCHs (information GH periphery area)
- ❖ Blood donor forums at present, in Thiruvananthapuram Dist. are inadequate, not well organized, poor in performance and not able to meet the demands of patients (most of them in urban areas).
- ❖ Patients are at the mercy of a few private blood banks and this is not a healthy practice
- ❖ Blood conservation techniques and judicious use of blood should be widely available (eg. To avoid single unit transfusion)
- ❖ Co-ordination among Voluntary Agencies to be done by a controlling authority for better efficiency

- ❖ PPH (Post Partum Haemorrhage), APH (Anti Partum Haemorrhage) and other similar cases needing immediate blood transfusion have to be referred to MCH (which is 20 minutes travel by car) (information periphery Govt. Hospitals.)
- ❖ There is need of a NBTS (National Blood Transfusion Service) with branches in all districts and Taluks.

3. PROBLEMS OF PATIENTS AND RELATIVES IN PROCURING BLOOD DONORS :

500 samples of patients and relatives awaiting transfusion were randomly selected for the study . The samples were chosen from the blood banks visited.. Among the samples, there were 288 patients from outside the district. The sample profile is displayed in Figures 2 ,3 & 4 Number of admission days ranged from three to ninety days. Average number of days taken by patients of Thiruvananthapuram District for arranging of positive blood group donors was 1.35 days and for those from outside was 1.86 days. Average number of days taken by patients of Thiruvananthapuram District for arranging of negative blood group donors was 2.31 days and average number of places approached was 3.56 places. Average number of days taken by outside patients for arranging of negative blood groups was 3.64 days and average number of places visited was 6.21. The study further showed that 32% were “worried and in tension” . 53.2% were “not sure of getting blood donors”.Only 12% were confident of arranging blood donors. Seven patients had paid money for their donors, and 34 were approached by people for paid donations.5.4% of by standers had to donate blood compulsorily for their patients as replacement for their patients during the present admissions. There was an apprehension on the “interest and attitude” of women towards blood donation and their involvement with it . In wards of hospitals, majority of the bystanders were

women, and there was only “a luke warm “response from them. More than 60% did not know from where and how their patient was getting blood and they considered it the responsibility of their male relatives.

Through out the study there was no mention of full-fledged support or organized blood donor forum activity on a wide scale. The study revealed that, youth Forums, local clubs, resident associations, political parties, are some bodies identified by the respondents as groups interested in this area, and all were scattered and most of them were in the urban area.

4. PERCEPTION AND OPINION OF DRUG CONTROLLING AUTHORITY ON BLOOD DONATION:

The office of the Drug Controller of Thiruvananthapuram District was approached for their opinion on the issue of blood donors pertaining to this District.

The observations the authority are given below:

- There is a lack of precise data on requirement of blood, donations and utilization of blood
- Among the 11 blood banks, 9 fall within in the city area
- Organised blood donor programmes are lacking. The Drug controller authority at present cannot take up such programmes and this should be entrusted to NGOs.
- Neyyatinkkara and Attingal Taluks need blood banks in the vicinity
- A Regional blood bank for the whole District with entirely Voluntary Blood Donor is the ideal solution to meet the total requirement, with least problems to patients.

SALIENT FINDINGS OF PHASE I:

- ❖ Replacement Blood Donors (donors brought by relatives for their blood needs) is the prevailing system
- ❖ Voluntary Donors account for less than 10% of blood donations
- ❖ Approximately 44,040 units are the annual blood collection of Thiruvananthapuram District.
- ❖ With the exception of scattered blood donor forums, large scale blood donor organizations, or involvement of NGO's with full fledged blood donor organization activity is absent.

- ❖ Comprehensive data on demand or supply of blood is lacking from interfacing authorities connected with blood banking.
- ❖ Co-ordinated blood bank activity is totally absent (no uniform rates for blood units, sharing of resources etc.)
- ❖ The complete responsibility of transport of blood units to hospitals without blood banks lies with individual patients
- ❖ Hospital Development Committees has adopted a positive attitude towards blood banks
- ❖ All categories of respondents are unanimous in their observation that there is a need for ongoing, organized blood donor motivation, and awareness programmes.
- ❖ The professionals involved in blood banking have stressed on the need for a Regional Blood Transfusion Service, which will be the solution to problems of patients in organizing for blood donors, availability of blood in periphery areas and transportation of blood.
- ❖ There was an apprehension in the interest and attitude of the women. Their involvement in the area of blood donation.. More than 60% did not know from where and how their patient was getting blood and they considered it the responsibility of their male relatives.

The first phase of the project was completed in the first 8 months and the results of the survey showed that arrangement of blood donors was a problem faced by patients. Voluntary blood donation programme was far from satisfactory, emergency situations did pose a problem. Blood Donor forums were scattered and not organised to meet the needs of the people. Lack of network among blood banks caused serious problems affecting, especially the periphery areas of the city where there are no blood banks in the vicinity. Patients have to depend on private (commercial) blood banks. Blood conservation techniques and judicious use of blood should be made widely available. There is a need for a co-ordinating agency like a National Blood Transfusion Service guided by a National Policy. Comprehensive data on demand and supply of blood is lacking. Most important of all, all categories of respondents are of unanimous

opinion that there is a need for ongoing blood donor motivation and awareness programmes and it should be extended beyond the city areas. Lack of organised NGO activity in the field of blood donor motivation is glaring.

One advantage of this study is that the SCTIMST, Division of Blood Transfusion Service one of the premier blood banks in the State, has taken positive steps to extend its services to the hospitals, in the district, where there are no blood banks. Dr. Ambika Nanu, Head of Blood Transfusion, AIIMS, New Delhi, one of the leading Blood Transfusion specialists of the country, when appraised on the project, appreciated on the results based on the study. Some of her observations were, three main blood banks of the District MCH, SCTIMST and RCC were situated in the same campus. The private sector blood banks contributed very less. She was recommending a centralised service for the District, which would be standardised, cost effective and bring down the problems of patients considerably. She was also concerned about the very low rate of voluntary blood donation (less than 10 %) and recommended that we do away with replacement donors (that is donors arranged by patients). She advised that we start mobile collections, as done in Delhi. The prospects of a Panchayat based voluntary blood donation programme was an idea that impressed her and she commented that it would serve the cause for expanding the voluntary base, and procure “safe blood” for the society.

CHAPTER III

Phase II

1. ORGANISATION OF THE COMMUNITY INTERVENTION PROGRAMME:

PLACE OF WORK is

VILAPPIL PANCHAYAT

Vilappil Panchayat is a Grama panchayat on the periphery area of Thiruvananthapuram city. Figure:5 shows the geographical map of the Panchayat. It is divided into 12 wards (1999), with each ward being represented politically by a ward member in the Panchayat.

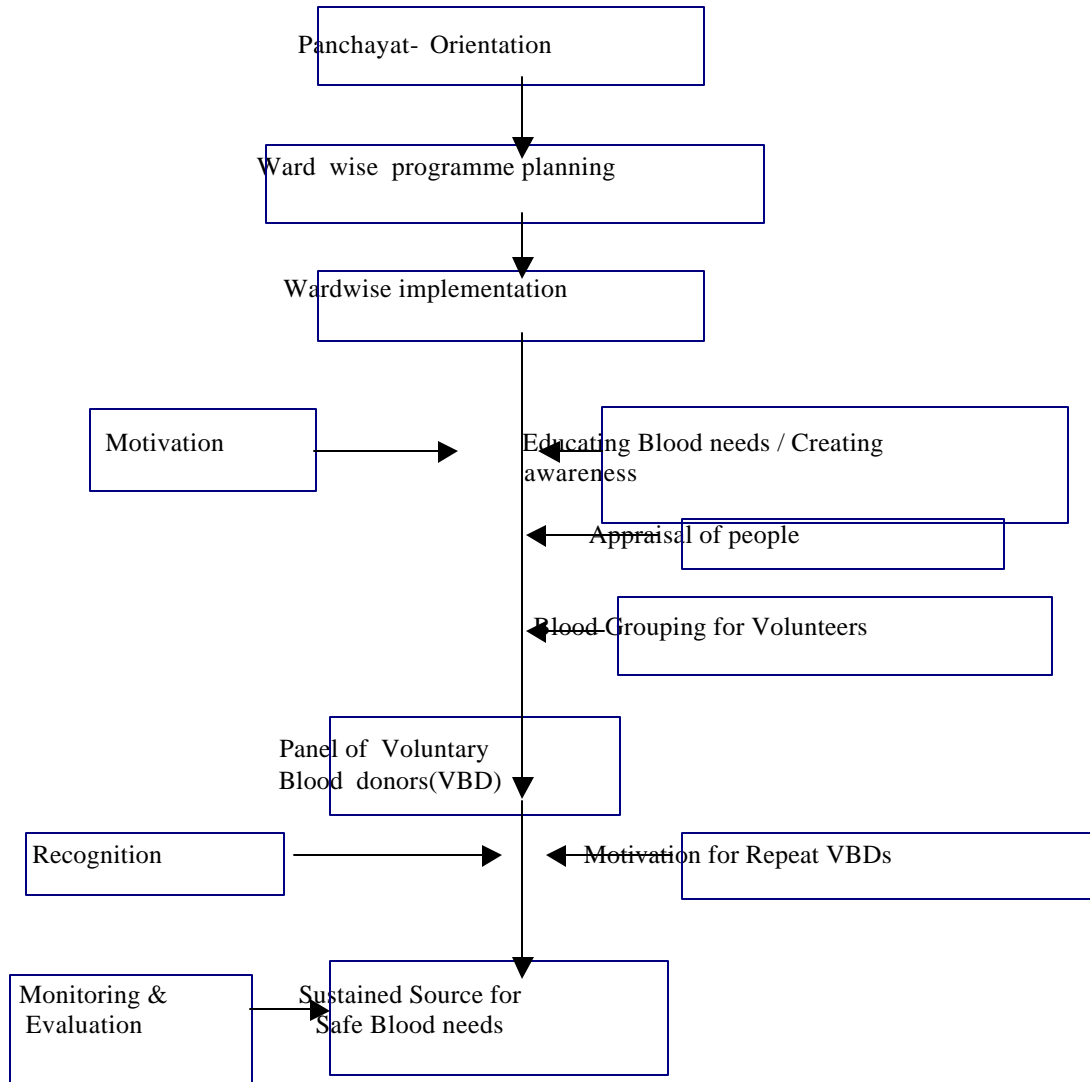
The population (1991 census): (Above 6 yrs) = 24,714

Males : 12,325 and Females: 12,389

The programme was planned and launched in the community, as a participatory programme. Accordingly 'a yogam' was conducted at the St. Xavier's School with the Panchayat president as the head, panchayat members and members of the community, as the members. The project objectives were put forward with the help of visual aids, and the project investigator explained to them the different aspects of the programme. The idea was discussed and debated and was finally accepted as a programme which would be helpful to bring to the forefront the health needs of the community. The panchayat president took the initiative to put it up in the agenda of the next Grama sabha panchayat meeting. The idea was finally approved and it was planned that we carry on the work with the village panchayat member of each ward as the chairman for their respective wards.

A well chalked out plan was drawn with the participation of the people, various committees were formed to implement the plan, the members of the committees were selected by the people themselves. A complete plan for the whole panchayat, based onwards was drawn. The minimum number of meetings, classes etc was planned for each ward shown below as flow chart Fig.6.

Fig. 6 FLOW CHART of programme plan :



In the present project “the Guide to effective participation by David Wilcox” formed the important aid to the participatory approach practice..

The following ten were taken as key ideas :

- Level of Participation
- Initiation and process
- Control
- Power and purpose
- Stakeholders and community
- Partnership
- Commitment
- Ownership of Ideas
- Confidence and capacity

2. TOOLS AND TECHNIQUES :

Semi - structured Interviews:

This was the lifeline for the initial stages of the programme. The investigator and the research associate were the permanent members of the investigation and were the people who conducted the interviews, while the others of the team were only resource persons or technical personnel. The identified key persons were subjected to the interview .The checklist was prepared with the following main items:

- ◆ a general social profile
- ◆ a general geographical profile
- ◆ a political profile
 - on attitude of the person towards the programme
 - to identify key persons etc.

Group discussions:

Focus group discussions was the technique that was most widely used. It gave the scope for a collective frame and focus for discovery and exploration for action.

It was put into use:

1. To generate more information .
2. To stimulate new ideas and thoughts
3. To facilitate decision making
4. Diagnosing the situations and problems
5. To create interest and make it a collective learning process

the decisions, concerning the programme were taken only after such group interactions. It brought people together to think about, to discuss, and come up with solutions and methods most suited for their Panchayat. It was during one such group discussion that the idea of “a survey to be done by the volunteers from their respective wards” was brought forward, as the best tool for interaction with people. The focus group discussions resulted in committee formations and distribution of responsibilities, at different stages to carry on the programme. The formation of “V-SAGAR”(the blood donor forum of the Panchayat) was also the result of group interaction.

Workshops :

Workshops are ideal techniques , for action programmes, where people are brought together with a common agenda and given the opportunity of expression. The ownership”feeling of a programme comes in through this technique and inculcates confidence in the participants to take responsibilities.It gives the opportunity to learn from each other’s mistakes . It helps to formulate blue prints for programmes,prepare people mentally for the programme , and serves as an open forum for criticism.

The first two orientation and leadership workshops served as useful starters for the programme, the workshops were planned with a combination of talks, seminar and full-fledged group discussions , in which the groups interacted and came out with plans.Plans and problems were discussed and then feasible plans were drawn for their respective wards and the Panchayat as a whole. The groups were organised on ward basis so that there was inter as well intra - ward discussions, and equal opportunity was given to each of the wards to represent themselves. The Panchayat president and vice

presidents were present for the workshops. The programme was continued with, on field workshops in each of the wards, in the locations as suggested by the respective ward representatives.

Observation:

Observation as a tool in qualitative research is indispensable. Understanding of prevailing atmosphere is sometimes possible only through observation. The investigator had the following check list of items to be observed from the very beginning of the programme:

- Factors that may hinder the programme
- Factors assisting the process
- Women's participation
- Decision taking by people
- Conflict / consensus process
- Interaction between ward member/ blood donor convenor / programme co-ordinator of the Panchayat

As there was no multidisciplinary team, which was one of the limitations on the observations, it was difficult to compare and contrast observations made ; however observation was a technique that was handy , in many situations. For example, the researcher through keen observation found that “party politics ” played an important role in community programmes and the influence was so strong that sometimes it could even mar the best planned out programmes. Therefore, it was very crucial for the researcher to take a neutral stand. Another observation made was that ` social recognition' is an incentive for informal leaders to take up responsibilities, in such programmes. Women's participation was observed to be good and there was sustained interest. “Leaders” had a hierarchical way of arranging themselves, and the Panchayat

Ward members saw themselves at the top, the blood donor convenors arrange themselves at the middle and the other group leaders like mahila samajams or other groups at a level lower. There were frequent ego clashes, when one tried to dominate the other. Leadership played a very important role and it was observed that the success of programme lies in the leadership given. There was difference in performance of wards, where there was efficient leadership and where the leader was lacking in his /her efficiency (ward IV is example of the first type, who ultimately headed the sub committee formed for the formation of the registered society V- sagar. The ward member of ward II failed to give the necessary leadership support and the ward resulted with poor showing, in the survey).

Documentation:

Documentation was one thing that we planned from the very beginning. The investigator and the research associate formed a team. The research associate made a complete note of the minutes of the meetings, formal, informal etc. The investigator made a note of the process and this helped to arrive at conclusions, to evaluate, to help in the planning process and to offer suggestions to the people whenever they needed it. Very often, the group composition changed and it would be partly of members that had participated earlier and some of them new. It is here that our team had a vital role where we could brief up what had happened previously. Documentation as a research tool is very obvious but since it was an action programme the researcher was very conscious of the role as a facilitator, and the immediate contributions that could be made to the community, with this tool.

3. ACTIVITIES FORMULATED AND IMPLEMENTED :

i) Training workshop for the leaders of the programme:

On the agenda, the very first step taken was to conduct workshop for the community leaders, who were to give leadership to the programme. Originally only one workshop was planned but, then the community felt it was better to hold two such workshops instead of one, and it was split up and held for the first five wards and then for the next seven wards. Table 7 gives the details of the workshop, with the dates, classes, sessions etc. The one day workshop was held at SCTIMST, Blood Bank, (the resource institution) and the participants consisted of ward members of respective wards and four others interested in the programme and interested to take the responsibility of blood donor forum convenors. The first workshop was held in February 1999, for the first 5 wards and the second in July 1999 for the next seven wards. Forenoon was covered with four lectures on blood and its facts, importance of blood donation; transfusion transmitted diseases and role of leaders in participatory programmes etc. and followed by question and answer session. It was interesting to note that all wards were represented and at least 60% of persons who attended this programme were involved in the ward activities later on. The afternoon session consisted of a group session; here groups were formed and each ward representative was encouraged to voice their opinions, suggestions and to give their plan of activity for their respective ward. This exercise was very useful as the group session gave the participants to “theoretically plan activities” in their respective wards.

The participants now had better idea of what was the expected line of action, and there was more clarity of their role. Same type of workshop was held for the next seven wards and this too was well attended by the representatives of respective wards. An evaluation session was held after each workshop to understand the reactions of the participants (here it should be noted that we had improved on the classes of the second batch, based on the comments of the first). Here it is worth mentioning that it was a good experience of bringing one of the premier institutions of the State like, the SCTIMST situated in the urban area of the district, into close contact with a rural community, to make it enable to share its resources (services of doctors, technicians of the blood bank, its knowledge and skill for the betterment of the community. The leadership workshops were held in SCTIMST campus and demonstrations of blood donation, in the blood bank itself).

Table6 : Leadership training and workshop for community leaders in blood donation programme of Vilappil Grama Panchayat

Date & Place of Workshop	Ward Nos.	No. of Participants		Total
		Male	Female	
27.02.1999 SCTIMST Blood bank	I, II, III, IV & V	16	11	27
	VI, VII, VIII, IX, X, XI & XII	23	13	36

ii. Assessment of the community through a Participatory Health Survey of the Panchayat:

During the pre meeting of ward 2, of the Panchayat, the elected blood donor committee convenor, came up with the idea of a health survey which would be a good reason to visit houses, to inform the people about the programme and also to collect data on households so that this would be useful to the community at some point of time, (It is worth noting that the PHC later made use the data in one of the wards, for their vaccination programme, for children under 3 years). The data was computerised, to be transferred to the Panchayat, when its system will be ready. Here it has to be documented that, the items in the survey card was developed using the voting system for each item on the card and included after a debate and final vote for the item.

The health survey served the purpose of :

- ◆ Assessment of the social / health profile of the people, by the people themselves
- ◆ As a communication technique to inform / assess the attitude of the community towards the programme.

The survey was conducted by the committee members / volunteers of each respective wards assisted by their neighbourhood groups / Mahila samajams and other social groups already present in the Panchayat. Meetings were conducted in each ward for this purpose and under the guidance of their respective ward members/ blood donor convenors the survey cards were divided into 100 / 50 number piles and distributed among the volunteers. The meeting was headed by the respective ward member and the ward blood donor forum convenor. The survey card was completely explained to the volunteers, a demonstration of how to fill the cards was held and doubts clarified. This

was done in each of the twelve wards separately. An interesting phenomenon noted as a sort of mental mapping exercise that was done by the ward member and the people, was to allot areas of survey among themselves eg. One person would say that there are 600 houses in that Ward, and one will volunteer to do 50 houses beginning from the east of house A, then they will draw a mental map and the second 50 houses will be allotted to the second and so on, till they have mentally covered all the houses. It is a experience to note that most of them know who lives on which side of a stream, how many houses are clustered around a landmark etc ! Here the investigator would like place on record that the whole survey was done on a completely voluntary basis, by the volunteers with no remuneration at all.

The survey cards were collected and analysed by the investigator. An attempt to have participatory analysis failed after one such exercise, as it was time consuming and accuracy, followup was difficult to manage. Around 3980 households had been covered by the volunteers (ie. 64.91 % of house holds, according to the Panchyat level statistics collected in 1991 which gives the total number of households to be 6131). Table 7 gives a ward wise classification of households covered. Semi structured interview conducted in the initial stage of the project had put the number of households in each ward to be between 400 – 600 nos. The result of the survey shows that 6 wards had covered more than 400 houses. The least performance was in ward 2. It is an irony that this was the ward from where the idea originated. Perhaps the ward member (observation was that she would come for the meetings in her ward , would be phisically present for sometime and would leave within a few minutes giving one

reason or other, she could not give the leadership to the programme .)and could not get enough support to take up the task.

Table 7 No.of households covered by the survey

Ward No.	Households
I	495
II	31
III	260
IV	611
V	110
VI	440
VII	148
VIII	476
IX	323
X	452
XI	434
XII	200
Total	3980

The investigator has made a random analysis of 2265 families, data from 5 wards, out of the total of 3980 household surveyed(ie 59.9%) . This analysis of the panchayat provided a profile of the population we were dealing with. The details are presented below .

The number of households , and number of members in the given sample of five wards is given in Table 9 and the male female profile is given in Table 10.The sex ratio in this sample was 49.5 : 50.5 (male- female).

Table 8: No. of families and members in the analysis sample

Ward No.	No. of households	No. of Family Members
I	495	2128
III	260	1143
IV	611	2515
VI	423	1778
VIII	476	1983
Total	2265	9547

Table 9 : Male- Female profile

Gender	I	III	IV	VI	VIII	Total
Male	1075	569	1245	877	957	4723
Female	1053	574	1270	901	1025	4823

Male = 49.47% ; females = 50.5 %

The age wise analysis in the selected wards revealed that the eligible blood donor population (ie. above 18 to 60 years) worked out to be appx. 60.38 %(Table 11).

Table 10 : Sample population – age wise distribution

Ward No.	0-6	7-12	13-17	18-50	51-60	>61	Total
----------	-----	------	-------	-------	-------	-----	-------

I	221	195	249	1131	180	152	2128
III	127	82	144	617	93	80	1143
IV	259	252	326	1326	173	179	2515
VI	176	186	249	903	128	132	1774
VIII	202	165	286	1087	118	114	1972
Total	985	880	1254	5064	692	657	9532

The literacy rate in the wards worked out to be 90%.The education profile analysis is shown below in Table 12.

Table 11 : Education status of the samples

Ward No.	Not Educated	06 Lower Age	Primary Q H S	College	Total
I	145	221	1401	361	2128
III	72	127	776	168	1143
IV	250	259	1668	338	2515
VI	178	176	1215	209	1778
VIII	279	202	1329	173	1983
Total	924	985	6389	1249	9547

Table 12 : Occupational profile of the samples

Ward No.	Govt.	Pvt.	Coolie	F. HW	STU & C	Others	No job	Old	Total
1	130	47	395	497	630	51	197	181	2128
III	49	9	255	272	320	35	108	95	1143
IV	106	66	507	558	848	68	169	193	2515
VI	178	176	1215	209	1778	176	1215	209	1778
VIII	25	5	497	535	629	56	119	117	1983
Total	336	154	2001	2266	3014	279	765	734	9547

* F.HW - Female - House wife No job - Unemployed
 STU & C - Student & Children Old - Old age

Table 13 : Socio Economic Status

Ward No.	Upper	Middle	Lower	Total
I	29	308	158	495
III	8	78	174	260
IV	57	259	295	611
VI	8	130	285	423
VIII	4	95	377	476
Total	106	870	1289	2265

Lower socio economic group worked out to be 56.90 %, the marginal group (Table 13).

Table 14 : Health status as perceived by the people

Ward No.	Better	Bad	Total	W.No.	Handicapped	Mental illness	Others
I	1831	297	2128	I	23	9	
III	1032	111	1143	III	2	6	
IV	2377	138	2515	IV	18	9	4
V	1632	146	1778	V	13	10	44
VIII	1813	170	1983	VIII	14	5	13
Total	8685	862	9547	Total	70	39	61

The above table shows that 90.9 % of the people were perceived to be healthy (health was defined as ability to carry on their day to day normal activities, without much hindrance). Nine per cent were perceived to be in bad health (out of which and 1.7 % were handicapped and ill persons)

Some details on the basic facilities available to the people to maintain health are presented in Tables 16 and 17. About 76% had pucca toilets in their houses. Water and toilet facilities are some of the primary indicators of health for the people. About 75% were having own water resources; 16% depended on own well; 7.5% used public well and remaining on public tap.

Table 15 : Pucca facilities available for individual houses (toilet)

Ward No.	Yes	No	Total
I	451	44	495
III	228	32	260
IV	528	83	611
VI	366	57	423
VIII	365	111	476
Total	1738	527	2265

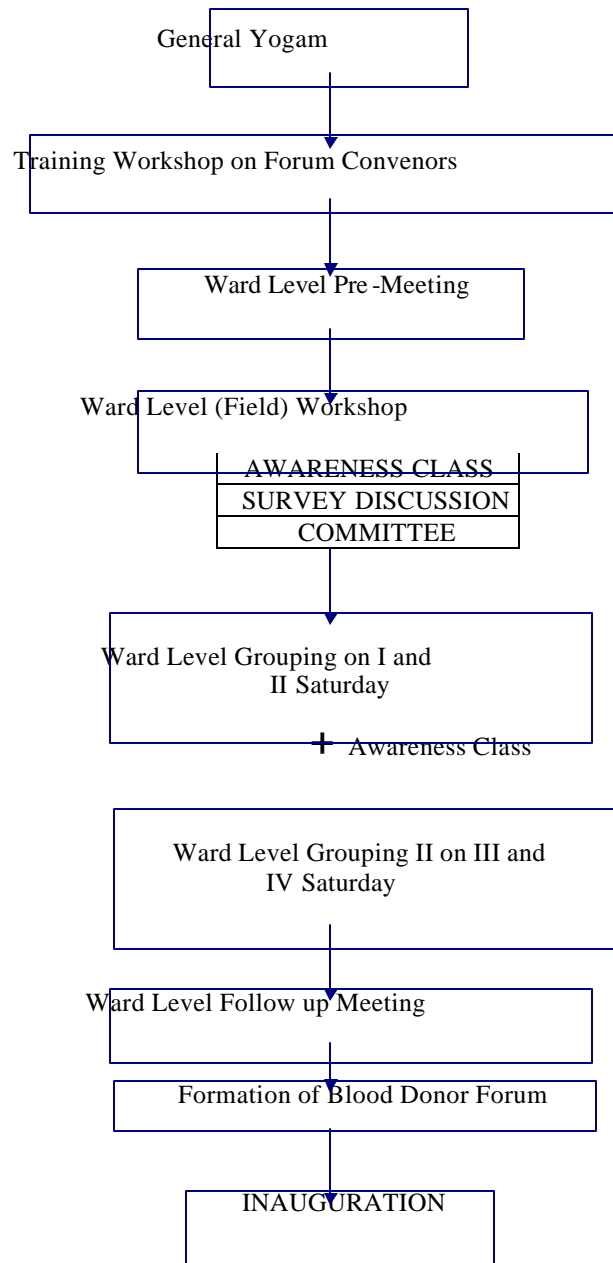
Table 16 : Drinking water facility available for individual houses

Ward No.	Own tap	Own well	Public tap	Public well	Total
I	388	135	0	17	540
III	192	34	0	42	264
IV	419	110	35	57	616
VI	336	59	0	42	430
VIII	409	36	0	31	476
Total	1744	374	35	173	2326

iii) Ward wise action for awareness building on Blood donation:

After the survey, it was decided to take up the blood donation programme on a ward wise basis, for it was seen from the planning of the survey that, people found it convenient to organise themselves better on “one ward “basis (it was observed that there was a “our” feeling present and a sense of belonging to a particular ward was higher, than when compared to as the Panchayat as a whole, moreover the local leaders had a better say in their immediate surroundings than in a wider circle). One month for each ward was the plan and activities were planned on ward to ward basis. The 12 wards were thus completed, by repeating, the same programmes for each and every ward so that, every ward had the same opportunity. It also gave a platform for evaluation so that we could take better decisions on factors like locations, time etc. and for better performance in the next ward. A flow chart showing activities in each ward is presented below in Fig 7.

Fig 7 WARD WISE ACTIVITY FLOW DIAGRAM:



The ward wise activities are explained below for better comprehension:

a. Pre Meeting:

This was named as pre meeting, for it preceded the awareness class, and blood grouping sessions and this was the first meeting for each ward. It was like a "Focus

Group” organised to explain the objectives of the programme to that specific ward (There was the necessity to arrange this only for the first five wards (Table 17), for by the time the turn of the other wards came, the news had already spread to the other wards and they learnt the objectives, hence only five such meetings were held).

b. On Field Seminars

Twelve field seminars were conducted in the respective wards, on the day, time and place as decided by the ward committee. At the end of the session, there was a discussion hour. The agenda for the next programme of the ward was decided and any specific problems were discussed. Visual aids, demonstrations etc were used in the seminars.

c. Awareness Class on Blood Donation:

The awareness classes were organised in each of the ward. The resource person was the Blood Transfusion Officer, from SCTIMST, it was an “on field programme” and the team spent the whole day with the people. The classes preceded the Blood grouping sessions so that maximum number of persons benefited. Most of the places the sound system was thus arranged (as that for public functions) so that a sizeable area could be covered. Table 17 gives details of the first five wards and table 18 explains the information on blood grouping in 12 wards.

Table 17 : Details of meetings, on field workshop and blood grouping sessions of first five wards – date wise

Sl. No.	Ward No.	Date & Place of Pre- Meeting	Date & Place of Workshop	Date & Place of 1 st Blood Group	Date & Place of II nd Blood Group
1.	I	25.02.1999	20.03.1999	10.04.1999	24.04.1999

		St. Xavier's H.S. Peyad	Geetanjali Tutorial	St. Xavier's H.S. Peyad	St. Xavier's H.S. Peyad
2.	II	06.03.1999 Govt. L.P.S. Peyad	20.03.1999 Govt. L.P.S. Peyad	08.05.1999 Govt. L.P.S. Peyad	22.05.1999 Panchayat Building Cheelapara
3.	III	14.03.1999 Vijay Tutorial Kattuvila	16.05.1999 Vijay Tutorial Kattuvila	10.07.1999 Vijay Tutorial Kattuvila	24.07.1999 Vittiyam Ground
4.	IV	13.03.1999 St. Mary's L.P.S. Puliyarakonam	17.04.1999 St. Mary's L.P.S. Puliyarakonam	12.06.1999 St. Mary's L.P.S. Puliyarakonam	26.06.1999 Govt. L.P.S. Tirithvmmoola
5.	V	04.07.1999 Navadharsana Turorial, Mailady	07.08.1999 Hindi Vidyalaya Mailady	14.08.1999 St. Joseph Nursery Vellaikadavu	28.08.1999 Sai Hospital Puliyarakonam

d. Blood Grouping Sessions:

One month was allotted for each ward, and two blood grouping sessions, on alternate Saturdays were organised. The Blood grouping session was from morning 9am to evening 4pm. Tables - give a profile of the blood grouping data. The community was encouraged to form panels of donors for immediate use of the people.

Table 18 : Total participation in Blood Grouping

Sl.No.	Ward No.	I Grouping	IIBlood Grouping	Total
1	I	79	222	301
2	II	168	92	260
3	III	124	54	178
4	IV	217	216	333
5	V	123	91	214

6	VI	143	137	280
7	VII	180	102	282
8	VIII	244	180	424
9	IX	306	161	467
10	X	240	55	295
11	XI	122	91	213
12	XII	55	124	179
		2001	1425	3426

19 % of he Total population of the Panchyat has participated in the blood grouping.

Table 19 : Participation of members in Blood grouping ward / gender wise with dates of grouping programmes

Sl.No.	W.No.	G.No.	Male	Female	Total	Ward Name	Date
1	I	I	34	45	79	High School	10.04.1999
		II	121	101	222		24.04.1999
2	II	I	85	83	168	Peyad	08.05.1999
		II	48	44	92		22.05.1999
3	III	I	71	53	124	Turuthimoola	10.07.1999
		II	24	30	54		24.07.1999
4	IV	I	108	109	217	Puliyarakonam	12.06.1999
		II	48	68	116		26.06.1999
5	V	I	64	59	123	Vellanikadavu	14.08.1999
		II	56	35	91		28.08.1999
6	VI	I	64	79	143	Chowalloor	18.09.1999
		II	65	72	137		25.09.1999
7	VII	I	121	59	180	Nooliyode	09.10.1999
		II	48	54	102		23.10.1999
8	VIII	I	131	113	244	Cherukode	13.11.1999
		II	54	126	180		27.11.1999
9	IX	I	148	158	306	Karode	11.12.1999
		II	54	107	161		18.12.1999
10	X	I	118	122	240	Vilappilsala	15.01.2000
		II	28	27	55		29.01.2000
11	XI	I	46	76	122	Karuvilanji	12.02.2000
		II	48	43	91		19.02.2000
12	XII	I	14	41	55	Punnatanam	11.03.2000
		II	61	63	124		18.03.2000
			1659	1767	3426		

The continuity in the dates will show that there was a complete co-operation from the people to conduct blood grouping programmes in the their respective wards in the month and days (Saturdays) as was planned in advance. This was possible only because the people were included in the planning process from the very beginning itself. Moreover “on field meetings” conducted just one or two weeks prior to the grouping sessions, in each ward facilitated the process.

Table 20 : BLOOD GROUP among the participants- ward wise

Sl.No.	Ward No.	+ve Blood gr				-ve Blood gr				Total +ve	Total -ve	Total
		A ⁺	B ⁺	AB ⁺	O ⁺	A ⁻	B ⁻	AB ⁻	O ⁻			
1	I	14	19	6	31	2	5	0	2	70	9	79
		55	54	13	83	3	4	2	8	205	17	222
2	II	29	43	16	64	4	1	0	11	152	16	168
		22	23	8	23	4	3	2	7	76	16	92
3	III	21	24	7	52	3	4	0	13	104	20	124
		13	16	1	22	1	0	1	0	52	2	54
4	IV	44	63	10	75	7	8	1	9	192	25	217
		27	25	9	48	0	2	1	4	109	7	116
5	V	34	25	4	49	1	2	1	7	112	11	123
		31	19	7	25	0	4	0	5	82	9	91
6	VI	30	37	6	63	2	2	0	3	136	7	143
		19	36	7	59	3	3	1	9	121	16	137
7	VII	38	48	11	68	6	2	0	7	165	15	180
		20	25	2	46	2	3	0	4	93	9	102
8	VIII	42	60	14	93	7	12	13	3	209	35	244
		39	36	10	77	3	7	2	6	162	19	180
9	IX	59	58	20	142	2	5	2	18	279	27	306
		31	55	10	56	0	5	1	2	152	8	160
10	X	54	57	17	87	4	9	1	11	215	25	240
		10	11	2	27	0	1	1	3	50	5	55
11	XI	33	33	7	38	5	2	1	3	111	11	122
		22	23	6	32	5	2	0	1	83	8	91
12	XII	16	10	4	18	4	0	1	2	48	7	55
		26	48	5	41	2	0	1	1	120	4	124
		729	848	202	1319	70	86	32	139	3098	327	3425

90.45% were of positive blood groups and 9.6% were of negative blood group.
*****16.5 % of negative blood groups are found concentrated in the area of Cherkode.**

Table 21 : Age wise participation of male population in blood grouping

Sno	Wno	Gno	Age Group					Total	Total	
			<15	15-20	20-30	30-40	40-50			50-70
1.	I	I		09	03	14	04	04	34	155
		II		35	34	23	11	18	121	
2.	II	I		9	26	28	11	11	85	133
		II		12	8	10	12	6	48	
3.	III	I		53	06	02	5	5	71	095
		II		02	4	5	10	3	24	
4.	IV	I		20	21	28	31	8	108	156
		II		9	19	15	3	2	48	
5.	V	I	4	7	07	20	17	9	64	120
		II	2	05	15	17	11	6	56	
6.	VI	I		18	11	14	15	6	64	129
		II	1	09	11	22	12	10	65	
7.	VII	I	2	10	30	37	22	20	121	169
		II		20	21	01	03	3	48	
8.	VIII	I	1	25	24	26	25	30	131	185
		II		9	13	12	14	6	54	
9.	IX	I	1	36	31	26	30	24	148	202
		II		7	12	16	8	11	54	
10.	X	I		33	15	29	28	13	118	146
		II	1	6	12	03	01	5	28	
11.	XI	I		8	18	3	9	8	46	094
		II		05	09	18	7	9	48	
12.	XII	I			02	2	2	8	14	75
		II		7	33	8	6	7	61	
			12	354	385	379	297	232		1659

*48.4% of the people participated in blood grouping were males.
15-50 age group of males formed the major(85%) Category.*

Table 22 : Number of females participated in Blood Grouping – Age wise

Sno	Wno	Gno	Age Group						Tot	Total
			<15	15-20	20-30	30-40	40-50	50-70		
1	I	I		4	16	08	7	10	45	146
		II	20	26	19	22	14	101		
2	II	I		17	20	20	18	08	83	127
		II		9	9	16	05	5	44	
3	III	I		28	3	9	9	4	53	083
		II		7	7	07	5	4	30	
4	IV	I		22	35	22	20	10	109	177
		II		19	14	17	14	4	68	
5	V	I	9	13	14	09	05	9	59	094
		II	3	1	4	13	7	7	35	
6	VI	I	3	16	16	15	10	19	79	151
		II	14	20	12	09	9	8	72	
7	VII	I	2	11	08	14	11	13	59	113
		II	1	27	07	7	5	7	54	
8	VIII	I		19	22	25	21	26	113	239
		II		17	23	41	26	19	126	
9	IX	I	1	22	20	47	38	30	158	265
		II		11	22	27	19	28	107	
10	X	I		20	33	29	17	23	122	149
		II		15	4	2	4	02		
11	XI	I	1	11	15	17	18	14	76	119
		II		9	7	12	10	5	43	
12	XII	I		3	6	13	12	7	41	104
		II	2	9	14	16	15	7	63	
Total			36	350	357	414	327	283	1767	1767

51.6 % of people participated in blood grouping were females.
(81% in the age group of 15-50.)

e. Studies conducted as part of the programme:

i) Knowledge and Attitude on Blood Donation:

Studies conducted to assess the attitude and knowledge among the 13 and above age groups prior to conducting awareness classes on blood donation d with a questionnaire, immediately before workshops or classes, showed that there was a positive attitude towards blood donation; while the knowledge was only low in certain aspects and only average in others.

Attitude of the people on blood donation (n = 253):	
Item	Response
Blood donation is not harmful to health	76% agreed
Society must give importance to blood donation	80% agreed
Are you willing to register your name for Blood donation	67% agreed
Perception of success on blood donor forum in their respective wards	68%
Knowledge level of the people to blood donation (n = 253):	
Item	Correct response
Time gap between the blood donations (Three months)	41%
Minimum age for blood donation (18 years)	33%
Maximum age for blood donation (55 years)	36%
Minimum weight for the donation (45 kg)	39%
Time by which blood is recouped in the body (24 hours)	37%
Minimum Hb level needed to donate (12.5 g %)	32%
Life of Red Blood Cells in the body (120 days)	41%

ii)Th
given us
so we con
grouping

had
ons,
the
the

programme , but survey was poor in these parts . But people gave reasons like distance, death of a local person, age bar, blood group known and other reasons. Hence we came to a conclusion that there was no boycott for the programme from any area , or section, and this helped us to go with our work. We conducted the study, by interview method, with a semi structured interview schedule. We entitled the study as “investigation and information” for the objective was to investigate and if anything was wrong to give the correct information and clarify situations then and there. The table below shows the results of the study:

N = 56 houses	
Good opinion about the blood donor programme	92 %
Had Information about programme	64 %
From other sources	
Survey done only in 6 – 8 houses in this sample	

f. Follow up Meetings

Follow-up meetings were held for planning the forthcoming agenda of the programme as per the request of the local leaders.

f. Inauguration functions:

Two such functions were organised for the first five wards separately and second seven wards separately, to formally announce that the blood donor forums were formed (Split up of such meetings and functions gave focus as well as a chance for frequent interaction with the community).

g. Concluding Seminar:

A concluding seminar was held at SCTIMST, blood bank for the persons giving leadership to the programme, which included the ward members, blood donor convenors etc. An opportunity was given to them to discuss the future line of action. As a result of which A SUB COMMITTEE was formed, to plan for the final public function, and to draw a future agenda for the programme.

g. Final Public Function:

A final public function was organised to make more people committed to the programme. The Vilappil Panchayat Blood Donor Programme was given the name of V- SAGAR (Vilappil Panchayat Social Awareness for Grama Arogya Raksha) and was formally inaugurated by the speaker of Kerala Assembly .

h. Registration of the Fo rum V -SAGAR:

The SUB Committee chosen for the purpose along with the investigator formulated the bylaws and regulations for registration of the forum under the Societies Act.

i. Monitoring of the programme:

The programme has to be monitored for at least two years more as a step to ensure sustainability of the programme.

The Results in a nutshell:

The community intervention programme of the project was completed in the stipulated time of 18 months, as envisaged. This required meticulous planning involving the institutions and the community. Planning was most crucial to the success of the project. The plans were drawn involving the community, all points were discussed and pros and cons debated. The consensus plan thus drawn, was easier for the community to carry out, for they knew the programme from top to bottom, and made implementation easier.

Execution of the project was in carried out in phases. The same programmes were implemented in all the wards, with minor changes, based on evaluation and suitability of the ward involved.

- The project was able to introduce the voluntary blood donor programme in the periphery area of Thiruvananthapuram District.
- The awareness and blood grouping programme was implemented with the full co-operation and participation of the people(involving them in the planning, implementation process from the very beginning) in each and every ward of the Panchayat ,with provision for blood donor forum in each of the wards.
- The Voluntary Blood Donor Programme of the Panchayat has been registered as a registered organisation.under the societies Act as V-SAGAR(Vilappil – Social Awareness for Grama Arogya Raksha), and units of this in each of the 12 wards.

CHAPTER IV

DISCUSSION AND CONCLUSION

The project has achieved the objective of creating awareness in the community rich learning experience for the investigator. The community has been initiated into an experience of “self help” for their health related issue of procuring voluntary blood donors. The programme has to be monitored and followed up until the community becomes self sufficient to sustain it.

Some of the observations of the process are discussed under :

People's Participation in health oriented programmes:

Though the project has been completed and the objective of creating awareness in the community related to self reliance in blood needs and formation of a Panchayat based Blood Donor Forum has been achieved, this is “only the beginning” of a long process. It was a development of a process promoting feelings of equality for all people involved. Decisions were on the basis of discussions and consensus rather than election, or domination by a single person or group. Efforts were made to maintain harmony among different sections. There was conflict situations that arose, openly but was sorted out for the common good of the programme. There were mediators among the group that took the initiative.

Case Studies of interesting experiences of types of *people's involvement* in the programme:

Experience in ward III :

The programmes in wards I & II had gone on the line as expected, but we had some problems with the ward III in that, there was not much co-ordination between the ward member and local leaders and communication was lacking. Two obvious

reasons that immediately came up were that both belonged to diagonally opposite political parties, and the style of functioning of the ward member was usually of the same pattern for all programmes. We could manage rather well with the first blood grouping programme in the ward, with the help of the local tutorial college. But we were in a fix for the second session, for despite of the promises and planning after the first session, there was no arrangement made in the venue of the second grouping programme. When the team for blood grouping arrived, there was no sign of the ward member or the convenor. Soon a resident of the area took up the leadership, she was in her early sixties, her son was away and she was staying with her daughter in law. She had information about the programme, and had a printed copy of the publicity notice of the programme. With her help we set up our blood grouping camp and she soon gathered the youth of her area got them placed at vantage points of their locality and got people to participate in the camp. By afternoon the ward member arrived apologetically, and the our 'lady saviour' as we friendly addressed her, gave him a good piece of her mind! But it was her involvement, that saved the day for us !

Experience in ward IV:

This was a ward, where we had a different experience from that of the previous one. There was perfect planning, discipline in adherence to time, programme etc. There was enough publicity, placards were put up registration counters were set up, blood donors were registered then and there. The ward member, convenor and volunteers shared responsibility there was no communication gap and good co-ordination. The social relationship was also obvious because a sort of community lunch was planned and we all shared food and ate together, for the day. Obviously, this came out as the

best ward of the Panchayat in this programme. The ward member and convenors are members of the Adhoc committee of the registered society V-sagar .

Experience with Primary Health Centre:

The investigator, as part of the observation factor, did not apply any pressure on the PHC, to participate in the programme. But took all steps to keep the officer informed, about the programme. The investigator had checked, with the Panchayat president, the ward member of the respective ward, where the PHC is situated, whether information of the programme had been given to the PHC. The health Inspector of the PHC had actively participated in the programme on individual capacity as volunteer and part of advisory committee of Vellaikadavu ward, the PHC sub centre, nursing personnel participated in the programme as a volunteer of Chawaloor ward. The survey data was used for vaccination programme etc. But the PHC as an institution is yet to take initiative, to participate in the programme!

Acceptance an important principle:

To accept people 'as they are' was an important principle to be adopted by the investigator. This allowed unequal people to participate, each according to their own capacity. An opportunity was given to learn from mistakes, to evaluate their own capabilities. Accept people as they are, not as some people think they ought to be helped to build self-confidence, especially in marginalized communities. It encouraged personal, cooperative relationships, rather than impersonal, conflictual, or authoritarian relationships. It made the group sensitive to other people's feelings.

Role of researcher in Participatory approach:

The researcher played the role of only a facilitator for stimulating people to change. The process was more important, the way things were done - rather than the urge to have results achieved. The idea was to enable people to develop their own analysis of their problems/ issues. Experts had stressed the importance to start 'where people are', and not where we think they ought to be. The responsibility of the researcher was to help people to analyse their situation, consider findings, and plan. The researcher enabled people to examine several courses of action consequences of each option. A plan when selected, it was the PI's role to assist in implementing the plan by raising issues and possible weaknesses and by helping to locate resources.

"Side Bench Technique":

The researcher had come up with a technique for increasing the role of people in participatory programmes and one that helped the investigator to play the role of facilitator in a better way. This technique was practised by the investigator through out the programme, and was convinced by the utility of the technique. The technique as the name implies, is the position that the researcher occupies during meetings, and discussions in the community. From the start, the investigator/facilitator never occupied the dais or seat on the opposite side. The facilitator had seating on the side. This gave the clue to the community that the investigator did not take decisions, or directly interfere with the activities but is always present there to facilitate. This is a comfortable position for the facilitator, for listening, observation and contemplation of the proceedings. Even if the seating was organised in a round pattern, the facilitator purposefully played midway position away from the leadership position. The researcher

had the opportunity to test the utility of this technique at least in minimum of 24 meetings. This technique served as a "visual aid " and helped to put across the philosophy of facilitator across the table. The people took up more responsibilities and decisions, when this technique was practised. There was a danger of the people mistaking the passiveness of the investigator, but in the long run it was an advantage for as the project progressed, there were signs of people taking more decisions on their own, along with their leaders. This will also prove to be helpful when the investigator has to wean away from the project.

“The Investigator did not focus only on solutions to problems but on human development. The responsibility for a project's success always lies with the people” (Stringer, 1996). ‘The investigator, in the role of the facilitator, must appear legitimate but neutral and non-threatening to all groups involved, and thus his or her role had to be carefully negotiated with each of the relevant social groups. The facilitator must not be seen to be closely associated with any particular group; members must be able to feel that they can talk to the facilitator freely and had the confidence that their comments will not be passed on to other groups’ (Stringer, 1996).

“In many situations individuals tend to react negatively to authoritarian processes. Where the imposition of outside authority has an impact on their lives, even if with the best of intentions, they often respond with aggression, directed at those who are controlling their lives; apathy; which sucks their vitality and leaves them with feelings of hopelessness or helplessness; and/or avoidance, which isolates them from the source of authoritarian control” (Stringer, 1996).

Continuous Interaction:

Continuous interaction with the community is needed to build the necessary rapport. We grabbed all opportunity for this and had umpteen number of gatherings, formal, informal, focus etc. This helped to spread the message of the project throughout the Panchayat. We were surprised that the wards, where we had not yet started an intervention were aware of the objectives of the project and were eagerly waiting for their turn.

Monitoring an important tool for sustainability:

The role of the researcher in monitoring occupies a prime position. Only this can ensure the sustainability of the programme. And this can not be time bound, some communities may take longer time than others, and it depends on the the type of programme also.

Time bound projects a limitation of 'Action research'

Time bound projects are a serious limitation of action programmes. There is a danger of the researcher, becoming apprehensive, and interfering in the participatory process, hindering it from taking its full course. The researcher has to be conscious of this and restrict oneself, from hurrying through the programme.

CASE FOR INSTITUTIONALISATION OF THE PROGRAMME:

The people of the area are not that naïve or passive, they do protest rather vehemently if they feel that something is contrary to their interests (their recent negative reaction to the “waste disposal” programme of the Government is an example). There was no any adverse reaction / opposition to the voluntary blood donor programme from the very beginning, though people were sceptical about it. People co-operated well and the programme went on rather smoothly. But there was political bickering here and there with a few negative comments but it did not affect the programme from moving forward. The investigator need not had to plead for the programme at any stage. From the very start, the investigator had kept a very low profile and projected only a facilitator image. May be this was the reason that the leaders of the respective wards took up the responsibility to carry out the programme in their respective wards. Perhaps this helped to fulfil their need for” social recognition”,(an incentive for leadership activities) and helped to boost their image in the community. The common man was perhaps interested, as it was something concerned with the health of himself and his family.

Around 19 % of the total population of the panchayat had participated in the blood grouping sessions. The women’s participation on the whole is commendable,(in leadership programmes around 40% were women, in blood grouping sessions around 50% were women). It was a positive sign of the people’s interest in health matters that could successfully carryout the programme in all the wards ; except in one ward (in ward III, the ward member was not present for the second grouping session).The ward

members of the respective ward were present for the main meetings and blood group sessions. The picture of success of the initial programmes, patronage and the support of the people, till now makes the investigator feel that there is case for institutionalising the programme, from the point of sustainability, and benefit to the people. However such programmes can be valued only on the basis of outcome and benefit to the community in the long run and one that will out live the funding period. There will be a need for monitoring and evaluation. Institutionalising will mean, “to establish the programme”, to make it “a significant practice”. This process of institutionalisation will have to adopt the following strategies:

- Make key members of the community to enhance their leadership for the programme
- To identify target agencies within the community to add this programme, to their agenda of activities.
- To bring about a network and co-ordination between the above two.
- To evolve a permanent structure for the programme

.
A practical model of institutionalisation should have the four components of individuals, organisations, networking and guiding / co-ordinating agency. This is a challenge to a community organiser, for much depends on the sustained interest of the people in the programme and any programme can survive only if it meets the “needs” of the people .Very often needs are always not “wants” , people have to be convinced of their needs !

Attempts to disseminate the model:

The State AIDS Cell of Thiruvananthapuram, the Institution responsible for “blood safety” has been apprised of the programme and continuous efforts are being made to bring , panchayat based blood donor programmes to become part its agenda. Attempts are being made to propogate this Panchayat Blood Donor programme ,as a model for other panchayats , the blood donor forum representative from Calicut has been apprised of the programme , as a first step to sensitise other areas. This programme when discussed in a meeting of AVBD officials from TamilNad, caught their inetrest and the investigator was invited to present the “Panchayat Model of recruiting blood donors at their meet in Chennai.

CONCLUSION:

The interplay of knowledge, attitude and behaviour is always a challenge to sociology, one impinging on the other to bring about change. Increasing the knowledge does have an effect on attitude and brings positive change in behaviour in individuals. The community is made up of a number of subsystems that are responsible for behaviour of people and one important, such system, observed is the political sector, which seems to have a strong influence on community programmes. Leadership is one of the components of any programme and most of the influential leaders seem to have a political leaning. The factor “the source of external intervention”, is also important. The uniqueness is that it has been carried out on a complete participatory basis, with the technical help of SCTIMST, blood bank. It is an example of a premier institution cooperating with the community so that there is a sharing of resources. People study carefully the source and their “participation in the partnership” much depends on it. Factors like the credentials of the investigator, the institution are examined and watched

closely, before people put in their efforts into the programme. Here the greatest incentive to the people was the resource centre SCTIMST, which has a good image among the people (a belief that it has something offer to them!), the investigator was seen as the link between the resources and the Panchayat. So far the community has been responding well, how the community, responds after this is the real success ! Time and again it is seen that such programmes have to always to withstand the 'test of time' ! The challenge lies in facilitating the community to sustain the programme, and for this there should be "**growth and activity**". The fact that awareness has been created, is beyond doubt for without which , we would not have been able to reach this far.

ACKNOWLEDGMENT:

The Principal Investigator deeply acknowledges the trust placed by the Director, SCTIMST, in the researcher to take up community project, and the continuous encouragement through out the programme. The PI would like to acknowledge the Programme Co-ordinator of KRPLLD, Dr. K. Narayanan Nair, for the full support and "freedom of work " given to carry out the programme. We are thankful to KRPLLD for the financial assistance of the project. The cooperation and help rendered by the Panchayat President Dr.K.Krishnan and the Ward Members of Vilappil Panchayat is gratefully acknowledged. The Investigator would like to profusely thank all the volunteers of the Panchayat for their services for this humanitarian programme. The resource persons of the project Blood Transfusion Officers and staff of SCTIMST Blood Bank, Mr. Mohandas.K , project officer CACEE, University of Kerala, the research assistant Mr. Shinoj and the panchayat programme co-ordinator Mr.Sasamalam Sasi are immensely acknowledged for their valuable contributions.

REFERENCES :

Anonymous, 1994. Ethics in Blood Transfusion Service. *Gift of Blood*, AVBD, West Bengal.34:1.

Anonymous, 1998. *Gift of love*, AVBD, West Bengal. 54:1.

Anonymous, 1999. WHO guidelines on blood safety. *Gift of blood*. AVBD, West Bengal. 55:1-2.

Bowling ,A 1997. Research Methods in Health.pp366 - 370

Chiliaoutakis. J, Trakas, D.J, Socrataki, F., Lemonidou, C and Papaioqnnou, D. 1994. Blood Donor behaviour in Greece: Implications for health policy. *Soc .Sci. Med.*

38(10): 1461 -1467

DGHS,1990. National guide book on blood donor motivation. Directorate General of Health Services, Ministry of health and family welfare, Govt. of India. New Delhi. 1-4 pp.

Jaisy Mahtai and Ramankutty, V. 1996. On Transfusion Medicine. *Current Science*, 70:5-10.

KSBTS, 1994. Report of the Expert Group. Kerala State Transfusion Services. Health and family welfare Dept, Govt. of Kerala. 94pp.

Leon, G, Hernandez. T, Quiros, AM, Maio, A and Garcia, L. 1998. How to reduce the prevalence of HIV positive blood donors. *Invest.Clina* 39(4):307 - 321.

Loss, APM and Sibinga, 1998. Why people do not donate Blood? In: Organisation and management of Blood Transfusion Services: Policies and Plans. Ed. Barucha, Z. Dept. of Transfusion Medicine, Tata Memorial Hospital, Mumbai. pp69.

Makroo, R.N. and Raina, V.1996. Current Blood Transfusion Practices in India and Safety of Blood. *Transfusion Medicine* 96, New Delhi.p1.

Rajagopalan, M and Pulimood, R 1998. Attitudes of medical and nursing students towards blood donation. *National Med. J. India* 11(1):12-13.

Stringer, E.T 1996. Action Research A handbook for practioners. London: Sage publications. pp19

Thompson, W W. 1993. Blood donation behaviour of hispanics in the lower Rio Grande valley. *Transfusion* 33(4):333 – 335.

Uton Muchtar Rafei, 1998. Organisation and Management of Blood Transfusion Services-Plans and Policies. International Conference, November 22-24,1998. WHO, Regional Office, New Delhi.

Young, I F.1998. Past, Present and Future Development of Red Cross/Red Crescent Blood Transfusion Services. Organisation and management of Blood Transfusion Services: Policies and Plans. Ed. Barucha , Z. Department of Transfusion Medicine, Tata Memorial Hospital, Mumbai. p 90.

SIGNATURE OF THE

(Ms. USHA KANDASWAMY)

Date: 25/6/2001

PRINCIPAL INVESTIGATOR

SUMMARY

- Participatory approach to voluntary blood donation programme to augment voluntary blood donation programme in the peripheral areas of Thiruvananthapuram District, was a project initiated to
- This programme was launched in Vilappil Panchayat
- This programme was from from January 1999 to June 2000
- The objective of this programme was to create awareness on blood donation and make the Panchayat self sufficient in their blood needs.
- The Panchayat will become the first to try out this programme and become a model for others
- The Programme was carried out on a ward to ward basis in all the 12 wards, consisting of, workshops, seminars, blood grouping camps, formation of blood donor forums etc.
-

5 TECHNICAL PROGRAMME (AS ENVISAGED AT THE ON SET IT SELF):

i. Identification of location :

Single Panchayat on the basis of wards will be chosen. Community will be selected after briefing to the Panchayat and Community leaders.

ii. Selection of local clubs :

Selecting the youth clubs or libraries in the location.

iii. Launching of the Forum :

- Formal inauguration of the program
- Dissemination of knowledge on blood donation to dispel the fear, doubts and to put forth the facts
- Blood grouping among the individuals of the panchayat
- Panel of VBDs
- Formulation of VBD Forum
- Periodical meeting for motivation
- Incentives to the organisers and donors
- Recognition Certificates
- Rolling trophies / programmes

iv. Technical Intervention :

Technical help and advice will be extended

v. Role of Investigators :

- Motivation
- Monitoring
- Guiding and suggestions
- Evaluation and assessment

vi. Role of Community leaders :

- Leadership
- Encouragement
- Facilities
- Sustained Support

Some Points to take care :

- workable agenda
- Liaison Officer
- Public meeting
- Consultative Committee
- Planning

ANNEXURE II

1. Map of Vilappil Panchayat - The Place of Work
2. Transect of the Location
3. Final Public Function- Details
4. Registration of V Sagar

POPULATION DETAILS - SECONDARY DATA

12 WARDS

Male = 14144
Female = 14166
Total = 28306

5 WARDS

Male = 5895
Female = 5900
Total = 11795

TOTAL POPULATION OF ABOVE 6 YEARS

Male = 12325
Female = 12389
Total = 24714

Male = 5135
Female = 5161
Total = 10296

7. PRACTICAL UTILITY of the intervention:

This action programme aimed to make a study of the present status of blood transfusion services in Thiruvananthapuram as a preliminary step and then proceed to sub urban areas , where blood donor programmes were not organised to the extent it was in the city areas .The intervention was based on the following

- (a) Organised 'Blood Donor Forums' in the sub urban areas are a necessity and not an optional service
- (b) The need of VBDs is ever increasing. Currently the source is Colleges, Government and Private Institutions in the city area
- (c) The threat of 'Transfusion Transmitted Diseases' (TTD) makes it necessary that VBDs are stream lined through this programme. VBDs should be the source of safe blood to the needy
- (d) There is a wide gap between the demand and supply of blood for Transfusion
- (e) Motivated persons, to donate blood will be an asset to the community and can handle an emergency without panic.
- (f) Experimentation on participatory approach to community blood donation programme for sustainability, validation and dependability.

