



OPERATIONS
HANDBOOK FOR
RANGOONWALA
COMMUNITY
CENTRES



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Acknowledgements:

The Rangoonwala Community Centre(RCC) model as we see it at present, has evolved over a period of time.

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Nisreen Ebrahim
CEO

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Introduction

The purpose of this handbook is twofold. First, the Rangoonwala Foundation (India) Trust (RF(IIT)) has gained extensive experience of developing activity-based community centres in Mumbai and would like to formalise its knowledge. The handbook therefore describes the Rangoonwala Community Centre (RCC) model in a structured way, representing our current approach to designing, implementing and operating a community centre.

Second, the organisation has gauged the impact of the RCC Model to be significant in the communities in which it operates. We would like to make all or part of the model available to more organisations and communities. This handbook is therefore designed to be a basis for others to implement community centres of a similar kind, as a means of scaling up the work and extending the positive impact of the RCC model beyond its current locations.

A key principle underlying the RCC Model is that a community centre should be part of the fabric of the community. This means that it has community support through local people valuing the activities of the RCC and volunteers working there to build its works. But more importantly, the people served by the RCC must feel a level of ownership of the Centre as a key part of the life of the community.

With this principle in mind, there are three ways in which an RCC could be implemented using this handbook:

1. Where an organisation seeks to set up a community centre using the handbook as a reference guide and will do so independently.
2. Where an organisation seeks to set up a community centre using the handbook as a reference guide and would like mentoring and support from us to do so.
3. Where an organisation wants to make use of the content of the handbook to add value to its existing work by specifically using the activity model of the community centre to give rootedness to its issue based work.

Irrespective of the approach adopted, RF(I)T will propose an agreement with the implementing organisation that will provide for:

- ▶ An understanding on how the material will be used.
- ▶ Definition of the training, mentoring and other materials that may be required by the requesting organisation, as well as how the costs will be covered.
- ▶ A description of the roles and responsibilities of the two organisations.

The purpose of the agreement is not to be an obstacle to any organisation wishing to implement the RCC model. Instead, it seeks to ensure that there is clarity about expectations on either side, which may include a minimal role for RF(I)T.

Option 3 encapsulates another underlying principle of the RCC model. We believe it can be adopted and used by an organisation working on any development theme or issue that wishes to strengthen the development focus of their activities. For example, for organisations active on rights-based programs, an RCC is a way to connect more strongly with the community through activities that local people consider important. So, rights-based work can be integrated to an RCC and an RCC can be developed as part of rights-based development work.

The RCC, as a model of community development, cannot be completely self-sustaining if it chooses to work with vulnerable people. While community contributions for services used are an intrinsic part of the model, activity-based break evens can be worked out as a way of establishing levels of user fees. The organisation choosing to operationalise the RCC model will have to make a judgement call by considering pros and cons of fee levels. For example, will sustainability be at the cost of excluding the really vulnerable, who will not be able to afford the user fees? Or will the organisation secure committed funding for at least a period of 3 to 5 years to gauge the impact of an RCC in the area?

Community outreach and community-based activities like health awareness campaigns, community-based activities with children etc. are an intrinsic part of the RCC model. There are no community contributions for these activities and processes. These are investments in community development and returns are non-monetary.

One part of sustainability is being able to meet the operating cost of an RCC. The other part is achieving community ownership by building a strong cadre of community volunteers. While it is difficult to assign a monetary value to this, the organisation can work on processes of 'handing over' the RCC to the local community as part of its withdrawal strategy if it so chooses. Funding substitution can be a part of this process.

As per our estimates and experience of operating RCCs for a decade, the setup of an RCC requires an annual financial outlay of INR 2,500,000 to INR 3,000,000. This is the cost of the basic set-up and operations at optimum levels. We strongly recommend a resource commitment for a period of at least three to five years for a meaningful intervention.

Investment commitments will have to factor in the human resource costs of the pre-operative stage and decisions that the organisation will make on the scale of operations. It may be decided to stagger activities, following a step ladder system of progression by implementing one set of activities, stabilising those so they run smoothly and then taking on another. In subsequent years, a proportion of the set-up costs will be replaced with costs of expansion and depreciation.

The financial resources that need to be committed for an RCC will be influenced by many variables. Significant ones include geographical location and whether trained personnel including resource persons are available, implying the potential need for investments for the training of trainers. This handbook details the financial parameters which will serve as a tool for committing resources as well as contextual substitution, meaning that any variable or unit of the indicative budget can be substituted according to the local context or decisions the organisation makes on implementation.

These are matters that an organisation considering an RCC should assess carefully. Otherwise, community intervention models working to fixed timeframes and rigid project delivery formats often negate the very development issues they sought to address in the first place.

Our guidance for readers of this handbook wishing to use its content in their own work is that we would like you to do so. However, we would also ask that you contact the Rangoonwala Foundation (India) Trust so we can discuss how we can help you. A simple way will be through updated information and knowledge. Another approach is to enter into a partnership or agreement that provides more formal work together to achieve a scaling-up of the RCC Model to reach more people in need of its services.

Section 1: The Rangoonwala Community Centre (RCC) Model

1.1 Rangoonwala Foundation (India) Trust (RF(I)T)

Rangoonwala Foundation (India) Trust [RF(I)T] is a Mumbai based, non-political, not-for-profit development organisation committed to sustainable people-centered inclusive development. Our mission is to enable marginalised communities to become more vibrant and dynamic by engaging them in socio-economic development initiatives directed at building capacities, thereby *helping people help themselves*.

Central to our approach are the Six Ks, that enable RF(I)T to structure its work according to universal considerations of the path from activity to impact.

The Six K's



RF(I)T has been operating in Mumbai since 2003 as a Public Charitable Trust, with Rangoonwala Community Centres being one of the programmes we operate.

Our Ummeed Medical Assistance Programme facilitates treatments for major illnesses and also provides small hospital-based disbursements to assist people during difficult periods.

Our Utkarsh Scholarship Programme for professional Higher Education provides support to students, linked to a volunteering programme and Campus Ambassadors initiative.

RF(I)T runs campaigns that focus on rights and awareness, examples being the Satark Patients' Rights and Utthaan Right to Higher Education campaigns. We have raised awareness of chronic kidney disease and tuberculosis among vulnerable populations within Mumbai, as part of a concerted effort to prevent these diseases through helping people reduce their vulnerability.

Our Partner Support Programme supports work in fields that include education, health, disability and livelihoods.

Within the context of a range of experiences and involvement in development work, the RCC model has emerged to become a key element of our work.

1.2 The Rangoonwala Community Centres

The Rangoonwala Community Centres (RCCs) are the direct community intervention programmes of RF(I)T that have emerged from our belief that resource-poor communities, particularly women and children, need physical spaces in their midst to come together to address their development needs and capacity building skills.

In an economic order that is continuously deepening the socio-economic divide, families at the lower end of the economic pyramid in urban conglomerations unwittingly become victims of economic as well as resultant social pressures. These tend to impact families in two very specific ways, with far reaching consequences. These are health and education.

With this vision, we conduct various capacity-building and health-related activities with Women and Children at our six Community Centres at seven locations in resource poor areas of Premnagar, Subashnagar and Shivtekdi in Jogeshwari (E); at Mahakali in Andheri (E) and Anandwadi-Kurar goan and Pathanwadi in Malad (E).

Our Centre-based activities emerge through a continuous interaction with the community, particularly women, to understand their needs and aspirations as well as to develop a mindset that motivates them to focus on their self-development. Flexibility is intrinsic to the RCC Model, allowing us to respond to the changing external environment and resultant needs of the people with whom we work.



1.3 The Activity to Impact pathway

RF(I)T operates according to the spectrum of an activity plan to impact model. The activity to impact approach rests on the premise that people coming together for participation in activities can serve as a catalyst for broader community outcomes. This approach identifies what can be done in communities to achieve a desired impact, weaving together the 6 K's described in the previous section. The result provides for an inbuilt evaluation mechanism that enables us to review our work from activity to impact, providing both assessment and accountability to our stakeholders — most importantly, the people that we work with.

Activities are derived from extensive consultation with community members. Participation in RCC activities, however, is designed to generate impact beyond the activity itself. Examples of how RCC activities generate impact are provided below.

Activity	Impact
Women learn computing skills	▶ Women are better able to connect to today's world ▶ Women are able to relate to their children's education ▶ Women increase employability skills ▶ Women reconnect to 'learning' after along gap where family has taken priority
Women attend WCCs	▶ Women's health improves
Women participate in health camps	▶ Women have made the transition to thinking proactively about their health
Women train in vocational skills	▶ Increase in self esteem ▶ Women seen as 'contributors' in the family ▶ Increase in Women's social worth ▶ Opportunity income earned by making things oneself ▶ Women use skills to generate income by selling products and services
Senior citizens participate in a summer camp	▶ Senior citizens feel less lonely and have a broader support system
Children prepare and exhibit projects for Bal Umang	▶ Children develop a scientific temperament and better analytic skills
Girls learn English	▶ Boosts confidence and girls are better able to connect with the world
RCC Pratibimb event	▶ At least 25% of women setting up stalls for the first time become entrepreneurs
Capacity Building of Volunteers	▶ Community ownership of RCC
Festival Camps for children	▶ Children become sensitive and understand different cultures and festivals ▶ Promotes bonding and value building for communal harmony amongst children

Our approach to measuring the impacts that result is described in Section 8.

1.4 Experiences of RCCs in Mumbai

Rangoonwala Community Centres (RCCs) operate in six resource-poor communities in Mumbai. Working closely with women in these communities to understand and address their concerns, the RCCs in Mumbai have developed activities in seven main programme areas:

- ▶ **Capacity-building programs:** including computer literacy, wellness and life skills (e.g. yoga, English communication).
- ▶ **Vocational Training:** including long-term courses (e.g. beautician, massage), and short-term courses (e.g. cooking, painting, jewellery making).
- ▶ **Entrepreneurship Development:** Vocational training is the base for entrepreneurship development. Inbuilt in each module are inputs required for a trainee to practice the skill on her own. RCC provides platforms like Pratibimb etc. for a direct interface with potential clients.
- ▶ **Health-based interventions:** including Woman and Child Clinics (WCCs), clinic talks, health camps, and TB awareness-raising activities.
- ▶ **Community Engagement:** through Sahayaks, Spearheads and Volunteers, Monthly Open Forums that address particular topics of interest (e.g. parenting, substance abuse, women's safety), and Community-based interventions (i.e. the Tuberculosis Awareness, Satark Patients Rights Campaign, Community based activities with children through Bal Umang).
- ▶ **Working with Children:** including Children Drop In Activity (fun, non-structured learning), Children's Club, Summer Camp, School Outreach, and Bal Umang (where children build scientific and analytical skills through designing and presenting projects).
- ▶ **Working with Senior Citizens:** including Senior Citizens Club and Summer Camp.



RCC activities in Mumbai engage women and children in improving their own health and wellbeing. In the year 2013–2014, over 25,000 women sought help through the Woman and Child Clinics, and over 20,000 of these women were provided with medicines and supplementary vitamins. Over 1,200 women received vocational training through RCC short-term courses. In the same year, RCC children's activities reached over 30,000 children; over 1,500 senior citizens participated in RCC programs, and a tuberculosis awareness-raising campaign reached close to 90,000 in RCC operational areas. Overall, RCCs reached out to 441,303 people in 2013–14, while 76,187 women and children participated in RCC activities during this period.

A key feature of the Mumbai RCCs is their focus on community ownership. The centres provide a space for women of the community not only to learn and participate, but to train and to lead. Community women who have been trained by the RCC in the past often reinvest their skills and talents to teach other community women. The case study below describes the current focus of the two RCCs located at Pathanwadi.

Pathanwadi; two RCCs meeting diverse needs

There are two RCCs at Pathanwadi and they tend to be called the old and the new locations. Established in 2011 and 2012 respectively, they are the most recent of the RCCs developed by RF(I)T. Located in Malad (east), as with many areas of Mumbai, conditions can be starkly different between neighbouring bastis (or small areas, sometimes known as pockets) of housing, depending on the history of settlement there and the socio-economic conditions that apply. Malad represents a good example of diversity of socio-economic conditions affecting education, housing, water, sanitation and health. It presents challenges typical for people in resource-poor settings in Mumbai.

Ambedkar Nagar (see top image on left) is an example of an area where needs are especially acute. Housing is little more than shelters erected by families on public forest land within the city over which they have no rights of permanent occupation. Reused timber, blue plastic tarpaulins and cardboard are predominant building materials. Access to water is through communal tap that operates for a certain period each day and is shared with large numbers of other people. Sanitation is rudimentary, through use of open land. Levels of poverty are very high, accompanied by diseases associated with poor hygiene and nutrition.

From this high level of needs, the RCCs serve populations living in bastis with conditions ranging from slightly to significantly better than Ambedkar Nagar. Where people have more stable income, greater awareness of how to care for their health and more stable tenure, their needs are less acute, they are less often in situations of crisis and they are more able to focus on meeting development needs beyond day-to-day struggles. Kadamwadi is an example of an area that represents an improved situation where compared with the most needy bastis served by the RCCs at Pathanwadi.

Both Centres offer the mix of activities that are common to the RCC model, within physical spaces that are essentially a rectangular space. Operating from two locations was necessitated by the limitation of not finding the required space at one location. So two spaces were identified that enable the RCC to offer the full range of activities. Pathanwadi illustrates the paradox of poor living conditions existing cheek by jowl with small-scale industrial workshops that escalate property prices. The new location is on the first floor of a house and is divided to enable computer-based activities to take place in a separate area, while the old location occupies ground floor premises (see lower image on left). The schedule for a typical week in the old location includes reading activities, Children's Clubs and drop in activities, volunteer meetings, practice for events and a club for senior citizens. During afternoons, the space is generally used for a range of training courses. Three days each week the Woman and Child Clinic, starts in the morning and winds up before the training courses begin in the afternoon.

The Pathanwadi new location offers a similar range of activities, but with the inclusion of computer literacy and skill training using the six computers that occupy a dedicated area. Applications taught and practiced include MS Office, desktop publishing, Tally and use of the internet.

The success of the RCCs at Pathanwadi hinge on the people that work there and the participants who make use of the activities and facilities available. A cadre of volunteers helps ensure that the community has a stake in its success. Skilled resource persons maintain the programme of activities relating to skills, health and meeting specific needs. While the staff themselves take responsibility for building rapport, outreach, quality and coordination of activities.

In considering the work of an RCC such as the one at Pathanwadi, it is important to take into account the overall strategy adopted by RF(I)T. We commenced the development of the RCC model as a pilot in 2005, with the belief that women and children in resource poor areas need physical spaces in their midst to focus on their development needs. Within this, we focussed on capacity building and health activities to bring them to the centre as a starting point to focus on a range of issues.

Commencing in Premnagar, Jogeshwari (East) in June 2005, we felt we needed a time span of three years to test our approach. However, towards the end of 2007, the response of the stakeholders, particularly women and children to the RCC model was so positive that we were confident of replicating the RCC at other locations.

We established RCCs in Subashnagar and Shivtekdi, Jogeshwari (East) and Mahakali, Andheri (East) in 2008, Anandwadi-Kurar Gaon, Malad (East) in 2010 and at two locations in Pathanwadi, Malad (East) in 2011 and 2012. The evolution of a programme of RCCs has enabled us to concentrate on the geographical boundaries and coverage of the services to make sure that each centre reaches a large population and can also count on the right number of participants, volunteers and resource persons for the surrounding area. Filling gaps in services and being sure to meet priority local needs has been central to the model, as will be described in greater detail later in this handbook.

In broad terms the results of the work to date are that high numbers of people have been reached through the six RCCs. Mumbai is unique in its very high population densities, a key factor in the outreach figures provided earlier in this section. Outreach has led to engagement and positive impact for the people who have participated in RCC activities. This impact has been demonstrated mainly through women achieving a greater focus on themselves and their needs. We have seen changes in health-seeking behaviours, more women wanting to develop their skills and capacities and incremental improvements in income and in small-scale entrepreneurship. The following case studies illustrate examples of changes in the lives of individuals.

A zeal for learning: Habib Fakir

Habib Fakir enters the Rangoonwala Community Centre (RCC) at Pathanwadi, Malad with a grin on his face. The easy camaraderie he shares with the staff is evident as he stops by and greets them. This 14-year-old boy has been associated with the RCC Centre since July 2012 when he applied for the Basic Computer Course. Since then, Habib has come a long way.

He has been an active member of the Children's Club, completed Desktop Publishing Course, Aerobics class, Summer Camp and Festival camp, among others. He is currently doing the Basic English Speaking course.

The list is indeed long and the impact goes beyond gaining skills and knowledge. The staff has observed distinct changes in his personality. But what moves them most is the way he has imbibed RF(I)T values, his way of thinking and his zeal to learn at such a young age. He has big dreams for his future, "I love computers! I want to do engineering, in either hardware or software, though I love software applications and especially Desk Top Publishing. Earlier I used be afraid of a computer. But now, my computer teacher in school is amazed at how much I know." A student of Divine Child High School, he got A2 Grade in Class VIII.

As member of the Children's Club, Habib performed on stage at Bal Utsav, RCC's celebration of children's day, which gives an annual platform for children from its resource poor communities to learn and spend a fun day together. This was the first time he performed on stage and since then has overcome his stage fright. With minimal guidance from his elder brother Aamir, Habib presented a 'Best of Waste' project during Bal Umang, a first time initiative in RCC to promote scientific and analytical thinking among children.

Habib has not kept all the positive news to himself. Instead he chooses to spread awareness in his community, among other children, and even adults. He has brought many children to the different courses since he has joined. His parents understand the value of all that he learns in RCC and are especially supportive in this respect. Habib shares, "I tell all my friends to come to RCC. When my best friend Faizal's parents were not letting him come to RCC centre, my Dad spoke with his father and told them about all the good things that my brother and I have learnt at the RCC. When someone comes to the RCC, it can only be for his or her good."



Finding new talents as a senior citizen: Sumedha Mayenkar

Sumedha Mayenkar joined the RCC at Subhash Nagar, Jogeshwari at the age of seventy-one. She was encouraged to visit the RCC clinic and participate in activities organised there, such as yoga classes. She had always wanted to be a dancer, but had never had the opportunity to learn. One day, a teacher at the RCC said, "If you dance, the children will see you and be inspired to join as well!"

Mayenkar realised that she had never had a chance to express herself, and that this would be the ideal way to realise her childhood dream. The RCC has given her a platform to perform her dances on stage and, in doing so, to lead the way for other women at the centre. One of these women, Ranjana Nag, says that she doesn't



feel alone anymore because she has found a new family at the RCC. Another woman inspired by Mayenkar to dance, Sushma Chiplunkar, describes the women that she met at the RCC as her support system. Mayenkar says that after joining the RCC, she feels empowered and is proud to be a woman. She says, "My life has changed completely. I have become confident, and now I want to make other women just as confident."

Independence and support for tuberculosis-affected families: Mehrunissa Abdul Khalik

Mehrunissa Abdul Khalik is a widow who lives with her five children. She became associated with the RCC at Premnagar through its TB program, which provided essential medicines for her husband in the final years of his life. Importantly, the RCC also connected her with awareness programs and support groups formed by TB-affected families. She explains that 'My way of thinking changed since being associated with RCC... I want each one of my daughters to study and do well in life, to be strong and independent.'



From trainee to trainer: the Sheikh family women

Salma Sheikh began her association with the RCC at Subhashnagar when she decided to take courses there in jewellery, cooking and massage. When her young niece, Zoya participated in an RCC children's summer camp, Zoya's mother (Salma's sister-in-law), Mehejebeen also became involved in the centre to study the art of mehendi. Both Salma and Mehejebeen have made the shift from being trainees of the centre to becoming trainers, and now earn extra income by teaching other women the skills they have learned at the centre. On her role as a trainer, Salma says, "Teaching women different skills has given me a perspective on how people think. Not everyone has equal capacity — I need to change my techniques accordingly. I have become a calmer person since joining RCC." Eight-year-old Zoya has found inspiration in watching her mother and her aunt become trainers: "I love coming to the RCC. I get to play so many games in the summer camp with friends. I love studying English. I am going to grow up to become a teacher."



1.5 Replicating the RCC Model

The RCC model is replicable once contextualised to the grassroots situation and the conditions and circumstances that apply in a location where an RCC is being considered.

This handbook provides a framework to enable an organisation to learn about the model and to consider three aspects of the way in which the RCC Model relates to their existing strategy and aims:

1. The **strategic fit** with their organisation, especially through the values and principles that underlie the model
2. The **skills, competencies, capacity and resources** required to establish and operate an RCC
3. The **methods and processes** required for an RCC to maximise its positive impact locally

We have observed in the implementation of RCCs, that the model gives a 'rootedness' to work since it enables process-based work to be related to a physical space in the community and within an activity-based framework. The activity-centric model enables people to make changes in their lives in an incremental and fundamental way as it brings in the discipline and the habit of individual participation. For example, a lady will have to make the time to come to the Centre for a training course she has enrolled for, at a particular time in the day and as per the frequency of the training per week for the duration of the training. The motivation to participate is the catalyst and different development processes and issues are then easier to integrate since she is already closely involved with the Centre.

Hence the RCC model is suitable for a range of organisations working in different settings, whether urban or rural, engaged in issue-based work like access to water, land tenure, child rights and others. In effect the model achieves an important balance. It enables people to participate in practical work and balances the struggles of process-based work while ensuring that other development needs are addressed. And it does this through a capacity-building and health-related framework.

Ultimately, our aim in producing this handbook is to support others by sharing our knowledge and experience of how to work towards the launch and then the operation of a Community Centre. Although relatively simple as a concept, an effective RCC requires strong operational coordination and a clear focus on the community.

Section 2: Setting up a Rangoonwala Community Centre

2.1 Motivations for an RCC

In our experience, the initial idea of establishing an RCC usually comes from a local NGO observing what is missing in the community. For example, they might see that there is nowhere for women and children to go, outside the home, or there is a lack of activities to help people develop their skills. Or they may be worried that women are neglecting their health.

The need for a physical space in which positive activities are taking place is all-important. RCCs are often modest spaces in crowded locations, but any space dedicated to the interests of women and children is a good start. Each location or Centre has its own unique identity, drawing from the socioeconomic profile, needs and issues of the community in each locality. Hence activities are also conducted based on community needs.

An RCC is best established through a step-wise process that we will describe in subsequent sections of this handbook and which is illustrated below.



Needs assessment



Area profile and mapping



Rapport-building with stakeholders



Identify space for an RCC



Design programmes to meet need



Set up facilities



Run programmes

2.2 Making the decision to start an RCC in a particular location

2.2.1 Needs assessment

Despite having a motivation to do something along the lines of an RCC, any organisation considering developing an RCC must do a more formal assessment of needs.

We consider that organisations approaching an area tend to fit one of two categories. The first applies to an NGO or a local group that wants to establish an RCC and has a track record of working in a particular area. In this case, it will have to assess the need in the context of the programmes and services the RCC has to offer and their alignment and complementarity with the organisation's existing work. The second category applies to an organisation that is relatively new to an area and wishes to explore the potential for an RCC.

In both cases, a process of needs assessment is required. For the first, the organisation is likely to already have a good network locally and significant insights into the profile of the area, the people who live there and the gaps or unmet needs that exist. Their ability to conduct the needs assessment is strong since they will know who to talk to and should already have available to them much of the information they require.

In the second case, where the organisation is new to an area, the needs assessment is likely to take on more of the character of a feasibility study for an RCC. The organisation will be learning new information on every aspect of the area, its people and their needs, as a basis for deciding whether to proceed with an RCC.

Needs assessment involves the collection of information (called data) about the area, which we divide into two types:



The needs assessment process is to ensure that there will be no duplication of initiatives by a future RCC. It also makes sure that the work of the RCC complements the work of others and, most importantly, is directed towards the most important needs identified locally.

The limitations to needs assessment

A purist approach to assessing needs might suggest that the role of the researcher is to listen and to observe. In doing so, local people themselves will be able to define what is missing and where the gaps lie in the services and the support they require to achieve their development aspirations.

In reality, we have found that taking a more pragmatic approach is better. In the process of establishing RCCs, people we meet want to share their experience of living in the area and making use of the opportunities that exist. They are often migrants from other places and so they know what services and facilities are available elsewhere. But they also want to know the ideas and suggestions of RF(I)T.

To coin a phrase, 'nobody knows what they don't know'. So it is important that an RCC understands the limitations to needs assessment. Many people will not have seen for themselves the difference that certain activities and opportunities can make to the community.

The assessment of needs is research work and should be managed in a disciplined way. It begins with an identified team of para professionals going to the area to be assessed. The main way in which primary data is obtained is through focus group discussions of a minimum of twenty participants, from which the team will obtain information about the area (see separate focus group discussion guide on the following page).

The steps usually taken for the assessment of needs are:

1. A team of para professionals is identified by the organisation
2. Secondary data is sourced and discussed e.g. Google maps, map of the area from the Municipal Corporation ward office, data from Health post, anganwadis, schools, offices of elected representatives
3. The team starts identifying stakeholders e.g. anaganwadi teachers, community health workers (their number in the area is also indicative of population as they are tasked to service a pre-decided number of the population), self-help groups, mahila mandals, youth groups, elected representatives, CBOs, NGOs, schools, doctors, private clinics, diagnostic labs, health posts, government dispensary, government maternity hospital, peripheral hospital, community elders, local leaders and all other relevant contacts.
4. A continuous parallel process of stakeholder dialogue along with gathering secondary data is undertaken, allowing time to obtain official data from the government.
5. Secondary data is sourced through government entities such as the ward office, official maps and through internet-based searches. A listing of bastis in the area is prepared.
6. Focus group discussions are conducted in each basti with at least 20 people participating
7. Analysis of primary and secondary data is carried out to produce a baseline study.

This process is a systematic approach that can be applied in any new location, even if the sources of data vary.

2.2.2 Primary data

The collection of primary data focuses on facts.

Much of the data and information we collect is from other NGOs, similar groups and local sources like medical practitioners, grocery shops (local banias), corner tea shops and other places where good local knowledge is available. The latter can be a wealth of information which can be compared with official data to enable a realistic call for decision-making.

Valuable topics on which to gather information include:

- ▶ What do women do?
Is there an unaddressed capacity-building need?
- ▶ Of the total population, what is the percentage of women, children, senior citizens, gender break-up, issues, access to government entitlements?
- ▶ What are the health issues?
What facilities are available to address them?
- ▶ What are the education and health facilities available? What is the quality of services offered, affordability and accessibility
- ▶ What is the focus on educating children? Are there gender biases? Are children first generation learners?
- ▶ Are co-curricular and extra-curricular activities available for children? Is there any focus on life skills education?
- ▶ What is the current and proposed focus of work of organizations/ groups involved in development work?
- ▶ Economic and social vulnerability.
- ▶ Data on religion, regional groups, caste, composition of population vis-a-vis gender, adult and children. Efforts should also be put in to understand the underlying dynamics (if any) between groups.
- ▶ Occupational trends.
- ▶ Political climate.

Focus groups can be very efficient and effective ways of collecting information because they allow for a group of people to discuss a subject, providing often richer and more thorough ways to address it than a structured survey, which does not encourage exploration of the subject. Focus group discussions (FGDs) therefore contribute to the needs assessment process. FGDs should be conducted in each basti listed of the proposed area of intervention, ideally with a group of around twenty people for urban locations where population density is high.

To understand the area, the people and their needs, a FGD is conducted as follows:

Start with an introduction of the NGO, what they do, where they are currently operating, issues they work on, etc. The idea is to start to build confidence and rapport.

Explain the RCC model and the reason for the FGD as a tool to assess if the area needs such an intervention. This includes describing how the FGD and their inputs will help in the process.

Information collected from the FGD includes:

1. The population of the area (to ratify and compare with secondary data available).
2. The proportions of women, men, children and senior citizens.
3. The daily routine of women and children.
4. Common occupations of people living in the area.
5. A description of how the area has changed over time in the context of urban planning; if so how and what is the impact on the people.
6. What is the type and quality of local infrastructure, especially access to water, electricity and sanitation.
7. Which schools do children attend and what is the proportion of government, aided and unaided schools. School timings each day.
8. Opportunities for co-curricular and extra-curricular activities for children.
9. Whether there is a culture of tuition for children.
10. Locally perceived health issues.
11. Who women go to, when they fall ill.
12. Capacity building opportunities for women and children e.g. tailoring classes, computer classes etc.
13. Other NGOs, CBOs, Mahila Mandals, SHGs in the area. Their focus areas and activities they undertake.
14. Who are perceived as local leaders, social workers, people in leadership role and their contribution to the area.
15. Habitat patterns, owned versus rented homes, tenure and mobility.
16. Any other information that people would like to share about the area.

2.2.3 Secondary data

Available secondary data of resource-poor bastis in the city/town/village will need to be studied. This will consist of:

- ▶ Official maps and data from government sources (Municipal Corporation, Panchayat, Ward Office, Education Department, Health Post, etc.) related to population statistics and composition as well as other demographic details.

The team developing the RCC will need to maintain an awareness of any sources of data that arise since any relevant information that contributes to their baseline knowledge will be valuable.

2.2.4 From needs assessment to bridging the gaps

The product of a needs assessment is a short report that combines quantitative and qualitative information to include:

- ▶ A list of bastis of the areas with their populations.
- ▶ A list of key stakeholders such as local institutions, people in leadership positions, government agencies.
- ▶ Characteristics of existing facilities and services, for example, it could be that there is a health post but it is not fully functional, private doctors are male only, unqualified medical practitioners are operating in the area.
- ▶ A table of what RCCs can offer against the existing facilities in the community.

We define a gap as an unmet need in the community. For example, if there are no affordable computer teaching programs in the area then it is considered a gap. If health services are limited or inaccessible then there is a gap in health provision.

Having identified an unmet need in the community, we then proceed to work out what the RCC can offer compared to existing facilities. The table below uses health and capacity-building as an example of typical situations that arise and the way that the RCC is considered against an analysis of local gaps.

Activity	Existing facilities in the area	Options for the RCC
Woman and Child Clinic (WCC) 	Health post is fully functional.	No need to set up WCC, a referral system will do.
	Health post not fully functional.	Look deeper into local efforts to advocate to make it fully functional.
	No health post in the close vicinity.	How are health needs met? What are health services available? How much do they cost? Do women access these services — comfort level and cost.
	Number, location of private health practitioners. Cost of the services. Availability in terms of time. Are they qualified? Number of alternate medicine practitioners. Number of qualified lady doctors.	This data, contextualized with the socio-economic cultural indicators obtained through a process of dialogue with the community over a period of time, helps the RCC decide whether to set up the WCC or not.
Computer Literacy Programme (CLP) 	Do schools in the area offer computer education? Is it good, hands-on learning or a tokenism (e.g. one class of 30 minutes in a week, where children do not have access to computers, it is more of a theory session with 1 or 2 computers for a class of 60 children).	This data, contextualised with the socio-economic cultural indicators and obtained through a process of dialogue with the community over a period of time, helps the RCC decide whether to start the CLP or not.
	Are there other affordable facilities for computer learning e.g. other NGOs?	This data, contextualised with the socio-economic cultural indicators and obtained through a process of dialogue with the community over a period of time, helps the RCC decide whether to start the CLP or not.
	Is there any opportunity for first time learners, including women? (For an RCC it is important for women to have functional knowledge of computers to:	This data, contextualised with the socio-economic cultural indicators and obtained through a process of dialogue with the community over a period of time, helps the RCC decide whether to start the CLP or not.
	▶ keep abreast of what and how their children learn ▶ not be marginalised in current times of computer-based functional applications ▶ to open up opportunities).	

If gaps are identified which the RCC model of intervention of centre-based capacity building and health initiatives with women and children can address, we will proceed with the next step of Area Profiling and Mapping. This means the needs assessment process is critical to the decision of setting up an RCC in a particular area or not.

The needs assessment and area profile therefore enables the organisation to gauge both what is required and what is available to people locally. The RCC is designed to bridge at least some of the identified gaps.



2.2.5 Criteria for decision-making

The persons involved in decision-making on the RCC will now have to review the information and data emerging out of the need assessment and area profiling & mapping process.

The decision whether to set up an RCC in the area needs to be taken at this stage.

Key criteria against which the decision to establish an RCC is made are:

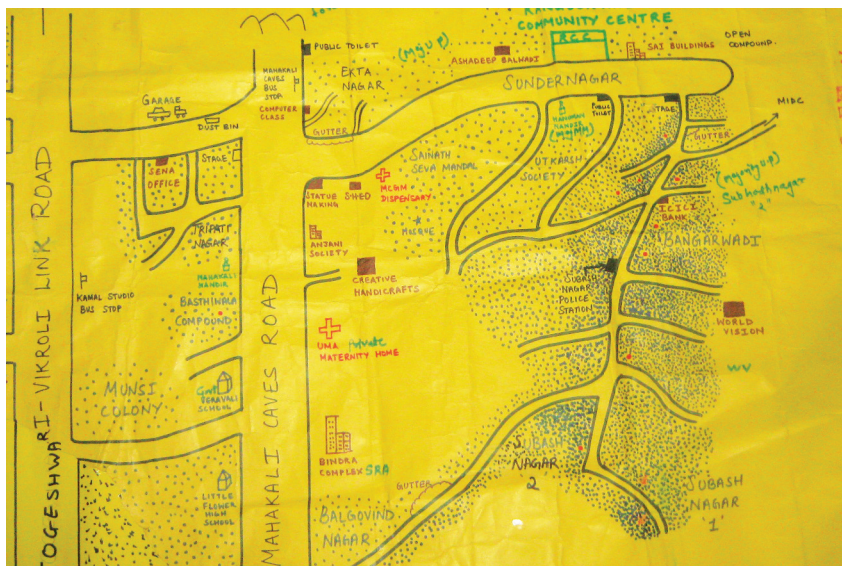
- ▶ In an urban context, for the RCC to be effective, it should service a population of at least 100,000 people.
- ▶ The RCC will not duplicate or detract from existing services and facilities in the area.
- ▶ There is community interest in the potential of an RCC and therefore likely to be high usage by local people and mobilization of volunteers.
- ▶ The RCC will bridge the gap of unmet needs related to capacity building and health of women and children.
- ▶ Future urban development and resulting population shifts will not affect the RCC in a negative way for a period of at least 3 to 5 years.

2.2.6 Area profiling and mapping process

Once a decision has been made to proceed with the RCC, an area profile and map should be prepared. This work involves collating the primary and secondary data collected through the need assessment process. An area map will be collated and documented in the form of an area profile and the same will be mapped for clarity.

Note: Below is a representative sample of the area profile of Prajapurpada, a basti of RCC Mahakali; followed by a snapshot of the RCC Mahakali area map.

	Population	1400 (4-5 people per house)
	Landmark	Sariput Nagar
	Demographic Breakup	Mixed population of Marathi, Adivasi people, Bhaiyaa, Bengali, Muslims
	Number of houses	250
	Per Capita income/month	1500
	Education facilities	There are two Anganwadis in this area. Majority of adults are illiterate in this area. Orientation towards education is positive. Children go to Veravali Municipal school, Sai Baba Trust School. Some students also go to private schools like St. Xavier's, Chourasia School etc. Less than 10 % of students enrol for professional courses like engineering, medical, hotel management etc. Majority of the students are enrolled in Ismail Yusuf & Tolani College.
	Healthcare services	There is no municipal health post nearby. Holy Spirit Hospital is nearby, hence residents who can afford services, mostly go to this hospital. Women also go to Phadke Nursing Home, Uma Nursing Home, and Sakarkar Nursing Home for childbirth. Most women go to MCGM hospitals for gynecological problems. There are no chemist shops or diagnostic labs in this area. Men who work in SEEPZ (a local economic zone) have membership with Kamgar Hospital and prefer to go there.
	Occupations	50 % of population work in SEEPZ. Mostly adivasis are construction workers, gardeners. 80% women work in private companies or are engaged in home-based work like childcare, jewellery or bindi making etc.
	Sanitation facilities	Sanitation facilities are sufficient in this area and usually remain clean. Very few have a toilet in their houses. No water logging, as the whole of Mahakali Caves area is on a higher altitude.
	Other Trusts/ NGO's/CBO's	Water supply is continuous, since there is a leakage in the pipeline. Mahila Mandals and Bachat Gats are active in this area (Bachat Gat initiative taken by women to save money in a common account, to help each other in time of need).



The area profile and map will clearly indicate:

- The different pockets (bastis) with population data bifurcating slum and non-slum population. Names of settlements (chawls) are also listed.
- The health (including sanitation) and education infrastructure — medical practitioners, Government dispensary, health post, maternity hospitals; anganwadis, schools, colleges, coaching classes, computer classes, other vocational training institutes or informal facilities
- Information is also gathered on health and education seeking behaviour, health and education consciousness, issues related to health and education — specifically women's health and occupational health
- Livelihood-related information; formal and informal employment, analysis of women engaged in paid work, home-based or not, level of flexibility
- Daily life cycle of women and children; water timings, school timings, electricity and sanitation facilities etc. lifestyle patterns including time taken off for major festivals and other social events, including periods of visits to native places.
- Location, target groups and numbers serviced, user fees of institutions, groups offering services similar to that of the proposed RCC
- Places of worship
- Community halls and other public places
- Location base and hold of political parties
- Location base, influence and issue focus areas of other stakeholders like Mahila Mandals, Youth Groups, Self Help Groups, Community Based Organisations, other NGOs etc. This helps avoid duplication of work.
- Roads
- Topography demarcating areas that are prone to water scarcity or water logging etc.
- Other landmarks and information that will be of useful reference for the proposed RCC

The result of this process is a detailed description of the proposed area of intervention, relevant facts and data related to it and a snapshot in the form of an area map. The mapping will determine the operational boundaries of the proposed RCC. It will anticipate any macro-level urban development plans, including roads and other infrastructure.

2.2.7 Needs-based rating of community areas

To enable the RCC to apply its work and resources in a way that best meets local needs, we use a rating that brings together assessments of the following characteristics of a pocket or basti:

- ▶ Socio-economic condition — income, available facilities in home, average family size, dependency.
- ▶ Fulfilment of basic needs — food, clothing, water, shelter etc.
- ▶ Living condition — condition of the house — Raw, permanent, well equipped etc.
- ▶ Sanitation facilities — Number of toilets per population, maintenance, physical condition and availability of drainage facility, pipelines etc.
- ▶ Displacement chances — Forest land, rented accommodation or own house.
- ▶ Availability, accessibility and affordability of health facilities, health status.
- ▶ Availability, accessibility and affordability of education facilities, status of education, school/ college dropouts.
- ▶ Livelihood resources, employment status of local population, occupations, earnings, salaried/ non-salaried, fixed, daily wage.
- ▶ Attitude towards capacity-building opportunities; willingness and choice.
- ▶ Health-seeking behaviours; awareness and level of interest.
- ▶ Awareness level of the community
- ▶ Vulnerability
- ▶ Status of women in the community.
- ▶ Social issues.



Area rating	Description
A: Very needy	Very low socio-economic condition, not fulfilling basic needs like food, shelter, clothing etc. No health facilities, no education facilities, access to government school only and high level of school dropouts, no infrastructure and facilities like toilets, no sanitation and drainage facilities etc. Chances of displacement are high because they may have insecure tenure or be occupying land without permission. Quality of house construction very poor, made up of raw material like plastic, papers etc. Living in very unhygienic condition leads to poor health, lack of awareness about health issues which leads to spread of disease in the area on larger scale e.g. tuberculosis, lack of health-seeking behaviours, lack of capacity-building attitude. Low employability or livelihood sources, daily wage earners, lack of availability of income sources but dependency is more. Social problems are at high levels including unemployment, substance abuse, domestic violence etc. Awareness level is low so people do not perceive or understand their needs. RCC team therefore requires more efforts to enrol people in RCC activities. Initial focus on health and short-term courses.
B: Needy	Low socio-economic condition but people have some income sources to fulfil basic needs but not securely. There is a lack of health facilities, lack of education facilities and affordability is a problem. The school dropout rate is comparatively low compared to 'A' areas. Children can get access to BMC or local schools having low fees. People have infrastructure like permanent houses and facilities like toilets but not in good condition. There is a lack of maintenance and numbers of toilets may be very low, such as one toilet block for the entire community. There is no threat of displacement. Most people do not have a fixed income through service but have small business or work on a daily wage basis. Continuous and regular follow-up is required to make people aware of health and other issues; after brainstorming they start to think about it more carefully. Low levels of positive attitude towards capacity-building and health-seeking behaviours.
C: Average	Socio-economic situation is good, people own their houses and they can fulfil their basic needs. They have a positive attitude to capacity-building and are able to achieve more by searching for opportunities for self-development and improved incomes. Access to better health and education services is not dependent on subsidised or free resources. People have infrastructure like toilets but mostly common toilets which are well maintained. There is no threat of displacement. People have fixed incomes through business, service or regular daily wages. People can access private schools and there is awareness in the area about the importance of education. The school dropout rate is low as parents are concerned about their children's education. Not much follow-up is required from RCC staff. People understand the value of the activities offered. They demonstrate a positive capacity-building attitude and health-seeking behaviour is better. Social problems like substance abuse and domestic violence are prevalent but not often visible.
D: Stable	People with good socio-economic situations, who own their houses. They have a good understanding about self-development and women want to enrol for capacity-building courses or vocational training courses as a hobby or for additional skills. If a woman is a homemaker, then through RCC activities she thinks of steps to improve her skills further. People earn fixed incomes through service or business. Most often they have a toilet facility inside the home and good sanitation facilities. They prefer private health practitioners (or doctors) as they can afford to pay for these services. Children attend expensive schools with no or low school dropout rate. Families live in permanent well-equipped houses, maintained in hygienic conditions with no threat of displacement. Health-seeking behaviours and a strong capacity-building attitude exists. Social problems like substance abuse, domestic violence are not visible as social barriers are high. Awareness level of social issues is high and due to availability of financial resources, people are convinced of the value of personal and social development.

2.3 Initiating the RCC

Once a decision has been made to establish an RCC in a particular area, two parallel processes are conducted:

1. Rapport-building with stakeholders
2. Identifying space for an RCC

This means that while the staff of the organisation is going about the work of actually finding a place for the RCC they are also developing trust and confidence with local people who may want to make use of the services to be offered there. It is an exciting period as the idea starts to become reality.

2.3.1 Building rapport with the local community

The team identified for implementing the RCC will start building rapport with the local community. It is important that they can explain to people what is proposed for the Centre and so a basket of services and community-based initiatives that will form the proposed RCCs activity plan will now need to be worked out.

These services will be a combination of those which respond to the needs of the women and children in the area for health and capacity-building as well as activities and initiatives required by the organisation and known to be effective in other locations. The basket of services is therefore based on a practical understanding that the potential beneficiaries may not be able to articulate their needs (see box in Section 2.2.1.). The organisation may also wish to achieve a uniformity of activities across its programmes and to integrate them into the RCC model to maximise its impact.

Building rapport is a continuous process that involves meeting various stakeholders in the community to gain a better understanding of their interests and priorities as well as to introduce the RCC model to them. It is the entry point to build mutual understanding and trust between the potential beneficiaries and the RCC. Specifically this process should include:

Women and children

- ▶ Understand daily life cycles of women and children, especially what are the time slots available to them to focus on activities that the RCC proposes to offer. This will depend on school timings, water timings, occupations of family members in paid work, meaning when they go to work and come back from work and hence the responsibilities that women have as homemakers and the time that they can be motivated to take out for themselves.
- ▶ Understand and build strategies to overcome cultural factors that may be a barrier in capacity-building.
- ▶ Regular interaction with community women and identify women with leadership qualities, especially to strengthen their association with RCC and nurture them as volunteers.
- ▶ Identify places frequented by women and children in groups e.g. water taps, market places, ration shops, near schools and meet for regular interaction and information sharing.
- ▶ Organise community meetings for cross-learning, sharing and bonding between women of the area.
- ▶ Establish a strong information base, so that community women and children feel that they are gaining from interacting with the RCC team is a pre-requisite for effective rapport building.

Health stakeholders

Regular meetings and dialogue with health service providers like area doctors, chemists, government health officials like medical health officers, health post staff, staff involved in immunisation programmes. This can be achieved by visits to clinics, Ward Office, government dispensaries, health posts and peripheral hospitals of the area.

Education stakeholders

Regular meetings and dialogue with Education Department officials, area schools, anganwadis, teachers based in the community, coaching classes. Interaction with youth who have braved odds to educate themselves with an understanding of education related issues faced by the people of the area.

Civil society groups

Networking with like-minded NGOs, CBOs, mahila mandals, youth groups, self-help groups and others for synergising local efforts.

People in leadership roles

To gain a better understanding of socio-economic-political dynamics, it is important for RCC staff to meet local leaders, elected representatives, community elders and leaders, businessmen and local entrepreneurs for a better understanding of local dynamics and contextualising this for effective implementation of RCC activities.

Effective rapport-building leads to six tangible results:

1. The RCC will have been introduced to a wide range of people in the community
2. Their comments, suggestions and views will have been heard by RCC staff
3. A database of contacts will have been developed as an important tool for the RCC
4. Goodwill and understanding will have been built
5. Changes and trends in the locality will have been anticipated
6. There will be two-way communication from RCC to the people and, more importantly, from the people to the RCC

An important lesson for us has been that building rapport takes persistence.

What rapport looks and feels like

To be effective in the early stages of the RCC, the staff need to have achieved a good level of trust and confidence with local people. For staff of the RF(I)T, we know that a good level of rapport has been achieved when:

- ▶ Local people call us or visit us.
- ▶ They invite us to their homes for meetings.
- ▶ They appear comfortable with us and are willing to share their ideas and feelings.
- ▶ We have established good communication and sound working relationships with important institutions like local schools.
- ▶ We consider we know a lot of people and have insights into the way the community functions.
- ▶ Local people introduce us to their friends and extended family or send them to the Centre to find out what is on offer for them.
- ▶ People don't close doors on us when we visit their houses.
- ▶ If people face difficulties, they feel RCC is the place to unburden themselves.
- ▶ The RCC is considered by local people as a place to guide them or refer them to the appropriate resources, such as for people with disabilities, referrals for major health issues and other needs.

Rapport is not always tangible, so it is important to reflect on whether it is being achieved since the support and involvement of local people is critical to its success.

A key point here is that the RCC should always be striving to be an important resource for the community. In practice, this means it is well networked and to offer referrals to other organisations for issues that it does not directly work on. The aim should be to be a zero rejection centre to respond to issues from the people who request advice and assistance. In other words, the RCC should be the place for people to go to find out valuable information to meet their needs.

2.3.2 Identification of space for the RCC

While the building of rapport with the community takes place, RCC staff will also need to identify a physical space for the RCC. Options include:

- ▶ Identifying government spaces earmarked for community development work and try to obtain permissions to use these for the RCC.
- ▶ Identify local people keen on the development of the area and persuade them to give space for the RCC.
- ▶ Identify a location which will be central to the operational area boundary decided for the RCC and try to find around 1,000 square feet built up, carpet area of space which is suitable for the RCC.

The location should be easy to access and convenient for commuting, perceived as safe and accessible to all groups of women and children of the area.

Once a space is identified, there are some important considerations:

- a) Legal due diligence should be undertaken.
- b) A rent or lease option is preferred initially, at least until community processes mature. Based on resource availability and a social cost-benefit analysis, the option to buy can be explored later.
- c) Availability of water (including storage options) and electricity are pre-requisites.

A target to aim for is to have identified a physical space for the RCC within four months. If the identification takes longer than two months, the RCC should organise activities like summer camps, festival camps, health camps in space requested from area schools, or other community spaces. It is important that the RCC is seen to be doing some work to maintain its credibility and build local confidence. Exposure visits to existing RCCs, other activities of the organisation or other organisations should also be undertaken to broaden the horizons of the people of the community and reinforce the connection of the staff to other issues and practices.

Another key lesson from the work of RCCs to date is that compromises may be needed on the kind of space available at the outset. In other words, it may be far from perfect. However, what is important is to commence activities so that local people have the chance to become involved and can see that the RCC is functioning.

2.3.3 Layout of the RCC

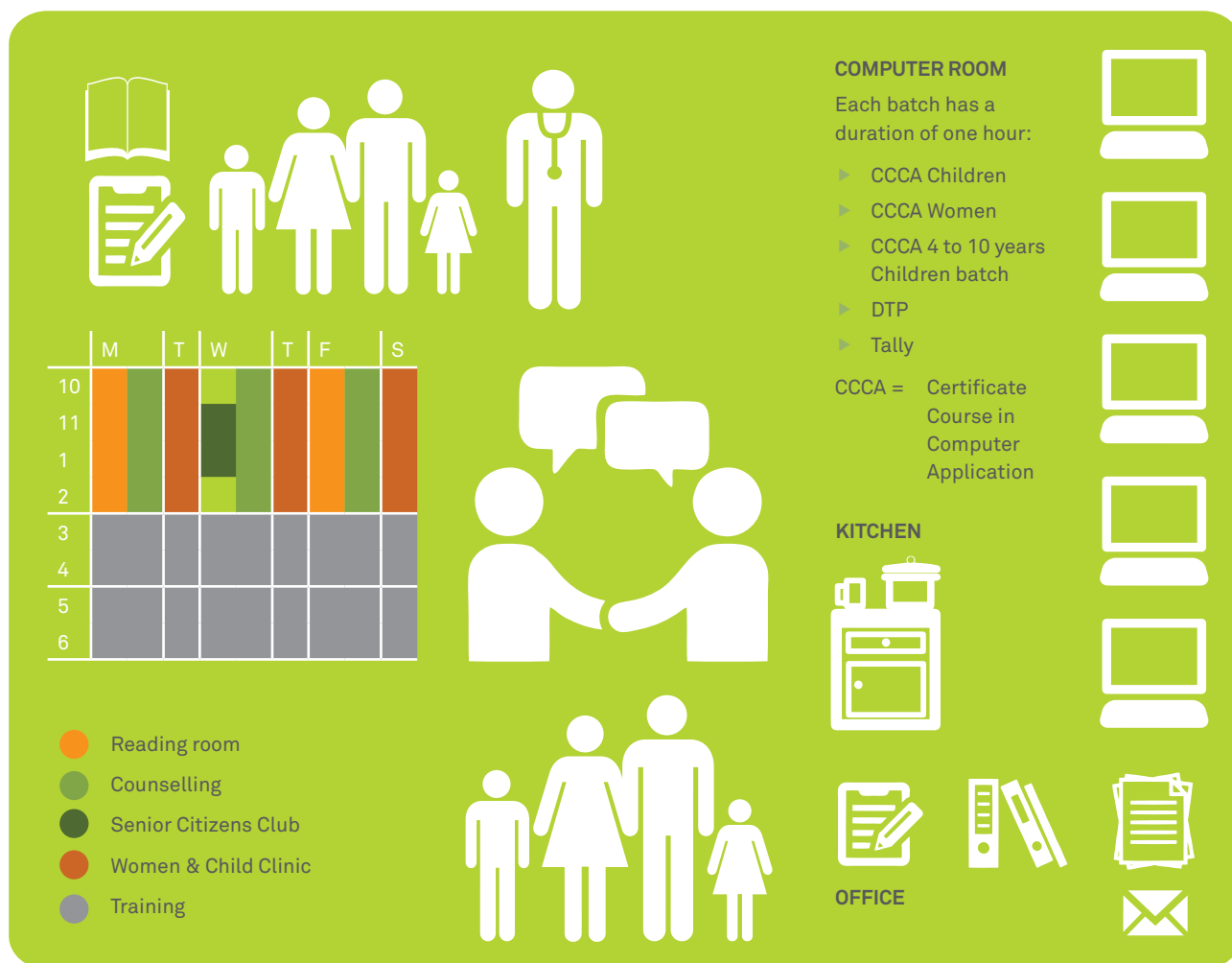
An RCC will ideally comprise:

- ▶ An administration area of 100 square feet with one computer work station with printer, scanner, photocopy, fax, telephone and internet connectivity.
- ▶ A dedicated space of around 200 square feet for computer training.
- ▶ A room of around 300 square feet which will double as a Woman and Child Clinic in the morning and a training area later.
- ▶ A 300 square feet training area.

Combinations of ground and first floor, adjacent spaces also work for an RCC, in case a single unit is difficult to find. This is very often the case in urban slums.

Individual RCCs have developed ways of using their space efficiently to provide a range of activities each day. We have described in Section 1 a case study for the RCCs in Pathanwadi. In a similar way, the Prem Nagar RCC consists of three function rooms; two upstairs and one downstairs. One upstairs room contains six PCs to deliver hour-long computer literacy programs to women and children of different skill levels throughout the day. The second room, adjoined by a kitchen, serves as a reading room some mornings, and a Woman and Child Clinic (WCC) on others. Once a week the room is used for Senior Citizens Club. Meanwhile, downstairs, a third function room provides space for the School Outreach Program six mornings a week. In the afternoons both rooms become training spaces and, occasionally, meeting rooms.

Prem Nagar RCC Upstairs



Prem Nagar RCC Downstairs



While the specific spaces and activities differ from centre to centre, they all follow the same general pattern. All the RCCs have a computer room with 5–6 PCs, and 1–2 rooms for other activities. All Centres run a WCC three days per week, and provide a reading room at least twice a week. In some centres, the reading room doubles as a space for meetings, group discussions, and other related activities. Training programs tend to use the spaces in the afternoons and evenings.

2.3.4 Aesthetics, culture and branding

An RCC should be a cheerful and informative place. Given that many local people live in environments that may be dark and cramped, the RCC is a chance to be a different setting and one that is welcoming.

Each RCC has a display of materials on training courses, health issues, images of people and events and products of practical sessions, such as flowers, embroidery and rangoli. The display is updated as new material becomes available after activities and events. It is customary to sing a prayer song before activities and the RF(I)T song as well, from time to time.

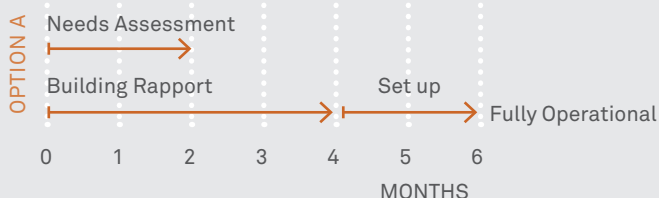
Important information is also displayed of current relevance to people coming to the RCC, such as help line numbers, government schemes and other opportunities. The underlying principle is that people should feel that coming to RCC translates to new information for them. This also helps encourage passersby to return and perhaps become participants

The name and logo of the centre is displayed prominently outside the building. The logo is also used for the Sahayaks' community bag and other products. The purpose is identity building and strengthening the RCC connection and feeling of ownership.

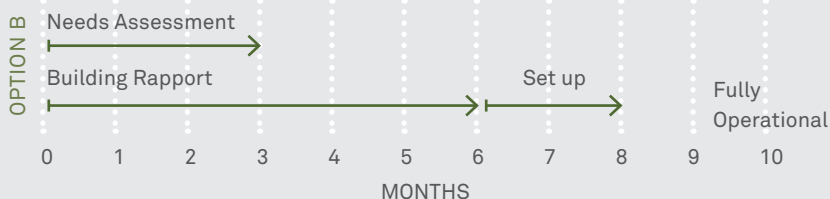


From idea to implementation; a timetable for establishing an RCC

For an area in which an organisation has already been working (Option A), the periods required for each step are likely to be:



For an area in which an organisation proposes to set up an RCC, but does not have an operational base (Option B), the periods required for each step are likely to be:



Once the physical space is set up, then activities should start immediately (e.g. health camp, film screening, community meeting and other activities to build trust in the community. If, after six months the organisation does not have a space they should start with some of the activities anyway. In the meantime, an activity plan, identification of resource persons and other work can continue to enable the RCC to be fully functional.

The timetable described here is an important indicator of capacity. If an organisation cannot complete the needs assessment in three months then it is a signal that they are unlikely to have the capacity for the implementation of the RCC model as a whole.

2.3.5 Financial parameters and investment implications

Budgeting for an RCC will involve recurring and non-recurring expenses. Start-up costs related to the space and setting up of the RCC as well as operating costs based on the activity plan for the year will have to be considered so that the Centre can rely on a sound budget for income and expenditure.

Annual cost of operating a Rangoonwala Community Centre

The table below provides typical annual costs for the operation of an RCC. It divides into three main components;

1. Programme costs
2. Programme support costs
3. Capital and set-up costs

The number of beneficiaries is as per target set for the team; 85% of the target is considered to be fully functional capacity, which in this example is 20,300 people reached. All costs are in Indian Rupees.

Costs may differ according to location and the infrastructure the organisation wishing to set up an RCC already has. Costs are basic functional ones in a basti setting. These are indicative and can be adapted as per organisation's norms.

Description	Budget	Remarks
1. PROGRAMME COSTS		
Core RCC activities		
Stationery and printing	25,000	
Documentation	10,000	
Computer literacy programme	100,000	For 400 people. This figure may change depending on the composition of groups for training
English communication women, children and youth	43,200	40 women and 40 children
Exposure visits	25,000	50 women
Events		
RCC Pratibimb (as a one day event)	150,000	185 direct participants (30 women in cultural competitions, 30 entrepreneurs as stall holders, 125 women in skill competitions). 1000 footfalls at the event
RCC Melava	30,000	100 women
Festival camps for women and children	10,000	20 women and 40 children
Bal Utsav (as a one day event)	125,000	750 children
Bal Umang	15,000	750 children
Summer camps for children, adolescents, senior citizens	90,000	120 participants
Volunteer and cadre development		
Training for volunteers and spearheads	12,500	35 women
Health programme		
Women and child clinic	270,000	3600 patients
Community-based health awareness	20,000	15,000 people
Health camps	67,500	675 women
Monthly open forum and debates	18,000	400 participants for MOF; 120 for debates
Vocational training for women	360,000	300 trainees
Yoga	18,000	20 women
Aerobics for women	20,000	20 women
Counselling for women	50,000	Counselling services for individuals on a weekly frequency = 192
Vocational and group activities		
Vocational activity	50,000	25 understudy entrepreneurs
Senior citizens clubs	9,000	25 regular members
Children's activity + yuva saarthi	38,000	50 children
Activity/ programme fund	25,000	
Programme total	INR 1,581,200	
Less: Community contribution	450,000	
RCC NET PROGRAMME TOTAL	INR 1,131,200	Total RCC outreach: 23,957 people 85% of total = 20,363, which is rounded to 20,300 people

2. PROGRAMME SUPPORT COSTS		
Assistance fees	600,000	
Local conveyance	3,500	
Electricity	30,000	
Rent	300,000	
Telephone/internet	30,000	Combined billing for telephone and internet
Mobile	6,000	
Stationery and printing	4,000	Most costs are programme linked
Newspaper and magazines	3,000	
Staff welfare	6,000	
Centre cleaning	12,000	
Insurance	15,000	
Repairs and maintenance	25,000	
Training and capacity-building	10,000	
Miscellaneous and contingencies	1,000	
Courier and postage	1,200	
Total support cost	INR 1,046,700	RCC staff also conduct activities
RCC Total (1 + 2)	INR 2,177,900	
3. CAPITAL AND SET-UP COSTS		
Set-up costs	50,000	
Furniture and fixtures	25,000	
Computers and related equipment	175,000	
Deposit for telephone connection	1,500	
Deposit for RCC rented space	100,000	
Women and child clinic set up	20,000	
Telephone/mobile/office equipment/camera	25,000	
TOTAL CAPITAL AND SET-UP COSTS	396,500	
Total cost of an RCC including set-up (1+2+3)	INR 2,574,400	

Cost per person for an RCC Model: INR 107 per annum for full target and INR 127 at 85% capacity.

Note:

The cost per person will vary based on the number and scale of activities implemented. Refer Annexure Section 2; 2.3.1 for the RCC Indicative Annual Operational Plan

1. One RCC will need an annual investment of INR 2,500,000 to INR 3,000,000.
2. The above operating costs include basic set-up costs.
3. The costs of the pre operative phase will have to be worked out considering timelines indicated in Section 2.3.4,
4. There will be many variables to the costs indicated. Contextual substitution will be required for scale as well as geographical location, meaning that some variables or units will vary and need to be substituted for others in the table to reflect the context.
5. A financial commitment of three to five years is recommended.

2.3.6 Administration and accounts

This is the backbone of the RCC model of work, since the work is activity-centric and therefore requires efficient systems and processes for managing resources across a range of trainers, participants, events and materials. The RCC model is also based on the premise that there should be contributions (however minimal) from the beneficiaries. This is to ensure ownership and commitment as well as value the services that the RCC offers, as nothing is 'free'.

Operational expenses will be managed according to the accounting policies and procedures of the organisation. Further details on administrative processes are provided in Annexure (2.1.6).

Human resources

Experience to date has shown that finding and recruiting the right people is the key for RCC operationalisation. A suitable team will comprise:

1. One Coordinator with a balance of community processes, administrative, programme delivery and documentation skills. The Coordinator will be responsible for the smooth day to day operations of the RCC and will report to the holder of this programme vertical in the organisation.
2. The Coordinator will be supported by two full-time para professional social workers. Their role will be to conduct outreach work, community mobilization and related processes, as well as hands-on facilitation of centre-based activities. If the operational area of an RCC is large, the option of a third professional or activity support staff member can be considered later.
3. A full-time computer teacher, who has record keeping and data entry as a secondary task.
4. The core full-time team will be supported by activity-based resource persons for health and capacity building services, as well as cleaners.
5. As community processes mature, volunteer cadre building will be continuously focused on, to increase community ownership as well as to support the functioning of the RCC. A reward system (monetary or non-monetary) will have to be worked out for the volunteer cadre as per the organisation's norms.

Of course, recruiting the right mix of people and skills to the team is only one part of the human resource needs of an RCC. The members of a small RCC team need to have the aptitude for multi-tasking so that a range of work is being handled at the same time and to make sure the work of the RCC is cost-effective and viable in the long term.

The underlying principle of the RCC staff and team structure is to establish a lean, cost-effective structure, with a core team and flexible need-based resource person group, linked to the activities of the RCC.

2.3.7 Critical success factors in setting up an RCC

To conclude this section, we summarise the most important human factors in establishing an RCC. Staff at existing RCCs have good experiences to share. When we asked them to reflect on what is most important in establishing a new RCC, this is what they said:

'You have to know the people'

'It is important to assess needs without bias'

'Teamwork'

'Having sound objectives and a comprehensive approach beyond the activities themselves'

'Communication with the community so local people know what you are trying to achieve'

'Good rapport with key local stakeholders like teachers. These are people who know the community well'

'Understanding families well and having insights on how they work as a unit'

'Being closely aware of the problems of the area such as health issues, poor or inadequate education facilities, children not studying well, family stress, poverty and child labour'

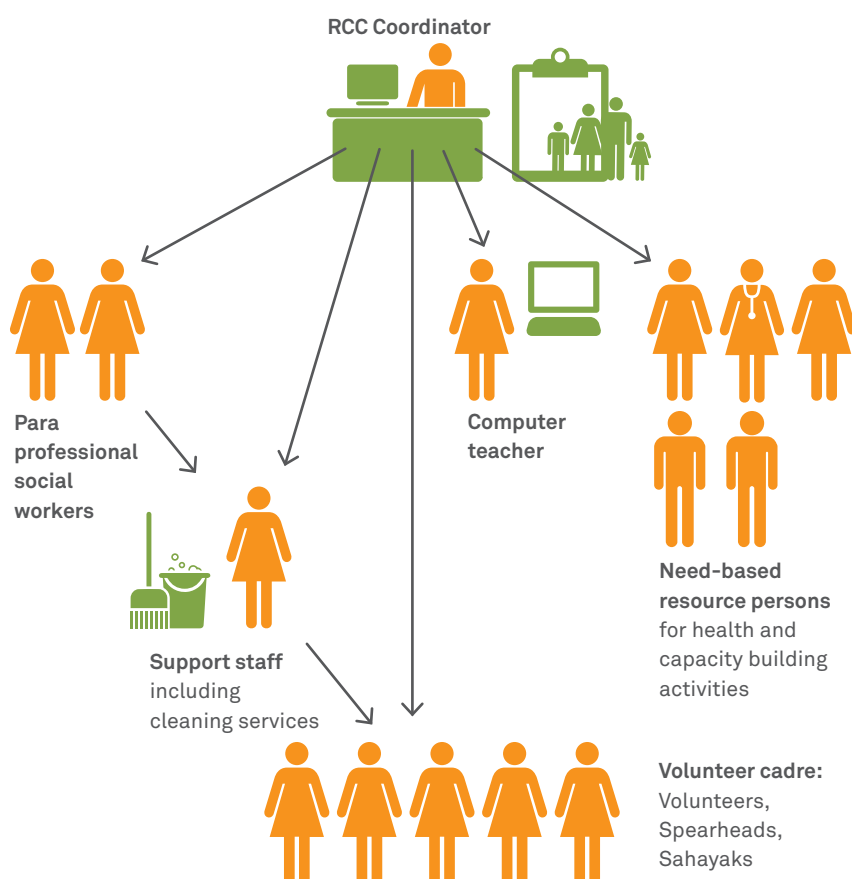
'Listening to the community is critical'

'The needs of the community should be understood precisely, especially in working out the training program'

'We have all needed to be good at handling different people and their needs and concerns'

'Providing a comfortable place that feels like a second home to people who spend time there'

Every location is different, but the comments above we believe to be advice that is universally sound.



Section 3: Community engagement

3.1 The role of outreach work

Being in the midst of people, for the people, specifically for women and children implies that community engagement has to be a continuous process for an RCC.

As a rule of thumb, once the RCC starts operations, 50% of the time of the team should continue to be dedicated to field work. The balance 50% of the time will now be taken up for Centre-based tasks.

This process of outreach enables the RCC to have a finger on the pulse of the area; to communicate RCC activities to the people and bring back issues and local situational changes to the RCC. This is important as the RCC continues to remain a need-based model which adapts and modifies activities to local needs.

The team has a target of making at least ten new contacts in a month, while continuing to remain connected with earlier contacts, building on and strengthening the chain, taking care that old links are not lost.

3.2 Strategies for mobilization

The concept of mobilization is the motivational role that the RCC team continues to play, motivating people to connect with the RCC activities. More contacts and a deeper understanding of the community is then possible.

Strategies used for mobilization are door-to-door dialogue, community meetings, taking the help of those who have a standing in the community to reach out to others and continuing to connect with various stakeholders listed earlier.

Information, Education and Awareness (IEC) materials are an important tool for retention, follow-up, reinforcement. These should be simple to read, visually appealing and in the language understood by most people of the community. These are distributed as widely as possible and are integral to any community engagement strategy adopted.

Community-based awareness programmes are used as strategies to focus on particular issues through poster exhibitions, signature campaigns, distributing Information, Education & Communication materials (IEC), by setting up 'Community Desks', doing puppet shows and /or street plays.

RCC observes World Health Day, TB Day, World Kidney Day etc. We also use these strategies to spread awareness on Patients' Rights or outbreaks of seasonal illnesses like malaria, current concerns like water contamination, substance abuse etc.

While a focused campaign on TB awareness is relevant to our operational areas, this can be adapted to the situational context for concerns like malnutrition, anemia, HIV etc.

Another approach that RCC adopts to community engagement is community-based activities. These are in the form of street plays that simply share information of RCC activities to issue based ones on health awareness like tuberculosis, chronic kidney disease, Patients Rights, etc.

Street plays are followed by community walks through the area the following day to strengthen the connect as well as gauge the impact of the activity.

The RCC model is activity-based. The intervention will be meaningful only if the community responds through participation. Hence the continuous process of rapport-building and mobilization has to translate to enrolment in activities as per pre-decided targets detailed in the annual activity calendar.

Volunteer cadre building strengthens community engagement and leads to community ownership of the RCC (detailed in Section 7).





Section 4: Training and capacity-building

4.1 Rationale

The community-based processes of RCCs involve proactive engagement with women and children in the RCC operational areas through identification, rapport building, motivating and mobilizing to serve the twin objectives of promoting capacity-building and health-seeking behaviours.

RCCs being located in the midst of communities help circumvent the hurdle of trade-offs that women face with family responsibilities and other commitments. We have found that the most significant barrier that needs to be overcome is to build a mindset that encourages women to focus on their own capacity building. RCCs therefore create opportunities for capacity building in places that are easily accessible for women and children and at a nominal cost to them.

RCCs offer a range of training courses of variable durations with the following objectives:

1. To support the overall capacity-building of community women and children
2. To foster learning as a positive habit
3. To create a space for interaction, bonding and cross learning
4. To enhance self-respect, self-worth and hence the position of women within the family and social circle. This contributes to empowerment.
5. If needs be, to enable skills to be used for income generation. The RCC gives due attention to entrepreneurship development.

4.2 Selection of training courses

4.2.1 Factors influencing the selection of training

The training courses offered at an RCC emerge from the need assessment process. They take into account the following considerations:

1. Already existing options available in the area and their cost, so that there is no duplication for the intended target group
2. Whether it is possible to add value to existing skill sets
3. What people wish to learn
4. What training courses will contribute to individual, family and area development. Hence the need may not be initially perceived by the intended beneficiaries, but the organisation foresees it and will have to work towards a buy-in from the intended target group.
5. Skills learnt should not entail considerable resource investment to practice, be it in terms of physical space, equipment or money. For example, an RCC will offer a hand embroidery rather than a tailoring or machine embroidery course.
6. The skills should be such that can be easily practiced even with frequent relocations, which is common due to lack of security of tenure of housing in resource poor areas.

4.2.2 Scheduling of training courses

The information gathered through the area mapping and rapport building processes will be useful in scheduling work. Training courses will have to be scheduled in the 'me time' of women. i.e. taking into consideration their daily routines, like collecting water, cooking, packing tiffins for the family, meal times for those at home, dropping and fetching children to and from school etc.

Training courses will also have to take into consideration festival time, religious practices, (e.g. scheduling a beautician or mehendi training in Ramazaan in a predominantly muslim area when women are observing roza), extremes in climate (e.g. outdoor activities in the monsoon) and local cultural practices.

Also important are school timings for specific age groups, the medium of instruction, exam schedules and vacation periods of children and students, since all these factors will affect the availability of women and children.

Typically, in a July to June annual cycle, the following schedule can be followed and adjusted to suit local factors

Month	Training courses	Remarks
July to September	Long-term training courses	Usually of 3 months duration, varying frequency. The training courses are mainly for women, after the start of the academic year for children
October to November	Short-term training courses; festival camps	This is Diwali time, where women find it difficult to commit time over a longer period. The time coinciding with school and college vacations is ideal to conduct activities for children
December to February	Long-term training courses	This is post festival and pre-exam time, which helps focus on a longer term time commitment
March to June	Short-term training courses and summer camps	Exam and vacation time. The period mid April to the first week of June is for children's activities which are otherwise difficult to schedule due to pre-occupation with academics

An indicative example of annual planning is included in Section 2 of the Annexures.

4.2.3 Preparation for implementing a training

Once the RCC decides on the types of training courses to be conducted, modules for each training are worked upon with subject experts. Modules are broken down into session-wise training plans and the training methodology is worked out. Neither the module nor the methodology can be changed without prior permission of the RCC Coordinator. The Coordinator will consult the subject experts, so that the quality of deliverables is not compromised.

Equipment and materials required for the training are procured as per the expected enrolment. A panel of Resource Persons are identified to conduct the training courses. The scale and terms of payment are decided (per hour or per session). Resource Persons are oriented to the work and objectives of the organisation, core values, training module and methodology. Their consent is taken in writing to adhere to these conditions. An example of an agreement with a Resource Person is included as in Section 4 of the Annexures. There has to be a back-up provided for the resource person to ensure continuity of the training.

For participants, training enrolment forms are printed and pre-determined contributions are taken for each training. Receipts are given for every contribution received by the RCC team member. This exchange is designed to ensure the inputs received are valued and to ensure commitment and accountability both from the RCC and the trainees. The RCC team member has the responsibility to keep the collection of community contribution in the secure box assigned to them. Random checking of the contributions against receipt books can be done by the Coordinator any time. Community contributions are accumulated every fortnight and deposited in the organisation's designated bank account. This task is the joint responsibility of the Accounts department of the Organisation and the Centre Coordinator.

Once the training schedule is fixed, the process of enrolment is according to set targets of numbers as well as focus areas. One RCC team member is assigned the responsibility of the smooth functioning of the training. This includes coordination with the resource person, ensuring that the resource person fills in the time log regularly and to verify the same. It also includes pre-session preparation like getting the materials for the training ready and safely putting them away after the training session. It also includes continuous dialogue with the trainees to strengthen rapport, get feedback on the training, follow-up of absentee trainees.

Before the start of the training, the trainee details as per their enrolment forms are filled into the activity register. Attendance of each session is recorded by the Resource Person and initialled at the end of each session. Certificates are awarded for training of ten sessions or more. For this 80% attendance and passing the exam is a pre-requisite. Exams will be conducted by external Resource Persons.

Trainees have to fill in and submit feedback forms. This is important for evaluation of the training courses. A Certificate Distribution Programme is organised and a dignitary invited to be present. The programme can be used as an information sharing as well as input session of general relevance. Friends and family members of trainees should be invited for this programme. It helps build their self-esteem. Trainees should be encouraged to enrol in other training courses at the RCC, this helps comprehensive capacity building and a long term association is a more apt for impact assessment.

Computer literacy is a continuous capacity-building programme for women, children and youth at RCCs. Space in the Centre is dedicated for Computer training. Special batches are earmarked for women, most of whom are first time learners. Computer training at RCCs cover MS Office, Tally (accounting package) and Desk Top Publishing (DTP). The training courses are a combination of basic functional learning of computers as well as vocational training courses.

Training courses are offered in variations of long and short term. Special batches are organised for four to ten year olds. RCCs have full time trainers for this programme. As a value addition, an RCC should tie up with a Computer Training Academy as technical resource partners. Similar arrangements are preferable for other skill based courses like beautician training, jewellery-making, etc.

Government recognition and joint certification by government agencies or reputed resource partners adds value to the training courses, increases credibility of the organisation and the employability of the trainees.



4.2.4 Representative sample of training courses

The table below reflects the courses offered by RF(I)T through the RCCs at the time of preparation of this handbook. We modify the training programmes over time depending on experiences we have and improvements we are able to make.

Detailed training modules are available from RF(I)T for each of the courses included in the table.

Activity	Duration	Frequency	Sessions	(INR)	Remarks
Certificate course in computer application (CCCA) Note: All computer courses will be taught in the latest software version	3 months	1 hour Thrice a week, alternate days	36	250	MS Office — Word, Excel, Power Point, internet and emailing. 2 trainees: 1 computer 1 trainee: 1 computer for women's batch
CCCA crash course	1 month	1 hour 6 days a week	24	250	MS Office: Word, Excel, Power Point, internet and emailing. 2 trainees: 1 computer 1 trainee: 1 computer for women's batch
Excel crash course	2 weeks	1½ hours 6 days a week	12	150	Detailed learning of Excel, various formulas; practical assignments, projects. 1 trainee: 1 computer
Internet crash course	2 weeks	1 hour 6 days a week	12	150	Use of search engines. Emailing, internet linked text messaging to mobiles etc. 1 trainee : 1 computer
DTP	3 months	1½ hours Thrice a week, alternate days	36	600	Use of Corel Draw and its various functions, practical knowledge of designing, projects. 1 trainee: 1 computer
Tally	3 months	1½ hours Thrice a week, alternate days	36	800	Basic accounting rules and use of the accounting software. 1 trainee: 1 computer
Computer Literacy for 4–10 year children	3 months	1 hour Thrice a week, alternate days	36	250	Computer literacy and computer aided language, math and general knowledge modules. 2 trainees : 1 computer
Crash course: Computer Literacy for 4–10 year children	2 weeks	6 days a week	12	100	Computer literacy and computer aided language, math and general knowledge modules. 2 trainees : 1 computer
Counselling	3 months	3 hours Once a week	12	100	Understanding self, building coping mechanisms to deal with stress of day to day life. For women with leadership qualities, to create the equivalent of barefoot counsellors.
English Speaking for women / children	3 months	2 hours Thrice a week	36	300	Focus on functional learning, communication, confidence building.
Yuva Saarthi	2 weeks	2 hours 6 days a week	12	300	Focus on personality development, resume updating, internet access, English communication etc. for 10th & 12th standard youth.
Yoga	3 months	2 hours Thrice a week	36	250	Focus on mental and physical health.
Aerobics	3 months	2 hours Thrice a week	36	400	Fun filled time for physical exercise.
Beautician Basic	3 months	2 hours Thrice a week	36	1000	Basic beautician skills.
Beautician Advance	3 months	2 hours Thrice a week	36	1200	Advanced beautician skills, equips to take this up as a profession.
Beautician bridal make-up	3 months	2 hours Thrice a week	36	1500	Enhances skills further as well as income earning potential as it equips women with skills for special occasions.

Indicative Community Contribution = (INR)

Hand embroidery	3 months	2 hours Thrice a week	36	500	Comprehensive skill of different stitches at an advanced level, enhances income earning potential to a professional level.
Massage	3 months	2 hours Thrice a week	36	300	Massage techniques taught in a scientific way.
Multi-vocational skills training (15 days)(Phynol, liquid soap, detergent, incense stick making, candle making, diya painting, paper bag making / Sanskarbharti, marketing, packaging, costing etc.)	15 days	2 hours 6 days a week		300	Equips with different skills. Used for own consumption translates to opportunity income and enables income earning as well.
Warli painting	10 days	2 hours 6 days a week		400	Traditional Maharashtrian painting, which reflects a story. Adapted to contemporary products.
Jewellery making	15 days	2 hours 6 days a week		400	Skill taught for making traditional jewellery.
Flower making	15 days	2 hours 6 days a week		400	Skill taught for making flowers, which can be used to make contemporary products like brooches, hair clips as well as the time tested bouquets, with variations in between.
Sanskarbharti	10 days	2 hours daily		100	Basic & advance skills for Rangoli used for symbolic welcome for festival and special occasions. Enhances income earning potential.
Cooking class (multi cuisine)	5 days	2 hours daily		250	Punjabi, Chinese, fusion food, various sauces. Skills that provide opportunities for earning income.
Cooking — Cake & chocolates	5 days	2 hours daily		250	Cakes without ovens or microwaves and a variety of chocolates.
Festival course for women / Children / Senior Citizens	5 days	2 hours daily		200/ 100/ 70	Sensitisation to different cultures, fosters communal harmony. For women the focus is on making items used in the home at festival time. For children it is art and craft linked to learning more about festivals of different communities and for senior citizens it is a platform to share traditional knowledge and learn new skills.
First aid training	3 months	3 hours once a week	12	50	Basic first aid, till medical help can be accessed. Do and don'ts for various illnesses
Summer camp for senior citizens	5 days	3 hours daily		70	A Summer time break from routine through a set of specially designed fun-filled activities
Children's club	3 months	3 hours Once a week		250	Life skills and personality development, through a series of activities
Children's Drop in Activity	Alternate days / flexible timings				Tailored for very vulnerable areas, where it is difficult to harness energies of the young in a structured format, activities geared as one off, but tailored to have impact for the consistent
Summer camp for children/ adolescent girls	10 days includes 1 full day outing	3 hours 6 days a week		200	A summer time break from routine through a set of specially designed fun-filled extra-curricular activities. Health check-ups are also built in. Separate batches for adolescent girls with sessions with lady doctors to focus on the changes this phase of life brings
Drawing class for children	3 months	2 hours Twice a week	20	250	Platform for nurturing inherent skills

Notes

1. Materials for each activity/ training are provided by RCC.
2. Detailed and practical modules are available from RF(I)T that provide for the training of trainers.
3. While modules are fixed for each training, the frequency and timing of sessions can be decided based on local suitability.
4. Vocational training courses have inbuilt sessions on sourcing, costing, packaging and marketing to enable entrepreneurship development.
5. The list of training courses and the months in which they will be conducted, along with the indicative community contribution is printed on the RCC's information, education and communication (IEC) materials, like pamphlets. These are widely disseminated to aid mobilization.

4.2.5 Vocational Activity

The RCC model promotes entrepreneurship development. Each vocational training module factors in raw material sourcing, costing, pricing, packaging and marketing inputs. RCC connects trainees to marketing channels and also provides opportunities through placing orders for in-house events (snacks for summer camps, meals for workshops, gifts, etc.) and through platforms like RCC Pratibimb and RF(I)T's Pratibimb. The contacts made through these events, lead to further income earning opportunities. On an average, at least 25% of women who put up stalls for the first time at RCC Pratibimb, emerge as entrepreneurs.

While individual enterprise is desirable, women do need support in terms of product design and development as well initial investment in high value products like jewellery, garments etc. RCC provides this through vocational activities. The subsequent direct interface with customers boosts confidence for women, often leading to greater independence. RCC continues to support those who are not able to go ahead on their own through its small yet dedicated vocational activity programme.



4.2.6 Monthly Open Forums

The Monthly Open Forums (MOF) are a platform for knowledge building and information sharing on topics of current relevance to the community, so that people in RCC operational areas remain abreast of current developments. As the name suggests, this is a forum open for all those who are interested in the topic of the month.

RCCs organise eight Monthly Open Forums in a year. The summer months and those which overlap with major festivals are left out. Topics of relevance are listed out as part of the annual planning exercise. An indicative list is:

- ▶ Parenting
- ▶ Substance Abuse
- ▶ Child sexual abuse
- ▶ Gender sensitisation
- ▶ Health schemes of the Government
- ▶ Public Distribution System
- ▶ Career guidance
- ▶ Women's safety
- ▶ Home remedies
- ▶ Solid waste management
- ▶ Learning disability
- ▶ First Aid

The day and week of the month (say, every third Wednesday of the month) on which the Monthly Open Forum will be organised is pre-decided. A time slot of three hours is earmarked at a pre-decided time, most suitable to the women to participate. This is printed on the RCC's IEC for distribution and promotion of the MOF.

Subject experts are identified and invited to conduct the session.

The input session is usually of two hours duration with orientation and general information sharing added by the RCC team. The session also includes an interactive period that allows questions to the subject expert, observations and feedback. If individuals need more information, further facilitation on a case to case basis is done by the RCC team with the subject expert or referral done to another organisation working on the issue.

Attendance is maintained for the MOF in a separate register. The RCC team is properly briefed about the topic, based on which they mobilize for good participation from the community. Prior coordination is done with the Subject Expert for arrangements required e.g. LCD, display structures, material required; and the needful is done in advance by the RCC team. Handouts for information retention are desirable. Written communication (email) is undertaken by the RCC Coordinator with the subject expert, to re-state the RCC's objective and expectations from the session, the target group, methodology to be adopted, summation of the session plan and written confirmation. Logistic arrangements and directions for reaching the RCC are also communicated. This is also reconfirmed a day before the MOF.

4.2.7 Initiatives with Senior Citizens

In any community, the wisdom and experience of senior citizens deserves respect. However, too often a sense of worthlessness combined with being the convenient person and continuous presence on whom the family can dump their unwanted chores often overwhelms them. With increased life expectancy made complex by health concerns, society at large is struggling to grapple with issues faced by senior citizens.

RCCs provide the physical space for senior women to rediscover themselves. Weekly senior citizen clubs are organised at RCCs. This initiative involves:

1. Identifying senior citizens in the area and arriving at a consensus on what time suits them best to meet at the RCC for two hours a week. If need be, dialogue is established with the family to free them from other responsibilities for this time.
2. Formulating session plans on a quarterly basis that provide for rapport-building, bonding, confidence-building and fun, combined with a learning quotient.
3. Designating a day in a month for birthday celebrations. All members whose birthdays fall in that particular month, will celebrate their birthday that day. Those who do not know their birthdays, will chose a month in which to celebrate it. The group will choose a symbolic way in which to celebrate their birthday, such as cutting a cake. The 'party' arrangements will be initially made by RCC. Based on the socio-economic profile, the RCC will decide on a one time registration fee (preferable) or a monthly contribution. Concessions and waivers can be allowed, so that none who wish to participate are excluded.
4. Identifying volunteers in the community who can conduct sessions, once the group stabilises and the association with the RCC is strong. A training of trainers programme will be conducted for the team as well as the volunteers as work with senior citizens requires specific skills
5. Encouraging the group to give themselves a name e.g. Aashayein. This helps them develop their own identity and a sense of belonging. Linkages can be established with other agencies to facilitate entitlements like senior citizen cards etc. Monthly input sessions from external resource persons and interaction with other interest groups strengthens the process of work with senior citizens.



Section 5: The RCC Health Programme

5.1 Rationale

Women, more particularly from the vulnerable socio-economic strata tend to neglect their health, keeping an eye on the family budget. The objective of the RCC Health Programme is to promote health-seeking behaviour among women and children. This is achieved through services such as:

- ▶ Woman and Child Clinics
- ▶ Diagnostic referrals
- ▶ Awareness-raising through Clinic Talks
- ▶ Health Camps for women

This section describes each of these services.

5.2 Woman and Child Clinic

5.2.1 Establishing a Woman and Child Clinic

The Woman and Child Clinic (WCC) is the specific response of the RCCs to the perceived and unperceived health needs of the community through a comprehensive process of health check ups, treatments, health tracking and referrals, be it for diagnostics or further specialised treatment.

To operate a WCC, a qualified (MBBS) lady doctor will need to be empanelled and a back-up doctor also identified for uninterrupted treatment of patients. The WCC will operate on alternate day mornings with a team of one lady to handle registrations and one to dispense medicines, both identified and trained by the RCC.

Furniture and fixtures for the clinic will need to be in place, namely a table and chair for the doctor, at least 20 chairs for patients (for examination and for the waiting area), as well as two tables and two chairs for the registration and medicine dispensing stations.

Medical equipment like an examination bed, light, blood pressure measurement, stethoscope, weighing scale, etc. as well as general medicines required will need to be finalised in consultation with the Clinic Doctor. To be cost-effective, it should be ordered through connections with pharmaceutical companies or distributors. The requirements will have to be periodically reviewed and modified, in keeping with the health advances and needs of the patients at the WCC.

Stationery for the WCC will include patients' books, referral notes, token books, receipt books for specialised medication, each of which will need to be printed. See Section 5 of the Annexures for details. Registers for medicine stocks and patients records also have to be maintained, with data preferably computerised for easy tracking. Examples of forms are also included in Section 5 of the Annexures.



Charges for various services at the clinic and the health programme are decided by the organisation, keeping in mind the income levels of the target beneficiaries. An indicative list is as follows:

First time registration (including Patient Record Book)	Rs. 50
Regular ongoing medicines (for 2 days)	Rs. 10
Medicines for extra days	Pro-rata of Rs. 10/ 2 days
Dressing	Rs.20
Copper T insertion	Rs. 50
First time registration for specialized medication	Rs. 70/-
Specialised medicines (for diabetes, hypertension, asthma, cardiac ailments, thyroid etc.), calcium, iron and folic acid supplements	Rule of thumb: Re.1 / tablet or lower than procurement rate; whichever is less
Diagnostics referrals	As per concessional rates negotiated through tie-ups

5.2.2 Process followed at the Woman and Child Clinic

The facilities available at the WCC and the timings will be continuously communicated to the people through the outreach work of the RCC team. The WCC is for women of all ages and children up to the age of twelve years, as it has been observed that they are the most neglected in terms of seeking health services.

A first-time patient is given a Patient Record Book (see Section 5 of the Annexures). This records the patient's medical history and medication. It also specifies when the patient has to be examined by the doctor and periodicity of tests for diabetes, hypertension, cardiac problems, etc. A queue system is followed where patients are given token numbers at the registration desk and their record books are kept in that order, to be called for check up by the doctor. For follow up visits, the queue token and the payment token is provided. As described previously, all monetary contributions are backed by tokens or receipts and receipts are given for specialised and supplementary medication.

The WCC registration desk maintains records of all patients and notes down the doctor's remarks for follow-ups. A reminder call is made for timely follow-up examinations. In case of default, the RCC team does a home visit to motivate the patients to regularly take care of their health. Specialised and supplementary medicines are given regularly, and consultation with the doctor is undertaken as per the frequency specified in the Patient Record Book. In this way, the RCC's WCC does health tracking, and is not merely a health service provider.

One RCC team member is always present in the WCC for maintaining dialogue with patients, to gain a better understanding of health issues, to build rapport with the patients, to share information about the RCC and most importantly, ensure smooth functioning of the WCC. Concessions or free treatment is given to the extremely vulnerable, ensuring that no one is excluded due to monetary constraints. The RCC team does a home visit to assess the economic situation and the report is discussed in the team meeting, based on which the RCC Coordinator takes a final decision on the extent of concession provided.

5.3 Diagnostic referrals

The RCC links up with reputed diagnostic laboratories and pathology labs. The WCC Doctor's prior approval is required on the reliability of reports. Concessional rates are negotiated for various tests. Periodic visits by the lab technician to the RCC for pathology sample collection and report delivery is also negotiated. This enhances diagnostic compliance. The rate chart is agreed upon between the RCC and the lab in writing. This is done to make holistic and accurate health care more accessible for the poor women and children in the RCC area. The rate chart is prominently displayed and referral chit given by the RCC for tests recommended by the WCC Doctor.

5.4 Clinic Talks

The idea of Clinic Talks is to enable a better understanding of health issues and the means of addressing them through an interactive forum between the doctor, the patients and community women more generally.

The process followed for Clinic Talks is that the week and day of the month for the clinic talk are decided as part of the Annual Planning process of the RCC. The information is included in the RCC's IEC, which is widely circulated in the RCC operational area. Monthly topics for the Clinic Talk are also pre-decided. An indicative list is:

- ▶ Malaria
- ▶ Diarrhoea and dehydration
- ▶ Anemia
- ▶ Bone density
- ▶ Kidney disease
- ▶ Jaundice
- ▶ Seasonal illnesses
- ▶ Typhoid
- ▶ Cancer
- ▶ Thyroid
- ▶ Tuberculosis
- ▶ Obesity
- ▶ Viral diseases
- ▶ Piles
- ▶ Rheumatism/arthritis
- ▶ Skin problems
- ▶ Dental care and oral hygiene

Care is taken to share and reinforce information related to the health camps scheduled in a particular month. The WCC Doctor comes out to the patients' waiting area on the pre-decided day, when the captive audience is at a peak. She shares information on the health topic. Queries raised by patients are responded to, even if they do not pertain to the topic of the clinic talk. Additional relevant information of current health concern e.g. dengue, influenza etc. is given at the same time.

Aids such as pictorial charts or audio-visuals are used to make the topic more interesting and to retain attention. Special mobilization is done by the RCC team for the clinic talk and relevant IECs are distributed. To enable a focused discussion, the duration of the Clinic Talk should not be more than 20 minutes, with another 10 minutes for responses to questions raised.

5.5 Health Camps for Women

Health Camps are the cornerstones of an RCC's health programme. Mobilisation and enrolment for the camp combined with distribution of specially prepared IECs for the topic help build awareness on the related health issue. The subsequent follow-ups and health tracking of the participants, through the WCCs, makes for a meaningful health intervention.

The process followed for organising health camps at an RCC are that the types and number of health camps in a year are decided as part of the Annual Planning process of the RCC. Decisions are also taken in which month a health camp will be held. This is included in the RCCs IEC, which is widely circulated in the operational area. IEC material on the health camp topic is developed and ratified by RCC empanelled doctors and health experts.

The target enrolment of each health camp is pre-decided, along with the contribution for registration for the camp. Tokens are printed for this purpose and enrolled persons are given registration numbers and time slots, which are hand written by the RCC team issuing the token. The time slot allocation prevents crowding and long waiting periods. The corresponding entry is made in the Health Camp Register. Telephone numbers of enrolled persons are mandatory as they help follow-up. Enrolment is stopped once the target is achieved, but interested persons (their names and contact numbers) are kept on a waiting list. They are called in if there are last minute drop outs.

Resource partners are explored and empanelled to conduct the camps and the most suitable date and time slot is firmed up. It is desirable that a lady doctor be in attendance at the health camp. On the day of the camp, a registration desk is set up. The enrolled persons will come in on designated time slots. The Health Camp Register with the enrolled person's names, contact number in the sequence order of the tokens is prepared before the camp. The tokens are taken and names ticked in the register. The enrolled person proceeds for testing. In case of health concerns, the patient is checked and guided by the doctor attending the health camp or referred to the WCC.

The day and time of report availability is displayed and message reinforced, so that women come at the designated time and date to collect their reports. The RCC team will maintain records of all the reports (preferably computerised) before they are distributed. The recording parameters are pre-decided in consultation with the WCC Doctor.

The data is shared with the WCC Doctor and her comments noted for follow-up. If reports are normal, the patients are handed over the reports. They can register and follow-up at the WCC, if they still wish to seek the doctor's consultation. If the reports are not normal, it is mandatory to consult the WCC Doctor. Follow-up treatment, further diagnostics, referrals are recommended by the doctor. The WCC team makes a note of this and follows up with the patient, to ensure that the needful is done. Home visits are done for follow-ups by the RCC team to motivate them to care about their health if patients do not meet required medical compliance.

Health check-ups and blood group testing are a mandatory component of Summer Camps for Children, as otherwise their health tracking is difficult as it overlaps with academic schedules. The RCCs follow a pattern of a range of health camps to build awareness on different health issues for the first three years. Later this is narrowed down to a limited range of health camps for health tracking. Initially, the following health camps are organised:

Sr. No.		Name of the camp	Set target	Target Group	Age limit/preference
1		Blood Group Camp	150	Women & children	Any age
2		Anemia Detection Camp	130	Women	Any age
3		Bone Density Camp	130	Women	Preferably 35+
4		Diabetes and Blood Pressure Camp	130	Women	Preferably 30+
5		Kidney Status Camp	Target is not set as such as this is for those with diabetes and hypertension (but around 50 to 60 women participate)	Women	Any age
6		Cancer Detection Camp	100	Women	Any age but gynaecological check-up only for married women
7		Dental Care Camp	150	Women and children	Any age
8		Eye Care Camp	150	Women and children	Any age

Subsequently, the focus is on health issues identified, and other issues continue to be addressed through referrals. For example, as anemia is common amongst women, RCCs have developed a model of quarterly camps for the same set of women. Health parameters are tracked through special indicators, including diet patterns. The enrolled women are given cards, which is their unique ID. Quarterly camp dates are printed on this card. Despite this, the RCC team will make reminder phone calls and visits. All the women, including those with normal reports are tested quarterly. See Section 5 of the Annexures for anemia camp formats and anemia card.

Section 6: Events and Special programmes

With the focus on work with women and children, Women's Day and Children's Day celebrations are signature events for RCC.

6.1 RCC Pratibimb

RCC celebrates Women's Day with RCC Pratibimb, a two day event giving a platform for:

- ▶ Cultural expression for women through dance and skit competitions on women's empowerment.
- ▶ Showcasing entrepreneurial skills by putting up stalls for the sale of products or services.
- ▶ Individual participation in skill based competitions.

The event requires detailed planning, preparation and precise implementation. Responsibilities are pre assigned to the team and volunteers. The indicative plan of a two day event, the way RF(I)T organises it for the 6 RCCs, is included in the Annexures Section 6.1

Participation is restricted to trainees and those associated with the Centre.

While the concept, script and song for the cultural competition has to independently come from the participants, RCC makes available the expertise of choreographers and theatre persons to build capacities as well as confidence to perform before a large audience. This group activity and team work enhances bonding amongst the women.

Entrepreneurship development is integral to the RCC model with vocational training courses building in components of sourcing, costing, pricing, packaging and marketing. RCC Pratibimb gives impetus to entrepreneurship development. Product samples and prices are screened and approval is necessary. In our experience, 25% of first time participants become regular entrepreneurs after RCC Pratibimb.

The individual skill-based competitions like Mehendi, Sanskar Bharti, hand embroidery, paper bag making, Warli painting, computer based logo designing etc. boost excellence. RCC Pratibimb felicitates women associated with RCC who have demonstrated volunteering and leadership skills with Mahila Puraskars.





6.2 Bal Utsav

RCC celebrates Children's Day with Bal Utsav, a fun-filled event with activities linked to creative learning, scientific thinking, disability sensitization and a platform for cultural expression through dance, skit and fancy dress competitions on pre decided, currently relevant themes like environment, women's safety, peace, communal harmony, cleanliness etc.

Children compete in group and individual performances, exhibit and explain projects they have made and participate in a range of activities organised for them. The event is for children, schools and children's organisations of the RCC area.

For both events special guests are invited. External judges are given guidelines to judge the competitions. The underlying spirit is of celebration, inclusion, confidence-boosting, recognition and self-esteem. Certificates are awarded for participation and prizes for individual as well as group excellence.

The event requires detailed planning, preparation and precise implementation. Responsibilities are pre-assigned to the team and volunteers. The indicative plan of a two day event, the way RF(I)T organises it for the 6 RCCs, is included in the Annexures in Section 6.2.

6.3 Special Programmes

6.3.1 Bal Umang projects

Children associated with RCCs are encouraged to present projects at an annual exhibition in the Centre. The objective is to build a scientific temperament and sensitivity to current issues of common relevance. Use of recycled materials, opportunities for self-expression and creativity are all encouraged.

Certificates are awarded for participation and medals for winners judged by external experts. Family members and area people coming to the Centre to encourage the participants increase numbers of people coming to the Centre and strengthen connections with the community.

6.3.2 Bal Umang; community-based activities with children

For the RCC, outreach to children is limited compared to that of women. This is addressed through school linked interventions like the School Outreach Programme which gives inputs on life skills and health awareness through specifically structured modules.

There are many children with whom the RCC cannot interact in a School or Centre setting.

Bal Umang takes creative learning through fun-filled activities to the children in their bastis, to bridge this gap.

Specific spots in different areas are listed, a schedule for conducting activities is made and team members and volunteers trained to conduct the activities standardised for content and method.

6.3.3 Mahila Melava

RCC organises this event twice in a year to reconnect with old contacts who have moved on and connect those who remain as community based contacts, but are a challenge to connect to RCC activities. This programme has a 'get-together' format through interactive games and activities. It is fun and refreshing, as well as an opportunity for the RCC team to share information. The desired output is renewed bonds and new connects.

6.3.4 Debate Forums

Monthly debate forums in RCCs are organised to encourage focused thinking on currently pressing issues. Topics are announced in advance and women mobilized to participate are divided into groups 'for' and 'against'. They collectively discuss the topic, prepare points to be put forth in the debate. This leads to clarity in thought and building of collective opinion and broader sharing. The Centre makes available information relevant to the topic. Indicative topics for debate are; the safety of children, gender equality, fire crackers as part of festivities, domestic violence, secularism etc.

Section 7: Volunteer Cadre Building

Under the RCC model, the role of volunteers is a significant one. We aim to enable people who become volunteers to progress in their skills and responsibilities over time.

The basic steps in the incorporation and development of volunteers begins with the identification of a volunteer as a person who could take on greater responsibility in the RCC context. Often, beneficiaries become volunteers and so the many people who participate in the activities of the RCC are the starting point for identifying volunteers. When a person seeks to become a volunteer, we consider this to be a process of 'going beyond self' to serve the wider community.

Volunteers have their own contacts and are able to help the RCC reach more people. We start by engaging people as volunteers for six months. We support them to build their skills and capacity and we provide mentoring for them. The mentoring process aligns with the values of the RCC. Their capacity building takes place through specific training. The Volunteer's outreach will be limited to their own contacts — family, neighbourhood, social contacts etc.

If the volunteer remains committed at this level for at least six months, she can be taken to next level of mentoring that reinforces values and capacity building. Volunteers are categorised according to their roles and responsibilities. A natural progression is encouraged so individuals can take on more responsibility as their skills and experience improves. The two next levels of progress for volunteers are:

1. A 'Spearhead' is a volunteer who works beyond her immediate contact base by spreading out to reach more people. Again, she is supported by mentoring to build her skills. The Spearhead is confident of going beyond her own contact base in the RCC area and is engaged by the RCC in a different level of activities like community-based awareness programmes, street plays, puppet shows.
2. A 'Sahayak' is an advanced volunteer who represents the RCC throughout the community and takes on responsibilities way beyond her original capacity. She also embodies the values of the RCC and she is the link between the RCC and the Community in the area. She can lead independently, represent the RCC and support any function that may be required. Capacity building continues to enable the Sahayak to develop her skills and as an investment in the work she does for others in the community.

Volunteers receive a nominal payment to acknowledge the value of their work. A typical payment is Rs.200/- per day plus travel costs and other actual expenses. Care should be taken to match the token payment to the current minimum wage so that the time individuals contribute is properly respected.

Cadre-building for Volunteers, Spearheads and Sahayaks can translate to community ownership and can be seen as a sustainability model for the RCC. As community processes mature, volunteer cadre building should remain an area of continuous focus for the RCC. This increases community participation as well as community ownership of the intervention. They also support the continuous functioning of an RCC.



Section 8: Planning, reviews and impact assessment

8.1 From needs to impact to sustainability

For the start of operations, the RCC team will have to plan activities based on gaps that emerge from the needs assessment process.

A strategic plan articulating how the RCC model seeks to achieve a positive impact in the community should set the parameters for the annual plan. A commitment to continue at least for five years is desirable for the intervention to be meaningful. It should then translate to community ownership increasing in direct proportion with time, leading to sustainability. Integrating the RCC with government models of community development is also an option.

The previous sections of the handbook as well as the indicative annual activity plan (Annexure 2.3.1) will help define and direct the process.

8.2 Maintaining a focus on results

Operational and implementation discipline is the key to making the RCC model work. The mindset required is 'we have to make this happen'. This attitude, as well as motivation, critical reflection and realistic goal setting from the organisation, will help the team take in their stride fluctuations, unforeseen circumstances and unexpected situations that occur in community-based work.

The RCC model needs hands-on leadership to make it work. The organisation seeking to implement it should be prepared to do this, leading from the front and taking responsibility for tackling inevitable problems that arise along the way. Periodic reviews will help factor in external changes, but care should be taken not to compromise the annual targets. At the most, they should be adjusted rather than significantly changed.

8.3 Collecting data on impact

The annual review process should start at the beginning of the fourth quarter of the year in which the RCC is established. Compilation of quantitative data and qualitative documentation (compiled from reports as per formats in the different sections of the Annexures) on monthly, quarterly and aggregating to annual feeds into the annual review process. The annual review is a time for going back to the drawing board, reflecting on areas of intervention, operational boundaries, activities, processes, achievements, challenges, stakeholder analysis, community dynamics, macro level changes and other key factors in the effectiveness of the RCC. The annual review format (Annexure 8.2) describes this process. The review leads to planning for the next year.

Impact assessment is critical for the evaluation of the effectiveness of the RCC. Quantitative as well as qualitative indicators will help assess if we have been able to make a difference, and if so, how. Indicators are as follows:

Quantitative indicators

1. Target vs. actual enrolments
2. Drop outs
3. How many have engaged repeatedly
4. Comparison of beneficiary data on service seekers (clinics), vocational training vis a vis other capacity building and life and wellness training courses like English communication for women, yoga and counselling
5. Gender bifurcation of children in computer literacy
6. Treatment linked data of clinics to that of health camps — tracking individual engagement history as well as area wise data and analyse it using the A, B, C, D rating system

Qualitative indicators

1. Attendance and participation in clinic talks, debates and monthly open forums
2. Attitudinal changes of the community, for example, whether women allocate themselves 'me time'
3. The extent to which health-seeking behaviour is articulated by women
4. The degree to which a capacity-building focus for women is apparent
5. To what extent have vocational training courses translated to self-respect, family and social esteem
6. To what extent have vocational training courses translated to income generation and incremental incomes
7. How many women are willing to engage as volunteers
8. The extent to which responses have changed from resistance to interest to eagerness to participate and proactively give suggestions about what activities they would like at the RCC

RF(I)T has developed a Management Information System to generate a unique ID for each person associated with it, so that we can track association history and the team has reference data on who to engage for what purpose.

8.4 Achieving an assessment of impact

Through the information gathered against each of the indicators described above, the team managing an RCC can build a picture of the impact being achieved. This is the 'data that tells a story' that is crucial to all impact assessment processes.

The story that we are seeking is one that provides insights into the effectiveness of the RCC and enables us to make adjustments to strategies, plans and resources for the work. Ultimately, we want to reach the maximum positive impact in the most cost-effective way. Collecting and analysing data through a review process enables an organisation running an RCC to achieve this aim.

8.5. An assessment of the RCC Model

Like any operational design or model, an RCC will require an inbuilt mechanism to assess its current and future potential. The SWOT Analytical Tool enables us to assess the RCC Model through its strengths, weaknesses, opportunities and threats. SWOT is an active and dynamic assessment tool, enabling an RCC to anticipate, plan for and respond to internal and external factors.

Below is an illustrative example, which can be expanded or modified according to local conditions or the emphases of the organisation operating the RCC.

Strengths

- ▶ Empowering people
- ▶ Higher accessibility for women and children
- ▶ Low cost
- ▶ Basket of activities, enabling a range of engagement
- ▶ Centre-based as well as community-based activities
- ▶ Community ownership through volunteer cadre building
- ▶ Investing in the community and its people

Opportunities

- ▶ Empowerment of women and children
- ▶ Provides a platform to build harmony by breaking class, caste and religious barriers through a 'being together, bonding forever' approach
- ▶ Integration with government schemes for women and child welfare, health and skill development
- ▶ Creates awareness of rights and entitlements

Weaknesses

- ▶ Facilities limited by available infrastructure
- ▶ Dependence on resource persons for health and capacity building activities
- ▶ Activity-based model does not allow the flexibility of a process-based model
- ▶ Model is not financially self-sustaining unless economies of scale cross-subsidise certain activities and processes

Threats

- ▶ Demolitions of buildings, leading to displacement of people
- ▶ Redevelopment, leading to displacement of people
- ▶ Legal and regulatory restrictions
- ▶ Space availability for an RCC
- ▶ Social, economic and political disturbances
- ▶ Natural calamities
- ▶ Funding for operations/RCC is exhausted



Section 9: Conclusion

Establishing and operating a Rangoonwala Community Centre requires an organisation to have a range of skills and competencies. They include good management and administration capacity, the ability to undertake needs assessments and skills in working with many different people and organisations. RCC staff also need an awareness of health issues, artistic skills and creativity, an ability to see through an initiative to achieve results and many others.

Above all, an RCC is about social, economic and human development. This means that the fundamental skills required of the staff and volunteers of an RCC are those for successful work with people living in the communities we serve. This means understanding their needs and what they can offer, listening and hearing what they say, being sensitive to the challenges they face, being clear about what is available and what is not and being open and supportive. Without these attributes, an RCC will not realise the potential that 'a physical space with activities' can offer in achieving individual, family and community aspirations.

An RCC may not be intrinsically sustainable in monetary terms. While some specific activities can break even, depending on economic conditions and the social vulnerability of women and children within the operational area of the RCC, expenditure on community processes will have to be considered as an investment in the longer-term achievements of the RCC. Development and empowerment measured against pre-determined qualitative indicators will be the eventual returns on investment.

The decision to invest in an RCC will require a resource commitment of INR 2,500,000 to INR 3,000,000 per annum for a period of three to five years for it to be a meaningful intervention that achieves significant tangible results.

This handbook and its Annexures is a living document. This is the first edition and we expect it to change and improve as RCCs develop and as we learn from our activities and the people with whom we work. It is an attempt to present, for the first time, comprehensive knowledge on setting up a Rangoonwala Community Centre. Your feedback is welcome.





