COMMUNITY HEALTH CELL

47/1 St Mark's Road
Bangalore 560001
22 March 1988

THE STATE OF INDIA'S HEALTH REPORT
(an initiative facilitated by VHAI, New Delhi)

Section: Education of the Health Team

A--A Statistical overview of the quantitative response in the 50's, 60's, 70's & 80's. (Pictorial presentation)
Trends and inadequacies
Manpower trends--comparisons

B--Medical Education

1. 150 years of Rhetoric/relevance
ii. The PSM Departments--enablers or blocks:
iii. Community oriented medical colleges--tinkering with reform
iv. The 'Shrivastava' Report--a serious indictment
v. The Kottayam and Jamnagar experiments - lost initiatives
vi. The 'ROME' programme - white elephants let loose
vii. Capitation fee medical college - business in medical seats.
viii. An alternative curriculum - a non-starter
(responses of MCI, IAAME, mfc)

C--Nursing Education

i. Overview of 5 decades--inadequate investment and confusing classifications.
ii. A 'status' problem and a gender bias
iii. Community 'nursing' alternatives

D--Paramedical training

i. The uniprpose responses of the 50's & 60's.
ii. The multipurpose metamorphosis - Kartar Singh Committee & beyond.

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iii. The Gandhigram explorations
iv. Evolving the three tier system - workers, supervisors and assistants.

E -- The Community Health worker

i. The NGO Pioneers
ii. The CHW scheme and evaluation - euphoria and disillusionment
iii. The CHW - lackey or liberator - the NGO innovation continues
iv. The anganwadi worker - ICDS alternative
v. Alternative pedagogy - helping health workers learn: the Indian experience.

F -- Education in Public Health

i. DPH to MD - loss of the old guards
ii. The story of three institutions: AIIPHH/AIIMS/NIHFW
iii. The community health alternative - masters/diplomas/leaders JNU/RUHSA/Deenabandhu
iv. Courses and more courses - the mushrooming NGO sector

G -- Training of Dais

i. Recognising the traditional 'obstetrician'
ii. Training - from condescension to dialogue

H -- Education in Mental Health

i. Reaching the unreached
ii. Educational innovation to promote mental health skills in the 3-tier health system.

I -- Training in the 'Traditional' sector

i. The non-allopathic training base - recognising the step brother
ii. Where are we heading in Ayurveda, Homeopathy, Unani, Siddha, Yoga and Naturopathy?

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iii. Seperate streams or integration--a knotty problem in training.

J--Continuing Education of the Health Team

i. A non-starter programme
ii. Leaving the field for pharmaceuticals and multinationals.

K--Educating the Health Team - A final comment

a. Trends towards Health for All by 2000 AD: challenges/alternatives
b. Building on failures/ inadequacies and micro level experiences
c. A plea for an alternative pedagogy & plan for manpower education.

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Resource persons for ection apart from Community Health Cell Team, Bangalore

1. Dhruv Mankad and contributors to mfc medical education anthology
2. FRCH Bombay (Ravi Duggal)
3. Prof Banerji, JNU, CSMCH
4. Rani and Abhay Bang, Search, Gadchiroli
5. Ulhas Jajoo, MGIMS Sevagram
6. ARCH Team, Mangrol
7. Mohan Isaac & Joseph Panackel, NIMHANS
8. Abraham Joseph, CMC Vellore
9. Daleep Mukerji, CHAI (ex-RUHSA)
10. Prem and Hari John, ACHAN & ANITRA
11. Mira Shiva, Manjunath and VHAI Community Health team
12. CS Pandav, AIIMS
13. Dr CM Francis, Editor, Health Action
14. Prof George Joseph CSI Healing Ministry, Madras
15. PK Karthikeyaini (ex Rural Health Cell, GOI)
16. Community Health Team, CHAI, Hyderabad

All these persons will be informed about the outline of the section and equested to send their own papers on the subject or any other papers/reports/comments that they feel are relevant to the different sub-units of the section. Some of them will be requested to contribute some of the box items.

Four rescurce centres will be particularly tapped for background information--VHAI Documentation Centre, FRCH, JNU-CSMCH and mfc/CHC.

The section will be put together by Ravi Narayan and the rest of the Community Health Cell team in Bangalore.

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* An exploration of the known indicators of health like IMR, Life expectancy, MMR and Under-5 mortality etc., should feature in one of the first chapters and a critical view of the broad trends since independence. In spite of their limitations and the inadequate data bases, these do give some idea of the State of health of our population and offer a possibility of comparison with other countries. With some creative communications, these statistics and comparisons could bring out the stark realities and inadequacies of our situation--even some of the inequalities for that matter.

* Section II A. While obesity is a growing problem it is limited to a small number in a particular strata and should not get over emphasised.

* Section II A3 & A4 — of particular interest to us. Send further details of the evolving format.

* Section II A5 — SCs, landless labourers and urban slum residents are equally vulnerable groups and their nutritional status could be explored in item iii) other disadvantaged groups.

* Section II A6 — Lathyrism is an unusual and unique case study but the problems of anemia, Vitamin A deficiency and endemic goitre are of far greater epidemiological significance. NIN has done pioneering work on Vitamin A resulting in the world's largest 6 monthly distribution programme and this needs definite comment.

* Section II A7 — The relevance of nutrition rehabilitation centres are in question. Therefore, is it a worthwhile case study? The focus on the other hand could be a wise range of projects using locally prepared nutritional supplements not necessarily in the NRC type set up but more community oriented.

* Section II A8 — Food toxins particularly mycotoxins are a major problem and could be featured in a box item

* Section III — Could the changing agricultural environment be introduced as a separate chapter or subsection? The range of health problems atteibuted to agricultural maldevelopment are more than nutritional problems and pesticides; spread of malaria, Japanese encephalitis, problems related to large dams, marginalisation of rural poor and consequent changes in their health and nutrition, changing work patterns of women agricultural workers and its effects and so on. Would you want a draft outline with furhter details?
While talking of environment and pollution there is a tendency to concentrate on urban and factory environment because of the diversity of the problem but the changing agricultural environment, in sheer magnitude of the people at risk is a far greater problem.

* Section II A5 — Mental Health could well feature as a separate section rather than be clubbed with social environment. While adverse environment does affect mental health, mental health is more than just that..

* Section V A2. — Medical Education is an important area no doubt, and we need to refer to the curriculum changes, Kottayam experiment etc., but it would be better to call this section something broader to encompass nursing/pharmacy education as well as the wide range of para medical training including MPWs and CHWs. There are lots of issues and inadequacies but also lots of NGO alternative initiatives.

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*Section V
A4 This section needs to explore and document the role of the large variety of issue raising groups which include groups like mfc/SHR; Co-ordinating agencies like VHAI/CHAI/CMAI and the increasing range of smaller and sometimes more localised health activist and action groups Here again NGO roles can be critically explored.

While focussing on NGO Projects it is important not to project role of NGOs as 'innovators of model projects' but part of a wider NGO response where project building is only one of a three-pronged response. The other two being 'Innovative training' and 'issue raising'.

* Section V
A5 The sub-sections of primary Health Care are questionable especially items iv) and v). These could feature in a sparate section on Secondary/Tertiary Health Care. It is important to record and critically comment on the secondary/tertiary health care build up since Independence and the pre-occupation with curative, institution and high tech medical model approach to health services in India and the increasing privatisation and corporate industry take over of recent years.

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* Some additional projects/initiatives/issues that could feature as box items somewhere in the report:

(a) LOCOST Baroda - Low Cost rational therapeutics
(b) ARCH, Mangrol - Under 5 care to rehabilitation of tribals evicted by Narmada Dam.
(c) Traditional birth attendants - situation and training experience.
(d) Deenabandhu - Herbal medicine dimension
(e) Lok Vidgyan Sanghatana, Maharastra
(f) Arogya Dakshata Mandal, Pune
(g) Appropriate technology in health care.

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* Some resource persons

i. Nutrition/Agriculture: Dr SG Srikantiah, ex-NIN
Vandana Shiva - agricultural policy

ii Endemic goitre : CS Pandav (AIIMS New Delhi)

iii Medical Research : FRCH team Amar Jesani etc/Padma Prakash

iv. Drug issues : Anant Phadke, Mira Shiva, Dinesh Abrol etc.

v. Traditional systems : Dhruv Mankad

vi. Anemia/malnutrition in women : Kamala Jayarao

There are many others but you probably have a much larger updated list by now. We could add to it when we get it or atleast suggest people for areas where no resource persons have still been identified.

* A good bibliography highlighting the large range of meaningful publications, reports and project reviews could be an additional feature of the report so that readers interested in further details could follow up.

* We could support the sections on Health Status, Nutrition and Agriculture, Health, & Agricultural Development, Medical Education, Pesticides, Role of voluntary organisations, non-formal health education, Appropriate technologies in health care and health research. You must have already identified resource persons for these sections. We could be in touch with them and or respond to initial drafts by them.

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THE DOEGULING TIBETAN RESETTLEMENT HOSPITAL ASSOCIATION

(Registered under the Karnataka Sc ties Registration Act. 1960, Regd. Society/RGN/78/UK/25)

P.O.TIBETAN COLONY • MUNDGOD-581411(N.K.) • KARNATAKA STATE • INDIA

Ref. Date .....

A BRIEF COMPREHENSIVE REPORT ABOUT MUNDGOD DOEGULING TIBETAN RESETTLEMENT AND D.T.R. HOSPITAL AND IT'S ACTIVITIES: PREPARED FOR THE PRESENTATION THE 1ST ANNUAL TIBETAN HEALTH REVIEW MEETING HELD FROM 4th to 11th OCTOBER 1993 AT DHARAMSHALA.

BY: TENPA T.K. HEALTH CO-ORDINATOR/ FIVE SECRETARY

A BRIEF INTRODUCTION OF THE MUNDGOD DOEGULING TIBETAN SETTLEMENT WITH RESPECT TO ITS POPULATION, AREA & SOURCE OF INCOME

Popularly called as Mundgod Settlement is officially called The Mundgod Doeguling Tibetan Resettlement P.O. Tattihalli, Tibetan Colony. It's inception or the process of resettlement of Tibetans began in the year 1967 on a total area of 4000 acres of land for an estimated population of 5000 people only which was divided into 11 Villages out of which two Villages are exclusively for the monks. The process of resettlement is still continueing despite the non-availability of extra land and the present population is about 11000 peoples to be exact 10757 as per 1992-93 report from the Representative Office.

Initially these settlers source of income or their livelyhood was expacted from the 32 guandas of land alloted only to the adult members of the family. That is to say that at present the livelyhood of the nearly 11 thousand people should come from this wet land of 3055 acres of land. Considering the present population and the scarcity of land, the initial objective of providing the settlers need from their land produce is made impossible. Thus the settlers are forced to look out for an alternative source of income to suppliment their family needs. These outside source include some going out into the cities for selling sweaters and others as their hired hands. Aparts from the Cooperative Society's Carpet Weaving Centres and the Tailoring and Mechanical Automobile Workshop, settled interpruners in the settlement is limited to a few restaurants, petty shops and small provision shops.

Thus the general source of income of the settlers are more dependent on the outside sources rather than the originally intended land produce because of the fractionalisation of cultivateable wet land and even this is also dependent on the monsoon rain which is never predictable despite the great scientific progress we have made in weather forecasting. Since the outside source is mainly the selling of the sweater and this too depends a lot on the seasons, the very source of income of the Tibetan settlers is always not sure, yet they all servive on uncertain source of income except the organisational and the institutional staffs.

On the whole the Mundgod Doeguling settlement is one of the poorer settlement yet it is the biggest Tibetan cluster outside Tibet. There is the need to help these people to generate a more secure and regular income to bring an overall improvement of the settlement and its settlers.

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Facilities avail in this settlement are as follows:

9 Creches
9 Nursery Schools
2 Primary Schools
1 Middle School
1 Higher Secondary School.

2 Banks
1 Post Office
1 Automobile Workshop
4 Carpet Weaving Centres
1 Tailoring Centre
1 40 bedded Hospital
1 12 bedded T.B. Isolation Ward
1 Dispensary
11 Branch Clinics for Community Health Workers.

2 Flour Mills
8 Restaurants
4 Provision Stores
Motorable road through the villages with Govt. buses plying thrice a day.
1 Home for Aged and the Infirmed
2 Monastic Study Centres with Libraries
1 Nunnery.

POPULATION

	1985	1986	1987	1988	1989	1990	1991	1992	1993
MALE	5147	5254	5419	5788	5748	5854	6696	7163	7439
FEMALE	3403	3636	3664	3875	3875	3562	3207	3285	3390
TOTAL	8550	8890	9083	9663	9623	9416	9903	10448	10829
UNDER 5	741	764	696	719	685	54	570	1056	530

A NOTE ABOUT D.T.R. HOSPITAL

Doeguling Tibetan Refugee Settlement Hospital was established in the year 1969 with assistance from Myrada to catter the health needs of 5000 initial settlers and the local villagers surrounding this settlement. Presently nearly 11 thousand people live here.

It has a bed capacity of about 40 beds initially and now we have an additional 12 bedded T.B. Isolation ward. It has all the basic facilities like moderately equiped laboratory, an X-ray unit with a 300 MA X-ray machine, Delivery room, Small Operation room with few surgical equipments, a Dental unit with Dental Chairs and an Ophthalmic unit with Opthalmic technician.

The following are the services rendered by this Hospital :

- Regular Out patient services
- Regular In patient services
- Regular Eye Clinic and monthly Eye Operations
- Regular T.B. Clinic
- Monthly free dental clinic,

all these are at the Main Hospital.

Under MCH programme following are the servicesp provided:

- Anti and post natal services
- Growth monitoring of the under 5yrs children
- Immunisation programme.

Since half of the settlement population lives about 6 KMs away from this DTR Hospital as an out reach for these people we have a branch dispensary at Village No. 6 which provides daily out patient services and MCH programes are also conducted regularly here.

As inadditional out reach facility to check the childrens health problems, visits to creches, Nurseries and Schools are conducted at regular intervals. Our CHW are involved in the improvement of the community's health hygeine. They go into the community and check and educate the local public about health and healthy habits.

Super vission and maintenance of T.B. treatment is record is one of their most important contributions alongwith monitoring of the immunisation programes and its implementation.

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This Hospital has 31 personals as its staffs and the breakup of this number as per their job asignments are as follows:-

CLINICAL SECTION:

Resident Medical Officer	- 1
Staff Nurse RNS	- 2
Pharmacist	- 1
Auxillary Nurse	- 1
Laboratory Technician	- 1
X-Ray Technician	- 1
Biller cum Asst.	- 1
Nurse Aid - - - - - - - -	- 4
C.H.W. - - - - - - - -	- 7
Plumber/Generator Operator	- 1
Washerwomen	- 1
Cook	- 1
Cooks Asst.	- 1
Gardener/Peon	- 1
Sweeper	- 3

OFFICE SECTION:

Health Co-ordinator	- 1
Accountant	- 1
Cashier/Office Secretary	- 1
Driver	- 1

Financial Status of the Hospital:

Financially speaking the Hospital and its services are mainly dependent on the grands received from the Department of Health, CTA of H.H. The Dalai Lama, Dharamsala. Keeping in mind the objectives of this Hospital as to provide health services to poor, most of its services are at concessional rate and there are many medicines disponsed free of charge, therefore the Hospitals daily cash collections are bare minimal. Therefore, the Hospital cannot maintain itself or built its future on these minimal collections but can exist only under a sufficient regular yearly grand from the Department of Health. If the Department has plans of stopping this grand then a new plan programme to generate regular income needs tobe initiated with active assistance

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from all the concerned parties that is the local settlers, Representatives Office, the Dept. of Health and other related organisations who have direct bearing on this Hospital like for example the monasteries must contribute in a much better way as they are the chief benificiaries of this Hospital services. The present condition of this Hospital building and its equipment and their renovation and repairs cost are one of this Hospitals biggest concern considering its expected cost which could be a substantial amount taking into account the size of the Hospital and its present state and the cost of the labour and material in the market.

Despite all these difficulties an short comings the MTR Hospital has every scope to develop itself into a competent utility centre taking into consideration the basic facilities and the infrastructure available here provided it gets all the financial and moral support it will need for a few years time. I am optimistic that each of you will extend the required help to improve this Hospital. I would like te thank you in anticipation.

Submitted by:

Tenpa T.K. (Mr.)

OPD & IN-PATIENT

	1985	1986	1987	1988	1989	1990	1991	1992	1993
O P D	25956	21684	21536	17690	13937	6777	6581	8236	8677
INPATIENT	607	696	625	578	505	493	645	574	412

T.B. PROGRAME

Under our T.B. Programe T.B. treatment is carried out by our Medical staffs and the C.H.Ws as per the guide lines set by the DOH and its various Medical Consultants.

Financially our T.B. programme is sponsored by DOH with condition that the IIIrd line patients must pay the 50% of their medicinal cost.
The figures for the various years of our T.B. patients are as follows:-

	1985	1986	1987	1988	1989	1990	1991	1992	1993
PT	78	75	109	100	125	127	173	162	127
XPT	4	1	6	5	11	2	13	4	9
Sputum -ve	50	41	59	59	112	107	132	106	84
Sputum +ve	32	35	56	46	24	22	54	60	52
NEW CASE	80	76	111	99	92	103	170	107	108
RELAPSE	2	-	4	6	34	26	17	59	28
I LINE	48	38	70	65	100	60	74	64	59
II LINE	34	38	45	40	36	69	112	91	70
III LINE	-	-	-	-	-	-	-	11	7
DEATH	1	1	4	2	2	3	4	5	4
STOP	56	104	78	104	33	84	168	100	65
TOTAL	82	76	115	105	136	129	186	166	136

IMMUNIZATION PROGRAME

Immunization programe of Children of D.T.R. Settlement is being looked after by DTR Hospital with active assistance from the local PHC who provide us with required vaccines and in return we provide them daily conveyence and other related expenses.

The figure of Immunization for the time period from 1985 to 1993 is as follows :-

	1985	1986	1987	1988	1989	1990	1991	1992	1993
B C G	450	87	229	103	94	100	87	66	51
D P T I DOSE	20	116	93	85	92	101	84	73	55
II "	10	102	83	75	85	96	81	77	61
III "	4	116	88	57	80	116	74	65	62
POLIO I "	20	118	93	85	92	96	78	73	54
II "	10	102	83	75	85	93	78	78	58
III "	4	116	88	57	80	86	71	64	58
MEASLES	46	82	113	105	103	79	77	65	48
BOOSTER DOSE I	-	119	75	47	34	73	74	93	72
" II	-	91	21	43	68	71	92	93	93
TOTAL -	564	1049	966	732	813	911	790	747	612

MOTHER AND CHILD HEALTH

Under this programe we have our anti and post natal care of the expected mothers with featal development monitored. Haematanic and T.T. vaccines are given to these pregnant women alongwith advice to consume nutricious diets. Our CHW check on these expected and new mothers to safe guard their health. The statistic in this field are as follows :-

YEAR	ANTENA -TAL	BIRTH	HOSPITAL DELIVERY	OUTSIDE DELIVERY	HOME DELIVERY	NEONATAL DEATH	TOTAL DEATH
1985	1059	146	36	47	63	3	75
1986	895	102	39	25	39	1	87
1987	783	96	24	25	33	4	74
1988	395	80	33	14	32	2	47
1989	1270	103	17	36	50	2	76
1990	470	96	24	32	40	1	69
1991	1035	108	23	44	41	3	65
1992	775	109	17	48	43	1	75
1993	281	63	21	25	17	1	78

BIRTH AND DEATH

Maintaining of birth and death records is very difficult where people are not very serious about what they say or where people have little regard for the importance of maintaining an accurate statistics. Anyhow the datas as per the available source of records are as follows :-

	1985	1986	1987	1988	1989	1990	1991	1992	1993
BIRTH	146	102	96	80	103	115	104	101	78
DEATH	75	87	74	47	76	69	65	75	48

OPHTHALMIC SERVICE

Under our eye clinic, we conduct regular (daily) eye clinic by our Ophthalmic Nurse and we conduct regular monthly eye operations. Though this programe is sponsored by CBM through Bangalore Office the funds received is not sufficient enough to carry out and give satisfactory services to all, as unlike other southern settlements where the Doctors fees and the conveyence is paid directly by the CBM to Dr. Philip Kuruvilla where as here in Kadgod the Hospital has to pay from the limited funds it received from the CBM. Therefore, I would like to appeal to DOH for additional funds towards this expenses.

	1987	1988	1989	1990	1991	1992	1993
O.P.	117	276	245	330	598	495	403
OPERATION	-	22	18	19	21	6	14
MATURE CATARACT	22	25	4	8	37	21	21
PTERYGIUM	20	36	9	14	25	10	4
GLAUCOMA	-	1	-	3	1	4	3
OTHERS	3	5	-	2	11	2	4

DENTAL SERVICES

D.T.R. Hospital conducts regular free monthly dental clinics. The services include free consultation, extraction, temporary filling and assist in refering to the college Hospital at Dharward. D.T.R. Hospital conducts its free dental clinic with active cooperation and support from S.D.M. Dental College at Dharward. The figures are as follows :

YEAR	FILLING	EXTRACTION	ADVISED COME TO DHARWARD	TOTAL O.P.D.
1991	103	102	27	242
1992	121	193	16	230
1993 Aug.	115	103	16	234

UNDER 5 CLINIC

Under 5 Clinic are conducted alongwith immunisation. Regular visits to creches and nurseries are planed.

	1985	1986	1987	1988	1989	1990	1991	1992	1993
0 - 1	141	107	103	62	90	96	117	138	100
1 - 5	600	657	593	655	599	451	453	918	432
Under-5	741	764	696	717	689	547	570	1056	530

SCHOOL CHILDREN HEALTH

Since this settlement has 4 different units of schools all managed by the CST with a hostel for the Higher Secondary Students. The Staff Nurse of the school takes care of their health alongwith regular, twice a week visit from our Medical Officer. All serious cases and more complicated cases needing investigations are referred to the Hospital.

WATER SUPPLY

Luckily this settlement doesnot suffer from non availability of drinking water, some villages do find that they do not get enough water to meet all their needs.

The condition of the water is fairly good that is to say most of the Villages main sources of drinking water are from deep bore well which is considered potable, but it is not always that people drink this bore well water as this supply is solely dependent on regular supply of electricity and proper maintanence of pum sets etc. Therefore there are many days when people have to use hand pump water or shallow well water as drinking water and these water are not usually very potable but needs to be treated if they would like to use it as their drinking water. In such circumstance the no. of hand pumps in the villages are not sufficient to meet the needs of entire village. To give figural picture of the water availibility condition of this settlement is as follows:

Total No. of over head water tanks in the DTR settlement are: 40 (16+12+12)
Source of water to all these pumps are deep bore well water. The average capacity of these over head water storage tanks are about 4000 gallons each. Numbers of handpumps in the settlement - 27 (~~16+12+12~~) 5+4+18
Average No. of hand pumps per village - 2.5
On the whole the quantity of water is below expected consumption level and hence this shortages will effect the sanitation and hygenic of the settlers to a considerable extend espacially its surroundings and their personal hygiene.

Finally it is good to see in the community that a section of people are there who are aware of the need of timely and occasional treatment of drinking water. A brief education about the importance of maintaining clean water tanks protection, storage of drinking water obtained from the deep bore well and also the need to boil all the handpump water whenever they have to use it as drinking water, these basic education was given to all the village leaders as a primary instruction and plan for further education in this line to promote the use of safe drinking water to prevent the spread of water borne diseases or the spreads of epedemics have been planed. In addition to this we plan to treat the drinking water at regular intervals as and when the need arises provided our financial circumstance permits or if we could get regular financial assistance from DoH or any other body in this field.

SANITATION

The word sanitation means acts helping to maintain proper health and healthy surroundings which inturn means proper dispersal of waste, garbage and proper maintainence of sewer and sewage water through well planed drainage system.

Like all the Indian Villages when the resettlement of Tibetans began in clusters called Camps or Villages nobody thought of or felt the need for a proper planed drainage system. The few flush toilets that were build were also pits storage or single chamber types. The people or the settlers themselves didnot find the need to lay a planed drainage and sewer systems because of the following reasons:

1 They are not used to using flush toilets
2 They didnot have the habit of using a planed drainage system, they didnot see the need.
3 Even if some of them wanted to use flush toilets they never had a required money and know how to build one.
4 Most of these people considered using or construction of a flush toilet not as a basic health requirement but as luxury convenience.
5 The vast open space around them has never made them feel the shortages of space where they can relieve themselves without any pre and post extra work or excreta dispersal or disposal expenses.

Since a few years now people's habits and attitude have changed a lot these days we can see people using and also constructing hygenic flush toilets with view not only to make themself more convenient but also to improve their health and the cleanliness of the surrounding. This is a great improvement in the sanitory line but there are still many more who are not willing to build one but there are many who cannot effort to build one either because of financial problems or because of lack of technical know how and some with both problems.

Shortage of sufficient water for this purpose is another deterrent factor. Anyhow to give a clear picture of the settlements sanitations position interms of no. of toilets is as follows :-
Presently there are .466... toilets in this settlement and their break up as per village and toilets per family is as follows;

Contd..2.

Total No. of toilets in the settlement - 466
Total No. of toilets per Village 35·5 -
One toilet for ~~w~~ every ....3·2..... families
Percentage of toilet per family ...31·1.....%

The over all sanitation situation of this settlement is in a much better place than ever before. Considering the people's positive attitude and the present awareness due to their exposure to the importance of having hygenic toilets which can make a lot of difference in their health status. Heavy monsoon rains is one of the most deterrent factor in their maintainence of proper sanitation in this settlement, otherwise despite all these disadvantages this settlement's sanitation could improve, we are pursuit of doing our best to help them achieving our common interest goal. If the Dept. of Health or any other organisation or even individuals who would like to experiment or initiate project which are aimed at improving the ~~xx~~ sanitation and health or its maintainence procedures, we welcome you to our settlement and try your good intention with us and we will put in our best wherever we are required or in whatever way we can put in our mark.

DTRH/

ENVIRONMENT

Talking of environment I shall not deal with global environmental danger or its present scenarios but because I am or we are not concerned with it, but because our settlement people will find it hard to understand and corelate the resultant effect. But I will rather stick to the impure air they breath because of their own irresponsible act, mainly due to improper disposal of garbages and the conversion of every gutter and open space around their respective villages or monasteries into open lavatories and garbage dumps.

The seeone factors is the denudation of the forest around the village for fire wood. Therefore, there is an urgent need to promote more cost effective Biogasunits and promotion solar water boiler or cookers, there will not save the poor people from getting physical beating from the forest rangers but will reduce their work load. This way we can save the environment and improve the peoples health also. Another important I would like to suggest is if the DoH or its various donars could initiate or promote the use of low wattage, highly lumunicent lights, like professor Reddy's DEFENDUS project explain. This can save the people and the environment (air) from the hazards of using very dim light at night, the frequent use of heavily sooty kerosine oil lamps on the health of an individual.

Now if we talk about enveronment al issues in terms of number of trees planted in this settlement then the picture is not too bad as there are a total of 21,208 trees planted in their respective gardens and on t the road sides of the settlements main roads. Then when we talk about enveronment in terms of toilets and garbage disposeable systems and numbers garbage bins, then the picture a scaring one. There are only about 13 garbagebins for the whole settlement and even these are not used properly. The most surprising observation to me is that the village which has maximum no. garbage bins is one of the dirtiest village. This is an indicator that mere provossion of garbage bins alone will not solve our health & enveronment problems. What is needed is health education stressing the importance of proper disposal of garbages and much more important is the need for will to change old habbits and an acceptence of shared responsibility must come from the respective settlers themself. Only then can we bring some change or safeguard the enveronment around us.

THE DOEGULING TIBETAN RESETTLEMENT HOSPITAL ASSOCIATION

(Registered under the Karnataka Societies Registration Act. 1960, Regd. Society/RGN/78/UK/25)

P.O.TIBETAN COLONY • MUNDGOD-581411(N.K.) • KARNATAKA STATE • INDIA

Ref. Date .....

Suggestions;

I There is an urgent need to change the public attitude from a mere dorment dorment receiver to an active retriver class, where they themselves should come forward seeking health facility and services and extend their cooperation to all those who are trying to promote public health. The respective local individuals must accept social responsibiltyof saf guarding their own community's health and the enveronment arround them to promote their own health.

II The Representatives Offices must give more importance to the cause of public health and pay greater importance in the maintainance of public hygeine and sanitation.

III The monastries must allot specific time for health education and the Abbots and the disiplanarians of the various Monastries should check the misuse of public gutters and open spaces arround their respective monastries from converting into open toilets and garbage dumps.

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ADD India
(ACTION ON DISABILITY AND DEVELOPMENT INDIA)

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RICHMOND TOWN,
Bangalore 560025

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ADD INDIA

INTRODUCTION

1. The aim of ADD (ACTION ON DISABILITY AND DEVELOPMENT) organisations is to promote self-help among disabled people in poor communities. The first ADD organisation was established in Frome, Somerset in the UK in 1985 and the second in India in 1989. ADD UK is in the process of facilitating local disabled people and their friends in Uganda, Sudan and Burkina Faso to establish ADD organisations. At present ADD UK is registered in these countries. The ultimate aim is to establish an international network of organisations promoting self-help.

ADD UK

2. ADD UK works in 14 countries. It has the following services :

   2.1 Development Training Services;

   2.2 Planning Services;

   2.3 Orthopaedic and Mobility Services;

   In addition it also offers partnership and funding.

ADD INDIA

3. ADD India was registered under the Karnataka Societies Registration Act in October, 1989. ADD India has seven Governing Body members, out of whom three are disabled people. ADD India is completely autonomous promoting the basic ethos and philosophy of ADD network which is self-help among disabled people.

PHILOSOPHY

4. ADD organisations believe that disabled people are in the best position to know their needs and therefore should be properly consulted and supported to meet these needs if they so desire. They should have the opportunity to manage any programme undertaken with them, thus facilitating leadership development.

5. A disabled person understands the development needs of another disabled person because of a shared disadvantage.

STRATEGY

6. The strategy in India has been to facilitate existing voluntary agencies to work with disabled people to promote self-help. The estimate of voluntary agencies in India working with non-disabled people mostly in villages varies from 8 to 15 thousand. They already have infrastructure and staff. It is cost effective to add on development work with disabled people to their existing work. In addition disabled people, after all, live in the villages where these agencies are already working. The aim of any programme with disabled people is to integrate them into the community they live in. So it is imperative that work with disabled people should also be an integral part of voluntary work.

ROLE OF ADD INDIA

7. The role and function of ADD India is to develop partnership with these agencies and to support them. ADD India provides the following services within an agreed framework :

7.1 Formulating policies on work with disabled people;

7.2 Designing programme;

7.3 Developing systems for implementation and monitoring;

7.4 Training partners in these areas;

7.5 Training partners' staff at all levels in disability awareness and field workers in animation and group work techniques.

7.6 Assisting partners to liaise with Government, educational and rehabilitation institutions.

7.7 Supporting partners to establish services for medical rehabilitation, primary education, skills training and communications development.

METHODOLOGY

8. Disabled people are victims of a culture of dependence and silence in poor communities. Change in their situation as envisaged by them can occur only if and when they themselves feel the need for the change and are willing to work towards it.

9. ADD organisations encourage disabled people to form their own organisations through a process of animation. This slow long process of animation gives disabled people the space and time to reflect on their situation, to build up their confidence in their own ability and find strength in being together as a group. In time disabled people find that the group they belong to accepts them for what they are, and does not reject them for what they are not. It may also be for many disabled people that it is for the first time in their lives where they have an opportunity to speak what they feel without fear of being reprimanded. This process also enables them to identify their own needs and the best ways of fulfilling them.

10. As a result of this process, parents of disabled children are beginning to recognise the need to educate their disabled children and adult disabled people, the need to acquire skills for self-employment. Needs for housing, transportation, basic rehabilitation services and so on are beginning to emerge.

MANAGEMENT STRUCTURE

11. Development work with disabled people is part and parcel of the voluntary agency which has a partnership with ADD India. One of the office bearers of the partner agency or the paid Executive is responsible and accountable for this work. All the relevant staff of the agency support this work. At present it has partnership with six agencies.

12. This work has a full time field worker in four agencies and in the other two, this work is taken on by existing staff involved in other work. The full-time workers cover 20 villages in one agency and the whole Mandalam in the other three. Where the staff are involved in other work, they support groups in five villages. Their task is primarily to animate groups of disabled people and support them in whatever they want to do to change their situation. They are also responsible to support groups of disabled people to liaise with local Government and non-Government agencies, maintaining accounts of membership fees, admission of disabled children into schools and allied activities.

FIRST THREE YEAR PHASE OF THE PROGRAMME

13. The development programme with disabled people in South India from January 1987 has resulted in partnership with eight voluntary agencies. Its aim has been to promote self-help among disabled people in the villages where these agencies are already working with other marginalised people : Young India Project - Bathalapalli Action Group in Anantapur District, Young India Project - Kalahasti Action Group, Young India Project - Sathyavedu Action Group and Integrated Rural Development Society (IRDS) in Chittoor District, Rural Development Trust in Anantapur District, New Education for Liberation in South Arcot District PREPARE in Chengai MGR District and League for Education and Development in Tiruchirapalli District. The partnership with New Education for Liberation ended in 1990 and with Young India Project - Bathalapalli Action Group in 1992. Among these eight, IRDS has just commenced work.

14. The current partnerships have established 98 self-help groups of disabled people. These groups total membership is about 1,470, covering an age range upto 40 years.

ACHIEVEMENTS

15. The major achievements of the first phase of the programme has been that it has enabled these people to realise that they need the same opportunities in life as able bodied people in order to become active and effective in their communities. They have also realised that the change will not take place unless they themselves work for it. Through the formation of self-help groups a forum has been created for disabled people to get together and debate their needs and, as a result, disability is definitely gaining visibility and importance as an issue in the areas covered by the programme.

16. In addition this work has enabled disabled people - men, women, and children to access opportunities in the environment both from Government and non-Governmental sectors. Opportunities include education, self-employment, transportation and housing. Availing benefits from Government schemes enabled disabled people to meet their initial expressed needs. The process of availing benefits from these schemes has encouraged disabled people to strengthen their conviction "TOGETHER WE CAN"

17. The members of self-help groups contribute between 50 paise to Rs.5/- a month as membership fee and have opened bank or Post Office accounts. This money is collected and is used by them to meet the expenses of their own group for administrative, postage and travel connected for availing benefits from Government schemes

18. The other indicators of the impact of this work are:

18.1 Observance of the World Day of disabled people and contributing effort and money for such observance;

18.2 Non-disabled cadres and disabled people enacting street plays on social problems of disabled people;

18.3 Developing leadership among themselves and increasing their capacity for analysis and questioning;

18.4 Participating in street plays in the mela of agricultural labourers;

18.5 Disabled people doing skilled jobs, offering to train other disabled people;

18.6 Disabled women assisting other disabled women with marital issues;

18.7 Joining the efforts of agricultural labourers on obtaining land pattas;

18.8 A disabled person contesting the district Secretaryship of the agricultural labourers union;

18.9 Parents of disabled children motivating their counterparts to educate their children.

THE SECOND THREE YEAR PHASE OF THE PROGRAMME

19. The aim of this period will be to consolidate the existing work and to facilitate new voluntary agencies to reach more disabled people in 150 new villages resulting in the establishment of 30 new self-help groups every year. In addition, the specific focus in programme areas will be on :

19.1 Developing and establishing a Rehabilitation Service;

19.2 Developing and establishing a Skills Development Service;

19.3 Creating a Forum of Disabled Women and

19.4 Establishing a Communications Development Service.

REHABILITATION SERVICE

20. Almost all the existing facilities for education, training and rehabilitation for disabled people are in cities and in towns, whereas more than 60% of them live in villages. ADD India aims to make rehabilitation services available in villages.

21. For this service to be effective, it needs support at different levels. ADD India's partners need to have their own core team of people to establish and manage this service. The core team would consist of four people with formal training in special education of visually impaired children, hearing impaired children, mentally disabled children and orthopaedic/physio technician. This core team would need the support at the field level. The existing field staff doing organisational work with disabled people would have to be trained on an on-going basis to provide this support. The other element of support will include referral centres for medical rehabilitation. ADD India's aim is to achieve all these by using existing facilities in institutions for disabled people and hospitals.

22. As a first step ADD India had organised training of all the eight existing field staff in orientation and mobility, daily living skills and braille for a period of two months. A two-week Workshop on Working with Children with Hearing Impairment was also organised for these workers. ADD India has now organised training of the core team for Young India Project (YIP), Rural Development Trust (RDT), and PREPARE at their own cost as detailed below :

Partners	No. of Sponsored Candidates	Discipline
YIP	2	Special Education of Visually Impaired Children
YIP	1	Special Education of Hearing Impaired Children
YIP	2	Orthopaedic/Physio Technician
RDT	2	Special Education of Mentally Disabled Children
RDT	1	Special Education of Hearing Impaired Children
RDT	2	Orthopaedic/Physio Technician
PREPARE	1	Orthopaedic Technician
PREPARE	1	Physio Technician

23. The formal training provided does not include any input on management of these services, which is crucial to the success of this programme. ADD India's role is to provide this input on a monthly basis initially for a period of one year. Its role is also to establish referral networks for medical rehabilitation and to set up a resource base for its partners with the support of sympathetic professionals in cities. Without such a base upgrading knowledge and technology will not be possible.

24. At present this role is being fulfilled with the support of the existing staff of ADD India.

25. Once this service is fully established, integrated education of disabled children in regular village schools will become a reality in the programme areas.

26. Parents are seeing the need to educate their disabled children. They are not willing to send them to special schools as they are hundreds of kilometres away from their homes. They want their disabled children to be educated in their own or nearby villages like other non-disabled children.

SKILLS DEVELOPMENT SERVICE

27. Most disabled people do not have even agricultural skills in villages. Increasing the earning capacity of disabled people is one of the major aims of ADD India's development programme. This aim can be achieved only through skills development. The strategy is as follows :

27.1 To raise awareness of disabled people and the community they live in about the potential of disabled people to do skilled jobs;

27.2 To identify marketable skills in programme areas;

27.3 To organise skills development training for disabled people and

27.4 To develop and establish a system for marketing their skills, products and services.

28. Finding viable income generating programmes for marginalised people has been a challenge for decades. This is more difficult when it comes to disabled people for the following reasons :

28.1 In the first place disabled people are made to believe that they cannot do anything on their own because of their disability. This is due to religious prejudices, social attitude and lack of information.

28.2 Disabled people are in the same socio economic context as their non-disabled peers. The additional element to be addressed is adaptations of tools and equipment to suit different disabilities. Then there is also the whole issue of skills and trades being done by particular caste.

FORUM OF DISABLED WOMEN

29. Disabled women form about 30% of the present total membership of the group. ADD India has become aware that disabled women's situation is more oppressive than disabled men's. They are worse off than their non-disabled counterparts.

30. If disabled women are to express the anguish and pain of their oppression, they need a forum for themselves animated by women.

31. Therefore, ADD India has employed one woman Field Coordinator for this purpose. Her role will be to train women field staff of ADD India partners to work with disabled women and to support them to meet their needs.

32. The strategy is also to develop support services such as counselling and legal aid by using existing organisation.

COMMUNICATIONS DEVELOPMENT SERVICES

33. Development work with disabled people follows the same principles as the work with non-disabled people and there fore needs similar inputs and infrastructure. Media is being used in work with non-disabled people. In work with disabled people media is used to a limited extent in areas such as prevention, early detection, early intervention and rehabilitation; but it is not being used to promote disability as a development issue.

34. Many disabled people ADD India works with, are not only physically stunted but also psychologically stunted due to lack of early childhood stimulation, rejection by family and peer groups. while physical stunting due to malnutrition results in a permanent impairment, the 'psychological stunting' in disabled children or adults can be healed. Psychological stunting manifests itself in disabled people in villages being dependant in not being able to comprehend and articulate.

35. The roles village communities assign to disabled people are being a watchman, a shepherd and shepherdess or at best a shopkeeper and at worst a beggar in an income generating context. Part of the reason for the community assigning only these roles to disabled people is because they have not seen any disabled people playing other roles in similar communities.

36. Seeing is believing. Therefore, if attitude has to change, disabled people and the communities they live in have to see examples of other disabled people playing positive roles in their communities. Examples of such roles could include carpenter or a mason or a tailor or a school teacher serving as resource people to their village communities.

37. Attitudinal change cannot occur in void. The best input to facilitate this process is audio visuals of living examples of disabled people being resource people to their communities through skills needed by that community. The aim of ADD India's work is also to increase the earning capacity of disabled people, because this contributes to their gaining independence and human dignity. Equalization of opportunities becomes probable with a better economic base.

38. ADD India has a three year plan to establish a sustainable resource base for communications, disability and development. The aims of this service are :

    38.1 To develop material, using folk media and the conventional media for training in animation and dissemination of information;

    38.2 To develop audio visual material to raise awareness of disabled people and their village community in the potential of disabled people and to inspire them;

    38.3 To develop a pool of trained people in villages to continue to use appropriate media to promote disability as an attitudinal and social issue.

CONCLUSION

39. ADD India's work is only a small beginning towards promoting self-help among disabled people in Indian villages. The 1,470 disabled people with whom ADD India works is only a minute fraction of the total estimated disabled population of 24 million people. About 60% of this population is spread over 600,000 villages.

BV:MK:SG
30 July, 1992

Resume of ADD India's Experience: 1987 - 92.

Introduction:

1. ADD (Action on Disability and Development) in the U.K. began in 1987, to explore whether development/organizational work with disabled people can be added on to existing rural development voluntary structures in India. The history, philosophy, strategy, methodology and the current status of work are described in a document entitled "ADD India".

2. This documents ADD India's experience in promoting this work which includes experiences with Voluntary agencies in rural development, disabled people, Family and Community in rural areas, Government, and Service agencies.

3. Voluntary agencies:

   These agencies promote work in health, literacy, credit, ecology, organizing people and in other sectors. Those for disabled people promote medical rehabilitation, literacy, and vocational rehabilitation. Disability as a socio-political issue is still new to the sector. Disability is a non-issue for most of these agencies.

4. All most all voluntary agencies are unaware of the magnitude, nature and extent of the problem of the disabled people. They perceive this work to be of specialists in nature and are daunted by the task of equipping themselves to do this work. This image ofcourse has its roots in disability being promoted as a medical and rehabilitation model in the last two centuries. Religion has played its role in ingraining welfare oriented values.

5. Disabled people are marginalised in society. Work for them also follow suit. Most non-disabled people's interaction with disabled people takes place in public places. They occupy a few insignificant moments of their consciousness. These moments produce stereo-typed responses of welfare/charity either in the form of material, thought, feelings and or behaviour.

6. Disability issues are neither taught nor written about except in professional courses, such as medicine and paramedical courses. This issue does not find a place in development studies.

7. These reasons coupled with the fact, that disabled people form not even 5% of the population and are scattered, has left the voluntary sector in a state of indifference to disability as a social issue.

8. ADD India has facilitated or is facilitating 9 agencies to do development and organizational work with disabled people. The fact that they are undertaken this work and are doing it as well as their commitment and competence permit is commendable in the light of the level of awareness described above.

9. No doubt, this work is integrated into these agencies. However, the quantum of energy, time and resource allocation are not proportionate to the magnitude of the problem or in keeping with their other programmes. One agency got involved in this work for money. A group of middle class disabled people broke up with money as a contributing factor.

10. Two agencies who promoted rehabilitation work for disabled people on a small scale, had intended to do it differently, resulting in a development programme with them. While they do organizational work of disabled people, the slant is still rehabilitational.

11. Four agencies do only organizational work of non-disabled people. Out of these, two continue to do this and attempt to integrate rehabilitation in to the structure where as the third has swung to rehabilitation. The fourth agency is a new one.

12. One other agency does organizational work of non-disabled people and promotes income generating initiatives. The experience with this agency shows that it may have the balance between organizational and rehabilitation appropriately. This is still to be validated.

13. Reporting and documentation of this work is being done at a desirable level in only two agencies. These two agencies also have effective co-ordination of the work. Others have a set back and are pre - occupied with management problems. In the past, ADD India was partly filling the management void in these agencies by their monthly visits. Having recognized this problem, ADD India now works only with the agencies who have a person playing the co-ordinating function, either as part of his other work or full time.

14. **Disabled people, Family, Community and Government:**

Disabled people do not feel that they have the same human needs as non-disabled people except for the basic needs of food, clothes and shelter. Their deprivation of love and affection, emotional security, belongingness, self-respect have all left them with low - self worth, apathy, depression and dependence. The origins of current social attitudes towards disabled people can be found in religion and in Manusmruti.

15. Dhritashtra, Sakuni and Manthara (more commonly known as "Guni") represent characters of helplessness and villainy. The countless proverbs about disabled people being naughty, wicked, and signs of bad omen all reflect social attitude towards disabled people through history. The belief that through disability one pays for his past sins compounds the problem. Manusmruti prescribes that disabled people should be isolated from rituals, festivals, marriage and property. The Media also projects them, either as heroes or as villains and not as ordinary human beings. They are also made into an object of fun and ridicule.

16. Christianity promulgates values of disabled people of being helpless and the need for society to protect and be charitably exposed towards them. The Roman and Greek cultures perceive disabled people as a result of divine possession and disabled people are classed as 'village idiots', and 'cripples'.

17. During the Industrial Revolution people with impairments became a class of industrial rejects. But the industrial society found a solution to the 'problem' of what to do with people who did nit fit its agenda: the Institution. Here the disabled could be looked after - and forgotten about.

18. Pre-natal genetic screening is geared towards eliminating disability by ensuring that disabled babies are not born.

19. The family, the community and Government reflect these ingrained attitudes towards disabled people. Disabled people in turn have become victims of this attitude, resulting in their apathy and aggression. Both family and community discourage disabled people initially from getting together to start exploring self-help initiatives. Recognizing this, ADD India is beginning to work first with community leaders and family about changing their own attitudes towards disabled people.

20. Service agencies:

Their services manifest the age-old charitable attitude towards disabled people. By and large, their doors are open to disabled people covered by the programme. Since, disability work does not have its rightful place in the priority ladder of these agencies, they are not supporting people, to take full advantage of these opportunities. Even this, is beginning to change for the better.

21. Despite these constraints, the major achievements of the first phase of the programme has been that it has enabled 1,992 disabled people to realize that they need the same opportunities in life as non-disabled people in order to become active and effective in their communities. They have also realised that the change will not take place unless they themselves work for it. Through the formation of self- help groups a forum has been created for disabled people to get together and debate their needs and, as a result, disability is definitely gaining visibility and importance as an issue in the areas covered by the programme.

22. In addition, this work has enabled disabled people - men, women and children to access opportunities in the environment both from government and non-Governmental sectors. Opportunities include education, self-employment, transportation, housing and land. Availing benefits from these schemes has encouraged disabled people to strengthen their conviction" TOGETHER WE CAN"

23. The members of self-help groups contribute between 50 paise to Rs.5/- a month as membership fee and have opened bank or post office accounts. This money is collected and is used by them to meet the expenses of their own group for administrative, postage and travel connected for availing benefits from Government schemes.

24. The other indicators of the impact of this work are:

* Observance of the World Day of Disabled People and contributing effort and money for such observance;

* Non-disabled cadres and disabled people enacting street plays on social problems of disabled people;

* Developing leadership among themselves and increasing their capacity for analysis and questioning;

* Participating in street plays in the mela of

agricultural labourers;

* Disabled people doing skilled jobs, offering to train other disabled people;

* Disabled women assisting other disabled women with marital issues;

* Joining the efforts of agricultural labourers on obtaining land pattas;

* A disabled person contesting the district secretaryship of the agricultural labourers union;

* Parents of disabled children motivating their counterparts to educate their children;

* Having collective meetings to debate common issues;

* Exploring possibility of setting up a union for themselves;

* 'Creative workshop' for disabled children ;.

* Puppet show by cadres to raise awareness of community of the social problems of disabled people;

* Self-help groups establishing a small credit revolving fund; and

* Self-help group finding shelter for one of its members.

25. Disabled people when they first meet, have a lot of expectations of receiving material benefits. Over a period of time (6-9 months), other values such as human dignity, self reliance, self-help begin to emerge and dominate.

BV:SG: 30 NOV 1992.

ACTION ON DISABILITY AND DEVELOPMENT - INDIA
(ADD INDIA)

FOURTH ANNUAL REPORT FOR THE PERIOD ENDED 31 MARCH 1993

This was a year of consolidation, development of a new service and new partnerships.

CURRENT FARTNERSHIPS:

Young India Project: (YIP)

ADD India works with three Action Groups of YIP - Bathalapalli Action Group (BAG), Kalahasti Action Group (KAG) and Sathyavedu Action Group (SAG)

Bathalapalli Action Group: (BAG)

This group has extended their work to cover villages in Thadamari and Narpala mandals. They have recruited one woman cadre to cope with the new work.

BAG also organised an assessment camp for orthopaedically disabled people. 1,200 people attended the camp from the whole district of Ananthapur.

BAG is managing this work on its own.

Kalahasti Action Group: (KAG)

Training:

One week Workshop on Disability and Development for eight cadres of YIP working with disabled people and one cadre from Integrated Rural Development Society (a partner of YIP) has been held. This was followed by a refresher course for three days.

Creative Workshop for children and Song Workshop for disabled people and cadres were conducted.

Field Work:

KAG has come to the position of managing the field work on its own with out ADD India's support. Monthly review and planning meeting have become a part and parcel of their programme with disabled people.

Sangha leaders conduct one meeting every month, and the other is conducted with the support of the field workers. They support the Sanghas in networking with Government, Bank and other service agencies.

Referrals:

Contacts have been established with four schools for hearing impaired children and also with other hospitals and rehabilitation agencies. Forty eight children will be admitted into special and common schools.

Income Generation:

Seven people got financial assistance from Government. The Venkateshwara Gramina Bank has come forward to provide financial assistance to disabled people in the form of loans.

Two people with fifteen years experience in promoting entrepreneurship in villages visited KAG. They are likely to use their services.

Collective of Disabled People:

Two collectives of disabled people were held and in each collective, about 300 disabled people participated. Probably, for the first time in India the collectives of rural disabled people have been orgsnised.

ADD India's Current Support:

ADD India's current support to KAG is to train Sangha leaders and to firm up on the net work for medical Rehabilitation and Primary Education which is already established.

Assessment Programmes:

An assessment camp for hearing impaired people was conducted with the support of National Institute of Hearing Handicapped and two ENT doctors from Victoria hospital, Bangalore, in KAG area. Few people from IRDS also attended this camp. 122 people were assessed. The follow-up is taken up by KAG.

Another assessment programme for orthopaedically disabled children was initiated in KAG area. The purpose of this exercise was to orient parents and also teach them about the importance of physiotherapy and the appropriate exercises with the support of The Association of Physically Handicapped team from Bangalore. In the process, the cadres were also trained in the simple techniques of physiotherapy.

78 persons were assessed and they were recommended physiotherapy exercises, surgery or orthopaedic aids according to their degree of disability and needs.

Follow up visits will be held during May and July 1993.

KAG is net working with the local hospitals for surgery and aids and appliances.

Expansion:

At Present KAG works with disabled people only in 88 villages of 4 mandals - Buchinadi Kandriga. K.V.B.Puram, Thottempedu, and Sri Kalahasti. During 93-94, KAG intends to cover all the villages in these mandalams resulting in new Sanghas of disabled people. They are also beginning to work with disabled people in the neighbouring district of Nellore. To cope with this work, they have recruited two more cadres, one of them, disabled.

Sathyavedu Action Group: (SAG)

SAG has expanded its work with disabled people to Pichattur mandal in Chittoor District and Tada mandal in Nellore District. They have recruited one more cadre to cope with the expansion.

SAG is also managing this work on its own.

Orthopaedic Workshop :

An orthopaedic workshop has been set up in Penukonda by YIP. This will produce appropriate technology orthopaedic aids and appliances, which are affordable by poor people. Two technicians who have completed their training in Handicap International, Pondicherry are currently doing this work. YIP has also sent two women for training as orthopaedic technicians to APH. They would be trained in making other types of orthopaedic appliances.

TRAINING FOR YOUNG INDIA PROJECT NEW CADRES:

ADD India facilitated a meeting with YIP and Divine Light Trust for the Blind (DLTB) to support YIP to organise its rehabilitation service. The outcome was :

YIP will begin work with disabled people in 42 mandalams in Andhra Pradesh with 42 new full time cadres;

They will be trained in rehabilitation by DLTB and in organisational work by ADD India;

YIP will appoint a full time Coordinator at the central level to coordinate its entire work with disabled people in all the mandalams;

The President of YIP, himself has decided to co-ordinate the programme till a suitable person is appointed, which is a positive sign and reflects the level of commitment.

The module envisaged is that the cadres would be trained in two groups of 21 each. One group will be trained during 1993 and the other during 1994. This training will be followed up by quarterly review and planning meetings for four quarters. Disabled people will participate in these meetings. ADD India's support there after will be train sangha leaders. Once this method of working is tested, this will be replicated in other states as well.

The syllabus is in the process of being developed.

Rural Development Trust: (RDT)

RDT has a full pledged team of rehabilitation workers consisting of Special teachers for people with Hearing Impairment, Mental Retardation and Orthopaedic Technicians. These technicians have set up a fully equipped workshop to produce appropriate technology orthopaedic appliances which are affordable by poor people. Services are also being developed for people with Hearing Impairment and Mental Retardation. They have expanded their work to 48 more villages.

League for Education And Development (LEAD):

ADD India took a new approach in training LEAD staff to work with disabled people. Instead of commencing the work and the training simultaneously, LEAD staff assigned to work with disabled people underwent training for eight days over a period of four months before beginning to organise disabled people.

Field Work:

14 Sanghas are established with a total membership of 151 people from 30 villages.

The field work is being managed by LEAD field staff. However, ADD India's support to the field will continue to those staff who need strengthening. ADD India will also conduct Sangha Leaders Training and develop Net Work.

Training:

Apart from development training, LEAD staff attended a workshop on causes and prevention of disability.

A ten day workshop on puppetry was also organised during this period.

Sangha leaders training will commence during 93-94.

Income generation:

A Market Research agency made an exploratory visit to determine whether a market research would be beneficial to promote viable income generating projects. Its recommendations are being considered by LEAD.

Referral Net work:

Network has been established with various hospitals and rehabilitation agencies, that are situated in and around Trichy.

PREPARE

The field work is being managed by PREPARE field staff. ADD India's current support is to train new field staff in Disability and Development and in group work techniques as some of the old staff who were trained by ADD India left. The support also includes developing net work for medical Rehabilitation. PREPARE is still in the process of appointing a person in charge for this programme.

Training:

Sixty dhais (traditional birth attendants) were trained in disability as a development issue and on their role in motivating disabled people in villages.

A workshop was organised for parents of children with hearing impairment. This motivated a few parents to send their hearing impaired children to special schools.

Prepare also got two people trained as orthopaedic technicians - one of them attended a full time course and the other, a part time course. Handicap International, Pondicherry has been assessing polio affected children and providing the follow up, including aids and appliances.

A ten day puppetry workshop was also conducted for PREPARE staff and volunteers.

The sangha leaders training will commence during 93-94.

NEW PARTNERSHIPS

13 agencies have been in contact with ADD India during this year. Among these, the following organisations have resulted in partnerships:

Integrated Rural Development Society (IRDS) - Andhra Pradesh.

Ibrahimpatanam Taluka Agricultural Labourers Union (ITALU), Andhra Pradesh.

Chaitanya Institute for Youth and Rural Development (CHINYARD) - Karnataka

INTEGRATED RURAL DEVELOPMENT SOCIETY: (IRDS)

Integrated Rural Development Society (IRDS), Narayanavaram in Chittoor District is registered society established in 1989. They do organisational work among landless labourers and do CAPART and the Department of Social Welfare programmes. They are an Action Group of Young India Project called Narayanavaram Action Group (NAG). The group consists of 13 cadres and one full time cadre to work with disabled people. Four Sanghas have been developed during this period with the membership of about 80 people.

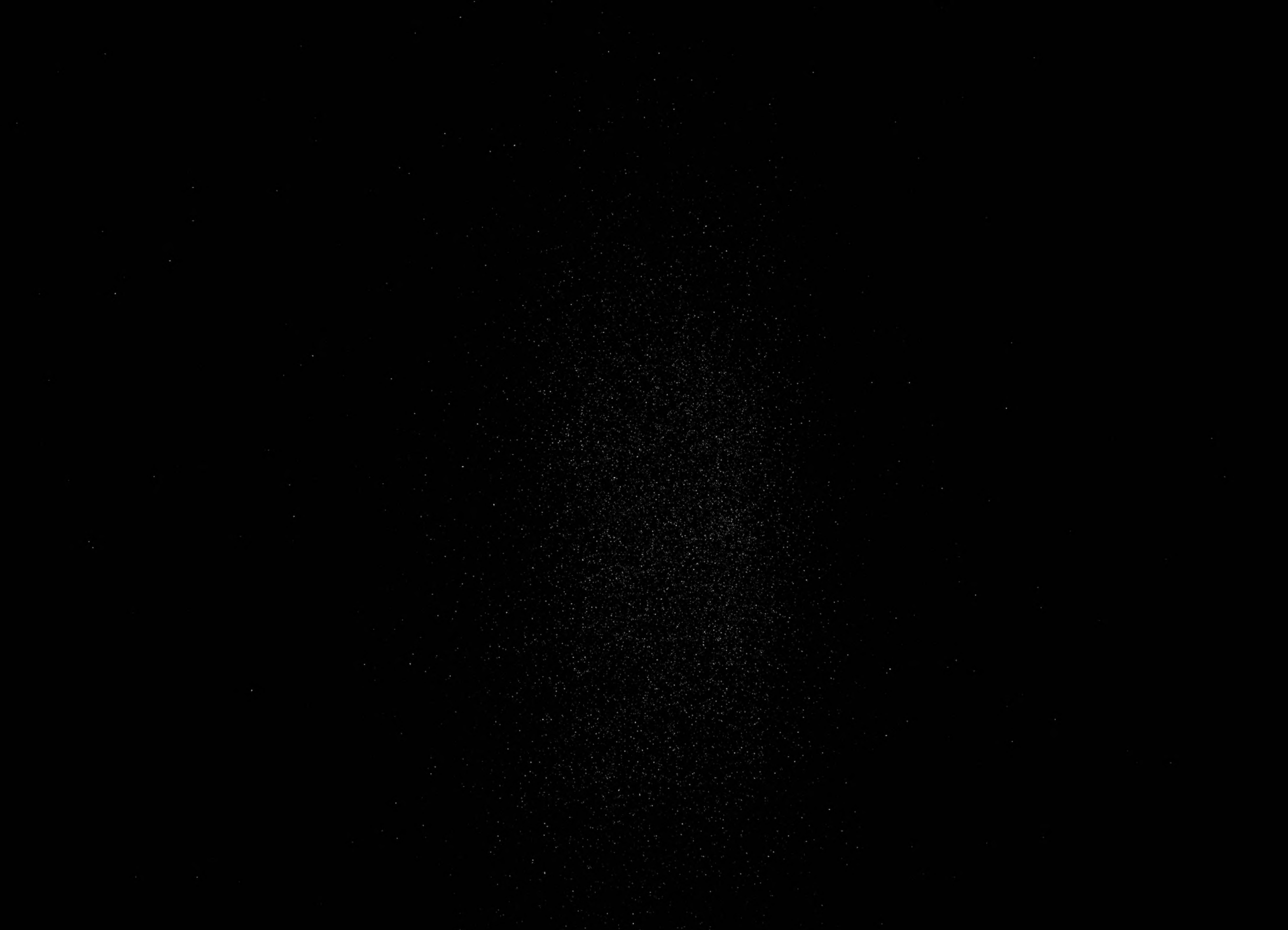
IBRAHIMPATANAM TALUKA AGRICULTURAL LABOURERS UNION:

The Agricultural Labourers Union was registered in 1986 and has 3000 members. This union has been facilitated by an outstanding lawyer.

The cadres were trained in "disability as a development issue" and one day awareness training was conducted for more than 50 volunteers of ITALU.

The cadres were also trained in "Causes, prevention and simple intervention of all disabilities" for three days.

The work has commenced in establishing 12 Sanghas of Disabled People.



CHAITANYA INSTITUTE OF YOUTH AND RURAL DEVELOPMENT: (CHINYARD)

CHINYARD was established in 1990. Their focus of work is on Health and on organising Women around thrift saving.

ADD India has had preliminary discussions with CHINYARD and the training of field workers and volunteers has already commenced.

NEW SERVICE:

Communication, Disability and Development is a new service of ADD India. Media has been used in development work for the last two decades in India. The objective of this service is to enable field workers and disabled people through training to use both the electronic and folk media in development work with disabled people. This service has a full time co-ordinator and this service taps the talents of a pool of resource people from outside the organisation.

Photo Language Presentation:

A photo language presentation on the life of a disabled person has been made and field tested. The script to use the first photo language presentation of a disabled person is completed. A second photo language presentation is also being completed during this period. These presentations are being used in training sessions to demonstrate people's perceptions of disability.

Creative Workshop:

A Two-day Creative Workshop for 25 disabled children was held during August, 1992. The Workshop basically dealt with production of creative toys.

Puppetry Workshop:

Two workshops on puppetry for disabled people and the field staff was conducted. The themes of puppet shows were social issues of disabled people - Education, Property and Marriage. The response to the Puppet Show has been encouraging from disabled people and the community.

Visuals:

Discussion triggers and flip charts have been developed, to be used as tools for animating groups of disabled people and for training.

Work on producing posters to campaign for the Rights of Disabled Children is in progress. Timetable for children above 5th standard with the message to children about disability is also being developed.

The other results of this service include developing sketches for training in Rehabilitation and for Development.

Materials for training animaters have also been developed during this period.

Song Workshop:

A three day workshop to compose songs focussing on social problems and disabled people was also conducted during this period.

ADD India Promotional Film:

The promotional film on Add India's work is completed.

Film on Disabled people doing Skilled Work:

The recy for the film on disabled people doing skilled work is completed.

Work with other organisations:

ADD India served as faculty on :

1 A course for Orthopaedic Technicians organised by Handicap International, Pondicherry;

2 A course for activists organised by Indian Social Institute, Bangalore and

3 One-day orientation on disability and development organised for 40 participants from 14 NGOs in Valliyur by RUCODE, India.

These are steps in ADD India's attempt to get disability as a development issue on to the curriculum of existing training programmes.

ADD India participated in the evaluation of VIKLANG KENDRA - ALLAHABAD, a partner of OXFAM, Lucknow. This has paved the way for ADD India to play such a role in the disability sector.

RECOGNITION BY THE STATE GOVERNMENT:

This has been obtained as a special case reflecting the relationship of ADD India with the Government of Karnataka.

We take this opportunity to put on record our gratitude to our funders, partners, Government, other agencies and the general public for their support to our work.

Bangalore
24 April 1993

Hony. Secretary,
ADD India.

Ref:C:Rep92-93.SG.

WORLD AIDS DAY SATELLITE MEETING

5TH NOVEMBER 1992

VENUE : INSA/INDIA OFFICE

INTRODUCTION

Since many NGO's and Government representatives could not attend the earlier World AIDS Day Workshop held on 17th October 1992, they requested for a satellite meeting to get involved with World AIDS Day activities.

THE PARTICIPANTS AND THEIR PROPOSED PLANS FOR WORLD AIDS DAY

A total of 10 participants attended this meeting. The Government representatives expressed financial constraints but offered to join in the AIDS Walk being organised by INSA/India. The Government can also contact Doordarshan and AIR for flash AIDS prevention messages and distribute pamphlets and posters as required.

It was suggested that every pamphlet and poster carry information on where the public could tap more AIDS related information and counselling services. The representative from the Lion's Club offered to collect contributions to supplement funds for the AIDS Walk.

The participants who attended the meeting are :

NAME	ADDRESS	TEL. NO
01. Dr. Gundappa	Joint Director - AIDS Directorate Of Health & Family Welfare Anand Rao Circle Bangalore - 560 009	71950 (O)
02. Dr.K.Chandrashekar	Deputy Director - AIDS Director of Health & Family Welfare Anand Rao Circle Bangalore - 560 009	75832
03. Mr.V. Benjamin	C/o. Community Health Cell. Koramangala Bangalore	531598

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	NAME	ADDRESS	TEL. NO.
04.	Mr.Joseph George	Manav Vikas Kendra U T C 63, Millers Road Bangalore - 560 046	330015(MVK) 333438(UTC)
05.	Mr. Solomon J.P.	MAYA 209, Commerce House 9/1, Cunningham Road Bangalore - 560 052	265400
06.	Dr. Shashidhar	Lions' Club 28, II Cross, II Main Vasantha Nagar Bangalore	264195(R) 266807(O)
07.	Mr. A.S. Murthy	Kalanidir, 5th Cross Hanumanth Nagar Bangalore - 560 019	624253
08.	Mr. Lokeshyap	Brindavan, 5th A Main Vijaynagar Bangalore - 560 040	300967
09.	Ms.T.L.Jacintha	Cleveland Town Bangalore - 560 005	
10.	Ms. Nalini	Asst. Prog. Officer Shramik Vidya Peth Directorate of Mass Education F Street, Kalasipalayam Bangalore - 560 002	609821(O) 530132 (R)

CONCLUSION

As D-Day draws nearer, we hope that, atleast 90% of the Bangalore population will be reached with basic AIDS prevention messages through these multi pronged approaches.

INSA/INDIA
No. 2, Benson Road,
Benson Town,
BANGALORE-560 046.

REPORT OF TWO WORKSHOPS ON "STRATEGIES FOR IMPROVING AIDS PREVENTION EDUCATION IN SCHOOLS & JUNIOR COLLEGES, BANGALORE"

FOR HEADS OF SCHOOLS/COLLEGES HELD ON THE 24th of July '92 and 11th of August '92.

INTRODUCTION :

In May 1991, when INSA/India hosted a similar Workshop for Heads of Schools, we received an apathetic response with only 12 people attending. This year, the response has been overwhelming. Twentytwo (22) of the twentyfive invited attended the first Workshop and thirtyeight of the forty invited attended the second one.

THE PARTICIPANTS :

Most of the Participants were Principals/Heads of their Institutions. Those who could not attend sent their senior biology teachers for the Workshop. The first Workshop concentrated on private educational institutions and the second on Bangalore City Corporation High Schools. The participants who attended the first Workshop were:

1. Ms.E.R.Shantha,
   Asst.Mistress,
   Smt.Gangamma Hombe Gowda-
   Girls High School.
2. Ms.Sharadamba
   Asst.Mistress,
   Sharada Stree Samaja Girls
   High School.
3. Mr.K.V.Andrews,
   Principal,
   St.Mary's Public School.
4. Ms.N.Kamalamma,
   Head Mistress,
   Papu Girls High School.
5. Sr.Rose Mary,
   Head Mistress,
   Mariam Nilaya High School.
6. Mrs.Aysha Bibi,
   Senior Asst.& Biology Teacher
   515,Army Base Worksho High Schl.
7. Sr.Josephine Hoover,
   Principal,
   St.Joseph's Convent.
8. Mr.Teppo,
   Asst.Master,
   St.Germain High School.
9. Mrs.Manasa M.S.
   Senior Biology Teacher,
   St.Paul's English School.
10. Ms.R.Shantha Kumari,
    Asst.Mistress,
    Rani Carala Devi High School.
11. Mrs.Mary Mathew,
    Senior Teacher,
    Bangalore International School.
12. Mr.Mohd.Hussain,
    Head Master,
    Quwathul Islam High School.
13. Sr.Shalini D'Souza,
    Head Mistress,
    Nirmala Girls High School.
14. Mrs.Shylaja,
    Biology Teacher,
    Tagore Memorial High School.
15. Sr.Mary Noel,
    St.Theresa's Girls High School
16. Mrs.M.B.Geetha,
    Asst.Mistress,
    M.L.A.High School.
17. Ms.Seethalakshmi,
    Assistant Mistress,
    Basavanagudi Girls Govt.
    Junior College.
18. Mrs.Gajalakshmi Murugesh,
    Hombe Gowda Boys High School,
19. Mr.K.S.Nagaraju,
    Head Master,
    Kamatha Girls High School.

20. Mrs.Jyoti P.Lal
21. Mrs.M.Geetha,
St.Mira's High School.

22. Prof.Sheila Isaac,
Principal,
SSMV College.

The participants who attended the second Workshop from Corporation High Schools were :

1. Mr.Krishne Gowda,
Head Master,
Corpn.Boys High School,
Jogupalya.

2. Ms.P.P.Vimala
Head Mistress,
Corpn.Girls High School
Dispensary Road.

3. Ms.Malika Begum,
Head Mistress,
Corpn.High School for Boys,
Cox Town.

4. Ms.Asmath Khatoon,
Head Mistress,
Corpn.Girls High School,
Gandhinagar.

5. Ms.Jayalakshmi,
Head Mistress,
Corpn.Girls High School,
Banappa Park,

6. Ms.Jayanthi C.R.
Head Mistress,
Corpn.Primary School,
Lakkasandra.

7. Mr.V.Rajashekara,
Head Master,
Corpn.Boys High School
Austin Town.

8. Mr.M.Nempanna,
Incharge Principal,
Corpn.Junior College & High
School for Girls,
Austin Town,

9. Ms.N.Sampangamma,
Head Mistress,
Corpn.Girls High School,
Kodandarampuram.

10. Mr.Kodandaramaiahsetty,
Principal,
Corpn.Junior College for Girls,
Jogupalaya.

11. Mr.K.K.Ravindranatha,
Principal,
Pre University College,
Tasker Town.

12. Mr.Raghuveera E
Head Master,
Corpn.High School,
Pillanna Garden.

13. Ms.Usha E.Naik
Teacher
Corpn.Primary School,
Govindaraj Nagar.

14. Ms.M.Mudalagiraiah,
Head Master,
Corpn.Higher Elementry School,
Wheelasandra.

15. Ms.A.Victoria,
16. Ms.S.Gowramma,
Corpn.Higher Elementry School,
Austin Town.

17. Ms.K.C.Sharadamma,
Head Mistress,
Corpn.Girls High School
Ashok Nagar.

18. Mr.Abdul Hafiz,
Head Master,
Corpn.High School,
Shanthi Nagar.

19. Mr.Syed Usman,
Asst.Master,
Corpn.Girls High School,
Murphy Town.

20. Mr.T.K.Gajarajan,
Physical Education Officer,
Bangalore City Corporation.

21. Mr.K.Veerakempaiah,
Head Master,
Corpn.Girls High School,
Gayathri Nagar.

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22. Mr.Dakshina Murthi Pillai,
Corpn.Junior College for Girls,
Cleveland Town,

23. Mr.D.L.Chandrashekar,
Corpn.Pre.Un.College,
Chamarajapet.

24. Mr.K.Varadan,
Head Master,
Corporation Girls High School,
Jayamahal.

25. Mr.N.S.Rajan,
Asst.Master,
Corpn.Junior College for Girls,
Sriramapura.

26. Mr.P.V.Veerabhadraiah,
Asst.Master,
Corpn.High School,
Vijayanagar.

27. Mr.D.V.Shivegowda,
Corpn.High School,
Marappanpalya.

28. Ms.F.S.Kamala,
Head Mistress,
Corpn.Girls High School,
Dayananda Nagar.

29. Mr.T.L.Siddaiah,
Head Master,
Corpn.High School,
Byrasandra.

30. Ms.G.S.Premalatha,
Head Mistress,
Corpn.Boys High School,
Srirampura.

31. Mrs.Zobeda Bagum,
Head Mistress,
Tasker Town.

32. Mr.Michale Pragasam,
Principal,
Corpn.Junior College,
Magadi Road.

33. Mr.Y.M.Nadegowda,
Head Master,
Corpn.Girls High School,
K.G.Nagar.

34. Mr.Maghdoom Shareef ,
Corpn.Primary School,
Broadway.

35. Mr.Munirangaiah,
Corpn.Girls High School,
Mathikere Layout.

36. Mr.Rathnakara Hebbar,
Corpn.Junior College,
Kasturba Nagar.

37. Mr.N.S.Keerthinarayan Rao
Head Master,
Corpn.Girls High Schdol
Cottonpet.

38. Mr.Surendra Neal,
Corpn.High School,
Ganginagar.

The high degree of the participation in the latter Workshop was possible because of the special interest taken by the Corporation Education Officer, Ms.Shanthimathi, who also attended part of the Workshop.

THE WORKSHOPS' AIM AND OBJECTIVES :

The aim and objectives for the Workshopswere drawn out by INSA/India as follows:

AIMS:

To promote immediate plans for incorporating AIDS Educational activities as part of ongoing school programmes with the active participation of Heads of Schools.

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OBJECTIVES :

By the end of the Workshop, the participants will:

(a) discuss appropriate approaches to AIDS Awareness building programmes in their respective schools.

(b) outline approaches to formulate future policies for dealing with HIV infected persons, be they students or staff in their schools.

(c) support the training of the High School teachers for ongoing AIDS Education Programmes in their schools.

(d) express willingness to lend support and actively participate in public AIDS awareness campaigns: eg. on World AIDS Day.

THE WORKSHOP PROCEEDINGS:

Both the Workshops were designed to elicit optimum participation from the participants. Having begun with a short introduction and pre evaluation, Dr.V.Ravi from the Neuro Virology Department of NIMHANS discussed the Cause, Spread and Prevention of AIDS and the need for urgent interventions in India.

This was followed by a short video film on what interventions other countries have started. The group then discussed appropriate strategies for AIDS prevention education in schools/colleges. A list of this is appended as Appendix I.

The noon session began with a discussion on the psychosocial aspects related to HIV infected persons - with special reference to children and staff who have HIV infection. The groups worked out approaches to dealing with such situations.

Finally, members of the groups gave us dates for INSA/India to conduct the AIDS Education Session in their schools. One principal of a Corporation High School (which we had covered with AIDS education in January 1991) felt confident to conduct the AIDS Prevention education (with INSA's help) and has planned to do so in the near future. We hope for more such positive initiatives by others in the future.

The Workshop ended with each participant filling up the post test questionnaire and renewing premises to build up AIDS Prevention education programmes in their areas.

THE VENUE :

Both workshops were held in Hotel Harsha, whose staff who took over the catering to enable the participants and INSA/India to concentrate entirely on the Workshop.

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It was also interesting to note the number of the hotel boys who were interested in the programme and followed it closely!

CONCLUSION :

INSA/India wishes to express its thanks to the Heads and participants who attended both workshops. We also wish to record our deepest appreciation to Dr.V.Ravi who continues to be a constant supporter of the AIDS Prevention Education in schools and to lead the discussions at the Workshops and Dr.V.Benjamin was present for the 2nd Workshop and helped us. We have no words to express our deepest gratitude to Ms.Shanthimathi, Corporation Education Officer, whose doors were always open for INSA/India and whose tireless efforts resulted in a 100% turnout at the latter Workshop. INSA/India does not forget its donor the Ford Foundation, who made this possible.

These two Workshops were a fitting finil to 1st Project year of AIDS Prevention Education in schools/colleges of Bangalore and a curtain raiser to our subsequent three years.

With best wishes from INSA/India team,

Sujatha de Magry, Edwina Pereira, Bhanu Paul, Bhagavandas, Geetha, Charlet and Tina King.

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APPENDIX 'I'

Group Discussion on:

"Appropriate strategies for AIDS Prevention Education in High Schools and junior Colleges".

1st Workshop :

GROUP I's sharing :

1. Creating awareness to parents, students and teachers by talking them about AIDS.
2. Intervene at government levels to incorporate AIDS into syllabus.
3. Have AIDS Education programmes for schools in the neighbourhood coordinated by one of the participant schools.
4. Invite INSA to discuss AIDS Prevention Education at the Board Meeting of Principals.
5. Encourage Head Master/Mistress Association to pass a resolution to include AIDS Education in their schools.
6. Put up posters in schools/public places.
7. Encourage individual teachers to educate parents of the children in their class.

GROUP II's sharing :

1. Select a school as a lead school to that other teachers from different other schools closeby can come for AIDS Prevention Education.
2. Train all teachers of one school on AIDS
3. Take the Reproduction subject for Xth standard students first and then AIDS can be done easily.
4. Put up literature on AIDS in school notice boards.
5. Have ongoing programmes to update teachers.
6. Have workshop for different teachers not just biology teachers. They have to be frank and open and free with children. Continuity of such workshops should be there.
7. Organise inter-school quiz competition on AIDS
8. Keep June-August free because it is the best time to contact schools for AIDS Prevention sessions.
9. Contact the Directorate of Text Books and Commissioner of Public Instruction and discuss the dire need for AIDS Prevention Education.

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2nd Workshop (Corporation Schools)

GROUP I's Sharing :

1. Talk to the staff about AIDS
2. Invite INSA to Project their films on AIDS
3. Obtain literature from INSA on AIDS and distribute.
4. Motivate teachers to talk to students about AIDS Prevention.
5. Request the Health Department of the Bangalore City Corporation to deliver talks (MOH's)related to AIDS.
6. Invite eminent doctors from National Institutes for talks and symposia on AIDS/Drugs etc.
7. Promote children to write on AIDS and other aspects of health and hygiene.
8. The Bangalore Maha Nagara Palika may publish literature on health with attention to AIDS-Prevention to be distributed freely to the students.
9. Arrange quiz programme on health in general and AIDS in particular with some prizes.
10. Put up posters on AIDS Prevention on notice boards.
11. Call parents meeting, impress upon them the topic of AIDS along with other aspects of health and hygiene.
12. Financial aid may be given by Bangalore City Corporation or INSA for holding meetings of staff and parents on AIDS and other aspects, atleast nominally.
13. Involve voluntary associations like the Rotary in the AIDS Prevention projects.

GROUP II's sharing :

1. Arrange staff meeting in the school to discuss about AIDS
2. Children should be shown through films that AIDS is spreading through a virus.
3. Moral education periods should be utilised for AIDS discussion.
4. Eminent doctors should be invited to the school and lectures should be arranged on AIDS.
5. Posters and literatures concerning to AIDS should be displayed in the schools to enlighten the children.
6. World AIDS Day should be conducted in the schools on 1st December every year in a benefiting manner.

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7. Films concerning AIDS should be screened in the schools.

8. During health education periods AIDS should be introduced in school syllabus.

9. "Responsible individual behaviour" slogan in solution for the problem should be highlighted.

Group III's sharing :

1. Head Master/Mistress can conduct staff meeting to educate the teachers regarding AIDS and request the biology teacher to pass on information regarding sex education to their students whenever the situation arises in the class room.

2. Head Master/Mistress should arrange for a meeting inviting INSA or local doctor who knows about AIDS.

3. Celebrate World AIDS day on Dec.1st every year in the schools/ colleges.

4. Display in the school notice board, pictures and pamphlets on AIDS.

5. Visiting a hospital along with selected students to observe AIDS Patients.

6. While conducting teachers and parents meeting Head Master/Mistress may explain rapid spreading of AIDS.in India and its prevention

7. Institutions having T.V.may arrange films on AIDS.

8. Head Master/Head Mistress may take the help of INSA in order to educate children.

9. Responsible individual behaviour should be created among the students through moral education.

10. Request the department to introduce AIDS chapter in the syllabus of biological science.

11. Spoken language should be used to propagate message about AIDS prevention.

GROUP IV's sharing :

1. Bring in awareness among the staff members regarding AIDS

2. This year's teachers Seminar should be on Prevention of AIDS and related matters. Debate Essay, Competions and models to be prepared by the schools.

3. Arrange for lectures by the teachers in their class rooms and make the students aware of the seriousness of the problem.

4. Preferably have the smaller groups to be addressed by the teachers.

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5. Try to involve all the teachers in educating the students. Encourage students to make posters, pictures and drawings on AIDS Prevention.

6. Arrange for lectures and film shows from outside agencies. Involve INSA with the school programme, request them to supply posters in local languages preferably.

7. INSA is requested to involve the mass media like TV, Radio, Cinema and other agencies to publicese AIDS prevention . Introduce short films in between TV film, Cinema, Chitrahaar programmes during prime time like the one shown today (Karate-Kids)

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INTERNATIONAL NURSING SERVICES ASSOCIATION/INDIA

No.2, Benson Road,
Benson Town,
BANGALORE - 560 046

WORLD AIDS DAY REPORT
1st December, 1991

INTRODUCTION

Being one of the few Organizations in Bangalore actively involved in AIDS Prevention Education, INSA/India was requested by other agencies to coordinate efforts in Bangalore for creating public awareness on World AIDS Day, 1991.

In preparation for this, INSA/India organised a Workshop for related Government officials, voluntary agencies and the media to plan activities for World AIDS Day. This Workshop was well attended by the Government officials - Dr.Gundappa, Joint Director, Dr.Samiullah and Mr.Baladev and by voluntary agencies like Madhyam, Media Centre, CHAST, Joint Women's Programme, The Family Planning Association of India etc. Though the constraints of time and funds remained, the planning between Government, voluntary agencies and the press helped make World AIDS Day in Bangalore the first coordinated effort towards AIDS Prevention in Bangalore, in particular and Karnataka in general.

TOWARDS WORLD AIDS DAY ACTIVITIES

With 1st December being World AIDS Day, INSA/India with active collaboration with the Government, other voluntary agencies and the press undertook the following activities:

1. *Factories, Youth Clubs, the Government and INSA/India:*

   INSA/India received posters and pamphlets on AIDS prevention from the Karnataka State AIDS Cell and distributed the same in 13 large scale industries in Bangalore with discussions with the respective Human/Personel Relations Officers to put them up in strategic points in factories to increase workers' awareness of AIDS prevention. Ten youth groups also were given the same with extensive discussions with their leaders. The target population covered thus was estimated to be 10,000 - if not more.

2. *Divya Shanti - the Government and INSA/India :*

   Divya Shanti, a voluntary agency Organised a World AIDS Week from 30th November to 6th December. Dr.Gundappa, Joint Director and others from the State AIDS Cell were present at the inaugural and AIDS related material were given for the occasion. The week consisted of various AIDS education related programmes and INSA/India was asked to speak about AIDS Prevention to three groups organised by Divya Shanti :

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(a) the slum women from closeby slums

(b) their high school boys and girls

(c) their staff, teachers and social workers.

3. Madhyam - Government and INSA/India :

Madhyam, a voluntary agency who has links with the press conference on the eve of World AIDS Day, so that all newspapers (all languages) carried an AIDS related article on World AIDS Day. About 70 newspaper/periodical agencies were contacted and about 1/2 that number turned up for the press conference held at the Press Club of India. The speakers were Dr.Gundappa, from the State AIDS Cell, Dr.Savi from NIMHANS - Neuro Virology Department and INSA/India.

4. C.M.A.I's one day retreat "Sharing the Challenge" :

The Christian Medical Association of India in Bangalore held a retreat in St.Mark's Cathedral for their member organisations to increase AIDS Prevention awareness and INSA/India was one of their speakers on that occasion. Others were representatives from St.John's Medical College, Bangalore, and NIMHANS.

5. Karnataka Child Development Council, Madhyam, I.Y.C. and INSA/India :

A hundred trainees of creches (balsevika teachers) of the Karnataka State Child development council were exposed to AIDS Prevention education through a discussion and video film organised by INSA/India and followed by a puppet show organised by the Indian Health Organisation(IHO) Bangalore branch and Madhyam. These balsevika teachers have access to women in the communities where an anganwadi (creche) is situated. Government made posters were used also. Madhyam and IHO also performed puppet shows in various slums around Bangalore to spread AIDS prevention messages.

6. Other activities :

The Karnataka State AIDS Cell proposed to send a circular to each of their primary and district health centres to undertake AIDS education activities and distributed the WHO World AIDS Day pamphlet to each of them. INSA/India conducted an AIDS Education programme in Jyoti Nivas College as part of its ongoing programmes.

CONCLUSION

The motto "Sharing the Challenge" became a reality in Bangalore City with voluntary and Governmental agencies collaborating to spread AIDS and HIV prevention awareness on World AIDS Day, 1991. INSA/India thanks all who participated and hopes the collaboration effort will be strengthened as time goes on.

THE INSA/India team.

REPORT ON THE WORKSHOP ON

"TOWARDS WORLD AIDS DAY 1992"

Date : 17th October 1992

Venue : Hotel Ramsha,
Shivajinagar,
Bangalore

Organised By : Madhyam Communications &
INSA/India.

INTRODUCTION :

With 1st December being World AIDS Day (WAD) and the theme for 1992 being "A Community Commitment", INSA/India approached Madhyam Communications to help organise a Workshop for interested NGO's and Government Organisations in Bangalore to prepare plans and co-ordinate efforts to make World AIDS Day (week) 1992- a means to disseminate AIDS Prevention messages to the general public. The Workshop aimed to find out what AIDS related activity each organisation was doing, what resources were at their disposal, what each could do for WAD and from where resources could be tapped and pooled to raise public awareness on WAD.

THE PARTICIPANTS :

Though 95 organisations/persons were contacted through letters and telephone, a total of 15 persons from various non - governmental organisations and one representing the Government attended the workshop. They were :

NAME	ADDRESS	TEL NO.
01. Dr. Nanjunde Gowda	Deputy Director (Publication) Health & Family Welfare Dept. Anand Rao Circle Bangalore - 560 009	74039
02. Mr. Joseph George	Gnana Vikas Kendra United Theological College 17, Millers Road Bangalore - 560 046	333438 332844
03. Ms.Usha Ashok Kumar	Lect.(Dept. Of Women Studies) Mount Carmel College	261759

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04. Dr. Sowbhagya Putteram	Asst. Professor (Neuro Pathology) M.I.[illegible] P.B. No.2909 Bangalore - 560 029	642121 Extn. Neuro Path
05. Dr. Ravi Mohan M.	Blood Bank Officer Indian Red Cross Society Bangalore - 560 001	264205
06. Mr. Rajaram	Consultant for Working Children 26/1, Vasanthapura Garden Dhoopanahalli Indiranagar Bangalore - 560 008	572111 575258
07. Dr.Latha Jagannathan	Trustee Bangalore Medical Services Trust Imperial Court Cunningham Road Bangalore - 560 001	266131 (O) 569799 (R)
08. Ms. Maya Sharma	Correspondent Doordarshan J.C. Road Bangalore - 560 006	333201 (O) 642702 (R)
09. Ms.Jayshri Kothavale	Counsellor F.P.A.I. 127, Srinidhi, Extn.12-13th Cross West Park Road Malleswaram Bangalore - 560 055	365647
10. Mr. Samson John	Journalist Sanja Jaya Vani Queens Road Bangalore - 560 001	263941
11. Mr.S.V.Srinivas Murthy	Co-ordinator Indian Red Cross Society 26, Race Course Road Bangalore - 560 001	264205 (O) 268430 (O) 530258 (R)
12. Dr.Sneha Kulkarni	Indian Society Of Health Administrators Ulsoor Bangalore	574297
13. Ms. Meera Chakraborty	Menini 15, 4th H Block Rajajinagar Bangalore - 560 010	358127

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14. Ms. Nalini	Asst. Prog. Officer Shramik Vidya Peth Directorate Of Mass Education F Street, Kalasipalayam Bangalore - 560 002	609821 (O) 530132 (R)
15. Ms. Alka	Indian Health Organisation No.9 J.C. Lane Balepet Bangalore - 560 053	72712
16. Dr. Elizabeth Peeri D.	Divya Jyanthi Christian Association Lingarajpuram Bangalore - 560 084	

ORGANISERS

01. Ms.Sucharita Eashwar	Prog. Director	575800
02. Ms. Janaki		
03. Ms. Sudha		

MADHYAN COMMUNICATIONS
P.B. 4610
59, Miller Road
Benson Town
BANGALORE - 560 046

01. Ms Sujatha de Negry	Prog. Director	562522 (R)
02. Ms. Edwina Pereira	Asst. Prog. Director	561201 (R)
03. Ms. Bhanu Paul	Faculty Member	

INSA / IMTA
No.87, 1st Floor
3rd Cross,
Nandidurg Road Extn.
BANGALORE - 560 046

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THE WORKSHOP PROCEEDINGS :

The workshop began with a short introduction which helped each one get to know each other. A discussion on the Indian AIDS scenario and the need for stepping up intervention was then focussed upon, after which, a video presentation on what other countries were doing for AIDS prevention was screened. This set the tone for each participant to discuss in detail specific actions they could take up for WAD 1992 and follow up actions for the rest of the year. These are summarised below :

01. Madhyam Communications is presently involved with raising health awareness through various media.

For WAD 1992, they plan to :

i) organise a Press Conference in the preceding week, so that all major newspapers carry non-threatening factual AIDS related messages during WAD 1992.

ii) organise a poster competition on AIDS in Mount Carmel College.

iii) Puppets shows/street plays on AIDS at public places (Shivajinagar, Majestic) and as requested. Please inform them before-hand.

02. INSA / India

i) AIDS walk with schools and other participating

ii) distribution of posters, pamphlets, inserts in magazines targetting industries.

iii) concept (AIDS) letters for religious heads to use during their preaching.

iv) AIDS education sessions as requested.

03. Dr.Nanjunde Gowda: being Deputy Director (Publications) he could, with permission of his superior Mrs. Susheela, (Jt. Director IEC - Phone 71040) make available Govt. posters and pamphlets on AIDS as per request. The other government contacts are :

i) Dr. Chandrashekhar Nayak, Deputy Director (AIDS) Phone 73151 Extn.294

ii) Dr.Honnabhave, Addn. Director for National AIDS Control Programme.

They could participate in the press conference and may be able to help getting Doordarshan slots for AIDS related messages.

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04. Mr. Joseph George : Manav Vikas Kendra (MVK) does offer counselling services and is prepared to do counselling for HIV infected persons (unofficially). They can train counsellors for AIDS specifically if others need such training (Contact : Dr. Carlos Welsh, Director).

05. Ms.Usha Ashok Kumar from Mount Carmel College is organising :

i) the poster competition on AIDS with Madhyam Communication.

ii) an AIDS education session for 900 students on 3rd December 1992 with INSA/India.

06. Mr. Rajaram from Concern For Working Children shared that every month they deal with one theme and since December is already planned for, they would adopt AIDS as the theme for February 1993 during which month AIDS educational messages will be highlighted through puppet shows, video films, discussions etc. They will also place AIDS inserts in their wall newspaper - Bhima.

07. Dr. Latha Jagannathan invites members to let others know that blood can be tested for HIV 1 + 2 at Bangalore Medical Services Trust for Rs.75/-. For WAD '92 she could get business concerns to sponsor production of AIDS prevention messages for Doordarshan and hoardings if Doordarshan will offer time free and publish the sponsor's name. She also has a counselling centre 'Vishwas' which at present is not doing counselling for HIV & AIDS related persons till the staff are trained.

08. Ms. Maya Sharma from Doordarshan's Insight programme offers to cover WAD activities done by others (so please inform her of your specific activity, date and place). She has offered to help arrange a meeting with the required personnel at DD to make Dr.Latha Jagannathan's offer a reality.

09. Ms. Jayashri Kothavale, a counsellor at FPAI is organising a Seminar on AIDS on the 2nd/3rd December 1992 for college students. The FPAI has a good booklet "Talking AIDS" which is available on request for Rs.10/- each plus postage.

10. Mr. Samson John would write an article highlighting basic AIDS prevention messages for his newspaper Sanjaya Vani.

11. Mr. S.V. Srinivas Murthy from Indian Red Cross Society (IRCS) offers to make available blood testing facilities for HIV 1 + 2 testing at a nominal fee.

He is also the National Vice President of the IRCS of India and will spread AIDS related information through them.

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12. Ms. Meera Chakraberty from Manini plans to stage street plays and puppet shows on AIDS in slums of the city with Madhyam Communication's help.

13. Dr. Sneha Kulkarni from ISHA is presently undertaking HIV surveillance studies in selected slums for the Govt. of India. She has to discuss plans for WAD with her team and will let us know.

14. Ms. Nalini from Shramik Vidya Peeth (SVP) has offered to organise the women from slums to participate in INSA's AIDS Walk. Also to promote AIDS education in slums through puppet shows with Madhyam Communication's help. They could also undertake spreading AIDS messages through street plays on request.

15. Ms. Alka from IHO has at her disposal pamphlets, booklets in Kannada, Hindi and English and posters on AIDS for distribution. Those who need them could make requests. She also has videos on AIDS for sale.

16. Dr. Elizabeth Pearl will undertake AIDS prevention education in surrounding Bangalur slums and arrange for the Vijaya Shanthi school to be covered via INSA during that period.

TO SUMMARISE :

For i) booklets on AIDS contact - FPAI & IHO

ii) pamphlets & posters on AIDS - Govt. , INSA & IHO

iii) video cassettes on AIDS - INSA (Rs.350/- per cassette) & IHO

iv) puppet shows on AIDS - Madhyam Communication

v) street plays on AIDS - Madhyam Communication & SVP

vi) AIDS education in schools, colleges, slums, industries - INSA

vii) Counselling Services - CREST & MVK

viii) If you find hoardings available for AIDS - Dr.Latha

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CONCLUSION :

We have together , just taken one step forward. But with our total commitment together, we can go miles towards making no one in Bangalore say "I got AIDS because I didn't know how to protect myself". This needs our commitment - a community commitment.

INSA
International Nursing Services Association
RURAL HEALTH DEVELOPMENT TRAINERS' PROGRAMME
AIDS EDUCATION PROGRAMME

REPORTING ON THE AIDS PREVENTION EDUCATION IN SCHOOLS FOR THE PERIOD SEPTEMBER 1992 TO FEBRUARY 1993

INTRODUCTION :

Many milestones have been covered with the AIDS Prevention Education in Schools during this period. Hence, there is much to share and we hope this will be as interesting to read as it has been for us to write. During this period, several Workshops have been held, many schools reached and Tibetan settlements visited to spread AIDS Prevention messages. With exams far away, it was a good time to contact schools because they were prepared to spare the time for us to talk to the students. We also had the added advantage of the weather being kind which prompted us to visit those Tibetan settlements which would be near difficult to reach in summer.

TIBETAN SETTLEMENTS :

INSA's AIDS Prevention Education Programmes were held in a remote, small Tibetan village of Mainpath in Ambikapur District, Madhya Pradesh, which has a population of 1468 approximately. Further down into Maharashtra is the village of Bandara with a 1103 strong population where the programme was again repeated. At both these places, the response was good plus, the settlement officer, with prior notice from us and the Department of Health, Dharamsala, made sure that atleast one person from each family attended the sessions. At both these settlements, approximately 900 to 1000 persons attended the sessions. Also, two Tibetan schools at each settlement with a total of 95 students were covered. An interesting fact that seems to emerge as we cover the Tibetan population is that homosexuality is unknown amongst them. If it does exist, people are unaware of it !

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SCHOOLS AND COLLEGES

Back in Bangalore, we worked at high speed to try and cover as many schools and colleges as we could before they began preparations for the final exams. Whether it was because of the increased coverage about AIDS in the News or whether word had spread of our Workshops and visits to other schools we might never know, but all of a sudden there was greater acceptance of AIDS Prevention Education from us. Besides, we were even being invited to those schools who at first had shunned us. Another bit of luck that came our way was getting to know a group of young enthusiastic people, all of whom are students from various colleges and who belong to an international student organisation called AISEC, which originated in Brussels. Of late, these people have been contacting schools and colleges, making all the necessary arrangements and then inviting us to go over and conduct the AIDS Prevention Education. This has been of great help plus, it has saved us a lot of time waiting around principals' offices to get an appointment.

The breakdown of the number of schools and colleges covered from i.e. September 1992 to February 1993 :

SYLLABUS FOLLOWED	SCHOOLS/COLLEGES Covered	ENGLISH MED. Boys	ENGLISH MED. Girls	KANNADA MED Boys	KANNADA MED Girls
S.S.L.C	38	1226	1766	1915	4230
I.S.C.	3	103	170	--	--
C.B.S.E.	-	--	--	--	--
COLLEGE	11	45	3740	--	--
	52	1374	5676	1915	4230

Total No. of High Schools & Colleges covered 52

Boys in High Schools & Colleges = 3,289

Girls in High Schools & Colleges = 9,906

Total Number of Students covered = 13,195

Total Number of Staff covered = 38

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OTHER GROUPS :

Apart from schools and colleges, the School of Nursing at St. Martha's Hospital, Bangalore, invited us to address a group of about 100 student nurses, doctors and paramedicals. The C.M.A.I., also invited us to speak to 150 members of various church groups.

Since March 1993, AIDS messages are being flashed three to four times a week on Bangalore Doordarshan after the local Kannada news. This message is followed by the next frame saying, "for more information, contact INSA/India", followed by our address. This has brought in a flood of letters from the public requesting more information from us !

WORKSHOPS :

One of our main aims in conducting workshops was to gain entrance into the teaching institution and this approach has certainly helped in a big way. Principals and senior faculty who were hesitant to have us talk to their students were confident and comfortable to invite us after attending the Workshop and knowing how we handled the subject. During the last six months, we completed three workshops as follows :

17th September 1992

Eighteen Principals/Lecturers from colleges attended this Workshop. The discussions were lively and interesting. Some good suggestions came from this group for e.g. :

a) NSS programmes can integrate AIDS Education which then can be extended to the slums.

b) Have a special AIDS Workshop for 2 - 3 NSS sutdents from each college so that they can spread the message.

c) It is not enough to do a one off education - there has to be continuous reinforcement.

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18th September 1992

Sixteen Imams from selected mosques of Bangalore were invited to a Workshop. The interest shown was very encouraging and each left the Workshop with a decision to speak about AIDS at their Friday prayers. As one Imam remarked, "if we speak to them now they will be able to protect themselves".

17th October 1992

This workshop was for various NGos, government persons from the Department of Health and the Press in preparation for World AIDS Day.

17th to 21st November 1992

The highlight of all our Workshops was the INSA UTSAV which was organised to celebrate INSA/India's 10th anniversary. The main theme of the UTSAV was "AIDS Prevention Strategies, Communication and Counselling." A total of 120 of INSA/India and INSA/USA alumni registered but only 80 persons attended the Workshop. It involved four complete days of discussion and looking at various aspects of AIDS. On the last day each of the Workshop participants made a commitment to include preventive counselling of AIDS into their ongoing programmes. Many of these participans, since returning to their projects, (most of them located in interior villages) have started talking about AIDS. (A complete report on the UTSAV is being prepared and will be sent shortly.) An unique feature was the message on the spread and prevention of HIV, presented in the Yakshagana dance form (the folk dance of Karnataka) in which the role of the HIV was performed by the only male member of the INSA/India staff Mr. M. Bhagavandas.

PUB NITE

On December 4th, Mr. Ajit mani of Intervention, and his colleagues took on a fundraising campaign for INSA/India's AIDS Programmes at the Black Cadillac Pub in Bangalore. There was an overwhelming response from individuals and companies. The TTK group was one of the major contributors. After all expenses were met, Interventions handed us a cheque for Rs.34,766.10. The money is to be used for dubbing the films, "Karate Kid" into various regional languages.

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INSA/India is in correspondence with Street Kids International, Canada, regarding this. with the remaining money, if any, other educational material will be developed.

WORLD AIDS DAY

Over 1500 school children participated in a 6 kilometer walk which was flagged off by the Hon'ble Mayor of Bangalore City. They walked the route wearing their red ribbons signifying AIDS awareness and, distributing pamphlets on AIDS prevention. The entire expenses for this programme on World AIDS Day was funded by the NGO AIDS Cell. Nevertheless, it is being included in this report since school children were involved.

STAFF TRAINING :

With the increasing load of work with schools and colleges on AIDS, it became impossible for only the INSA/India faculty to handle all the classes. As time passed, we realised that our secretaries had become equally competent in imparting AIDS Prevention education. To provide them with more information and help them develop greater confidence, we sent the three of them to the Christian Medical College, Vellore, to attend one of Dr. Jacob K. John's programmes. With this exposure, we find that their enthusiasm in the programme has shot up. the three secretaries who went for the training from March 22nd to 26th, 1993, were Mrs. Charlet, Mrs. Abigail Thomas and Mrs. Tina King who do the classes in English.

EVALUATION :

We requested Interventions to do an evaluation of our AIDS Prevention Education in schools, taking a random sample of 500, a topline report was prepared, which is being enclosed.

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CONCLUSION :

As always we owe our continued success to many who have helped us. Dr.Ravi from the Department of Virology, NIMHANS, for his continued interest in our programmes and for being our regular resource person for every Workshop; Dr.Jacob K.John for his help, support and encouragement. We are especially grateful to Dr.John for having taken time off to come and help us conduct the Workshop for the Muslim Imams. To our Governing Board members who allow us to grow and above all to Ford Foundation without whose support we would not be where we are. A tortoise sitting on a gatepost remarked, "I got here only because someone put me here. "Thank you, Ford Foundation, for putting us where we are !

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International Nursing Services Association
RURAL HEALTH DEVELOPMENT TRAINERS PROGRAMME
AIDS EDUCATION PROGRAMME
2, BENSON ROAD, BENSON TOWN, BANGALORE 560 046 CABLE : INSAINDIA

SECOND HALF YEARLY REPORT OF THE (NGO-AIDS CELL FUNDED) INSA/INDIA PROJECT FOR "DEVELOP-ING AIDS EDUCATION NETWORKS IN INDUSTRIES & BUSINESS CONCERNS IN BANGALORE CITY"
DECEMBER 1992 - MAY 1993

INTRODUCTION :

Having been involved in AIDS Prevention Education in Schools/Colleges of Bangalore, and the Tibetan Resettlement Colonies in India, we felt we could reach out to a such larger population through direct intervention with the factory workers in Industries, this way we would be targetting a large captive populace in Bangalore who are at risk of infection. It clearly pinned us down to start AIDS Prevention Education for factory workers in Bangalore and now there is no looking back!

We share with you our 2nd half yearly report highlighting the activities of the project during this period.

ACTIVITIES

a) December 92 - February 93

This quarter began with the AIDS Walk on December 1st. Around 1700 students who had been covered with AIDS Prevention Education participated in the 4 Kms Walk through central areas of Bangalore city. Prior to the Walk, several industries were contacted to participate through complementaries; which resulted in industries partly donating banners, refreshments and transportation used. The Walk was flagged off by the Mayor of Bangalore city, was given police support, and free first aid services from the St. John's Ambulance Association. The Walk on December 1st helped to spread AIDS Prevention messages through the banners carried by the students and the distribution of 10,000 pamphlets. This was later screened on Bangalore Doordarshan several times.

Some post-happenings of this Walk are that :

* a matron of a local government hospital approached INSA for more AIDS information : Her son who halted his vehicle at a traffic stop en route to work was presented with a pamphlet by students participating in the Walk.

* the Rotary Club of Hiriyur, North Karnataka received one of our pamphlets and reproduced 10,000 of them for distribution in their town during that week.

* Bangalore Doordarshan has screened AIDS Prevention messages several times at prime time citing INSA with our full address/phone number to be contacted for more information. We are still unaware of our benefactor.

* we have subsequently received several queries by mail and continue to do so.

Besides the Walk on World AIDS Day, pamphlets were distributed at a subsequent International Women's Bazaar.

Several industries were contacted for conducting AIDS Prevention Education sessions in the latter part of this quarter.

The first AIDS Prevention Education was held on the 27th of February '93 at the Bharat Fritz Werner Ltd. Unlike our planned coverage of the entire worker cadre at the industry, this factory selected representatives from the management and workers to come together for an initial session which included discussions about the Cause, Spread and Prevention of AIDS and a video presentation of an AIDS film followed by a question and answer session.

March - May 1993

Since then we have covered workers in eight industries despite the various set backs we have had to face upto during our visits to Industries while requesting them and convincing them on the need for AIDS Prevention Education. In all, a total of 23 factories were contacted. All of them had not sent their representatives to attend an earlier/Workshop on the 10th October 92 when we addressed the Managers of various factories. We have been rebuffed by some of the factory management staff with petty excuses such as "We don't have the time", "our productivity could be affected", "our factory workers are ignorant" and so on, as a result we were able to complete only 9 industries (of the targetted 10 industries for the first project year). Below is a list of the factories where we completed the AIDS Prevention education in Kannada and/or English.

1. Bharat Frith Werner Ltd

2. Southern Railways Mazdoor Union (Madras), Bangalore Branch - 2 sessions

3. Kirloskar Electric Co' Ltd

4. Tata Tea Ltd - 4 sessions

5. H. Dasappa & Sons Pvt Ltd

6. Indian Oil Corporation Ltd

7. Bharat Petroleum Corporation Ltd

8. Indian Oxygen Ltd

9. Indian Tobacco Company Ltd - 2 sessions (sessions continuing in June '93)

INSA
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AIDS EDUCATION PROGRAMME

Below are the details of the number of factories, sessions and workers covered from December 92 to May 93.

Name of Industry	No. of workers Male	Female	Work Force	Lang
1. Bharat Fritz Werner Ltd	40		750	Kann/ Eng
2. a) Southern Railways Mazdoor Union (Madras), B'lore Branch - workers	56	4		Eng
b) " -Doctors	4	8		"
3. Kirloskar Electric Co' Ltd	150		2500	Kann
4. Tata Tea Ltd -1 sess	65			Eng
" -2 sess	50			Kann
" -3 sess	75			"
" -4 sess	120			"
5. H. Dasappa & Sons Pvt Ltd	85	15	200	Kann/ Eng
6. Indian Oil Corporation Ltd	47	3		"
7. Bharat Petroleum Corporation Ltd	75	5		"
8. Indian Oxygen Ltd	40			Kann
9. Indian Tobacco Co' Ltd — 1 session	40		2000	"
" - 2 session	40		"	"

****

87, 1ST FLOOR, 3RD CROSS, NANDIDURG ROAD EXTENSION, BANGALORE - 560 046.

HALF YEAR ADMINISTRATIVE DETAILS

a) Staff : The INSA/India team has been further strengthened with a full time staff on the Industries budget, Ms. Tina King who is exclusively in charge of contacting and arranging for the AIDS Prevention Education sessions in Industries. Tina King is supported in her work by the rest of the INSA/India team who are actively involved in the promotion of this project.

b) Finances : The detailed statement of accounts for the last financial year is sent to you with this report.

FORWARD PLANS :

Though this project ends in May '93, we have a few others who have requested INSA/India for AIDS Prevention Education sessions lined up for July 93. We plan to reinforce AIDS Prevention messages to workers already covered through a Newsletter. Our AIDS Information Cell is open for any of their individual queries too. We plan to continue as per plan in the Project Proposal subject to the availability of funds.

CONCLUSION :

We are very grateful and owe this project's success to NGO-Cell, New Delhi but for whose financial support and co-operation, this project would not have been possible. We also take this opportunity in thanking the management in all the industries where we have conducted the AIDS Education, for all their support and co-operation in making our combined efforts worthwhile. We hope that to some extent we have opened the door for discussions on framing policies in each of these factories. We hope that all those factory workers who we have educated will pass the information to their family members, neighbours, friends and others and join hands with us in helping to contain AIDS.

THE INSA TEAM

REPORT ON THE INSA/INDIA WORKSHOPS ON STRATEGIES FOR AIDS EDUCATION IN HIGH SCHOOLS & COLLEGES

For Heads of Schools/Colleges Held on the 17th - 19th August 1993

INTRODUCTION :

With a view to cover all Government and Govt Aided High Schools with AIDS Education in the next phase, INSA/India contacted the Department of Education who, once motivated sent a joint circular to all the schools in their juridiction through the Deputy Director of Public Instruction. One hundred and fifty schools were contacted to attend a one day Workshop on any of the 3 consecutive days the dates also jointly chosen. However on the last day (19th August) the Department of Education had an urgent internal meeting of all their Head masters. The INSA/India Workshop was, at the last moment limited to just the 17th of August. On this day 54 Heads attended. On the 18th of August, since 11 Heads attended we had the Wosrkshop for them also. On the 19th 3 Heads turned up and we talked to them on a one-to-one basis. It is with pleasure that we present you with this consolidated report of the Workshops on "Strategies for AIDS Education in High Schools and Colleges".

THE PARTICIPANTS :

A total of 65 attended the Workshop each of whom have an average of 500-1000 High School students. They belong to the fully aided Govt.Schools, partly aided and some were from private schools who have Government recognition.

There were 42 men and 23 women 92% were Head Masters/Mistress and 8% were senior teachers delegated by their Heads who were not free. A list of Participants who attended on all three days is appended (Appendix I)

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THE WORKSHOP DESIGN :

Beginning with a welcome, introduction and a pre-evaluation, a discussion on the global perspective, cause, spread and prevention of AIDS ensued. This was followed by screening Shyam Benegal's "Scourge". The psychosocial aspects of AIDS in relation to schools, parents and staff was then discussed. Following this, participants were broken into groups of not more than 7 each to discuss appropriate strategies for AIDS Education in their High Schools and Colleges. A synopsis of this is given as Appendix II. A video film that has been screened in the 100 odd schools that INSA has already covered with AIDS Education was then screened (Karate Kids) to get feed back on its appropriateness in their school/college settings. Most of the Heads felt that 'Karate Kids' (in English & Kannada) would be fine in schools while 'Scourge' would be better in Colleges. (Karate Kid has been dubbed in Kannada and is priced at Rs.300/ plus postage for sale).

Each participant was then handed a RED RIBBON - a symbol for uniting to spread AIDS Prevention education. Though their files contained basic AIDS information related to schools, participants requested more information and bought a Kannada version of 'Talking AIDS' and some other bought English versions availagble. Fifteen participants requested INSA to conduct the AIDS Education Programme in their schools giving us an exact date and time. The rest also welcomed such education but promised to let us know the exact date and time within a week as they needed to discuss it with their staff. Even as the Workshop ended participants were singling out INSA staff to let us know what other education strategies to use and how all their misconceptions and fears about AIDS were cleared.

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POST WORKSHOP QUESTIONNAIRE

At the end of the Workshop participants were requested to share their opinion on the following through a written questionnaire.

*** the need for HIV Prevention

All of them unanimously stressed the importance of educating students on the cause, spread, prevention of AIDS. They felt they could facilitate this process through expediting red-tape to enable INSA to do this education in their schools as just the first step.

*** measures to be taken if one of their staff has HIV infection

89% of the participants felt that they should be supported, allowed to continue work, should not be isolated but counselled. Whatever palliative treatment to be made accessible through financial assistance confidentiality to be strictly maintained.

Of the 11% who did not agree, 4% felt they should be asked to go on voluntary retirement and that they needed to be isolated. They also felt that students be kept away from such a staff. 4% did not respond to the question.

*** measures to be taken if one of their children has HIV infection

91% of the participants felt the child need not be isolated under normal circumstances while 9% said 'Yes' to isolation. 93% of the participants strongly reiterated that the child can continue school. 84% of the participants felt there was no need for informing others about the child's HIV status even to the parents, while 16% responded that parents ought to know.

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Many of the participants discussed in small informal groups and with the INSA team conflicting situations like a HIV positive pregnant women 'should she abort or no ?'. Participants were beginning to think of AIDS - not just from the disease perspective - but about the many grey areas behind the human mind and soul of an HIV infected person.

CONCLUSION :

We take this opportunity to thank each Head Master, Head Mistress who took time out to attend the Workshop and tender valuable suggestions to strengthen AIDS Education in school/college settings. We thank the decision makers in the Department of Education who consented to participate in AIDS prevention education through first delegating their Heads. All this would not have been possible withoutn the timely, silent support of our donor. Thank you, Ford Foundation.

Appendix - I

LIST OF PARTICIPANTS

N A M E	SCHOOL/COLLEGE
1. Mr.H.S.Pani Rao	Govt.Girls High School
2. Mr.B.Shankar Rao Gujjar	Govt.P.U.College
3. Mr.Shantha Kumar	Govt.High School
4. Ms.N.Sharada	Mahila Vidyalaya High School
5. Ms.Y.V.Rajalakshmi	PVP High School
6. Ms Rose Mary	Carmel High School
7. Ms.K.Emerencia	St.Alphonsus High School
8. Mr.M.V.Satyanarayan Rao	Govt.High School
9. Ms.K.Anusuya	Ananda Composite Jr.College
10.Ms.M.R.Vijayalakshmi	Govt.High School
11.Ms.Neerajakshi	Vidhya Mandhir High School
12.Ms.Hameede	Fatima Girls High School
13.Mr.Abdul Rawoof	Govt.High School
14.Mr.K.Swamy	Govt.High School
15.Mr.N.P.Raghavendra Rao	B & L P.U.College
16.Mr.V.G.Hegde	N.K.S.English High School
17.Mr.G.V.Nagaraj	B & L High School
18.Mr.Sunder Raj	A.E.S.High School
19.Mr.Dhruva Rao K	HMT Secondary School
20.Mr.Pandurangaiah Setty	Govt.High School
21.Ms.C.Arulambikai	Gandhi Vidya Shala High Schl.
22.Ms.Vijaya Kumari	K.R.W.A.Vidyaniketan
23.Ms.Harsha Shanthilal	Adarsha Girls High School
24.Ms.V.C.Aleyamma	Vyalikaval High School
25.Ms.Shakira Begum	The Beacon High School
26.Ms.Shakuntala Bai	Govt.High Schl.Rajajinagar
27.Mr.H.S.Swamy	Govt.High Schl.-Palace G.Halli
28.Mr.Anwar Shariff	Govt.High Schl.-Hebbal
29.Mr.Vishwanathachary	Govt.High Schl.-Makali
30.Mr.P.Raghavendra	AMS Composite P.U.College
31.Mr.V.Lakshmana Rao	Bapuji Residential High Schl.
32.Mr.Abdul Aleem	Govt.High School, Cox Town
33.Mr.B.Ramakrishna	Siddartha Gauthama High Schl.
34.Mr.T.S.Rajagopal	Govt.High Schl.- Yeshwanthpur
35.Mr.Somasundaram	Raghavendra High School
36.Mr.Narayana Rao	Siddartha Junior College
37.Ms.Fahmida Rahim	Govt.High Schl.- S.Nagar
38.Ms.Rajeswari Murthy	Sri Raghavendra Ashrama H.S.
39.Mr.Srinivasa Murthy	Sri Raghavendra Ashrama H.S.
40.Mr.N.Hanumantharaya	B.S.A.P.Girls High School

41 Mr.S.Narasimhaiah	Sri Veena Sarada High School
42.Mr.M.S.Kempayya Math	Govt.P.U.College,Yelahanka
43.Ms.Manjula Devi	Govt.P.U.College for Girls
44.Mr.Govindappa	P.V.P.High School
45.Ms.Ananthalakshmi S.T.	Rajajinagar Girls High Schl.
46.Ms.Vasantha Malliya	R.P.A.High School
47.Ms.Shantha Devi R.N.	Sri Vani Girls High School
48.Mr.M.S.Kempaiah Math	Govt.P.U.College,Yelahanka
49.Mr.B.M.Bhat	Vikasa High School
50.Mr.M.A.Alfred Joseph	B'lore Tamilsanga Kamaraj H.S.
51.Mr.Dennis Monteiro	Shree Shambavi Girls H.S.
52.Ms.Tahera Gulam Mohmed	Viswakalaniketan Model Eng.H.S.
53.Mr.Abdul Aleem	Govt.High School, Cox Town
54.Mr.M.C.Naik	Govt.P.U.College, Peenya
55.Mr.Chebbi	Universal Edn.Society H.S.
56.Mr.Chikkaveeraiah	Sri Chennakeshavaswamy H.S
57.Mr.Venkatesh M.K.	Kempegowda High School
58.Mr.D.B.Nanjundaiah	Gandhi Vidyalaya High Schl.
59.Mr.H.B.Krishna Murthy	B.P.Indian High School
60.Mr.B.Nagaraju	Mithra High School
61.Mr.K.Siddalingaiah	Mt.Hermon High School
62.Mr.D.P.Telagi	Jagadguru Shri Jayadeva H.S.
63.Ms.B.M.Premaleela	Tagore Memorial High School
64.Ms.Gayathri G Rao	Anupama English High School
65.Mr.Sannaya Manja	Seva Ashrama High School

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'Appendix II'

STRATEGIES FOR AIDS PREVENTION EDUCATION IN SCHOOLS

1. To impart Moral values of life through stories, plays.
2. To stress on developing healthy habits.
3. To arrange exhibitions, film shows, display of charts, posters - depicting the alarming state of AIDS.
4. To create awareness of the AIDS to utilise whenever the occassion arises while teaching.
5. To include AIDS topic in curriculum.
6. To arrange for lectures by Doctors and experts in the field.
7. To organise quiz programmes, painting competition, Essay competitions, Debate etc....
8. Children must have the knowledge of proper sex education so they were aware of AIDS.
9. It can also be celeberated AIDS Day in a grand manner on 1st December.
10. Displaying banners and plashcards on AIDS in schools

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INSA/INDIA AIDS EDUCATION PROGRAMME

In 1989, an idea began to take shape. The more we talked of it the more we felt that INSA/India needed to get itself involved with Preventive AIDS Education in Schools and Colleges in and around Bangalore City and the Tibetan settlements in India. A four year plan was drawn up and a modest budget prepared. Yet every door we knocked on was politely but firmly shut, but the persistant search by three women-two nurses and a teacher continued till a person in Ford Foundation listened, believed in us and in our project. There was no money immediately available, but with a small amount of Rs.15,000/- INSA/India launched the programme in October 1990. Schools and Junior Colleges were notified through 400 letters, which brought in a positive response from 36 Schools and one rejection. The rest kept silent.

After a brief course on AIDS at C.M.C., Vellore, the INSA/India team offered the first education programme in a Corporation High School cum Junior College. Here, we talked with about six hundred girls. We were given a one hour session which stretched well over two hours and it was with reluctance the girls allowed us to go. Since then we have talked in another School in Bangalore and 14 Tibetan Schools in South India Covering almost 2000 Tibetan students, 600 Tibetan men and women. This was due to the fact, we had encouraged Dr.Kelsang, a Tibetan doctor to train with us at C.M.C., Vellore.

A direct outcome of our training at C.M.C., Vellore, was an offer from Dr.Jacob K John, Head of the Department of Psychiatry and AIDS, who offered to do a Workshop for us for 20 Heads of Schools in Bangalore. Although 20 were invited we had only 13 persons who turned up. The Workshop was a success with requests for continued updates on the AIDS status in the country plus invitations to their Schools. A further Workshop on Counselling for AIDS cases was organised with assistance from C.M.C., Vellore, for Religious Heads. Five from each religious groups were invited. The Roman Catholic and the Protestant Churches, the Mullas from the Muslim Mosques and three Hindus. Eventually we had only nine persons come, of these none were Muslims. Four Protestants, four Roman Catholic

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and one from the Universal Consiousness Group. Nevertheless, we were happy that we have been able to have nine more join the fight against AIDS.

In July we have conducted another Workshop for 28 of our INSA/India graduates from South India. This has been in collaboration with the Indian Health Organization. All have returned to their Institutions with plans on preventive education for the Communities they work and live with. The pebble has created its ripples. The messages will travel fast to various corners of this country.

The school AIDS Education Programme started in August 1991 and during that year we conducted seesions at 17 schools and one college. Due to various reasons such as the closure of schools and colleges. This year (1992), INSA/India with its 7 member team to cover as many schools as possible so that more boys/girls will know how AIDS is caused and how they can prevent HIV infection.

It is towards, accomplishing this endeavour that we seek your invaluable cooperation.

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SECOND HALF YEARLY REPORT (MARCH 92 - AUGUST 92)

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INSA/INDIA'S AIDS PREVENTION EDUCATION

I N

High Schools and Colleges of Bangalore

& Tibetan Resettlement Colonies in India

INTRODUCTION :

This report contains the outline of the work completed by INSA/India for the second half of the first year of funding for the above project.

During the first four months not much could be done in schools and colleges because of this was the time when all educational institutiens were preparing their students for their final exams. Hence, no institution was prepared to sacrifice 2 hours for us to meet and talk with students. However, all gave us appointments for the next academic year. This being a lull period for us with schools and colleges, we decided to cover the Tibetan settlements.

TIBETAN SETTLEMENTS :

During the early half of the year we had covered six Tibetan settlements in the south. Hence, we decided to complete covering the balance 3 settlements before we moved into the remaining areas in India. Having contacted the settlements secretaries through Dr.Kalsang Phuntsok, a young Tibetan doctor, from the Kollegal settlement who had been part of our team from the onset of the programme, we began our visits. We had excellent cooperation from all the settlement authorities as a result our coverage was good. Usually, two from INSA/India and Dr.Phuntsok would visit a settlement together and speak to groups. While Dr.Kalsang Phuntsok spoke to the men and young boys, the INSA/India staff, with the assistance of translators usually from the settlements' health department spoke to other groups. However, when we spoke to the High School students we found that there was no need for a translator. Before the end of February 1992 we were able to cover the southern settlements at Hunsur, Bylaguppe and Mungod in Karnataka.

In April, we went to Dharamsala, the seat of the Tibetan Government in Exile, to cover as many settlements in Himachal Pradesh. During this visit, with the assistance of the Health Secretariat , we had a session with the Secretariat staff, which, for some reason was not to well attended, inspite of

the Minister for Health chairing the proceedings. However, those present showed a lot of interest and many questions were asked and doubts cleared. In Dharamsala we also covered a very large school population. The Upper TCV (Tibetan Children's Village) schools for boys and girls, where approximately 800 High school students attended, plus the Lower TCV school where the principal wanted us to speak to children from 7th standard upwards, saying that "Children are never too young to know the truth of protecting themselves".

It was refreshing to meet such a progressive Principal. From Dharamsala, the Health Secretariate arranged for us to visit their settlement in Bhir and Chaunthra. Enroute, we stopped at Toshijog where the Tibetan dance festival was in progress. Here, Dr. Phuntsok and the INEA/India staff spoke to sixty adults, men and women. The settlement officer made it mandatory for at least one person from each family to attend the AIDS education session. From here, the next stop was Bhir, where a group of 35 Tibetans were addressed that evening. The next day at the Bhir schools approximately 600 boys and 200 girls were covered with AIDS education in two separate sessions. These students were newcomers from Tibet and were being prepared to join the mainstream of education/employment. A group of fortyfive persons were also addressed at the Chaunthra settlement. With this, our total coverage of Tibetans with direct AIDS Prevention Education is as follows:

Men	240
Women	191
Girls	1064
Boys	975
Total	2470

IN BANGALORE :

During the second half of this year upto August 1992 we held a total of 2 Workshops for Heads of schools and senior faculty. It was interesting to note that for these Workshops, we had less problems with eliciting their participation. The reasons could be that more people see the need to have more information on AIDS, more of the school authorities see the need for this information reaching their students, the Workshops fell in the 1st term of the academic calendar and finally the venue for all the Workshops were not in an institution but at one of the hotels.

When Miss Shanthimathi, the Bangalore City Corporation Chief Education Officer heard about our programme, she requested us to do a special Workshop for the 43 Heads of Corporation Schools in Bangalore City, which we did and thanks to her interest, we had 36 people attending the Workshop. What is more is that she also made sure that all the 43 Corporation High Schools invited the INEA/India team to do its AIDS Prevention Education Programme for their students.

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A major session at these Workshops have been to get these Administrators and Faculty to consider policy decisions concerning staff/students with an HIV positive status. We have had them look at medical reimbursements, sick leave rules etc and have helped them realise the need to form/ clear-cut policies before they are confronted with the actual problem.

In all a total of 2 Workshops were held in the 1st Project Year (upto August 1991-1992) given below :

	Men	Women	Total
Corporation Schools	26	12	38
Christian Schools	1	4	5
Hindu Trust Schools	1	7	8
Other Schools	2	4	6
TOTAL	30	27	57

AIDS PREVENTION EDUCATION IN SCHOOLS AND COLLEGES :

From August 13th, 1991 to August 12th, 1992 the IMSA/India team have carried out AIDS Prevention Education in a total of 34 schools. A break down of the types of schools covered the number of boys and girls reached are shown in the table given below.

	Boys	Girls	Total
Government Schools	900	500	1400
Corporation Schools	-	-	-
Christian Schools	1666	2498	4164
Others Schools	1945	1593	3538
Tibetan Schools	356	833	1189
	4867 +	5424 =	10291

The following table gives the medium of education and the type of examination the students were being prepared for. It also shows the language used for AIDS Prevention Education in the Schools.

	Boys	Girls	English	Kannada	Tibetan
S.S.L.C.	4480	3666	6100	2036	–
I.C.S.E.	378	378	756	–	–
C.B.S.E.	239	950	713	–	476
College	90	110	150	50	–
Total ::	5187 +	5104=10291	7729 +	2086 +	476 =10291

The following tables below summarise the work of INSA/India over the 1st year of this Project.

Table - I

Type of School/ College	AUGUST 91 - FEBRUARY 92			MARCH 92 - AUGUST 92			Grand Total
	Boys	Girls	Total	Boys	Girls	Total	
S.S.L.C.	69	661	730	4480	3666	8146	8876
I.C.S.E.	623	349	977	378	378	756	1733
C.B.S.E.	714	500	1214	239	950	1189	2403
College	–	213	213	90	110	200	413
Total ::	1411	1723	3134	5187	5104	10291	13425

Table - II

Type of School/ College	AUGUST 91 - FEBRUARY 92				MARCH 92 - AUGUST 92				Grand total of Schl
	No. of Schools	Eng.	Kan.	Tib.	No. of Schools	Eng.	Kan.	Tib	
S.S.L.C.	7	6	1	–	28	19	9	–	35
I.C.S.E.	4	4	–	–	2	2	–	–	6
C.B.S.E.	3	3	–	–	3	1	–	2	6
College	1	1	–	–	1	1	–	–	2
TOTAL ::	15	14	1	–	34	23	9	2	49

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TABLE - III

Distribution of men and women covered by AIDS education by the languages used for teaching :

	AUG.91 - FEB.92					MARCH 92 - AUGUST 92				
	Group	No.	Eng.	Kan.	Tib.	Group.	No.	Eng.	Kan.	Tib.
Men	5	420	1	-	3	1	45	1	-	-
Women	5	590	2	-	4	1	96	-	1	-
Total	10	1010	3	-	7	2	141	1	1	-

COMPETITIONS :

POSTER COMPETITION :

In schools where we had covered with AIDS Prevention Education, we decided to conduct a poster competition on AIDS for the High School students. The poster competition was held at three centres on 8-8-1992. The school authorities were very cooperative in allowing us to use the school premises for this competition were St.John's High School, Cleveland Town, Bangalore-560 005, Stella Maris Girls High School, Gayathridevi Park Extn. Bangalore-560 003 and International Year of Child Community Centre, next to R.T.Nagar Post Office, Bangalore-32. In all we had about 130 participants from 10 schools. Through the posters, however we evaluated that the participants knew how to prevent AIDS. Although at the outset we had announced three prizes, the two judges - Mr.Jyothi Sahi, the famous artist and Mr.Prakash Michael, a graduate from the J.J.School of Art felt that none of the posters qualified for a 1st, 2nd and 3rd prizes. Hence, ten consolation prizes of Rs.50/- each were awarded to the following students :

1.	Rekhavathi	Stella Maris Girls High School
2.	Sonal R.	Stella Maris Girls High School
3.	Sheeba Mathew	Stella Maris Girls High School
4.	Swapna Y.	Stella Maris Girls High School
5.	Madhavi Rao	Nirmala Rani High School
6.	Kanicka Mary	Nirmala Girls High School
7.	S.Ugesh Kumar	MGES English High School
8.	Naveen P.	Adarsha Vidya Kendra
9.	R.Shivakumar	Adarsha Vidya Kendra
10.	Cassius Yates	Colonel Hill High School

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DEBATE COMPETITION :

On 10-8-1992, an inter-house debate competition on AIDS was held at Nirmala Girls High School in Ernakulam. The students were well-prepared and each presentation was good, making the final selection a difficult one. The judges for this event were Sr.Shalini, Dr.Prasad and Mr.Bhagwadas. The winning house was awarded a prize of Rs.300/-. This competition provided a platform for reinforcing AIDS prevention messages to all the students from their peers.

QUIZ COMPETITION :

At St.Germain's Boys High School, we discussed the possibility of having an inter-house quiz competition with the Principal, Fr.Menezes and the senior teachers. Permission was granted and on 3-8-1992 the competition was conducted by the INSA/India Faculty with Dr.V.Benjamin as the subject expert. The prizes were distributed as follows :

1st prize Rs.300/- to Aranjo House
2nd prize Rs.200/- to Froger House
3rd prize Rs.100/- to Thomas House

All these competitions were held as a follow-up to the AIDS Prevention Education we had given and it was a good way to evaluate our ability to disseminate information.

AIDS NEWS LETTER :

By 12th August 1992, a total of 34 schools and colleges were covered and though reinforcement of AIDS Prevention were attempted through the Quiz, Debate and Poster Competitions not all schools participated. To target all the schools with reinforced AIDS Prevention Education, INSA/India brought out a Newsletter, which after a brainstorming Session was named "TEEN-AIDS News letter". We planned to keep it short and splice it with cartoons and pictures.

The TEEN-AIDS News letter was also distributed to each Tibetan settlements in Karnataka and Dharamsala, covered during this Project period.

Feed back from the Principals and students about the first edition of the TEEN-AIDS News letter has been encouraging and INSA/India plans to bring this out twice every year.

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AIDS PREVENTION SPIN-OFFS :

Since INSA/India does not have a TV and VCP, we have to hire these from a shop. Soon we had the shopman introducing us to High Schools we did not know existed and we had the shopman motivating the heads of schools he knew to invite us to address the students.

Mr.Paul, who has been doing all our printing had taken our AIDS Prevention Education Pamphlet to the press for printing. Soon he had all the employees of the printing press wanting to know all about AIDS and he was able to give a 30 minutes talk to them. Mr.Paul is the husband of Ehanu Paul's who is a faculty member of INSA/India.

The newspaper agent who saw some of the photographs at the office was eager to know more about AIDS. After hearing about it from the INSA/India staff, he requested us for 200 pamphlets which he promised to insert into each newspaper that he would be delivering the next day saying "this is very serious and it is important for people to know how to protect themselves. The least I can do is to help spread the message and I shall do this free of cost. Usually we charge 10ps.to place a pamphlet in each newspaper".

With severe water shortage in Bangalore we have had to buy tankers of water, so all these boys have received AIDS Prevention Education; so also the rig team who came to drill a well. Besides these, the INSA/India team has been invited to speak with four youth groups in 2 churches, members of the Community Health Cell (an NGO) and 30 seminarians.

Youth groups	–	149
Other groups Men and women	–	50

STAFF INVOLVEMENT :

During the first half of our AIDS Prevention Education Program we realised that it would not be possible for only the faculty to take on the teaching in schools. We soon realised that in most schools we would be addressing almost 300 to 800 or more high school students each time. Yet, we were anxious that each person did not have to deal with more than 100 students each time to allow for some sort of rapport to build up. Hence, we decided to educate all the staff at the office on AIDS Prevention. As a result, the five faculty members plus the two secretaries are all involved with the AIDS Prevention Education in schools. Hidden talents of teaching which lay dormant with our secretaries have now been realised by us and with confidence we can leave them to conduct these sessions.

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In May this year Mr.Bhagwandas and Miss Geetha Lenagee - to Christian Medical College to attend a course on AIDS conducted by Dr.Jacob M.John. They found it very useful in boosting their confidence to take the classes in AIDS Prevention Education in schools, Colleges and for the public. We hope to send our secretaries for the next course that C.M.C. plans to have. The present core IVSA/India AIDS Education team are Mrs.Sujatha Deshmukh, Mrs.Edwina Pereira, Mrs.Phanu Paul, Mr.Bhagwandas, Ms.Geetha Lenagee, Mrs.Charlot and Mrs.Abigail.

CONCLUSION :

When IVSA/India started this project last year, the response from schools were not so encouraging. Perhaps, they were not aware of the seriousness of the problem, or perhaps we were new to them. However, since January 1992, the response has been very encouraging. Perhaps, the one single factor that opened the doors of many institutions to us were the Workshops we have held for the Heads of Schools and Colleges. One of the major fears of the institutions is "how much sex-education will be given". Some of these fears voiced have been "why pollute the innocent minds with information on AIDS" - this because we will be speaking to them on both hetero and homo-sexual transmission and its prevention. Other questions have been "Is there a need to do sex education ?" or "can you omit showing them pictures or talking to them about condoms". At one school we were requested to fast forward a cartoon film which showed what a Condom is ! Fortunately, fewer schools have these inhibitions and most are grateful to us for covering sex education as well. Although human reproductive system is a part of the high school syllabus, many teachers are too embaressed to teach it. As one person informed us "when I come to that chapter I give a set of notes to the students and ask them to read it at home".

It is a pity that our schools are still unable to handle sex education to the students in a sensible way, especially as most parents are unable to deal with it. What is also evident to us is that the students have gained knowledge to sex from friends, cheap ponographic literature and movies all leading towards an unhealthy and perverted attitude towards sex. We hope that through AIDS Prevention Education the students have some access to correct information on not only AIDS but also proper sex education.

It would be wrong on our part to give the impression that our path has been paved with success all the way. Our one big set-back is our inability to have the 'elilist' mission schools involved in this project. We have tried to draw them into Workshops and tried to meet them for discussions but have not been very successful. May be, we need to change our approach. Nevertheless, we will continue to try.

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There is no doubt that through AIDS Prevention Education in Schools INSA/India has walked into an area of work which has brought us in contact with several people, widened our area of knowledge and given us a great deal of confidence to undertake similar projects. We could not have come so far without the unstinted support we have received from our friends. Dr.V.Ravi, from the Department of Neuro Virology, NIMHANS who has been our constant Resource Person at every Workshop, Dr.Jacob John, who came Bangalore on several occasions as our Resource Person for the earlier Workshops, and still is always ready to help us, to our Governing Board Members for their interest and support and finally to Ford Foundation and to Dr.Saroj Pachauri, their consultant, without whom this project would never have taken off. We are thankful to them for having seen the potential in us and for having the faith in us and look forward to our continued collaboration.

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REPORT OF INSA/INDIA'S AIDS PREVENTION EDUCATION IN
High Schools and Colleges of Bangalore
& Tibetan Resettlement Colonies in India.

INTRODUCTION :

Early in January 1991, INSA/India did a preliminary survey of schools to determine how many would be willing to have the INSA/India team visit their schools and talk to their students on AIDS. The survey was conducted by INSA by sending out letters with a stamped and self addressed post card where the concerned authority only had to tick the appropriate box, stamp it with the school seal and return it to us

A total of 400 letters were sent after we had procured the list of schools with their addresses from the Inspectorate of Schools. Of the letters sent, we received 36 positive replies. We decided to start with this small group of schools.

However, before we launched the programme, we realised our need to have ourselves trained, since whatever knowledge we had of AIDS was from books. Hence, a request was made to C.M.C, Vellore, who readily agreed to do a special 3 days' training programme to meet our specific needs. The course, structured by the Department of Virology and Psychiatry, was interesting, informative and thought provoking. It had us discussing for hours long after class trying to find answers to some of the psycho-social problems this minute, invisible virus caused in the trail of havoc it leaves behind. This course also gave us the opportunity to interact with those C.M.C staff who were in charge of the AIDS programme there.

Further collaboration with Dr. John was discussed which resulted in two workshops being conducted by Dr. John and expenses for which were met by C.M.C. This was a big help since INSA/India had only a meagre budget of Rs.10,000/- placed aside for AIDS education till the grant was received.

WORKSHOPS :

Two Workshops were conducted with the help of Dr. Jacob K. John; one was for 14 Heads of Schools and the other was for 11 Religious Heads. For both Workshops we had invited 20 persons but for various reasons, known and unknown, all did not attend. The main reason for only 14 Heads of Schools attending was because the Workshop was held on a day when most schools reopened. We have learnt our lesson and in future will consult the school calendars. For the Religious Heads Workshop, we had invited 5 Muslim Mullas, 5 Hindu Priests, 5 Roman Catholic and 5 Protestant Priests. Although all agreed to come even on the morning of the Workshop, we had only 8 persons who eventually turned up plus 2 ladies (psychologists) who were interested in attending. In all, we had 5 Roman Catholic priests, 3 Protestant priests, one person from the Universal Brotherhood, no Hindu or Muslims. At both Workshops Dr. John encouraged group discussions on dealing with real life situations.

Participants were asked to look at their existing staff policies in case someone became HIV positive. Much time was spent in discussing how to counsel HIV positive persons and how to develop support groups. Some excellent films were shown.

These two Workshops were followed with another for 25 of our INSA/India graduates who are working in the field and have not had the opportunity of knowing about AIDS. This because INSA/India started integrating the subject on AIDS only from the 13th Training Programme onwards in 1989. The 25 persons who were invited came from various parts of South India. The Workshop was for 3 days and the entire expenses were met by I.H.O, Indian Health Organisation. Dr. Vijay Thakur of I,H.O was our main resource person.

All the participants found the Workshop very useful and informative. A great deal of time was spent by Dr. Thakur on how to counsel a person with HIV infection and also his/her relatives. Each session was supported with group discussions and an appropriate movie. Two of the 25 participants who attended this Workshop have returned to their projects and developed AIDS prevention education in a big way. Sr. Sudha who is in Bhilai has begun a project covering all her schools while Sr. Mary Jacob at Kambampadu village of Vijayawada District has been doing an intensive education programme in her village in Andhra Pradesh as can be seen from her letters.

The first school covered on January 1991 was a Corporation High School where, in two sessions, we addressed approximately 350 girls. The next was a convent with 120 well-informed students. Then, from January to July, we covered the schools and the adult population in three of the major Tibetan resettlement colonies in South India.

INSA/India and Ford Foundation :

Having done the above spade work and gained some experience, we had a sound base to launch the AIDS Prevention Education in Schools on a wider scale. Hence, when we received the grant from Ford Foundation in August 1991, we stepped up the pace of coverage. The following tables show the extent of schools, colleges and adult population covered before and after receiving the grant, the languages used for teaching and the type of schools covered :

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SCHOOLS COVERED BEFORE GRANT WAS RECEIVED (JANUARY - AUGUST 1991)

TABLE I

Distribution of students covered by AIDS education by the type of school/college they attend :

Type of School	Boys	Girls	Total
S.S.L.C	-	350	350
C.B.S.E	-	120	120
I.C.S.E	222	333	555
College students	-	-	-
Total	222	803	1025

TABLE II

Distribution of Institutions covered for AIDS education by the language used for teaching :

Type of School	No. of Schools	Languages used Eng.	Kann.	Tib.
S.S.L.C	1	1	-	-
I.C.S.E	1	1	-	-
C.B.S.E	3	3	-	-
College	-	-	-	-
Total	5	5	-	-

TABLE III

Distribution of men and women covered by AIDS education by the languages used for teaching :

Adults covered	No. of groups	Languages used Eng.	Kann.	Tib.	Nos.
Men	2	-	-	2	400
Women	3	-	-	3	250
Total	5	-	-	5	650

SCHOOLS /INSTITUTIONS COVERED AFTER RECEIVING GRANT FROM AUGUST 1991 TO FEBRUARY 1992:

TABLE IV

Distribution of Boys and Girls covered for AIDS education by the different systems of education :

Type of School/college	Boys	Girls	Total
S.S.L.C	69	661	730
I.C.S.E	628	349	977
C.B.S.E	714	500	1214
College	-	213	213
Total	1411	1723	3134

TABLE V

Distribution of types of schools covered for AIDS education by languages used for teaching :

Type of school/college	No. of schools	Languages used Eng.	Kann.	Tib.
S.S.L.C	7	6	1	-
I.C.S.E	4	4	-	-
C.B.S.E	3	3	-	-
College	1	1	-	-
Total	15	14	1	-

TABLE VI

Distribution of men and women covered by AIDS education by the languages used for teaching :

	NO. of group	Total No.	Language used Eng.	Kann.	Tib.
Men	5	420	1	-	3
Women	5	590	2	-	4
Total	10	1010	3	-	7

Contd..P/-

TABLE VII

Distribution of adults covered for AIDS education by their setting :

Adults covered	Church Club	Tibetan Community	Slum	Total
Men	-	420	-	420
Women	40	535	15	590
Total	40	955	15	1010

INSA/India - AIDS QUESTIONNAIRE

Name of School : .....

Class/Std .....Institution (SSLC, ICSE,ISC.....)

Your Age : ..... Religion .....

Medium of Instruction :..... (English, Kannada, Tamil ,

Tibetan, Hindi, Others .....)

	TRUE	FALSE	DON'T KNOW
1. Human Immunodefiency Virus causes AIDS.	☐	☐	☐
2. An HIV infected person can look and feel healthy, but can pass the infection to others.	☐	☐	☐
3. An HIV infected person may not suffer with AIDS for many years.	☐	☐	☐
4. The HIV infection is passed on from person to person mainly through			
Sexual Intercourse	☐	☐	☐
Blood Transfusion	☐	☐	☐
5. You can get AIDS by mosquito and bug bites.	☐	☐	☐
6. Sharing infected needles and syringes can pass on the HIV infection.	☐	☐	☐

7. Greeting friends with hugs and kisses can pass on the HIV infection. ☐ ☐ ☐

8. Use of good quality condoms/ Nirodh during sexual intercourse reduces the chances of getting infected with HIV. ☐ ☐ ☐

9. Oral contraceptives like Mala-D can protect you from becoming infected with HIV during sexual intercourse. ☐ ☐ ☐

10. AIDS can be cured with expensive treatment. ☐ ☐ ☐

The above table has since been changed, the revised table will be printed out in our next report.

From the above table, the answers received during the pre and post tests show that the areas requiring more knowledge were with questions 2a & b, 5,7,8 and 9. The table shown has been recorded from the answers received from 291 High school students where areas lacking in information can be seen.

CONCLUSION :

This report covers only 6 months that is from mid-august to the end of febtuary 1992. However, since this report has been delayed it would not be out of place to state that from February to July 1992, we have covered 34 schools. A detailed report concerning this will be submitted by the end of August 1992.

We, at INSA/India, thank Ford Foundation for helping us to launch this project which, like the proverbial ripple, has spread correct information on AIDS to many.

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International Nursing Services Association
RURAL HEALTH DEVELOPMENT TRAINERS' PROGRAMME
AIDS EDUCATION PROGRAMME

REPORTING ON THE AIDS PREVENTION EDUCATION IN SCHOOLS FOR THE PERIOD MARCH 1993 TO AUGUST 1993

INTRODUCTION :

This report covers our work done from March 1993 to August 1993. With exams just round the corner no school or college was keen to have us visit the schools and take up the class time. Hence this period was spent by covering Youth Clubs, updating our knowledge and acting as Resource Persons for various seminars in and outside the city.

MARCH 1993

Mrs.Charlet, Mrs.Abigail Thomas and Mrs.Tina King attended the four day Course on AIDS, organised by Dr.Jacob K John and the Psychiatric Department of C.M.C.Vellore. We felt it necessary to send these three ladies for the course, because, with the increase in the number of requests for AIDS Prevention Education the INSA/India Faculty found it difficult to meet the demand. Secondly in most High Schools, classes were found to have more than 600 to 800 students making it impossible for only the faculty to teach. Hence, it was decided that we would send our three secretaries for the course. They returned feeling very confident to be able to impart information. What we discovered was that they are excellent teachers and are now actively involved with the AIDS Prevention Programme. March also saw the end of the XXth Training Programme, through which 14 Participants of the Rural Health and Development Training Programme received AIDS Prevention Education Programme. Several of them have returned to their organization with plans to begin AIDS Prevention Education.

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87, 1ST FLOOR, 3RD CROSS, NANDIDURG ROAD EXTENSION, BANGALORE - 560 046.

APRIL 1993

A lot of time was spent contacting the Commissioner of Public Instruction (CPI) and the three Deputy Directors of Public Instruction (DDPI) to have them collaborate with INSA/India and have the Principals of the schools under their jurisdiction to attend the Workshop on AIDS Prevention Education in schools and Junior Colleges. We also contacted the Commissioner and Joint Director of Youth Clubs for Bangalore. We felt that an important section, namely the young adults, were not being reached by us. With this in mind, we decided to contact the youth clubs in the city.

The three DDPIs, the Commissioner and Joint Director of Youth Clubs were very supportive of our programme and extended all cooperations. However it must be mentioned that to meet each we had to make more than ten trips a lot of time and energy spent, but worth it in the end. A lot of time was also spent by the staff collating the Pre and Post test questionnaires completed by High School and College students.

MAY 1993

The INSA/India team was invited to talk on AIDS at one Youth Club and at two slums in the city. The slum programme was organised by one of the NGOs working in the area.

Some of the interesting questions we had were :

1. Earlier it said AIDS came from forestpeople and they started destroying it is it true ?
2. Can the virus be killed by boiling it for 20 minutes ?
3. Even if the blood is removed from that person then does it cure the person ?
4. Why can't doctors and blood banks be made more responsible ?
5. If a faithful housewife gets HIV/AIDS, whose to blame?

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6. What care is given in other Countries for an AIDS case?
   How applicable is that care here ?
7. So far, what is the families' reaction to having one of their members infected (in India) ?
8. What else can we do to help prevent AIDS ?
9. If we change the infected blood then can we get rid of the disease ?
10. If we have oral sex only with our partner regularly do you think I can get AIDS ?

JUNE 1993

Since most of the schools were just reopening, it was difficult for the INSA/India team to be given a slot by the managements.

A paper was presented by Sujatha de Magry on AIDS Prevention Education in schools at the Respect for Life Conference at Bangalore. Bhanu Paul who had left for a Course with INSA/USA presented a paper on AIDS Prevention Education in schools at the NCIH at Washington, plus she was also asked to chair a panel discussion. Both of which she did well and was appreciated.

JULY 1993

The momentum of reaching the Youth began to increase, with several invitations coming in. Seven Youth Clubs were covered. A total of 400 youth attended the sessions. With further request to speak at slums, INSA/India carried it programme to 387 people in slums.

July also saw us busy with preparation to translate the much used film 'Karate Kid' into Kannada. Having received permission from Street Kid International, Canada, we have successfully dubbed the film. This will be a big advantage with the teaching as this is one film that has been frequently used by us for all groups; one that is enjoyable and at the same time gives accurate information and the desired message. We now have the Kannada version for sale. The money for this was raised by Interventions at the Pubnite.

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AUGUST 1993

Three workshops are being organised for Heads of Schools from each of the Zones. Each Zone has approximately 300 schools, some of which we have already covered. Three Workshops are planned for 17th, 18th and 19th. At each Workshop there will be 50 Principals. A consolidated report is enclosed herewith.

The AIDS Education Programme was conducted in 8 schools covering 831 boys and 993 girls in their teens during this month.

The INSA Teen AIDS Newsletter (a copy of which is enclosed) was sent to the 116 schools and colleges that we have so far covered with AIDS Prevention Education.

Plans are also underway to conduct an indepth AIDS Education Programme for deputed teachers from the High Schools and Colleges we have so far covered to be able to carry on the AIDS Prevention Education Programmes for the subsequent batches of students.

CONCLUSION :

There have been no staff changes nor any on the Governing Board. All of us thank Ford Foundation for their continued support.

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REPORT ON HEALTH ACTIVITIES UNDERTAKEN IN H.D.KOTE PROJECT

INTRODUCTION:

Health Sector has been one of the most important and key program area in MYRADA/PLAN H.D.Kote Project. The primary aim of the Project is to establish a micro level primary health care development system, which could be managed and sustained by the community at the village level. It has been observed that there has been good support, cooperation and involvement of the people and Govt. in all our health activities.

It would be quite difficult to consolidate the health activities which the Project has implemented during the last decade. However, we will try to mention the activities undertaken by the Project. The entire health activities can be broadly classified into :

I. Preventive Health Care.

II. Curative Health Care.

III. Development of Individual and Community Health Infrastructure.

I. PREVENTIVE HEALTH CARE PROGRAMME :

The following are some of the programs:

1. In order to bring down the infant mortality rate from 120/1000 in 1981 to 70/1000 by 1995 the following programmes were undertaken.

   A. Training of Village Birth Attendance (Dais): Every village has a traditional birth attendant and she is basically called as 'Sollagathi' (Village Traditional Dais). She attends to all the child births in the village. Though she did not undergo any systematic training in maternity practice somehow, she manages her job. She is backed by vast experience. She comes from the lower strata of the society, but is acceptable to the community. Her services are inexpensive. She is available in the village all the time. However, she carries her profession in the traditional way and uses orthodox methods and about 80-85% child delivery is done by her at the village level. Lack of appropriate modern scientific outlook, absence of aseptic technic and antiseptic precaution often leads to untold misery like foetal maternal death at times. Dais and villagers both accept this as fate. Added to this, most of the Dais are illiterate and their services are restricted to home delivery practice only.

   MYRADA/PLAN H.D.Kote Project with the help of Self-Help Credit Groups (SHCGs) were able to identify such dais and organised a training course of short duration, to make them better suited for conducting aseptic home maternity practice. Through proper exposure, the linkages between proper antenatal/postnatal care, breast feeding, child care, preparation of nutritious food using locally available materials, oral rehydration therapy(ORT), immunisation to children and pregnant women, hygiene and home sanitation, etc., were made clear to them. Once the training programme was completed, a small kit/bag containing scissors,

dettol, cotton, neem oil, soap, blade, thread, 1 1/2 mtrs rexin cloth, one note book, pen, saree and such essential items required to conduct home deliveries especially under better hygiene condition were given to them. This was regularly replenished by the Project. The dais previously used old knife, sickle, etc., to cut the umbilical cord of the new born babies. Consequently, neonatal, tetanus/maternal deaths were in alarming number. These Dais now wash their hands with soap and water thoroughly, before touching the case and use a sterilized sharp scissors or safety blade to cut the umbilical cord. They also motivate the pregnant woman to go to the nearest PHC to get tetanus toxoid (TT) atleast 2 times during the last trimester of pregnancy. These dais also inform all pregnant women that she would attend to the child birth only if the pregnant lady is vaccinated. This motivates them to oblige and follow the vaccination schedule.The saree was to be worn by the Dai only when she would go to conduct the deliveries. The note book and the pen were given to record the date and name of the woman who delivered. As most of the Dais were illiterate, this would be written by one of the SHCG members, or by an Anganawadi teacher, if she was available.

Dais meeting would be arranged at the cluster level once in 2-3 months and the information of the work done would be documented by MYRADA/PLAN staff (Sector Officer/Extension Officer). For every aseptic delivery she conducts, she gets Rs.5/- , which comprised of Rs.3/- for aseptic delivery, Rs.1/- if the pregnant women is motivated to get 2 TT injection and Rs.1/- if the dai visits at least twice the mother and child within one month. From the past 4 years, the Project has trained 252 Dais and these Dais have conducted 10947 aseptic home deliveries.

B. VILLAGE HEALTH PROMOTERS(VHPs): These persons are also identified by the SHCGs and MYRADA/PLAN staff. The VHP usually would have an education qualification between V to X std. and may be a boy or a girl. Even Anganavadi teachers are selected. These VHPs undergo a residential training varying from 10-20 days and are trained in community health activities in order to support the traditional dais work, like organising immunisation camp, promotion of nutrition Program, personnel hygiene, development of homestead plots, maintenance of sanitary surroundings, first aid, etc. So far, the Project has trained 65 VHPs. These VHPs create awareness on various health aspects which are essential among rural women and men. These trained VHPs organise health education classes on the importance of immunisation, safe drinking water, demonstration of ORT, promote astra ole and kitchen garden, etc. This has enabled many people to pay attention to health related issues. They are also reoriented once in 3-6 months.

The above activities has been able to bring down IMR to 74/1000.

The Dais and VHP supplement and complement each others work at the village level. The focus has been to train more Dais and VHPs, so that each village will have the above, thus leaving behind grass root level workers, who will take care of community health activities when the Project phases out.

2. Health Fund:

The SHCGs were encouraged to start a health fund on their own. The SHCGs members contribute between Rs.10-25/- each and a matching grant @ 1:1 to 1:4 is given by the Project. The fund is part of the Common Fund, but this fund is kept separately and is used only for health needs of the members. The purpose of the fund is to ensure, speedy,

timely and necessary cash to meet medical needs of the family, so that the family do not fall into clutches of money lenders during such emergencies. Normally, the SHCGs charge very little or no interest. Money is returnable in easy installments and is managed by them. So far almost 70% of the SHCGs have health fund in their groups and the fund is managed solely by them.

3. Immunisation to children and pregnant woman:

The Project also assists the Government Health Department in organising immunisation to children 0-5 years (DTP, BCG, measles) and pregnant woman. The pregnant women and children are identified by our Dais. The VHPs and Dais arrange a meeting of all pregnant woman and mothers whose children need to be immunised. The Govt. health educator educates the community and a date is fixed for the immunisation camp. Usually, the Govt. personnel with vaccines are sent by the Project jeep and immunisation is conducted at one time covering 3-5 villages in one day. In emergencies when there is shortage of vaccines, the Project helps to get the vaccines, so that immunisation is conducted on time.

4. Nutrition Program:

The following are some of thenutrition programmes undertaken :

a) The programme was initiated after the Child Baseline Survey. The malnourished children survey identified areas of malnutrition. Selected villages were taken up for the implementation in 1991. The coverage was for 12-60 months old children. In 1992 it extended to pregnant and lactating mothers. Now the identification of children is done by Anganwadi Teachers who are trained by the Project and is verified by the Govt. medical doctors in camps, organised by MYRADA/PLAN. Children are weighed before, during (every month) and at the close of the programme. Records of weights are maintained by the Anganwadi teachers. Each SHCG has put up a time table and entrusted few members in the group to be responsible for timely supply of supplementary food which comprises of ground nut with jaggery, eggs, milk, mango or papaya, banana, boiled bengalgram, etc. The SHCGs also undertake preparation and distribution of food to the children and mothers. About 961 women and 962 children were covered from the past one year. Before the programme is taken up all the children to be covered under this programme are dewormed. A total of 1713 children were dewormed in the last Fiscal Year (July '92-June '93) and were also given Iron and B complex tablets, thereby combating worm infestation.

b) Poultry Birds (4+1) were distributed to 869 chronic patients suffering from TB, anemia, malnutrition, etc., for rearing and using eggs for consumption, so as to improve the patients nutritional status of food intake.

c) Vegetable Seeds: Six to eight different hybrid varieties of vegetable seeds, including greens of high nutritive value were distributed to 10964 families from the past 4 years to develop kitchen garden through the SHCG, so as to consume the same and enrich their nutritional food intake.

d) Family Planning: In order to propagate Family Planning and encourage small family happy norms 16 Family Planning Camps were conducted and 1379 women underwent laproscopy and tubectomy operations. These women who underwent the above operations were assisted with nutritious food like 50-75 kgs of ragi, 5 kg of different pulses (Bengalgram, Greengram, Dal), 10 kgs of wheat and 2 kgs of oil, with a view to ensure at least 15 days rest for them, otherwise they would go in search of casual labour, as they need to earn their livelihood and this would affect their health. The Govt. would contribute Rs.135/- per women, who underwent the above operation. This program was done in collaboration with Family Planning Association of India, Govt. Health Department and Dais, who were trained by MYRADA/PLAN.

5. Health Education:

Community health education was imparted in 95 villages in last Fiscal Year for a duration of half a day to 2 days. The trainings were organised by the Project and was conducted by Govt. health training team. Subjects dealt were immunisation, mother and child care, breast feeding, personal hygiene, supplementary nutrition food preparation, ORT, first aid, epilepsy, use of astra ole & biogas, etc.

II. CURATIVE HEALTH CARE:

1. Hospitalisation:

This program is restricted normally to Foster Families. Whenever the families have to undergo major hospitalisation and the families do not have the capacity to meet the requirements, the Project meets the entire expenditure of the patient and is treated as a grant. The SHCGs monitors and keeps control over the actual expenditure and disbursement of money. Usually, it is reimbursement of the SHCGs, after they have spent the money on the patient, after proper approval from the Project. The travel and food expenses are borne by beneficiaries except in few cases, where MYRADA/PLAN meets all the expenses on genuine cases. So far MYRADA/PLAN has assisted 356 patients from the past 5 years.

2. Training for the Blind:

An Officer was deputed from the "Centre for the Rehabilitation of the Blind", Bangalore. A total of 33 young blind men were trained to be independent of others for their day to day activities. 12 of them were enrolled in the school for the blind in Mysore.

3. Rehabilitation of the Handicapped:

The District Rehabilitation Centre for the handicapped, Mysore, came forward and requested MYRADA/PLAN's assistance to identify the physically handicapped/ retarded children and they offered to treat them. Several camps were arranged in collaboration with the Project. The centre has supplied hearing, walking aids, crutches, etc.

Where surgery was required, the Centre arranged for it in the Govt. and JSS hospitals, they charged for medicine and surgery, which was borne by the Project. About 57 members benefitted from this Programme, during the last Fiscal Year (July '91 - June '92).

Health Camps:

20 health camps were organised. This includes eye, leprosy, skin, TB, blood, general checkup, etc. A total of 3524 patients attended these camps. The Programme was chalked out by the Project and a team of Doctors from Mysore, visited these camps. Eye camp was organised in 2 villages in collaboration with Lions Club and Swamy Vivekanands Youth Movement (Voluntary Agency). About 265 persons were treated in both the camps. Operations were conducted and spectacles were provided. Food was supplied by the Project and cost of specialist fees, accommodation, travel and drugs were borne by the above agencies.

III. INFRASTRUCTURE DEVELOPMENT:

The following are some of the Health infrastructure development programmes, taken for both individual and community.

A. Individual Health Infrastructure Development Programmes:

1. Housing: So far the Project has assisted the community to build 2008 houses for houseless Foster and Target Group Families. The houses are 20' X 12' sq.ft with 2 windows, 2 ventilators and one door. The families have contributed site and unskilled labour, apart from daily supervision. From the past 2 years, the Project has not been using wood for all its construction programmes. The target is to provide houses to all houseless Foster Families by Fiscal Year '96.

The Project has also assisted 525 families for repair of their houses. Materials like tiles, bricks, doors, windows, cement for flooring and plastering of walls and roofing materials have been provided to improve their housing condition, thus providing basic shelter.

2.Electrification of houses: So far 2544 families have been assisted for electrification with 2 bulbs and a socket to their home. The cost of electrification comes to Rs.900/- to 1200/-, of which 15-20% is contributed by the families. This programme will not only lessen the expenditure on the cost of scare kerosene, but will also provide better environment and encourage school going children to study.

3. Low Cost Latrine: Low cost latrine has been taken up in the Project area from the past 5-6 years. Though, we have installed more than 1200 latrines, most of them are not being used and this programme is unsuccessful. On analysis, we find that it was wrong selection of villages, as well as beneficiaries and in most of the places, adequate water was not available. Only the low cost latrine slabs were distributed and we expected the families to build walls around them. Therefore, the programme failed. Now a new low cost latrine UNICEF model is introduced in collaboration with Govt. The Govt. supplies one bag of cement and low cost latrine unit, which comprises of cumoed, vent pipe, and fly trap. The Project supplied bricks and skilled labour. This program was taken only where Potable Water systems were commissioned and 281 latrines have been completed in FY 92 and the programme is found to be successful. 2 community latrines and 20 school toilets were also constructed with the purpose of maintaining hygiene in and around schools and community surroundings.

4. Astra ole & Biogas Program: In order to encourage families to use smokeless efficient stove, astraole was introduced. This helped the families to have smokeless kitchen, reduced the time for cooking and also reduced fuel cost. This program greatly benefitted the women who would have inhaled the smoke, which would have had an affect on the eye and lungs. The Project has built so far 4219 astraoles from the past four years.

Apart from this 300 biogas plants of 1 cubic metre and 122 plants of 2 cubic metre has been constructed and commissioned from the past 5 years in the Project area.

B.COMMUNITY HEALTH INFRASTRUCTURE DEVELOPMENT:

1. Potable Water System: In order to ensure community have access to safe drinking water supply and so contribute to a reduction of infant mortality, adult mortality and reduce water borne disease, 93 villages were covered under this scheme. The community and Govt. contributed almost 30-50% of cost. But only in 50 villages, the scheme has been commissioned. This is basically because though 30 systems are completed in all respects, these systems are pending because they have not been energised by the Karnataka Electricity Board. To preserve the quality of water, platform construction around taps, cleaning of the potable water tanks twice a year, is done by the community and local Govt. Apart from this, 23 villages have also been assisted for extension of pipeline as the villages have grown. Platform construction and animal water trough are made necessary components of the system. Management of the system once commissioned is the joint responsibility of the SHCG and local govt (Mandal).

   The Project has also arranged 5 batches of training to men and women for a duration of 2-3 days each on borewell handpump maintenance. Main subjects dealt were maintenance of handpumps, methods of preventing water from pollution, role of rural women and children in the maintenance of handpumps, need for environment education to community and control of water borne diseases. The Govt. has contributed roughly around Rs.10 lakhs during the past 3-4 years towards implementing potable water scheme..

2. Support to Govt. Primary Health Centres and Primary Health Units: Supporting the Govt. PHC and PHUs with basic construction (1 maternity ward, 2 family planning sub centres, 1 dormitory for general hospital) and equipments (X-ray machine, refrigerator, beds, sterlisers, dental unit, etc.,) has strengthened the much needed infrastructure development of the existing govt. medicare system, which would help to provide assistance towards curative health.

3. Drainage: U shaped stone slab drainage with cement patch work was taken up in 21 villages of the Project area involving SHCGs, Mandal Panchayat and the residents of the respective villages. In 5 villages the drainage work is completed. The villagers dug trenches and contributed unskilled labour.

PROSPECTS:-

Construction of houses to houseless families, Potable water, electrification of houses, drainage & promotion of nutrition programs to malnourished children and pregnant women, immunisation to children and pregnant women will be taken on a massive scale in the next 4 years, so that all the target group families will have basic shelter, safe drinking water, better hygienic condition and will improve the status of malnourished children, thus bringing down IMR, with Govt. and community participation and contribution. The health fund which has been established will be further strengthened with community contribution, participation and management. The focus will be on training more Dais and VHPs, so that each village will have the above, thus leaving behind grass root level workers, who will take care of the community health activities, when the Project phases out.

COMMUNITY HEALTH PROGRAMMES

Department of Community Health
St. John's Medical College Bangalore 560 034

C O N T E N T S

As a Nongovernmental body of many years standing, the Community Health department of the St. John's Medical College has developed for itself significant social commitmments. The main focus of the activities of the Department of Community Health is on the following areas:

1. Development of Health Training Programs for auxiliary and lay personnel.
2. Coordination of training efforts with the Health Needs of other Voluntary organizations.
3. Enhanced collaborative research with private Voluntary organizations and Governmental health sector.
4. Developmment of Extension education capabilities by the Department.
5. Evolution of problem based learning methodologies for medical, paramedical and lay training.
6. Staff development by way of exposure to varied training and research oppurtunities at all levels of trainee capabilities, thus emphasizing the place of "Health Team" approach in training.
7. Development of Urban training and research oppurtunities in anticipation of future health needs.
8. Opening up of exciting frontiers in medical science research such as PRA techniques, qualitative research methodologies, plantation medicine specifics etc.

STAFF POSITION OF THE DEPARTMENT

Doctors	-	11
Para-medicals	-	7
Others	-	5

HEALTH CENTRES UTILISED FOR TRAINING/ SERVICE/RESEARCH ACTIVITIES

	Place	Catchment Population
1. Urban:	a) Shanthinagar Urban Hlth.Centre	51,000
	b) Rajendranagar Slums	5,700
	c) Lakshmanrao Nagar Slums	7,000
2. Rural:	a) Dommasandra Pri.Health Centre	48,000
	b) Anekal Pri.Health Centre	56,000
	c) Bidadi Primary Health Centre	43,000
	d) Mugulur Sub-centre	10,000
	e) Solur Health Centre	5,000
	f) Sriramanahalli Health Centre	10,000
	g) Hoskote Health Centre	20,000
	h) Kalakunteagrahara Health Centre	7,000
	i) United Planters Association of Southern India Estates	

PROFESSIONAL TRAINING PROGRAMMES

I. Under-graduate Medical Education

a) Rural Orientation Program Camp
Conducted during the months of January-February, the main objective of the camp is to expose the medical students to the various facets of rural life through a residential program at the Mugulur Health Centre. The students visit all the rural sub-centres and are guided in determining the various factors which govern rural life such as Agriculture, Animal Husbandry, Small Scale Industries, Fairs, Festivals, Customs and traditions, Commerce and Trade, Transport, Traditional systems of health, Housing and Environment, Role of women in Society, Maternal Care practices, Child Care practices and Food practices. These are presented in the form of field projects by groups of the students. An additional feature is their exposure to many innovative teaching methodologies such as simulation games etc. In addition,the students also organize many "Child to Child" health education programmes, Mothers motivation programs, Health Teaching etc. Faculty of the Department of Community Health are resident at the camp throughout.

b) Community Health Action Program Camp (Rural/Urban)
This is a program for the VII term senior Clinical students and has an Urban and Rural component. It is conducted for four weeks duration.

i) Urban Component: It enables the student to understand delivery of health care in urban areas, assess the effects of the workplace on health and to plan a health intervention strategy for a specified group. It also allows him a bird's eye view of the Nongovernmental sector in health care.

ii) Rural Component: The student studies clinical problems in the context of family and social parameters and can assess the status of the community by collating and analysing data collected by qualitative and quantitative epidemiological techniques. He also arrives at an understanding of the rural health care delivery system and the functions thereof and can plan and carry out an appropriate health education program for the community.

c) Clinico-Social Case Work

This is conducted every month, by posting them in batches to the rural and urban health centres. Their training involves case work in the field, working up the social aspects of a number of communicable diseases as well as antenatal cases. The objective is to train the students to consider a case as a holistic health care problem rather than a mere clinical entity. The socio-economic causes,contributing factors and consequences of major diseases are highlighted in this training program in addition to the usual clinical features of the diseases. An important feature is the study of health care utilization by patients and the implications of such patterns.

d) Institutional Visits

This is an effort to expose our students to real life situations, they are taken to various health institutes, field projects and institutions of public health importance. Here they get a chance to interact with other health agencies and their staff and get an idea of actual field problems in health care.

e) Seminars, Symposia and Lectures

Over 400 hours are spent in the theoretical and practical training of medical students during the course of their undergraduate period. All subjects ranging from Maternal and Child Health, Epidemiology and Nutrition to Behavioural Sciences, Health management and National Programmes are taught using conventional and innovative teaching techniques.

f) National Service Scheme (NSS)

Under this scheme, the medical students carry out community health and development projects at various villages in batches once a week. In contrast to the generally known NSS activities, the NSS program of this institution aims at highlighting community health and community development as the main features of this service. Education for school children, adult education, school health education, improving environmental health, afforestation etc., are some of the main components of this program.

g) Rural Internship Training Program
All interns, in batches are posted to the Rural Health Centre for a period of three months each. They are posted to all the rural centres enumerated earlier which includes Plantation Estate hospitals, Non-government organization hospitals and Government hospitals.Apart from managing the rural clinic, these interns are also involved in epidemiological surveys, domiciliary visits, domiciliary deliveries, immunization and school health. Besides, they participate in all the other rural services programmes conducted by the department. They have successfully participated in field evaluation surveys for immunization coverage (UNICEF) in remote villages in a number of Districts in Karnataka.

h) Elective Training for Foreign Medical Graduates
Students from Universities in U.K., New Zealand, Holland, USA, Germany, Sweden, Australia, Ireland undergo 4 weeks posting in our department. They are trained through participative learning in our Rural & Urban Slums Field Health Programmes.

II.Post-graduate Medical Education:

a) M.D. (Community Health)
This course commenced from February 1991 with a course capacity of 2 students each year. The stress is on field based and experiential learning. Thesis topics are directly related to evaluation of ongoing departmental field programmes, so that outcomes are utilised for betterment of programmes. Self-learning, Seminars, Group discussions and Field visits to other health projects, are the methodologies followed. The thesis topics chosen are as follows:

i) Evaluation of Community Health Workers Course conducted by St. John's since 1981 - 90
ii) Health System Analysis and Evaluation of Plantation Health Services at United Planters' Association of Southern India Estates.
iii) Health Needs Assessment in Rural Field Area of Mugulur Health Centre.
iv) Health Seeking Behaviour of a Rural Population
v) Deployment of School children in promoting CSSM in a rural community

b) Academic Exchange Program
A formal Academic Exchange program has been established with LUND University, Malmo, Sweden. The objective was to promote exchange of Post-graduate students for shared field experiences in Community Health. One of our post-graduates conducted a study on "Evaluation of Community Participation in Alcohol Prevention Program in Kirseberg, Sweden" . Likewise two of their students undertook a field study in our health centres on " Follow-up of Pulmonary Tuberculosis treatment in India"among other programs.

III. Continuing Medical Education:

a) For Government Medical Officers
Under the Child Survival and Safe Motherhood Program of the Government of India and UNICEF, 60 medical officers of the Karnataka Health Services have already been trained by faculty drawn from our staff. We have also conducted various courses under the Universal Immunization and Oral Rehydration Therapy Program of UNICEF and Government of India at our institution.

b) Colloquium for Practitioners of Indigenous systems of Medicine:
Forty practitioners of the disciplines of Homeopathy, Ayurveda, Siddha, Unani, Herbal, Herbo-mineral, Acupressure and Acupuncture, Yoga participated in a One-day Colloquium held during May 1991. Invited Allopathic Specialists from our hospital had an opportunity to interact creatively with these Indigenous practitioners. The main objective of this colloquium was to bring about a mutual appreciation of the basic principles of the various systems.

c) Plantation Medical Officers Course: As part of our collaboration with UPASI, a refresher course is conducted for Medical Officers of various plantation hospitals. We have also conducted specific training workshops at the plantations and our department. The topics covered range through Rational Drug Therapy, Pesticide Toxicity Management, Health Care Financing, Health Information Systems and Health Records Maintenance and Health Welfare Audits.

IV. Nursing Education
The categories of Nursing students trained in Community Health include:

i) Diploma Certificate Course in Nursing and Midwifery
ii) Post-Diploma B.Sc. in Nursing
iii) B.Sc. Nursing

Apart from the regular didactic lectures in Community Health topics, the main involvement of the department is in the Rural Training Camps. The objectives are similar to the Rural Camps of medical students. Each camp is of ten days duration at the Rural Health Centres and conducted in collaboration with the staff the College of Nursing.

TRAINING OF AUXILIARY WORKERS

I. Community Health Workers Course

This programme is designed to train lay persons working in difficult areas in the basics of health care and health referral. It is a 3 month course conducted at the Mugulur health Training Centre of the College.The course content is arranged in an easily understood life cycle format and a problem based style is adopted for the training. Topics covered include First Aid, Home Nursing, Natural Family Planning, Herbal Medicine, Counselling, Community development and Human Biology are also conducted. The posting comprises mainly of various field projects on the Dynamics of rural life, rural Mobile clinic work, Domiciliary deliveries, Maternal and Child health, School health etc. Rural Project Planning and Management of health centres is also taught to the community health workers. Inclusive of the current 28th Basic course for Community Health Workers, a total of 536 Community Health Workers from every state in India and also from Nepal have been trained.

II. Anganwadi Workers Training Program (Karnataka State Council for Child Welfare)

This is conducted twice a month at our Rural Centres throughout the year. The trainees are both pre-placement and in-service. The topics covered First Aid, Applied Nutrition, Peoples'organisation & participation, Antenatal/Intranatal/ and Postnatal care, Psycho-social problems in children, Safe Drinking Water, Blood and Anaemia.

III. Traditional Birth Attendants (TBAs)

a) Contact Training Program:

A one day program to create awareness of scientific antenatal, natal, postnatal care among the Traditional Village Midwives in our field practice areas of our rural centers in order to reduce Maternal Mortality. Training programmes for 40 trainees have been conducted. The emphasis is on attaining Safe Motherhood status in our field areas.

b) Regular Training Program:

These are Extension Training Programs conducted for other Non-governmental Organisations at their respective centres. The NGOs involved were MYRADA, Samooha Project (ACTION AID), Sabala Project (ACTION AID). The training objectives are similar to the above mentioned Contact program and many such programs were conducted. Apart fromm these a significant contribution has been in the training of health workers from these NGOs in appropriate water purification techniques and other felt needs areas.

c) Health Animators Training Program:
These are a cadre of voluntary workers selected from the community. Their main task is to initiate health actions through motivational programmes for which the scientific input is given by our department including methods of motivation, communication, evaluation and strategies for implementation of Basic Health Care. The Animators from the following organisations, namely MYRADA, Association for Physically Handicapped, Womens' Voice, Viveknagar Slums, have been trained by our staff.

HEALTH RELATED TRAINING PROGRAMMES

I. Health Management Training Workshop for Plantation Managers
Major workshops at UPASI Head quarters on the plantations, are conducted by our staff. The areas of training include Health Economics, Health Welfare Auditing, Costing, Social Welfare Programs, Health Information Systems and Water Systems Management.

II. Food Hygiene Course for Hotel Managers and Supervisors
A five-Day training program is conducted to provide knowledge and skills in the areas of Food storage, Food preparations, Food serving, Waste food disposal, Management of Food poisoning, Prevention of Food Adulteration and Elements of Microbiology.

III .Food Hygiene Course for Cooks and Servers
This course is similar to the above mentioned course but is conducted at the Hotel premises itself in the local language, for Cooks and Servers. The topics are especially selected to reflect Indian foods and Indigenous techniques of food preparations. The course is of 5 days duration.

IV. Teachers' Training Program
The main objective of this program is to train Rural School Teachers in the organization of School Health Services, early diagnosis of childhood ailments, identification of Psycho-social problems in children, Monitoring growth and development, detecting Malnutrition status, Applying First Aid Measures and also detecting early cases of Leprosy in children. This is a monthly program conducted in Anekal Taluk for 40 teachers per session. Similar programmes have also been conducted in Bangarapet.

V. Training program for Deacons, Seminarians and others
A One-week training program for Deacons and Seminarians from various seminaries are conducted. Skill oriented teaching in the fields of First Aid, Personal Hygiene, Home Nursing, Management of Common Ailments are the main thrust of these needbased training sessions.

VI. Training Programmes in First Aid
One-week skill oriented training programs in First Aid have been conducted for the workers of the following organisations:

a) Karnataka Association for the Blind
b) OXFAM
c) MYRADA
d) ESCORTS Industries

VII. Training in Occupational Health
With the objective of imparting specific training in the early detection of Occupational Hazards and evolving preventive and control methods, One-day training programmed in Occupational health were conducted for the following industries:

a) Indian Telephone Industries
b) ESCORTS
c) Thermax Company

VIII. Training Programmes in AIDS
These are single contact programs designed to arouse curiosity and awareness about AIDS among as varied a selection of the community as possible. The sessions are arranged in a question and answer format in order to clarify issues raised by the audience more than to expound on the clinical characteristics of the disease. AIDS awareness programmes have been conducted for the following organizations :

a) Stumpp, Scheule and Somappa
b) College of Nursing, SJMCH
c) Krupanidhi College of Pharmacy
d) Catholic Sabha of Bangalore.
e) Bishop Cotton's Girls School
f) Mount Carmmel College

IX. Natural Family Planning
Training programmes in the field of Billings Ovulation Method, have been conducted for medical students, nursing students, community health workers and health animators at Mugulur and Hosur (MYRADA) and GOA University.

X. Child to Child Health Education
Using behavioral methods, unique methods of teaching children to teach other children,specific health education program have been conducted in all the Rural and Urban Health Centre areas. Novel methods of utilizing other communication channels such as Child-to-Mother, Mother-to-Mother, Child-to-Community strategies have been evolved. A highly creative experience, CtC has yielded a rich harvest of innovative dramas, songs and dances that are used for community

education. CtC education has been used as an entry point for more conventional intervention in many communities.

XI. Group Motivation Program for Parents of Spastic Children
This program was conducted for the parents of spastic children identified in Mugulur area and serves as an example of a departmental response to a locally identified need. The program included skill development in the Home Management of Spastic children by the parents of these children. Field visits and house motivation techniques were also employed as was the use of locally available appropriate technology for aiding the disabled children. This program was conducted in collaboration with Spastic Society (Bangalore).

XII. Women's Literacy Program
This program being conducted in Adugodi slums, Shantinagar is an important experiment in combining literacy with health education. A significant feature is the health discussion that evolves from the very words that help develop the reading and writing skills of these impoverished, illiterate women. An interesting spin off has been the attention to personal hygiene that these women have shown on coming to the literacy classes.

XII. Development Training
Training has been given to members of the Mahila Mandals of the 16 target villages in Mugulur area in respect of Tailoring, Poultry farming, Sheep rearing, Rabbit rearing and Agarbatti rolling. This has been done after assessment of both the local needs and of local resources. The women were taken to the resource centres for each of these income generating possibilities and were given an intensive briefing on their pros and cons. Some of the intensely exciting features that have been incoporated into these programs are

* homebased income generating scheme
* use of hybrid varieties which are resistant to local diesease
* use of high profit, low cost varieties
* development of poultry banks

EVALUATION

The Department has considerable experience with evaluation. These range from large scale evaluation of City Health Needs Assessment and District Immunization Coverage Evaluation to Investigation of Food poisoning outbreak and Water Systems Analysis of an industry. Many of these are related to our training and service involvement with industry, Core group on Immunization of the Government of karnataka, and the Catholic health system. Some of our Evaluatory projects include:

Urban needs assessment of Bangalore City
Health welfare audit of UPASI plantations
UIP Coverage Evaluation of
Water System Analysis of Escorts factory, Hosur
Evaluation of the Community Health Workers Course at SJMC
Evaluation of Community Health capability of the St Martha's Hospital, Bangalore
Food Hygiene Quality of SJMC Canteen

SERVICE PROGRAMMES

PROGRAM	PLACE	FREQUENCY
1) **Fixed Rural Health Centres** * Primary Health Care Activities * Residential Doctors available * Venue for Rural Training Camps	a) Mugulur HTC b) Bidadi PHC c) Dommasandra PHC d) Mallur HC e) Solur HC f) Sriramanahalli HC g) Hoskote HC h) Kalakunte HC i) Estate Hosp.	Throughout the year
2) **Rural Mobile Clinic** * Curative and Preventive Services (Immunization MCH Services) * Internship Training * Field Visits	18 villages in the Primary Health Centres of Dommasandra, Anekal & Bidadi	Daily
3) **Urban Health Program** * Child to Community progam * Women's Literacy program	Shantinagar slums	5 days/week
4) **Maternal & Child Health Clinics** * Checkup of	Mugulur HTC Kalakunte HC	Once a fortnight
1) Pregnant Women 2) Newly Delivered Mothers	Mallur HC	Once a month
3) Infants & Under-fives * Immunization	Anekal PHC Dommasandra PHC	Once a week
5) **School Health Services** * Medical Check-up * Child to Child Hlth.Education * Screening for Learning disabilities * Leprosy Detection	Mugulur Chikkatirupathi Hebbagodi Madiwala Adugodi Bidadi	On-going
6) **Specialist Camps** * Providing secondary care * Screening & Diagnostic Services * Specialities involved		
i) OBG ii) Dermatology iii) ENT iv) Dental v) Ophthalmology vi) Orthopedics vii) Pediatrics	All Rural Centres Urban Centre	Once a month Thrice a year

7) **Natural Family Planning Services**	All Rural Centres	On-going
8) **Mahila Mandal Group Motivation Program** * Motivation for health activities	Bidadi Chikkatirupathi Mugulur Urban Slums	On-going
9) **Referral Services** for Tertiary Care to hospitals	From all Rural Centres & Urban Slums	On-going
10) **Exhibitions on Health**	All Rural & Urban Health Centres St.John's Medical College	Once a month
11) **Industrial Health Services** * Pre-placement examination * Periodic Medical Examination * Factory Safety Survey * Industrial Canteen Food Hygiene Education * Preparation of Health Education Material for Sericulture Hazards	Stumpp, Schuele & Somappa Central Silk Board Indian Telephone Industries	Twice a year/ need based
12) **Canteen Inspection Services** to ensure Food hygiene practices	St. John's Medical College Hospital Canteen & Dietary Section	Once in six months

RESEARCH

Project:	Place	Sponsoring Agency
1) Women in Health & Development Improving Womens' Health and Socio-economic status through training, self-financing & cooperatives using net-work of village level change agents.	Mugulur & 15 neighboring villages	FORD Foundation
2) Tobacco Related Diseases in Plantations A ten year prospective cohort study on 1,00,000 workers.	U.P.A.S.I. Estates	Nat. Institute of Health,USA
3) Delivery of Primary Health Services in Slums Based on the Need Assessment of Slum Dwellers Strengthening Delivery of Pri.Hlth.Services Ensuring full community participation	Bangalore City 401 Slums	World Bank
4) Education Strategy in early detection of Cervical Cancer Training of Local Midwives in the Detection of early Cervical Cancer Health Education Strategy for Cervical Cancer Awareness among Rural women.	Dommasandra Bidadi Anekal Solur	Indian Council of Medical Research & Kidwai Cancer Institute
5) Health System Analysis of Plantation Health Services Evaluation for recommending cost effective methods of delivery of plantation health services	U.P.A.S.I. Estates	U.P.A.S.I.

6) Evaluation of Community Health Workers Training Program Actual health needs of community served Current health work being done by CHWs Relevance of content and methodology of CHW courses conducted in St. John's.	All India	Diocese
7) Evaluating Health Needs of Rural Communities around Mugulur Health Centre Community level and family level surveys to determine felt needs of the rural community in the field of health Using the above information to plan community health services at Mugulur Health Centre	Mugulur Health Training Centre & surrounding 15 villages	St. John's
8) Health Seeking Behaviour of a Rural Population	Mugulur Health Training Centre & surrounding 15 villages	St. John's
9) Deployment of School Children in Promoting CSSM in a rural Community	Kalakunteagrahara Health Centre and surrounding villages	St. John's

MUGULUR HEALTH TRAINING CENTRE

St. John's has constructed its own Rural Health Training Centre at Mugulur village. The purpose is to conduct all training programmes in a fully residential manner at Mugulur village. Residential facilities for staff and trainees and provision of learning situations have been provided. All programmes are coordinated with a Central Village Health Committee at Mugulur consisting of members chosen from surrounding 15 villages. The emphasis is on residential training facilities and provision of Primary Health Care facilities only.

MAHILA VIKAS PROJECT

The Mahila Vikas project is a health cum development scheme funded by the Ford Foundation. Its basic and most enduring tenet is the empowerment of rural women by lifting the yoke of economic submission through income generation oppurtunities and women's groups organization. Started in 1991, the project is in its third year. Mahila Mandals have been organized in all 16 villages covered by the project by locally recruited Health cum Development Trainers. The women are able to take the decision making with respect to health into their own hands. Poultry farming with the special 'Giriraja' variety of chickens, tailoring classes, rabbit rearing, agarbatti rolling and the special ' Bandur' sheep rearing are in place. On the health front, Traditional Birth Attendants have been trained in the 5 cleans of delivery and the necessity of early registration of pregnancy. The Mugulur Health Training Centre provides local medical support in case of need.

CENTRAL DOCUMENTATION AND MONITORING

Staff members of the department and Rural Health Centre doctors collate and analyze Health Data. The objective is to create extensive documentation of all activities in order to facilitate evaluation of the work of the department.

At Mugulur Health Training Centre, a Family Folder system has been adopted which permits easy transcription to the cumulative records while yielding good individual data. The Mugulur HTC has organised its morbidity records to fall in line with the ICD classification of disease and all daily and monthly records are in this format.

There is extensive descriptive documentation of the processes of the various activities undertaken at all health centres. An important example is the Urban Child to Child program and the Mahila Vikas project.

Yet another important feature is the use of Graphical displays at the Mugulur HTC and at the Department to depict results of studies as well as trainee profiles etc.

There is also a Central museum of photos showing the different activities and programs of the Department. These provide an oppurtunity for Guests to review the strides that the Department has been making in Community oriented Health Care.

HEALTH STATUS OF THE PEOPLE OF KARNATAKA IN THE CONTEXT OF THE HEALTH SITUATION IN INDIA.

Background paper prepared for the
Annual General Body Meeting of

FEVORD-K

17-18 May 1990

at Belgaum

by

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C O N T E N T S

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A. INTRODUCTION

1. What is health?

Health is defined by the World Health Organization (1948) as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. This implies a goal of positive health for each individual in society. India had suggested that spiritual health be also included in this definition.

We need to try to understand the general status of health of the people of India and of Karnataka in the context of this definition. Here we would be looking at the levels of health of the population as a whole and not merely that of individuals. However, keeping in mind the many stratifications of class, caste and gender that are present in Indian society today, it would be equally important to try and understand the health status of these different sub-groups of the populations. There would also be differences according to age and occupation. Tribal and urban slum populations also have levels of health resulting from their own particular socio-economic-political-cultural situation.

2. How do we measure health?

Given the above definition it is rather difficult to measure the exact status of health of people. However, over the years certain indicators have been developed which give some estimate of the levels of health and disease which can be used to compare different populations and to monitor changes in the same population over time. Some of these are life expectancy, infant mortality rate, maternal mortality rate etc. These terms will be explained as we go along. For specific diseases we can get a picture of the disease load in a population by their incidence and prevalence.

There needs to be a good health information collection system to work out these indicators. And to do this there needs to be a well spread out health service system which most people use, which works relatively efficiently and where records regarding various health and disease events are well maintained.

In India, though the development of the health infrastructure, throughout the country, by the government, in terms of number of sub-centres and primary health centres established and number of health personnel trained has shown a large quantum increase, the level of functional efficacy of these facilities leaves much to be desired. It is also an accepted fact that the data collected at these centres is of questionable quality. However, the census, the National Sample Surveys, studies by research institutions and data from some voluntary health projects do provide us with useful information regarding the health indicators mentioned above.

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3. Some background factors to consider

When we try and understand the health status of the people of India it is important to keep in mind the magnitude of our country--the geographic size and even more its population. We are second only to China in population size, there being 850 million of us. This is equal to the population of USSR, USA and Japan put together. It is said we add an Australia to our population every year.

Our vast population is also very diverse:for instance people in very different geographic areas from the snowy Himalayas, the deserts of Rajasthan, the great river valleys, the hilly regions and coastal belts; there are different ethnic background, a variety of language groups, religions and cultures; levels of socio-economic development, education and political consciousness also vary a great deal. All these factors affect health in numerous ways; hence, talking about the health status of the people of India as a whole is a very broad generalization. The average figures given in the tables hide differences that occur from place to place and group to group. Within Karnataka itself, there are differences in the health indicators between urban and rural areas and from district to district. It would be revealing to know the breakup by income level, caste/tribe, age and sex.

Another factor to consider is that the health of individuals, communities and populations is a dynamic state, changing over time, responding to a number of factors which have a relationship with it. It has been observed in populations that as certain diseases decline, others may become apparent or develop anew. This has been termed the onion-peel effect.

4. Major health problems in India

Keeping in mind all the above factors it can be said broadly that in India people suffer from the diseases of poverty alongside the diseases of modernization. The 30-40% of the population under the poverty line (about 230-300 million) and also the lower middle class continue to bear the burden of malnutrition which takes its greatest toll from children and mothers. They also suffer from the lack of clean water. and sanitation, adequate housing and clothing all of which result in various communicable or infectious diseases:eg., tuberculosis, leprosy, gastroenteritis, typhoid, cholera, jaundice, diarrhoeas, malaria filaria etc., This ill health affects the working and earning capacity of people.and often results in disability and even unnecessary and early death. The tragedy is that most of these diseases are preventable. by an overall equitable development process and also by public health measures.

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TABLE 1

Percentage of population below the poverty line 1983-84 (Provisional)

	Rural	Urban	Combined
Karnataka	37.5	29.2	35.0
Kerala	26.1	30.1	26.8
All India	40.4	28.1	37.4

Source: Status Report 1988-89, Govt of Karnataka, Dept. of Health & Family Welfare.

Modernization, industrialization and urbanization have brought along their own ills. There are many specific occupational health problems and environmental pollution problems associated with the various industries. In agriculture also there is extensive use of chemicals as fertilizers and pesticides which enter the food chain affecting the total population, though more specially the sprayers and agricultural workers. Rural urban migration has resulted in the growth of the 'septic fringes of cities' where people have to live in dehumanized conditions resulting in many social health problems in addition to those of poverty: eg., broken families, alcoholism, prostitution gambling etc. Rapidly growing cities face a major strain on their basic services, air pollution, traffic accidents, housing problems and alienation of the individual with its accompanying host of psychological and psychiatric problems. Cancers, cardiovascular diseases and stress related disorders are on the increase.

B. FOCUSSING ON KARNATAKA

Karnataka is better than the national average in all the health indicators, coming second only to Kerala in some. However much more remains to be done. A brief overview of the health situation will now be given highlighting only the more important aspects.

1. The population and its distribution

With a population of 37.1 million (1981 census), Karnataka accounts for 5.42% of India's population, ranking 8th among the States in terms of population size. With an area of 191,791 sq kms the population density is 194/sq km (all India 216/sq km). Estimates of the population in 1990 are 44.48 million.

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The following table gives some of the features of the distribution of the pooulation in Karnataka.

Table 2

Population distribution in Karnataka (1981)
(T = Total; R = Rural; U = Urban)

	Area in Km	Popula-tion	Males	Females	Sex Ratio	%Urban Population
T	191,791	37135714	18922627	18213087	963	
R	188108.2	26406108	13352400	13053708	978	
U	3682.8	10729606	5570227	5159379	926	28.89

Source: Health Information of India, 1987, CBHI, DGHS, NewDelhi

(a) The sex-ratio is the number of females per 1000 males. In most countries of the world this is in favour of females. However in India (and Pakistan, Bangladesh, Afganistan etc) it is the reverse and more importantly has been steadily decreasing since the turn of the century, even post-Independence. The decline has come to a halt only in the last census (1981). The only two States in India to have a positive sex ratio are Kerala and Goa. Within Karnataka, Dakshin Kannada Dist also has a positive ratio. Otherwise it varies in the different States and Districts. The adverse sex ratio has been ascribed as being due to various casues--high maternal mortality following early marriage and repeated pregnancies, poor educational status of women, low utilisation of health services by women--the underlying reason being the inferior status of women in society.

Table 3

Conditions of children and women in India

Indicator	India	Developing countries	Developed countries
1. Infant Mortality (deaths) (per 1000 live births per year)	125	96	20
2. % of new borns weing less than 2.5 kg	27.5	18	9
3. % of anaemia among pregnant women	70	60	20
4. Maternal mortality per 100,000 live births/per year	418	400	20

Source: Health Care in India, 1983, Joseph G et al, CSA, Bangalore

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(b) The age distribution of the population in Karnataka is as follows (1981 census)

0-14 years	: 39.6%
15--59 years	: 53.8%
60 + years	: 6.6%

This is very similar to the all India pattern. With almost 40% of the population being children, ours is predominantly a young population.

(c) Though the indicators of child health have shown some improvement over the years, it still remains a matter of serious concern. As shown in Table 3, the infant mortality which is the number of children who die before they reach the age of one year still remains unacceptably high. About 30% of newborn babies have a low birthweight (less than 2.5 kg). These babies are three times more likely to die in infancy than babies of normal weight at birth. The under 5 or toddler death rate is also very high.

Table 4

Estimated Infant Mortality Rates, 1985

	Rural	Urban	Combined
India	105	57	95
Uttar Pradesh	152	77	40
Karnataka	80	41	71
Kerala	32	30	31

Source: Registrar General, India

As can be seen, Karnat ka is on the lower side of the range of IMR's among the States.Having reached thus far it would be useful to have a more detailed district wise and population group wise break up of IMR. Perhaps Volags in Karnataka could study this measure in their respective areas as it is an acceptable and good indicator of the standard of life of a given population.

Table 5

Other childhood death rates - All India, 1983

Age Specific death rate	Rural Male	Rural Female	Urban Male	Urban Female
0-4 year	40.5	43.1	21.1	21.7
5-8 years	3.4	4.0	2.0	1.8
10-14 years	1.7	2.0	0.9	1.2

Source: Health Information of India, 1987, CBHI, DGHS, New Delhi

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In India, deaths of children still account for about 40% of the total deaths that occur--28.8% in Karnataka. A very large number of these are preventable and we need to make specific efforts to allow these numerous children, the full bloom of their lives.

(d) The urban population of Karnataka has been growing and is high (28.9%) compared to the all India figure of 23.31%. It is necessary to find out what percentage of the urban population are slum dwellers. A large chunk -- 30% of the urban population--are in Bangalore, the remaining being spread over 281 towns.

Urban areas monopolise much of the health care and other social service facilities. These include finances available from both the government and private sector, highly trained health personnel, sophisticated capital intensive equipment and medical facilities.

In the village and hamlets, medical facilities are scarce and of poor quality. There is a shortage of basic essential drugs and vaccines. There are poorly trained staff in charge of large areas and basic public health measures of safe water supply and facilities for sanitation very inadequate. The disparities of income and living conditions along with the above factors is revealed in the striking difference in health indicators between urban and rural areas.

Table 6

Urban/Rural inequalities (%) in India

	Urban	Rural
1. Population (1981)	23.7	76.3
2. Doctors (1961-71)	70-80	20-30
3. Nurses/ANMs (1971)	60	40
4. Hospitals (1981)	73.9	26.1
5. Dispensaries (1981)	20.2	69.8
6. Hospitals/dispensary beds (1981)	83	17

Source: Health Care in India, Joseph G et al, 1983, CSA, Bangalore

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Table 7

Urban/Rural Health indicators

	Karnataka		India	
	Urban	Rural	Urban	Rural
1. Birth rate (1986)	26.8	29.9	27.1	34.2
2. Death Rate (1986)	6.8	9.4	7.6	12.2
3. Infant mortality rate (1986)	47	82	62	105
4. Expectation of life at birth (1976-1980)	64	53.9	60.1	50.6

Source: Status Report 1988-89, Govt of Karnataka, Dept of Health & Family Welfare, Bangalore

2. Birth and Death Rates

The crude birth rate is the number of births per 1000 population per year. Amongst the States, Goa and Kerala have the lowest birth rates. The goal of the family welfare programme is to reduce the crude birth rate to 27/1000 population by 2000 AD (it is already 19.1/1000 population in Goa). These targets and the programme are not applicable to tribal populations. In Karnataka it is 29/1000 (1985)

The crude death rate is the number of deaths per 1000 population per year. Karnataka has already reached the national goal of a crude death rate of 9/1000 population to be achieved by 2000AD.

3. Changes in health indicators over time

A brief picture of the change in health indicators that have occurred in India since Independence is as follows:

Table 8

Year	Birth rate	Death rate	Infant Mortality Rate	Life expectancy at birth
1941-51	39.9	27.4	134	32.1
1951-61	41.7	22.8	146	41.3
1961-71	41.2	19.0	138	45.6
1980	33.3	12.4	127	52.1

Source: Health Care in India, Joseph G et al, CSA, Bangalore

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4. Growth Rate

Since Independence the death rate in India has declined more steeply compared to the birth rate which decreased only gradually. Hence we have a high growth rate with an enormous increase in total population from 361 million in 1951 to 685 million in 1981. We are estimated to be 840 million now. In Karnataka, the increase in population has been from million in 1951 to 37 million in 1981.

Here one must mention the experience of some Volags working with defined population groups who state that there is an under-enumeration of the total population in their area: eg., in tribal regions. It would be important to have an estimate of the extent to which this occurs as it would have serious implications.

Only some health indicators have been highlighted in the Section above to present a general idea of the health situation prevailing in India and particularly in Karnataka.

C. NUTRITION LEVELS

The nutritional status of individuals is closely linked to their health status, determining to a large extent their resistance to disease. The optimal growth and development of children is also dependent on good nutrition. There are also specific nutrition deficiency diseases like protein calorie malnutrition, iron deficiency, anaemia, Vit. A deficiency, Vit B & D deficiency etc.

Some statistics regarding child malnutrition at an all India level are:

1. % of infants with low birth weight	:30%
2. % of malnourished children (moderate/severe)	:around 40%
3. Children affected by iron deficiency anaemia	:around 50%
4. Number of children turning blind each year mainly due to Vit. A deficiency (estimate)	:40,000

(Source: Future--Development Perspectives on Children, UNICEF (Based mainly on government statistics relating mostly to 1986).

The National Nutrition Monitoring Bureau systematically collects information on a representative stratified sample of households in rural and urban areas in 10 States of the country, of which Karnataka is one. Every fifth rural household does not eat adequately and among children below 4 years of age, one in 3 consumes less food than recommended.

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Family income and land ownership are critical determinants of food intake. Those who own more than 10 acres of land have a mean intake of 3100 calories per day, those who own less than 5 acres ate 2600 calories per day while landless labourers consumed 2300 calories on an average. Protein intake showed a similar trend. Overall the calorie intake in Karnataka is higher than in neighbouring States like Andhra and Maharashtra.

Fluorosis caused by excess fluorine in the water, has been reported to be a public health problem in some areas, affecting the bony skeleton, teeth, sometimes causing knock knees. High levels of fluoride (5-11 ppm) in open well water has been reported in villages of Chitradurga, Tumkur and Bellary districts. Dental fluorisis affected 75.76% of individuals surveyed in Mundargi Taluk of Dharward Dist where the fluoride content of water was 3-7.6ppm. Fluorosis has also been reported in some areas close to dams with the possible causal factor being ecological changes caused by construction of dams.

D. DISEASE PROFILES IN KARNATAKA

An understanding of the quantum load of different diseases in a population also gives an idea of the level of health of the population. However, this is more easily said than done particularly in India. Some of the difficulties in measuring disease have been mentioned in the earlier part of the note. The situation is even more complex because several systems of medicine/healing practices are actively present here, each with their own approaches to disease/ symptom complexes. Hence government health services cannot be the base used to measure disease in the community as only part of a population may use that service. The only alternative is to conduct community based surveys which are very expensive and cumbersome undertakings. Given the scant resources in the health sector it has not been possible to conduct nation wide sample surveys to measure different diseases. More complete information is available about some diseases: eg., leprosy and tuberculosis for which there are National Health programmes with active case detection.

Available information on some of the diseases in Karnataka as given in the Status Report 1988-89, Government of Karnataka, Dept of Health and Family Welfare, will now be given.

Table 9

	1987		1988 (Provisional)	
	Cases	Deaths	Cases	Deaths
A. Respiratory diseases				
1. Tuberculosis	103006	1140	125303	1172
2.i.Acute Respiratory infection			192127	75
.Pneumonia			6599	84

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Table 9 (contd..)

	1987		1988 (Provisional)	
	Cases	Deaths	Cases	Deaths
B. Gastro-intestinal diseases				
3. Dysentry (all forms)	543944	91		
4. Acute diarrhoeal diseases			205161	237
5. Gastroenteritis	85393	524	14091	639
6. Cholera	1918	87	2167	70
7. Infectious hepatitis	7774	122	5413	60
8. Typhoid	17941	28	15406	36
C.				
9. Malaria: total positive cases	88505		127008	
Plasmodium falciparum cases	29582		37667	
10. Filaria	2457		11870	
11. Leprosy				
D. Vaccine preventable childhood diseases				
12. Diphtheria	2223	16	550	12
13. Measles	8522	25	4481	25
14. Whooping cough	4928	14	7113	12
15. Poliomyelitis	2456	30	759	22
16. Tetanus	1517	314	4841	299
E. Others				
17. Influenza	339827	8		
18. Chickenpox	2387	4		
19. Japanese encephalitis	132	43	81	27
20. Kyasanur Forest Disease	51	10	56	6

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Table 9 (contd...)

	1987		1988 (Provisional)	
	Cases	Deaths	Cases	Deaths
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22.Meningicoccal infection	523	73	118	12
23.Syphilis	5375	2	5749	1
24.Gonococcal infection	5036		7620	
25.Encephalitis	1347	190		
26.Haemorrhagic fever	53			
27.Guinea worm	990			
28.All other diseases	7927329	13991	7683977	10045

These figures are of those patients/cases who reported to the government health services. They do not represent the actual incidence of the disease in the community. A survey in Chiraigaon Block, Varanasi showed that 77% of the population never used the primary health centre servicesad only 10.4% of illnesses in that community were attended to at the primary health centre. The number of deaths due to the different diseases given in the Table also do not represent the disease mortality rate but probably are the number who died out of those who reported. Hence, it would be unwise to draw too many inferences from this data.

Based on other reports and interactions with several people all that one can say is that tuberculosis is still a major public health problem more than 40 years after Independence causing much suffering, disability and death in the prime of life. It is a disease that affects children and young adults especially males. All development workers should be aware of the National Tuberculosis programme and create an awareness about the facilities provided under this.

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Leprosy: The average prevalence rate for the entire State is given as 3/1000 population in 1989. However, there are large regional differences. The districts with high prevalence rates (per 1000 population) are:

Raichur	8.8	Gulbarga	8.6	Bellary	6.9
Bidar	5.7	Bijapur	5.3	Mysore	3.9
Mandya	3.6	Kolar	3.6		

The vaccine preventable diseases in childhood are diphtheria, whooping cough, tetanus, poliomyelitis, measles and tuberculosis. Great emphasis is being given to immunization programmes by the government, sponsored by UNICEF, through the Universal Immunization Programme (UIP) and the Technology Mission. Unfortunately it is being converted into a verticalised, top-down, target-oriented programme during the past few years. The history of our own health services and programmes has shown that an integrated health service at the level of the community works best, is most cost-effective and acceptable to the people. But this lesson seems to have been lost under various pressures and compulsions working at an international and national level.

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Kyasanur Forest Disease (KFD) is a viral disease transmitted by ticks to man. It was first reported in 1956-57 in Kyasanur Forest in Shimoga district. It also affects adjoining areas of Uttar Kannada, Chickmagalur and Dakshin Kannada districts. KFD is associated with the felling of forests and clearing of land for agricultural use. Those at greatest risk of infection are cultivators visiting the forest accompanied by their animals or for cutting wood.

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This is a brief overview of some of the communicable diseases. Non-communicable diseases including cancers, cardiovascular diseases, diabetes, mental ill health have not been discussed.

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E. CONCLUSION

Causation of disease and the determinants of health

Concepts regarding the causation of disease or ill-health have evolved from miasmic theories (factors relating mainly to the environment) to germ theories (discovery of bacteria, parasites, viruses etc) to multifactorial theories (a number of factors including both the above) in the West. In India, our own ancient systems understood the health of individuals to be the result of a composite of physical, mental and spiritual factors and the importance of food, cleanliness, good housing and a disciplined way of life were accepted as necessary for good health. Whether social, economic and political factors were recognised is a debatable issue.

Presently, however, it is accepted that some of the basic determinants of the health status of a population are:

i. adequate and equitable distribution of income, food, shelter and clothing;

ii. accessibility to safe water supply, sanitation facilities, education and employment;

iii. a healthy environment; and

iv. healthy social relationships and life styles.

The role played by the health care services is secondary to these.

It has been shown by the histories of the developed countries that communicable diseases like tuberculosis, leprosy and gastrointestinal diseases declined before the era of antibiotics and vaccines following the improvement of the socio-economic condition of the population and by implementation of basic measures of sanitation.

Thus groups involved with rural development work, education, awareness building, conscientization all contribute significantly to improving the health status of people.

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HEALTH STATUS OF THE PEOPLE OF KARNATAKA IN THE CONTEXT OF THE HEALTH SITUATION IN INDIA.

Background paper prepared for the
Annual General Body Meeting of

FEVORD-K

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at Belgaum

by

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C O N T E N T S

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A. INTRODUCTION

1. What is health?

Health is defined by the World Health Organization (1948) as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. This implies a goal of positive health for each individual in society. India had suggested that spiritual health be also included in this definition.

We need to try to understand the general status of health of the people of India and of Karnataka in the context of this definition. Here we would be looking at the levels of health of the population as a whole and not merely that of individuals. However, keeping in mind the many stratifications of class, caste and gender that are present in Indian society today, it would be equally important to try and understand the health status of these different sub-groups of the populations. There would also be differences according to age and occupation. Tribal and urban slum populations also have levels of health resulting from their own particular socio-economic-political-cultural situation.

2. How do we measure health?

Given the above definition it is rather difficult to measure the exact status of health of people. However, over the years certain indicators have been developed which give some estimate of the levels of health and disease which can be used to compare different populations and to monitor changes in the same population over time. Some of these are life expectancy, infant mortality rate, maternal mortality rate etc. These terms will be explained as we go along. For specific diseases we can get a picture of the disease load in a population by their incidence and prevalence.

There needs to be a good health information collection system to work out these indicators. And to do this there needs to be a well spread out health service system which most people use, which works relatively efficiently and where records regarding various health and disease events are well maintained.

In India, though the development of the health infrastructure, throughout the country, by the government, in terms of number of sub-centres and primary health centres established and number of health personnel trained has shown a large quantum increase, the level of functional efficacy of these facilities leaves much to be desired. It is also an accepted fact that the data collected at these centres is of questionable quality. However, the census, the National Sample Surveys, studies by research institutions and data from some voluntary health projects do provide us with useful information regarding the health indicators mentioned above.

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3. Some background factors to consider

When we try and understand the health status of the people of India it is important to keep in mind the magnitude of our country--the geographic size and even more its population. We are second only to China in population size, there being 850 million of us. This is equal to the population of USSR, USA and Japan put together. It is said we add an Australia to our population every year.

Our vast population is also very diverse:for instance people in very different geographic areas from the snowy Himalayas, the deserts of Rajasthan, the great river valleys, the hilly regions and coastal belts; there are different ethnic background, a variety of language grouns, religions and cultures; levels of socio-economic development, education and political consciousness also vary a great deal. All these factors affect health in numerous ways; hence, talking about the health status of the people of India as a whole is a very broad generalization. The average figures given in the tables hide differences that occur from place to place and group to group. Within Karnataka itself, there are differences in the health indicators between urban and rural areas and from district to district. It would be revealing to know the breakup by income level, caste/tribe, age and sex.

Another factor to consider is that the health of individuals, communities and populations is a dynamic state, changing over time, responding to a number of factors which have a relationship with it. It has been observed in populations that as certain diseases decline, others may become apparent or develop anew. This has been termed the onion-peel effect.

4. Major health problems in India

Keeping in mind all the above factors it can be said broadly that in India people suffer from the diseases of poverty alongside the diseases of modernization. The 30-40% of the population under the poverty line (about 230-300 million) and also the lower middle class continue to bear the burden of malnutrition which takes its greatest toll from children and mothers. They also suffer from the lack of clean water. and sanitation, adequate housing and clothing all of which result in various communicable or infectious diseases:eg., tuberculosis, leprosy, gastroenteritis, typhoid, cholera, jaundice, diarrhoeas, malaria filaria etc., This ill health affects the working and earning capacity of people.and often results in disability and even unnecessary and early death. The tragedy is that most of these diseases are preventable. by an overall equitable development process and also by public health measures.

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TABLE 1

Percentage of population below the poverty line 1983-84 (Provisional)

	Rural	Urban	Combined
Karnataka	37.5	29.2	35.0
Kerala	26.1	30.1	26.8
All India	40.4	28.1	37.4

Source: Status Report 1988-89, Govt of Karnataka, Dept. of Health & Family Welfare.

Modernization, industrialization and urbanization have brought along their own ills. There are many specific occupational health problems and environmental pollution problems associated with the various industries. In agriculture also there is extensive use of chemicals as fertilizers and pesticides which enter the food chain affecting the total population, though more specially the sprayers and agricultural workers. Rural urban migration has resulted in the growth of the 'septic fringes of cities' where people have to live in dehumanized conditions resulting in many social health problems in addition to those of poverty: eg., broken families, alcoholism, prostitution gambling etc. Rapidly growing cities face a major strain on their basic services, air pollution, traffic accidents, housing problems and alienation of the individual with its accompanying host of psychological and psychiatric problems. Cancers, cardiovascular diseases and stress related disorders are on the increase.

B. FOCUSSING ON KARNATAKA

Karnataka is better than the national average in all the health indicators, coming second only to Kerala in some. However much more remains to be done. A brief overview of the health situation will now be given highlighting only the more important aspects.

1. The population and its distribution

With a population of 37.1 million (1981 census), Karnataka accounts for 5.42% of India's population, ranking 8th among the States in terms of population size. With an area of 191,791 sq kms the population density is 194/sq km (all India 216/sq km). Estimates of the population in 1990 are 44.48 million.

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The following table gives some of the features of the distribution of the population in Karnataka.

Table 2

Population distribution in Karnataka (1981)
(T = Total; R = Rural; U = Urban)

	Area in Km	Population	Males	Females	Sex Ratio	%Urban Population
T	191,791	37135714	18922627	18213087	963	
R	188108.2	26406108	13352400	13053708	978	
U	3682.8	10729606	5570227	5159379	926	28.89

Source: Health Information of India, 1987, CBHI, DGHS, NewDelhi

(a) The sex-ratio is the number of females per 1000 males. In most countries of the world this is in favour of females. However in India (and Pakistan, Bangladesh, Afganistan etc) it is the reverse and more importantly has been steadily decreasing since the turn of the century, even post-Independence. The decline has come to a halt only in the last census (1981). The only two States in India to have a positive sex ratio are Kerala and Goa. Within Karnataka, Dakshin Kannada Dist also has a positive ratio. Otherwise it varies in the different States and Districts. The adverse sex ratio has been ascribed as being due to various casues--high maternal mortality following early marriage and repeated pregnancies, poor educational status of women, low utilisation of health services by women--the underlying reason being the inferior status of woman in society.

Table 3

Conditions of children and women in India

Indicator	India	Developing countries	Developed countries
1. Infant Mortality (deaths) (per 1000 live births per year)	125	96	20
2. % of new borns weing less than 2.5 kg	27.5	18	9
3. % of anaemia among pregnant women	70	60	20
4. Maternal mortality per 100,000 live births/per year	418	400	20

Source: Health Care in India, 1983, Joseph G et al, CSA, Bangalore

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(b) The age distribution of the population in Karnataka is as follows (1981 census)

0-14 years	: 39.6%
15--59 years	: 53.8%
60 + years	: 6.6%

This is very similar to the all India pattern. With almost 40% of the population being children, ours is predominantly a young population.

(c) Though the indicators of child health have shown some improvement over the years, it still remains a matter of serious concern. As shown in Table 3, the infant mortality which is the number of children who die before they reach the age of one year still remains unacceptably high. About 30% of newborn babies have a low birthweight (less than 2.5 kg). These babies are three times more likely to die in infancy than babies of normal weight at birth. The under 5 or toddler death rate is also very high.

Table 4

Estimated Infant Mortality Rates, 1985

	Rural	Urban	Combined
India	105	57	95
Uttar Pradesh	152	77	140
Karnataka	80	41	71
Kerala	32	30	31

Source: Registrar General, India

As can be seen, Karnat ka is on the lower side of the range of IMR's among the States.Having reached thus far it would be useful to have a more detailed district wise and population group wise break up of IMR. Perhaps Volags in Karnataka could study this measure in their respective areas as it is an acceptable and good indicator of the standard of life of a given population.

Table 5

Other childhood death rates - All India, 1983

Age Specific death rate	Rural Male	Rural Female	Urban Male	Urban Female
0-4 year	40.5	43.1	21.1	21.7
5-8 years	3.4	4.0	2.0	1.8
10-14 years	1.7	2.0	0.9	1.2

Source: Health Information of India, 1987, CBHI, DGHS, New Delhi

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In India, deaths of children still account for about 40% of the total deaths that occur--28.8% in Karnataka. A very large number of these are preventable and we need to make specific efforts to allow these numerous children, the full bloom of their lives.

(d) The urban population of Karnataka has been growing and is high (28.9%) compared to the all India figure of 23.31%. It is necessary to find out what percentage of the urban population are slum dwellers. A large chunk -- 30% of the urban population--are in Bangalore, the remaining being spread over 281 towns.

Urban areas monopolise much of the health care and other social service facilities. These include finances available from both the government and private sector, highly trained health personnel, sophisticated capital intensive equipment and medical facilities.

In the village and hamlets, medical facilities are scarce and of poor quality. There is a shortage of basic essential drugs and vaccines. There are poorly trained staff in charge of large areas and basic public health measures of safe water supply and facilities for sanitation very inadequate. The disparities of income and living conditions along with the above factors is revealed in the striking difference in health indicators between urban and rural areas.

Table 6

Urban/Rural inequalities (%) in India

	Urban	Rural
1. Population (1981)	23.7	76.3
2. Doctors (1961-71)	70-80	20-30
3. Nurses/ANMs (1971)	60	40
4. Hospitals (1981)	73.9	26.1
5. Dispensaries (1981)	20.2	69.8
6. Hospitals/dispensary beds (1981)	83	17

Source: Health Care in India, Joseph G et al, 1983, CSA, Bangalore

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Table 7

Urban/Rural Health indicators

	Karnataka		India	
	Urban	Rural	Urban	Rural
1. Birth rate (1986)	26.8	29.9	27.1	34.2
2. Death Rate (1986)	6.8	9.4	7.6	12.2
3. Infant mortality rate (1986)	47	82	62	105
4. Expectation of life at birth (1976-1980)	64	53.9	60.1	50.6

Source: Status Report 1988-89, Govt of Karnataka, Dept of Health & Family Welfare, Bangalore

2. Birth and Death Rates

The crude birth rate is the number of births per 1000 population per year. Amongst the States, Goa and Kerala have the lowest birth rates. The goal of the family welfare programme is to reduce the crude birth rate to 27/1000 population by 2000 AD (it is already 19.1/1000 population in Goa). These targets and the programme are not applicable to tribal populations. In Karnataka it is 29/1000 (1985)

The crude death rate is the number of deaths per 1000 population per year. Karnataka has already reached the national goal of a crude death rate of 9/1000 population to be achieved by 2000AD.

3. Changes in health indicators over time

A brief picture of the change in health indicators that have occurred in India since Independence is as follows:

Table 8

Year	Birth rate	Death rate	Infant Mortality Rate	Life expectancy at birth
1941-51	39.9	27.4	134	32.1
1951-61	41.7	22.8	146	41.3
1961-71	41.2	19.0	138	45.6
1980	33.3	12.4	127	52.1

Source: Health Care in India, Joseph G et al, CSA, Bangalore

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4. Growth Rate

Since Independence the death rate in India has declined more steeply compared to the birth rate which decreased only gradually. Hence we have a high growth rate with an enormous increase in total population from 361 million in 1951 to 685 million in 1981. We are estimated to be 840 million now. In Karnataka, the increase in population has been from million in 1951 to 37 million in 1981.

Here one must mention the experience of some Volags working with defined population grouns who state that there is an under-enumeration of the total population in their area: eg., in tribal regions. It would be important to have an estimate of the extent to which this occurs as it would have serious implications.

Only some health indicators have been highlighted in the Section above to present a general idea of the health situation prevailing in India and particularly in Karnataka.

C. NUTRITION LEVELS

The nutritional status of individuals is closely linked to their health status, determining to a large extent their resistance to disease. The optimal growth and development of children is also dependent on good nutrition. There are also specific nutrition deficiency diseases like protein calorie malnutrition, iron deficiency, anaemia, Vit. A deficiency, Vit B & D deficiency etc.

Some statistics regarding child malnutrition at an all India level are:

1. % of infants with low birth weight	:30%
2. % of malnourished children (moderate/severe)	:around 40%
3. Children affected by iron deficiency anaemia	:around 50%
4. Number of children turning blind each year mainly due to Vit. A deficiency (estimate)	:40,000

(Source: Future--Development Perspectives on Children, UNICEF (Based mainly on government statistics relating mostly to 1986).

The National Nutrition Monitoring Bureau systematically collects information on a representative stratified sample of households in rural and urban areas in 10 States of the country, of which Karnataka is one. Every fifth rural household does not eat adequately and among children below 4 years of age, one in 3 consumes less food than recommended.

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Family income and land ownership are critical determinants of food intake. Those who own more than 10 acres of land have a mean intake of 3100 calories per day, those who own less than 5 acres ate 2600 calories per day while landless labourers consumed 2300 calories on an average. Protein intake showed a similar trend. Overall the calorie intake in Karnataka is higher than in neighbouring States like Andhra and Maharashtra.

Fluorosis caused by excess fluorine in the water, has been reported to be a public health problem in some areas, affecting the bony skeleton, teeth, sometimes causing knock knees. High levels of fluoride (5-11 ppm) in open well water has been reported in villages of Chitradurga, Tumkur and Bellary districts. Dental fluorisis affected 75.76% of individuals surveyed in Mundargi Taluk of Dharward Dist where the fluoride content of water was 3-7.6ppm. Fluorosis has also been reported in some areas close to dams with the possible causal factor being ecological changes caused by construction of dams.

D. DISEASE PROFILES IN KARNATAKA

An understanding of the quantum load of different diseases in a population also gives an idea of the level of health of the population. However, this is more easily said than done particularly in India. Some of the difficulties in measuring disease have been mentioned in the earlier part of the note. The situation is even more complex because several systems of medicine/healing practices are actively present here, each with their own approaches to disease/ symptom complexes. Hence government health services cannot be the base used to measure disease in the community as only part of a population may use that service. The only alternative is to conduct community based surveys which are very expensive and cumbersome undertakings. Given the scant resources in the health sector it has not been possible to conduct nation wide sample surveys to measure different diseases. More complete information is available about some diseases: eg., leprosy and tuberculosis for which there are National Health programmes with active case detection.

Available information on some of the diseases in Karnataka as given in the Status Report 1988-89, Government of Karnataka, Dept of Health and Family Welfare, will now be given.

Table 9

	1987		1988 (Provisional)	
	Cases	Deaths	Cases	Deaths
A. Respiratory diseases				
1. Tuberculosis	103006	1140	125303	1172
2.i.Acute Respiratory infection			192127	75
.Pneumonia			6599	84

contd.....10

Table 9 (contd..)

	1987		1988 (Provisional)	
	Cases	Deaths	Cases	Deaths
B. Gastro-intestinal diseases				
3. Dysentry (all forms)	543944	91		
4. Acute diarrhoeal diseases			205161	237
5. Gastroenteritis	85393	524	14091	639
6. Cholera	1918	87	2167	70
7. Infectious hepatitis	7774	122	5413	60
8. Typhoid	17941	28	15406	36
C.				
9. Malaria: total positive cases	88505		127008	
Plasmodium falciparum cases	29582		37667	
10. Filaria	2457		11870	
11. Leprosy				
D. Vaccine preventable childhood diseases				
12. Diphtheria	2223	16	550	12
13. Measles	8522	25	4481	25
14. Whooping cough	4928	14	7113	12
15. Poliomyelitis	2456	30	759	22
16. Tetanus	1517	314	4841	299
E. Others				
17. Influenza	339827	8		
18. Chickenpox	2387	4		
19. Japanese encephalitis	132	43	81	27
20. Kyasanur Forest Disease	51	10	56	6

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SOLVING PROBLEMS AND MAKING DECISIONS

When a group (or an individual) is faced with solving a problem or making a decision, there are five steps which can be followed. These steps will make for greater clarity and effectiveness while considering the problem or the decision, and they will also lead to a better final decision.

1. Define the problem

Ask yourselves "What is the real problem before us?" If you cannot agree on what the problem is, you certainly will not agree on the solution! A clearly-defined problem is already a great help towards a solution.

What appears to be the problem may be only a superficial sympton. Underneath there may be larger and deeper issues.

Express the problem in "How to..." terms. Do not say, 'the problem is moderating discussions', but, " The problem is how to learn to moderate discussions effectively".

2. COLLECT POSSIBLE SOLUTIONS

Ask yourselves, 'what are the possible solutions to this problem?' Make a list of all the ideas, possible solutions and suggestions without evaluating any of them. (The process is similar to 'brain-storming').

It is important to separate the collecting of ideas in this step from evaluation: The evaluation should come only in the third step. If you evaluate ideas in this second step, itwill inhibit the contribution of further ideas.

Make the list of possible solutions as long and complete as possible. Some people believe that the quality of the final decision depends on the number of possible solutions collected during this second step.

3. Evaluate the possible solutions and choose the best

Ask yourselves, "Of all the alternatives we have listed, which is the best solution?"

Weigh the pros and cons of each possible solution.

Encourage dissent and disagreement among the members of the group. This will help in the completed examination of every possibility. Beware of easy agreements-they probably have not been thought through completely. At the same time, avoid being defensive or making others feel defensive. Try to separate the ideas and solutions from the individuals who contributed them.

There are two important aspects to an effective decision One is the quality of the decision. Ask yourselves, "Does this decision accomplish our purpose? Will it effectively solve the problem?" The second aspect is the acceptability of the decision to those who have to carry it out.

If you find that you now need further information or an expert opinion, get it before the decision is made, not afterwards!