S. J Chandler

DRAFT FOR DISCUSSION

Sustainable Integrated Mother and Child Healthcare in Rural India

Updated knowledge on health status of mother and children in select villages in rural India, as well as overview over the current accessible primary health care and self-care options

STUDY PROTOCOL

TransDisciplinary University

Institute of Trans-Disciplinary Health Sciences and Technology , Bangalore, India

and

NAFKAM
National Research Center in Alternative and Complementary Medicine

National Research Centre in Alternative and Complementary Medicine (NAFKAM),

UiT Arctic University of Norway, Tromsø, Norway

(Grant Letter Ref. No.Ind-14/0006)

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Abbreviations and definitions

ANC	Ante Natal Care
AYUSH	Ayurveda, Yoga, Unani, Siddha and Homeopathy
CBO	Community Based Organisation
IMR	Infant Mortality Rate
MCH	Mother and Child Healthcare
MMR	Maternal Mortality Rate
NAFKAM	National Research Centre in Complementary and Alternative Medicine, Norway
PNC	Post Natal Care
PRA	Participatory Rapid Appraisal
TDU	Trans Disciplinary University
U5MR	Under 5 children Mortality Rate
UHC	Universal Health Care

1. Introduction

1.1 Background

Observers of the healthcare scenario in India, and perhaps other countries in Asia, recognize that in the 21st century innovative knowledge and strategies are required to achieve universal coverage in primary healthcare. In India the current *effective reach* of State sponsored health care programs is estimated to be around 30% of the population and 69% of health expenditure of average households, even today, is *out of pocket*. Furthermore national surveys reveal that the second highest reason for rural indebtedness is on account of "borrowing" for meeting health care expenses. The Western medicine-based model of primary healthcare thus has had limited penetration in rural India despite huge investments([1]) .

Two of the Millennium Development Goals specifically target mothers and children. The United Nations Development Program (UNDP) in India has been monitoring the development, and report substantial challenges in achieving these goals. India's Under Five Mortality Rate (U5MR) is expected to decline to 70 per 1,000 live births by 2015 which is still short of the 2015 target of 42 per 1,000 live births. Likewise, the Maternal Mortality Rate (MMR) is required to be reduced to 109 per 100,000 live births by 2015. India is expected to fall short of the 2015 target by 26 points. Both U5MR and MMR are influenced by several aspects in society, but adequate and appropriate primary health care is always central.

In this situation several strategies are possible. To achieve full coverage of state sponsored health care programs is likely to remain a long-term goal. In the meantime the 70% of the population without these programs need to gain access to alternatives which are optimized with regard to documentation and, subsequently, access. The existing "Traditional Indian Health Sciences" acknowledged as AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy) constitute the core of primary health care services for this segment of the population. For emergencies and surgery Western medicine is the preferred first choice, for common ailments it is usually Ayurveda, Siddha, Yoga, Unani, Swa-rigpa or homeopathy, for chronic conditions it may initially be Western medicine, if available, and then a rebound to some other system if there is insufficient relief. India has, over 200000(2) herbal formulations in its traditional pharmacopeia, and 6500(3) traditionally known medicinal plant species distributed across ecosystems.

The "Traditional Indian Health Sciences" are based on a long-standing traditional use with wealth of experiential knowledge supported by sophisticated theoretical foundations. In 21st

[1] Planning Commission, Govt. of India, 2012 Steering Committee Report on Health Sector confirms that 69% of health expenditure of households is *out of pocket*

[2] FRLHT data base 2013

[3] WHO, Global Atlas on Traditional Medicine, Gerard Bodekar, 2008

century societies this knowledge needs to be supplemented with, and revalidated by modern basic, clinical and translational research in an epistemologically appropriate framework.

1.2 Indo-Norway Initiative for Sustainable Integrated Mother and Child Healthcare

An Indo-Norway Project (Ref. No. IND-14/0006 ITD-HST University) has been financially supported by the Ministry of Foreign Affairs, Government of Norway for a planning phase of a Mixed-methods Research and Development Project to optimize sustainable integrated primary health care for women and children based on available Indian Traditional Health Sciences in collaboration with Western conventional medicine.

Treatments prioritized in the project will be chosen based on this background situation report and priorities given in governmental and WHO/UNDP reports and strategies. The deliverables will support local and central health authorities in planning and implementing improved low-cost health services for women and children in rural areas in India.

During the Planning Phase of the above project for Sustainable Integrated Mother and Child Healthcare in rural India, it is proposed to prepare a comprehensive plan for the implementation of a mixed-methods program for Norway-India research and development cooperation, to optimize sustainable integrated primary health care for women and children based on available Indian Traditional Health Sciences in collaboration with Western conventional medicine.

The planned effect for the target group of the project is:

Mother and children in select villages of rural India gain insight into their own health risks and current treatment options.

Planned products and/ or services of the planning phase are:

1) Baseline data on health status of mother and children in select villages in rural India and

2) Overview of current accessible primary healthcare and self-care options.

1.3 Collaborating Partners

The India team comprises of 3 partners:

a. Institute of Trans-Disciplinary Health Sciences and Technology University (TDU), Bangalore.
b. Pune University and
c. Field CBOs: i) Accord, Gudalur, Nilgris District, ii) Tribal Health Initiative, Sittilingi, Harur Taluk, Dharmapuri District, Tamilnadu and iii) Sri Vivekananda Youth Movement, H.D. Kote Taluk, Mysore.

The Norway team comprises of 3 partners:

a. NAFKAM, Tromso

b. Arctic University of Tromso
c. University of Oslo

2. Objectives

In all the objectives, the target population will be women and children, with emphasis on mothers and children under 5 years. Both preventive and curative aspects of health care will be enquired into in order to obtain as broad a canvas as possible on the utilization of traditional folk and AYUSH systems.

1. To document the existing knowledge regarding:
   a. use of traditional home based health practices including ethnic diets, in prevention and management of common health conditions (households)
   b. services of traditional healthcare providers - folk healers, dais and knowledgeable women
   c. services of institutional healthcare providers, both government and non-government (non-profit and for profit)
2. To generate data on health outcomes with special focus on mother and child healthcare (MCH[4])
   - Incidence of diseases with special focus on mother and child healthcare (MCH) (Secondary data)
   - Clinical outcomes of MCH related conditions covered by existing public health system and institutional providers (Secondary data)
3. To document health seeking behavior (conditions, percentage trends) and costs involved especially regarding women's health with a focus on mother and child
   - Households: Home remedies (preventive and curative), ethnic diets, health practices, life style, Household health expenditure as baseline information on Primary, Secondary and Tertiary care (Sample survey)
   - Costs saved by the self help inputs (Sample survey)
   - Folk healers: Different streams including Traditional Birth Attendants (Sample survey + PRA)
   - Institutional healthcare providers: Both Government and Non-government (Primary data from providers)
4. To document presence, scale of abundance and distribution of medicinal plants known and used in community knowledge and Indian Systems of Medicine, i.e. Ayurveda or

[4] MCH includes healthcare needs of women and children in Reproductive, Maternal, Newborn, Child and Adolescent stages.

Siddha or Unani, including assessment of availability of these plant entities by the local communities.

3. Scope of the Project

3.1 The survey findings will establish baseline incidence, prevalence, clinical outcomes of select mother/child health problems in selected sub-district sites. It will also describe currently used treatment options in selected sub-district sites including community use of locally available medicinal plants, government and non-government (for profit and not-for-profit healthcare providers), household health expenditure

3.2 The findings of the baseline survey will also provide a basis for developing a taluka level database which in turn would result in short-listing of Traditional Knowledge (TK) interventions in mother/child health problems to be designed and implemented during the implementation phase of the above project.

3.3 Shortlist high priority Primary Healthcare needs of community with a focus on Mother and Child Health by triangulating community perception, CBO experience, local government and National Household and Family Survey Data (based on primary and secondary data)

4. Methodology

4.1 Study design: The study will include mixed methods research employing qualitative and quantitative research methods.

4.1.1 Quantitative research methods

a. Baseline Survey of households
b. Household health expenditure
c. Assessment of scale of abundance of medicinal plant resources

4.1.2 Qualitative research methodsa. Key informant interviews[5]:

i. Structured interviews of traditional healers, community health workers, birth attendants /midwifes and primary care providers
W/ mother & Recently delivered mothe

b. Participatory data collection methods:
   i. Free listing – illness and possible causes, home remedies
   ii. Timeline – pregnancy, postnatal and childhood events (illness and treatment)

[5] Nordeng et al.: Traditional medicine practitioners'knowledge and views on treatment of pregnant women in three regions of Mali. Journal of Ethnobiology and Ethnomedicine 2013 9:67.

5. Study settings:

The proposed survey is proposed to be undertaken in southern Indian states and in at least two with CBO's (possibly in the third taluka which will depend on the availability of financial resources from the project grant) and one without CBO Sub-districts (Talukas) in Karnataka and Tamilnadu, India,[6]

Annexure 1 contains map depicting 3 CBOs and their information.

Field CBOs are identified as follows

i) Accord, Gudalur, Nilgris District,
ii) Tribal Health Initiative, Sittilingi, Harur Taluk, Dharmapuri District, Tamilnadu
iii) Sri Vivekananda Youth Movement, H.D. Kote Taluk, Mysore.

5.1 Sample size for household survey

Assuming that about 40% of households[7] use of traditional healers and home based remedies with an error rate of 20%, type 1 error of 5%, power of 80%, the sample size in each Taluka will be around 200.

5.2 Study Design and Sampling Plan

i. It is proposed to utilize a two stage sampling with first stage being the block and the second stage being the villages and surveying all the households in the selected villages or a sample from the selected villages would provide ultimately the total sample of 200 households per Taluka. Approximately at least 800 households from the four talukas would be selected for the survey. 10% of the sample will be randomly selected for Quality Control and will be resurveyed by a supervisor.
ii. The questionnaires will be administered to these households and the resulting data will be tabulated as frequency tables. Appropriate summary statistics will be calculated.

[6] Profiles of 3 proposed CBOs are given in Annexure-2 of the Project Plan along with their web addresses, namely http://www.adivasi.net, http://www.svym.org/ and http://www.tribalhealth.org.

[7] The above assumption is based on the finding from the National Health System Resource Centre's Survey on Role of AYUSH and LHT, by Ritu Priya and Shweta, 2010, NHSRC, Ministry of Health and Family Welfare, Government of India, which reported the use of LHTs to be still in the range of 50-75% in the states with relatively good health services, i.e., Tamil Nadu, Kerala, Haryana and Karnataka (those with higher average state per capita income and better-developed general health services in the public and private sectors).

6. Expected baseline data

The baseline survey protocol would be designed based on both qualitative and quantitative methods as follows:

6.1 Collection of data from Institutional healthcare providers

Data on a) health service providers and the populations covered by them, b) incidence of diseases and c) clinical outcomes will be collected from Primary Sources viz. i) Government and Non-Government (for profit and not for profit) institutional healthcare providers and coverage of populations served by them and ii) non-institutional healthcare service providers, viz. folk healers at the village level and knowledgeable persons at the household level. The details of data that will be collected as per the attached in-depth questionnaire for institutional healthcare providers in **Annexure-2**. Secondary data published by Government Health Department which will also need to be collected through focus group discussions with representatives of government and non-government healthcare providers.

6.2 Botanical Survey

Data on a) presence, b) distribution pattern, c) scale of abundance of medicinal plants used by local community as well as the codified Indian Systems of Medicine (Ayurveda, Siddha and Unani) will be collected through Participatory Rapid Appraisal (PRA) including Transect Walk, followed by botanical survey. The botanical team of TDU will undertake botanical surveys in the selected sub-districts through perambulation and sampled plots to assess the presence and scale of abundance of the medicinal plant resources. As per the prevailing standards for assessing the forest plant resources a sampling intensity of 0.01% will be employed in each of the strata, identified using base maps generated by KSRSAC. Randomly located sample plots of 0.1 ha each will be laid to assess the population of tree species. In each of these 0.1ha sized plots, two subplots of 3m x 3m will be laid to assess the population levels of shrubs and climbers and another four subplots of 1m x 1m to access the populations of herbaceous flora.

The details of data that will be collected as described above is given in **Annexure-3**.

Appropriate plot sampling after stratification including home gardens and neighbouring landscapes, available vegetation and ecological GIS maps, to assess the distribution pattern of medicinal plants in the selected sub-districts along with an assessment of scale of abundance.

Participatory Rapid Assessment (PRA) exercise, in the selected cluster of villages, to document local knowledge and practices regarding use of medicinal plant resources by the inhabitants.

6.3 Household Survey

Data on community utilisation of health service providers, including folk healers and knowledgeable persons as well as on household health expenditure would be obtained through household sample survey with the help of an interview schedule. A sample of the interview

schedule that will be used to collect household data as described above is given in **Annexure-4**. A sample each of in-depth questionnaires which will be used to collect the data from mothers with Under 5 children is given in **Annexure 5** and mothers who have recently delivered is given in **Annexure 6**.

6.4 Collection of data from Non-Institutional / Community based healthcare providers

Data from Non-institutional healthcare providers regarding a) number of patients covered by them, b) health conditions treated and c) costs of treatment will be collected from Primary Sources viz. folk healers and dais at the village level and knowledgeable persons at the household level. The details of data that will be collected as per the attached in-depth questionnaire for folk or traditional healers or dais in **Annexure-7**.

6.5 Prior Informed Consent

A Prior Informed Consent will be obtained from the respondents before collecting baseline data. A format of the same is given in **Annexure-8**. A Confidentiality Agreement is given in **Annexure-9** which will be provided to the respondents of Traditional Knowledge prior to colletion of data.

6.5 Pilot testing

Pilot testing of the survey tool will be undertaken in at least one or two villages each in one non-CBO area before the Protocol Workshop scheduled to be held from 10th to 12th February 2014.

An user friendly software which supports field documentation using tablets and statistical analysis will be designed by TDU team for collection and analysis of the baseline survey results.

7. Implementation of the survey

10 Field Investigators in each of the selected sub-districts would be trained and involved in the household data collection as per sampling design. They will be monitored and supervised by one Supervisor per sub-district. A Survey Coordinator would coordinate the implementation of the survey.

8. Project Timeline

As a part of the planning phase activities, a draft protocol for "baseline" field survey to collect data from selected sub-districts in India is to be developed and presented at the Protocol Workshop to be held from 10th to 12th February 2015. The survey will be implemented from 16th February to 15th July 2015.

9. Expected outcome

Sub-district level baseline survey reports on:

- Health seeking behavior
- Documentation of Traditional Knowledge for selected health conditions with a focus on mother and child health
- Population coverage
- Clinical outcomes
- Health expenditure
- Medicinal plants (Presence, Abundance and Distribution pattern)

10. Components of questionnaire

The core portion of the questionnaire includes questions about the following:

- Attitudes and feelings about the most recent pregnancy
- Content and source of prenatal care
- Maternal alcohol and tobacco consumption
- Physical abuse before and during pregnancy
- Pregnancy-related morbidity
- Infant health care
- Contraceptive use
- Mother's knowledge of pregnancy-related health issues, such as adverse effects of tobacco and alcohol; benefits of folic acid; and risks of HIV

This will generate data for

- Incidence of MCH diseases,
- Clinical outcomes of MCH related conditions covered by existing health systems
- Discussion: Should this be used as is, or some modifications are needed? This does not have many post natal questions.
- Source: http://www.cdc.gov/prams/questionnaire.htm#core

11. Study site Profile

(Based on WHO document 'Community-Based Initiatives Series' Monitoring, supervisory and evaluation tools for community-based initiatives. WHO Regional Office for the Eastern Mediterranean, Cairo 2010)

11.1. General Information

- Name of the country:
- Name of the state or province:
- Name of the district or locality or municipality:
- Name of the demonstration site:
- Type of the demonstration site (select only one) : Rural Urban
- Specify in which year the programme started at this site:

11.2. Demographic information

- Number of households:

Male Female

- Number of the population under 15: ....
- Number of the population above 15: ....

11.3. Management of health facilities

Is any health facility available at this site? Yes No

If yes, select the type of staff responsible for running the health facility at the site:

Doctors

Nurses

Midwives

Dispensers

Health workers

Health volunteers/activists

Others (specify)

11.4. Availability of basic infrastructure and social facilities

Please select the available facilities in this site (select all that apply):

Mobile health team

Trained birth attendants

Primary school

Secondary school

Electricity

Bank

Safe drinking-water (partial)

System for garbage collection and disposal of waste

Paved roads to the closest city/town
Public transportation to closest city/town

11.5. Community organizations

- Number of trained cluster representatives (CRs):
- Number of established village or community development committees (VDCs or CDCs):
- Number of male members in VDCs or CDCs:
- Number of female members in VDC s or CDCs:
- Number of established village or community development sub-committees:

If sub-committees have been formed, indicate the relevant area of work:

Health

Women

Youth

Education

Others (specify) :

- Is there any local nongovernmental organization or community-based organization that is active at the site? Yes No

If yes, specify name and area of work for each:

No.	Nongovernmental organization or community-based organization	Areas of work

11.6. Education Male Female

- Number of children of school age (between 5 and 15 years):
- Number of children 5 to 15 years old enrolled in schools:
- Number of illiterate adults (15+ years):

11.7. Health and sanitation

(all data should be based on last 12 months)

- Number of live births:
- Number of deaths under 1 month of age:
- Number of deaths 1 month to 12 months of age:
- Number of deaths 12 months to under 5 years of age:
- Number of newborns with low birth weight (< 2500 g):
- Number of mothers who died due to pregnancy and its complications:
- Number of pregnancies assisted by trained birth attendants:
- Number of children who completed 12 months of age at the reporting date:

- Number of children who completed 12 months at the reporting date and were immunized against vaccine-preventable diseases:
- Number of households with access to safe and sustainable drinking-water:
- Number of households with access to sustainable sanitation facilities (latrine and solid waste management):

11.8. Major community-based interventions

Health/nutrition
Major outcome:

Gender equity and women's development

Major outcome:

Water and sanitation
Major outcome:

Community-based health insurance schemes

Major outcome:

Literacy classes
Major outcome:

Upgrading schools
Major outcome:

Women's vocational training centres
Major outcome:

Computer literacy centres
Major outcome:

Road construction
Major outcome:

Agriculture
Major outcome:

Livestock
Major outcome:

Irrigation
Major outcome:

Micro-credit
Major outcome:

Other (please specify)
Major outcome:

12. Assumptions of study

However, it is targeting to areas where delivery of modern medicine is 'at its best' with the presence of CBOs. The CBOs we have selected are now delivering healthcare only through modern medicine as additional services to the community with available government healthcare delivery system. We want to know how Ayurveda based healthcare interventions can improve this situation when tried with modern medicine in these 'privileged pockets'.

Delivery of modern medicine in many villages is currently poor but it may improve in future (our assumption is within 5 to 10 years) and they may reach to the level of 'privileged pockets' where our CBOs are currently working. Our study will be helpful for these villages even in future. Thus the importance of our study is, it will be much more relevant for 'future India'. Not even for India, Prof Vinjar thinks that it may be helpful to developed world where modern medicine is already 'at its best'. Thus this study, in true sense, explores 'Integrative Medicine intervention'.

Our Norway team thinks that a control village (without CBO) will represent India (and developing world) where modern medicine is 'not delivered as expected'. This will solve representation of other strata of such villages and communities.

This is the basis of selection of these sub-districts and scientific rationale of our study.

These will be used for 'baseline survey'; we will conduct the pilot study in the same population.

Another important aspect is about objective of baseline study. More than measuring prevalence, it aims at 'assessing needs in the areas of MCH and define interventions'. Hence our methods also include qualitative studies like focused group interviews and timelines. For example, our questionnaire may have a limit for cross sectional data as 3 – 6 months to reduce recall. In this case, the quantitative design (survey) may not be sufficient to cover events for a complete year; hence qualitative methods may supply that piece of information. We are going to consider a particular observation, which may not evident in survey. At the same time, we want to maintain power and precision of our study, hence our sample size logic and calculation should also be robust.

Annexure 1 – CBO Profiles – Population Details and Maps

ACCORD

The genesis of ACCORD begins itself with the establishment of Adivasi Munnetra Sangam (AMS) which means Tribal Development Association. It goes back to 1986 when Stan and Mari started ACCORD as a part of an activist group and in response to the rampant land alienation of the adivasis in the Gudalur Valley joined the adivasis to help organise themselves in order to assert their human rights - especially their land rights. Some adivasi youth came forward to go from village to village, urging the adivasis to be united, to protect their land and to stand up to the people encroaching into their livelihood resources, however powerful they might be. They went from village after village exhorting the people to be confident and fight the injustice.

LAND STRUGGLE

These motivated adivasi youth, called Animators held a series of meetings in the villages. This resulted in the formation of many village level Sangams - a name for the unity of the adivasis. The village sangams started responding to issues of injustice and exploitation and helped the adivasis regain their land. People started resisting.

Suddenly they realised the strength of their numbers - and the value of their Unity. The village sangams helped adivasis shed their fear of 'powerful' people - be it the non-tribal landowners or the Government officials. Till today, everyone in the adivasi community considers this 'freedom from fear' as the biggest achievement of this movement. The village sangams eventually federated to form 'Adivasi Munnetra Sangam' (AMS). In 1988.

A massive Land Rights Campaign was organised in the entire region, culminating in a protest demonstration by AMS in Gudalur on December 5, 1988. This was the first public display of defiance and show of solidarity by more than 10000 adivasis. The issue of adivasi land alienation and their struggle for human rights were emphatically articulated by the adivasi leaders in the demonstration.

From then onwards, AMS continues to be the political voice of the adivasi community in Gudalur valley, highlighting the major issues concerning the adivasi community. Today, there are about 12500 members in the AMS spread in more than 200 villages in the Gudalur and Pandalur taluks of the Nilgiris district in Tamilnadu.

The law enforcement agencies and the development machinery of the Government, the local population, and most importantly, all the adivasis recognise AMS as the representative and identity of the adivasi community here. This mass organisation of the adivasis has come a long way since then – successfully fighting for their rights, encouraging them to take back the land and pursuing legal means to demand justice.

But, it was not a question of land alone. The social indicators of the adivasis in terms of health, education and economic status were very poor. Even while organising the people for their political rights, the adivasi activists of AMS were moved by the plight of their people and resolved to address the other problems facing the community. The village level discussions prompted us to initiate some 'traditional' development programmes, along with the political activities.

DEVELOPMENT PROGRAMMES

The health situation of the adivasis was pathetic. There was an urgent need to prevent unnecessary deaths and provide health care. So, they launched the community health programme in the villages – training adivasi women on preventive health care, immunising and monitoring the pregnant women and children, and improving health awareness in the community. This intensive programme immediately resulted in a dramatic improvement in the health status of the adivasi community.

Simultaneously, they had to tackle the question of economic needs and productivity of the land taken over by the adivasis. When the land was not productive and did not generate any income, it was difficult for the adivasis to keep it under their possession. After lot of discussions in the villages, it was decided to plant the land with Tea.

The choice of tea was a strategic one - it was a permanent crop and hence can be a proof of their possession and cultivation of land for many years. Moreover, the mainstream economy in Gudalur valley was tea-based and hence the adivasis too will become active participants in the predominant economic activity of the region.

A massive tea plantation programme was undertaken. They raised their own tea nursery, and trained some adivasi youth on the management of the nursery. Simultaneously, sangam members were trained intensively in tea cultivation and provided all the necessary support and skills for maintaining the plots. Today, more than 1000 adivasi farmers are Tea growers (traditionally a rich man's crop!) and more importantly, their land is productive and safe from encroachers. Many adivasi families are settled agriculturists now and their wage incomes are supplemented by the earnings from cultivating tea, coffee and pepper.

Similarly, they made interventions in the education field too. As the mainstream educational system was alien to the adivasi community, the first job was to become a bridge between the children (most of whom were first generation learners) and the Government schools. Taking the children to the schools and teaching them in their own languages were the tasks of the adivasi education volunteers.

Right from inception, they believed that the role of external development agencies like ACCORD is basically that of a catalyst and hence it has to withdraw as an institution once the process of change initiated by us becomes sustainable. After that, they adivasis have to take over the entire development process in their own hands. They also realised that they have to institutionalise the development activities into formal or informal organisations in order to effect an irreversible change in the process of development of the adivasi community.

So, their strategy was to institutionalise the development programmes, train the adivasi youth to manage these institutions by providing necessary managerial skills and to encourage the adivasi sangams to govern these institutions.

HEALTH

Accordingly, the entire health programme was hived off as a separate organisation called ASHWINI, which is at present covering over 220 adivasi villages through 8 health sub-centres and the Gudalur Adivasi Hospital. All the nurses in the hospital and the health animators in the sub-centres are chosen from the adivasi community by the village sangams. They were trained intensively by well-qualified doctors to provide comprehensive health care to the adivasi community.

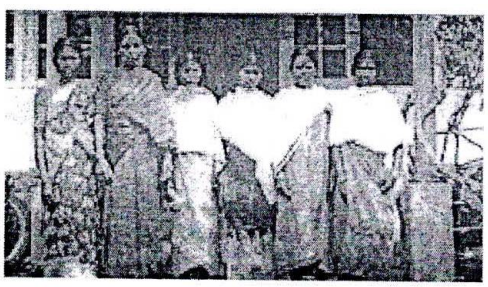
Today, maternal mortality of the adivasi women in Gudalur Valley has been reduced to zero - thanks to the elaborate Ante Natal Care provided to all the AMS members. A systematic immunisation programme has succeeded in bringing down the death rate among the adivasi children. The infant mortality rate among the AMS families is less than half of the national average. Given the extremely difficult physical terrain in the area and poor economic conditions of the adivasis, this is no mean an achievement. This was possible only due to the sustained involvement of a large number of women and men in the adivasi community at various levels. A wealth of knowledge and resource persons have been created in the adivasi villages.

The Executive Committee of ASHWINI is comprised entirely of adivasi members. The entire financing of the health programme is being managed by ASHWINI independently through internal incomes, donor support and with the help of an innovative health insurance programme.

Though ASHWINI as an independent organisation was started only in 1990, its genesis dates back to 1986 when Stan Thekaekara and his wife, Mari started ACCORD, a Non-Governmental Organisation in Gudalur. Their main objective was to to fight against the unjust alienation of the adivasi lands and other human rights violations by organising them as a strong group.

They facilitated the formation of village level sangams and these sangams enabled the adivasi families to prevent any of their land getting encroached by powerful non-tribals of that area or by the Government authorities. More than 200 such village sangams had been formed within two years. These sangams were federated at the taluk level into "Adivasi Munnetra Sangam" which till today remains the representative organisation of the adivasis, fighting for their just rights and striving for the socio-economic development of the adivasi community.

But, it was not only the problem of land. The village sangams again and again brought up the issue of health care. Women were dying during childbirth. Children were suffering from easily preventable diseases. Some intervention was urgently required. But, Stan and Marie were not doctors. They started looking out for some doctors through their contacts. Fortunately, they met two young doctors, Dr.Devadasan and his wife, Dr. Roopa, quite eager to take up the challenge.



COMMUNITY HEALTH PROGRAMME

Deva and Roopa joined ACCORD in 1987 just after their graduation from the Christian Medical College, Vellore and

launched a community health programme in the adivasi villages. The main focus was to train village level Health Workers (HW) selected from the community itself, to identify and prevent illnesses like diarrhoea, to provide immunisation and nutrition to the pregnant women and young children, and generally to improve health awareness among the adivasi community. The team went from village to village, participated in the sangam meetings and regularly monitored the progress of the pregnant women and children.

Within a few years, the preventable deaths among the adivasis (like due to diarrhoea or during childbirth) were more-or-less eliminated. The HWs did a tremendous job in the programme, kept highlighting the health issues in the villages and closely followed-up the individual cases. The immunisation status of the children & pregnant mothers dramatically improved with the launch of the community health programme. Issues like growth monitoring and nutrition were constantly brought to the notice of the parents by the health workers.

Thus far, the health programme consisted entirely of these field activities. In spite of the successful community health programme, there were inevitable cases needing hospitalisation, there were high-risk pregnancies which required the women to deliver in a hospital, and acute cases of diarrhoea and fever among children too needed hospitalisation. Deva and Roopa used to refer such patients to the local Government hospital or to the private clinics.

But, the experience with these hospitals was not very encouraging since the care and treatment given to these patients was not satisfactory, the doctors weren't there many times in the Government hospitals, the costs of treatment in private clinics were high (ACCORD subsidised these costs). Deva and Roopa were torn between following a few cases in these hospitals and visiting the villages all over the taluk.

Quite encouraged by the success of the community health programme and the role played by the adivasi health workers, the adivasi community felt that the next logical step would be to start a hospital of their own. There was a heavy demand from the village sangams to start a hospital. But the doctors were reluctant, saying that Hospital is a permanent institution which needs to be run 24 hours a day, all through the year - and for many years. The health team at that time was not equipped to handle such an institution. Moreover, the ACCORD team strongly felt that their intervention had to be time-bound and they will withdraw after a few years when the AMS can take over the initiative of protecting the rights of the adivasis. But, hospital is a permanent form of intervention which cannot be withdrawn. And, in any case, where are the nurses in the adivasi community? Another basic philosophy of ACCORD was to identify youth from the community itself to deliver all the services to the people and to train them! And, Doctors??

GUDALUR ADIVASI HOSPITAL

However, the community was strong in its demand and felt that the community health programme needed a hospital of its own to make it much more effective and acceptable to the people. So, they started a search for suitable people. Again as a curious coincidence, there landed up a doctor couple, Shyla and Nandakumar, willing to be part of the health programme. Having the ideal combination of skills as Gynaecologist and Surgeon, they were what the "doctor ordered" and the people were looking for! Young adivasi girls were identified by the sangams and the new doctors started training them as nurses. Thus was born the "Gudalur Adivasi Hospital" [GAH]. In 1990.

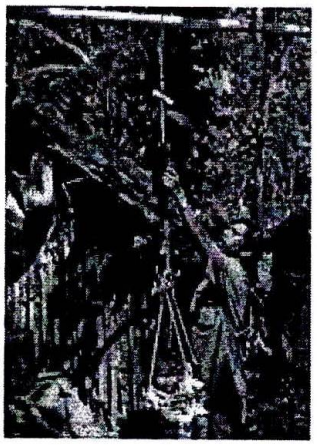
With the establishment of the Hospital, they realised that this intervention is going to continue for many years, and structurally, it has to be different from that of ACCORD or AMS. So, the health programmes, activities and the staff were hived off from ACCORD and a separate legal entity called ASHWINI was registered. From then onwards, Ashwini took care of the health issues concerning the adivasis and poor people of this area. While Deva and Roopa continued their focus on the community health programme, Shyla and Nandakumar started training tribal girls as Nurses. It was a major cultural change for the girls -

from innocent village life to a three-shifts-a-day routine in the hospital. Training had to start from elementary Maths and English.

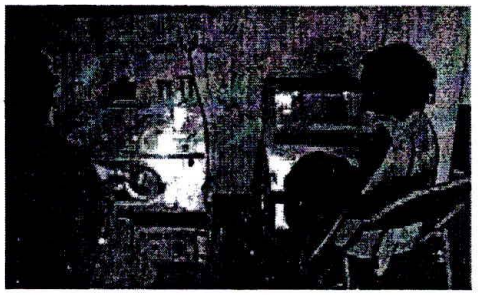
These adivasi nurses have come a long way in the next 18 years. They have become experts in conducting deliveries, in assisting the doctors in surgeries, in the general administration of the hospital, in ordering and managing the drug stocks, in designing systems to monitor the performance of the hospital (All the patient details have been computerised after 1996) and in analysing the financial aspects of the hospital management. They are constantly trained and their skills are upgraded to keep up with the growth of the programme.

Today, the Adivasi Hospital is one of the most sought after hospital in the Gudalur valley, not only by the tribals, but also by the non-tribals of the local area. Patients are brought from distant villages by ambulance and good quality care is given. As all the staff are from the community and can talk the tribal languages, the tribal patients feel at home. Efforts were constantly made to keep the place culturally acceptable to them and the community gradually adjusted to the change. Today, there are cots in the hospital, they come forward for surgeries and many of them regularly show up for antenatal checkups, etc. Some more young doctors came and worked in the hospital for brief periods - the health team getting enriched by the interaction with each of these doctors. Some quantitative details on the functioning of the hospital can be given by their Statistics section, if required.

SUB-CENTRES



Till 1994, the health programme consisted of preventive care given by the HWs at the villages and curative care provided at the GAH. However, during many interactions with the sangam members, a need was felt to have another intermediate level comprising of a group of villages. The AMS had already divided the sangam villages into eight administrative zones called "Areas" and an Area Centre was coordinating the sangam activities of that particular Area. From 1995 onwards, a health Sub-Centre was started in each of these Area Centres.



These Sub-Centres coordinate the community health programme in the villages of that Area, provide first aid and primary level curative care by dispensing medicines, Screen patients regularly, refer those needing doctor's intervention to Gudalur Adivasi Hospital and follow-up the patients discharged from the Hospital. Initially the senior nurses and health staff took responsibility to manage these sub-centres. Later, a few more adivasi girls were trained specifically to run these sub-centres - They are called "Health Animators". As per the need, they keep shifting between the hospital and the sub-centres, so as to strike a balance between the curative and preventive programmes and to keep their skills sharpened and updated.

MANAGEMENT

Monitoring and review of the activities, both in the villages and in the hospital are done by the staff themselves in the monthly meetings. Besides, a Working Committee comprising of a few senior nurses and health animators has been constituted. This group looks ahead, takes care of the long term planning, budgeting and other policy issues.

ASHWINI is registered as a Charitable Society under the Tamilnadu State Societies Registration Act. The General Body of the Society is constituted from the senior AMS activists, the adivasi nurses / health animators and the doctors. All the members of the Executive Committee are adivasis. Thus, though ASHWINI is legally an independent identity, it continues to function under the umbrella of the AMS as an institution owned and managed by the adivasis themselves for their own development.

FUNDING SUPPORT

The Community Health Programme was started in 1987 with the financial assistance of Action Aid, a charity agency from UK. The Hospital programme was supported by CEBEMO (at present called CORD AID), a Dutch funding agency for about six years till 1997. There were many individual donations from friends in India and abroad.

At present, there are a few Donor Agencies / Institutions supporting their work. Sir Ratan Tata Trust, Mumbai is supporting their Health Insurance Scheme, by providing the Insurance Premium for the last five years. SRTT is also supporting their community mental health programme. During the last few years, they are able to mobilise resources from the Government of Tamilnadu as well for HIV / AIDS control programme, tuberculosis control programme and for the mobile outreach activities.

Even though the hospital is able to generate income from the non-tribal patients and the Health Insurance Scheme, the community health programme needs to be subsidised for some more years. Hence, the financial support of these institutions and many individuals / friends is quite crucial to continue their work.

For more details, visit their website: http://www.adivasi.net

Contact Person Mr. Stan Thekkekara,Dr. Nandakumar Menon

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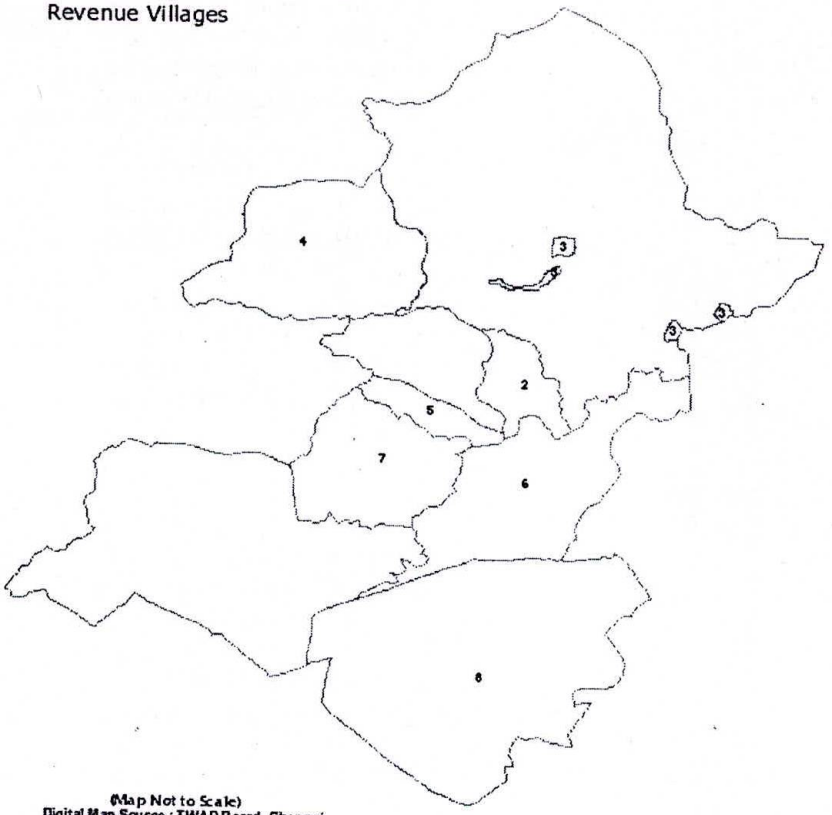
Fax + 91-4262-261504

Population Details, Census 2011, Provisional abstracts

Gudalur Taluka (Sub-district), Nilgris District, Tamilnadu

Population details	Male	Female	Total	No. of households	Household size
Rural	4176	4071	8247		
Urban	47721	49228	96949		
Population	51897	53299	105196		
Children in group 0-6 years	5455	5241	10696		
Literates	42229	39726	81955		
Rural households				Not yet available	
Urban households					

The Nilgiris : Gudalur Taluk
Revenue Villages



(Map Not to Scale)
Digital Map Source : TWAD Board, Chennai
Web Design: NIC,TNSC

Gudalur Taluk - Revenue Villages		
Number of Revenue Villages		**8**
Cherumully	**Devala**	**Gudalur**
Mudumalai	**Nellakotta**	**O'valley**
Padanthorai	**Sreemadurai**	

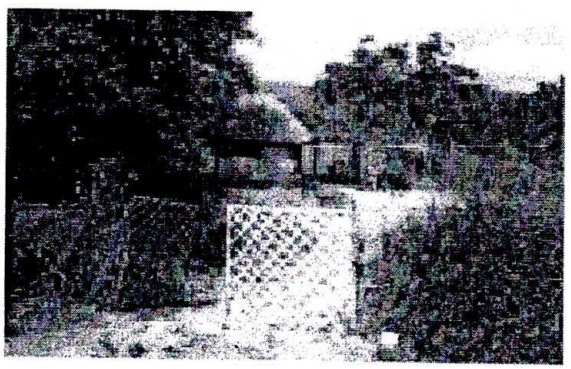
Tribal Health Initiative

Tribal Health Initiative was started in 1992 by Dr. Regi George and Dr. Lalitha Regi. Today, they have expanded into a team of over 45 highly trained people, working to improve the lives of the tribal communities living in the Sittilingi valley and surrounding hills through a variety of programmes in health care, community health, farming and craft initiatives, etc...

Brief history

The Sittilingi valley and the surrounding Kalvarayan and Sitteri Hills are inhabited primarily by tribal people, "Malavasis" or "Hill People" who eke out a living through sustenance or rain fed agriculture. About fifty thousand people live here.

Less than two decades ago, in 1992, one out of five babies in the Sittilingi valley died before they completed their first year and many mothers died in childbirth. The nearest hospital was 48 kilometres away and to find one with surgical facilities meant a journey of over 100 kilometres. The area was remote and badly served by public transport. Buses at that time would run four times a day but even getting to a bus could involve a walk across fields lasting several hours.



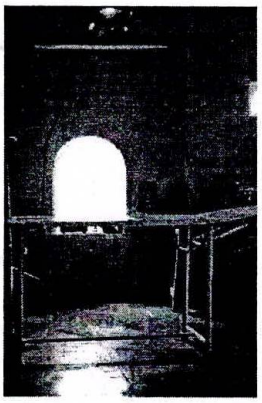
Tribal Health Initiative campus in 1995

THI started with a small Out Patient Unit in a thatched hut IN 1993. Three years later, mostly due to the support of friends and a few grants, they had built a ten bedded hospital with a rudimentary operation theatre, labour room, neonatal care, emergency room and laboratory.

In 1996, Tribal Health Initiative (THI) started training local tribal girls as Health Workers (THI's term for nurse midwives). They are now dedicated, competent and mature women who form the backbone of their hospital. They are able to diagnose and treat common problems, assist in the operating theatre, conduct deliveries, care for inpatients and go out to the villages for antenatal and child health checkups.

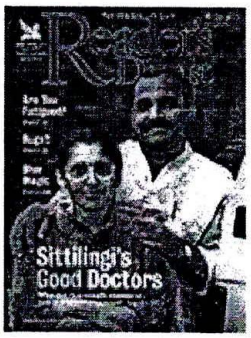
THI also has a second group of older women called Health Auxiliaries who have been chosen by their respective communities. They live in the villages and come to Sittilingi every month for reporting and training. They offer advice on good nutrition, hygiene, birthing practices and simple ailments. They host the field clinics for pregnant mothers and children. They also ensure that all babies born at home are

seen within the first week by their Health Workers. Many of them are now the key stones for community activities like farming and craft and act as facilitators for all community development work.



THI's old operation theatre with a steel table and 100W bulb

Today, Tribal Health Initiative runs a full-fledged 30 bed primary care hospital and has extended its services to conduct education programmes and outreach clinics in the 33 villages situated in the area. The impact has been dramatic.



THI was featured in Reader's Digest in 2001

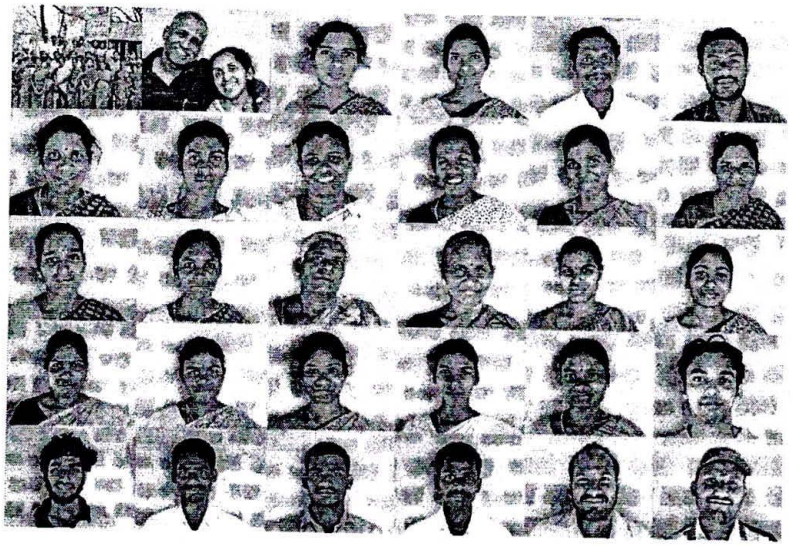
The proportion of pregnant mothers coming for antenatal check-ups has increased from 11 per cent to 90 per cent since the outreach clinics began. Infants dying within one year of birth has plummeted to 20/100 [it was 147/1000 when they started] and undernourishment has come down by 80%.

After 10 years of work in the Sittilingi valley, the project underwent an impact evaluation. A significant outcome was the conclusion that their work, based on their vision of health, should encompass areas such as education, livelihoods and basic community needs. In order to understand unmet needs, the team decided to have one to one discussions with the villagers of the 21 villages covered by THI. Out of this process, their newer initiatives have emerged such as the Organic Farming Initiative and the Tribal Craft Initiative.

They have demonstrated that in a relationship of trust, ordinary tribal people can come and successfully learn the skills needed to care for their communities.

Who are the team members of Tribal Health Initiative?

The THI Team consists of more than 60 permanent staff as in 2013.



More than two third of their permanent staff are women.

Tribal Health Initiative was started in 1992 by Dr. Regi George and Dr. Lalitha Regi. Today we have expanded into a team of over 45 highly trained people, working to improve the lives of the tribal communities living in the Sittilingi valley and surrounding hills through a variety of programmes in health care, community health, farming and craft work.

THI's vision is that the people of Sittilingi valley and Kalrayan Hills lead a better quality of life.

THI's hope:

- To attain the highest possible level of physical, mental and social health.
- To enhance their socio-economic status while retaining their pride, self-respect and self-reliance and ensuring their active participation in programmes meant for their welfare.
- To create an atmosphere highly conducive for the growth and development of local cultures and customs.

THI seeks to work with tribal people in a spirit of peace, understanding, trust, and justice.

THI's mission for the people of Sittilingi and the Kalrayan Hills is:

- To be an educator to protect and promote health and improve basic knowledge levels.
- To provide affordable and acceptable basic health care services to the area.
- To be a facilitator to help people undertake collective action for their welfare
- To provide a support system to help people come back to sustainable methods of farming
- To facilitate peoples knowledge about their rights and responsibilities and help them exercise

- To help them acquire additional skills and assist them in achieving self reliance through small scale entrepreneurship
- To provide support for the social upliftment while retaining and building on their local cultural strengths

The basic values for THI work is:

- Faith in the people and their wisdom
- Sincerity , honesty and total commitment in our work
- Secular and non political
- To respect the dignity of every individual

What THI team does?

Tribal Health Initiative views health as a state of mental, social and economic well-being and not the mere absence of disease. Their health interventions go beyond merely providing curative and preventive medical services. They see their farming and craft initiatives as being directly connected to maintaining health and well-being in the communities they serve. This is supported by the Educational Initiative , Thulir and the Technology Initiative.

Broadly speaking the following are the activities of THI:

Tribal Hospital

THI runs a 30 bed secondary level hospital which admits patients with medical, surgical and obstetric problems. The hospital serves as a base for their health outreach programme.

Community Health Programme

THI's health outreach programme provides simple curative, preventive and ambulance services to 33 villages in the Sittilingi valley and the Kalrayan Hills. This programme caters to a tribal population of 16000 tribals.

Farming Initiative

THI's Farming Initiative aims to enable farmers to practice economically and ecologically sound agriculture. They have 200 farmers now doing wholly organic agriculture.

Craft Initiative

The Craft Initiative enables local Lambadi women to become economically self-reliant while preserving their traditional embroidery. Their products are sold under the brand name Porgai, which means 'pride' in their dialect.

Governance

They are accredited by the Credibility Alliance [certificate CA/28/2014] for accounting transparency and good work culture.

Board of Trustees

Dr. Regi M George
Dr. Lalitha Regi
Prof. M Ravindran
Dr. Sara Bhattacharji
Dr. Indru Tupulur
Prof. N. Kamalamma
Dr. Sukanya Rangamani
Dr. Guru Nagarajan

The Board of Trustees meets twice a year to discuss policies and major projects. The Executive Committee, consisting of 3 trustees, meet once in 3 months to review work and take decisions. A Working Committee consisting of 7 Staff members, meet every month to take day to day decisions on work. Full Staff meetings are held every month to review work and plan ahead.

Their summarized accounts can be viewed from their website.

For more details about our CBO partner, please visit their website http://www.tribalhealth.org.

THI's address is:

Tribal Health Initiative,
Sittilingi, Harur PO, Dharmapuri District,
Tamil Nadu – 636 906.
INDIA.

Contact persons and phone numbers are:

Dr. Regi George or Dr. Lalitha Regi:

+91-9585799061; (Office phone – to contact ward, farming office and craft , ask for extension from office)

Email

thisittilingi@gmail.com
office@tribalhealth.org

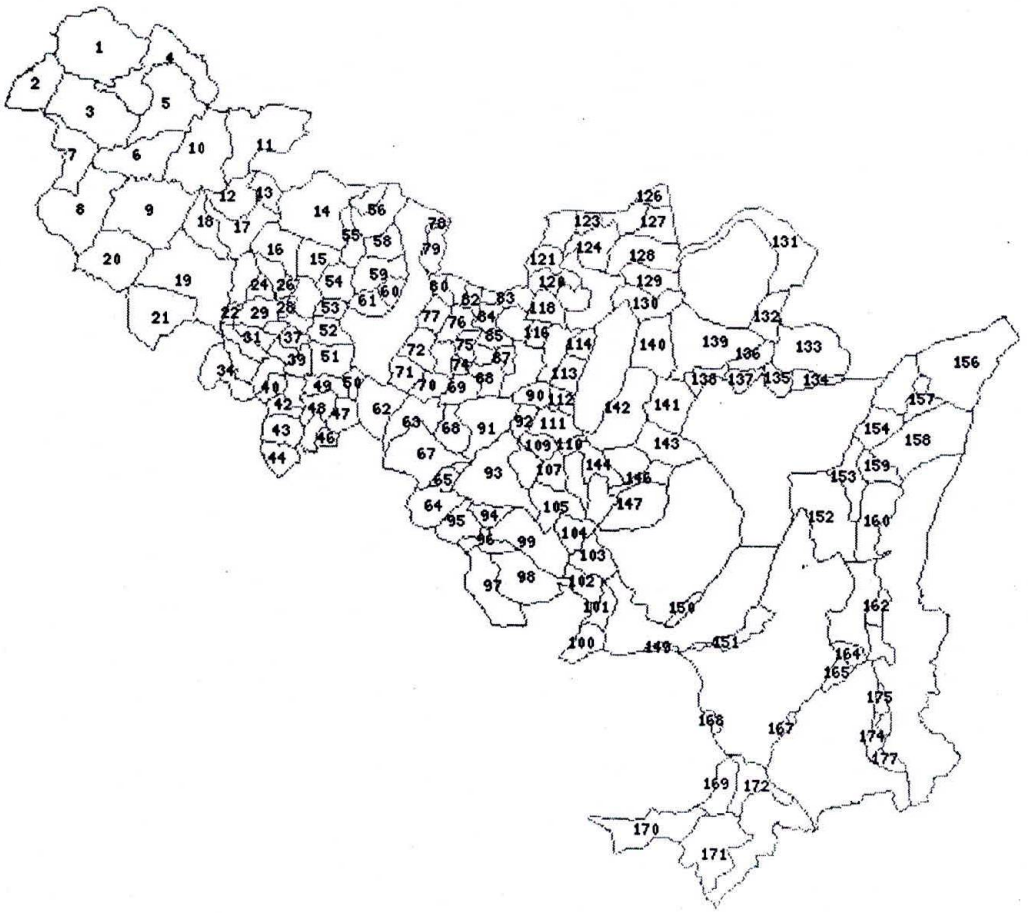
Population Details, Census 2011, Provisional abstracts

Harur Taluka (Sub-district), Dharmapuri District, Tamilnadu

Population details	Male	Female	Total	No. of households	Household size
Rural	103511	99330	202841		
Urban	18705	18811	37516		
Population	122216	118141	240357		
Children in group 0-6 years	13903	12865	26768		
Literates	83863	64274	148137		
Rural households				Not yet available	
Urban households					

Dharmapuri : Harur Taluk

Revenue Villages



(Map Not to Scale)

Digital Map Source : TWAD Board, Chennai

Web Design: NIC,TNSC

Harur Taluk - Revenue Villages		
Number of Revenue Villages		**177**
Achalavadi	**Agraharam**	**Agraharam**
Alampatti	**Ammapettai**	**Andipatty**
Andipatty	**Andiyur**	**Appiyampatty**
Avalampatty	**Avalur**	**Bairnayakampatty**
Battalahalli	**Bodinaickenpatty**	**Chandrapuram**
Chellampatty	**Chettikuttai**	**Chinnakoundanpatty**
Chinnapannimadugu	**Dasirihalli**	**Doddampatti**
Elavadai	**Ellapudayampatty**	**Ettipatti**
Ganapathipatty	**Gettupatti**	**Gobinathampatti**
Gudalur	**Harur**	**Iachchambadi**
Ichchambadi	**Ilaiyampatti**	**Irumattur**
Ittalahapatty	**Ittiampatty**	**Jadaiyankombai**
Jakkupatti	**Jangalavadi**	**Kalladipatty**
Kalladipatty	**Kamalampatty**	**Kambainallur**
Kambalai	**Karappadi**	**Karuthampatty**
Kattavadichampatty	**Kattiripatty**	**Kattur**
Kavoipatty	**Kelavalli**	**Kilanur**
Kilapparai	**Kilchengampadi**	**Kilmorappur**
Kiraipatty	**Kodamandapatty**	**Koluthambinatham**
Konampatty	**Kondampatty**	**Kondayampatti**
Kongarapatti	**Kongavembu**	**Kosapatty**
Kothanampatty	**Kottapatty**	**Kottarapatty**
Kudumiyampatty	**Kumarampatty**	**Kurumbapattiy**
Kurumbapatty	**Kurumbapatty**	**Kuttapatty**
Kuttipatty	**Lingapuram**	**Malatangi**
Mambadi	**Mampatty**	**Mandikulampatty**
Mangalapatty	**Marudipatti**	**Mattiyampatti**
Mattiyampatti	**Maveripatty**	**Maveripatty**
Melanur	**Melsengambadi**	**Mettupatti**
Mettuvalasai	**Mobirippatti**	**Mondukuli**
Morappur	**Morasappatti**	**Mottayampatti**
Mukkanurpatti	**Mungilpatti**	**Nachanampatti**
Nachanampatti	Nadupatti	Narippalli

Nariyampatti	Navalai	Nayinakavundampatti
Neruppandakuppam	Obilinayakkanpatti	Pachchanampatti
Palaiyam	Palaiyam	Pallipatti
Pallipatti	Panamarathupatti	Pannikulam
Papinayakkanvalasai	Paraiyapatti	Perayapannimaduvu
Periyapatti	Polayampalli	Ponneri
Poyyapatti	Pudinattam	Pudur
Rasalampatti	Reddippatti	Runganavalasai
S.thadampatti	Sakkilipatti	Samanattam
Samandahalli	Sandappatti	Selambai
Sengandippatti	Sennampatti	Senrayampatti
Setrapatti	Sikkalur	Sikkampatti
Singirippatti	Sittilingi	Soriyampatti
Sundangipatti	Suranattam	Surappatti
Tadaravalasai	Tamaleripatti	Tamarakoliyampatti
Tambal	Tammichettipatti	Tandekuppam
Tanippadi	Tarisal	Tekkanampatti
Thadampatti	Thadampatti	Theerthamalai
Thippampatti	Thoppampatti	Thuranampatti
Vadappatti	Vadugapatti	Vagurappampatti
Valaduppu	Vanakkambadi	Varunathirtham
Vedakattamaduvu	Vedapatti	Vedarampatti
Velampatti	Velampatti	Velanur
Velimadurai	Vengiyampatti	Vengiyampatti
Veppampatti	Veppanatham	Veppasennampatti
Vetrapatti	Vetrapatti	Virappanayakanpatti

SRI VIVEKANANDA YOUTH MOVEMENT

Swami Vivekananda Youth Movement (SVYM) is a development organization, engaged in building a new civil society in India through its grassroots to policy-level action in Health, Education and Community Development sectors. Acting as a key promoter-facilitator in the community's efforts towards self-reliance and empowerment, SVYM is developing local, innovative and cost-effective solutions to sustain community-driven progress. SVYM is also rooted to its values of Satya, Ahimsa, Seva and Tyaga, which is reflected in its program design and delivery, transactions with its stakeholders, resource utilization, disclosures and openness to public scrutiny. Buying in support from the community, working in healthy partnership with the Government and corporate sectors and sharing its experiences with like-minded organizations have been the hallmark of SVYM's evolution over the past 28 years.

Core values are the driving force behind SVYM's work:

Satya - Truthfulness
Ahimsa - Non violence (both in thought and deeds)
Seva - Service
Tyaga - Sacrifice

SVYM's Vision

A caring and equitable society, free of deprivation and strife

SVYM's Mission

To facilitate and develop processes that improve the quality of life of people

History

The year was 1984. A group of young medical students led by R. Balasubramaniam at the Mysore Medical College (in Karnataka State, India) were starting to feel that the career in medicine they dreamt of pursuing was very different from the practice of medicine around them. They believed that they had in them to make a difference and make a positive impact on the lives of the poor and the marginalized. And so, they started the Swami Vivekananda Youth Movement (SVYM, for short), with initial assets of high ideals and all the positive benefits of inexperience.

Their initial intention was to provide rational, ethical and cost-effective medical care to the needy. They started small – collecting physician samples of medicines and distributing them to poor patients, organizing blood donation camps and weekly rural outreach clinics around Mysore. In 1987, destiny took them to Heggadadevanakote Taluk, the home of the displaced and dispossessed forest-based tribes. These indigenous people, belonging to five different clans – Jenukuruba, Kadukuruba, Yerava, Paniya and Bunde Soliga – had been displaced twice from their natural habitat by development projects of the Government, namely 'Project Tiger' and 'Kabini Reservoir', and were forced to live in penury on the fringes of the Bandipur National Park.

The medicos set up a clinic at a tribal hamlet named Brahmagiri, at a distance of about 80 km from Mysore city, with a little help from the Mysore District Administration. Realizing early that medicare by itself is not enough and hoping education to be a panacea to the gen-next, they opened an informal school for the tribal kids in a cow-shed in Brahmagiri. They were able to sail through the initial days of extreme uncertainty and struggle (and even ridicule!) by pluck, some luck and with help from unexpected quarters. As days passed, more people joined hands and the work took a definite shape. Socio economic empowerment activities were added to health and education, and the rural poor were also brought under the ambit - as the organization moved from the role of a 'provider' to a 'facilitator'. A 10-bed hospital was started at Kenchanahalli, along with a host of community-based programs in Health and Education. As the medicos returned in batches after completing their post graduation, the multi-specialty Vivekananda Memorial Hospital took shape at Saragur, with generous help from donors, friends and well-wishers. The organization continued to grow and expand in the 90s, with a definite vision and strategic direction.

SVYM's Programs

All of SVYM's programs and projects fall into 4 major sectors, namely 1. Health, 2. Education, 3. Socio-Economic Empowerment and 4. Training, Research, Advocacy and Consultancy, with Health being the largest in terms of number of people reached out to.

1. Health Program

The goal of the health program is to sustain quality of health care by providing equitable care with involvement of community and in alignment with the organizational interpretation of the core values. The key focus areas are – tribal and rural health, ayurveda (the Indian system of medicine), reproductive and child health, hygiene and sanitation, care and control of HIV/AIDS, tuberculosis and blindness.

The institution-based services under health are provided through the Vivekananda Memorial Hospitals (VMH) at Saragur and Kenchanahalli. VMH – Saragur is a 90-bed facility offering multi-specialty secondary care at an affordable cost to the rural and tribal populace. It is affiliated to the Rajiv Gandhi University of Health Sciences (RGUHS), Bangalore and offers the India's first post-graduate fellowship course in HIV medicine for medical and dental professionals. VMH – Kenchanahalli is a 10-bed facility offering primary care, along with options for ayurveda chikitsa. Our hospitals are recognized training centers for capacity building of entire gamut of health professionals – from specialists to grassroot workers.

Community based services are provided in the key focus areas listed above, through the outreach program and a network of grassroot level health workers called health facilitators. Our HIV control program, that offers comprehensive, inclusive and end-to-end care, is rated as one of the best in the country and has been hailed as a best-practice model by UNAIDS.

2. Educational Program

SVYM's educational initiatives strive to provide joyful, experiential and child-centered learning – focusing on values, literacy, numeracy and appropriate vocational training. The focus is on educating children in tribal hamlets, rural areas and urban slums. The key result areas are enrolment and retention of children, empowerment of communities, promotion of child rights, prevention of child labour,

providing impetus for higher education and promotion of teaching methodology and curriculum that is contextually relevant and culturally appropriate.

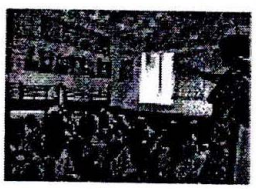
The services are provided through two schools – the Viveka Tribal Center for Learning at Hosahalli (semi-residential, formal school recognized by the Government of Karnataka) and the CBSE-affiliated Viveka School of Excellence at Saragur, and four community based initiatives – Shikshanavahini, Prerepana, Vidyakiran and Premavidya.

3. Socio-Economic Empowerment Program

SVYM's Socio-Economic Empowerment Program supports the development of self-reliant, informed, and engaged individuals and groups in rural and tribal communities. It was established in the 1980s when SVYM expanded beyond just providing health care and added a focus on addressing the root causes of the community's problems. With a special emphasis on youth and women's empowerment, the SEEP department seeks to enhance local awareness for social, political, and economic issues and catalyze community progress on the path of development.

Through programs in tribal development, public transparency, and community radio, SEEP expands social and economic opportunities for rural and tribal communities, works with communities to eradicate corruption in local government, and spreads information and awareness on local issues to promote real and lasting change.

Tribal Development Program



The Tribal Development Program works to promote the well being of tribal communities through three initiatives: self help groups, self-employment and entrepreneurship, and infrastructure creation.

Self Help Groups (A community-based initiative)

The Tribal Development Program established Self Help Groups serve as platforms for social, economic, and political empowerment. With support from the Tribal Development Program, these groups of 15 to 20 women meet weekly in their communities to collect group savings, take out micro-loans, discuss their community issues, and work together to solve their own problems. The Tribal Development Program organizes regular training sessions, regional meetings, and exposure visits to facilitate knowledge sharing, support, and collaboration between the groups, and the result has been inspiring. Increasingly, confident women leaders are asserting themselves and using their collective social power to effect real and lasting change in their communities.

Self-Employment and Entrepreneurship (An institution-based initiative)

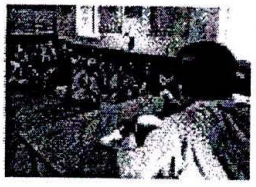
The Tribal Development Program's project in Self-Employment and Entrepreneurship seeks to create local and sustainable sources of income for rural and tribal people. In many communities, local employment opportunities are scarce, and people are forced to either work as daily wage laborers or migrate for months at a time to find work – uprooting their families, pulling their children out of school, and fracturing the community in the process.

The Self-Employment and Entrepreneurship initiative provides a local alternative by training people and skilled labor and encouraging them to stay local and generate wealth within their own communities. Through income generation projects across multiple villages, participants in the Self-Employment and Entrepreneurship initiative produce high-quality, hand-made artisan products such as fabric files, patterned bags, and woven lantana wood furniture. Coming Soon – Support these local artisans by buying products directly from our website! 100% of the profits go to the individual producer.

Infrastructure Creation (A community-based initiative)

In many rural areas, people are unable to live healthy lives because they lack access to basic things like safe drinking water, safe sanitation facilities, and efficient fuel sources. The Tribal Development Program facilitates the construction of basic infrastructure that solves these problems, such as toilets and eco-friendly biomass stoves, in order to reduce disease and improve their quality of life.

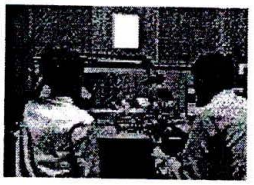
Community Movement Against Corruption



The Socio Economic Empowerment Program launched the Community Movement against Corruption project (a community based initiative) in 2009 with the goal of creating community awareness about social, political, and economic rights and entitlements, holding government offices accountable for providing basic services, and empowering local people to become strong advocates for their own needs. Through pamphlet distribution, street play, video showings, village meetings, and a mobile clinic, the Community Movement against corruption works towards strengthening Public Distribution system in H D Kote taluk.

A new initiative of the Community Movement Against Corruption is Mahiti Vedike, or "Information Forum," a project that empowers local youth to act as voluntary information ambassadors for their communities. By presenting information about government schemes at monthly Taluk meetings, telling people about their basic rights, and ensuring that they know how to access them, these young people use their energy and enthusiasm to act as disseminators of knowledge in their communities.

Community Radio



The Socio-Economic Empowerment Program launched "Jana Dhwani, or "Voice of the People" (an institution based initiative) in 2012. The first ever community radion station in Mysore district. Jana Dhwani provides listeners with timely and relevant information about local news, political, social, health issues, government schemes, and upcoming events through programs in various formats, including interviews, panel discussions, songs, soap operas, and public quizzes.

With community involvement in all stages of program planning and production, Jana Dhwani is truly a reflection of community ownership. By providing a platform for rural communities to express themselves, share their experiences, and discuss their problems, SVYM is able to facilitate the discovery of effective solutions.

4. Training, Research, Advocacy and Consultancy (TRAC)

TRAC was conceptualized to consolidate the learnings of our 25-plus years of work in the community and share them with like-minded organizations. It aims to serve India by building the potential of individuals & institutions for the development sector (Govt, NGOs and Corporates) and synergize their efforts for better, collective gain. It also strives to develop innovative programmatic models for the development sector and influence public policy.

TRAC services are provided through three institutions – Vivekananda Institute for Leadership Development (V-LEAD), Vivekananda Institute of Indian Studies (VIIS) and Grassroot Research and Advocacy Movement (GRAAM).

V-LEAD is affiliated to the University of Mysore and offers the Masters Program in Non-Profit (Development) Management. Another flag-ship program of TRAC, the 'Youth for Development', aims to create a trained, committed workforce of youth who can take up value-based developmental activities in rural areas. These two programs create career opportunities in development sector for the youth.

Vivekananda Institute of Indian Studies aims to enable contextually relevant development, founded in an understanding of Indian values, culture and tradition, and interpreted in a spirit of appreciative inquiry, while GRAAM is an institution for public policy research and program evaluation.

Governance

A 7-member Governing Body of SVYM is elected annually from among the General Body of members. The Governing Body is guided by a team of advisors, who are eminent and distinguished people drawn from various walks of life. The Governing Body meets regularly to take important decisions related to governance.

The Chief Executive Officer (CEO), nominated for a 3-year term by the Governing Body, is the Chief Functionary and oversees the management of the organization.

The heads of the 4 sectors of SVYM report to the CEO. The CEO's office directly looks after public relations, networking, resource mobilization and legal affairs of the organization. The CEO is assisted in his work by the Human Resource Development (HRD), Finance, Internal Audit, Documentation and Monitoring & Evaluation cells. The CEO is also guided by a consultative and facilitative body called Development Support Team (DST), comprising of people in the senior management. The DST initiates, supports, guides and synergizes organizational efforts towards achieving the strategic goals and objectives.

The Governing Body for the year 2014-15 is as follows:

Post	Name	Email Id
President	Dr. M.R.Seetharam	emmaress@svym.org.in
Vice President	Dr.Sudheer B.Bangalore	sudheer@svym.org.in
Secretary	Mr.Praveen Kumar Sayyaparaju	praveen@svym.org.in
Joint Secretary	Dr. Anil C	anil@svym.org.in
Treasurer	Dr. Dennis Chauhan	dennis@svym.org.in
Executive member	Dr. Vijayabhaskar Reddy	emailreddy@yahoo.com
Executive member	Dr. Ashwin A.M	drashwin@svym.org.in

Contact Persons:

Chief Executive Officer Dr. (Flt Lt).M.A.Balasubramanya mab@svym.org.in | ceo@svym.org.in
The CEO will be a permanent invitee to the Governing Body meetings.

Dr. R Balasubramaniam, Founder, Swami Vivekananda Youth Movement drrbalu@gmail.com | rbalu@svym.org.in |

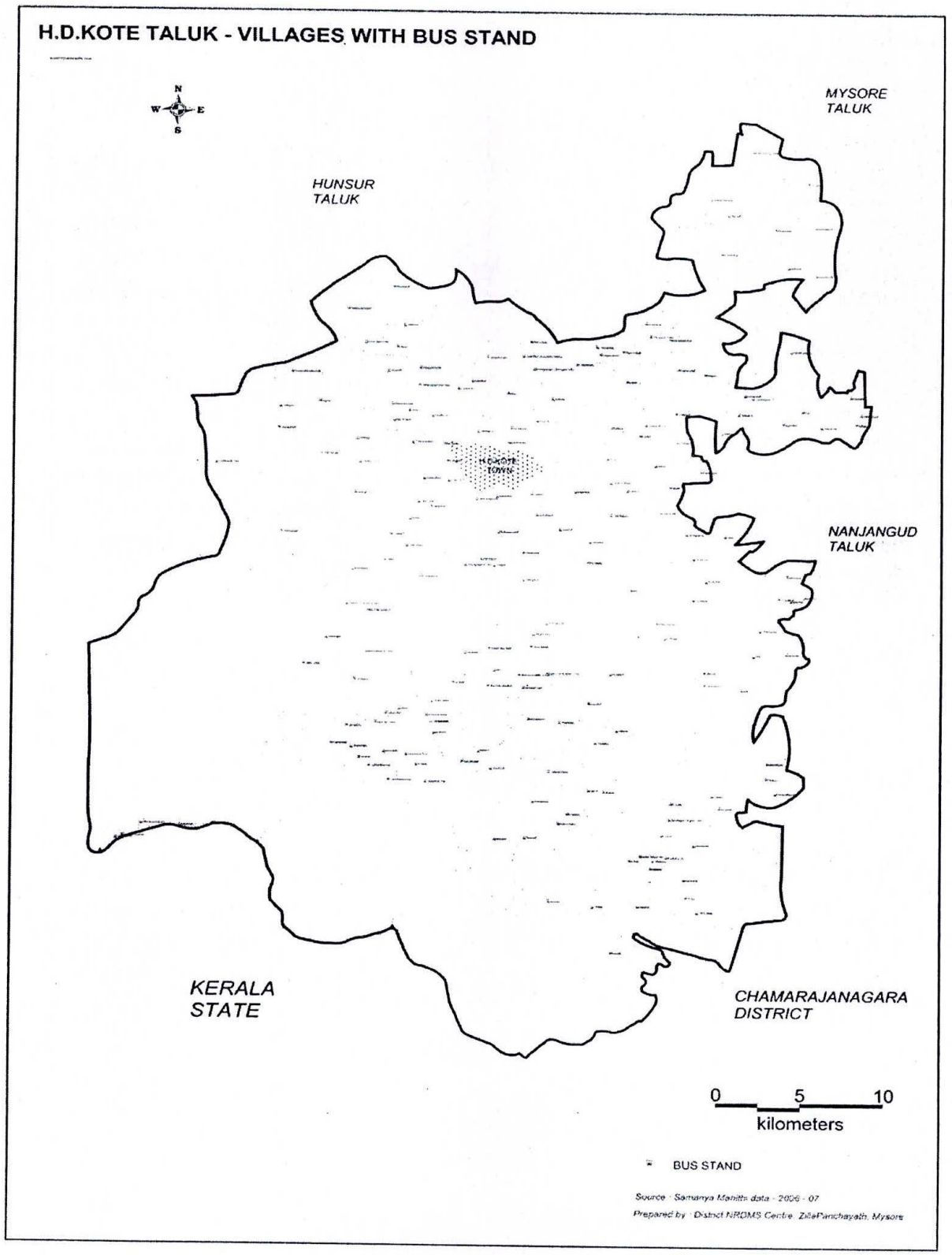
For more details about SVYM, please visit their website: http://www.svym.org/

Administrative Office Address is as given below:

Swami Vivekananda Youth Movement
Hanchipura Road, Saragur
H.D.Kote Taluk, Mysore District - 571121
Karnataka State, INDIA
Tel/Fax: (08228) 265877, 265412
Mobile: +91 9686666312
Email: svym@svym.org.in

H.D. Kote Taluka (Sub-district), Mysore District, Karnataka

Population details	Male	Female	Total	No. of households	Household size
Rural	119929	118039	237968		
Urban	12819	12919	25738		
Population	132748	130958	263706		
Children in group 0-6 years	Not yet available				
Literates	84021	66085	150106		
Rural				55430	4
Urban				6039	4


H.D.KOTE TALUK - VILLAGES WITH BUS STAND
N
W
E
S
MYSORE TALUK
HUNSUR TALUK
H.D.KOTE TOWN
NANJANGUD TALUK
KERALA STATE
CHAMARAJANAGARA DISTRICT
0
5
10
kilometers
BUS STAND
Source : Samanya Mahiti data - 2006 - 07
Prepared by : District NROMS Centre, ZillePanchayath, Mysore

KYATHANAHALLI
KANCHAMALLI
MADAPURA
THUMBASOGE
NOORALAKUPPE
K.BELTHURU
HANCHIPURA
BEECHANAHALLI
BIDARAHALLI
SAGARE
HEGGANURU
CHAKKODANAHALLI
ALANAHALLI
G.B.SARAGUR
CHIKKEREYURU
HYRIGE
HEBBALAGUPPE
NAGANAHALLI
HIRIHALLI
ANNUR
BHEEMANAHALLI
SAVVE
MANUGANAHALLI
KALLAMBALU
MULLUR
M.C.THALALU
B.MATAKERE
ANTHARASANTHE
N.BELTHURU
N.BEGURU
D.B.KUPPE

Annexure 2

DRAFT FOR DICUSSION

Schedule code: _____ Date: _____

In-depth questionnaire for Institutional healthcare provider

Objectives:

1. To document the -
   a. List of Services of institutional healthcare providers, both government and non-government (non-profit and for profit)
2. To generate data on –
   a. health outcomes with special focus on mother and child healthcare
   b. Incidence of diseases with special focus on mother and child healthcare
   c. Clinical outcomes of MCH related conditions covered by existing public health system and institutional providers
   d. List of conditions treated and costs of treatment

1. Name ~~and address~~ of the ~~institute~~ _____
2. Name of the respondent _____
3. Designation _____
4. Working hours and working days of institution

Sl. No.	Days	Working hours

5. Population served by the institution

6. List of services provided at institution

List of services	List of services

7. Who are the users of your services and why?

8. Who are not the users and why?

9. What are the cost for various services provided by your institution?

10. Average OP per month

_____

11. Average IP per month

_____

12. Health Conditions treated and costs of treatment

Health Conditions treated	Cost of treatment in Rs.

13. Specify the conditions treated for mother and children and costs of treatment

MCH Health conditions treated	Costs of treatment in Rs.

14. Please provide data on incidence of important health conditions with focus on mother and child health

Sl. No.	Health conditions	Total number of the cases reported during last one year

15. Do you provide any emergency services for mother and child health?

a. Yes
b. No

15.1 If yes specify

_____
_____
_____

15.2 If not, what you do?

_____
_____
_____

16. Immunization coverage

A. Mother .....%
B. Child .....%

17. ANC registration % _____

18. Number of deliveries in last one year? _____

19. Number of infant deaths in last one year? _____

20. Number of maternal deaths last one year? _____

21. Number of under 5 deaths last one year? _____

22. What educational and health service programs related to mother and child health that are conducted in villages?

_____

_____

23. Who are the audience of these programmes?

_____

_____

24. What is the impact of these programmes?

_____

_____

_____

_____

_____

_____

Annexure 3: Data to be collected during Botanical Survey

Objectives:

To collect the data on

a) presence,

b) distribution pattern,

c) scale of abundance of medicinal plants

used by local community as well as the codified Indian Systems of Medicine (Ayurveda, Siddha and Unani)

---

1. Date of survey .....
2. Name of the village:.....
3. Taluka:..... 4. District ..... 5. State .....

6. Forest range / Beat..... 7. Alt..... 8. Lat./Long .....

9. Collection No: .....

10. Botanical name (With popular synonyms):

.....

11. Family: ..... 12. Habit .....

13. Vernacular Names:

Sl. No.	Name	Language/ Dialect

14. Habitat (tick appropriate box):

Dense forest	Open forest	Rocky/Slopes	River side	Grassland	Marshy	Sandy

15. Unique characters of the plant

.....

.....

.....

.....

16. Local usages:

.....

.....

.....

.....

.....

17. Preparation of the medicine in detail/ Procedure

Name of the Preparation/ formula, if any	Detail of storage of medicine – if applicable	
Dosage and Administration		
		Use this column for translation/ remark on standard measurement, if any
How much? (E.g. one teaspoon or one tablespoon, one pinch etc.)		
How many time per day How many days		
Specification on dos for children above ..... day (s) up to..... year		
Specification on dose for infant aged above .....day (s) up to ..... Month		
Vehicle/ Adjuvant used in the administration and its quantity (if any) e.g. Honey, warm water, water, etc.		

18. Parts used:

.....

19. Trade information:

.....

.....

.....

20. Status (please tick whichever is applicable):

Wild	
Cultivated	
Planted	

21. Occurrence of species with approximate numbers (as per the healers' perspective):

Very common	Common	Less common	Rare

22. Name, age, gender, years of experience & address of the information provider:

.....

.....

.....

.....

.....

Name and signature of the investigator Date:

Name and signature of the person authenticating the data collected Date:

Annexure 4

DRAFT FOR DICUSSION

Schedule code: _____ Date: _____

Household Sample Survey Questionnaire

Objectives:

1. To document the -

   1.1 health seeking behavior and costs involved especially regarding women's health with a focus on mother and child health
   1.2 existing knowledge regarding use of traditional home based health practices including ethnic diets, life style, home remedies and medicinal plants in prevention and management of common health conditions
   1.3 Household health expenditure including costs saved by the self help inputs (home remedies) on Primary, Secondary and Tertiary care

1. Identification of study area

1.1 Name of the Non Governmental Organization _____
1.2 Name of the field Investigator: _____
1.3 Name of the village: _____
1.4 Name of the panchayat: _____
1.5 Name of the Taluka: _____
1.6 Name of the district: _____
1.7 Name of the state: _____

2. Respondent and household details

2.1 Name of the respondent: Code number
2.2 Religion:_____
2.3 Caste:_____
2.4 House details (no, name street, etc) _____
2.5 Type of family (Please tick whichever is applicable):
   a. Joint family
   b. Nuclear/single parent

2.6 Occupation of household members

Sl. No.	Household members	Age	Sex	Education	Occupation
1.	Member 1 Respondent				
2.	Member 2				
3.	Member 3				
4.	Member 4				
5.	Member 5				

2.7. Family Income per annum in Rs. _____ ?

2.8 Ownership of House

A. Owned
B. Rented
C. Free

2.9 Type of house:

A. Pucca
B. Semi pucca
C. Kutcha

2.10 What are the arrangements for drinking water?

A. Well
B. Bore-well
C. Grampanchayat supply
D. River

2.11 Does your family own ~~farm~~ land?

A. Yes
B. No

2.11.1 If yes, what are farm produces?

_____

_____

3. Perception of health and illness ?

3.1 What is health to you?

_____

_____

_____

_____

3.2 What is sickness or disease to you? ?

_____

_____

_____

4. Response to Health and illness

4.1 What actions do you take to maintain the health of the family members? /

A. Diet (Specify)
B. Lifestyle
C. Vaccination
D. Mosquito control: Net / Repellent
E. Personal hygiene:
F. Environmental hygiene:
G. Exercise
H. Any other specific measures, Please specify?

Therapeutic diets

_____

4.2 Do you have home remedy kit at home?

_____

_____

4.3 Does any of the member knows about home remedies / traditional health practices

more deep awareness practice

4.4 Where do your family members generally seek help from for health needs (for minor problems)?

A. Visit a temple
B. Home remedy (Specify)
C. Folk healers
D. Government hospital
E. Clinic of Private practitioners, please mention type (Allopath/AYUSH system)

4.5 Where do your family members generally seek help from for health needs (for major problems)?

A. Visit a temple
B. Home remedy (Specify)
C. Folk healers
D. Government hospital
E. Clinic of Private practitioners, please mention type (Allopath/AYUSH system)
F. Private Hospital. Mention type (Allopath/AYUSH System)

4.6 Does anyone in the family suffering from any chronic illnesses such as the following?

A. Hypertension
B. Diabetes
C. Tuberculosis
D. Sickle Cell Anemia
E. Others, Please Specify _____

4.7 Did you or any of your family members experience any illness during the last one year?

A. Yes
B. No

details who - what how many

4.7.1 If yes, what was the problem?

A. Minor (outpatient care)
B. Major (hospitalized)

4.7.2 Who Experienced? _____

4.7.3 Where did they seek help from in an order of priority

A. Went to temple
B. Home remedy
C. Sought the help of traditional healers
D. Went to a private practitioner
E. Went to a private hospital
F. Went to a government hospital

4.7.3.a If went to temple what did you do and what happened

_____

_____

_____

4.7.3.a.i How much did it cost? _____

4.7.3.b. If home remedy, what did you do and what happened? _____

_____

_____

4.7.3.b.i How much did it cost? _____

4.7.3.c. If went to traditional healer, what did he/she do?

_____

_____

4.7.3.c.i How much did he/she charge: _____

4.7.3.d. If Private practitioner what system he/she practices?

A. Allopath
B. Homeopath
C. Ayurveda
D. Siddha
E. Unani
F. Others,Specify: _____

4.7.3.d.i How much did he/she charge for the following?

1. Consultaton:_____
2. Diagnostics if any?_____
3. Medicines:_____

Total: _____

4.7.3.d.ii What happened

_____
_____
_____
_____

4.7.3.e. If went to a private hospital, where, what did they do and what happened?

_____
_____
_____

4.7.3.e.i How much did you spend for the following?

A. Consultation :_____
B. Diagnostics:_____
C. Medicines: _____
Total _____

4.8 How many times you or any of your family members went to each of the following places during the last one year?

4.8.1 Traditional Healers

A. Once/twice/ thrice/ more than three times
B. Approximate Cost: Rs. _____

4.8.2 Private Practitioners Clinic

A. Once/twice/ thrice/ more than three times
B. Approximate cost:
   i. Consultation Rs. _____
   ii. Investigation Rs. _____
   iii. Indirect costs like travel and food Rs. _____
   Total: Rs. _____

4.8.3 Private Hospital

A. Once/twice/ thrice/ more than three times
B. Approximate cost:
   i. Consultation Rs. _____
   ii. Investigation Rs. _____
   iii. Indirect costs like travel and food Rs. _____
   Total: Rs. _____

4.8.4 Government Hospital

A. Once/twice/ thrice/ more than three times
B. Approximate cost:
   i. Consultation Rs. _____
   ii. Investigation Rs. _____
   iii. Indirect costs like travel and food Rs. _____
   Total: Rs. _____

5. Do you have any kitchen garden or medicinal plant?

_____

_____

Name and Signature of the Field Investigator: Date:

Name and Signature of the Field Supervisor: Date:

N.B. We need to work out how we will estimate the annual health expenditure of the household and the purposes for which the expenses was incurred from the data of this questionnaire.

Annexure 5

DRAFT FOR DICUSSION

Schedule code: _____ Date: _____

In depth questionnaire with mother of U/5 children

Objectives:

1. To document the -

   1.1 health seeking behavior and costs involved especially regarding U/5 children's health
   1.2 existing knowledge regarding use of traditional home based health practices including ethnic diets, life style, home remedies and medicinal plants in prevention and management of common health conditions with a focus on U/5 children

---

1. Code No. of the mother (Respondent) _____
2. Village Name: _____
3. Age: _____
4. Total No of children _____

Sl. No.	Name	Age	Sex
1			
2			
3			
4			
5			
6			

5. How do you take care of health of your child? (What measures you take to prevent and promote the health of your children)
   a. Nutrition
   b. Personal hygiene
   c. Boil water and give
   d. Mosquito repellent/net
   e. Others specify_____

6. What traditional knowledge based diet or lifestyle practices you follow?

.....
.....
.....
.....
.....

7. What do you know about (colostrum) first milk of the mother after the delivery of a child?

_____
_____
_____

7.1 If you fed colostrum to your child, why?

_____
_____
_____

7.2 If you did not feed colostrum to your child, why?

_____
_____
_____

8. What do you know about additional feeding to a child?

_____
_____
_____
_____

9. When is the right time to give additional food?

a. <6 month
b. After 6 months
c. After 9 months

10. What will happen if additional food is not given at the right time to the child?

_____
_____
_____

11. What do you know about immunization to children?

_____
_____
_____

12. Why immunization is given to children?

_____
_____
_____

13. What are some of the health problems your children faced during the last one month?

a. Fever
b. Cough
c. Cold
d. Diarrhea
e. Jaundice
f. Scabies
g. Head lice
h. Skin

Others specify_____

14. Where did you seek help from and how many time?

Sl. No.	Health Conditions	Home care	Folk Healer/ Knowledgeable woman	Allopath	AYUSH	How many times
1	Fever					
2	Cough					
3	Cold					
4	Diarrhea					
5	Jaundice					
6	Scabies					
7	Head lice					
8	Skin					
9	Throat pain					
10	Stomach pain					
11	Vomiting					
12	Indigestion					
13	Constipation					

15. How much did you spend for each of the health conditions?

Sl. No.	Health Conditions	Direct expenses	Indirect expenses
1	Fever		
2	Cough		
3	Cold		
4	Diarrhea		
5	Jaundice		
6	Scabies		
7	Head lice		
8	Skin		
9	Throat pain		
10	Stomach pain		
11	Vomiting		
12	Indigestion		
13	Constipation		

16. Can you name some of the medicinal plants available in and around your village and What conditions are treated by them?

Sl. No.	Plant name	Uses

17. Who practices home remedies for U/5 children at your home?

A. Grand mother
B. Mother
C. Myself
D. Others (specify)

18. Do you seek help from outside the family?

_____

_____

19. What is the motivation for them to practice?

_____

_____

_____

_____

Annexure 6

DRAFT FOR DICUSSION

Schedule code: _____ Date: _____

In depth questionnaire with mothers who have recently delivered (less than a year)

Objectives:

1. To document the -

   1.1 health seeking behavior and costs involved especially regarding pregnancy

   1.2 existing knowledge regarding use of traditional home based health practices including ethnic diets, life style and home remedies with a focus on pregnancy

1. Code number of mother who recently delivered: _____
2. Village Name: _____
3. Age:_____
4. Date of delivery:_____
5. How did you come to know you were pregnant:

   _____

   _____

   _____
6. What was the rank of your last pregnancy?

   _____
7. Can you explain your pregnancy experience?

   _____

   _____

   _____

8. Why was this pregnancy necessary?

_____

_____

9. Where did you go for check up?

_____

10. How many times did you go for Ante-natal visits

a. One
b. Two
c. Three
d. > three

11. Did you receive IFA tablet

a. Yes
b. No

11.1 If yes did you take regularly?

_____

_____

_____

12. What happened during those visits?

_____

_____

_____

13. How much money did you spend, for what?

A. Consultation Rs. _____
B. Investigation Rs. _____
C. Medication Rs. _____
D. Travel and food costs Rs. _____
E. Others (Specify) Rs. _____

Total Rs. _____

14. What problems did you experience?

15. What medicines did you take?

16. What special diet did you take?

17. What food did you avoid?

18. What support did you get from the family?

19. Can you explain your delivery experience?

20. Type of delivery

A. Normal
B. LSCS (Caesarian)
C. Others (specify)

21. Place of delivery

A. Home
B. Sub-center
C. PHC
D. Government Hospital
E. Private Hospital

22. Complications if any during delivery

_____
_____
_____

23. How long were you there in the hospital?

_____
_____
_____

24. What advice was given during discharge?

_____
_____
_____

25. What did you like and what you did not like about the place of delivery?

_____
_____
_____

26. How much did you spend, for what?

a. Normal delivery Rs. _____
b. LSCS (Caesarian) Rs. _____
c. Was Episiotomy done (she may not know what it is the interviewer has to explain) Rs. _____
d. Others specify (complication if any) Rs. _____

27. Did you experience any of the following conditions during pregnancy and if experienced what was done?

Health Conditions	What did you do?
1. Anemia	
2. Diabetic	
3. Hypertension	
4. Bleeding	
5. Constipation	
6. Others (specify)	

28. Was there any complication during delivery?

a. Yes
b. No

28.1 If yes, specify?

_____
_____

28.2 What was done?

_____
_____
_____
_____

29. Did you follow any traditional practices during 9 months of pregnancy and for the safe delivery?

_____
_____
_____
_____
_____
_____

30. Have you done any traditional practices after delivery?

_____

_____

31. Do you follow any traditional knowledge based diet or lifestyle practices

A. Yes
B. No

31.1 If yes specify

_____

_____

_____

_____

_____

Annexure 7

DRAFT FOR DICUSSION

Schedule code: _____ Date: _____

In depth questionnaire with folk healers

Objectives:

1. To document the -

1.1 Services including the list of health conditions treated and costs involved in treatment of especially mother and child

1.2 Existing knowledge regarding use of traditional health practices with a focus on mother and child health

---

1. What is your name? _____
2. Father's / Husband's name: _____
3. Age: _____
4. Sex:
   a. Male
   b. Female
5. Village name : _____
6. Since how many years you are practicing? _____
7. How did you acquire the knowledge and skills? _____

8. What are the various conditions that you treat including problems of mother and children:

a. What conditions you treat in general?

_____

_____

b. What specific conditions of women and children do you treat?

_____

_____

c. How do you diagnose?

_____

_____

d. How do you treat?

_____

_____

e. How long is the treatment?

_____

_____

Fill in the following table as per the answers given by the respondent to the above questions

a	b	c	d	e
Name of Health Condition	Symptoms you observe to identify the condition	Treatment details (plants, method of preparation, dose)	Duration	**Subsequent** Correlation by supervisor of condition with Ayurveda/ Allopathy name

AED ICPC

- Specific conditions for both women & children

9. What is your motivation (what do you get in return for providing your service?

10. What do you do when you can't treat a condition? MCH

11. What preventive and positive health practices do you advise related to mother and child health?

12. Who uses your services and why?

13. Who do not use your services and why? ⇒

14. Do you charge your patients?

a. Yes
b. No
c. Sometimes

14.1 If yes/sometimes, how much? do you charge!

.....

.....

.....

other

15. What benefits do you get out of this practice?

_____

_____

_____

_____

16. How ~~can~~ we pass on this knowledge and practice to the next generation?

with you

_____

_____

_____

_____

_____

_____

_____

17. Do you know anyone else who practices folk medicine in your village?

_____

_____

Annexure 8

Respondent's Details

Name of the respondent:

Sex: Age:

Address:

Community:

Organisation:

Prior Consent Form (in Local Language)

I have been informed by the under-mentioned CBO/ NGO/ Government representative/ Researcher whose name and address are as given below:

Mr/ Ms/ Dr. ----------

Address ----------

That the information relating to baseline survey as per the format enclosed to prepare a Project Proposal Document on Sustainable Integrated Mother/Child Health Care in Rural India by the above mentioned CBO/ NGO in collaboration with Trans Disciplinary University, Bangalore.

I hereby give my prior informed consent to disclose the details with reference to baseline survey as mentioned above.

Sign / Thumb Impression of the respondent)

Date:

Place:

Annexure-9

Confidentiality Agreement (in Local Language)

We, the undersigned agree to keep the confidentiality of the information with reference to the baseline survey that we have obtained from the respondent and as shown in Annexure-10. We work for the CBO/ NGO / Government / Research Institution as given below.

Name of the investigator: Ms/ Mr/ Dr

_____

Sex: _____ Age: _____ years

Designation: _____

Name of the Chief Functionary of the
CBO/ NGO / Government / Research Institution in which the investigator works:
Ms/ Mr/ Dr _____

Address of the CBO/ NGO / Government / Research Institution which the investigator represents: _____

_____

___

We also confirm that after our explaining to the respondent that the information relating to baseline survey as per the format enclosed to prepare a Project Proposal Document on Sustainable Integrated Mother/Child Health Care in Rural India by the above mentioned CBO/ NGO in collaboration with Trans Disciplinary University, Bangalore.

Signature of the Investigator:

Date:

Place:

Signature of the Chief Functionary of the CBO/ NGO / Government / Research Institution in which the investigator works

Date:

Place

Guidelines / Questionnaire for Focus Group Discussion

Folk / Traditional Healers

1. What system do you practice?
2. How long you have been practicing?
3. How did you acquire this knowledge and skills?
4. What are the various conditions that you treat?
5. How do you diagnose a particular health problem?
6. Who seek your help?
7. What specific health conditions related to children you treat?
8. How do you treat each of them?
9. What specific health conditions related to women in reproductive age?
10. How do you treat them?
11. What would you do if you cannot treat a specific health condition?
12. What is your motivation for practicing?
13. What in return you get from the people whom you treat?
14. How many medicinal plants you will be able identify in your vicinity?
15. Can you comment on the availability of medicinal plants in your vicinity in the past and present?
16. How do you think this knowledge and skills be passed on to the next generation?