


Community Health Fellowship Scheme

June 2003 – May 2004

Report by

Dr. Abraham Thomas

Submitted to

The Community Health Cell,
#359, Jakkasandra 1st Main,
1st Block, Koramangala,
Bangalore – 560 034

Mentor

Dr. Ravi Narayan, *MD (AIIMS), DTPH (London), DIH (UK)*
Community Health Advisor – Community Health Cell
&
Global Coordinator, People's Health Movement, Bangalore

Field Mentor

Fr. John Vattamattom
CEO, Sanghamitra, Medak District, Andhra Pradesh

Fellowship Supported by :
Sir Ratan Tata Trust

Community Health Fellowship Scheme

June 2003 – May 2004

Report by

Dr. Abraham Thomas

Submitted to

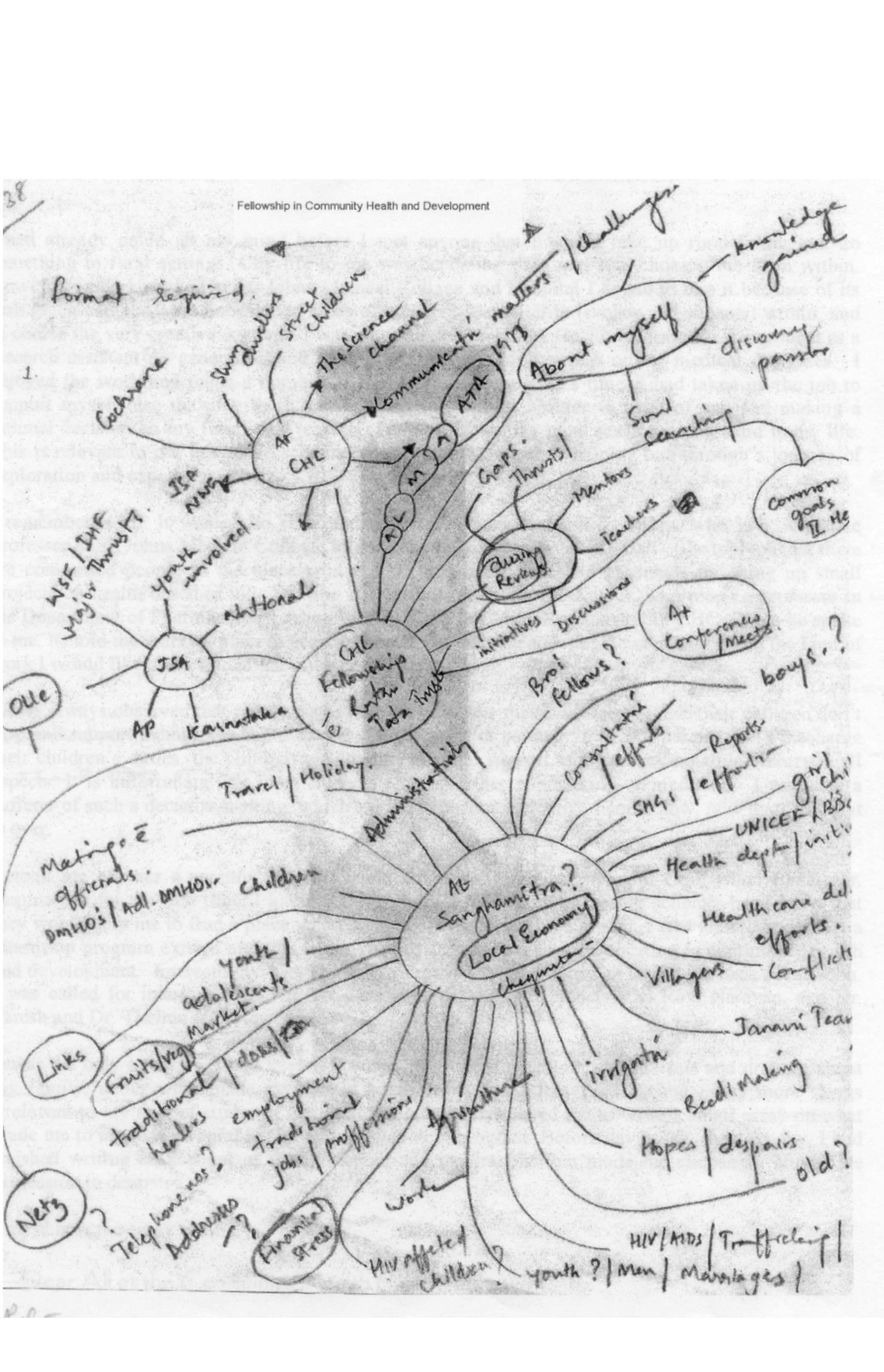
The Community Health Cell,
#359, Jakkasandra 1st Main,
1st Block, Koramangala,
Bangalore – 560 034

Dr. Ravi Narayan,
MD (AIIMS), DTPH (London), DIH (UK)
Mentor

Dr. Abraham Thomas

I dedicate this report to my forefathers,
Who moulded today
To my parents who let me dream, to
My teachers who set me free, and to
The people who let me be….

Contents



Fellowship in Community Health and Development
Format required.
About myself
challenges
knowledge gained
discovery
passion
Soul searching
Common goals
Communication matters
The Science channel
Street children
Slum dwellers
Cochrane
At CHC
ATA
Gaps. Thrusts
Mentors
Teachers
Review
Discussions
initiatives
At Conferences / Meets.
Youth involved.
Major Thrusts.
WSF / IHF
National
JSA
AP
Karnataka
CHC Fellowship Tata Trusts
Bro! Fellows?
boys.?
Consultation / efforts
Reports
Travel / Holiday.
Administratively
SHGs / efforts
UNICEF
Health dept / initiv
At Sanghamitra?
Local Economy
Health care del. efforts.
Conflicts
Villagers
Janani Team
children
DMHO's / Adl. DMHOs
youth / adolescents
market.
Links
Fruits/veg
traditional healers
employment
traditional jobs / proffessions
Agriculture
irrigation
Beedi Making
Hopes / despairs
old?
work
HIV affected children?
Financial stress
Telephone nos?
Addresses?
Netz?
HIV/AIDS / Trafficking
youth? / Men / Marriages

1. The paradigm shift and the selection process

I had made up my mind a few years ago that I would take up rural living. Life in the city was choking me and my life as a dentist I as eager to say goodbye to. When I worked at St. Johns Medical College and Hospital I began to like it for its lush green campus, vast unoccupied areas, and of course, very creative students. I was working with the Health Informatics Department as a research assistant, generating and editing information from various online medical databases. I enjoyed the work and made a number of friends in that one year. I had taken the job to support myself and to use the time to weigh various options and make rational decisions about my future and 'career'. My fellowship at Community Health Cell (CHC) was serendipitous. It started me on a journey of exploration and experimentation.

It took me another 4 months after I was first told about CHC an the unusual work it was doing before I came to it. There I met Mr. Gopinathan for the first time. I knew nothing about the fellowship scheme. I knew that CHC would help me find a place where I can work and contribute my bit. I was surprised to hear that a fellowship program exists and that is designed to help people choose a vocation in community health and development. A few days later I attended an interview at CHC.

It was the only interview I had attended where they asked me about my interests and dreams, about my family, about what made my family settle down in Andhra Pradesh and many more things seemingly irrelevant to my area of study. Before I left, Dr. Thelma Narayan asked me to write a small essay on what had made me approach a rural health and development program. Before day break the next day, I had finished writing an account of the influences and inspirations that made me choose an alternative profession to dentistry.

This is how the essay went…….

…Dear All at the Community Health Cell

It was really nice to have met Dr. Thelma and to have come to know a little more of the Community Health Cell.

Here, I am giving a brief account of the influences on my life that got me interested in the field of community health and promotion of health. I come from a small town / Panchayat in Andhra Pradesh. This is my 20th year away from home as I have been out in the boarding during school and college. Holidays and the first seven years in Kodur have had a tremendous effect on my thinking process. Interestingly they didn't manifest in earnest. Now, I simply want to be involved in the process of improving the living conditions, health and the general life of many people. In addition, I don't see myself being able to make a profit from my work or rather prefer that monthly pay packet. Interestingly, sometimes I dream of a community health research centre in my village.

We were a family of seven until recently when my grandmother passed away. My father grew up in Andhra Pradesh and my mother in Kerala. My father (Dr. M.S. Thomas) is a general practitioner in our own town (Kodur). Kodur is a gram panchayat and taluk. My father did his schooling, college and went to the university in Andhra unlike my mother who was in Kerala in the meantime. My family migrated to Andhra in the late 30s after my grandfather did his medicine from Stanley Medical College during his work with the leprosy mission in Gundalpet. Later he settled down in Kodur in the late 40s before which he was working with the mission hospital in Renigunta. The urgent need for a doctor in Kodur probably made him move to Kodur. He was a sincere and nice person from what I have heard. He had a school constructed for the primary school, a post office for the postal department, an office for the district education office, and a telephone exchange. I sometimes wonder how broader his views were and how high his reach was. His sudden illness and death was quite a shock to my family because my father was just married and had just started work at the CFC (Christian Fellowship Hospital) and three of his sisters were still not married. My father moved back go Kodur to continue his father's work. He worked with the Lions Club and the Leprosy Mission until they shut doors. He helped some of the early missionary medical services that were set up in the early seventies from Denmark, the US and Germany. During this time, he however did have a private practice (OP) that is only a outpatient set up. His patients still get their Pentids (sarabhai chemicals) and rarely does he prescribe higher molecules. We do not use pesticides in our garden and rarely do we use chemical manure. Our chickens at home are healthy and resistant to disease, and one chicken is about 11 years old and continues to lay or two at times. We are happy in our village set up. However, the scenario today is totally contradictory; the villagers use pesticides indiscriminately; the use of chemical fertilizers over organic manures seems to be fast gripping the farmers. The source of clean drinking water seems to be fast disappearing

because the ground water has been totally exhausted. Health care is a farce in the town because the doctors have turned into agents for the specialists in neighbouring Tirupathi and Madras. What really disturbs me even more is the lack of rains and proper Mango crops has worsened the socio-economic status of the people which has degraded the health status over time. Ignorance and lack of basic amenities is pushing many to suicide. These ever-constant deterioration needs to be addressed very soon. This responsibility has to be taken by someone sometime, and the buck should stop here.

I am encouraged by the work of many around me and by my instincts to think that community health needs and the general social needs can be met with constant effort from the part of many individuals. Moreover, with the large knowledge back of many responsible individuals in specific communities can be tapped to identify problems, solutions and also help formulation of policy and later monitor its implementation.

The encouragement of my parents has been very good and also been constant and ever refreshing. They supported me in various boarding schools and university too. I have been on my own since a year and I have been St. John's Medical College. I came into St. John's to actually do a study on oral microbes in November 2001 and worked under Dr. Ragini Macaden for a period of 4 months. Later, when the project failed to kick off due to financial problems, I spent a few months unemployed. Now, this is my 10th month of work in the Health Informatics Group of the Division of Nutrition. Here we generate fact sheets for the London School of Hygiene and Tropical Medicine. We research a subject and make medical literate in layman terms. I have learned the art of searching the medical evidence validating the same. I have gained a good hold in using computers to my advantage. In fact, I have gained a lot more than just this.

What I really want you to in earnest in your valuable advice and guidance. I would definitely need you to help me gather a perspective and direction to my work and study. I would be benefited in many ways by working with CHC; firstly, I would learn the ground level field work, the problems faced by every health worker on the field at various stages. In addition, I would learn the method of forging partnerships, networking with other organizations having group discussions, planning etc., I hope I would be able to do an internship with CHC and be a part of its activities.

The important feature of CHC and its new branches has given me a small idea of the broader objective of the CHC. I would be happy to hear from you and work with you in the days to come. I would like you to know that current job has helped me sustain myself during the last year, and I would be glad to continue this part if you have no objection.
But if the time constraints seem pressurizing, I would stop working at the Health Informatics Group".

The most interesting thing that happened to my life in that period of time, between attending the interview and being told I was selected for the internship, was an increase in my "Total Happiness Index". I thought even if this internship scheme doesn't come through, I still know who I should be associated with in the future. In short, it was wonderful to meet a group of highly committed people with a great sense of creativity and communication and their selection methodology was genuine, simple and open. I knew then that the philosophy of Gandhi still lives and it is possible to contribute to positive changes in the field of community health and development.

The internship programme structured for me began on 3 June 2003.

The orientation programme made helped to a large extent in my transition as a clinical person to a community health person. Clinically one tries to see thinks in black or white and see the disease as a separate entity and not as a part of a holistic entity.

Paradigm Shift		
Medical Model	→	Social Model
Individual	→	Community
Patient	→	People
Disease	→	Health
Providing	→	Enabling
Drugs Technology	→	Knowledge / Social Process
Professional Control	→	Demystification

This change of course was impending within but truly it was nurtured at the CHC and while working with Fr. John Vattamattom. The orientation programme was to a large extent useful to make the fellow / interns feel at home and also discover the areas of community health they like, or they are more likely to enjoy.

2. Introduction to Community Health & Orientation

A new chapter began on the June 3 2003. I had committed myself to a six-month program that would help me to learn about community health and development, and to develop my skills as well as strengthen my beliefs.

There were five of us in the three-week orientation program on health and development. The programme was designed to shake up our preconceived notions about 'community', health and disease. Some of the biases each of us carried were highlighted to let us understand the broader concepts of health. Our medicalized views on health and treatment were challenged with examples, discussions, and also role play. Our concern and sensitivity towards the underprivileged, sick, exploited, and the neglected was strengthened.

We had met all the staff members of CHC by then, but not at individually. When the staff opened up the Pandora's box on community health through their classes, we had the opportunity to meet them and learn about their initiatives and areas of interest.

Some of the areas covered in the classes were as follows

- A broader understanding of health - Community Health, Health Challenges, understanding doctors/healers roles, Community health needs, People's Health Movement/ Globalization etc.
- Communicable and Non-Communicable diseases
- Alcoholism
- Gender and Health,
- Food and Nutrition
- Traditional and Western Medicine – Philosophical paradigms
- Working with Communities – Various approaches
- Life skills
- Problem Identification and Solving, Creative and Critical Thinking, Decision Making Skills,
- Self awareness and Empathy
- Communication and Interpersonal Skills

- Stress and Emotional Management
- Counselling in Addiction.

After lectures one spent time in the Information Center at CHC. The Librarian, Mr. Swami, helps fish out the most untraceable book and journal. These classes were a much more interactive and relevant than many of my classes in university and school.

Through the three weeks of input sessions, I perceived the differences between primary health, community health and public health. But there was no concrete understanding of 'the whole picture' yet. I knew there were components of primary health and public health sphere that spoke of a larger picture of health, but the community health angle was still unclear. I had not lived in one while I worked on health and healthcare.

"Health for all by 2000" I always wondered about that. What had made them pick this date? Was it just a round figure? Now I know the seriousness with which the nations had come together that day, that time in Alma Ata. Most important of all, meeting the people who were involved with that time, who must have been as old as we are today, was very moving.

One of the most painful issues we discussed was female foeticide practice in India, and the alarming rates of such atrocities in the parts of the country. Dr. Mira Shiva, a senior staff of the VHAI (Voluntary Health Association of India) said that some informal studies done by observers in New Delhi showed a male to Female Ratio/1000 (MFR) as low as 650 for every 1000 male live births. This certainly reflected the urban Indian's adoption of the greed, and the obscene culture of male glorification. Unfortunately, no one opens their eyes to their own stand against life and the values of life. The stark contrasts between rural India and urban India was certainly on my mind but certainly not reinforced as it is today, after a year in rural Andhra Pradesh. In all, the state of health in India made me open my eyes wider to the issues surrounding us.

The National Working Group(NWG) meeting of the Jan Swasthya Abhiyan was the best introduction to community health and a public health perspective of the India's healthcare systems. Dr. Antia, plastic surgeon and community health specialist of the Foundation for Research in Community Health was particularly vocal about the nasty effects of the World Bank steering the course of the world's healthcare and health systems. Networks across India that had been contributing to the Movement briefly talked their own activities. The Catholic Health Association of India (CHAI), the CMAI……, the BGVS state units and the FMRAI had very extensive and innovative programmes in that direction. The Catholic Health Association of India (CHAI) of Tamil Nadu had collected more than five hundred thousand signatures for the Right to Health Campaign under the slogan "Health for All Now!)

This group planned activities for the year. At the meeting, the group paid special attention to the Right to Healthcare Campaign and ways to work with the National Human Rights Commission to take the campaign forward. They also discussed and planned activities for the International Health Forum preceding the World Social Forum in January 2004 at Mumbai. The group felt that a lot of young people need to be infused into the movement for the growth and long-term success of the movement.

The future of the communications between the partners was discussed in detail to enhance the links between the various partners of JSA and the People's Health Movement. These experiences strengthened my own faith in movements in India and elsewhere.

3. Learning at the Community Health Cell

The strength of the Community Health Cell lies in its simplicity, ethical values, and strong vision. It is indeed a great opportunity for young people like me to interact and learn from skilled and seasoned community and public health professionals like Dr. C. M. Francis, Dr. Ravi Narayan and Dr. Thelma Narayan. Dr. Paresh Kumar, sociologist, was particularly insightful into community dynamics and approaches. The Community Health Cell team consisting of Mr. Prahalad, Mr. Rajendran, Dr. Rajan Patil and Mr. S. J. Chander were generous with their inputs, advices, cooperation and help. **Dr. C. M. Francis's contribution to the cause of community health that still continues to date is a testimony to those young people pursuing a year's internship.** The library and documentation centre is particularly extensive and exhaustive. The staff paid a lot of attention to detail. Though there are some weaknesses in terms of computer networks and a stable access to the Internet, the overall resources available at the centre are excellent

After classes, we visited various initiatives (by mostly NGOs) as a part of the process of learning by doing. Among them were the initiatives with street children by **APSA (Association for the Promotion of Social Action)**, the **Community based Approach to Tackle Alcoholism (CHATA)**, an initiative of the Community Health Cell, and World Vision initiatives to educated youth and children in slums. We had also the chance to meet some nuns from different orders who were working with women in slums.

APSA

APSA has been working with street children for decades and has made headway in getting into the hearts of the children in the Jayanagar area. These children were often from very poor households, who were either orphaned due to disease or strife in family, or were let to fend for themselves from a very early age. Some of them ran away from home due to petty quarrels or sustained disagreements. They have a social network which offers support to a certain extent. They earned a living by begging and running errands. These children earned much more than what a coolie would earn in a whole day.

The youngest of the kids we met during one of our visits was a 6-year-old boy. He like many of the other children was addicted to sniffing Eras-ex. The children never compromised on some things - food, cigarettes, beedies, alcohol, and the eras-ex solution. The staff members of APSA had fallen in love with these children, and often wondered what they would do without them after a while. Wednesdays were special to the children, as the APSA staff would come to Jayanagar 4th Block, near the Bus Station to meet them. The children tried not to miss this meeting and often openly said that this was the only window they have to care and affection. APSA tried to give them legal support, counselling, and space to settle their differences amicably.

We observed from close quarters that these children were quick learners, and absolutely uninhibited. They had no reservations to talk about the police, violence, sex, and drugs. The children seemed to be affected at a deeper level and were lacking genuine love and concern, which is probably the result of an unending saga of homelessness, abuse, harassment, hate, revenge, fights, drugs, hurt and resentment. Their behaviour is the sum of societal neglect and gross lack of empathy.

Today, we are at a crucial stage when we stand on many such human time bombs such as these children who are finding their own meanings, their own paths, and evidently their own destinies. When antisocial elements in society get their hands on them, they would benefit from their confidence and hurt for illegal purposes such as violence, theft, drug trafficking, and commercial sex.

APSA is trying hard to rehabilitate them and to take them off the streets after counselling them adequately. Only a few have undergone a change of heart. As I think of those children my heart sinks; even their basic Right to Life is under question. Hardly any of these children see the daylight of adulthood and responsible living. Most die young due to disease as a result of lack of care, support systems and societal rejection. Very little is understood of the number of street children who have come out doing well on their own, or rather nothing is documented. Some of the boys end up working as 'hit-men' and local 'goondas'.

It would be miraculous, if we can rehabilitate such children in a rural setting with employment and schooling together, where their strengths are to be identified and their skills nurtured to be able to bring "the best citizens possible" out of them.

Community Health Based Approach To Tackle Alcoholism (CHATA)

Almost over one and a half years ago, Community Health Cell had taken up a pilot study to assess the effectiveness of a community health based approach to tackle alcoholism. Mr. Rajendran had initiated the study and action research on the approach with the help and support of other members of the Community Health Cell team.

This programme primarily aims at strengthening the support mechanisms in small communities prone to alcohol abuse and alcohol related problems. One of the methods adopted was to build close contact with the local communities through women's forums. Through the forums women shared with one another, their experiences with alcoholic husbands and children. This process moved the women in the community to action and made them take decisive steps in convincing their husbands and children to quit. Most often, it was the 'method' of using love and concern, which yielded better results. Force and confrontation was never used in this process. This yielded not only community participation in the programme but also a great deal of participation in other community developmental activities such as construction of roads, drains, and latrines. The people who underwent detoxification treatment at the National Institute of Mental Health and Neuro Sciences (NIMHANS) became community witnesses. Sudhamanagar Slum is a classic example of a success story in the little effort against the dreaded epidemic of alcoholism.

A study in NIMHANS of a 20 year follow of persons treated with hospital based care at the institute showed that only one of the 20 persons followed up continued to live as a alcoholic, while 10 died and the others were unavailable in their earlier places of stay. This depicts partly the ineffectiveness of hospital-based rehabilitation or rather its failure.

Some of the observations one would make at this point of the study on the reasons for the increasing trend of alcohol consumption would be

- The increased dissatisfaction among the marginalized about their social standing and a disgruntlement at the widening gap between the affluent and themselves
- Escapism from an unpleasant reality
- The unmet need of healthcare among the marginalized which has led a number of persons to a cycle of debt
- An exposure to alcohol in one's youth as a part of peer pressure and group-decision making
- The increased number of outlets serving alcohol and the setting up of targets by the State Government for which the traders even serve alcohol on credit to meet the requirement. In fact, the number of retail outlets for alcohol has had a steep four-fold rise in the past few years
- Lack of life skills and lack of basic self regulatory and self moderating capacity among the people due to extreme poverty and lack of information

As a part of the fellowship, I made the most by learning from Mr. Rajendran, his captivating style of community-based communication, his empathy, and his dedication to the cause of those under the grip of alcoholism.

Life Skills

Community Health Cell team member, Rajendran, also imparts life skills to adolescents in the slums. World Vision is working in the Rajendra Nagar slum area concentrating on education and vocational training of adolescent girls. Identification of children for the life skill education was not difficult there.

The life skills were imparted as a part of the tailoring classes the girls attended at school. The responses to the classes were tremendous, and the outcome of the classes was sometimes unbelievable.

Once, a girl asked Rajendran how it was possible to make her father stop drinking and also stop hitting her mother. She lived in a slum and was from a family of five. After asking a few questions, Rajendran observed that she wasn't very affectionate with her father though she loved him, and here was an opportunity for her to help him out with his problem.

He asked her to change her behaviour towards him. He asked her to go to him, sit next to him, give him a hug or hold him. He asked her to tell her father that he ought to show his love to them. The girl did so in the following days, and there was a miraculous outcome; the man quit his habit of drinking and promised to stay away from the habit. Though the incident smacked of a testimony in church, but it really did happen. It was a miracle we often forget we are capable of performing. It seemed to me that life skill education has enormous potential to help adolescents and young adults to face, solve and overcome hurdles in life, to make the right decisions and to take appropriate measures in stress situations.

The Anti-Tobacco Campaign

The Community Health Cell team has been working extensively on the issue of tobacco and poverty. Chander, who heads the initiatives along with consultations with the other team members, has been networking with various other NGOs and CBOs in strengthening the movement. College students are being roped in through interactive sessions and talks on the ill effects and the social paradigm of the problem. Anti-tobacco rallies and demonstrations have been held with the networks. This has been an ongoing activity of Community Health Cell for many years. Its pace and strategy have been well worked out to improve the current trend of the movement.

Movements and Campaigns

The People's Health Movement which took shape after the Dhaka summit of the People's Health Assembly in the year 2000 was of great significance to me

especially while considering the strength with which it dialogues with Government at national and international levels. The National movement called the Jan Swasthya Abhiyaan has groups in various states

Meet Sister Celina

A group of nuns located very close to the Ragigudda Slum near JP Nagar of Bangalore introduced us to many of the families, with whom they closely worked on economic empowerment initiatives. Some of the women of the slum agreed that since the economic empowerment programs were linked to the education of their children, their children's education got a higher priority. The initiatives of the religious nuns we were able to give us an in depth view of the economic empowerment programs among the urban poor.

Observations

- Many young adults and old were suffering from Tuberculosis (both history and symptoms suggested)
- Housing was poor and there was overcrowding in almost all the homes
- Many women lived on beedi-making and agarbatti-making for their livelihood
- Women deserted by their husbands too lived in the slum while taking care of their children and earning
- A lot of children were yet to be enrolled in schools and had not been sent to Anganwadi centres either
- The narrowness of the streets and the lack of space brings about frustration among children who enjoy space and freedom
- A lot of children were however yet to be enrolled in schools and had not been sent to Anganwadi centres either
- Slum dwellers seem warm and friendly always offering a seat or something to drink immediately afte being introduced.
- Slum dwellers are generally more resilient and strong. They have developed mechanisms to face the everyday struggles to survive and live too
- There are issues like goondaism and exploitation that are not spoken about. The slum dwellers remain under the grip of unscrupulous elements who often exploit of the weakest.

This exposure to various urban issues put forward many questions in my mind and had a tremendous impact on the way I speak with street children, alcoholics, house helps, vegetable vendors, auto drivers, and rickshaw pullers. I know now that each one has a narrative of resilience. These growing numbers of displaced people living in cities strikes me as a spill over of rural poverty.

People in villages are proud of their own villages. They have an identity, have an address of their own, sometimes even land of their own. Most often they have family and friends whom they know from birth. Here in the cities, they do not often have a sense of belonging. It takes a while before such belonging is felt in the city. Even card-carrying city dwellers often long for home after the fist few days in a new place.

My exposure confirmed what I had been told. Most health problems have an underlying social context and a socio-economic link. A larger displacement of the rural poor and an extreme growth of cities cannot be immediately prevented. It needs careful thought and political will for this to be gradually phased out, or even to be discouraged.

4. Setting Objectives & Planning the Year of Fellowship

After much internal introspection I arrived at a set of objectives that I set for myself for the one year of fellowship. I knew some would change and Dr. Ravi Narayan helped me break up these goals into smaller tasks.

Introspection

- To learn how Health is a part of development and to explore a vocation in Community Health taking into consideration wholesome health
- To be under the guidance of able and experienced hands and to share their dreams, experiences, approaches, failures and successes
- To build my own capacity and to change certain beliefs and assumptions that may be harmful
- To have a years time for soul searching on my stand in order to deepen my own understanding of the power centres that affect health at various levels

Community Health (General Learning)

- To integrate various aspects of Health with general sustainable development
- To internalise the aspects of equity, distribution of healthcare, and the access to healthcare.
- To understand the larger determinants of health and disease for developing necessary safeguards
- To understand and resist exploitative medical, pharmaceutical and other healthcare practices which impoverish middle and low-income groups
- To study the structure and function of the Public Health system as also of the Private healthcare system and understand the merits and demerits of each of them for planning an alternate system, where both coexist (perhaps) devoid of malpractice and negligence

Community Health (Field Learning)

- To develop a bond with people belonging to rural regions in India to understand their future in terms of the current context of healthcare
- To strive towards preserving the existing integrated systems of healthcare
- To bring about and promote local innovations in community based health systems and integrated development
- To be in a community based 'health and development' programme for removing biases that comes from distance learning.
- To try various approaches to reach village communities and to first understand their pace of life, they're needs and aspirations, before planning and intervention.
- To learn how concepts of Health can be kept simple, comprehensive and fair.

Networking

- To share the enthusiasm and commitment with other persons and organizations in the field of Health and Development
- To network with them and build capacities and plan a more streamlined and united approach for affecting greater challenges in policy that bring equity in access and distribution

Communication

- To understand and learn to the use of media to get across the concepts and practices in simple and effective healthcare models

5. The Journey with Sanghamitra

Here is a brief account of the one year of efforts, from Sanghamitra towards strengthening of the sub-centres in Chegunta Mandal. This is to give you a brief idea of the activities in the project that concluded end of August. In all these activities I have worked as a part of the team and always associated with the planning and implementation of these programmes.

In addition to the sub-centre revitalization programme the most important of the health initiatives taken up by Sanghamitra was the community eye health programme. This programme was planned and proposed to the Sight Savers International, which then came into operation in April 2004. It was indeed a good experience.for me to have been able to help in the project planning, and implementation. This showed me some of the most difficult areas in development including that of Human Resources and Human relations.

Today every village in the Mandal has a village health committee, self help groups that monitor their functioning and youth activists who report some of the gaps in the health system and how one could change things.

1. During the project period Sanghamitra strengthened the village level awareness on the public health system through daily village visits to meeting with Self Help Groups and the village Janani Committees. These village meetings contributed to increasing awareness among women about the health facilities, the services available and also regarding the duties of the public health personnel.

2. Most villages and hamlets in the Mandal were covered during the project period for purpose of strengthening the people changing their perceptions of the public health system. The Janani Committees became the main contact points of the villages during the year for all health related activities in the 36 villages and the 8 major hamlets. The village JANANI COMMITTEES have been imparted knowledge about the services of the public health system that are due to the public as a state responsibility and not as a welfare measure.

3. The JANANI committee members today help the health workers from both the public health department but also from NGOs and other Governmental Societies such as Velugu and DWCRA to conduct surveys, report deaths and report case studies of denial of healthcare in public and private healthcare facilities.

4. Though the time frame prescribed by the project to empower village Janani Teams, Village Health Committees and the Community Advisory Boards to take up the complete responsibility of locally monitoring the services was realized to be quite insufficient considering the slower pace of village life and the village reactivity to programmatic implementation of the project.

5. The project holder, Sanghamitra, facilitated people to make complaints regarding the poor services in the Public Health system in the area. These efforts initially brought about criticism from the Government Staff, but over time all the staff members realized that the project intervention was intended to bring back transparency in the services of the Public Health System. Today, many of the staff members continue to collaborate with the project holder and the Janani Team Members in activities that improve the health conditions of the people.

6. The health committees in some of the villages brought to the notice of Sanghamitra cases of denial of healthcare in many different places.

Integration - A vision with Fr. John

Integration has been Fr. John's dream from the time he was working with the Catholic Health Association of India (CHAI) as the director. As the founder and secretary of the organization Sanghamitra Fr. John is hopeful that the objectives with which they setup Sanghamitra would be realized some day. Fr. John always says that the deeper meaning of integration must be understood by the people, the leaders and the administration. So, he always begins with the staff of Sanghamitra lays emphasis on their role of integrating the health sector, the developmental

sector, the agricultural sector, the forest and environmental sectors, the education sectors and the administrative structure. He believes that true development would take place only when there is unison among these sectors.

During this one year...

- The sub centre revitalization programme
- I was closely associated with the village library project a population of 20000.
- The community eye health programme covering a population of over two hundred thousand
- Identification of children who are in the risk of being trafficked
- Working and interviewing Street sex workers

NB: Programme reports set as annexure

6. The Land and Plenty of Talents

Tapped or Untapped?

The Mandal of Chegunta is known for its diverse population and peaceful coexistence - different castes, religions, sects and economic strata, alike. This coexistence had contributed to the growth and development of the society in diverse ways.

Chegunta and its neighbouring mandals flourished once with weavers, artisans, basket makers, shoemakers, dressmakers, potters and acrobats. The strength of these art forms came from generations of dedication, steadfast local improvisations and a constant demand for the various products. The market and demand for these products and art forms had existed locally for many hundred years but unfortunately died a sudden death. The sudden changes in the open markets, mass industrial production, and lack of preparedness among artisans and neglect of such small industries impoverished the artists and lead a number of them to migration and suicide. Some of the well to do persons took to other lucrative professions. Today some of these professions lack the critical mass to voice their concerns about their difficult lives and dying professions. These people are also best at their own trade and profession. They are less inclined to other forms of livelihood opportunities and this warrants intervention from many quarters including those of Governmental agencies, NGOs, local bodies, women's collectives and surely that of the communities in which they live.

The Last Man Standing

The Weaver Community engaged in the making of cloth, sarees, dress material, dying and embroidery have only one person in the whole of three blocks (as far as the knowledge of the people of the community *(Padma Shali) continuing the profession of their ancestors. **Shri. Bala Narasaiah** is the last man standing, and does the long learnt art in pride. He does not produce many items but takes care that he does not stop spinning wheel. His wife is a proud and worried woman, who describes the pace of his work as "sacred". She again lightly puts it as "Nela oka pogu" (one yarn a month).

The Sanghamitra team that visited elderly man were touched by his sincerity, humbleness and simplicity, not to forget his hospitality. He said, he could teach this profession to patient, and eager youth who could carry on this profession. He said that women could well carry out this profession forward if they were given the necessary training and support. Shri. Bala Narasiah is the last man standing against the onslaught of the effects of industrialization, neo-liberal economic policies and globalisation.

Wooden Wonders

What was passed on from the fathers and forefathers of Mr. Md Sarvar Hussain today still holds hope and livelihood for the 20 families of Chettlathimmaipally. Wooden handicrafts - such as Units for garlands and wooden ornaments, Door knobs, Koolattam sticks, Dolls, and other small artistic carved wooden implements. The art from must have originated from the Mughal time and has a history of more that 150 years in this region. This art from provides a round the year employment and has an excellent export possibility in the years to come. Today, it is limited to Hyderabad but if explored, this art from can build into a very good small scale industry and the results for the communities needs no mention. Mr. Md Sarvar Hussain, and Mr. Md Kausar Hussain of Chettalthimmaipally have a lot of promise in store and we could well take them to higher strides through integration and support.

Bangles of Pearls

Chandampet has been long known for making bangles with pearl and precious stone inlay work. Today, as many as One thousand of such artisans have migrated from Chandampet for better prospects to other areas thus leaving the local economy in shambles. The support system in the local economy was devastated a few years ago when the market economy came into full thrust and industrial production of less exotic and cheap bangles were produced on a mass scale in various parts of the country. The local traders did not have the necessary inputs on aggressive marketing and were suffocated with the breakdown of their market.

Today, there is hope again with women involved in DWCRA SHG groups taking the lead in reviving the production lines of the profession. We hope that their effort have a long way to go and lots to promise the local economy and the pride of the people of Chandampet.

Potters with Empty Coffers

The potters the region have another miserable story to tell.... There are many potters and the new age pottery has not left them with much. The changes in the wants of the people and the changes in the lifestyle of the people has left them with little. The main employment generating source was earthen roof material. The roofs of concrete, which do not conform to the climatic conditions and health of the people, have decreased the demand for earthen roof material to an all time low, to almost nothing. Brick houses and concrete jungles in the area have not only affected the growth of the industry but also changed the economic support systems of the people of the area. Lack of knowledge and stagnation among the potters and other social factors has brought them to this pitiable situation.

Prospects for them seem bright when we see the brighter side-

Tile making units, brick making units and other small handicraft from making units of clay and mud can change the bleak future of the community....

Baskets of hopelessness

Basket making tribes in the area are underpaid and have been at the mercy of bargains and daily troubles. The skill passed on to them from generations is still being utilized to the maximum today... We need to bring hope to these people through a well thought strategy that would bring sustained equality in pay and earning. Improvement of skill through skill development classes and training programmes can bring much entry into the markets of cities and local minds.

Women neglected, society demolished

Women In the area have taken to beedi making putting their mental, social, physical, and spiritual health on a thin line ... We need to bring back the life of the people and identify with them closely, as close as to the heart. The changes in the economic patters, markets and the new age needs kept in mind we need to change things positively and for good. Women need to be not just empowered economically but also given their due in society through out programmes....

We need to bring back the glory of the skill in the area and involve the women in this effort to the maximum...

Schools of Weaving, Units for Bricks, Units for Wooden implements and basket making industries have lots to promise,., Aggressive marketing and education of local consumers of self sustainability of economies is the need of the HOUR.

B. Kondapur Village, Chegunta Mandal, Medak District
The Janani Team

Bonal S/C

1.	Sarpanch, Chairperson	Sri. Karingula Mallawa
2.	ANM, Convenor	Smt. M. Sarala Kumari
3.	Ward Member	Smt. Paleti Laxmi
4.	Anganwadi Worker	Smt. R. Napurnima
5.	Self Help Group Members	Smt. Srkali Mangamma Smt. Chanda Mangamma
6.	Mother's Committee President	Smt. Boya Padma
7.	Youth Activist Preferably Adolescent	Rangammapari Swapna

Action Plan area of ANM including all the Hamlets and Tandas

1. B. Kondapur
2. Bondal
3. Pulimadu
4. Kistapur (t)

_____ _____

ANM Signature Sarpanch, B.Kondapur

_____ _____

PHC Medical Officer Mandal Development Officer

7. Soul Searching

There is a lot of truth out there; we just need to realize them.… Live them and see what we need in our lives, take them and carry them for others to see. Truth is what will change hearts, not intellectual exercises –

I made this up.

There is a philosophy of Disease, the realization of `Self' during illnesses, the knowledge of civilizations, the philosophy of simple and holistic health, the humility of healers, simplicity of their thought, the need for sacrifices in life, the acceptance of natural death, and the simplicity of healing, which are the utmost lessons of health in the Indian context.

We have a rich culture that has a beautiful methodology of dealing with sickness and the soul way of dealing with losses, disease or disability. For example, we need to appreciate the concept of community based healing of the mental illnesses in many parts of the country. Though we are on a warpath trying to ape the western hospital based care, we need to keep the ever more simple and effective approaches of healthcare in the reach of all people. All!

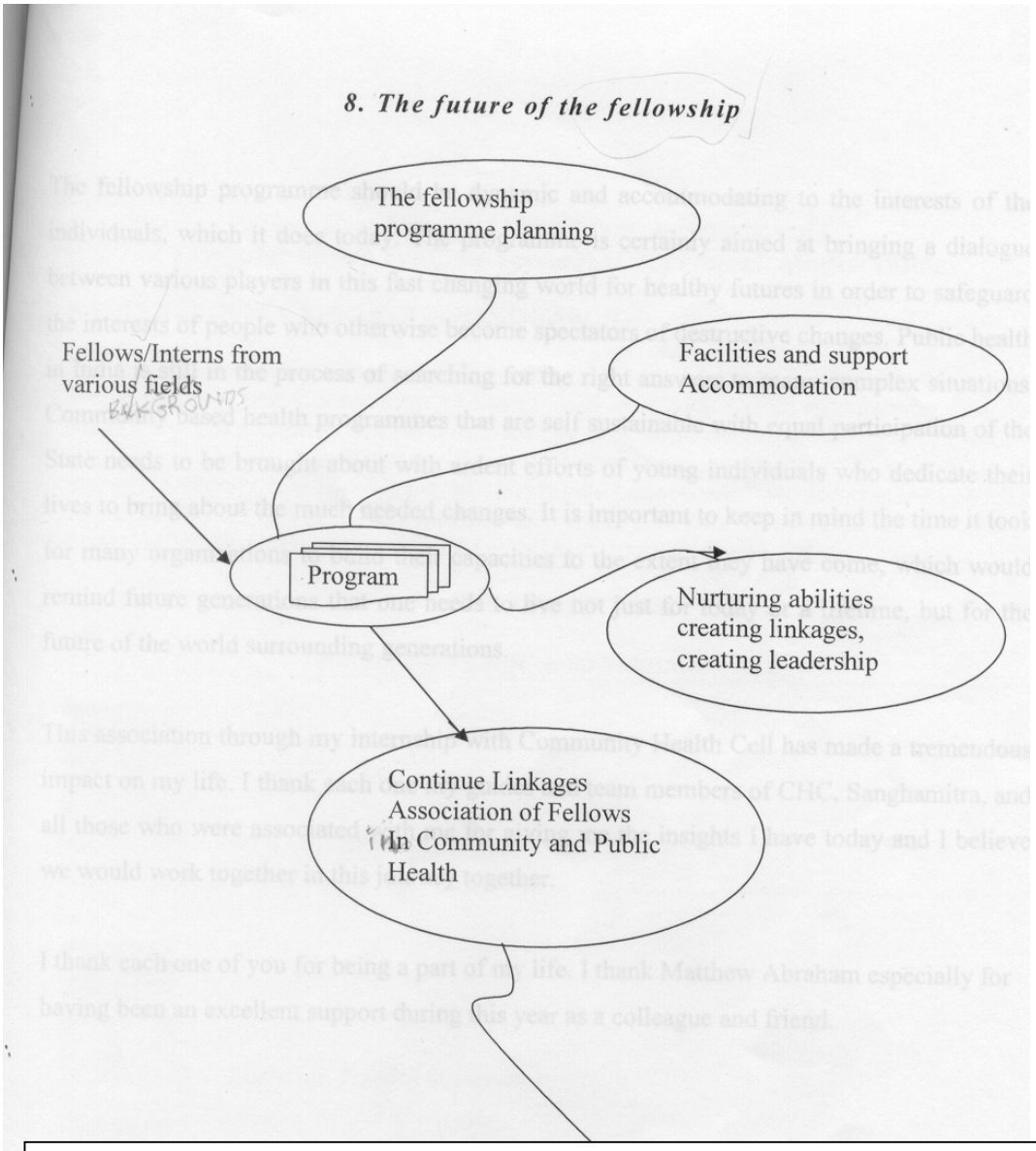
In September 2003 I began my journey with rural India's health, where fresh air, simple living, nutritious and fresh food, and love were in abundance. I surely did not look for what they did not have. `People - sure did not have my `know it all attitude'.

These were some of the most intriguing times of my life, when I was left to myself in a relatively underdeveloped region in terms of investments and industry and left to feel with the people what their everyday lives had to offer, the processes in place, the systems which were either or not in place, and to see the patterns of livelihood opportunities and future trends that were to come.

The experience alongside Sanghamitra work in the area was particularly enriching because the organization is young with its set of teething

problems, and with its own philosophy that's evolving with in-depth involvement in communities. One of the many things I learnt to be patient while looking at bringing about changes in systems. Patience is a virtue that has to be picked up whenever possible and this would be particularly useful to those working with the public health system, because of the intrinsic slow speeds with which things take their course. But, there is of course the need for a systematic involvement of communities in taking up health and development at all levels beginning from the villages up to the district and state than leaving anything to chance.

- As children we did know that we could change situations since we used pencils and erasers… but as we grow old we begin to believe that we cannot change things because we use indelible ink and we just feel suffocated without finding solutions.
- I made it up.



These fellows and interns can be placed in areas of interest such as public health economics, public health planning, financing, globalization and public health, disaster management, etc., or rather new areas such as public health and media, animation, communication strategies, creative writing, text book writing for school children. The spirit of CHC linking between activism and policy advocacy should be strength. CHC expands operations to other states or regions through these linkages

The fellowship programme should be dynamic and accommodating to the interests of the individuals, which it does today. The programme is certainly aimed at bringing a dialogue between various players in this fast changing world for healthy futures in order to safeguard the interests of people who otherwise become spectators of destructive changes. Public health in India is still in the process of searching for the right answers to many complex situations. Community based health programmes that are self sustainable with equal participation of the State needs to be brought about with ardent efforts of young individuals who dedicate their lives to bring about the much needed changes. It is important to keep in mind the time it took for many organizations to build their capacities to the extent they have come, which would remind future generations that one needs to live not just for today or a lifetime, but for the future of the world surrounding generations.

This association through my internship with Community Health Cell has made a tremendous impact on my life. I thank each one my guides and team members of CHC, Sanghamitra, and all those who were associated with me for giving me the insights I have today and I believe we would work together in this journey together.

I thank each one of you for being a part of my life. I thank Matthew Abraham especially ' having been an excellent support during this year as a colleague and friend.

ANNEXURES

Sanghamitra – Sight Savers International
Comprehensive Eye Care Services (CES) Project, Medak District

A brief account of Project Implementation

The project was initiated with the selection and training of 12 Eye Health Workers, one supervisor and the Coordinator of the project at ICARE, LVPEI, Hyderabad. The three week long training programme was carefully crafted to cater to the need of the CEHWs and supervisor staff members. One supervisor joined the team on 12 May 2004 (He is trained in community eye care and community based rehabilitation at ICARE LEPEI and was involved for six years with various initiatives in community eye care and community based rehabilitation programmes of LVPEI in conjunction with SSI).

The Project Team

Project Director	:	Fr. John Vattamattom, SVD
Dr. Abraham Thomas	:	Chief Project Coordinator
D. V. Ramana	:	Project Supervisor
K. Muthyalu	:	Project Supervisor

Community Health Workers

Pulaboina Devanand	Rukhsana Sultana
Pembarthi Laxman	Koppunnuri Veerapa
Kondal Reddy	Kolupula Anasuya
Kondal Goud	G. Srikanth
K. Radhakrishnan	Gatu Vinodha
M. Ramesh	Shabana

The Next Step after the Training

After the training programme, Sanghamitra conducted a Door-to-Door 'mock baseline survey' on Eye Health for three days in the neighbouring villages of its operational area. This was done primarily to evaluate the CEHW's performance at field level and to ensure efficacy of the actual baseline survey.

During this period, Sanghamitra arranged few training sessions with "Velugu" Resource Persons, "Local Doctors" and other in-house staff members regarding the local terrain, habits, diseases and socio-economic and sociological aspects of the area. This helped the CEHWs to understand the spirit of Sanghamitra and to know the other activities, with which Sanghamitra is actively involved. This also helped in bringing about integration of various activities of the organization.

The baseline survey on eye health began immediately after the return of the staff from their training at LVPEI.

For undertaking the survey Sanghamitra prepared the following materials:

- Baseline survey forms with translation (to Telugu) (provided by SSI)
- Consolidation forms and lists (provided by SSI)
- Area revenue details
- Population and other details from previous surveys of the Velugu Project (APRP)
- PHC and Sub-Centre details
- Route maps
- Lists of primary and secondary schools
- Lists of Auxiliary Nurses and Anganawadi teachers
- Details available with Sanghamitra about differently able children.

Physical Performance

I. Resource Built

Total number of review meetings	8
Total number of Awareness campaigns conducted at village level along with the baseline door-to-door survey	10
Digital video recording of the survey and educational programmes on eye health	1
Meetings with Velugu Project personnel [Govt. of Andhra Pradesh, Society for Elimination of Rural Poverty (SERP)]	2
Orientation of CEHWs to tapping local resources in project area	3

II. Eye Care Activity

Summary of Door-to-Door Survey

Total number of villages covered	33
Total number of Households surveyed	6228

	Adults		**Children**		**Total**		
Details	Male	Female	Male	Female	Male	Female	Grand Total
Total population covered	11947	12040	5365	5222	17312	17262	34574
Total number of curable cases	2332	3235	224	269	2556	3504	6060
Total number of incurable cases	34	21	3	1	37	22	59

TO DATE THE COMPREHENSIVE EYE CARE SERVICES PROGRAMME HAS ACHIEVED THE FOLLOWING:

- 33 villages and 18 hamlets have been covered through door-to-door survey
- a total revenue population of forty-six thousand (approximately) has been cove3red during this period. A total of 6928 households and a population of 35,547 participated in the survey.
- 59 incurable cases of blindness were identified so far (these cases need screening and further evaluation before Community Based Rehabilitation Programme (CBR) is begun
- a large number of cases of Vitamin A deficiency were also identified.

Many other eye-related diseases were seen and have been recorded for interventions at various stages.

(NB: The reasons for a difference between the revenue population and the actual covered population were found to be the following:

1. Migration to other places in search of work as a result of continuous drought conditions for the last 7 years.
2. Owing to people engaging in daily labour, and
3. Summer vacation]

The Baseline Survey – How we went about

The team of CEHWs were detailed for conducting the baseline survey in groups of 4-8 members. They have been covering an average of 25 households per day per person initially owing to lack of experience in conducting the survey and the learning involved. This has now been improved and it is targeted to touch 50 plus houses per day per CEHW. The lack of cycles and motorbikes was supplemented by using auto-rickshaws and other means of transport.

Activities planned for July

1. Conducting awareness programmes about the project and an Eye Health in the context of the baseline survey findings.
2. Planning meetings with ICDS / Anganwadi teachers regarding immunization programme linkages and IEC activities on eye health.
3. conducting training programmes on eye health for Anganwadi teachers and ANMs.
4. Conducting community based education programmes on eye health for Self Help Groups (formed by Sanghamitra and Government agencies). Village Panchayatiraj members, and Primary School Teachers.
5. Identification of resources and resource mobilization for screening programmes
6. Conducting community screening programmes.
7. Initiation of referral services to LVPEI through planning and MoUs (an introductory letter to the Director of LVPEI in this regard expected).
8. Launching of the CES Project at block level.

Concurrently, the baseline survey will continue in Toopran and Ramayampet Mandals.

Dear Mr. Vasanthram,

Here is a break up of the expenses Meghamala would incur in the next three years. The monthly expenses could be increased if the need be, but otherwise, I don't want it to be that she gets used to a lot of money she wasn't all these days.

Thank you,
Abraham.

Sl. No.	**Expenditure**	**Amount**	**Refundable**	**Yearly Total**
1.	College fees annually	2350.00	1800.00	550.00
2.	Hotel admission fee annually and deposit	2750.00	1300.00	1450.00
3.	Monthly Hostel fees and Mess Bill	1150.00	Nil	13,800.00
4.	Monthly Personal expenses	400.00	Saving for the month	4800.00
5.	Monthly expenses on stationery and purchases for material in labs and college	250.00	NA	3000.00
6.	Coordination expenses for Sanghamitra annually	1800.00		1800.00
7.	Clothes			1000.00
	Total support required			23,700.00
	Total scholarship received annually		3100.00	

The Science Channel

A process in progress

It takes many decades to launch satellites and longer to make them useful to common people. As a part of the same effort, ISRO plans to launch a Science Channel that would be accessible across the country.

To bring about participation and uniformity of character in the vision of the Channel, DECU (Development Education and Communications Unit) of the Indian Space Research Organization has initiated a contact programme all over the country. DECU had brainstorming sessions in various cities across the country with think tanks, scientists, students, farmers, union leaders, filmmakers, writers and people from the mass media. These sessions were held in Mumbai, Bangalore, Kolkotta, Gauhati, Delhi and Ahmedabad with the help of Ms. Chondita Mukherjee, a renowned docu-film maker and thinker. Various student-volunteers, professors, and representatives of Non-governmental Organizations helped in the success of the extensive and detailed consultations.

Community Health Cell too took part in the initial consultations, and later in the planning and facilitation of the two-day workshop at Bangalore. It took the lead in planning and formulating the framework of the content on health content on the proposed Science Channel. Dr. Sanjay Biswas, Professor of Mechanical Engineering at the Indian Institute of Science (IISc) was the key organizer of the initial brainstorming and planning of'the workshop. He also led the team in the final 2-day workshop held at 'Ashirwad', on St. Marks Road in Bangalore.

A survey was done in Andhra Pradesh prior to the consultations at Bangalore to bring out information on TV viewing among the southerners (Telugus, Kannadigas, Konkanis, Tamilians, Malayalies and other linguistic minorities). CHC took the lead in doing the survey on rural Tv viewing. This was crucial in giving shape to inputs for the health content on the channel.

The survey was conducted in Koduru, a block division in Cuddapah District of Andhra Pradesh; here a lot of issues related to TV viewing were brought to light.

Aims of the Survey

- To elicit the TV viewing patterns among rural populations.
- To evaluate the needs of TV viewers of rural areas & to elicit their understanding and its applications in their lives
- To evaluate their likes and dislikes about TV programs
- The role of TV in their lives today

And to understand

- The language preferences among various age groups
- The popular time slots for TV viewing and preferences among various age groups
- Their preferences and formats of TV programs
- How a Science Channel could help their communities?
- To evaluate the popularity ratings among rural TV viewers

The survey brought out facts about the necessity for an accessible, interesting and imaginative science channel that can bridge the rural urban divide on access to information and technology. The additional advantage of using the science channel to have interactive classrooms, was observed to be a useful proposition in the context of poor education quality among rural schools, both public and private schools.

Health Deliberations for The Science Channel

The two-day consultations were formulated to accommodate discussions on broad topics such as water, communication, management of the channel, and lastly communication technology. The proposed health component of the science channel was discussed with a panel of doctors, social workers, health personnel and free thinkers on the subject. Two areas of health that are often neglected - women's health and mental health were deliberated upon owing to availability of resource persons who happened to be specialists in women's health and mental health, respectively. The broad outlines with which the discussions started were based on the earlier survey.

- The channel should be socially relevant
- The inputs should be interesting, & technically and scientifically sound
- Something that came out of the survey was to keep the channel more focussed on the promotive aspects of health than on the curative.

I think the Science Channel is ISROs (Indian Space Research Organization's) most innovative brainchild in its efforts to make "Science for Everyone ".

Annexure 1 (The Minutes of the Deliberations)

Report on the Deliberations of the Health Group for the Science Channel

The composition of the health discussion group

1. Dr. Uma Sri, health communicator and specialist trainer in health communication
1. (Village school exercises and interactive learning through visuals), Worked with and organization called THREAD in Orissa
2. Elizabeth Vallikad, Former professor at the KIDVAI Institute Of Oncology, Bangalore. Currently head of the Department of Gynaecology at St. Johns Medical College, Bangalore
3. Dr. Srinivasa Murthy, Professor and Head of Psychiatry, NIMHANS (National Institute Of Mental Health And Neuro-Sciences), Bangalore Specializes in behavioral psychiatry and life skill education to children and adults
4. Dr. Sanjeev Jain, Professor of Psychiatry, NIMHAMS
5. Dr. Rajan Patil, Community Health Cell (Homeopathic Doctor, Epidemiologist, Specialist in Vector borne diseases such as Malaria, Kala Azar and Dengue)
6. Vajranna, (A village health activist)
7. Sachin D'souza (Intern, St. Johns Medical College and Hospital, founder of the Forum 19. (1). (a) which deals with various Current Issues, Health Issues, Rights issues and Awareness among various student groups across Bangalore.
8. Suvarna Deshpande, Video Production Unit (DECU)
9. Michael John, Film Maker, worked as a film maker with CHAD, Vellore on Leprosy and health related issues
10. Prof. Dr. Vidhyanand, Professor, Indian Institute of Science
11. Nirupama Sharma (Health Consultant), and
12. Dr. Abraham Thomas, Dentist, Fellow at the Community Health Cell, Bangalore.

The discussions were documented by a number of Students from Srishti School of Art ad Design

1. Nithya Rao	2. Shamin D'Souza,
3. Seema,	4. Ekta,
5. Natasha, and	6. Thomas.

(Students of Communication and Design)

In addition, this group of students helped not only with the documentation of the discussions but also by contributing innovative ideas and methods for the presentation of the various TV programmes on health. Their inputs are very valuable, and their doubts on health issues lent 'great strength' to the discussions.

Dr. Abraham Thomas, Focal Person for the Health discussions, moderated the various discussions. He is a Ratan Tata Fellow for Community Health, at Community Health Cell, Bangalore.

Minutes of the First Day Consultations

The initial discussions were aimed at identification of areas of health that require immediate attention and address. Various persons at the group discussions introduced themselves to each other and made themselves comfortable in the discussion group.

Prof. Dr. Vijayanand of the Indian Institute of Science suggested a documentary series with the use of the Normal Functions of the Body since basic physiological functions are interesting and is very important to know. During the later part of the discussions on women's health we found that this programme could be incorporated in education on the biological development of the foetus, genetic influences, and growth and development.

Dr. Srinivasa Murthy suggested that community health should be an important part of the channel and be dealt with at three different levels

1. **Grass Roots** (the people of India)
    a. Rural
    b. Urban
2. **Non- Professional**, (for the health workers at Village Level, Block Level, at Panchayat level and Anganwadi workers level)
3. **Professional**, (for doctors, nurses, technicians, druggists, etc.)

He also said that Mental Health was a very important subject for the channel and the professionals and the government have neglected mental health and the issues around it - eg. Dependence, Schizophrenia, geriatric mental health, myths and misconceptions on mental health, etc.

Dr. Elizabeth Vallikad suggested 'women's health as a pressing issue that has to be addressed with urgency through immediate action and constant intervention. She gave startling statistics of the incidence of female genital tract cancers (cervical cancer) and the high prevalence of this condition among Indian women; the commonest causes of death due to this cancer are late detection and neglect.

The necessity for science, scientific understanding of health and effective health at the grass root level was identified as an important step in the situation in India. Suggested by Dr. Sanjeev Jain, this concept was agreed upon by the participants.

Dr. Srinivasa Murthy also suggested that the channel should be working towards broadcasting (telecasting??)
- Three important areas

1. General information on health issues (health being a integral part of life - focusing on primary education, primary health, clean water, good housing, nutritious food - not drugs and treatment)
2. Controversial health issues through discussion and researched material, and
3. Specific validated health information

He also stressed the need to study areas of traditional medicine such as Unani, Ayurveda, Homeopathy, and other Holistic Medical practices in India and to use the channel to bring about the best of these areas and eliminate malpractices and misconceptions. Dr. Rajan Patil, who is a graduate of homeopathy, suggested the necessity to research various areas of holistic medicine and bring out the best the various fields can offer.

Dr. Elizabeth Vallikad added, "There is a great deal of unlearning that we must undergo to accept and to be open to the knowledge and methods of traditional medicine. Eg, traditionally postmenopausal women supplemented calcium to diet and avoided osteoporosis, instead it is compensated with so many drugs and supplements today that are not only expensive but unnecessary".

To address the general myths about health and healthy living many participants of the discussions thought the channel needs. The concept of buying health through

medicines was an important misconception identified even in the survey done in Koduru, Andhra Pradesh as a part of the run up to the workshop.

Dr. Sanjeev Jain suggested that there is a need to understand the anthropological aspects of belief systems and addressing them on those platforms, an important step towards effectively dealing with the mindset of the people.

The issues of gender and gender inequality in health access have been proven through PHC and hospital records in the past. Dr. Vallikad suggested it was important to bring about social equality of health.

She emphasized on the alarming rates of female foeticide and infanticide among the richest states in India (Punjab "754 females per 1000 males") as well as an alarming decrease in the female ratio in Kerala, which is traditionally a female friendly state. This suggests the negative use of high-end diagnostics (usually ultrasound machines) meant to be used in foetal monitoring.

Dr. Vallikad said, "The regulation of these diagnostic centers as well as implementation of laws stringently needs publicity and popular support through channels such as these". Making doctors responsible and aware of the consequences also needs special attention she said. At the policy level, attention must be paid on such criminal practices and their social implications and should be a salient feature of the health component of the channel.

Another major topic raised by Dr. Sanjeev Jain was the tendency of the Indian Medical Education to cater only to the deeper pockets, making health inaccessible to lower economic groups. The corporatization of health services and the corporate model of health care were discussed along with the influence of the global economy on our traditional and neo-healthcare systems. The transparency of these decisions and changes, and what they mean to the health of the common man was considered to be an important issue that needs to be researched and broadcast on the channel.

The necessity to integrate traditional approaches to health and health care and the medical sciences was another area of the discussion that was greatly emphasized.

The entry of health insurance and the corporate influence on policy of funding public health care systems was an important aspect of our health discussions. Dr. Sanjeev Jain and the students of the Srishti School Of Art And Design suggested these issues be discussed in open forums on TV for participation, for allowing feedback or criticism. (Eg. Big Fight).

Dr. Elizabeth Vallikad recommended that the influences of the environment on health be an essential focus of the channel because of the advent of the new age diseases which often find no causative agent behind the disease. To sum this up the areas such as

1. New age diseases (SARS, HIV, EBOLA, Viral Gastroenteritis)
2. Ecological medicine, and
3. Investigative medicine

Dr. Sanjeev Jain and Dr. Elizabeth Vallikad recommended these steps to keep pace with the various aspects of the diseases and their control.

The students from the Srishti School of Art suggested consumer Rights and the necessity to educate the public via discussion forums on TV and Design and was backed by Dr. Srinivasa Murthy.

Dr. Sanjeev Jain suggested that the evolution of health care practices in India from the traditional practices to the current day practices need to be studied and documented. In addition, the evolution of the National Institutes such as CMC-Vellore, AIIMS-New Delhi, JIPMER- Pondicherry, St. Johns Medical College-Bangalore, CMC-Ludhiana, JJ Hospital-Bombay, and many others need to be understood and documented via the Channel.

Many rural health centers and rural models of development and health should also be documented. The Jamked example of integrated development and empowerment can be an example of community participation.

Dr. Vallikad wanted the art of medicine to come out from the shadow of the science of medicine for the greater interest of bringing back the largely lost glory. Geriatrics, a neglected subject in our~ country, is another important subject that requires the attention of both the people and the policy makers because the large middle aged population of our country would constitute a large chunk (1/5~ ~f the population) in 20 years. Therefore, education regarding care of the old need to be addressed through the channel.

Dr. Vallikad suggested that Road traffic accidents, health hazards of various kinds (Industrial, Agricultural, etc.), are important issues to be addressed openly instead of cautioning through warnings.

Drunken driving, for example, is a very common practice in India, whereas in Europe or the US, enforcement is an effective deterrent.

Medical Ethics - regarding the current practice of medicine, the unethical prescription of drugs by doctors was seen as very critical problem. In contrast, practicing medicine by the oath one takes, and the need to be highlighting this with real life stories was suggested by Dr. Thomas and Dr. D'souza.

Dr. Rajan Patil suggested that communicable diseases have remained important healthcare issue draining our economy, and how they are sidelined. Educating people through the health component of the channel would be a novel way of reaching those who actually know very little about many diseases including Malaria, Kala Azar, Filariasis, TB, Typhoid, etc.

He suggested that **programmes on the causes of disease, prevention, and their** cures could be very informative and useful.

Eg: the fact that common malaria (malarial parasite) carrying mosquitoes breed in stagnant water over the sunshades, old buckets, and utensils lying outside. This can be avoided avoiding stagnant water and designing sunshades without a collection compartment (making it flat).

The issue of immunization, its common misconceptions, and realities could be incorporated into the popular scheme of soaps or family dramas, which would catch the attention of the public.

Dr. Abraham Thomas added that International issues on health and the and the changing rationale of treatment and drugs should be another focus. Debates on populist as well as controversial pro-rich policies, the issue of "Health For All" (and when the dream would be realized) and many other issues of international issues open to debate can be a part of the health component of the channel. In addition, policy level changes as a response to global pressures can be made debatable and open to the knowledge and approval of the public via this channel.

At the end of the first day of discus5ions, the team decided to have two areas of health for detailed discussions, so as to give shape to these areas from the stage that they are left at, at a later stage/ date.

We therefore decided that the issues of mental health and women and child health could be a major focus with the presence of eminent specialists from the field of Psychiatry and Gynecology. The fact that these areas need comprehensive and reinforced approaches to tackle such issues were discussed and agreed upon during the discussions. These areas, according to Dr. Sanjeev Jain, have been neglected and misunderstood by the general public all over the country for decades.

The women's health issue was initially discussed based on the different presentation formats we thought would be most important for airing the channel.

Filmmaker's opinion: Dr. Michael (SRISHTI) was of the opinion that we cannot make programmes overnight, because we do not have the resources or the material to formulate the content in excessive detail. He saw the need for a more comprehensive framework of the two topics being discussed and elaborated upon, which would then be valuable to decision-makers to take up issues and further make them into films or documentaries, or animations, or debates and discussions. He said, that the immediate need is to work out a blueprint of the two issues identified that would actually form the guidelines for the health component of the channel.

This wonderful suggestion from Michael helped us focus on women's physical and mental health with a focus on the issues as well as guidelines.

Dr. Uma Sri was keen that health problems of women be a part of a family drama or based in homes to help people identify with issues as well as retain the knowledge imparted to them. She said that various aspects of women's health could be incorporated at many stages and situations. The need to catch the attention and interest of women across the country was necessarily emphasized. She said, "Diseases of various kinds, illnesses and issues such as death can be depicted in family dramas".

Dr. Vallikad emphasized the necessity of bringing awareness about women and Women's Rights to all sections of society, and every woman. Encouraging sensitivity to everyday discrimination against women and inculcating a sense of equality among men and women should be a major focus of health and development. Many students from the Srishti school of Art and Design opined that gender issues should be debated and also discussed in open forums to learn people's perspectives.

The group suggested that The Woman's Life be divided into the following stages:

1. Preconception (normal biology of the reproductive system, the sequential changes, the question of contraception, sexually transmitted diseases, and a whole lot of healthy practices with a great deal of emphasis on the age related issues of health of a woman and the best age for pregnancy)
2. Conception The biological aspect of conception, fertilization and further development,
    - The question of finding the right time and planning a pregnancy, making most of the preparations for the new life
    - The truth that the birth of a girl is determined by the male and not the female

3. **Pregnancy**

    - The pressing issues of nutrition, immunization, monitoring, other related issues

- Foeticide and the issues of illegal sex determination · Legal issues and accountability
- Ethical issues
- Social Issues and the long-term implications on Society and Human Value Systems

4. Birth

Biology of birth, normal delivery, emergencies and complications)
The issue of birth in the context of family and friends and debatable issues of various groups of people across the country and abroad.

The girl child's life and her health could be best dealt by presenting it stages. The stages are

a. Neonatal Period
b. Infancy
c. Preschool (years of immunization)

5. Childhood

- Diarrhoeal diseases
- Mental health
- Child Abuse
- Discrimination and Rights Issues

6. School Age

- The difference of how the male child's life is better planned than the girl's life
- Growth and development and the understanding of one's own sexuality
- Abuse issues
- Development of breasts and the biological reasons and changes

7. **Menarche**

8. **Graduation and further development**
   Being ready for marriage and issues of health and development that influence the development and growth of humans.

9. The role as an adult, single woman and health issues of the single woman

10. As a mother and a companion

11. As a mother of growing children and their problems. Etc.

    (The students of Srishti thought of this concept together with Dr. Vallikad and Dr. Uma Sri)

    The programmes made in this sequential order can actually bring about interest in the understanding of the health among women and men about individual and group issues.

Dr. Vallikad was specifically suggested that the sociological part of gradual changes in a girl's life, which is brought about by the influence of elders in families, should be recorded. The fact that the girl child often finds her perplexed to recognize herself an untouchable during her menstrual periods (still practiced in many part of the country and rural areas).

Reason: The very issue of accepting that is required to withstand pain and that pain is normal should be eliminated from everyone's mind, including the Woman's mind. This is proven by the fact that women come with advanced problems as a result of self-neglect during the initial symptoms, whether it is dental pain, abdominal pain, cancerous growth, or abnormal discharge from the reproductive tract. **Giving the girl child the knowledge, and people, the understanding of biological changes, health and disease, and their purpose and nature, can break this kind of conditioning**.

On the second day, we had consultations with the two eminent staff members of the

National Institute of Mental Health and Neurosciences, (NIMHANS), Dr. Sanjeev Jain and Dr. Srinivasa Murthy.

Mental Health Discussions and Conclusions

At about 9:15 on the 5~ July, the health group met up in the NIMHANS premises in the Psychiatry Department. Dr. Sanjeev Jain had prepared for the consultations the previous day some of his views on mental health and the current mental health practices in India. He also was keen on the sociological and religious aspect of mental health and its relevance to our country in helping to shape and build support systems for the mentally ill.

He shared with us many basic needs in approaching the aspect of mental health in the context of the health component of the channel.

Guidelines:

1. One has to regard the existing discourse of mental health (the social, religious and medical belief systems) with that of practice and practicality. He said that there should be a dialogue between the beliefs and truths.
2. Increase the common knowledge of the general population on mental illnesses and normal deviation.

He was keen that the biological aspect of the working of the brain needs to be recorded and shown in order to improve awareness on the brain functions as - a very simple but still so complex system that controls many functions. This, he said, could be done interestingly, by comparing the human brain with that of the fly, or the worm or even that of other mammals.

At the same time he was keen on stressing on the fact that early detection of mental illnesses can be key to a cure. He also emphasized that the cure is available on an outpatient basis and that often drugs and therapy can help normal living among mentally ill. These, he suggested can be done by changing the general medias (movie) perception on mental illnesses, and therefore the general belief of the general population.

He posed the question "**Why is Mental Health Care a Neglected field**"?

- Clinical issues
- Controversial issues, and
- People's awareness

The fact that medical science says it can treat schizophrenia 100% with drugs and therapy is debatable. The drug policy is such that schizophrenic patients do not avail of free medicines is another area that needs to be discussed according to Dr. Sanjeev Jain.

--This could be an issue for discussion, and the question of irrationality of policy should be rectified with debate and dialogue.

Geriatric mental health is another area Dr. Sanjeev Jain believes needed immediate focus as most old people are kept at home and treated with total ignorance of the condition. The issue that most of our country has no treatment facilities for Alzheimer's is another issue he wanted to expose this via the channel. Comparatively, India was behind many Southeast Asian countries with a lower GDP in the mental health care facilities for Alzheimer's.

The two-day meet concluded with the presentations of the summary of the discussions and an overall perspective of the doctors, intellectuals, students, freethinkers, media persons, and others.

RGF Village Libraries
Second Quarterly Report (January to March 2004) Project No. 6/2003-1300/VL SANGHAMITRA

Village Libraries										
PROCESS INDICATORS	1	2	3	4	5	6	7	8	9	10
Cluster Code										
Library Code										
Name and address of the Library	RGF Rural Library, Chandalpet, Chandalpet village, Chegunta Mandal, Medak District	RGF Rural Library, Peddashivunoor, Peddashivunoor village, Chegunta Mandal, Medak District	RGF Rural Library, Reddipally, Reddipally village, Chegunta Mandal, Medak District	RGF Rural Library, Gollapally, Gollapally village, Chegunta Manda, Medak District.	RGF Rural Library, Bhimroopally, Bhimproopally village, Chegunta Mandal, Medak District	RGF Rural Library, Karnalpally, Karnalpally Village, Chegunta Mandal, Medak District.	RGF Rural Library, Upperpally, Upperpally village, Chegunta Mandal, Medak District.	RGF Rural Library, B. Kondapur, B. Kondapur village, Chegunta Mandal, Medak District.	RGF Rural Library, Vallabhapuram, Vallabapuram village, Chegunta Manda, Medak District	RGF Rural Library, Wadiaram, Wadiaram Village,Chegunta Mandal, Medak District.
Name of the Librarian	Mujammil Md.	T. Yadagiri	R. Sudhakar	D.R.Sunanda	Mallesh	V. Mahipal Reddy	B. Ravi Kumar	R. Swapna	B. Vanaja	D. Krishna
Date of Establishment	02.10.03	03.10.03	07.10.03	08.10.03	09.10.03	12.10.03	10.10.03	22.10.03	22.10.03	23.10.03
Total Number of Paying Members Male Female	 33 33 -	 30 30 -	 32 32 -	 30 30 -	 31 31 -	 50 50 -	 50 50 -	 40 40 -	 30 30 -	 58 58 -
Total number of readers	40	35	40	25	25	30	15	15	13	30
Steps taken to increase Membership	Encouragement	Encouragement	Encouragement	Encouragement	Encouragement	Encouragement	Encouragement	Encouragement	Encouragement	Encouragement
Number of Books Received from RGF till date	259	255	249	256	249	295	288	282	247	254
Number of books received fromother sources during the quarter	--	--	--	--	--	--	--	--	--	--
Total Number of books in the Library	259	255	249	256	249	295	288	282	247	254
Type of books preferred	General Knowledge, books on religions, novels, competition magazines, weeklies, fiction, B.Ed. Resource materials	General Knowledge, books on religions, novels, competition magazines, weeklies, fiction, B.Ed. Resource materials	General Knowledge, books on religions, novels, competition magazines, weeklies, fiction, B.Ed. Resource materials	General Knowledge, books on religions, novels, competition magazines, weeklies, fiction, B.Ed. Resource materials	General Knowledge, books on religions, novels, competition magazines, weeklies, fiction, B.Ed. Resource materials	General Knowledge, books on religions, novels, competition magazines, weeklies, fiction, B.Ed. Resource materials	General Knowledge, books on religions, novels, competition magazines, weeklies, fiction, B.Ed. Resource materials	General Knowledge, books on religions, novels, competition magazines, weeklies, fiction, B.Ed. Resource materials	General Knowledge, books on religions, novels, competition magazines, weeklies, fiction, B.Ed. Resource materials	General Knowledge, books on religions, novels, competition magazines, weeklies, fiction, B.Ed. Resource materials
Names of News papers / magazines / reaching the library	Eenadu	Eenadu	Eenadu	Eenadu	Eenadu	Eenadu Vaartha Andhra Jyothi Deccan Chronicle Magz.: Swathi	Eenadu	Eenadu	Eenadu	Eenadu
Are the newspapers / magazines reaching the library	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Average daily readership for newspapers / magazines Male Female Children	 40 - 10	 35 - 10	 40 - 10	 25 - 06	 25 - 05	 30 - 15	 30 - 10	 20 - 15	 13 - 05	 30 - 10
Number of Library Committee Meeting held	03	03	03	03	03	03	03	03	03	03

Any Important decisions taken by the library committees	--	--	--	--	--	--	--	--	--	--
Membership fee as decided by the Library Committee monthly Annual Any other	Monthly Minimum Rs. 5/-	Monthly Minimum Rs. 5/-	Monthly Minimum Rs. 5/-	Monthly Minimum Rs. 5/-	Monthly Minimum Rs. 5/-	Monthly Minimum Rs. 5/-	Monthly Minimum Rs. 5/-	Monthly Minimum Rs. 5/-	Monthly Minimum Rs. 5/-	Monthly Minimum Rs. 5/-
Timings of the Library as decided by the Library Committee	0700 – 0900 hrs 1700 – 1900 hrs	0800 – 1000 hrs 1800 – 2000 hrs	0700 – 0900 hrs 1700 – 1900 hrs	0700 – 0900 hrs	0700 – 0900 hrs 1800 – 2000 hrs	0630 – 0830 hrs 1700 – 1900 hrs	0700 – 0900 hrs 1800 – 2000 hrs	0700 – 0900 hrs 1700 – 1900 hrs	0700 – 0900 hrs	0630 – 0830 hrs 1700 – 1900 hrs
Steps taken to mobilize resources to collect donations in cash / in any other form	Personal interaction	Personal interaction	Personal interaction	Personal interaction	Personal interaction	Personal interaction	Personal interaction	Personal interaction	Personal interaction	Personal interaction
Amount of Fee / fine / donation collected in the quarter	--	--	--	--	--	--	--	--	--	--
Amount in Bank / PO till date	Rs. 500.00	Rs. 350.00	Rs.100.00	Rs.480.00	Rs. 360.00	Rs. 800.00	Rs. 750.00	Rs.757.00	Rs. 325.00	Rs. 380.00
Additional activities being undertaken in the library	--	--	--	--	--	--	--	--	--	--
Any other information / problem that you wish to share?	--	--	--	--	--	--	--	--	--	--

Notes:

1. Despite repeated efforts, the members of the libraries are not paying their membership dues regularly.
2. The members are more interested in reading Newspapers than books.
3. Educated women and girls have stopped using the libraries in all villages, perhaps because of the societal restrictions.
4. School going children have not been utilizing the facilities in the last two months on account of their annual examinations.
5. The library in **Reddipally** is not doing well, as far as payment of membership fee is concerned, though the readership is comparatively higher.
6. The librarian of **Bhimraopally,** B.Mallesh, has left the services owing to personal reasons. The Library Committee is now on the look out for a replacement.
7. The **Gollapally** Library has been shifted to a panchayat – owned building in the village from a private owned building. However, the condition of the panchayat building is poor.
8. The members of the **Vallabhapuram** library are planning to raise a sum of Rs. 2500.00 as donation for the library.