SIR RATAN TATA FELLOWSHIP IN COMMUNITY HEALTH

Reflection and Report

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INTRODUCTION:

An old fashioned building with lots of doors and windows. People – poor and helpless, going around it knocking at the different doors and windows. When it came to one window I felt that the knock was on ME ! What is it all about? Why this knock? Who are you? In the depth of my being I experienced this gentle inspiration; the old building is the medical profession. We were at the heart of it. They have replaced us with money, fame and technology. It was supposed to be a healing profession. We are looking for an opening to get back to its' core. Who will bring it back to its original purpose? Will you cooperate with us?

Sounds like a dream? But it gave me lot of confidence. The confidence that, my thought process was not completely out of touch with reality. That, I was not eccentric. Then came the document ROME (Reorientation of Medical Education) as a confirmation. In an era of technological advancement why should our pregnant mothers face delivery in fear of death? Why should 20 plus young mothers die when 1000 babies are born, especially when we are capable of doing neurosurgery to rectify the hydrocephalus of an unborn baby in uterus? Why should millions and millions of babies die due to diarrhea and dehydration when we are capable of assuring the survival of pre-term babies even of 30 weeks of gestational age? Why should malaria and TB continue to be the leading cause of death when we have all the knowledge and skills to contain them? Why are the doctors more interested in complicated procedures like corneal transplantation for a few people, when millions of children become blind due to vitamin A deficiency which can be prevented by a simple procedure of giving Vitamin A capsules once in 6 months? These where the questions that stared at me towards the end of my MBBS internship in 1992.

Then came the time to go for the crucial choice of the postgraduate degree which determined the key towards one's life status. Some wanted to go for anesthesia because they didn't want to interact with the patients. Knock them off at first sight; push them off from sight before they open their eyes. Some wanted radio diagnosis because life will be comfortable in the AC room. Some opted for ophthalmology because one can practice without many infrastructures. What disturbed me was not the specialty they chose (because every specialty is good in itself), but the criteria they had in choosing these specialties!

Twenty thousand plus medical professionals coming out every year. Why there is so much of shortage of them in the needy areas of India? Why are they so keen on working only in the big city hospitals? Why most of them go to the affluent countries to serve the elite when there is so much of need in our country?

Adolescents in their late teens (17-18 years); forced into 190 plus medical colleges due to various pressures of the family and the society. Forced to learn anatomy, biochemistry and physiology without much orientation as to why on earth they should study all these. A few dare to question. They are silenced. Probably these questions are too threatening for the young lecturers who happen to end up in one of these specialties

because the competition to get into clinical specialties is too much! In their desperation, who comes to the aid of these confused teenagers? Their equally confused seniors! They taught us that the objective of studying the above mentioned subjects is to CLEAR the exams so that one can have access to the stethoscope that is waiting for them in the clinical year. Over the years these teenagers have devised clever and easy ways of CLEARING the exams! But unfortunately even in the clinical year the story continues… Human beings are no more persons; but a case- an organ or a system to be studied. Who cares about the physical and emotional trauma the patient goes through – it is a wonderful case, which every one should come and learn. When do these teenagers first hear about some value (ethics)? The day of graduation, when they rattle through the famous Hippocratic Oath just before they receive their degree certificates. The irony is that at the time of taking this oath most of us had numbed our rationality with alcohol because of the euphoria of having become DOCTORS! Why is there not even a single lecture on medical ethics in the whole course of medical education? Why such an unjust emphasis on skills and knowledge at the cost of attitudes? Why none of the mentors in the medical education dare to talk to these teenagers about the goal of the medical profession – the very reason for its existence?

This was the context in which I decided to follow my heart's desire, instead of floating with the current. The journey was painful, especially in the initial stages. But providence lead me into the right persons, right books, right circumstances… who helped me in this journey; the journey from Medicine, to Community Medicine to Community Health. During this journey I was privileged to go through the experience of the CHAD(Community Health and Development) model of CMC Vellore. That experience gave me an idea about Primary Health Care (PHC) especially the 8 components being put into practice. Another experience I cherish during this journey is my 5 years with the Indian Redemptorists (one of the many congregations of the Catholic Church) of which I am a member. From the Redemptorists I picked up philosophy and psychology – which are essential to look at realities like truth & falsity, good & evil, meaning of life, relationships, pleasant & unpleasant feelings and so on. I learned about community life- how to live in harmony with people from various
cultures and backgrounds. How to work together even with difference of opinions and many other essentials of community life.

The Community Health Fellowship scheme and my Regency[1] complemented very well, that it was with a great satisfaction I started off the fellowship. At the end of my fellowship I am happy to acknowledge that this was another crucial phase in my journey.

[1] A year of break the Redemptorists take during the Course in Theology, where they get involved with the struggles of the poor and the marginalized of the society as part of their learning experience.

COMMUNITY HEALTH FELLOWSHIP LEARNING OBJECTIVES
(Prepared on 11.7.2003)

These are the objectives developed in consultation with mentors of fellowship, at the beginning of the Fellowship. However these objectives will continue to evolve through out the fellowship for the year 2003-04:

1. To have a first hand experience of the struggles of the urban poor like pavement dwellers, slum dwellers, street children, Commercial Sex Workers, etc.

2. To have a first hand experience of the struggles of the Rural Poor especially in North India.

3. To have brief exposures to various models in Primary Health Care and Community Health.

4. To develop long term personal relationship with individuals and groups who are working towards a better society.

5. To broaden the understanding about larger issues that affect health, like poverty, globalization, widening gap between rich and poor etc.

6. To broaden the understanding about the health care activities of the Christian churches especially the Catholic Church. Their priorities, policies, strengths and weaknesses.

7. To explore ways of improving and optimizing utilization of the available resources of the churches, NGOs and government in bringing forth Holistic Community Health and Development.

8. To broaden the understanding about the health related responsibilities of Government and International agencies like WHO, UNICEF etc. Their priorities, policies, strengths and weakness.

9. To have a deeper exposure to the various activities of CHC and to learn from its 20 years of experience in Community Health.

Chapter 1.
COMMUNITY HEALTH FELLOWSHIP SCHEME:
A Reflection

Given an opportunity I would have done my schooling, medical education – both undergraduate and postgraduate courses in a different way. But the last one year of community health fellowship I would do the same way. Why is it so? Is it that I did not learn anything from my schooling and medical education? Is it that it was so traumatic? I don't think so. There are many reasons for the above statement that I made. But to compress it all in one sentence, I would say that after my early childhood period of learning (till 5 years of age), once again I got an opportunity to 'follow my heart's desire', in the last one year. What I really liked about the fellowship was this: its sensitivity to the fellows' interests and aptitudes, its flexibility and openness, the quality of the mentoring and its emphasis on fostering attitudes and skills; in addition to the constant internalization of the basic concepts in community health.

In the beginning of the fellowship when I sat with my mentor and wrote my specific objectives for the year, it was not even in my wild dreams that I would get such an enriching experience over this one year. Because of its semi structured nature, as I proceeded with my fellowship many of the learning opportunities evolved..

The mentoring sessions:

In addition to the several one to one mentoring sessions and many informal peer sessions among the fellows, over this one-year we had two major debriefing sessions. Those sessions helped me to consolidate and internalize many of my experiences. As Socrates, the great philosopher rightly said "an un reflected life is not worth living", these reflections remain at the core of the learning process we experienced last year. During the first debriefing that was held in CHC from November 24-25, 2003, we learned a lot by reflecting our 5-6 months experience under five major headings. Drs. Ravi Narayan, Paresh Kumar, Thelma Narayan and C.M.Francis facilitated this process. They used five questions to stimulate our reflection process. These were the questions: From the last few months' experience,

What did you learn about yourself, your strengths and weaknesses?
What did you learn about your mission?
What did you learn about the people whom you were exposed to, their strengths and weaknesses?
What did you learn about the other catalysts who are working with the people, their strengths and weaknesses?
What did you learn about health and community health?

The second debriefing also was in CHC, from March 11-12, 2004. During this debriefing which was facilitated by the same CHC team, we reflected our experiences in line with the fellowship objectives and focused more on the knowledge, skills and attitudes we acquired over this one year. (Refer Annexure1). During this one year I experienced probably the best ever mentoring session I had in my life. This was an

unplanned informal 3-4 hours session, which I had with Dr. Thelma during a jeep journey we had together from Hanur to Bangalore. She was returning to Bangalore, after visiting me in the field as part of my fellowship placement.

The learning process:

Over centuries the Rationalists and the Empiricists kept on arguing about learning through reasoning, and experiential learning. Some one has compared the rationalists to ***spiders*** who sit in a corner and reflect to satisfy their need to reach truth and the empiricists as ***ants*** who go around and keep on gathering information to satisfy their need to achieve truth. During the past one-year, we were probably like the ***bees,*** where we not only gathered experiences and information, but also **processed** it to internalize it for the future.

Right from the beginning of the fellowship I was looking for some first hand field experiences especially from the viewpoint of the poor and the marginalized and I feel that I got it to my satisfaction. There are so many life stories regarding the struggles and the successes of the ordinary people, which I am carrying with me at the end of this fellowship. Putting it all together is beyond the scope of this write up.

Self discovery:

This fellowship also contributed to the process of my self-discovery. It helped me to discover and sharpen many of my skills, confirm many of my thoughts regarding my future mission and so on. It helped me to realize that my aptitude is more towards the **principles** of primary health care, especially 'community participation' and 'equitable distribution', than the 8 components of primary health care. I could also confirm my role in the general process of **community building**, as a base for community health and the specific role of a **net worker** in the process of working towards Holistic Community Health and Development. Probably I can consider this fellowship as a major phase of my gradual **paradigm shift** from Allopathic ***Medicine*** to Community Medicine to Community ***Health.***

Limitations:

None of us are unlimited beings. The fact that we are human means that we are limited. Because of my specific priorities, I could not learn much in depth, about broader issues related to health especially issues related to public health. I couldn't go much into policy issues, which affects the lives of millions of poor people in the world. Because of my extensive travel and my direct involvement with the day to day struggles of the poor and marginalized people in the society, I needed lot of time for myself to cope with the emotional drain which I experienced all through this year. As a result I could not spend much time for reading even the wonderful books and articles suggested as reading material during the fellowship. (Refer annexure2). But I am sure that I will go through those reading materials in the coming few years. This fellowship has given me enough motivation to do so and I will be able to make more sense out of this one-year experience, once I do the reading part.

Chapter 2.
EXPERIENCES WITH PEOPLE:

Section I.
URBAN POOR: Slum Experience.

Rajendranagar slum, Koramangala, Bangalore.

DATE:

July 10- November 26, 2003.

CONTEXT:

I always had in my mind the idea of working with the slum dwellers. But the first time I thought of the possibility of living in a slum was when I read the book The City of Joy by Dominique Lappire. When I discussed this idea with one of my companions Bro.Xavier, he too seemed to be interested. So we decided to spend a few months in a slum. We chose Rajendra Nagar because of CHCs involvement in it as part of an action research and its proximity to CHC.

ABOUT THE PLACE:

It is one of the 1000 plus slums in Bangalore. It is considered as the biggest slum in Bangalore. There are about 5000 houses with a population of about 30,000.

LEARNING EXPERIENCE:

The people are basically villagers who have migrated to the city for work. They still preserve some of the characteristics they carried with them from their village. Some of the issues we encountered there were: gender bias; problems related to accumulated anger; a tremendous need for health care, shelter and also emotional health; money lending and its consequences; injustice and corruption. We also stumbled across some activities, which we think have the potential to bring the people together as a community irrespective of their caste, class, gender and other differences. We prefer to call them as community building exercises, which is essential to bring forth community health. (Refer annexure3)

CONCLUSION:

So far I had experienced the realities of life from the viewpoint of a middle class, traditional, catholic, Keralite, community oriented doctor. This exposure helped me to look at realities of life a slum dweller. It has definitely made a difference in my attitudes; many of the prejudices being shed and time will have to prove the impact it has made in me.

Section II.
RURAL POOR: Jharkhand, Karnataka and Arunachal Pradesh.

Mahuadnar, Chechady valley, Lathehar dist., Jharkhand
Ranchi, Jharkhand

DATE:

December 8, 2003- January 10, 2004

CONTEXT:

As part of my fellowship objectives while I was looking for a brief exposure with the struggles of the rural poor, I came across Sr. Prabha, the director of CHABI. We met for the first time in Hyderabad during the national consultation on Universal Access to Health Care organized by CHAI. She too was fascinated about the idea and then we started working towards it.

ABOUT THE PLACE:

Jharkhand was formed as a separate state on August 9, 2000. Before that it was part of Bihar. It is divided into 18 districts, with Ranchi as its headquarters. It has a population of around 2.2 crores, with about 80 % of its population being tribals. Jharkhand is well known for it rich mineral wealth esp. bauxite and coal. It is also known for its vast fertile land with forests and sufficient surface and ground water. Mahuadanar is a small township, the epicenter of about 120 tribal villages scattered around in a beautiful valley called the Chechady valley. It is surrounded by mountains all around, is located in the Lathehar district and is about 50 km in radius.

LEARNING EXPERIENCE:

About the people:

The people are mostly tribals who belong to various tribal groups. They belong to the Dravidian race and are considered as the original inhabitants of India before the Arian invasion. Hence they are called the *Adivasis.* They live in typical *adivasi* villages with about 20-50 mud houses per village. They do mostly agriculture and use forest products as a source of income. By nature they are gentle, timid, hardworking, very hospitable and have a tremendous sense of belonging to their community. They consider agricultural land as common possession and help in each other's field in cultivation. They have a sense of celebrating life and hence they do create opportunities of celebrations, family as well as village, and use lot of singing and dancing where all irrespective of age and sex participate. They don't seem to be interested in entrepreneurship and amassing wealth for the future. They have a way of settling disputes through village meetings with the help of the elders. During their celebrations they use home made alcohol irrespective of age and sex. Many of them in course of time go on to addiction and end up with problems related to that.

Mortality and morbidity due to simple and preventable communicable diseases are very common. The major causes of infant mortality are diarrhea- dehydration, pneumonia, and malaria. Malaria and TB are the common causes of mortality and

morbidity among the adults. Morbidity related to antenatal and natal problems are also common. These can be attributed to ignorance, lack of health care facilities and so on.

The exploitation:

Exploitation is very common in this area. At a macro level, the politicians use various means to displace the *adivasis* from their land. One of the ways they use is by deliberately withholding development like provision of electricity, assistance for irrigation etc. as a result many of the youth migrate to other areas like Punjab for agricultural labour which they could have done in their on fields. Some youth get frustrated due to joblessness and get into destructive activities by joining the naxalites. Those who have been working with the tribals consider it as a conspiracy between the politicians and the multinational companies in order to take away the tribal land for mining the mineral wealth by displacing the *adivasis*. For this reason the govt. deliberately withhold health care facilities so that premature death due to preventable diseases will gradually eliminate the *adivasis*. Similarly primary education is also discouraged directly or indirectly. Even in 2004, there are many villages which are not electrified, but there are documents in Patna (the headquarters at that time) showing that many of these villages have been electrified even 20-25 years back. That is the level of corruption where politicians are siphoning money in the name of developmental projects.

At a local level the PHC doctors and other govt. officials take their salary without attending to their duties. In the cities and the township, outsiders like people from Bihar, Bengal, Kerala etc. dominate the business world making maximum profit out of the *adivasis.* One common sight in the villages is the picture of *adivasi* young men carrying bundles of firewood, which they cut illegally from the forest. They sell it to the business class in the township for merger amount. They do it for day-to-day survival without knowing that they are being exploited. Another exploitation is the illegal trafficking of young tribal girls in huge numbers to the cities like Mumbai and Delhi for cheap domestic labour.

The various catalysts who make a difference:

In this context I could meet a few good people who make a difference in the lives of these *adivasis*. Some of them live among the *adivasis* in the remote villages helping them in primary education, primary health care, empowerment against exploitation and so on. Some of their stories were very impressive. How they save the lives of people coming with dehydration, pneumonia, cerebral malaria and so on. People, who are brought in unconscious in the night, open their eyes by morning, sit up and eat by lunchtime and go home walking with their rolled up mat in hand by evening. The impressive fact is that this is done by ANM nurses who are the least in the medical hierarchy. They do it out of necessity because of lack of medical professionals and hospitals being very far from these villages. Moreover the poor *adivasis* cannot afford to visit the hospitals.

CONCLUSION:

This exposure was a very enriching experience for me. As a result I could get to know more about the strengths, weaknesses as well as the potential of the CHAI network. It also resulted in lot of constructive discussions and exchange of ideas between us,

regarding community health, our future mission and so on. It also gave me an opportunity to have a first hand experience of the struggles and aspirations of a group of *adivasis*. During this exposure I could also spend sometime studying and documenting a local medical insurance scheme, which had been going on for sometime. (Refer annexure 4)

Hanur, Kollegal, Chamrajnagar dist., Karnataka.

DURATION:

February 3- March 9, 2004.

CONTEXT:

The suggestion to spend some time in Hanur first came from Dr. Thelma Narayan during one of our discussions as part of my mentering process. Later I could meet Dr. Aquinas, the director of Holy Cross CRHP, Hanur, when she came to CHC for a meeting. That time we worked on an exposure programe for a group of thelogy students from CRI institute, Bangalore in her project and I was coordinating that program. During that program while I was in Hanur for a few days, we discussed the possibility of me spending some time in Hanur later sometime.

PLACE:

Hanur is a small township from where the holy cross CRHP reaches out to the 72 interior villages of its project area. This is a drought prone area located in one of the most backward districts of south Karnataka- Chamrajnagar dist.

LEARNING EXPERIENCE:

The people:

The people of this part of rural Karnataka are generally poor. Their main income was from agriculture and because of lack of rain and poor rainwater harvesting they have been facing drought for the past few years. Hence migration to the cities for work is a common phenomenon. As a result migrant malaria, which is brought from the cities, is slowly emerging as a problem. This area which was once non-endemic for malaria can become endemic due to presence of forest with the vector mosquito, once migrant malaria sets in. caste system is so much deep rooted in the people that it keeps them divided in working towards development. Another issue is discrimination due to gender. Alcoholism and child labour / bonded lobour are also very much prevalent in this area.

The exploitation:

From 1980's people started becoming aware of the need for village development through the Local Self Governments (LSG), esp. the gram panchayats. But their knowledge about LSG and the democratic process was quite insufficient. Hence implementing developmental projects through LSG became a profit making business. These projects benefited only a few individuals. The predominant caste used even the leaders of the minority and underprivileged for their own vested interests. Only a

minority got involved in this power game. Majority remained neutral. This resulted in formation of lot of groups and division that affected the overall development of the village. For example, the functioning of the govt. school was not depended on the teacher alone but on the school development committee (SDC). Lot of resources were allotted for the SDC, but again only a few influential people got involved in it. Most of the LSG projects were poverty alleviation programmes. Hence long-term infrastructure development like electricity, agriculture development was not done. The involvement of NGOs resulted in emergence of local leaders out of people's organizations like SHGs. For sometime they stood up for issues related to the poor and the marginalized, but in course of time the local politicians of the LSG absorbed them too.

When it comes to Health scenario, there are enough PHCs (16) in the Kollegal taluk and the govt. has upgraded them. There is at least one medical officer in each PHC. PHCs are provided with essential drugs. There are 69 sub centers with ANMs in them. They have an efficient reporting system. They even have mobile systems to reach the people in the villages. There is constant pressure from the govt. on the PHC officials to reach the health care services to the people. There are lot of reforms from the govt. in the field of education and health. In spite of all these the people are not benefiting because majority of them are unaware of these resources.

People's lack of awareness about ecology has resulted in massive deforestation in the name of development. Deforestation is done for firewood for brick making and turmeric processing. Lack of proper rainwater harvesting and exploitation of ground water for agriculture has forced the govt. to pass laws banning bore wells for agricultural purpose. This has resulted in widespread joblessness, frustration, antisocial activities and migration for quarry work. People's main concern is survival, not progress or development. In this context NGOs tend to make people dependent and make people escape from their responsibility.

CONCLUSION:

Through this exposure I could get a first hand experience of the dynamics of the functioning of a community health project. It was a good experiece to closely observe and participate in the issues associated with the day today running of a community based project like, the difficulties of the field staff, problems of accounts, documentation, the thrill of setting up a new endever (center for school dropouts and bonded labour children), the village meetings, the personal diffences of the team members and so on. It also gave me an experience of the struggles of the rural people of a drought prone area. During this exposure, I could also contribute to the project by helping them to setup an information system for the project. (Refer annexure5).

Sangram, Kurungkumey dist., Arunachal Pradesh

DURATION:

March 19- 31, 2004.

CONTEXT:

The suggestion for this exposure came from Dr. Aquinas. She had been invited by a group of educationalists- the Christian Brothers, who had been based in Sangram for the past few years. The purpose was to look into their newly started health project and to give suggestions for improvement. Dr. Aquinas being a physician felt that general medicine and community medicine would be an ideal combination for that purpose.

THE PLACE:

Arunachal Pradesh is part of the Himalayas at an average altitude of 3000 feet above sea level. It lays on the northeastern most tip of India, cradled between Bhutan, China and Burma. It is a hilly terrain with numerous rivers, waterfalls and thick virgin forest. It has a population of only about 8.5 lakhs, spread over a vast area of about 84 thousand sq. km. Kurungkumey is a newly formed district with a population of about 47 thousand spread out in 300 villages in 11 circles (*taluk*). Sangram is one of the circles and has 40 villages in it. Sangram is about 125 km from the nearest tar road and only way to reach there is by difficult mud road. To cover this 125 km it takes about 7-8 hours by jeep. There is no electricity or telephone facility in the Sangram circle.

LEARNING EXPERIENCE:

The people:

They belong to the indo-Mongoloid race and there are about 20 tribes in Arunachal. The inhabitants of sangram belong to the *nishi* tribe, which is one of the major tribes. Their language is also called *nishi*, which sounds like Chinese. Their staple food is rice, *daa*l and mustard leaves. They are generally very pleasant people, but can become wild and aggressive when they are angry. The males including children carry long and sharp knives hanging on their neck.

The status of the women in the society seemed to be very low. They are bought by men in exchange of *mithuns* (wild cattle) as wives and are considered as possessions of men. One man can posses more than one wife. According to those who have been there for some time, it is not a rare sight that unwilling young girls of 8-9 years being chained and dragged by their new owners (husbands) who could sometimes be in their 60s. It is not uncommon for a father to barter his juvenile daughter so that he can buy for his son or even for himself, a young bride.

They live in houses made of bamboo, which is built on wooden pillars on the hill slope. The house is an unusually long (200 feet) single room with a hearth in the middle. All the activities including cooking, eating, sleeping takes place around the central hearth. They defecate in a partially enclosed area within the house and breed swine below the toilet-cum-kitchen-cum-bedroom-cum-dining room, house. Have their babies' bottom licked by dogs. Eat with fingers with nails caked in mud from the fields. Eat meat of animals found dead and rotten in jungle. They take bath very rarely.

Sickness and death are attributed to the occult and the world of spirits. It is considered as a curse and demands costly animal sacrifices. The average human life span is less than 30 years. The under five mortality was found to be 425(1998 survey) in sangram. It is quite common for women to have delivered up to 10 babies but have only 4 or 5 surviving. The common causes of infant mortality are: diarrhea-dehydration, pneumonia, measles and so on. Women deliver by themselves without being assisted by anybody resulting in severe tear of the perineum and morbidity related to that. Suffering associated with pregnancy and childbirth are unimaginable.

According to the DHO, Dr. Bingia Tobin, there are 3 PHCs and 3 CHCs in the whole district. For these 6 health centers there are only 2 doctors of which one is on long leave and 4 ANMs and 1 staff nurse. The PHC in Sangram is run by the sweeper assistant. The pharmacist who is posted there lives in the town, which is 8 hours journey by jeep. She is very prompt in collecting her salary at the end of the month and the DHO himself is very much aware of these facts. But we were surprised to hear that in the district hospital there were 18 doctors sitting without much work and drawing regular salary.

CONCLUSION:

This exposure confirmed my thoughts that some thing has drastically gone wrong with the medical profession of India. It was one more confirmation of my decision to move into community health and my future mission. During that brief period the Christian Brothers had arranged such a wonderful schedule, where we got lot of opportunity for a wide exposure to the ground realities. In addition to the discussions with their health team, they had organized roadside clinics, well baby competitions, health education sessions and a 3-day training for VHWs. (Refer annexure6).

Chapter 3.
EXPERIENCES WITH SOME CATALYSTS:

Section I.
NGOs.

Association for promoting social action. (APSA), Annasandrapalaya, Bangalore.

DURATION:

August 26-29, 2003.

CONTEXT:

As part of my fellowship objectives I was interested to have an experience of the life of street children. I came to know more about APSA and its involvement with the street children during a workshop organized by them on street children.

THE ORGANIZATION:

APSA is a child centered community development organization. At the grass root level, APSA facilitate the empowerment of the urban poor through community-based projects to promote human and democratic rights. APSA also works at the macro level through advocacy and policy planning initiatives. Some of their initiatives are:

Nammane; a crisis intervention center for children in acute distress. Children rescued from difficult background like, child labour, street children, victims of violence and abuse find residential support here.

Navajeevana Nilaya: girls at risk who have graduated from *nammane* live here during their first year of employment. Here they acquire skills to live independently and learn to get over their exploitative past. The national and Karnataka open school systems give such children more flexible education options.

Child labour project: there are over 100 million child laborers in India. APSA works towards preventing the children of the urban poor becoming child laborers. It also work among urban child laborers who are in hazardous conditions towards their rescue and long term alternatives.

Child line: APSA runs a 24-hour toll free hotline for children in distress. Interventions range from medical help, shelter and protection from abuse.

Street community: an estimated 80 thousand street children live in Bangalore alone. APSA reaches out to these children in over 17 street locations. Special emphasis is placed on protecting girl children. There are short term interventions like drug desensitization and street level education. Long-term interventions like campaign for their basic democratic rights are also done. In addition to this APSA is also involved in slum outreach and the disabled in Bangalore as well as in Hyderabad.

LEARNING EXPERIENCES FROM APSA:

. The street community project of APSA provided me that opportunity. APSA works through their street educators who meet these children on a regular basis in over 17 street locations. I could spend a few days with these street kids in Jayanagar, Bangalore.

Shilpa: the first sight of her is still vivid in my eyes. Even though she was 11 year old, she seemed to me like a 7-8year old child. She was sitting leaning on to the compound wall of a big house with a small puppy in her hands. She was dirty, had torn shabby clothes on her. She hadn't eaten anything for the past 36 hours. Her friends, Raja, Bhuvanesh and Muniappa located her first. I was moved by the way these 3 friends of her shared the little food with her, which they had picked up from the dustbin. Solidarity in the midst of misery! Later Ramadevi, the street educator told me that Shilpa is into commercial sex work and is having white discharge PV for which she is refusing to go to hospital. While walking back I could sense emotions swelling up within me along with a few questions… Can we call an 11year old pre-pubertal girl a prostitute (CSW)? How can she be safe from sexual abuse when she is forced to sleep in the street? Are the conventional systems including the health system be of any help for her? She represents the millions of children deprived of basic human rights. And she too belongs to the human family! Manjula, Ammulu, Ellamma all of them had similar stories to tell.

Comprehensive Rural Health Project (CRHP), Jamkhed, Ahmednagar dist., Maharashtra, India.

DURATION:

September 16-18, 2003.

CONTEXT:

On the 6th of August 2003, I had a discussion with Dr. Mani Kaliath (consultant for CHAI) on the possibility of being part of a CHAI study team visiting a few model projects to learn from them. The official request came from CHAI on the 5th of September, 2003, to be part of a 6 member team to visit 2 projects; CRHP, Jamkhed and FRCH, Pune. Since this was very much in line with my fellowship objectives, of having a first hand experience of a few model projects in community health, I decided to be part of the team.

THE PROJECT:

Drs. Raj and Mebelle Arole started the project in 1970. They realized that the usual way of providing medical care – mainly curative in an established hospital, or clinic based on a western, medical model – was not improving the health of individuals or communities. They wanted to try a new approach; a community based primary health care and development approach. Their aim was to enable and empower people and communities to take health into their own hands. From the beginning of the project, the different village communities were involved and participated in a partnership relationship with the project staff.

The principles of this project were; equity, integration and empowerment. This was to improve the status of the women and the weaker sections of the society.

CRHP initially covered 8 villages. By 1980 it expanded rapidly to cover 70 villages with 10 million population. By 1985, 250 villages in karjat and Jamkhed talukas wwre covered serving a population of 25 million. In another tribal area, a 6-hour drive

from Jamkhed, CRHP works in the Bhandardara hills with 30 villages and 50 thousand population. This was developed by the Jamkhed villagers and is an example of an approach focusing on health information and income generation; without having a base hospital. In 1993 when Latur, 150 km from Jamkhed was destroyed by an earthquake, the villagers volunteered to go and live with the victims to help them. As a result a program was established there covering 25 thousand population in 20 villages. Since the beginning of the project, 50 million persons in 400 villages in Ahmednagar, Beed and Osmanabad districts have been involved in transforming their lives and communities through CRHP.

The impact of the program on the health status can be understood by looking at the following table:

Year	1971	1976	1986	1993
Infant mortality rate	176	52	49	19
Crude birth rate	40	34	28	20
Children under five years				
Immunization (DPT, Polio)	0.5%	81%	91%	92%
Malnutrition: wt for age	40%	30%	5%	5%
Maternal services				
Prenatal care	0.5%	80%	82%	96%
Deliveries by trained attendants	<0.5%	74%	83%	98%
Couples practicing family planning	<1%	38%	60%	60%
Chronic diseases				
Leprosy prevalence (per 1000)	-	2	1	0.1
TB Prevalence (per 1000)	-	15	11	6

Today Jamkhed project has developed into an internationally well-known training institute and research center. They conduct short courses in community health and development for many from all over the world.
This is the vision statement of CRHP:

"People are made in the image of God. They are endowed with talents and abilities and have the potential for personnel growth and development. We are called to facilitate and empower them, so that their health can be improved in a holistic and integrated way available to all with equity and justice"

LEARNING EXPERIENCE FROM JAMKHED:
Personal discussion with Dr. Arole: September 16, 2003.

Dr Arole started of with his childhood experience of suffering and sickness in rural Maharashtra, where he was born and brought up. His friends dying of plague and his mother suffering from breast abscess moved him. His undergraduate training in CMC, Vellore, good medical education and good role models. But he gradually realized that it was all out of touch with the Indian realities and the doctors came out found themselves misfits for the Indian scenario. The solution was not much of technological but of immersing oneself with the people. For him medicine became more than a science, it became an art of caring. Thus he moved from hospital, to village clinics to community health. They realized that 60-70% of the illness was due to impure water. Hence started working for water projects: e.g. 250 bore wells. While they were busy in the community,

they could empower the ANMs to manage most of the base hospital work. The diseases of the poor are simple and can be dealt easily. These simple problems if not intervened early may lead to complicated problems. According to him, it is impossible to sit in a big hospital and do primary health care / community health. Most of the time these big institutions are tapping all our energy. He emphasized the 3 basic principles they used – equity, integration and empowerment. Regarding the base hospital, they could deliberately limit it to a good secondary care center, affordable for the people with a good referral system. In the beginning they had about 400 out patients per day, most of them acute communicable diseases, 40% of them being children. Today it has come down to about 75 out patients, 2% of them being children. There is also a shift from, acute communicable, to chronic communicable to non- communicable diseases.

Meeting with VHWs: September 17, 2003. (Afternoon)

Their confidence and commitment were evident from the discussion we had with them. These were some of the things they shared:

" I carried a 7 month old child, 7 miles to catch a bus to base hospital in order to save it from snake bite poisoning"

" I conducted the delivery for a Muslim woman with TB, because nobody was willing to help her. Today that child is a big officer and he has great respect for me"

" When we help the blind the lame, we are doing something for god. Then they help each other"

Among the health workers there were 3 of them who deserve special mention; Yamunabai, Mukthabai and Moses. Yamunabai told proudly that she had conducted about 800 deliveries so far and needed the assistance of doctors in the base hospital only thrice. She also added that 20 years back she was an illiterate village woman who was afraid to come out of her house. Muktabai was invited to Geneva to address WHO delegates. She concluded her speech by showing them a lighted oil lamp in her hands; "you are like the chandeliers of this room. You bring light to others. But the common people cannot afford to come to you. We are like this oil lamp; we light the other lamps too and that will bring forth health for all."

Moses was a school drop out, after his 2nd standard. He came to Jamkhed as a construction worker for the base hospital. Aroles' were impressed by his commitment to whatever work he did. After the construction work was over he was given some simple responsibilities in the hospital. When he started showing interest in people with disability he was send for training in artificial limb in Jaipur. Today he has rehabilitated around 6000 people, goes to the African countries to train people in low cost rehabilitation technique and is the head of the department of the rehabilitation center of Jamkhed.

Meeting with the mobile team: September 18, 2003.

They are members of the team who can read and write. They are involved in assisting and supervising the VHWs. They have weekly meeting with the VHWs. They assist the VHWs by: support and reassurance at the field level. Helping them in completing their records. Helping them in their continuing education.

These were some of their words, which reveal their attitude towards the health workers:

" I consider VHW as my friend"

" She may be wrong. Instead of screaming at her I do the right thing and she learns."

" We understand their difficulties" " she is a volunteer. We look at her commitment and not her weakness" " we are a team. So we support each other." " We follow adult learning technique. Every one has brain and experiences." " In a team relationships are more important than supervision."
Where did they get these values and attitudes? They did not have separate value education. But they caught it from the Aroles; " the way they sat with us, their commitment, the way they corrected us, their love for the poor…. We witnessed it."

Visit to Gotgav: September 17, 2003. (Morning)

We had meeting with the village leaders in front of yamunabai's house. The village sarpanch was a harijan. It was impressive to see Brahmins, Marathas, harijans and women sitting together to share their experiences. They shared with pride how over the years they managed to overcome the caste differences, disrespect for women, alcoholism… and how they could work together towards the welfare of their village. There was one shahaji patil, a landlord who decided to follow the govt. rule of distributing excess land for the landless. When Rajiv Gandhi was the prime minister, the Gotgav representatives were invited to share their experiences with the cabinet members. They were proud of the fact that other villagers from all over the country are coming and seeking guidance from them. Before the Aroles came into the picture, they too were divided in the name of caste, class, gender and so on, which hindered their development process.

CONCLUSION:

As an under graduate and a postgraduate student I was familiar with the concept of health workers. I considered them as an extension of the medical system into the community and the lowest in the medical hierarchy. I never perceived their potential or their ability to transform society. It was an eye opener for me to see that an illiterate woman can make the WHO delegates give her a standing ovation in Geneva; that an illiterate woman can speak so confidently in a national consultation of experts that she has conducted 800 deliveries and needed the help of doctors only thrice in her whole carrier and that a school dropout after 2 yrs in school could become the head of the department of a rehabilitation center, could rehabilitate 6000 plus people without limbs, and could go to other countries quite often to train them in rehabilitation.

Parinche project, Foundation For Research in Community Health (FRCH), Pune, Maharashtra.

DATE OF VISIT:

September 19-21, 2003.

CONTEXT:

Same as Jamkhed visit.

ABOUT THE PROJECT:

Dr. N.H.Antia, a plastic surgeon, established FRCH in 1975. The purpose was to promote the concept of health care rather than mere care of illness. The emphasis is on the problems of the underprivileged sections of our society FRCH is involved in both conceptual research as well as field studies into the problems faced in achieving health for all. The aim is to influence govt. policy and to sensitize the people at all levels to the problems and the possibility of achieving good health at affordable cost. FRCH aims to create a peoples' health movement by demystifying medicine and increasing public awareness on health especially at the grassroots and by strengthening our own age-old health culture of the people. The Parinche project (named after the Parinche village which acts as the headquarters) was initiated in 1995. The main aim of the Parinche project was to device a training program for women that will result in overall development in these villages. This project was expected to help promote the concept of decentralized development under *Panchayti Raj*, where the village can become a self-sustaining entity for its various social and economic requirements. It also hoped to demonstrate a new mode of development that could be self-sustaining for use on a larger scale.

The project area covers a population of about 20 thousand in 13 *gram panchayats*. One third of the area consists of mountainous terrain with altitude up to 4000 feet. The villages in the upper regions are poorer than those in the valley. The villagers are largely engaged in cattle rearing and agriculture. FRCH selected interested women from their own communities in and around Parinche, and began educating these *tais* in various fields. Today FRCH has about 50 functioning *tais*. The Parinche project is an action research on the impact of health education and empowerment of women. Making them think, by asking questions does this empowerment.

LEARNING EXPERIENCES FROM PARINCHE:

Nirmala tai:

She wanted to become a nurse or a teacher. But like any other village girl of her place she too was married off soon after her 10^{th} standard. That was the end of her studies. When she heard of the *tai* training she was motivated to go for it. But her family including her husband was not so cooperative. So in the initial stages of the training she had to do additional work; both domestic and farm, in order to go for the training. Now her husband helps her in the domestic and farm work when she organizes the community. This is because he now realized that she is skilled and is capable of dealing with many problems of the people. She investigated a hepatitis epidemic in her village, with the help of NIV, Pune. She could identify the first case, the source of infection and could take measures along with the villagers to control the epidemic. She could recognize her

mother in law going for a stroke quite early; take her to the PHC first, then to the district hospital at the right time. When her mother in law was in bed for 3 months, she acted as the nurse, occupational therapist at home. Now her mother in law is capable of walking by herself and quite independent. She had the courage to question the PHC doctor against irrational practices and for a proper referral letter. The *tais* confront; yet they gain the confidence of those whom they confront. E.g. their husbands and the doctors. Part of her house is a library and is open for others to gain knowledge.

Sunitha tai:
After her *tai* training she took initiative to be trained as an *anganwadi* teacher and started an *anganwadi* by her own initiative. She learned cycling by her own initiative and cycles 3 km. every day to take care of 65 children in her *anganwadi*. In the 1st year there was no payment from the govt. In the 2nd year when the govt. wanted to appoint somebody else as the teacher, the people stood for her and got her appointed officially as the teacher. She is aware of her aptitude of children and enjoys her work.

Nanda tai:
She speaks proudly of her daughter whom she could make a trained nurse. According to the doctors her daughter is a better quality nurse and according to her mother in law she is a better quality housewife. She attributes all this to her empowerment through the *tai* training.

Kaladhari village:
This village is considered as a model village by the Maharashtra govt. and was given award for the same. Before 1995 this too was an ordinary village with starvation and children dying of diarrhea and dehydration. The difference started when Mr. Ankush parkandae became the *sarpanch*. He is just a 10th standard person who knows only *marati*. They received no special funds from the govt. but could mobilize the existing govt. funds to the maximum. They started with a watershed program. There was tremendous cooperation from the people because it was their felt need. With the availability of water, their agriculture improved, infant mortality came down and they started experiencing signs of prosperity. Then he initiated a movement to clean up the village. People took responsibility to clean up their on streets. The teachers, the students, the *sarpanch* all were involved in the process. Soakage pits and drains were made. Lots of dustbins were placed in the village. The PHC officials were requested do chlorination on a regular basis. The women and children were also trained in chlorination. The next initiative was the launching of a community-based organization (CBO). Today they have a milk-processing unit with a turn over of Rs.10 lakh per month of which Rs. 1 lakh is profit. This profit money is used for the development of the village. Another characteristic of this village is that there is 100% tax payment, which is also used for the development of the village. Since electricity has not yet reached there, one can see solar lamps and aero-generators in the village. The health status of the people improved considerably with food, water and sanitation in place. People are also made aware of the facilities in the PHC and they do make use of the facilities to the maximum. They make use of the referral services to the district as well as private hospitals in the city. Those who are poor are given assistance from the CBO for medical care. The role of FRCH in

the whole process was in identifying the potential of the *sarpanch* and providing appropriate and relevant information for him at the right time, directly and indirectly. Today kaladari village remains as an inspiration for many other villages and provides guidance for them for self-development.

Anganwadi, Khelwadi and Eco group:

The *tais* work with the govt. *anganwadis.* They teach them songs which contains messages for healthy life style, check their weights, look for nutritional deficiencies and so on. This is for children < 4 years. *Khelwadi* is for the children in the primary school. After school they go home and come back around 5.30 pm for an hour. The *tais* make them sit in a circle and demystify science and health issues through songs, games and demonstrations. E.g. Preparation of ORS. Eco group is for the older children. These children some times act as pressure groups when it comes to health issues.

CONCLUSION:

As someone has observed, every community has three categories of people; a few who are motivated for the Good, a few who are motivated for exploitation and a good majority who are passive onlookers. **"**It is better to light a candle rather than cursing the darkness". This exposure helped me to realize that by identifying those who are motivated for the Good, by supporting them and by building their capacity in various ways we can make a difference and they in turn will build a better society by taking with them even the good majority of passive onlookers too.

Catholic Health Association of India (CHAI)

DURATION:

August 5-6, 2003; September 16-21, 2003; December 8-January 10, 2004; April 5-11, 2004.

CONTEXT:

An exposure with CHAI was very much part of my fellowship objectives. The first opportunity came when Dr. Thelma suggested to attend the national consultation on universal access to health care organized by CHAI in Hydrabad on August 5, 2003. This was followed by spending a day in CHAI central office on August 6, 2003, where I could interact with various people including Dr. Mani Kaliath. Later I got an invitation to be part of a CHAI study team, which visited Jamkhed and FRCH, Pune between September 16-21, 2003. During second half of the fellowship, I could spend more than a month, in December and April, with CHABI, one of the regional units of CHAI. This visit was worked out with Sr. Prabha, the director of CHABI, when I met her in Hyderabad during the national consultation organized by CHAI.

ABOUT THE ORGANIZATION:

The origin of CHAI goes back to July 29, 1943 when 16 religious sisters representing 8 medical institutions of the then British India gathered at St. Josephs' hospital Guntur, Andhra Pradesh. That time there were 50 medical institutions in India. The convener of that meeting was Sr. Mary Glowrey, an Australian sister doctor. It was called Catholic Hospital Association (CHA) in that meeting. After independence it became the catholic hospital association of India (CHAI). In 1993 it was renamed as catholic health association of India.

The main thrust of CHAI is promotion of community health and community based health care. This implies a holistic understanding of health, building Healthy communities, enabling people esp. the poor and the marginalized to collectively take responsibility to attain and maintain health and to demand health as a right, to ensure the availability of health care at a reasonable cost by its members and so on..

The backbone of CHAI is the 3000 plus member organizations spread all over India. 80% of them are in remote and isolated areas. CHAI was divided into 11 regional units in order to cater to the varied regional needs and problems of the member organizations. They are: Andhra Pradesh (CHAP), Karnataka (CHAKA), Tamil Nadu (CHAT), Kerala, Orissa (OCHA), Maharashtra, Gujarat & Goa (CHAW), Madhya Pradesh (CHAMP), West Bengal, Bihar & Jharkhand (CHABI), Rajasthan & Uttar Pradesh (RUPCHA), And the North-East (NECHA).

Some of the activities of CHAI include: advocacy, health communication, capacity building, research and project evaluation, promoting alternate systems of medicine, networking and so on…

LEARNING EXPERIENCE FROM CHAI:

(Based on discussions with Drs. RN, TN, Mani Kaliath, Sr. Prabha, and a few members of CHAI)

The real strength of the CHAI network is its 3000 plus peripheral institutions with committed personnel having the right attitudes. Ideologically it has the potential to contribute much to bringing forth health for all in the Indian society. But in reality it is functioning only about 30% of its potential. Some of the issues which contributes to this problem are:

Health care at the periphery of the church: Most of the time, for the church authorities parish activities and education are at the center of its mission. Hence the CBCI Health Commission, CHAI, and health are at the periphery of the church's mission. If health itself is in the periphery where will community health be?

Congregational structures: about 200 congregations, which are governed by groups without much common interaction, own the 3000 plus member organizations.

Power struggle: within and among the congregations. Gender bias: sisters not given the same power to make their own decisions.

Profit motives: profit-making institutions given preference than community based work with the poor and marginalized. Competent sisters are often caught up in

profit making big institutions where as less competent sisters are send for community-based work for the masses.

Competency gap: even though they have the right motivation and attitudes, because of the lack of certain technical skills many of the sisters in the member institutions get burnt out and become frustrated. Leadership: lack of vision, experience and personal weaknesses of those at leadership also contribute to this.

Lack of an integrated approach: in the member institution community. E.g. Health center sisters and the community development sisters unable to work as a team.

Irrelevant training programs: the training programs conducted by CHAI central office away from the realities of the member institutions. Moreover the lack of consistency among the sisters who are send for important meetings.

CHAI central office problems: the presence of 40-45 unproductive clerical staff and program funds being diverted to maintain them.

CONCLUSION:

I know an old Catholic priest, who speaks very little. Once he told me "Mathew, the Catholic Church is a sleeping giant. If it is woken up, it can contribute much to the society, esp. regarding Justice and Peace." I was always convinced about the hidden potential of CHAI, in contributing much towards the struggle for Health for All in India. Today after my fellowship I consider CHAI as a big village with 3000 plus households, spread out all over India with most of the dynamics of any human community. There is power struggle, class difference, gender bias, lack of skills, lack of clarity regarding basic concepts in community health….., yet it has the potential to make a difference, to become leaven in the bread (society), transforming it from within.

Section II.
PEOPLES' MOVEMENTS.

Peoples Health Movement (PHM)

DURATION:

June 2003 – May 2004

CONTEXT:

I did not know about the existence of PHM before I started the fellowship. We happened to be based in a room in the PHM secretariat, especially in the initial phase of the fellowship. Today when I look back, that arrangement gave me lot of opportunity to have exposure to many of the activities of PHM.

THE MOVEMENT:

In 1978 govt. representative from all countries assembled together in Alma Ata and declared that they would ensure health for all by 2000 AD. This important pledge was won after a number of struggles and was a landmark in the struggle for health. But today most govt. health documents don't even mention that they made such a pledge in 1978.

To protest this betrayal by governments, people's movements across the world decided to come together for the peoples' health assembly at Dhaka, Bangladesh in December 2000. There were 1500 representatives from 91 countries all over the world. As a precursor to the assembly, in every country village level campaigns were organized to highlight the main issues in health and to ensure that people don't let governments forget the promise they had made.

In India, in January 2000, 18 national networks of voluntary organizations representing over 2000 different organizations came together to organize a large campaign on health for all, now! By the end of year 2000, people from all parts of India came together in 4 peoples' health trains and assembled at Calcutta for the national health assembly. A people's health charter was adopted with specific demands from the govt.

Delegated from different countries that had gone through similar movements met together in Dhaka to discuss strategies for building a global movement for health and to finalize the international peoples health charter. Thus was born the peoples health movement; a global coalition of peoples' organizations working on health rights and ensuring health for all now!

SOME SPECIFIC EXPOSURES:

National Working Group, PHM-India, Bangalore, July 26-27, 2003.(Ref. Annexure7)
National consultation on Universal Access to Health, Hydrabad, August 5, 2003.
Nationl workshop on Right to Health Care, Mumbai, September 5, 2003.
National public hearing on Right to Health Care, Mumbai, September 6, 2003.
International Health Forum, Mumbai, January, 14-15, 2004.
Meeting with ex-Health minister, Mauritius, PHM secretariat, Bangalore.
Meeting on Traditional Systems of Medicine, PHM secretariat, Bangalore.

Personal discussions with a few leaders of PHM-

Drs. Ravi Narayan, N.H.Antia, B.Ekbal, Saffrulla Chowdhary, Prem John, Narendra Gupta, Abhay Shukla, Sunder Raman, Unnikrishnan.

LEARNING EXPERIENCE:

All through my postgraduate studies I had this question in my mind. For the past many years we have enough and more knowledge and skills in the medical profession. For e.g. we know everything about diarrhea and dehydration, we have all the skills to prevent people getting it and dying from it. But even in this third millennium why should it continue to be the leading cause of death among children? Why should TB and malaria continue to be the leading cause of death among the youth? Medical profession has become too much biomedical and profit oriented. The socio economic political and cultural (SEPC) aspects of health are not taken into consideration. In this context health for all is impossible through medical professionals alone. Some times they remain as the greatest obstacle towards health for all. That is where people have to become aware that health is their right as well as their responsibility. Medicine and health has to be demystified. People should be able to exercise moral pressure on the authorities that behave irresponsible. I think that is where PHM has its role to play.

World Social Forum (WSF), Mumbai

DURATION:

January 16-20, 2004.

CONTEXT:

PHM had a role to play in the WSF. The International Heath Forum (IHF) was organized in Mumbai 2 days before the WSF, as a preparation for the WSF. Being associated with the PHM secretariat I was very much aware of the background work that was going on for the IHF and the WSF. I attended the WSF as part of the PHM team from the secretariat.

THE MOVEMENT:

The WSF is not an organization or an institution but a platform of different organizations. The India general council with about 200 organizations took up the challenge to build a process of alliance building and to organize this event. The 4th international gathering of the 2004 WSF, in Mumbai, is a dialogue to formulate a blue print for building another world- a plural, just, responsible and shared world which accords equal dignity and rights to all its people. The focus was on the impact of neo-liberal globalization and its processes, which are creating a small global ‘over-class’ and a vast increasingly vulnerable ‘under-class’ in every country. There were diverse forms of interaction; plenary sessions, conferences, panels, round tables, seminars, workshops, cultural events, solidarity meetings, rallies and marches. Even though the language used in the public address system was English, there was simultaneous translation into 11 languages through the radio system.

LEARNING EXPERIENCE:

Human beings are a mystery. There are many things we have learned about ourselves over the years. But still there are many more areas we need to discover about us. Our experiences, aptitudes, interests, involvement and mission vary from individual to individual. Yet sometimes we come across common interests. Those who are involved with the struggles of the oppressed and the marginalized sometimes feel the need for mutual support and solidarity. They also need revitalization at various levels. For me WSF was a forum for this. I was impressed in many ways. The 1000 plus workshops and meetings, to quench the thirst of the intellect, the variety of celebrations to quench the emotional need, the plurality of culture and language in an atmosphere of solidarity, the thousands of methods used to bring forth the cry for justice and peace by those who represent the oppressed and the voiceless, all were very impressive. I felt that in my little effort to bring forth a society of justice and peace, of care and concern, I was not alone!

Anti-Coco Cola Movement, Plachimada, Palakkad dist. , Kerala.

DURATION:

January 27- 28, 2004.

CONTEXT:

After the WSF while I was settling down in CHC, Dr. Thelma asked me whether I am interested in joining a team from South America to visit Plachimada. Even though I was not very keen, out of courtesy I agreed because I felt that my familiarity in the local language (Malayalam) would be of help to the team. But eventually it turned out to be a wonderful learning experience for me.

THE MOVEMENT:

Plachimada is a tiny village land in Moolathara village, Palakkad dist. of Kerala. Majority of the people depend on agriculture for their livelihood. The bottling plant started its production in 1998 on a 42-acre plot in violation of the Kerala land utilization act, 1967. The intention of this act was to prevent the use of agricultural land for non-agricultural purpose. Though it owns 42 acres the company is remitting land tax only for 34 acres to the *panchayat*. The working capacity of the unit is 1.5 million liters per day (until recently 1.2 million bottles of soft drinks were being loaded from the company every day). By 2004 the water scarcity has struck even the company that it is able to extract only 0.8 million liters of water per day from the bore wells.

About 370 laborers are working in the unit out of which 240 are casual temporary workers. The local residents who are employed in the company are only about 40-50 and are casual temporary workers. Among the temporary workers those who are recommended by the political leaders get an amount of Rs.100/- per day, whereas others get 60 per day for males and 50 per day for females.

Studies conducted by experts within the country as well as outside came with the findings that its not only water depletion but also environmental pollution that is happening in and around Plachimada. As a result agriculture, local economy, health status and even the day-to-day life of the people are affected. Anemia, low birth weight, hair loss, burning in eyes, vomiting, pain in the limbs, skin lesions etc. are shown to have of high relative risk. The level of lead and cadmium in drinking water were found to be quite high.

In this context residents of the area launched an agitation against coke on April 22, 2002, about 3 years after the company started its unit. On April 7, 2003 the local *panchayat* decided to cancel the companies license. But because of the ambiguous stand taken by the higher authorities and the state govt., the company is still functioning and the agitation is continuing. Representatives from the different peoples' movements from all over the world continue to come to Plachimada to extend their support to them.

LEARNING EXPERIENCE:

Over the past few years I have been listening to the debate on the positives and the negatives of globalization. I was not so much interested in this debate because I thought it was just an intellectual exercise, which is of no help for the common people. Visiting Plachimada made me interested in globalization. Listening to their stories of physical, economic and emotional distress made a difference. When they boiled the water in front of me to show the thick sediment, tasting that water which was like diluted acid, seeing some of the skin lesions all made me interested in knowing more about globalization.

Who will not get angry when one has to walk about 2-3 km. every day for water, leaving their little babies at home, when a few months ago they had the luxury of potable water at their door steps? Globalization is good…. But when somebody in another continent due to extreme selfishness and greed, try to amass wealth at the cost of the basic necessities of others who are helpless, can we still consider globalization good? The people of Plachimada may or may not succeed, but their story will always remain as an inspiration for the millions who are crushed by greed and selfishness.

CONCLUSION:

In addition to what I learned about the negative impact of globalization, I was impressed by the commitment of the South American team towards social justice. It was interesting to listen to the various stories of the struggle for social justice happening in the other parts of the world. It also gave me my first exposure to a press conference. (Refer annexure8).

Chapter 4.
CONFERENCES AND WORKSHOPS ATTENDED

Sexual development and sexual health in teenage street and slum children in India.

DATE AND VENUE:
July 22-25, Bangalore, India.

THE CONFERENCE:
Organized by: APSA, Bangalore, NIMHANS Bangalore and Youth incentives Netherlands.

Participants: about 50 participants from street and slum children's organizations.

Objectives:

- To share the recent research findings on teenage sexuality in street and slum children in India.
- To discuss the preliminary ideas for interventions with as many organizations as possible
- To incorporate the best ideas into the program
- The conference may help to build skills for effective intervention
- The conference may spur the growth of a movement or network of organizations interested in street children in south India.
- To initiate the process of developing a very practical and user friendly activities workbook and staff training manual, relevant to the specific life circumstances of teenage street and slum children.

The Program:
These were the topics covered in the conference:
Day I: introduction to adolescence and sexuality.
Street boys and sexuality – a study
Street girls and sexuality – a study
This was followed by discussion

Day II: there were four parallel workshops
How to work with teenage street and slum boys and girls; attitudes and skills
How to work with teenage street and slum boys and girls; using creative methods
Sensitizing to adolescent sexuality; personal memories and attitudes
Sensitizing to adolescent sexuality; sexual rights and sexual health

Day III: there were two parallel workshops in five small subgroups.

Translation into an intervention program- developing sexuality related activities. (The 5 themes were: intimacy, consent, STDs & HIV / AIDS, pleasure and urge, what is good for me and how to take control over my life)

Translation into an intervention program- developing psychology related activities (the 5 themes were: general influence of peers, substance use, loneliness, coping with problems, future orientation)

This was followed by active presentations of the ideas and the form and content of the workbook (intervention program)

Day IV: further discussions on the workbook and the staff-training module, which was done in four small subgroups, followed by presentations by the subgroups.

LEARNING EXPERIENCES:

A child as soon as it is born does not walk or run. It goes through a growth process which takes quite a lot of time. In that process it crawls, creeps and falls. The society is very tolerant to that process and supports the child in that process. It is almost the same when the child goes through the process of learning to speak. There is lot of understanding and support from the society. But when it comes to the process of sexual and emotional maturity the society seems to be very intolerant and judgmental. This conference provided an environment where most of us could become at ease with sexuality and discussions around it. In the context of the current HIV / AIDS pandemic it is not only condoms but sexual and emotional maturity also is important. There was a lot of professionalism and participation in the process of the workshop

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Cochrane workshop on systematic reviews and meta-analysis

DATE AND VENUE:

August 19, 2003. NIMHANS, Bangalore.

THE WORKSHOP:

Organized by: CHC, NIMHANS and St. Johns Medical College, Bangalore.

Participants: about 30, mostly medical graduates and postgraduates.

Conducted by: Dr. Madhukar Pai, division of epidemiology, university of California, Berkeley.

Program: after a brief self-introduction of the participants, the workshop started around 9.00 am. These were the topics dealt with:

- Introduction to systematic review and meta-analysis.
- How to critically read systematic reviews and meta-analysis?
- Critical appraisal of a systematic review- small group session 1
- How to conduct a systematic review: formulating the review question
- How to conduct a systematic review: searching and including primary studies
- How to conduct a systematic review: extracting data and assessing study quality
- How to conduct a systematic review: analyzing the data
- How to conduct a systematic review: interpreting the results and writing the report
- Critical appraisal of a systematic review- small group session 2
- The Cochrane collaboration and Cochrane library.

LEARNING EXPERIENCES:

Every human mind, which is active, experience a hunger, the desire to know the truth. The mind gets satisfied only when it experiences the truth. In this era of information explosion, we are bombarded with lot of information, much of which is far from the truth. It is well known that all who conduct research and publish papers do not do so out of their passion for knowing and disseminating truth. In this context it was good to learn the technicalities of another research methodology, meta-analysis. Thanks to Madhukar Pai.

National Workshop on Right to Health Care.

DATE AND VENUE:

September 5, 2003., Bandra, Mumbai.

THE WORKSHOP:

Organized by: Jan Swasthya Abhiyan-PHM, India.

Participants: about 250 JSA activists from all over India.

Objectives:

- To discuss the perspective, content and the further campaign strategy regarding the right to health care
- To share the various cases of denial of health care, which were documented from various parts of India.

Program: the program started at 10 am. There were 4 sessions.

Session 1. Introduction of participants

Overview of the program and the issue of Right to Health Care

Session II. There were two parallel sessions on four topics.

Right to essential drugs

Right to health care in situations of conflicts and displacement.

Right to basic health services, including primary health care

Session III. This was the first post lunch session. This session included a short plenary presentation on the following topics:

Health rights in the context of the private medical sector.
Right to mental health care
Public health sector employees and the right to health care
Children's right to health care

This was followed by another parallel session with two topics;

Right to health care for unorganized workers and urban poor
Right to health care for HIV-AIDS affected persons

Session IV. The last session included

Sharing of cases of denial of health care documented from different parts of India. This was done in four groups.

Presentation and discussion on JSA strategy to establish the right to health care. The workshop ended by around 6.30 pm.

LEARNING EXPERIENCES:

Why is it that there is so much of denial of right to health care today? Some of the reasons are these: the negative impact of the Liberalization, Privatization and Globalization (LPG) policies; the decreasing involvement of the state regarding public health and the proliferation of the unregulated private sector. It was interesting to know that there are so many documents to justify this right; the UN declaration, the Alma Ata declaration, the constitution of India (art. 47), the supreme court judgment, the NHRC recommendation and so on. The enthusiasm of the activists from all over India was very evident and encouraging.

National Public Hearing on right to health care.

DATE AND VENUE:

September 6, 2003., Bandra, Mumbai.

THE CONSULTATION:

Organized by: Jan Swasthya Abhiyan-PHM, India.

Participants: about 250 JSA activists from all over India.

Objectives of the consultation:

Public hearing on the select testimonies from representatives from various states on specific examples of denial of access to health care

Presentations by leading public health and legal experts on right to health care

Response from NHRC and health ministry officials

Program: the program started at 10 am with a welcome address from Dr. N.H. Antia. This was followed by the inaugural address by Justice A.S. Anand, Chairperson, NHRC. Following this, representatives from various states presented selected testimonies of cases of denial of access to heath care. After that Prof. Satyaranjan Sathe spoke on the legal and constitutional entitlements for the right to health care. Dr. Abhay Shukla presented the framework and set of suggestions to establish the right to health care. The pre-lunch session ended by the concluding remarks of Dr. Justice A.S. Anand.

Post lunch session was mostly presentations and discussions based on the pervious days issues from parallel sessions. The consultation ended by 5.00 pm with a group discussion on how to take the campaign and JSA forward.

LEARNING EXPERIENCES:

The three basic functions of the state are: law and order, education and health care. Pulling out of it means the state is going against the constitution. When the state pulls out of these responsibilities the civil society comes under the mercy of the market. Hence the civil society need to be empowered; become watch dogs of the state and take control over the market. Laws can prevent a bad person from doing evil but it cannot make people do good. Legislation alone is not enough. Its implementation is also important. For that the civil society has a major role to play. In this context, the PHM is a ray of hope.

International Health Forum (IHF) for the defense of People' health

DATE AND VENUE:

January 14-15, 2004. Mumbai

THE WORKSHOP:

Organized by: peoples health movement (PHM)

Participants: about 700 participants from 50 countries, from all over the world

Objectives of the forum: to bring together individuals, groups, organizations and movements involved in the struggle for making the voices of the unheard heard and to attain heath for all.

To review concerns on a wide range of broader, national and global determinants which affect health for all. (globalization, militarism, war, exclusion due to gender ethnic minority status, disability, poverty and marginalization)

To share the experiences, alternatives and strategies evolving at local national and global levels in meeting these challenges.

To evolve the further course of the PHM at global, national and regional levels

To mainstream health in the events of the WSF through involvement of health activists and professionals in cross-sectoral issues.

Program:

Day I: the program started at 9.00 am. The inaugural session had the following topics:

Overview on confronting the challenges of globalization through health work: perspectives, struggles and strategies.

Short report on the PHM and the main challenges before it

Presentations by regions on challenges, struggles and the role of PHM(Asia, Africa, Americas, Europe and India)

Case studies from countries

This was followed by 2 parallel plenary: Globalization, health policies and health sector reforms

Health under war, occupation and militarization.

The day ended around 7.00 pm with 7 parallel workshops: Globalization and health policy.

Promoting synergy: towards joint antiwar action

Learning from the global tobacco control campaign

Liberation medicine

Globalization and health sector reforms

Health teams for health for all (CHWs etc.)

Traditional / alternative systems of medicine and primary health care

Day II. Had 3 plenary sessions: HIV / AIDS and resurgence of communicable diseases- confronting the crisis

Women, population policies and violence

Health care and the marginalized

After lunch break there were 7 more parallel workshops: key issues in women's health

Voices of the unheard; children, adolescents and persons with disability

HIV / AIDS and the resurgence of communicable diseases

Globalization, poverty, hunger and death

New economics and its impact on medical practice in India

Social determinants of mental health and PHM

Environmental justice and peoples' health- confronting toxics in our communities

The day ended at 7.00 pm with a closing plenary: reviving the spirit of Alma Ata- the challenges before us

Towards a Mumbai declaration - an action plan building on the plenary and workshops

LEARNING EXPERIENCES:

Since there were lots of parallel workshops, I could not attend all that I wanted to. But it was a good experience to listen to some of the testimonies from different parts of the world. It was interesting to see that even in the so-called developed countries there are

people who do not have access to proper health care. The solidarity of the people from different nations, cultures and races was very impressive.

Community Health Workshop:

DATE AND VENUE:

April 14-16, 2004. Bangalore.

THE WORKSHOP:

Refer annexure9

LEARNING EXPERIENCES:

This workshop was a good way of concluding the fellowship. The four topics- Right to health care, globalization, VHWs and community health financing were areas we were involved in during our fellowship. It helped me to deepen my understanding on these topics. We could raise many questions and discuss it freely.

Chapter 5.
TRAINING PROGRAM CONDUCTED:

Community Health Orientation Programme

PARTICIPANTS:

2nd year theology students of CRI Brothers.

DURATION & VENUE:

October 6th to 24th, 2003. Vidyadeep College, Bangalore.

INTRODUCTION

At the request of Bro. George T.V., Dean of studies of CRI Brothers Institute, CHC conducted a three week community health orientation programme for the 2nd year Theology students. In discussion with Dr. Thelma I decided to take the responsibility for co-coordinating the programme as part of the fellowship experience. My companion Br. Xavier C.Ss.R was also involved in organizing the programme. Mr. Rajendran assisted us in the process.

OVERVIEW OF THE PROGRAMME

The community health orientation course began on the 6th of October Monday at 9am. It started with introduction followed by an icebreaker called "*toss salad*". I gave an introduction and the purpose of the course. We had a break for half an hour and then at 10.30 I took a session on **Communicable and Non communicable Disease**. I began this session with a game which brought out different kinds of diseases from the participants. It was a very interactive session. Dr. Paresh Kumar took a session on **Working with Communities**. It was very inspiring and informative. After noon we visited **Snehadaan** a home for the AIDS patients run by Camilians. Fr. Mathew Perumpil the director of Snehadaan, spoke about HIV/ AIDS, its prevention and rehabilitation. He also shared his experiences in working with AIDS patients. It was amazing and very inspiring. After supper we had the sharing of reflections of the day. Many expressed that their visit to Snehadaan was a great eye opener and it changed their attitudes towards AIDS patients.

7th October Tuesday:

The day began with the session by Dr. Francis on **Health situation of India**. After the tea break he took another session on **Health Apostolate of the Church**. He challenged the participants by asking different questions. At the end of the session I asked a few questions and Dr. Francis gave very inspiring answers. This was followed by a session on **Levels of prevention and Health promotion**. It was very informative. The post lunch sessions began with Dr. Shiridi Prasad. He took a session on **Alternative Systems of Medicine**. He began his class by asking questions to bring out various indigenous systems of medicine which the participants knew. Then he categorized and

explained each of the systems. This was followed by a session on **Health, Community health and Holistic health**. A lot of transparencies with diagrams were used and they brought out the essence very clearly. After supper we had the summing up of the day. In that session many of the participants expressed that the day was hectic and no time to reflect. So we decided to modify the daily schedule and give more time for group and individual reflections. That night we showed them the movie Lesser Humans.

8th October Wednesday

Morning we had the prayer at 6.30 conducted by one of the six groups which we divided for group discussions. The first session was taken by Bro. Xavier on **Critical and Creative Thinking**. He began his session with a magic show and connected it to the question how we should think critically. He asked them to decorate one person with three news paper sheets and some broom sticks to bring out their creativity. After the tea break we decided to give them time for group reflection. We came back for a session on **NGO's**. I started the session with an inspiring story and explained the dynamics of NGO's with lots of examples. After the lunch we sent them to four NGO's, **APSA, APD, Navajeevan and Shishu Bhavan** in which two were religious and the other two secular. They went in small groups of 6 members each. After supper we had the summing up of the day were the groups shared their reflections about the field visit.

October 9th Thursday

The day began with the morning prayer. The first two session was on **Health and Nutrition** by Ms. Padmasini. She made it very simple and practical. After that Dr. Mary Thomas took a session on **Women's Health**. She brought some magazines and showed to the participants how women are considered today and she explained how we could empower them. The post lunch session began with Dr. Mohan Isaac on **Mental health and Family health**. He explained by showing different transparencies, it was very informative and helped the participants to understand the importance of mental health which is one of the components of health. Evening we had a panel discussion with Ms. Donna and Fr. Ignace C.Ss.R. Ms. Donna spoke about **Equity in health especially gender issues,** she shared how women are denied of health care. She gave lot of examples of cases from her own experiences and answered many questions of the participants. It was amazing to see her conviction and commitment. Fr. Ignace C.Ss.R shared about **Equity in health especially poverty issues** using his experiences in North India and how he shifted from preaching to prevention of Malaria. It was thought provoking and inspiring.

October 10th Friday

The first session was given by Dr. Rajan Patil on **Environment and health**. He explained the role of environment in health. After tea we gave them time for group reflection. Before the lunch break we had a **Panel discussion** with the slum youth regarding the problems of the youth in the slum. Five of them shared about their life, difficulties and kinds of work they do. The participants were moved by their genuine sharing and openness. After lunch we had another panel discussion on **TB., Malaria and Alcohol**. Rajendran and Chander spoke with their experience on the ill effects of Alcohol

and Tobacco and its implications on the individual and society. Evening Bro. Xavier took a session on **Interpersonal relationship and community life**. He explained the different qualities which a person need to inculcate to live a healthy community life. After dinner we organized a **Musical evening**. We taught them some action songs and the participants put up dances, skits and songs. It was like a celebration.

October 11th Saturday

Last day of the orientation programme. We started the day with **Monsoon game**. The participants were divided into 5 small groups. Mr. Prahalad coordinated the game. After the game we had the sharing of the participants about their learning experiences from the game. They said that the game helped them to understand the dynamics of poverty among the villagers and how the monsoon plays a important role in their lives. After the tea break the CHC team Rajan Patil, Prahalad and Chander shared about G**lobalization, Peoples Health Movement and the Charter**. After that we planned for the two weeks exposure programme.

EXPOSURE PROGRAMME

We left for Mysore on 13th morning and we reached RLHP (Rural Literacy and Health Project) by 11.am. We decided to spend rest of the day by going around and visiting the important tourist spots in Mysore. The next day we went to meet Fr. Chitoor. He is staying in a village which is around 45kms away from Mysore. We had break fast with him and then he gave a brief summary about his work and his herbal garden. He took us around and explained about each plant and its usage. The participants were amazed by seeing so many medicinal plants which they considered as wild plants or weeds. After our lunch Sr. Mary brought some medicines made out of Herbs and explained about its preparation and usage. Some of the participants bought herbal medicine for their minor health complains. We went to see the Kabini dam which is just 5kms away from Fr. Chitoor's place. We got back to RLHP for our night stay.

15th of October

Next day, we went to the Organization for the Development of people (ODP). It is the Mysore Diocesan Social Service Society, a voluntary, non- profitable organization aiming to enable community based people's groups to become self reliant. Fr. Vincent Fernandez the director gave a brief introduction about their work and experiences. The participants asked many questions and his answers were genuine and inspiring. He took us around to their various income generating projects which they have started for the poor village girls. We visited the stationary unit were they make Note books, then to tailoring unit were uniforms are stitched for various schools and leather bags of different kinds. In the food processing unit they prepare some snacks based on the orders given by the customers. We were surprised about their sale and profit margins and how the illiterate girls were able to earn and support their families. Some of the participants bought bags to show our support and solidarity. We got back to RLHP for lunch and at 2.30pm Mr. Joy the director of RLHP spoke to us about their work and experiences. They are working in the slums in Mysore, they have build up SHG's, shelter for the street boys and girls. After

his talk we divided the participants in to four groups and sent them to different slums were RLHP is working. After our dinner we had sharing of reflections. The participants expressed that some of them visited developed slums which can no longer be called as slums and others visited an underdeveloped slum. The participants appreciated the good initiatives of RLHP.

16th of October

we went to H.D.Kote to visit the organization called Swami Vivekananda Youth Movement. Dr. Balasubramaniam gave an introduction about the organization and its activities. He shared the origin, principles, achievements and the challenges of the organization. It was a good sharing. After that we went around the tribal hospital where they follow one of their guiding principles, '*Nothing is given free*'. For any treatment and surgery a tribal has to pay just Rs.5/- for all the expenses. We were impressed when we went to every nook and corner of the hospital which is well equipped and totally people oriented. After that we went to a tribal haadi for a visit and spoke with some of the tribals. Then we got back to the hospital were Dr. Balasubramanium spoke more about their various projects and it was an interactive, question – answer session. Evening before reaching our place for night stay we dropped in, to watch a street play performed by the VYM staff in one of the tribal haadis on tobacco control. It was something exciting and new for us.

17th October

Next day, we visited the tribal school situated near the forest which follows non conventional method of education for the tribal children keeping in mind their cultures, customs, practices and needs. The structure of the school is something new and creative. We had an hour of group sharing in one of the classrooms in the school. We reached RLHP for dinner.

18th October

We went for a gathering of old aged people in a slum organized by RLHP. There were around 300 old men and women. It was nice to see them dancing, singing, and participating in the fancy dress and fashion show competitions. In the evening street girls from the RLHP centre gave a cultural programme for us and the participants performed some dances and songs for the girls. Some children shared about their experiences in the street and how they were are rehabilitated here. It was very heart breaking and distressing to listen to their stories.

19th to 23rd October

We left RLHP and reached Hanur which is about 40kms from Kollegal and visited Comprehensive Rural Health Project. The holy cross sisters have taken up this project which covers 76 villages. Sr. Aquinas is the director. We decided to leave it to the participants to identify and choose what they would like to do in the coming 4 days. After supper we had an open session with Sr. Aquinas. She shared about what they were doing in the villages and what were the possible areas where the participants could involve themselves. Fifteen of the participants opted to go and stay together in a hall which was 2kms away from a village and wanted to work for the village in the water shed

project (lets call them group A). Five other participants decided to stay inside another village in families and work in their fields (lets call them group B). One participant chose to go with a staff of CRHP to identify bonded child labourers in the villages and another went along with the mobile clinic to different villages.

Group A worked in the watershed project in few fields of the farmers in the village on the first day. The next day they wanted to do something for the whole village. But they experienced non- cooperation from the villagers and so they themselves repaired the roads and cleared up the Govt. school campus in the village.

Where as group B ate what the villagers gave them and worked in their fields. Some villagers joined them in repairing the roads. They experienced good cooperation from the villagers. On the last day evening they gathered the whole village and organized a cultural programme for them. There were dances, skits, jokes and they also made the village youngsters to dance and sing in the programme.

24th morning

We had a debriefing of the four days experience in the village. The exposure programme ended in a happy note even though some felt that expect the stay in the village the whole programme was a waste of time. The participants agreed to submit a final collective reflection and report before November 10th, and to have a final presentation of about 2-3 hours to the Vidyadeep Institute and CHC consultants before November 15th. After lunch we left for Bangalore.

OBSERVATIONS :

1. Community health orientation programme as whole is a very good module – both the one-week orientation as well as two weeks exposure. But for whom, it is conducted is also very important. A group that has sufficient emotional maturity, social orientation and an inclination for poor can benefit maximum from this course.

2. There was a conflict regarding the expectations of the participants and the formatters. Some of the participants wanted to live 3 weeks with poor people and do manual work. Formatters wanted community health orientation programme. This conflict became very obvious towards the 2nd week of the program.

3. The participants could be classified into 3 groups. A minority of highly motivated and 'other oriented' group (about 5-6); another minority of highly motivated but more of 'self centered' group (about 3-4) and a majority of a docile group which had no stand of its own (about 10-12). The self centered group was quite influential and could take the docile group also with them most of the time.

4. There was pressure from the participants to compromise on two basic principles consciously chosen for this program, i.e. 'Participatory' approach and 'Ballonistic' approach.

5. When the conflict regarding expectations became quite evident, the participants were encouraged to come together and express their feelings and thoughts freely in the group. The dynamics of that group sharing was a very good learning experience for us. It lasted for about one hour and we could listen to them without being defensive or reacting, especially when the general feeling was that the program was a 'waste of time' and there was no connection between the one week orientation and the exposure program. It was painful, but our non-defensive listening attitude helped the group itself to confront each other and over come the crisis. At the end of that group process it became evident that the program was a 'waste of time' only for a minority which expected a manual work experience. But this minority could confuse the whole group, especially the docile group.

6. Based on the observations of the above mentioned group process, we could help the participants to make the final week (CRHP experience) more appropriate and relevant by incorporating their interests, needs and aptitudes. Thus they chose to spend their last week in doing manual work, staying with the villagers. One group (5) decided to live within the village, work with for and eat what ever the families gave them. Another group (15) decided to stay outside the village, prepare food for themselves and work for a watershed project in the village.

GROUP A (15)	**GROUP B (5)**
Experienced the positive aspect of community life only among themselves (15)	Experienced the positive aspects of community life both among themselves (5) as well as with the villagers.
Experienced resistance from the villagers	Experienced cooperation from the villagers
Self survival became the priority (e.g. food etc) than the mission	Mission became the priority than self survival
Probably will become institutionalized trying to transform Society from outside	Probably will become leaven in the bread, transforming society from within

7. We perceived that there was a general feeling that group B was successful that group A. but the final reflection at CRHP after the work experience could resolve the issue. Even though group B apparently gave the impression of being successful, group A too had a very rich experience. Both the groups experienced the positive aspects of community life like mutual support, cooperation, each one as a complementary member with various gifts and talents, meaningful prayer and recreation, respect for each other and so on. The difference was; group B lived an intense community life in the midst of a positive experience (Cooperation from villagers) and group A too experienced intense community life in the midst of a negative experience (resistance from villagers).

LIMITATIONS :

1. As far as this course is concerned we were conducting it for the 1st time.

2. Lack of availability of some of the experienced CHC consultants for some sessions of the 1st week orientation

3. We missed the rich experience of Mr. S. D. Rajendran who has coordinated similar courses in the past especially during the one week orientation phase. He was coordinating another program which was going on simultaneously.

4. We missed the experience of Dr. Paresh Kumar especially regarding the field visit to Vivekananda Youth Movement in H. D. Kote.

5. Canceling some of the already finalized sessions had brought difficulties in last minute arrangements.

6. Lack of availability of updated phone nos. and email ids of resource persons and groups.

7. The multiple roles we played, like developing the programme, organizing it, and becoming resource persons for about 5-6 sessions was very stressful.

SUGGESTIONS FOR IMPROVEMENT:

1. Interacting with the participants without a preset questionnaire might help to understand whether they are prepared for this particular course. It would also avoid conflict of expectations.

2. If the group is not ready for this course suggest some other course which will address their need. Another possibility would be being extremely flexible to address their felt need and then take up community health orientation course at a later stage.

3. It would be nice to have an interaction with the formatters and the participants together, to avoid communication gap.

4. The programme coordinator(s) becoming a participant observer through out the program can achieve the following:

    a. It will help to identify and resolve the problems among themselves that comes up during the programme.
    b. It will help to he/she to bring innovations during the programme.
    c. Generate new insights for improving the programme in the future.

5. Total cost of the Programme comes about Rs.40,000. Hence the economic feasibility of the programme should be taken into consideration in the future.

CONCLUSION:

This course, with its one-week of theory and 2 weeks of exposure seems to be a wonderful program evolved by the many years of experience of CHC. But at the same time it is important to conduct this course for motivated and other oriented groups for its optimum utility. Though we experienced 'emotional drain' by organizing this program, it was a wonderful learning experience for us. We acknowledge our sincere thanks to the CHC team as a whole, for the trust and confidence they had in us even though it was evident that we were conducting this course for the first time. (For programme schedule and participant evaluation, refer annexure10)

CONCLUSION

There was a phase in my life where I could see only hopelessness and misery around me. Pessimism was my predominant expression. Is the society beyond redemption? That was the question, which resounded in my mind very often. I was getting disillusioned by the consumerist trend, which was gradually taking over the medical profession. But somewhere along my life I started encountering people who instead of cursing darkness, were trying to light a lamp. Even though they were a few, they were making a difference in the society. Coming in touch with them was a pleasant surprise for me. It gave me enthusiasm to move out of my pessimism and to begin the journey, which led me into the world of community Health. These people whom I encountered helped me to make a gradual transition from the world of hospital to community-based projects to people's movements – the coming together of those lights that were making a difference in the society.

This write up may not have many of the characteristics of a scientific work. It was a deliberate choice from my part to write it this way. Probably it can be considered as an expression of, my own transition from a purely scientific world to a human world. Earlier I mentioned that this fellowship was a significant stage in my journey. Does it mean that I have ended this journey? No! It will continue. We (fellows of 2004) have already started working on ways of being in touch with each other, in order to make our contribution towards a just society. I hope that more and more youngsters may get opportunities like this. Our journey will continue along with the millions of the poor and the exploited as long as there is gross injustice, exploitation and misery.

ANNEXURES

Annexure 1
Two-Day Debriefing of the fellows of 2003-2004

11th and 12th March
Community Health Cell, Bangalore

The Community Health Fellowship scheme was offered to Mr. Naveen Thomas (MSW) Dr. Mathew Abraham (MD in community Medicine), and Dr. Abraham Thomas (Dentist), for the year 2003 and 2004. The activities and learning experiences of the fellows was facilitated through a discussion panel by the mentors at Community Health Cell. Dr. Thelma Narayan, Dr. C.M. Francis, Dr. Ravi Narayan, Dr. Paresh Kumar and Mr. S. J. Chander were the facilitators of the discussions.

The discussions were held over two days with 2 sessions a day.

The sessions were

1. Reflections on the One-Year Fellowship in line with the objectives of the fellowship
2. The skills and the knowledge acquired over this period
3. Values and attitudes acquired and imbibed over this period
4. Reflections over the Process of learning

Session I

Facilitator: Dr. C.M. Francis
Effectiveness of the fellowship / internship scheme in line with the objectives

The session started with a 20 minutes introduction by Dr. C. M Francis highlighting the objectives of the scheme and the importance of the learning process. This was followed by the fellows spending 30 minutes recollecting and writing down all the learning experiences they had in line with the objectives and also those outside the objectives.

Deepening of the understanding and praxis of community health

Cognitive Domain

- A gradual deepening of the understanding of the difference between medicine, community medicine and community health was possible for the fellows
- A deepening of the understanding of the components and principles of primary health was achieved

- Understanding the dynamics of the communities was also possible through the fellowship

Affective Domain

- The motivation and interest to work towards community health was strengthened to a great extent

Social Context

- The interrelation between rural poverty and the expansions of urban slums became evident through this experience
- The dynamics of exploitation of tribal communities by people from outside was seen and experienced
- Caste, Gender and Class divides that adversely affect health and development in various communities was understood

Session II
Facilitator: Dr. Ravi Narayan
Skills and Knowledge acquired during the Scheme

The fellows were facilitated into a process of discovering the skills and knowledge, which they acquired or developed during the time period

Existing Skills Sharpened	New Skills Acquired	Opportunities Lost (in acquiring certain expected skills)
1. Reflective Action	1. Mentoring Skills	1. Organizational Management Skills
2. Reporting	2. Connectivity (Internet, Mobiles, using Computers, Making presentations, etc.,)	2. Epidemiological Skills
3. Adjusting to a wide range of environmental condition	3. Using certain Epidemiological Software (EpiInfo)	3. Public Speaking
4. Participatory Observation	4. Evolving Structures through organizing programmes	
5. Networking	5. Project Writing and Analysis	
6. Communication		
7. Coping with emotional Stress		
8. Interviewing Skills		

9. Management Skills
10. Group Dynamics
11. Driving
12. Research Methodology
13. Integration, summarizing and assimilation of information
14. Facilitating skills and training skills
15. Critical Evaluation
16. Conflict Management Skills
17. Public Relations management

Session III
Facilitator: Dr. Thelma Narayan
<u>Attitudes and values in Community Health</u>

The fellows were provoked into thinking – Why are we doing, what we do in Community Health?

The questions put forward for the same were…

1. What are the values and attitudes necessary for Community Health?
2. What are the values and attitudes that led you into community health?
3. In your experience with the various catalysts (placement organization) what values and attitudes did you encounter and pick up?

Honesty	**Integrity**
Empowerment	**Justice**
Patience	**Openness to Learning**
Humility	**Prudence**
Faith in People's Abilities and Power	**Respect for people, their culture, and beliefs**
Respect for the living and non-living (Environment and Nature)	**Self-Esteem**
Hope (positive attitude)	**Emotional and Sexual Maturity**
Flexibility	**Forgiveness**
Courage and sense of Mission	**Accepting our human limitations**
Humanness	**Coping with suffering**
Being non-judgmental	

Many of these attitudes are acquired, learnt behaviors, which have come with time and experience. Some of them were rediscovered or understood during the Fellowship as important strengths of community health work

In some situations, it was thought that values need to be personalized. I.e. putting oneself in the shoes of the various stakeholders involved in an issue before we take a decision.

Session IV

Facilitator: Dr. Paresh Kumar
The Process of Learning during the Fellowship

The process of learning was discussed within the following headers

1. Uncertainty of entry into the Community
2. Urgency felt during the time period due to the lack of time
3. Adaptability
4. Loss of Autonomy

Uncertainty

Since the experiences of the three fellows varied in areas such as, situation, time-frame, location, partner organization, personal objective and local needs, the Fellowship yielded a variety of rich experiences.

There was a healthy uncertainty where the fellows could evolve and sharpen their objectives all through the time period. The uncertainty of place, job responsibilities to be taken up, the partner organization's aims and work force, new culture, language and so on were the key to the wide range of adaptations the fellows underwent.

Urgency felt during the time period due to the lack of time

In some cases there was a certain amount of urgency felt due to the lack of time allotted to each mission, while in some of the cases there was an extension of time allotted to the original learning experience.

Conclusion

All the Fellows found this experience beneficial and rather enriching to their lives and beliefs which led them to take up Community Health and Development as a vocation. Some of the existing values and skills were deepened and strengthened, some were rediscovered, and some were put into use.

When it was raised and discussed, whether we are reinventing the wheel by making supporting another condensed course of social work, the fellows felt that this was not only a technical short course, but it was also a value based learning process for the overall growth of a community health person. This course was more of getting to know the philosophy of community health and deepening it at an experiential level.

Annexure 2

Community and Public Health Internship/Fellowship Scheme.

Reading List

A. Books and Reports

1. Compendium of Recommendations of various committees on Health and development (1973-1975)
   -Central Bureau of Helath Itelligence (1985)

2. Health Services and Medical Education-A programme for immediate action
   -Group on Medaical Education and Support Manpower (Srivastaca Report), GOI. 1974.

3. Primary Health Care: A Report of the International conference on Primary Health Care; Alma Ata, USSR. 6-12 September 1978.
   -WHO-UNICEF (1978)

4. Health for All- An Alternative Strategy
–ICSSR-ICMR (1981)

5. National Health Policy
-Ministry of Health and Family Welfare GOI (1982)

6. Investing in Health: World development Report-1993
-World Bank (1993)

7. In search of Diagnosis
-MFC (1977)

8. Health Care: Which way to go ?
-MFC

9. Under the Lens: Health and Medicine
- MFC

10. Rakku's Story: Structures of ill-health and the Source of Change
-Zurbrigg, Sheila (1984)

11. Health and Family Planning Services in India_ An Epidemiological, Social-Cultural and Political Analysis and Perspectives
-Banerji, D.

12. Poverty, Class and Health Culture in India
-Banerji, D. (1982)

13. State of India's Health
-Mukhopadhyaya, Alok (1992)

14. My Name is Today
-Morley, David., Lovel Hermione. (1986)

Annexure III

Our Experience in a Slum

Participatory Observation and reflection

By
Mathew Abraham and Xavier

Rajendra Nagar Slum
Bangalore
(From July 10th to November 26th 2003)

Introduction

After making a decision to live in a slum for participatory observation, we had four slums in our mind. W visited the four slums and then chose Rajendra Nagar slum (opposite to the National Games Village) due to its proximity to CHC (Community Health Cell). We tried to get a room through World Vision, which has its office and a school in the slum, but did not succeed. Then we decided to go on our own. As we were walking in the slum we met a lady in a cycle shop who told us that it would take at least tow days to find a room. Then we walked further and found a common toilet. We went inside to have a look and there we met Arumugam, the one who collects money from the toilet users. We asked him whether we could get a room to stay. He took us around and showed us three rooms. We chose a small room, which was simple and fitting for our objectives and purpose.

Learning Experience from the Inconveniences

Sanitation Problem

The first day in the morning, we go up early and went for mass to Infant Jesus Church. After the mass we were coming back to our room. On the roadside there were children sitting and defecating. The whole place was stinking and my companion Xavier started getting giddy. We reached a small bridge. Underneath there was an open drain

flowing and on the bridge there was garbage and human excreta. Any over stepping would result in us stamping on the night soil! Xavier held on to me and we somehow managed to reach our room. We took rest fro sometime and went to a hotel for breakfast. When we tried to eat all that we had seen came to our minds and we could not eat. We were wondering why people don't take their children to eh common toilets. Two months later we found the answer. We paid Rs. 1/- per person for using the toilet daily, so for a month it was Rs.30/- per person. Most families in the slum have more than five to seven members. If every member uses the toilet once in a day it adds up to Rs. 180/- to Rs. 210/- a month, which is quite a big amount for him or her. Hence once women use these common toilets. This realization helped us to understand and not accuse or judge these people.

Problem of Sleep

Being used to sleeping in our own rooms, We had to make do with a small room where there was just enough place for town people to sleep. My leg used to touch the wall! When Xavier turned he would touch me and I used to get up, it was the same if I turned in my sleep as well! Both of us used to get up very often in the middle of the night. When we were finding it difficult to sleep in our room we came to know later that there were as many as five people staying in our room before we came. One night we went to Raja's(one of the youth in the slum) house to see his nephew who was sick. It was a small hut and they had already gone to bed. We saw a saree being tied across the room dividing it into two portions. Soon we realized that on the other side were Rajas sister and her husband. The rest of the family slept on this side while Raja slept on the road making this sacrifice for this sister. But there was no privacy for the couple.

Bathing Problem

Initially we were taking bath inside our room. When I took bath Xavier sat outside the room and when he took bath I did the same. After our bath, the room would be flooded and we would mop it before we left. This is the story of every house in the slum because most of them don't have separate bathrooms.

Ventilation Problem

We locked our room and went fro a two-week exposure programme near Mysore with the CRI brothers. When we came back, we found our room full of fungus and all our clothes we affected by it. When we asked our neighbors who they manage, they said that they don't go out for such a long time. They got no letter, no phone calls, rarely any and visitors. But in spite of all this they seemed happy.

Electricity Problem

Our house owner was tapping electricity illegally without paying the bill. In the first week of every month, the Electricity Board Officer would come and cut the connection. For few days we had no power in our room and on top f that there were no windows or ventilation. We managed with candles. Some of the huts in our street had no electricity at all and used kerosene lamps in the night.

Rainwater

One night when I was out of station, my companion Xavier was sleeping. It was the rainy season and our room started to leak in toe to three places. Since we had only a small vessel, Xavier couldn't do much until an idea struck him. He climbed up and tied a plastic cover to the place where it was leaking and then continued to sleep peacefully. We have seen people emptying water from their houses in the night during the rainy season as the drain overflows into their very homes. The situation is very pathetic.

Some Issues that We Encountered

Gender Bias

When we first reached the slum a girl came running towards us from her house and asked whether we would take tuition for her. We asked her name and her reply shocked us! Her name was ***'Venda'*** which means '***I/We don't want'*** in Tamil. I had never heard such a name before. We were disturbed and angry with her parents for giving her such a name. We started calling her ***Shalini***. Two months later we got a chance to chat with her mother. We asked her why she gave such name to her daughter. Then she shared her story with us.

This woman already had two daughters and was pregnant with the third child. All her relatives cursed her saying she was incapable of bearing a male child. So by all means she wanted a boy, but she delivered a girl! She was disappointed and frustrated while many of her relatives did not even come t se the baby. Then one of her relatives told her to give her baby such a name so that the next child would be a boy! We were able to understand her.

Money Lenders

Shalini's father once told us, "When I get up in the morning my head is spinning and I am completely confused." He is a mason and earns around Rs. 4000/- per month. His wife does domestic work in three families and earns around Rs.1700/-, the second daughter works in a textile company and earns around Rs. 2000/-. Thus the monthly income of this family comes to around Rs. 8000/-. But in spite of this all the children look malnourished. We asked them the reason and he told us that he had to pay a monthly interest of Rs. 5000/- He had borrowed Rs. 50, 000 for his eldest daughters wedding and had been paying the above amount as interest for the past two and a half years. This meant that he ha already paid around 1,50,000 as interest and he was yet to return he principle of Rs. 50,000/- Initially we were angry with the money lenders but when we spoke to our mentors, we realized that money lending flourishes on account of the pro-rich banking system. Later on we met a Bank Manager in Kollegal called Mr. Vijaya Krishnan who gave money for the poor village SHGs than for big businessmen. It helped us realize that even in the Banking System, there are officials who are pro-poor.

Injustice and Corruption

Most of the days we had dinner from a roadside noodles shop in the slum. Meshak comes with his son David around 7 pm and sells noodles and fried rice till 11.30 pm. One day while we were eating, two policemen came in their official bike and stopped before the shop, Meshak ran and gave them some money. After sometime tow men came and

ordered noodles and fried rice. When it was ready they just took the parcels away without paying for it. Meshak told us that hey belonged to the crime branch. He also told us that 50% of his profit went to the police in this form. Every day policemen come there between 9.15 and 9.30 pm and collect money from all the shops. We asked him what would happen if he refuses to pay. He said that they would not allow him to keep his shop. He also said that there is no permission to keep shops on the roadside so ***they have to give something to the police***.

Is this not a form of legal roudism? The policemen collect not only money but all that is required for their family from vegetables to fruits without paying a pie. The ones who are supposed to protect have themselves become the threat. Why are the police anti-poor and using the law to crush these poor while they escort the rich?

We met some contract men who were cleaning the road. They had come from Andhra Pradesh. The contractors bring them promising a good salary. But once they are given jobs, they are paid only 1800/- a month and asked to sign a receipt o 2000/0 this contractor takes Rs. 200/- from each worker and he just sits at home! He owns 106 lorries! They also said that they are throw on out of their jobs if they ask for justice. To sustain their families they have to take up more than one work. They come back home angry and tired. Couldn't this explain why they try to find solace in alcohol? Why they are rude with their spouses and children?

One day at around 6 in the morning, we saw a long queue of people standing with cans and ration cards. Kerosene was being distributed from a tempo van. Out of curiosity we went near them and started a conversation with them. Slowly we realized that what was due to them was denied. They were paying Rs. 100/- for 10 litres of kerosene, but were only being given 8 litres! And in front of them it was being sold for Rs. 15/- per litre in black. We were angry and asked them why they don't assert their rights. They were indifferent. They said that these were daily happenings and asked why they should loose even the little they were getting by doing any such thing.

According o the WHO, health is a physical, mental and social well being! Will there be health in the midst of the day to day struggle for existence? Will there be health in the midst of injustice?

Accumulated Anger

Raja is a 23-year-old youngster in the slum who goes for construction work. He drinks alcohol everyday, takes 30 packets of Panparag and goes for gang fights. The rich also use him as a pawn to settle scores. When he was 7 years old, one day he refused to go to school because his teacher hit him the previous day. His father was drunk and hit him badly insisting that he should go to school. When his father had finished punishing him, his mother made him naked, prepared jaggery paste and applied it on his body, and left him near an anthill. He cried helplessly when being bitten by ants but no one helped him. As he was sharing this tears rolled down his eyes. At the age of eighteen, he was arrested for attempted murder. He was beaten up by the police in the station so badly that he could not walk properly and when they took him to the court he was asked to say that he fell in the toilet. Two years he was in the jail and experienced a lot of torture.

Today he enjoys spending time with us in our room along with other youth. He is no more the same Raja whom we met in the beginning. He takes only 5 packets of Panparag and has a deep desire to quit from alcohol. W never told him change but

listened to him and maybe our non-judgmental attitude brought about this transformation in him. Thanga, Joseph etc. are youngsters in the sum like Raja. The traumatic childhood and other bad experiences have made them extremely angry people. They are used by the underworld and politicians to settle scores and kill people. Sometimes we wonder couldn't there be an association between these 'angry youth' and violence like terrorism, communal riots etc.

Emotional Health

Everyday when we opened our door, before we could enter the room children would enter. Even changing our clothes had to be done in their midst. They use to make us sit and fought with each other to get a place in our laps. They hugged us and told us certain things which made us understand deeper issues. These are some of their own words:

"I don't like my mother or father, I like you"	Ammullu 4yrs.
"My father dips my face in the drain if I commit a mistake"	Ammullu 4yrs.
"My father beats me with his belt."	Sangeetha 4yrs.
" My grandfather calls me a prostitute when he is drunk."	Nayeema 14yrs.
"I don't want to live I want to die."	Shabana 13 yrs.

Some call their own children –'You Prostitute.' We have heard it ourselves.

Initially we were angry with their parents but slowly we realized that they too are oppressed and struggling to cope with their day to day pressures. We asked a question to ourselves. What is the real nee? Isn' t Love, affection, and healing of the past traumatic experiences? Can development from outside without peoples involvement sustain? Community building is essential for sustainable development. Unless we deal with those issues can we think of sustainable development? Can building houses, schools, putting pipelines, without building community help in sustainable development? Will disciplining children from outside without addressing their emotional problems and needs result in a better society in the future?

On of our dilemmas was whether to discipline them by giving them tuitions or to address their emotional needs? We tried both. With the smaller children we gave a lot of emotional support and love by playing with them and allowing them to sit in our laps. With the teenagers we tried tuitions but slowly we realized that under the cover of tuitions they too were coming to us to express their emotional needs and problems.

Will teaching Mathematics, Science and other subjects without addressing the emotional issues make the children responsible citizens of tomorrow?

Will teaching philosophy and theology without addressing their emotional issues result in better religious and priests?

Will teaching anatomy, pharmacology and surgery alone without sensitizing them to the needs of the people result in bringing forth good doctors (healers)?

Community Building Exercises

Our entry point into the slum was through children. They did not hesitate to come to us. We opened our door for them and spent a lot of time initially with them. They were

very possessive in the beginning. Whenever they brought some sweets for us we used to share it with al the children present at that's time. Initially some of them were angry but later they started sharing with others themselves. After a few months, they suggested that we cook and eat together. All the children came together cooked food, shared it and ate as one family. Seeing the children cooking food the youth also wanted to do the same. We encouraged them and all had a good meal. We felt that these were opportunities for community building where people come together in spite of their differences.

We found some youngsters addicted to alcohol and tobacco. We wanted to do something about it without telling them to change. So we put posters with pictures explaining the consequences of taking alcohol and tobacco. When they saw those pictures they were curious and asked us what they meant. We sued this opportunity to explain the ill effects of alcohol and tobacco. When they expressed their desire to quite from these habits, we encouraged them. On some days we had informal question-answer on AIDS, VD, Sexuality and friendship. We taught them life skills using their own life situations and events. We went wit them for movies and enjoyed every bit of being with them. But the next day when we gathered in the night we helped them to look at the movie and life in general critically.

The youth after coming back from their work were getting into gambling and other games wasting their money. So we taught them to play chess, snake and ladder and other games, which they could play together and enjoy.

Xavier went with a Muslim family to Mysore for a wedding. They went in a vehicle meant for transportation of goods. They were 25 of them sitting in that small vehicle. On the way it started to rain and all got wet since there was no cover for the vehicle. They stayed in Mysore for tow days, enjoyed the celebrations and came back in the same tempo. It was a wonderful experience and it brought us closer to our neighbours and others. We had food in their houses and participated in their celebrations. They helped us in our needs and share their problems with us.

One of the great feasts in the slum is Mother Mary's feats. They have a flag hoisting 9 days before the feast and on the last day i.e., the 8th of September they have a very grand celebration. On the 7th night the slum youth brought some 50 kgs of rice and 30 kgs of onion, tomato and other vegetables. A big plastic cover was spread on the ground and all the sacks were emptied on that. All families gathered together to cut the vegetables. We joined them and it went up to 12.30 in the night. Another group was decorating the statue of Mary. Children were dancing and entertaining the group. Next day the youth distributed rice and tea for all the people in that locality. It was a great celebration. The initiative was taken by the youth and each family had contributed around Rs. 100/- for the expenses. We realized that these celebrations also bring divided families together and lots of reconciliation takes place as they work together for the feast. In our seminary when we hear loud music from the nearby slum, we shout at them without knowing that in these celebrations there is a lot of community building and reconciliation taking place, music being a major tool in the process.

A Ray Of Hope In The Midst Of Poverty

Muni is a 24-year-old youth in the slum. He had never been to school. He used to help his uncle, a cobbler and thus picked up the skills of a cobbler. He saved some money

by doing construction work bought a cobblers kit and started his own shop. He shows tremendous responsibility to life. Arjun, Rajen, Nataraj are some other youngsters in the slum who shows responsibility towards life in the midst of misery and bad role models.

Viji is a ten-year-old girl studying in the 5th standard. After coming from school she some time selling fruits. She also takes responsibility in disciplining her younger siblings. She shows a kind of maturity far greater than her age. They appeared to us *a ray of hope* in the midst of their difficult childhood experiences, poverty and frustration.

Need For Comfort Zones

Is it possible to have a participatory observation without getting emotionally involved? Initially we thought that it was possible. But in the past five months there were so many situations where we experienced tremendous emotional drain. Some of them were due to physical inconveniences like viral fevers, allergy, diarrhea, problems of defecation, bathing etc. first time in our life we experienced that toilets can become an object of joy. In addition to this, when we listened to the stories of the children who have been physically and verbally abused by their parents, hardships and the distress of some of the youth, confusion and helplessness of the parents in coping with their day to day living, it was not easy for us. Sometimes we just wanted to run away. In that process we realized the importance and necessity of 'comfort zones' for those who got involved in the struggles of people. Gradually over the five months, we could identify some comfort zones, which used to help us to cope with our emotional strain. They were,

- PHM office (fellows room with a toilet)
- Reflections with our mentors
- Infant Jesus Church
- Some of our friends and their families
- Concern and companionship of the people in the slum
- The companionship between me and Xavier (Community Life)
- The innocence of the slum children

Conclusion

(From working for people->living with people)

When we decided to live in the slum we never had any intention to 'do anything.' Nor did we have any intention to influence and change people. Our intention was to have a direct experience of life in the slum by a participatory observation. But at the end of 5 months we realized that we and our room were becoming a hub for the people to come together and to get transformed. Our presence in their midst started the process of community building. When it was time for us to leave the slum they, especially the youth, started persuading us to stay on. When we asked them the reason many of them said:

> "I will tattoo your names on my upper arm to remind myself that some one loved me very much."

"We don't get people like you as friends, when you say you are leaving, we are not able to accept it."

"We might get a lot of friends, but we will never get friends like you."

When we asked them "there are around 25 to 30 NGOs working in this slum, why don't you feel the same with those NGOs as you feel with us?" they replied as follows,

"They come and work for us. For them we are beneficiaries of their projects but you came and lived with us. You respected us as equal human beings, participated in our activities and became on among us."

These five months helped us to realize the difference between the paradigm shift

Working for people
To
Working with people
To
Living with people

Probably the final step a community health activist could take is to live with them and for them.

Annexure IV

Health Insurance Scheme (HIS):

Chechady Valley

A Study
(11.12.03 – 30.12.03)

by

Dr. Mathew P. Abraham, C.Ss.R – MD (Community Medicine)
Sr. Prabha, HC – Director CHABI

Mahuadanr
10.01.04

CONTENTS

I INTRODUCTION

In this 3rd Millennium, with all the modern technology, knowledge and so many health professionals, why should people die prematurely of malaria, diarrhoea and other preventable diseases? This is the reality of many of the villages in Jharkhand even today! what is wrong with the current medical profession ? Commercialization? Profit motives? Alma Ata declaration (1978) recommended primary health care as a means to achieve health for all. All over the world, we still have health professionals committed to Primary Health Care. The health network of Chechady valley (Jharkhand) remains as a beacon of hope to this commitment.

What is impressive about the Chechady valley is the marvelous work done by the Missionaries over a century. The pioneering work of the Jesuits, the building up of tribal communities, the establishment of strong infrastructure in the form of parishes, health centres and schools covering about 120 villages in the Valley need to be definitely appreciated. Another inspiring fact of the Valley is the work of the sisters of various congregations who silently make a difference in the lives of the people. They save the lives of thousands of people who are brought to them with very little trace of life left in them. They are brought with cerebral malaria, tetanus, typhoid complicated abortions,

and so on. More over they make a difference in the lives of many more through health promotion and prevention with the help of the health workers and dais.

Health Insurance Scheme (HIS) of Chechady : A matter of pride

Today there are many agencies who try to build up self financing schemes for health care. They have various intentions ; some are profit oriented and some are people oriented. About 15 years ago inspired by RAHA model, Fr. Peter Jones and Fr. Ignatius initiated the HIS of Mahuadanr. This was done in the context of many poor people dying without accessing even the available medical care facility due to poverty and ignorance. The acceptance of HIS by the people was overwhelming and it flourished with great enthusiasm. People's contribution was given in kind (rice). A year ago, the premium was changed from kind to cash. This and some other factors weakened the scheme. CHABI's interaction with the health worker's lead to the realization that a scientific study need to be undertaken about the HIS, as early as possible.

II. AIM :

- To study and Document the Health Insurance Scheme (HIS) of the Chechady Valley.

OBJECTIVES :

1. To study the History especially the background and the process of evolution of the HIS from its inception till now.

2. To critically evaluate the strengths and the weaknesses of the HIS.

3. To document the experiences and opinions of the people involved in the HIS at various levels.

III METHODOLOGY :

- In depth interviews
- Group discussions
- Studying relevant documents

Table I: In depth Interviews

Sl. No.	Date of visit	Name	Desig-nation	Congregation	Place	No. of villages covered	HIS Yes / No
01	13.12.03	Mr. Fulgence	Health		Mahuadanr	25	Yes

			worker Carmel Hospital	--			
02	13.12.03	Sr. Philo	Nurse (ANM)	St. Joseph of Taubs	Pakripat	15	Yes
03	15.12.03	Sr. Sushma	Nurse	Srs. of Charity of Nazareth	Salae	19	Yes
04	15.12.03	Sr. Pyari Assa	Nurse (ANM)	Srs. of St.Joseph of the Aparision	Tundtoli	11	Yes
05	17.12.03	Sr.Rithamma	Nurse	St.Joseph of Taubs	Mayapur	35	Yes
06	18.12.03	Sr. Assumta Toppo	Nurse	Hand Maids of Mary	Chatma	6	No
07	19.12.03	Ms. Suchita Tigga	Nurse (ANM)	Holy Cross	Gothgav	15	Yes
08	20.12.03	Fr. Ignatius	HIS Director & Parish Priest	S.J	Mahuadanr	--	--
09	22.12.03	Sr. Prema Xalxo	Nurse	Disciples of Don Bosco	Dhawna	10	No
10	23.12.03	Sr. Rosalind	Administrator Carmel Hospital	CMC	Mahuadanr	--	--

Table II : Group Discussion[2]

Sl. No.	Date	Name of village	Clinic Area	Participants (Number)
01	23.12.03	Rega - Tonkatoli	Carmel Hospital	Villagers (13)
02	29.12.03	Parhi - Kenatoli	Carmel Hospital	Villagers (30)
03	29.12.03	-	Carmel Hospital	Health Workers (14)

IV. Results of the Study

1. Terms & Conditions of the health insurance scheme (HIS)

1. A minimum of 20 families are required to start the scheme in any particular village.
2. Each member deposit 5 Kg. Rice or equivalent Money to the church authority.
3. One leader is chosen from each village for voluntary service, she or he gets trained and receives a medical kit with emergency medicines.
4. Each member goes to this Health Worker (H.W) at the beginning of illness for treatment. H.W keeps a register and enter the name and treatment given. Reports are submitted to the centre during monthly meetings of all the health workers in the centre.
5. When H.W. fails to manage the case, patient is referred to the dispensary or the hospital with a letter and the scheme number. Treatment given should be mentioned in the referral letter.
6. Total cost benefit for the year is Rs.750/- for each member.
7. To continue membership, each member should attend the monthly meeting held in the villages by the respective staff.
8. Pregnant women ought to go for antenatal care at least thrice during pregnancy to benefit from the scheme incase of complications.
9. Any self induced illness (such as complications of induced abortion) will not benefit from the scheme.
10. Members are taught about the mutual benefit of the scheme and the value of helping one another.

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[2] - Rega – Tonkatoli was chosen because out of 30 families there, 24 were part of the HIS for the past few years.
- Parhi Kenatoli was chosen because out of 50 families none of them were part of the HIS.
- 14 health workers were those who came for the meeting in Carmel Hospital. The total no. of health workers of Carmel are 24.

11. Members are advised to complete all vaccinations available for adults and children
12. If a pregnant woman is a member, her child at birth is also eligible for scheme benefit for that year.

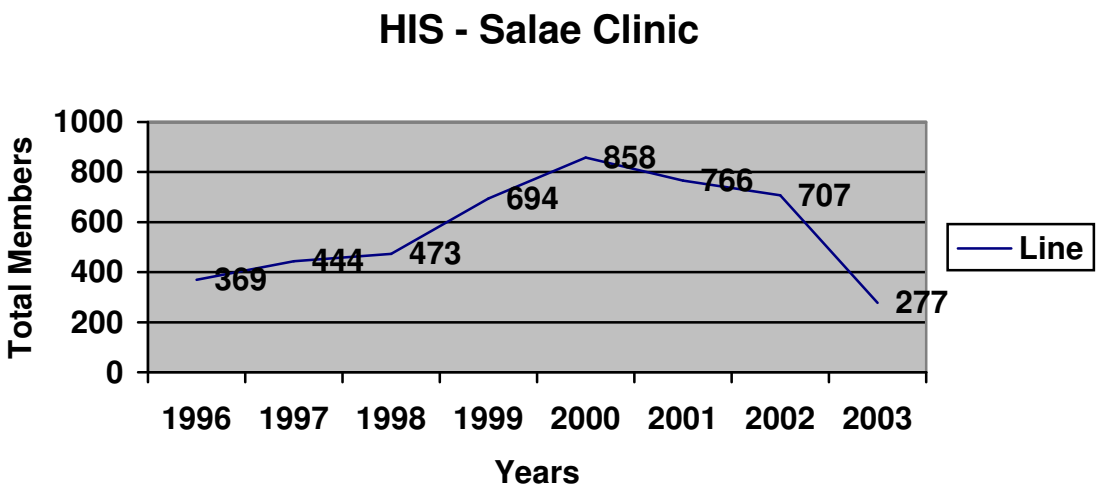
Members are paying about 25% of the total cost and the Jesuit Society covers the balance amount. There are seven dispensaries in the insurance scheme area. HIS members, go to the dispensaries for the initial treatment-referred by the health workers from the villages. Carmel Hospital functions as a secondary care centre Hospital and the dispensaries send timely bills to the church authority and get it paid from them. Monitoring and evaluation is done by the community health staff.

Table – III

2. Membership Pattern over the years

Year	1996	1997	1998	1999	2000	2001	2002	2003
Total Members	369	444	473	694	858	766	707	277
Total families	76	85	106	160	184	158	166	63

Graph - I



Graph - II

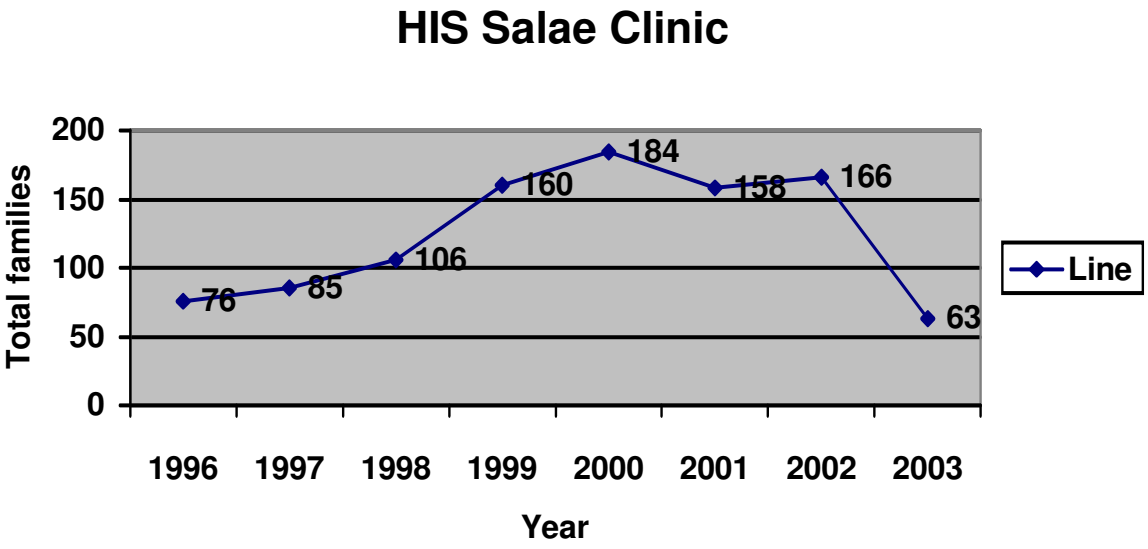
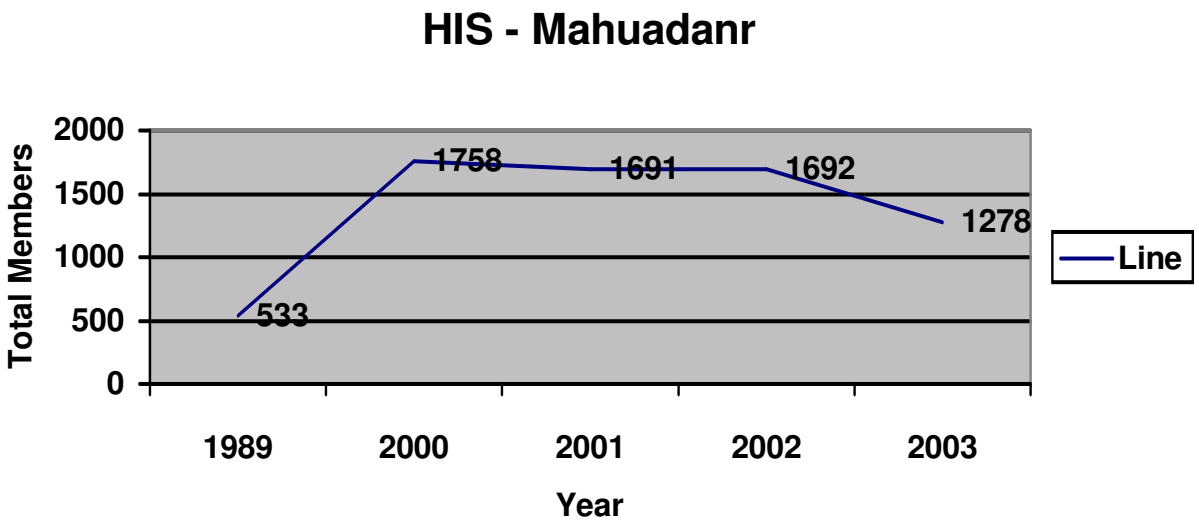


Table - IV

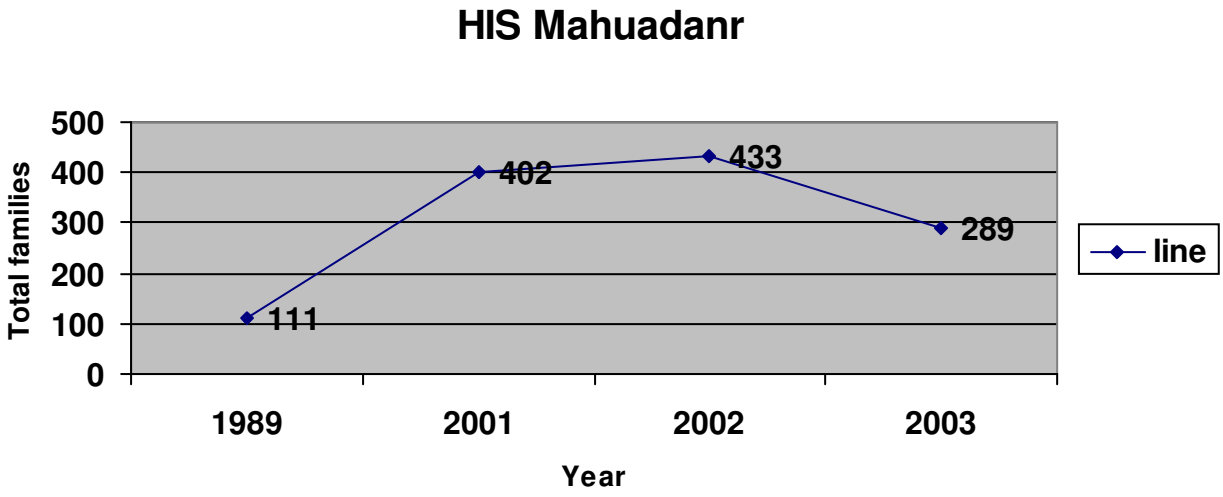
HIS Mahuadanr

Year	1989	2000	2001	2002	2003
Total Members	533	1758	1691	1692	1278
Total families	111	N.A	402	433	289

Graphs - III



Graphs - IV



3. Issues that came up during the interviews/Discussions:-

- **Director of HIS (Fr. Ignatius)**

  - He feels that the scheme is in a declining phase and fears that it might die out eventually
  - The expense every year is about Rs.5 lakhs and the income is very low (Rs. 2 Lakhs – 1 Lakh as interest on capital and 1 lakh as collection from people)
  - According to him, reasons to change from kind (Rice) to cash were these:-
    - Rice collected were of mixed variety
    - In the previous years selling of this rice was easy. People used to buy. Now people buy from market and can afford to buy better quality rice.
    - Many people in the scheme were selling their good quality rice in the market, buying the cheapest quality from market and was giving it for the scheme.

- **Sr. Nurses of the peripheral clinics:**

- Of the 8 clinics in Chechadi valley, 6 of them were very much aware of the HIS. Two of them (Dhawna and Chatma) were not aware of the scheme. They too have been going regularly for the bimonthly gathering of the nurses of the Chechdi area. According to Dhawana & Chatma nurses these was no HIS for the people of those areas.

- Rest of the 6 clinics (Mahuadanar, Pakripat, Sale, Tundtoli, Gotgav and Mayapur) have HIS running quite active. All of them were of very high opinion about the scheme. All of them said that this scheme is of a great help for the people especially the poor.

- All the 5 clinics felt that in the past 2 years the scheme is loosing popularity among people and is slowly facing a decline. (some even expressed the anxiety that the scheme might die out eventually). This was evident from the statistics of the past years from what ever limited documents which were available (Ref. Table III & IV and graphs)

Some of the reasons that were mentioned for this decline were these:-

1. Lack of proper communication between the centre (Mahuadanr), the peripheral units (clinics) and people.
2. The centralized decision making without involving the peripheral units (Sr. Nurses) or the people's representatives (VHWs / Panches)
3. Lack of sense of belongingness of the peripheral units to the scheme - Almost all of them

felt that the HIS was a Jesuit's scheme not the people's scheme. " Mahuadanr ka scheme

he na ? ". Hence many of the sisters as well as health workers are slowly loosing their

enthusiasm to work towards the progress of the scheme.

4. Shift of premium from kind (rice) to money (Rs.60/-) and again raising it to Rupees 80/- in the immediate next year.
5. Some peripheral clinics even felt that there is too much of formalities and difficulty to get the expenses reimbursed from the centre. (Availability of the Director)
6. False Propaganda against the HIS by some people with vested interests

Eg. a) The money lenders – village compounders etc.

These people propagate that: -

- Fathers are enjoying with the money collected from people.
- Those who are in the HIS are given second grade medication
- They will be converted into Christianity.
-

➢ **Health Workers meeting:-**

- HIS is a good scheme for the poor. They can access health care any time of the year even when they do not have money with them.
- For serious cases they can access to transportation (ambulance) too.
- HIS protects the poor from exploiters like – Compounders and money lenders
- If the HIS dies, diseases (esp. Malaria) still continue and poor people have to generate money by :-
  - borrowing from money lenders
  - selling animals, field or other possessions
  - getting into bonded labour for 3 – 4 yrs for just Rs.1000, where they will be given only food as wages.
- HIS Motivates people to attend monthly village meetings and thus get more informed about health and diseases.
- People want to continue in the HIS, but the increase in premium to Rs.80/- is affecting them, especially the big families. In spite of the increase in premium, even now many people are motivated to continue in HIS. " Its difficult for us, but some how we will raise Rs.80/- per head " was their response.
- Fr. Director meets health workers only once a year, (during the 3 day health convention) but has never spoken to them about the HIS.

➢ **Meeting with Beneficiaries :-**

a) Rega Tonkatoli

- All of them expressed that it is a very good scheme. It is of great help for the people.
- They found it difficult when the premium was shifted from kind (rice) to money.

- They were not even aware about the rise in premium from Rs.60/- to Rs.80/-. Not even the health workers or the panch were aware of it.
- According to them health is still a priority; but health is the last issue discussed in the village as well as the parish meetings. Hence health issues receive only little time for discussion and also by that time half of the crowed would have dispersed. (Am Sabha)
- When asked, " if the scheme dies? " this was their response – " Those who have money will go to the hospital. Poor will remain in the village and die "

6) Parhi Kenatoli:-

- In 1990 – 20 families were members of the HIS
  1991 – 17 families were members of the HIS
- They too feel that it's a good scheme
- During 1990, '91 some were benefited from the HIS, but not all those who were members. Those who were not benefited from HIS got discouraged and dropped out. Still some wanted to join the HIS but could not because of the '20 familes norm ' in the rule.
- When asked how many familes might join if the 20 family norms is relaxed they said that 10 – 15 families might join the HIS.

4. Suggestions that came from the stake holders:-

- Director meeting the above mentioned stake holders on a regular basis to exchange ideas and suggestions
- Collective decision making, by involving the peripheral clinics, health workers, peoples representatives and Director
- Flexibility in rules, terms and conditions according to the situation of the particular villages
- The HIS should be extended to more people
- More awareness creation about HIS should be done through
  - SHGs
  - Parish Priest's of the Chechadi Valley parishes announcing after mass
  - Gram Sabha, Catholic Sabha, Am Sabha etc.
- It is not just lack of awareness : generating so much money immediately is a problem. Hence people should be allowed to pay premium as installments.
- By reviving and propagating the founding philosophy " I am the Caretaker of my Brothers / Sisters too."
- Parish Priests of the peripheral clinic areas also assisting the Sisters in motivating people to join the HIS
- Some fund should be allowed to be handled at the peripheral clinics too.
- Poor harijans and non catholic tribals also should be included in the scheme.

- Reducing expenses by avoiding Medical representatives (Middle men). CHABI or some other common body acting as the agent to bring low cost generic drugs.
- Allow the scheme to die for 1 – 2 years, then people might realize its worth and then request to restart.

V DISCUSSION & RECOMMENDATIONS:-

On the whole stakeholders at all levels feel that the HIS is a very good scheme and it is of great help for the poor. All were worried about the declining trend of HIS especially in the past years. All of them expressed their anxiety about its too much of centralization especially in decision making, bypassing the stakeholders at the health centres and villages. However all of them feel that HIS should be continued and expanded to more people. The Director seemed to be burdened with too many responsibilities, being the Parish Priest and the rector of the S.J. Community. HIS seemed to be very low in the Director's priorities, as he seemed to be struggling for enough time. Documentation at the centre seemed to be grossly inadequate. This was true at the peripheral clinics too.

Hence we suggest the following recommendations for the revival of the HIS.

1. Since the backbone of the HIS is the health personals at the village level (VHW) and Health centre level (Nurses & Doctors), it should be built upon their strength.
2. The HIS needed to be decentralized especially regarding
    - Decision making
    - Collection of funds at the periphery (health centres)
    - In addition to the central fund, it is good to have a health centre fund to cover some of the medical expenses at the health centre and village level.
3. Directorship need to be taken up by somebody for whom HIS is a priority and have enough time to work towards its progress.
4. The communitarian bond, the strong infrastructure, the wealth & resources available in the communities of Chechady Valley has to be mobilized to its maximum potential. This includes generation of some funds for HIS at the local level too, through various income generation projects.
5. A system for documentation need to be developed and proper documents need to be maintained at all levels. These documents can be used for regular evaluation and monitoring of the HIS. This will also help others to learn from its experiences.

VI LIMITATIONS :-

1. Because it was Festival (Christmas) season. The availability of the Director was limited.

2. Since this study was done over a span of just 20 days the researcher could not organize more group meetings with the people at the village level.

3. Since there was limited knowledge of the local language, researcher could not go for ' focus group discussions ' but had to depend on ' group meetings ' with the help of a translator.

4. Lack of availability of sufficient documents, at the centre as well as in the peripheral clinics.

5. One of the peripheral Clinics, Cheropat was left out from the study due to lack of time.

VII CONCLUSION:-

The people of Chechady Valley have decided to walk on a less trodden path by accepting HIS. They are experiencing the positive effect of that decision. At this point of time dark clouds seems to be interfering the growth process of the HIS. When the present health care system prefers to walk through the path of expensive medical care for the rich minority, the great initiative taken in Chechady Valley towards a poor oriented health insurance is a matter of pride. Inorder to sustain the process of growth of HIS a timely intervention is obligatory. Let the poor and the abandoned receive our primary attention.

VIII ACKNOWLEDGEMENT

We express our heartfelt gratitude to the following people for their co-operation and support during this study.

- Fr. Ignatius – SJ, Parish Priest, Mahuadanr
- The Jesuit Community of Mahuadanr
- Dr. Romeo, CMC and the Carmel Hospital team
- The Carmel Sisters Community of Mahuadanr
- Mr. Fulgence and the other health workers of Mahuadanr
- The sisters of the health centers of Chachady Valley
- The people of Rega Tonkatoli and Parhi Kenatoli

Annexure V

HOLY CROSS CRHP

Information system
for
Monitoring and Evaluation

Hanur

March 2004

Mission statement:

To empower people especially the poor and marginalized for holistic health and through a comprehensive rural health care approach to bring about overall development of the economically and socially most backward villages, as health is integrally related to socio-economic well being.

Goal:

Holistic health and overall development in the project area

Objectives:

- Health for all through primary health care approach.
- Sustainable financial stability through SHG & IGPs
- Self relient communities which lives in harmony and works towards equity, justice and peace.

Principles and policies:

Empowerment, community participation, intersectoral coordination

Project area:

Area map, location, total population, No. of villages, cluster etc.

-

Organizational structure:

- Three tire structure

VHWs

- As a constant presence in the village with open senses getting to know the village dynamics and sharing their information with CRHP in order to plan and deal with for overall development.
- MCH care, Health education

Staff (animators)

- As a link between VHWs (community) and CRHP verifying and documenting the information shared by the VHW
- Animating groups and organizing programmes

[Monday morning to the field, stay back and return by Tuesday evening .
Wednesday consolidation of data – Planning.
Thursday morning to the field, stay back and return by Friday evening.
Saturday- consolidation- staff meeting.
Sunday- Holyday .

Wednesday and Saturday morning- monitoring of the staff (animators)]

Community for Mission

- Constant vigilance on the village dynamics with the help of the data generated from the field
- Constant brainstorming and reflection as a group, regarding the situation of the field.
- Supervision and monitoring of the staff.
- Capacity building of the staff, VHWs and Peoples organizations according to the need.
- Constant mentoring of the younger generation through exposure, reflection to extent services to more people (widening the mission areas)

Activities and Personnel:

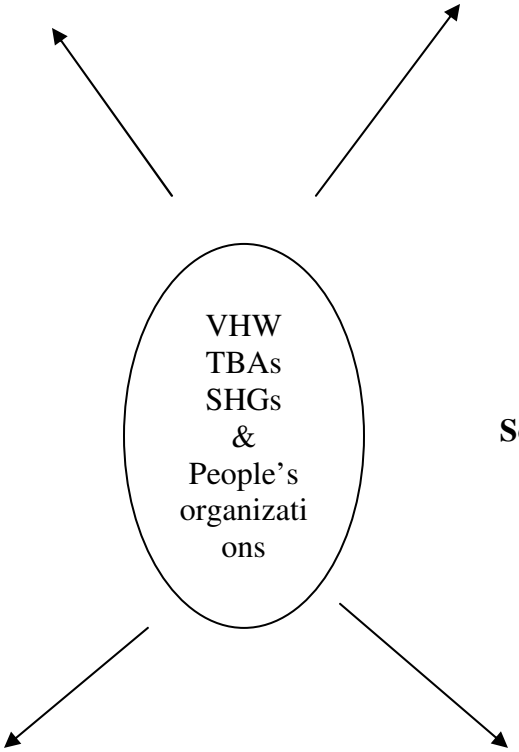
Village level activities

Economicdevelopment

- Savings (SHGs,IGPs)
- Rural entrepreneurship
- Skill training
- Food and water security (Agriculture,watershed)
- Water

Primary Health Care

- Health education What, Where, How often, How
- Maternal and Child Health ANC, Safe delivery, PNC, Preparation for marriage, Child care, Parenting.
- Child Health Feeding, Immunization.
- Treatment of Common diseases and injury Primary care, Referral services
- Control and prevention o local endemic diseases T.B. Control programme



Social Development

- Education (Non-formal, formal)
- Dealing social evils Bonded labour, child labour, Alcoholism, Caste atrocities , Gender
- Spiritual values Sharing, caring, equity, justice,forgivenessetc..


Community for mission
- Supervision and support
- Capacity Building
- Documentation
- Monitoring and evaluation
Conceptualizing
- Goals/ Objectives
- Vision/ Mission
- Over all plan
Ongoing research
Sr. Aquinas
Sr. Fidelis
Sr. Anice
Sr. Teena
community life, problem solving, healthy community.
Net working
Mentoring
Younger generation
Micro planning
- Documentation system
- Monitoring and evaluation system
Implementation
- Daily management

HOLY CROSS COMPREHENSIVE RURAL HEALTH PROJECT HANUR:
Monitoring tool – 1 ; Data related to DEATH.

Name of field staff:

Entry date	Name, Village,Cluster, Street House No.	Age	Sex	Date of Death	Place -D	Duration	Cause of Death

Sex: 1=male, 2=female
Place of death :1=Home,2=Hospital, 3=Others
Duration of sickness: 1=1-2 days, 2=3-7days, 3=8-30days,
4=1-6months, 5=7months-1yr, 6=>1

HOLY CROSS COMPREHENSIVE RURAL HEALTH

PROJECT HANUR:

Monitoring tool – 2 ; Data related to MORBIDITY (Diseases).

Name of the staff:

Entry date	Name , Village,Cluster, Street, House No	Age	Sex	Symptoms	Date of onset	Duration	Diagnosis

Sex : 1=Male, 2=Female **Duration (sickness):**1=1-2days,2=>2days-<2weeks, 3=>2weeks-3months,4=4-6months, 5=7-12 months, 6=>12months **Treatment where:** 1=VHW, 2=PHC, 3=GP,4=Hospital,5=Home **Treatment period:** 1=1day, 2=2-5days, 3=6-15 days,4=16-30 days, 5=>30days **Expense:** 1=<20Rs., 2=21-50, 3=51-100, 4=101-200, 5=201-300, 6=301-500, 7=501-1000, 8=1001-5000, 9=5001-10000, 10=>10,000

HOLY CROSS COMPREHENSIVE RURAL HEALTH PROJECT HANUR:
Monitoring tool – 3 ; Data related to MARRIAGE.

Name of field staff
Date

Name of couple Age

Address

Date of marriage

Approximate expenditure of marriage Dowry

Debt due to marriage Migration due to debt: yes / no

Any other relevant information

HOLY CROSS COMPREHENSIVE RURAL HEALTH PROJECT HANUR:
Monitoring tool – 4 ; Data related to VIOLENCE.

Name of field staff **Date**

Name Age Sex Caste

Village Cluster

Street House No.

Date of violence

Details of injury

Treatment details: Where ? VHW / PHC / GP / Others Admitted : Yes / No

Approximate expenditure duration of treatment

Diagnosis

Cause of violence

Any other relevant information

HOLY CROSS COMPREHENSIVE RURAL HEALTH PROJECT HANUR:
Monitoring tool – 5 ; Data related to ALCOHOLISM.

Name of field staff

Entry date	Name, Village, Cluster, Street, House No.	Age	Sex	Drinking pattern	Duration	Withdrawal Y/N	Expenditure	Problems of drinking Y/N		
								Medical	Family	Social

Sex: 1=male, 2=female **Drinking pattern:** 1=occasional, 2=once a week, 3=>3days a week, 4=daily **Drinking duration:** 1=<1yr, 2=1-2yrs, 3=3-5yrs, 4=6-10yrs, 5=11-20yrs, 6=>20yrs. **Weekly expenditure:** 1=<20Rs, 2=21-50, 3=51-100, 4=101-200, 5=201-300, 6=301-500, 7=501-700, 8=701-1000, 9=>1000

HOLY CROSS COMPREHENSIVE RURAL HEALTH PROJECT HANUR:
Monitoring tool – 6 ; Data related to SCHOOL DROPOUTS & BONDED LABOUR

Name of field staff Date

Entry	Name & Address	Age	Sex	Details of schooling			Details about work			
				Class	Date of dropping out	Reason for dropping out	Working	Place of work	Type of work	Bonded labour

HOLY CROSS COMPREHENSIVE RURAL HEALTH PROJECT HANUR:
Monitoring tool – 7 ; Data related to DISABILITY.

Name of field staff:

Entry date	Name , Village, street, House No.	Caste	Age	Sex	Rehabilitation			
					Type	Duration	Aware	Done

Sex : 1=Male, 2=Female **Dis Type :**1=Visual, 2=Hearing, 3=speech, 4=Locomotor 5=Mental , 6=Burns, 7=Cleft palate-lip, 8= Cerebral palsy, 9=others
Dis duration : 1=<1 month , 2=1-6 months, 3=7-12 months, 4=1-5 yrs, 5=6-10 yrs, 6=11-20 yrs, 7=>20 yrs

HOLY CROSS COMPREHENSIVE RURAL HEALTH PROJECT HANUR:
Monitoring tool – 7 ; Data related to PREGNANCY.

I General Information:

Name…….Age ☐

Residence: Project area/outside

Husband Name……..

Village……Cluster ☐

Street…….. House No.

Previous pregnancy details

No. of pregnancies ☐ No of abortions ☐

No of stillbirths ☐ No of live births ☐

No. of children alive ☐ boys ☐ girls ☐

II ANC details: (Quality of ANC:)

Registration of pregnancy. Y/N No. of checkups ☐

Place of registration .PHC /.G.P /.Hospital /.CRHP /.VHN

Details	TT1	TT2	Booster	IFA received	IFA consumed	B.P.	Weight	Abdomen	Urine albumin	Urine sugar
Y/N										
Number	×	×	×							
Place					×					

III Complications:

Any complications during pregnancy Y/N

1.APH 2. Abnormal presentation 3. IUGR 4. Multiple pregnancy 5. Hydramnios

6. Severe Aneamia 7. PIH 8. Heart disease 9. Diabetes Mellitus

Any complications during delivery Y/N

1. PPH 2. Infection 3. Others

IV Outcome of Pregnancy:

Date of delivery

Place of delivery 1. Home 2.PHC 3. Hospital 4.Subcentre 5.GP 6. Dispensary

Outcome

1.Normal 2. Pre term 3. instrumental delivery 4. Still birth 5. Caesarian

Person conducted delivery

1. Trained Dai 2. Untrained Dai 3. VHW 4. VHN 5. Doctor

Sex of Baby M/F

Birth wt. [ ] kg

Family Planning Y/N

If yes 1. Permanent 2. Temporary

Name of the field staff:

Date of data collection:

Annexure VI

Annexure VII

MINUTES OF THE NWG JSA MEETING
HELD ON 26TH AND 27TH OF JULY 2003
AT INDIAN SOCIAL INSTUTE, , BANGALORE.

MEMBERS PRESENT

1. Dr. N.H.Antia - Chairperson, JSA; Foundation for Research in Community Health.
2. Dr. B.Ekbal – Convenor, JSA; Kerala Sahitya Sahitya Parishad / Vice Chancellor, Kerala University.
3. Dr. Ravi Narayan – Coordinator, International Secretariat, PHM; Community Health Cell (CHC).
4. Dr. Zafarullah Chowdhury – PHM Steering Committee; Gonoshasthaya Kendra, Bangladesh.
5. Dr. K.Balasubramaniam – PHM, Steering Committee, Health Action International – Asia Pacific Region, Sri Lanka.
6. Dr. Mira Shiva - NWG Member and International PHM Link group; Voluntary Health Association of India.
7. Dr. Prem John – PHM Steering Committee; (ACHAN) Asian Community Health Action Network.
8. Dr.T.Sundararaman – Joint Convener; All India Peoples Science Network (AIPSN) / Bharat Gyan Vigyan Samiti (BGVS), Director State Health Resource centre, Chattisgarh .
9. Dr. Abhay Shukla, Joint Convener; National Secretariat; Jan Arogya Abhiyan, Maharashtra, CEHAT.
10. Dr. Amit Sengupta – Joint Convener; Delhi Science forum (DSF) / AIPSN.
11. Mr. Amitava Guha – Joint Convener; Federation of Medical Representatives Association of India (FMRAI), Calcutta West Bengal.
12. Dr. Thelma Narayan –Joint Convener; Society for Committee Awareness Research and Action (SOCHARA) / Jan Arogya Andolana-Karnataka (JAA-K).
13. Dr. P.V. Unnikrishnan – PHM / International Peoples Health Council (IPHC).
14. Dr Joe Varghese – NWG member; Christian Medical Association of India, Delhi.
15. Sr.Fatima – NWG Member; Catholic Health Association of India, Secunderabad.
16. Mr. Geo Jose- NWG Member; National Alliance of Peoples Movements (NAPM); Kerala.
17. Dr. Narendra Gupta – NWG Member; Rajasthan, PRAYAS, (Chittorgarh).

18. Sr. Concelia – JSA – Utter Pradesh; RUPCHA.
19. Mr. Prashant Kumar - NWG Member, Coordinator JSA-Delhi.
20. Ms. Jaya Velankar – NWG Member Maharashtra; WSF Committee member.
21. Sr. Gracy –CHAT, Tamilnadu.
22. Dr. Balaji Sampath, JSA – Tamil Nadu; Association for India's Development (AID); Tamilnadu Science Forum (TNSF); Arogya Iyakkam.
23. Fr. John Vattamattom – Andhra Pradesh, Sanghamitra, MEDAK District.
24. Ms. Ruth Manorama – NAWO, JSA- National Coordination Committee; Women's Voice.
25. Dr. H.Sudarshan – Chairperson, Jan Arogya Andolana, Karnataka; VGKK/ Lokayukta.
26. Ms. K.K. Sumithra – NFIW (Karnataka Unit) National Coordination Committee NCC
27. Ms. Vinutha – NFIW- (Karnataka Unit).
28. Mr. Mashood – AID –Bangalore – Karnataka.
29. Mr. Kutti Balaji – AID, Tamilnadu.
30. Dr. Hari John, Special Invitee, Chennai, Tamilnadu.
31. Mr. E. Basavaraju , State Coordinator JAA-K; Bharat Gyan Vigyan Samithi.
32. Mr. Harirammurthy, JAA_K; Foundation for Revitalisation of Local Health Traditions.
33. Ms. Aruna, Joint Womens Programme, JAA-K / NCC.
34. Mr. Prahlad – State Coordinator – JAA-K; CHC.
35. Ms. Amrutha – JAA-K; Mahila Samakhya, Karnataka.
36. Mr. Tomy Joseph - JAA-K ; CHAKA.
37. Mr. Prasanna Saligrama – Communication Officer, International PHM Secretariat.
38. Dr. Paresh Kumar – CHC/ JAA-K (Incharge organizational arrangements for this NWG Meeting).
39. Mr.S.J.Chander – CHC / JAA-K Bangalore Urban District Unit.
40. Mr.S.D.Rajendran – CHC.
41. Dr.Rajan Patil – CHC.
42. Dr.Rakhal Gaitonde –Christian Medical College, Vellore.
43. Dr. R. Balasubramaniam – Jan Arogya Andolana, Karnataka (from Vivekananda Foundation H.D.Kote Taluk, Mysore District).
44. Mrs. K.Balasubramaniam – Special Invitee Sri Lanka.
45. Dr. Mathew Abraham – Fellow CHC (Volunteer rapporteur).
46. Dr. Abraham Thomas – Intern, CHC (Volunteer rapporteur).
47. Mr. Xavier- CHC, trainee (Volunteer).
48. Ms. Geeta Menon, Observer, Jagruti Bangalore.
49. Ms. Veena Mathrani, Observer, Bangalore
50. Ms. Edwina Pereira, Observer, INSA-India, Bangalore.
51. Ms. Agatha, Observer, INSA – India, Bangalore.
52. Ms. Beena Vasantharam, Student Observer, CHC
53. Mr.V.Ramani, Observer, Siddha Research Hospital, Swagangai District, Tamilnadu.

54. Mr.Bidhaan, Green peace India, Bangalore

Introduction:

The two day deliberations started with a welcome note by Dr.Thelma Narayan, and followed by various persons sharing their work on ground.

These were the agenda for the 2 days of NWG meeting

1. Various JSA activities and individual experiences
2. Right to health care
3. Hunger watch
4. Organisation
5. Website
6. PHM – Global and JSA interface
7. WSF Mumbai and International Forum in defence of Health

M/s. Amrutha shared on the JAA Karnataka**,**
Dr. Abhay Shukla on Maharashtra JSA activities.
Mr. Prashanth on JSA Delhi
Sr. Concelia on JSA-UP
Dr.Narendra Gupta on JSA, Rajasthan
Sr. Gracy on JSA Tamil Nadu
Dr.Ekbal on JSA Kerala
Dr.Joe Varghese on CMAI
Mr.Geo Jose on NAPM.

These sharings along with some of the personal sharings by Mrs. Ruth Manorama, Dr. Antia, all created an environment of solidarity and concern for each other in the NWG. After this the group took each agenda for further discussions.

I. RIGHT TO HEALTH CARE CAMPAIGN

1. Right to health care campaign

Is part of right to health, which includes broader
Issues like water, nutrition, poverty etc but for the sake of advocacy we are focusing on right to ' Health Care'.

The major issues are

1. Do we have an uncritical attitude towards technological medicine?
2. Right to health care in the context of globalization
3. Public interest litigation on violation of right to health care, at national level.

Since NHRC cannot have an official public hearing, the possibility of a National public consultation on right to health care was explored. It was decided to have this consultation on September 6th in Mumbai.

The detailed plan for this consultation was worked out in the NWG meeting
3 sessions :

1st session –

- Public health in general
- Legal issues in public health

2nd session –

- Testimonies on violation of right to health care
  - individuals
  - institutions

3rd session –

- NHRC's response

Some of the ideas / questions came up are the following –

- The objective of the September 6th consultation should be to highlight 'structural' failures not to victimize individual doctors.
- This consultation should not contribute to the World Bank agenda of privatization of health care by blaming the public health sector for its failures. Hence we should also highlight areas where the public system has succeeded. If possible bring out a few 'mess-ups' in the private sector too.
- Should we address issues like
  - ♦ Corruption

- ♦ Health system seen as a milk cow by the politicians (transfers, promotions bribes etc)
- ♦ The inability of health department to use the allotted funds fully.
- ♦ Private sector getting involved in preventive and promotive care

- The format for the case studies with covering letter has been sent to various organizations.
- The question of how the case studies are going to be presented in the public consultation was also raised.
- It was decided to have one-day training programme on September 5th in association with consultation of September 6th for JSA members all over India.
- The participants for the September 5th and 6th programme

Western India – 80-100	Utter Pradesh -5
Rajasthan – 20	CMAI – 10
Madhya Pradesh – 20	CHAI – 10
Chathisgrah – 10	AIDWA – 10
Karnataka – 10	NFIW – 10
Andhra – 10	FMRAI – 20
Kerala – 5	NAPM – 20
Tamil Nadu –5	VHAI – 8

Remaining states – 5 each

- The group responsible for this programme

?

2. Advisory group for JSA :

Mr.Abhay Shukla brought up the possibility of having an advisory group for JSA, for the on going campaign. Some of the names came up were these :

- Mr.John Rakes
- Mr.Collin Gonsalves
- Ms.Ritu Priya
- Mr.Amarjith Sinha

These people are already working towards health for all and can become a potential group that can contribute much for JSA agenda. The possibility of inviting them for the September 6th meeting was also explored.

3. Technical Resource group : (TRG)

In the context of denyal of Health care, we should know,**what** 'denyal' means. Hence the necessity of a TRG.

- What should be the function of TRG?

TRG should compile documents and help others to make clear the following things.

- What are the services available in the primary health centre and the higher referral centres.
- What are the responsibilities of the staff in these centres?
- What are the standard treatment guide lines?

- <u>The persons suggested as the members of TRG are the following.</u>
- Dr.Thelma Narayan
- Mr.Abhay Shukla
- Dr.Meera Shiva
- Mr.Sunder Rajan
- Mr.Narendra Gupta and
- Ms.Vandana

- It was suggested to base this group in CHC , Bangalore because of its experience with government sector and its strength in documentation. Central government and NHRC documents also need to be collected. Amit Sen Gupta agreed to send some documents to TRG. Ms.Vandana might need some junior person to help her to send the documents to CHC.

- **Convenor of the TRG**
  ? Sunder Raman

When it comes to denyal of health services, not only the quantity but also quality of health care should be taken into consideration.

4. <u>Report on "State of health care in India"</u> :

The possibility of bringing this report on the 25th anniversary of Alma Ata declaration (HFA 2000) was discussed.

- <u>Who is bringing it out</u> ?
  Dr.Abhay Sukla

- <u>When</u> ?
  By end of September 2003

- <u>Formal release of the report will be done in WSF</u>
  As a run up to this formal release, releasing in all state capitals on December 10th 2003 (PHA anniversary)

- It was also suggested to bring out a popular version of the report (cartoon form)

5. **Right to health care' in election Manifesto of the political parties.**

The possibility of organizing a one day convention for all major political party representatives, before the election was explored. This is to make use of the pre-election availability of the politicians and to sensitize them to the right to health care agenda and if possible to push it into their election manifesto. It should be more than just a critique of the existing health system. It should also propose alternate models, the 'people centered' model of health care. The importance of focussing on MLAs and the Gram Panchayat representatives were also discussed.

The possibility of a follow up of this convention focussing on health ministry was also explored. The tentative date of this convention was fixed up in March 2004.

II. HUNGER WATCH:

This is a response to the starvation deaths happening in many states. Discussion was initiated on the 2 day meeting in Bhopal to be held on August 16th and 17th. There will be participants form 6-8 states. There is very good response form various NGOs especially the 'Right to food group'. JSA members are also welcome for the hunger watch meeting. Certain methodological issues like epidemiological issues, necessity of differentiating acute and chronic malnutrition; malnutrition and starvation deaths will be dealt by Dr.Rajan and Dr.Rakhal.

Issues on Anemia; measles/diarrheal deaths due to malnutrition; the quality of ICDS, midday meal programme are also important and need to be addressed. Broader issues related to starvation like, land ownership displacement of tribals etc are also important.

III. ORGAINSATION

The challenge highlighted was, how to keep JSA alive in the midst of the plurality of the groups involved in it?

All groups are doing something on health, but some of them are not only purely 'health groups', but non-health groups also.

Some of the suggestions came up for the strengthening of the 'organisation' of the JSA were these :

- A Brochure for JSA –
  The conversion of the people's health charter into a simple and attractive brochure.
- Development of a 'common minimum programme' which will be of interest for the member organisations.
- A team to visit the organisations on a personal basis and on a regular basis.

- Using the word ' facilitation' rather than coordination, when it comes to PHM activities and PHM is not trying to Co-ordinate but facilitate the process.
- The 5 PHA booklets jointly published by the 18 organisations strengthened PHM (JSA).

Why not more jointly published booklets? The option a 6th booklet on "Right to health care" was also considered.

IV. WEBSITE :

What is the objective of the Website ?

- Information exchange among the leaders of the PHM, so that they can take it to the grass roots.

Mr. Prasanna, the Communication Officer of the PHM Secretariat is incharge of the PHM Website. Mr. Prasanna will take responsibility for the JSA Website too, till somebody else takes it over.

Mr. Prasanna will take initiative to start an 'e' group for JSA. This e-group will have two components.

1. For information exchange.
2. For decision making.

- Mr.Prasanna agreed to do a demonstration of the Website during lunch break and also to circulate the format for e-group.
- It was agreed by the group to give a gentle nudge to each other, so that more and more information will be given to Mr. Prasanna from local, regional and state level.

VI. PHM GLOBAL AND JSA :

- Dr. Ravi Narayan (RN)gave an overview of the PHM Global Network and high lighted the importance of JSA considering itself as part of this larger network. He suggested the need to mention along with JSA, PHM-India in parenthesis, especially when it comes to communications to PHM of other countries.
- RN mentioned briefly about how PHA, got transformed into PHM, about the founding 8 (F8), steering group (F13) and the 92 member countries in 13 regions.

- In the PHM Website, to facilitate relevant discussions there are two types of circles.
    1. Country/state level circles (regional circles)
    2. Issue / event based circles.
       (e.g WHO circle; poverty circle; war conflict, disaster circle.)

  One can be part of regional circles or issue based circles depending upon each one's interest.
- PHM Secretariat – the idea is not to have a coordinating point but to have a contact point. Decision making is through the steering 'e' group. There are 3 staff in Secretariat(Dr. RN, Mr.Prasanna and Mr.Srinidhi)

All the members of PHM are considered as Technical full time persons contributing to PHM in their own capacity.

The Website of PHM is **Phmovement.org.**

- After the presentation of RN, there was a suggestion that it would be good for JSA to be in touch with PHM Secretariat. For eg. during the NWG meetings one session can be kept for the PHM secretariat. JSA should start thinking how can it contribute to the PHM secretariat. But PHM secretariat should take initiative for this.

VII W.S.F Mumbai (JAN 16-21,2004) and international forum in defense of health (Jan 14-16, 2004)

Mr.Amit Sen Gupta coordinated the discussion of WSF. (For details refer the hand out).

This is the first time WSF is conducted outside Brazil. Around 60,000-70,000 people are expected. The participants might exceed beyond that.

The main discussion was about the international forum for defence of health (Jan 14-15).

Focus will be on 5 issues related to health

- Globalization and health
- Militarism and health
- Patriarchy and health
- Exclusivism and health
- Health and the marginlized

Afternoons there will be 4 panel discussions running parallel. The themes has to be decided. These will be approximately 500-600 people for the forum of which about 250 will be from India.

Last date of initial registration will be on September 15th.

The topics should promote plurality.

It should not only highlight the badness of the system but also should provide hope by highlighting the good that people are already doing

- The possibility of pushing for a panel in WSF on health was also discussed.
- Receive suggestions by August 30th
- Finalize the topics by 10th December
- Teams to work on it has to be finalized. It is better to have one representative from each region.
- Regarding finances, it was decided that each JSA unit in India will contribute at least Rs.5,000/- to WSF, Mumbai.

Annexure 8

"Withdraw the support to Coke"

International Public Health Team that visited Plachimada appeals to the Kerala Chief Minister.

The Team denounces Coca Cola

Following the World Social Forum in Mumbai, a group of health activists representing the People's Health Movement of the Americas is visiting the state of Kerala with the explicit goal of expressing solidarity with the community of Plachimada in their struggle against Coca Cola.

The team consists of Edgar Isch, former Minister of the Environment of Ecuador, Dr. Arturo Quizhpe Peralta, Professor of Pediatrics at the University of Cuenca, Ecuador, Julio Monsalvo, a public health doctor from Argentina, and Jeff Conant, a U.S. health communications specialist. Together they represent the Americas branch of the People's Health Movement (PHM), a coalition of health activists and grass root health workers representing more then 100 countries.

The team was drawn to Plachimada by news reports, substantiated by BBC radio and the Kerala Pollution Control Board, that Coca Cola is responsible for dumping high levels of lead and cadmium in the local environment. Both substances are known to cause cancer, neurological disorders, and developmental disabilities.

Edgar Isch, former environment minister of Ecuador said, "What we witnessed in Plachimada worries us deeply. The poor health of the inhabitants appears closely linked with the existence of the Coca Cola plant. We exhort the government of Kerala and of India to take urgent measures to resolve the crisis. No community's water source should be robbed and polluted like this by any multinational giant."
Dr. Artro Quizhpe Peralta, a child health specialist, added, "In these situations the first victims are the mothers, who suffer deterioration of their physical and mental health, transporting water from more than 2 or 3 kilometers away. This has direct consequences on the care and development of their children. The children are the silent and innocent victims of this human tragedy, deprived of a healthy environment by a private corporation that destroys any notion of sustainability in the region."

"As members of the People's Health Movement, " Dr. Quizhpe Peralta said, "we will support the assembly of a team to monitor the health of the people of Plachimada and to denounce the corresponding abuse of human rights at the upcoming World Health Assembly in Geneva."

Julio Monsalvo of Argentina noted that "the story of the Coca Cola plant is a startling demonstration that a private company can set up shop with the stated goal of increasing employment-but with the immediate result of destruction of life, beginning with the water. My question is 'is this progress?' As a visitor, I have

tremendous admiration for the community's struggle, and level of consciousness, in particular among the women."

The team stated that they would take up the issue in their respective countries. In support of the overall movement against corporate globalization in North America and Latin America, as well as India, the team has urged the Chief Minister of Kerala, Mr. A.K.Antony, to immediately withdraw all support to the Coca Cola plant and to "make Kerala free from Coke and Pepsi."

Peoples Health Charter, the guiding spirit of the People's Health Movement says: "Hold transnational and national corporations, public institutions and the military accountable for their destructive and hazardous activities that impact on the environment and people's health." The Charter is the largest consensus document on health in the world.

The team will hold a press conference at Press club Ernakulam on 28 January at 11 a.m.

Signed by

Dr. Arturo Quiizphe
Coordinator, PHM, Ecuador
Co-Coordinator: International People's Health Council, Latin America

For further media enquiries: +91 (0) 9845091319 (Dr. Unnikrishnan PV)

Participants in the People's Health Movement team visiting Plachimada, Kerala.

1. Dr. Arturo Quizhpe, pediatrician and former dean of the Faculty of Medical Sciences, University of Cuenca, Ecuador. He is the Latin America coordinator of the People's Health Movement. He has worked in several research projects in nutrition and child development.

2. Edgar Isch Lopez a former Minister of the environment of Ecuador, the country with the largest biodiversity in the world. Edgar is outspoken on the issue of aerial fumigations in Plan Colombia, which he sees as a form of chemical warfare. Ecuador is also the site of the first international lawsuit against a United States oil company, the trial of Chevron/Texaco.

3. Julio Monsalvo, from Argentina, is with the International People's Health Council and People's Health Movement. For the last 29 years he has worked

with indigenous and rural communities in the north of Argentina. He lectures widely on ecosystem health.

4. Jeff Conant is an environment health educator, journalist, translator and anti-war campaigner representing the United States People's Health Movement. He works with the Hesperian Foundation, publisher of the well known book *where there is no Doctor*, as well undertaking many independent projects such as the Boycott Bush campaign and doing popular education to raise awareness about corporate crime and war profiteering.

5. Mathew P. Abraham is a community doctor from Bangalore, and a volunteer with the People's Health Movement, also based in Bangalore

Annexure IX

REPORT OF THE COMMUNITY HEALTH WORKSHOP

Date:

Venue:

Background:

Objectives of the workshop:

List of Participants:

DAY – I: Wednesday – 14-04-04.

The programme started at 9.30 am with a game to break the ice. Mr. Naveen Thomas initiated a process of the participants getting to know each other. This was followed by a brief interactive session on the expectations of the participants about the workshop. The following were some of the expectations, which came up through that session.

- To learn what the younger generation thinks of community health.
- To get some of the perspectives from the field
- To get to know how to train community health workers.
- To learn more about community health
- To share some of the community health experiences from the field
- To learn more about community health systems and public health issues.
- To search for new avenues in community health action.
- To have a better understanding of the four topics of the workshop; right to healthcare, globalization, community health workers and community health financing.
- To analyze the future, plan and strategize
- To enjoy this workshop as a 'recharger' through interaction with other catalysts.

In addition to these expectations, the group also brought out some key values, which are necessary for the effective practice of community health. Some of those values were;

- Humility
- Courage
- Determination
- Commitment
- Honesty
- Integrity
- Equity
- Team building around issues
- Genuineness
- Responsibility
- Simplicity
- Openness
- Empowerment
- Love……..

This was followed by a brief discussion to finalize the programme schedule prepared earlier.

The background of the workshop; how it emerged, its objectives, were brought out beautifully through a panel discussion. Dr. Sunil Kaul acted as the 'devil's advocate' by questioning Dr. Ravi Narayan on various issues. These were some of the issues, which came out through the panel discussion.

- This workshop is for the advantage of those who are undergoing the fellowship / internship scheme. Senior community health practitioners who are interested in the younger generation and community health fellows are brought together in order to learn from each other.
- Community health workers are not dead horses. The idea is not to look at CHW in isolation or as The Horse, but as one of the horses. When CHW and community health financing is seen in the context of primary health care as a whole, then both are effective.
- This workshop will also try to link up between four issues; two community level issues (micro level)
    1. Community health workers
    2. Community health financing

  Two global level issues (macro level)
    1. Right to health
    2. Globalization
- Other areas of concern for this workshop will be to look at the Social, economic, political and cultural dimensions of community health, which is usually overlooked in the traditional system of training of health professionals.
- This workshop will also try to help the participants to strike a balance between two major schools of thinking in community health; the cynical inactivity of the 'revolutionaries' and the unbound optimism of the 'field activists'.
- Regarding the outcome of the workshop, the focus will be more on the process. Fellows will have opportunities to debate, discuss and question many of the

key issues in community health. This workshop might also come out with a document, which may be circulated, in a larger group.

PANEL ONE: GLOBALIZATION AND RIGHT TO HEALTH CARE.

Panelists: Dr. Narendra Gupta and Dr. Thelma Narayan.

Dr. Gupta brought out issues related to right to health care through his brief presentation. According to the constitutional rights (art. 21) and Bhore committee report, right to health involves at least 6 areas. These are: RIGHT TO

1. Adequate and balanced FOOD
2. Adequate and safe WATER
3. Safe HOUSING
4. Safe WORKING CONDITIONS
5. Healthy LIFE STYLE
6. HEALTH CARE

There can be no health unless those bare necessities are met. According to Alma Ata declaration, these rights were the responsibilities of the govt. but in reality in our country, India, even today a huge chunk of people have no access to these basic rights. Majority of our workforce work in areas like fields, factories, construction sites etc. where there are no safe working conditions. When it comes to unhealthy lifestyle, the pressure of media and corporates are too much. (E.g. Tobacco and alcohol abuse; stress related diseases; indiscriminate and unsafe sexual activity….)

Even though these rights are the responsibility of the govt. many times they fail to do it. This is because of corruption as well as the pressure of external forces (corporate) on the govt. due to corporate globalization. (E.g. 35 rivers in India bought by Multinational companies without any consultation with the local people. USA refusing to sign the pollution control document.)

Dr. Gupta also explained how his organization 'PRAYAS' is actively involved in the struggles of the people of Rajasthan for these rights. PRAYAS helps the people to demand and fight for their rights. This is done by the formation of 'cadre of people' who works with these 6 human rights issues, in association with the youth, adolescents, women and children. Regarding the right to health care, PRAYAS works with the people to strengthen the govt. primary health care system. Some of the major experiments are the right to FOOD campaign and the right to INFORMATION campaign. They organized various public hearings for this cause.

India has surplus food grains, enough to feed all Indians even if there is 3yrs of drought. Food grains are getting rotten in the PDS go downs. There also a great need to develop infrastructure. Then why should there be unemployment? Why starvation? There is tremendous possibility of 'food for work' programmes. PRAYAS organizes public hearings and campaigns to build pressure on the govt. politicians try to downplay these campaigns. But today PRAYAS has become successful enough to the extent of even govt. officials

requesting them to organize campaigns on certain issues. According to Dr. Gupta, even in the govt. system there are the exploiters and the exploited. (E.g. ANMs, Medical Officers, etc.) PRAYAS has succeeded in mobilizing these exploited people to build pressure against the exploiters in the system.

Dr. Gupta also explained the 7-step process they follow in building up the 'cadre of people'. These steps are:

1. Informal interaction with the villagers.

2. Identifying a health contact' group in the village.

3. A 3-day residential training program for 12 people from the village. (This is a problem-based learning using modules and AV methods. They are made to think by asking questions.)

4. Health mapping (PRA techniques are used. Villagers are made aware of the
   Total burden of the disease in the village and
   The total burden of the expenses for these diseases.

5. **Formation of women's groups (SHGs etc.)**

6. Formation of adolescent groups.

7. Formation of 'village health committees' and village health charter'.

(By this time PRAYAS has enough data to discuss in the committee.) Once the village health charter is made, official approval of the *gram sabha* is got for the same.

Dr. Gupta's presentation was followed by a brief presentation by Dr. Thelma Narayan on the impact of globalization on the health of people.

- The poor are not a minority. They are present as big numbers in both developed and underdeveloped countries.
- Globalization is the process of lifting barriers to flow of goods, services, capital, knowledge, people…..
- The positive aspect of globalization includes; the growth in communication systems, sharing of values, solidarity and so on.
- The negatives of globalization includes; corporate capitalism', where global resources including essential commodities like drugs, food, water etc. are controlled. Those who are benefited by this process are only a few wealthy, but the majority are affected negatively. There is an increase in global and national wealth; but the gap between the rich and the poor are widening. More over the increase in wealth is more of virtual (speculative capital) than real.
- The impact of corporate capitalism are many; some of them are:
  Inequity

Increasing unemployment
Brain drain
Environmental pollution
Wars and conflicts
Loss of livelihood
Health problems…….

- There is an increase in the quantity of
  Weapons of mass destruction (WMD) and
  Weapons of individual destruction (WID) like tobacco, alcohol etc.
- Not all private sectors are bad. But there are corporate sectors whose only value is to accumulate wealth and more wealth even at the cost of basic human rights. These corporate private sectors are very powerful, above govt. and dictate norms to them.
- Hence majority of people are loosing control over the basic necessities of survival and determinants of health.

Our struggle is against this exploitation at a global level. Situation has come to the stage where we will have to join hands with govt. to stop the domination of these corporates.

After the break, there were 2 group discussions.

1. Group discussion among the fellows:
   So many questions and clarifications were raised by the fellows regarding globalization and its negative impact.

(Details of questions can be obtained from Dr. Silviya)

2. Group discussion among the mentors:

(Details from TN)

After the group discussion, there was a sharing by Fr. Eddie Premdas about the involvement of their organization in north Karnataka.

- Eddie gave an idea about the social context in which the people of that area are struggling to cope with.
- He also shared about how being a religious; he was inspired by his brief experience with CHC. After his CHC experience he went on to do MSW in TISS and started working with the people of north Karnataka, where he went for his project as an MSW student.
- Their focus is on the dalits of that area especially the women. According to him dalit women are victims of a double oppression. They use the SANGHARH method (which he picked up from NBA and Baba Amte), to make the existing govt. system work. He explained how he experienced the collective strength of women, where they came together to deal with issues like wife beating, caste violence, corruption in PHCs, PDS etc. and so on. His sharing was also very inspiring.

Since it was already around 6 pm., the experience sharing by fellows was postponed to the next day.

After supper the fellows had a very long informal chat with Dr. Narendra Gupta and Dr. Ullhas Jajoo. The senior community health practitioners shared many of their personal struggles as well as their achievements and dilemmas. It was a very inspiring and informative session. The fellows could go into deeper and personal questions related to community health practice. The session went into late night, till the last person fell asleep on the ISI lawn.

DAY TWO: 15.04.04 (Thursday)

The day started of with Dr. Ravi Narayan clarifying many of the questions raised by the fellows about globalization on the previous day. The senior community health practitioners were happy that the young generation is raising many relevant questions. Dr. RN expressed his anxiety about the 'market fundamentalism which is becoming a major problem today. Over the years there is a gradual shift in who regulates the market. The taking over of the market by the World Bank and the WTO, has brought in a situation where even the elected govt.'s are becoming helpless since the 80's. He concluded by saying that there is phenomenal evidence based on solid research, which brings out these facts. He urged the fellows to read more about this area and suggested lot of literature on globalization. Some of those books are:

1. Poverty, Class and Culture by D. Bannerjee
2. Socio, Cultural and Political Analysis of Health Policy in the 80's by D. Banerjee
3. Dying for Growth by Jim Kim et al
4. Globalization and its Discontents by Joseph
5. Pathologies of Power
6. Economy of Permanence
7. Hidden Connections by Fritz O'Capra
8. Social Science and Medicine by D. Banerjee and Rajni Kothari

PANEL TWO: COMMUNITY HEALTH WORKERS:

Panelists: Dr. Sunil Kaul and Dr. Ravi Narayan.

Dr. Sunil Kaul presented his experiences with CHW in Rajasthan and Assam. According to him, the experiments of PRAYAS may not work in northeast. Each area needs to have its on unique approach. He explained how the youth of northeast are taking control of justice issues of their area through the 'students unions'. He also explained about the selection process they use for CHWs and the training programs they have for them. They use a training manual of around 400 pages, for the above purpose. Women come with their children for training. They have a combination of classroom training and fieldwork. Once they start practicing as CHWs they can go back to the manual if necessary. He also mentioned about his 'hidden agenda' of working towards PEACE in the northeast

through the CHWs. This was followed by Dr. RNs session on CHWs. He brought out the effectiveness of health workers based on the available evidence from the various experiments done in India and other parts of the world. In India from 1964 onwards the village health workers (VHW) had been tried as one of the approaches to health care. These were the conclusions by those experiments:

- Women were found to be more effective than men.
- Volunteerism worked better.
- Social control over the CHWs worked better than professional control.
- Sky is the limit for the empowerment of CHWs. (some of them could do even surgery)
- The best training for CHW is problem based training; learning by doing.
- One method of training cannot be generalized for all the places.

The major threat to CHW was from the medical profession; the mind set which goes against demystification of health care. He also spoke about the difficulties faced when the CHW concept was taken to be up scaled at a larger level. This was illustrated through the *Jan Swasthya Rakshak* scheme of Madhya Pradesh, where 55,000 CHWs were selected and trained for this purpose.4

This session was followed by a group discussion among the fellows regarding CHWs. Here also lots of questions were raised, especially regarding the feasibility of up scaling this concept. Responding to some of those questions, the panelists explained how the 'bare foot' doctor project worked in china.

- They had a strong political will
- They went to the villages and asked the people; whom do you go to when you have trouble? That person was chosen irrespective of class, educational status, age, sex etc. medicine was demystified to them and they became very effective health workers.

Wherever the VHW became the part of a PROCESS, where the community played the role of a partner they succeeded. But when CHW becomes an extension of somebody's project, they became a failure.

After lunch break, Dr. Unnikrishnan, gave an interesting presentation on the impact of war and conflicts on the health of people. He brought out the horror of the situation in Iraq and Palestine due to the war.

PANEL THREE: COMMUNITY HEALTH FINANCING:

Panelists: Dr. Ulhas Jajoo

Dr. Ulhas presented the origin, philosophy and the process of the community health-financing project associated with MGIMS, Wardha (Maharashtra). He brought out the positive as well as the negative experiences associated with it. This was followed by a brief presentation by representatives from VGKK (Karnataka) and ACCORD, Gudalur

(Tamil Nadu). The presentation as well as the group discussion followed were very brief due to lack of time.

After supper the fellows had an informal get-together. This was an opportunity for the fellows to get to know each other more. They also shared about their learning experiences of the past two days and discussed about innovative ways of presenting them before the participants the next day.

DAY THREE: FRIDAY, 16.04.04.

The fellows presented their learning experiences of the past 2 days using a skit followed by each person sharing their experiences. On the whole the fellows felt that those 2 days were very much useful. The last year's fellows felt that this workshop was a good way of finishing the fellowship program. The new fellows felt that it was a good way to start the fellowship. Last year's fellows also shared their experiences from the field and how they benefited from the semi structured, person oriented mentoring, approach of the fellowship scheme. The fellows also discussed the possibility of being in touch with each other and associating with each other during the practice of community health in the future.

Compiled by Mathew Abraham and Anant Bhan

Annexure X

COMMUNITY HEALTH AWARENESS COURSE VIDYA DEEP INSTITUTE, CRI BROTHERS BANGALORE (Modified Schedule)

DATE: OCT 6TH – OCT 11th TIME: FROM 9am to 4.15 pm.

OCTOBER 6TH 2003, MONDAY.

TIME	TOPIC	RESOURCE PERSON
9 - 10am	Introduction and overview of the course	Bro. Mathew
10.30 – 11.30am	Diseases: Communicable and Non communicable (prevention and management)	Bro. Mathew
11.45 – 12.45am	Working with communities: approaches and challenges. Problems and needs assessment of communities.	Dr. Paresh Kumar
2.30 pm.	**Field visit** SNEHADAAN (HIV / AIDS)	
9pm – 10pm	**Group Reflection***	Bro. Mathew

OCTOBER 7TH 2003, TUESDAY.

TIME	TOPIC	RESOURCE PERSONS
9 - 10am	Health situation of India, govt. health services, referral levels and National health programmes,	Dr. Francis
10.30 – 11.30am	Health, healing, wholeness and health apostolate of the church.	Dr. Francis
11.45 – 12.45pm	Levels of prevention and health promotion.	Bro. Mathew
2.30pm – 4pm	Alternative systems of medicine.	Dr. Shiridi Prasad
6pm –7pm.	Health, community health and holistic health	Bro. Mathew
9pm - 10pm	Summing up of the day / video	

OCTOBER 8TH 2002, WEDNESDAY

TIME	TOPIC	RESOURCE PERSONS
9 - 10am	Critical Thinking and creative thinking	Bro. Xavier
10.30 – 11.30am	**Time for personal / group reflections***	Bro. Mathew
11.45 – 12.45am	NGOs / private (General Practitioners, polyclinic, corporate hospitals)	Dr. Thelma Bro. Mathew
2pm	**Field visit**	
9pm – 10pm	Summing up of the day	

OCTOBER 9TH 2002, THURSDAY

TIME	*TOPIC*	RESOURCE PERSON
9 - 10am	Health and Nutrition	Ms. Padmasini
10.30 – 11.30am	Health and Nutrition	Ms. Padmasini
11.45 – 12.45pm	Women health – a gender perspective.	Dr. Mary Thomas
2.30pm – 4pm	Mental health and family health.	Dr. Mohan Isaac
6pm – 7pm	**Panel discussion** : Equity in health (Poverty, Gender issues…etc.)	Mrs. Donna Fr. Ignace
9pm – 10pm	Summing up of the day	

OCTOBER 10TH 2002, FRIDAY

TIME	TOPIC	RESOURCE PERSON
9 - 10am	Environment and health (CHESS)	Dr. Rajan,
10.30 – 11.30am	**Time for personal / group reflections***	
11.45 – 12.45am	**Panel discussion – problems of the slum youth***	
230pm – 4pm	**Panel discussion** – TB, Malaria, Alcohol, Tobacco and CHC field programmes.	Dr. Rajen, Mr. Rajendren Mr. Chander
6.pm – 7pm.	Interpersonal relationship and community life	Bro. Xavier
9pm – 10pm.	Summing up of the day	

OCTOBER 11TH 2002, SATURDAY

TIME	TOPIC	RESOURCE PERSON
9am - 11.30am	Monsoon game (Including tea break)	
11.45 – 12.45m	Peoples health movement and the charter.	CHC team

FIELD EXPOSURE: FROM 13TH TO 27TH OF OCTOBER

Modified Schedule

13th Monday	Mysore visit*
14th Tuesday to	Herbal Medicine project (Fr. Joseph Chittoor)
15th Wednesday am 15th Wednesday pm	ODP- Mysore diocese RLHP – Slum visit
16th Thursday	Vivekanandha Youth Movement (VYM) Hospital
17th Friday	VYM – tribal school
18th Saturday	RlHP – Old age programme
19th Sunday	Travel to Holy Cross CRHP- Planning
20th Monday am. To 23 Thursday pm	Holy Cross Comprehensive Rural Health Programme. -Village experience
24th Friday am.	Debriefing (HCCRHP)
24th Friday Pm.	Back to Bangalore
13th November Thursday am.	Final Debriefing CHC consultants and CRI staffs.

EVALUATION OF THE PARTICIPANTS ON THE 1ST WEEK OF THE COMMUNITY HEALTH ORIENTATION PROGRAMME – CRI BROTHERS.
(Out of the 24 only 14 responded)

TOPIC	VERY POOR	POOR	OK	GOOD	VERY GOOD
Diseases: communicable and non communicable			28% (4)	57% (8)	7% (1)
Working with communities		7% (1)	42% (6)	42% (6)	7% (1)
Health, situation of India			50% (7)	35% (5)	7% (1)
Health, apostolate of church			42% (6)	50% (7)	
Levels of prevention			28% (4)	35% (5)	21% (3)
Alternative systems of			35%	57%	14%

medicine.			(5)	(8)	(2)
Health, community health and holistic health.			35% (5)	50% (7)	14% (2)
Critical and creative thinking.			28% (4)	57% (8)	21% (3)
NGO's \ private sector.			57% (8)	21% (3)	14% (2)
Health and Nutrition.			14% (2)	57% (8)	28% (4)
Women's health			28% (4)	28% (4)	42% (6)
Mental health		7% (1)	42% (6)	42% (6)	7% (1)
Environment and health		14% (2)	14% (2)	57% (8)	14% (2)
Interpersonal relationship			21% (3)	50% (7)	21% (3)
People's health movement			42% (6)	14% (2)	7% (1)
Monsoon game.	7% (1)		35% (5)	21% (3)	35% (5)
Panel discussions					
Equity in health			35% (5)	35% (5)	28% (4)
Problems of slum youth			7% (1)	42% (6)	50% (7)
Alcohol and tobacco.			35% (5)	50% (7)	7% (1)
Field visits					
Snehadaan				42% (6)	50% (7)
APD, APSA, Navajeeven and Shishu Bhavan				50% (7)	50% (7)

EVALUATION OF THE PARTICIPANTS ON THE 2 WEEKS COKMMUNITY HEALTH EXPOSURE PROGRAMME – CRI BROTHERS.
(Out of the 23 only 18 responded)

EXPOSURE	WASTE OF TIME	NO SO USEFUL	DON'T KNOW	USEFUL	VERY USEFUL
Herbal medicine Fr. Chittor	11% (2)	22% (4)		61% (11)	5% (1)
ODP- Mysore	11% (2)	11% (2)	22% (4)	33% (6)	11% (2)
Swami Vivekananda Youth Movement (SVYM)		5% (1)	11% (2)	33% (6)	44% (8)
a. Sharing by Dr. Bala		22% (4)	5% (1)	55% (10)	16% (3)
B. Hospital visit	11% (2)	27% (5)	16% (3)	44% (8)	
c. Tribal village visit	22% (4)	27% (5)	11% (2)	33% (6)	
d. Tribal school visit	16% (3)	11% (2)		55% (10)	16% (3)
e. Village street play	11% (2)	22% (4)	16% (3)	33% (6)	11%(2)
RLHP	22% (4)	16% (3)	11% (2)	38% (7)	11% (2)
a. slum visit	27% (5)			55% (10)	16% (3)
b. sharing by Mr. Joy	22% (4)	22% (4)	11% (2)	44% (8)	
c. Programme for the aged	33% (6)	22% (4)		22% (4)	16% (3)
Holy Cross CRHP	5% (1)	5% (1)	5% (1)	66% (12)	11% (2)
a. village experience		5% (1)		38% (7)	55% (10)
b. stay in the village				27% (5)	66% (12)
c. work experience				44% (8)	55% (10)
Group reflections	16% (3)	16% (3)	5% (1)	55% (10)	5% (1)
Community life experience		16% (3)	11% (2)	16% (3)	50% (9)
Exposure Programme as a whole	16% (3)	11% (2)	5% (1)	44% (8)	22% (4)

SOME COMMENTS OF THE PARTICIPANTS

1. First week of orientation

Very long sessions	Well organized
Too theoretical	Useful and interesting
No time for personal reflection.	Sharing and group discussions were meaningful
Not so interesting or helpful	We were treated as matured persons
Sessions crossing time limit	Cultural evening/ prayers were very good.
	Field visit was excellent

2. Two weeks of exposure

Not relevant for theologate level	Lot of freedom given
Objectives and the purpose was not clear	Needed more time in the village
Planning of the programme was poor	
Exposure not well organized	
Visiting NGOs was not necessary	