SIR RATAN TATA FELLOWSHIP IN COMMUNITY HEALTH

Sep-2004 to Nov-2005

REFLECTIONS AND REPORT

By

Vinay Viswanatha

MENTOR

Dr.Thelma Narayan

Community Health Cell (CHC),
BANGALORE

TABLE OF CONTENTS

TABLE OF CONTENTS 2

ACKNOWLEDGEMENTS 6

PREFACE 8

SECTION.1.

MY FELLOWSHIP IN A NUTSHELL 10

THE BEGINNING OF THE JOURNEY…. 10

A SHORT ACCOUNT OF MY JOURNEY THROUGH FELLOWSHIP: 12

EXPERIENCES & LEARNINGS DURING THE RATAN TATA FELLOWSHIP IN COMMUNITY HEALTH UNDER 'COMMUNITY HEALTH CELL' 13

FIELD EXPERIENCES: 13

TEACHING & TRAINING EXPERIENCE: 18

RESEARCH EXPERIENCE: 18

CONFERENCES & WORKSHOPS: 19

A REFLECTION AT THE END OF THE JOURNEY & A GLIMPSE OF MY FUTURE PLANS: 21

ANNEXURE NO.1. STATEMENT OF OBJECTIVES 25

SELF APPRAISAL OF THE PROCESS OF REALIZATION OF MY LEARNING OBJECTIVES 29

ACADEMIC DEVELOPMENT: 29

PERSONAL DEVELOPMENT: 36

SWOT ANALYSIS OF CHC FELLOWSHIP IN COMMUNITY HEALTH 38

STRENGTHS: 38

WEAKNESS: 41

OPPORTUNITIES: 41

THREATS: 42

SECTION. 2.

TO 'SEARCH' IN SEARCH OF KNOWLEDGE, INSPIRATION.... 43

BACK GROUND: 43

THE PROCESS OF LEARNING IN 'SEARCH': 43

LESSONS LEARNT: 45

CONCLUSION: 45

ANNEXURE No.1. MY REPORT AFTER FIRST WEEK IN 'SEARCH' 47

ANNEXURE No.2. CASE STUDY OF 'TRIBAL MALARIA CONTROL PROGRAM' UNDERTAKEN BY 'SEARCH' IN 36 TRIBAL VILLAGES OF GADCHIROLI DISTRICT OF MAHARASTRA 52

ANNEXURE No.3. REPORT OF MY WORK IN SEARCH DURING LAST ONE WEEK (14-12-2004 TO 20-12-2004) 87

ANNEXURE NO.4. LETTER OF GRATITUDE 89

TSUNAMI RELIEF WORK- A BRIEF REPORT OF THE FIRST TEAM FROM CHC, BANGALORE 91

BACKGROUND: 91

PLANNING THE RESPONSE: 92

ON THE 'MOVE': 93

IN ACTION-AID, CHENNAI: 94

IN THE 'FIELD': 95

OUR FIRST-DAY AT WORK: 96

DIALOGUE WITH THE COMMUNITY & THE PROCESS OF COMMUNITY BUILDING: 101

HEALTH RELATED WORKS: 102

ANNEXURE NO.1. THE LIST OF TEAM MEMBERS & THEIR DETAILS. 105

ANNEXURE.NO.2. CHECK LIST OF ESSENTIAL ITEMS. 108

REPORT OF 'A MEET WITH TSUNAMI DISASTER RELIEF DOCTORS FROM BMC' ORGANISED IN BMC 109

PREFACE: 109

PARTICIPANTS: 110

OBJECTIVES OF THE MEET: 110

THE 'MEET' PROPER: 111

ISSUES THAT EMERGED FROM THE MEET: 112

CONCLUSION: 112

APPENDIX 1. DETAILS OF VILUNTEERS 113

DETAILS OF VOLUNTEER FOR SECOND TEAM THROUGH COMMUNITY HEALTH CELL (6.1.2005) 115
ANNEXURE NO.2. NOTES FROM ADDRESSES OF DIGNITARIES 117

A BREIF REPORT ON VISIT TO TWO VILLAGES ON INVITATION BY RURAL HEALTH DEVELOPMENT CELL OF TVS FACTORY IN HOSUR **120**
BACKGROUND: 120
PURPOSE OF THE VISIT: 120
THE VISIT PROPER: 120
OUTCOME: 121
CONCLUSION: 121
ANNEXURE NO.1.PREPARATORY DISCUSSION WITH Dr.THELMA NARAYAN 122
ANNEXURE NO.2.VISIT TO KOTHAGONDAPALLI ICDS PROJECT 123
ANNEXURE NO.3.THE DIALOUGE PROCESS AT ANDIWADI WITH EXPECTING & NURSING MOTHERS OF BOTH VILLAGES 125

PROJECT PROPOSAL FOR ASSESSMENT OF NUTRITIONAL STATUS OF CHILDREN (0-6YEARS) IN 6 VILLAGES IN HOSUR TALUKA **128**
AIM: 128
OBJECTIVES: 128
THE PROCESS: 128
ASSESSMENT PHASE: 129
COMPONENTS OF THE ASSESSMENT PHASE: 130

QUESTIONNAIRE FOR 'KAP' STUDY OF CHILD FEEDING PRACTICE **133**
Section A. GENERAL INFORMATION 133
Section B 135
SECTION.C.WEANING 138

CASE STUDIES OF MITANIN PROGRAM **140**

CASE STUDY 1: 140

CASE STUDY 2: 140

CASE STUDY 3: 140

CASE STUDY NO. 4 141

CASE STUDY NO. 5 142

CASE STUDY NO.6: 143

CASE STUDY NO.8: 144

CASE STUDY NO.9: 144

CASE STUDY NO.10: 145

CASE STUDY NO.11: 146

CASE STUDY NO.12: 146

CASE STUDY NO.13: 147

CASE STUDY NO.14: 148

CASE STUDY NO.15: 148

REPORT OF THE WORKSHOP FOR PRIMARY SCHOOL TEACHERS ON 'WATER & HEALTH' 150

BACKGROUND: 150

THE WORKSHOP: 151

OBSERVATIONS: 152

'SWOT' ANALYSIS: 153
- **Strengths:** 153
- **Weakness:** 154
- **Opportunities:** 155
- **Threats:** 156

STUDY VISIT TO 'HCCRHP' – A REFLECTION 157

BACKGROUND: 157

THE PROCESS & THE EXPERIENCES: 158

MY LEARNINGS: 161

SECTION.3.PRESENTATIONS

MEDICAL EDUCATION IN KARNATAKA – A CRITICAL REVIEW

TSUNAMI RELIEF WORK- REFLECTIONS IN THE PERSPECTIVE OF DOCTORS

CONCEPTS FOR HEALTH AND DISEASE- NOTES FOR REFLECTION

ACKNOWLEDGEMENTS

This report of fellowship is the first person account of a dream of a young person by name Vinay (myself). There are wonderful people and ideas in this world that made this dream come true for me. I would like to thank all of them, in particular:

The team at CHC, for having provided me with the one of the best learning opportunities in life and making my stay in CHC a memorable experience. If not for this fellowship, I can imagine myself working my brains out their in the rat race for a seat in postgraduate medical education. Thank you CHC and team for all the experiences in the last one year.

All my mentors for their guidance and inspiration. Particularly I would like to thank my mentor, guide and friend Dr.Thelma Narayan. It was her patient guidance, incisive critique of my works and the opportunities that she provided me with during the fellowship period, which have played a crucial role in the success of my fellowship period. It was also her encouragement and honest appraisal of me as a fellow that has helped me to shape myself into a responsible professional. Thank you very much Madam.

All the team members of various organisations and movements- my learnings have to be greatly attributed to all of them whom I visited and interacted as a community health fellow. Thank you very much.

All my co-fellows and friends- old and new- for making my experience a pleasant one and for providing me with that much needed support at times of confusions and for sharing my happiness as their own.

All those powerful thinkers and community health practitioners- past and present - for giving me with ideas and framework to build upon and making me believe that 'another' world is possible.

My parents- For that unflinching belief in me in spite of the uncertainties that haunted their minds regarding my future.

Sir Ratan Tata Trust- For their vision to finance such a scheme and providing the young minds like myself an opportunity to learn those invaluable lessons in the field of community health.

Dr.Ravi Narayan and Dr.Abhay Bang- The two inspirational figures who have left an indelible mark in my life and for whose life I look up to for that fire and passion.
All the communities with whom I interacted as a fellow- Most importantly, I extend my heartfelt gratitude for all the community members with whom I interacted with for sharing their wisdom and traditional knowledge and for providing me an opportunity to have a quick look at their lives and understand community and its dynamics in a better form.

PREFACE

I am writing this introductory part of my report for the benefit of all potential readers of this report to help them with navigate through my report in an effortless manner.

First of all, I would like to stress on the fact that the report is a 'first person' account of my fellowship experiences and hence the term 'I' appears very prominently and not to the effect of me being an egotistical person. I request the readers to keep this fact in mind before they make any personal decisions on the reporter i.e. 'me'.

Section 1 of my report is a first person account of my personal reflections on my fellowship. It deals with the circumstances under which I joined the fellowship scheme, my learning objectives and their self-appraisal. It also describes a short account of my journey through the fellowship. A short 'SWOT Analysis' of the fellowship period is also included with a hope that it would aid CHC and Sir Ratan Tata Trust to make the fellowship even more robust.

Section 2 of the report deals with the detailed accounts of my experiences as a fellow. The experiences are presented in a chronological order and most of the reports were produced at the end of each experience. Hence, these reports deal with both technical and personal learnings during each fellowship experience. The report on my experiences as a research assistant of 'external evaluation team on Mitanin Program' is incomplete. This is due to the fact that I am not ethically permitted to divulge many details as a part of research team in individual capacity. Hence I have restricted myself to certain case studies I did, with the details leading to person and place being blocked out. Apart from this chapter, I have tried to be as detailed as possible while presenting the reports.

Section 3 of my reports includes few of the presentations I made in various forums whose details have been given in the concerned reports in section 2.

However, I acknowledge that my report is not a comprehensive report in terms of all the activities I undertook as a fellow. There has been an intentional omission of a few of the experiences as most of them were really short experiences and hence, I felt they did not warrant a full report.

I hope the report will be of some help to anyone who goes-through it, especially for the potential fellows. I would be most satisfied if the report succeeds in stimulating the readers to ask questions, even if the questions pertain to the sanity of my report! For, the greatest learning of my fellowship has been in inculcating the sense of 'ENQUIRY' and 'QUESTIONING'!!

MY FELLOWSHIP IN A NUTSHELL

THE BEGINNING OF THE JOURNEY….

To say that Community Health was 'the subject' that enthralled me during my medical college years would be a blatant lie. I was also interested in Pediatrics. As my ambition written in Epistyle of 1998-99 batch of BMC points out, I first wanted to be a Neonatologist and then in the long run the Director General of WHO (I am rather overtly ambitious!). Hence it is with some nostalgia that I recount my background and circumstances that led me to take-up the fellowship scheme.

The end of Internship, the 'honeymoon period' in a medical student's life, was very tumultuous and stressful. Having been graduated as a doctor, we were thrown into the 'real world'. The lives of medical students took a bizarre turn and were stripped off the personal, financial and professional security of the student life. The world became a rat race for that coveted PG seat in a credible institution. The parental pressure to settle down early, the societal pressure to earn that 'degree' and the professional pressure to choose 'the right specialty' (read high-paying specialty) bordered on vulgarity. At the same time, the lure of distant lands was something irresistible. The debates of the futility of a medical practice in India and the obstacles to move to a western nation in hope of superior education and life style seemed never-ending. Under such immense pressure, it was the collective decision of some life long friends that persuaded me to decide to pursue higher education in USA.

However, there was a confusion that remained unresolved. I was torn between my love for children and clinical practice and my equally strong passion towards Community Medicine. However the wanderlust in me tilted the balance towards Community Medicine and I solaced myself by deciding to concentrate on child health within the broad field of community medicine.

As a result of the above somewhat ill-informed and quirky decisions, I registered for the GRE examination as the first step towards pursuing a MPH degree in USA. Coming from a family without a 'last name', my registration went haywire and I ended up being registered and called as 'Dr.Vinay Viswanatha No Last Name' in the

records. I was infuriated. Not just on loosing my money but more importantly on the absurdity and the brazen impetuousness of the authorities.

It is under these rather peculiar circumstances that I decided to postpone my studies and gain some experience in the field. I also thought that a stint in the field would reflect better on my application and some good recommendation letters would help me to get an admission in a good college. When I began my search, CHC was the only name that popped up after my exhaustive enquiries with my post graduate seniors in the department of Community Medicine in BMC and few professors in various colleges across Bangalore. This made me remember my earlier encounters with CHC staff, in particular Dr.Ravi during one of the program they had organized in BMC auditorium. I vaguely remembered the short talk I had with Dr.Ravi in PHM office and the elated state henceforth the talk.

All the above factors forced me to call Dr.Ravi and fix an appointment with him. I can still remember that fortuitous day. What was supposed to have been a 30 minute meting went on for more than 90 minutes. I was mesmerized by Dr,Ravi (Later, I came to know that it was also my interview). I was transformed to a fantasy world listening to him. I was informed about the fellowship program and the procedures for applying. I was asked to come prepared for the fellowship interview with a formal application articulating my interests in Community Medicine. It was rather tentatively that I wrote my statement of objectives[1]. When I met Dr.Thelma Narayan for the interview, I was apprehensive to say the least. However, the interview turned out to be a pleasant affair and I felt that I was discussing with one of my friends about my life and future rather than giving a formal interview for a fellowship. The interview with Dr.C.M.Francis, though technical, was very enriching. By the time I finished my interviews, I was looking forward to join the fellowship and the wait for the call felt like one of the longest waits of my life. I was worried since I was informed that the fellowship for the season had already started and I was coming in at an irregular period. However, I had my fingers crossed since I knew my interviews had gone well and was informed by Dr.Thelma Narayan that there were few openings always kept for people coming at odd periods like me.

[1] Annexure No.1. Statement of objectives

And then, my wait turned out to be fruitful. I was informed about my selection and I started my journey in the new path of life on 6th September 2005. Initially I joined the fellowship for a period of 6 months which was later extended for 1 year. Retrospectively, I feel that it turned out to be the watershed event of my life. This I say because, the fellowship has completely changed the course of my life, both on personal and professional fronts, the changes being the focus of all my reflections in this report. The journey in the new path was thus initiated.

A SHORT ACCOUNT OF MY JOURNEY THROUGH FELLOWSHIP:

I was guided by Dr.Thelma Narayan, my mentor through out the journey. It was with her guidance that I drew out the learning objectives[2] for my fellowship period. The plans for the fulfillment of the same can be greatly attributed to Dr.Thelma who provided me with countless opportunities and kind guidance for the realization of the objectives.

The journey through my fellowship period has been an eventful one filled with moments of ecstasy and agony, moments of great hope and equally strong despair but singularly for its value in terms of diverse learning experiences it provided me with at every moment. The journey in professional terms has facilitated me to move through various phases starting from Preventive and Social Medicine then through Community Medicine later through Community Health afterwards through the Public Health and finally through New Public Health. Simultaneously on the personal front, the journey has been more turbulent for it made me question everything that was held sacred and inviolable in the deepest recess of my psyche. The journey of fellowship has opened a new vista and I believe that my life course has been altered in an irreversible way.

The following pages give a quick glimpse of various activities I undertook as a fellow of community health:

[2] Annexure No.2. Learning objectives of my Fellowship

EXPERIENCES & LEARNINGS DURING THE RATAN TATA FELLOWSHIP IN COMMUNITY HEALTH UNDER 'COMMUNITY HEALTH CELL'

PERIOD: I year (From September 2004 to November 2005 including a month long study leave)

MENTORS AT COMMUNITY HEALTH CELL:

- Dr.Thelma Narayan (Chief mentor), Coordinator, CHC.
- Dr.Ravi Narayan, Global Coorinator, People's Health Movement (PHM).
- Dr.C.M.Francis: Consultant, CHC.
- Mr.S.J.Chander; Mr.Rajendran; Mr.Naveem Thomas- Technical Staff of CHC

FIELD EXPERIENCES:

SVAMI VIVEKANANDA HEALTH MOVEMENT, HD KOTE, KARNATAKA:

- 1 week, as an exposure to Community Health Project
- Exposure to mobile health services for 30 hamlets of displaced tribal population
- Observations:
    1. Operation of a low cost community based hospital services
    2. Organization of field based Reproductive & Women's Health Services
    3. Operation of Sanitation & Hygiene program in 100 schools
    4. Operation of school & community development training catering for more than 20000 displaced tribal population

SOCIETY FOR EDUCATION, ACTION & RESEARCH IN COMMUNITY HEALTH (SEARCH), GADCHIROLI, MAHARASHTRA:

- 1 month
- Mentors: Drs Abhay & Rani Bhang & the team in SEARCH
- Undertook a case study of 'Tribal Malaria Control Program' undertaken by 'SEARCH' in 36 tribal villages of Gadchiroli District Of Maharashtra
- Observations & learnings:

1. The contours of the practice of community health in field with all its joys & sorrows particularly the ideas of Community Participation & Community Empowerment which are 'the' critical factors in success of any public/community health initiative.
2. The concept of 'action- research' in community health by perusing the literature on 'Daru Mukti Andolan' (Movement for ban on alcoholism) which resulted in the ban on sale & use of alcohol in Gadchiroli district.
3. The concept & philosophy of Community Health Workers scheme by a small study of CHW scheme in 36 tribal villages undertaken by SEARCH.
4. Community partnership & the need for having sensitive attitude towards community through study of tribal friendly hospital initiative.
5. The power of original idea & people centric research in Community Health through my exposure to 'Home Based Neonatal Care', a revolutionary concept in community based child health services.
6. The importance of comprehensive strategies to address socials problems by participating as an observer in 'Alcohol deaddiction program', both field based & institution based, which boasts of one of the highest 'one years sobriety rate' in the world.
7. The importance of catering to the 'felt needs' of the community through the Sickle Cell Anemia Study in Gadchiroli by SEARCH, which was a success in scientific community but a failure in the community for whose benefit it was done.

'MITANIN PROGRAM' IN CHATTISGARH:

- 45 days
- Mentors: Dr.Sunil Kaul, MBBS, MPH; Dr.Rajani Ved; Dr.Shyam Ashtekar, MBBS; Dr.Rakhal Gaitonde, MBBS, MD; Mr.Amulya Nidhi; Dr.Deepti Chirmuray, MBBS,MD

- Was involved in the External Evaluation of Mitanin Program[3] undertaken through the coordination of CHC on the request of State Health Resource Centre, Chattisgarh, Government of Chattisgarh & Government of India.
- As a research assistant I was involved in the formation of methodology of evaluation, development & field testing of the questionnaires, documentation of various case studies related to the program, & was the contact point for the group of investigators who came in at different point of the study.
- In addition, I accompanied 4 investigators at different periods to 8 out of the 12 blocks in our sample & hence had an extensive experience of the program across the breadth of the state.

TSUNAMI RELIEF WORKS IN NAGAPATTINAM DISTRICT OF TAMIL NADU:

- 15 days
- Was responsible for motivating & forming a team of 8 doctors, for medical relief in Tsunami affected areas, from Bangalore Medical College within a day of the Tsunami Disaster. This team sent under the banner of CHC worked in collaboration with NGOs & Government in the tsunami ravaged areas of Nagapattinam district of TamilNadu in the first two weeks after the disaster struck.
- Initial medical relief work covered 18 villages & later 3 villages were taken up for focused work.
- The work, along with the medical relief, mainly revolved around public health measures to mitigate the effects of disaster to ensure healthy & hygienic living conditions for the affected population.
- Community organization & their meaningful participation of the affected communities in their own relief works & restoration of the dignity of the

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[3] 'Mitanin Program' is a Health Program undertaken in Chhattisgarh state of India. Chhattisgarh is a predominantly tribal state with 46% of tribal population. The program is a huge Public-Private partnership initiative in which 60,000 women, both literate & illiterate, health workers were trained with the help of 2500 trainers across the state to provide first contact curative & preventive care in the village itself & also as activists to mobilized the community to improve public health services through cooperation & advocacy.

affected population were the guiding principles of our work during the relief phase.

HOLYCROSS COMPREHENSIVE RURAL HEALTH PROJECT (HCCRHP) IN HANNUR TALUKA OF KARNATAKA:

- I undertook independent participatory training of 32 Health Workers on various topics (both conventional & unconventional health topics) of Health including water & health, environmental & personal hygiene and sanitation, diarrhea & its management, vaccination, alcoholism, child marriage, reproductive health especially of young girls, child labor, & malaria.
- I was also involved in the initiation of 'Health Promoting School Program' in 10 primary schools in the taluka. I was a part of the team that was involved in the formulation of the concept, contents & processes of the entire program. The program has now been approved by the Government of Karnataka & I will be working for the success of the same from December onwards as a team member of HCCRHP.
- In addition, I was involved in the Participatory rural appraisal, & subsequent selection of women health workers in 6 villages of the area.
- I personally was involved in the rescue of a 9 year old boy who was held as a bonded labor in an agricultural field.
- I was responsible for the formation of a 'health monitoring & promoting committee' in the residential school of HCCHP catering to the needs of the children rescued from bonded labor.

IN ANDAROUND BANGALORE:

- Study visit to 18 slums in Bangalore as a technical adviser from CHC to support action-research project undertaken by 'Jana Sahayog' (meaning Association for people's co-operation) to study the quality of drinking water being supplied by the Government to the slum dwelling poor people in these 18 slums. When not a single sample was found fit for domestic usage, leave alone for drinking purpose, the communities took the fight to the

Government. Since, they were armed with the irrefutable evidence, Government was forced to accept its failure & take corrective measures.

- As an observer, I studied ‘Community Health Approach to Tackle Alcohol related problems’ undertaken by CHC in 3 slums of Bangalore.
- Was a part of the team from CHC involved in the Health Education drive in schools & colleges in Bangalore with a focus on education on adverse effect of tobacco use & with an intention of reducing the same in young generation
- Was a part of the CHC team that undertook a ‘study of nutritional status of 0-6 year old children in 6 villages of Hosur taluka’ on the request of TVS Motor industry of the area & the design of an appropriate intervention program to reduce malnutrition & improve nutritional status of the children in those villages. I formulated the project proposal & was instrumental in designing the methodology of the study. I also prepared the questionnaire to study the knowledge, attitude & practice of child feeding in the area.
- I undertook training of 200 primary school teachers in Magadi & Ramanagaram talukas of Karnataka state, as a resource person from CHC on the request of Bharat Gyan Vigyan Samithi (meaning in English -India Knowledge & Science Forum), on the topic of ‘Water, Hygiene, Sanitation & Health’.
- I took initiative to organize ‘A Meet with Tsunami Disaster Relief Doctors from Bangalore Medical College (BMC)’ in BMC, to share the experience of volunteers in the disaster relief work with the staff & students of BMC. It was also an attempt to start a process within the BMC to start a ‘disaster management cell’ in BMC to be prepared to meet the future challenges of disasters, both manmade & natural, in India. This process is still on, though with many difficulties of dealing with the bureaucracy.
- I was personally responsible to include the issue of ‘People’s Concern over privatization & commercialization of Medical Education in Karnataka’ in the agenda of the 2nd Karnataka State People’s Health Assembly, that took place as a preparatory meeting for Global 2nd People’s Health Assembly that took place in Ecuador in July 2005.

TEACHING & TRAINING EXPERIENCE:

- Involved in the teaching program for 30 MSc (Master of science) students in 'Psychosocial rehabilitation' from Richmond fellowship college on the topics of The concept, definition, determinants & dimensions of Health & diseases, spectrum of health & diseases, the natural history of diseases, the theories of disease causation, the concept & levels of prevention, methods of health promotion, concept & understanding of primary health care, National Health Programs in India with special reference to Mental health program in India for two batches in two consecutive years starting from 2004.
- Undertook independent 'participatory training' of 32 Women Health Workers on various topics (both conventional & unconventional health topics) of Health including water & health, environmental & personal hygiene and sanitation, diarrhea & its management, vaccination, alcoholism, child marriage, reproductive health especially of young girls, child labor, & malaria in HCCRHP in Hannur.
- AS a resource person from CHC, I undertook training of 200 primary school teachers in Magadi & Ramanagaram talukas of Karnataka state, on the request of Bharat Gyan Vigyan Samithi (meaning in English –All India Knowledge & Science Forum), on the topic of 'Water, Hygiene, Sanitation & Health'.

RESEARCH EXPERIENCE:

- As a research assistant, I was part of the team that was involved in the 'External Evaluation of Mitanin Program in Chattisgarh' & I was involved in the formulation of methodology of evaluation, development & field testing of the questionnaires. I also documented various case studies related to the program, & was the contact point for the group of investigators who came in at different point of time during the study. I accompanied 4 chief investigators in the field for more than 25 days & actually visited 8 out of 12 sample blocks in our study where I was involved in the field evaluation process looking at

the perspectives of the community, providers & planners about the whole program.

- Was a part of the CHC team that undertook a nutritional research project in 6 villages of Hosur taluka on the request of TVS Motor industry, situated in the area, with an aim of assessment of nutritional status of children between 0-6 years of age in 6 villages of Hosur taluka of Krishnagiri district of Tamilnadu state & to plan & enable interventional measures to mitigate malnutrition in children & to promote the development of children & ensure them a healthy childhood. I was on the two member team from CHC which made preliminary appraisal visits to the villages for situation analysis & I prepared the project proposal & was instrumental in designing the methodology of the study. I also prepared the questionnaire to study the knowledge, attitude & practice of child feeding in the area. Later, I was involved in the design & implementation of the intervention program.
- Study visit to 18 slums in Bangalore as a technical adviser from CHC to support action-research project undertaken by 'Jana Sahayog' (meaning Association for people's co-operation) to study the quality of drinking water being supplied by the Government to the slum dwelling poor people in these 18 slums. I was involved in the selection of water collection points & collection of water samples for analysis in the slums. In addition, I was also a part of the team in CHC that produced the report When not a single sample was found fit for domestic usage, leave alone for drinking purpose, the communities took the fight to the Government. Since, they were armed with the irrefutable evidence, Government was forced to accept its failure & take corrective measures.

CONFERENCES & WORKSHOPS:

- Was a participant in the five days workshop on 'Basic Training in Ethical Issues' in Bangalore jointly organized by University of California San Fransico Fogatry Training project & Samuha, a Bangalore based NGO.

- Participated as a student observer in the South Indian regional workshop for evolution of a 'national health program for control of non-communicable diseases' jointly organized by WHO-SEARO & Indian Council for Medical Research (ICMR) & hosted by Preventive & Social Medicine department of St.John's Medical College.
- Participated as the coordinator of the issue of impact of privatization & commercialization of Medical Education in Karnataka & also was the main presenter on the topic in the 2nd Karnataka State People's Health Assembly in Bangalore.
- Personally took the initiative to organize 'A Meet with Tsunami Disaster Relief Doctors from Bangalore Medical College (BMC)' in BMC, to share the experience of volunteers in the disaster relief work with the staff & students of BMC. I presented the experiences of the first team from CHC of which I was one of the members. It was mainly an attempt to start a process within the BMC to start a 'disaster management cell' in BMC to be prepared to meet the future challenges of disasters, both manmade & natural, in India. This process is still on, though with many difficulties of dealing with the bureaucracy.
- Participated in the two weeks long 'orientation program' for community health fellows in CHC covering the broad ranging & cross cutting issues of Public Health.
- Participated in the workshop of CHC to formulate the post-relief phase of disaster management response of CHC in the tsunami affected areas of TamilNadu. At present CHC has formed an ancillary team based in Chennai for undertaking the long time developmental work in tsunami affected areas with special focus on the component of Community Health.
- Participated as one of the three fellow representatives in the three day workshop in CHC for planning the feasibility of evolution of CHC into a school of Public Health.
- Participated in the NGO-Coordination workshop in Bangalore for coordinating & prioritizing the response of Bangalore based NGOs in their

response to Tsunami disaster to make the response more efficient & people friendly.

Most of these experiences have been dealt with in-detail in the section 2 of this report. As the experiences show, I was fortunate to have had one of the most wide-ranging exposures as fellow traveler in community health.

A REFLECTION AT THE END OF THE JOURNEY & A GLIMPSE OF MY FUTURE PLANS:

I am finishing my journey in Fellowship in CHC on 5th November & the main outcome of the fellowship is that, it has helped me to **realize my aim in life & commit myself to be a Community Health Worker for the rest of my life**. The journey through the Fellowship period has been an eventful one, which has not only resulted in a major professional decision, but also has had a **profound effect on my personal life & value system**. It also has helped to further my knowledge of community health practice & social processes. Among the various processes of Community Health that I was exposed to, there are two areas to which I would like to dedicate my life to & which I believe are few of the very important processes to realize the cherished goal of 'Health for All'.

- **Community Health Workers:** It all started at SEARCH in Gadchiroli under the inspiring guidance of Drs Abhay & Rani Bang & grew in me throughout the last one year- the motif of Community Health Workers as the 'Change Agents' in the society has enthralled me & I think at this point of time, that CHW is going to be my focus area of work in the future. The **philosophy of & operationalisation of the CHW scheme to promote community empowerment, emancipate them from the clutches of western medicine & to forge a partnership with the community to demand for a 'more' free & fair world, where even the 'poor people' matter & health is ensured not as a**

‘privilege’ of the few, but as an ‘entitlement’ for all has attracted me to it for no bounds. As a result I concentrated on further understanding of the concept of CHW during the rest of my fellowship period. The concept & its understanding was furthered by perusing the available literature, discussions with experienced people in the topic, & also during my stint in Chhattisgarh, as the research assistant for ‘External Evaluation of Mitanin Program, one of the many attempts to scale up CHW program from a small, NGO run program to huge, Public owned program catering to the entire state. The culmination of my learning process in the CHW scheme in Fellowship period came in Holy Cross Comprehensive Rural Health Project (HCCRHP) in Hannur in Karnataka state of India, where I was involved in the selection, training, & monitoring of CHW & hence, was able to assess my preparedness & experience the joys & sorrows of my preferred work.

- **Health as a Human Right & Equity in Health Care:** Another area of Community Health that has interested & at the same befuddled me is the issue of Health as a Human Right & the issue of Equity in health & health care. **I cant & don’t understand the ‘real’ reasons behind non-realization of ‘Health For All by 2000 AD’ for, the world has more wealth than it ever had in it’s history but still the ‘majority’ people are reeling under the burden of poverty & ill health. It is not just a subject of interest for me but is a passion, for my blood boils in anger when I look at the injustice in the world.** Hence, I have decided to place all my future work in Community Health as a part of larger strategy towards actualization of Health as a Human Right; based on the ideals of equality, justice & freedom.

FUTURE PLANS:

- **Immediate:** From December onwards, I am going back to Hannur & continue the work in HCCRHP. I am going to get involved in the organisation of primary health care in more than 60 impoverished villages in the area

through the CHW program. In addition, I will also take forward the 'Health Promoting Schools Program' in 10 primary Schools in the area, which I initiated along with the team at HCCRHP during the period of my Fellowship Days in HCCRHP. I will also continue my cherished activity of training, monitoring & understanding of community health workers. At the same time I would like to put to test the Paulo Friere's 'participatory approach of training for transformation' & document our local experience of the same.

- **Short-term:** At the same time, I am planning to undertake my higher education in Public Health in one of the appropriate institutes. During my reflection period of fellowship, one strong advice I received was to start & finish my higher education as fast as possible as both Dr.Ravi & Dr.Thelma (Myself included) felt that I have had adequate field exposure & it would be unwise to postpone my studies further. After long discussions with Dr.Ravi & Dr.Thelma, I have decided to apply in Johns Hopkins School of Public Health (JHSPS), Harvard School of Public Health (HSPH) & London School of Hygiene and Tropical Medicine (LSHTM). All these schools have an unmatched reputation as Schools of Public Health & more importantly, the course contents offered seem to be tailor made for my specific needs.

- **Long-term: To be a Community Health Activist involved in the evolution of a method to help people identify tools within themselves, their community & their state to solve the problems in the most appropriate & sustainable ways with a special focus on CHW schemes. In the long run, my "goal" is to develop a comprehensive CHW scheme; building on all the experiences of all such program across the world. To work towards this goal, I intend to work for any number of required years in the field.**

  At the same time, I will continue to work in collaboration with other groups & movements working towards realization of the dream of 'Health for All' with operationalisation of Health as a human right.

Ultimately, I would like to continue as a teacher to share & learn with students of community health, like me, the processes of 'real community health'.

ANNEXURE NO.1. STATEMENT OF OBJECTIVES

To, 20-08-2004,

The fellowship coordinator
Community Health Cell,
Bangalore.

Respected Sir/Madam,

"Prevention is better than cure". I know it sounds hackneyed. It has become the most over used, albeit most misused, statement in the world. But it is this cliché that has inspired me to write this letter and apply for the fellowship programme offered by your esteemed organization.

With a good performance in my school days and a good rank in C.E.T., I got admitted to B.M.C. I pursued my medical undergraduate studies in the prestigious B.M.C. between 1998 & 2004 and successfully graduated with "M.B.B.S." degree in june-2004.

Now, I am standing at the cross-roads of my professional life. With the burden of selecting a 'specialty subject' for myself, I am confused. But, because Community Medicine is the subject that enthralled me the most during my U-G life and it has a career prospect that excites me to no bounds, I would like to give it a try.

As a subject, I was always amazed by the simplistic approach of P&SM towards health, by which it reached to large masses in a single go. It gives me goose bumps to think that small pox is eradicated; Polio once considered a fatal disease is on the verge of being eradicated and every day millions of children all over the world are being saved from mortality and morbidity through U.I.P. It gives me a sense of awe to read of the astronomical number of people it reaches out to and that too in a non-

discriminatory way. The accomplishments of this field of medicine have struck a cord in me.

I was exposed to field realities of health care system of INDIA during my internship. What stood out during this period was the relevance and scope of P&SM in health care delivery. I found the therapeutic approach given in the Park & Park textbook of P&SM was the most practical and effective. That 1 year was also an eye opener for me. It showed me the bare realities of our health care system. It is but an irony that while people are “straightening their noses” for a couple of thousands of rupees, many are dying for lack of basic medical care. It agonizes me to think of these inequalities.

Bad experiences, though dominating, were not my only experiences. I was sweetly surprised to see how a simple method of distribution of IFA tablets through village health workers has made a substantial improvement in the health condition of women. School Health Check Up Camps were my favorite activities. It showed me what a difference a trained and knowledge teacher can make in the young lives. It was exemplified by an anganawadi teacher I met in a remote village, who insisted and taught simple ides of hygiene and cleanliness on the part of children. No surprise, the children were the healthiest among all schools I had visited. At Pavagoda, a remote place 180 km from Bangalore, I worked as a resident intern in a Rural Health Centre. It showed me one more facet of P&SM. Through RNTCP programme undertaken by the centre I learnt how a dedicated team of doctor and health workers can inspire a community and actively seek their participation in health care delivery and planning. Also I served as a PHC doctor in Venktapura 14 kms from Pavagoda. It is here I learnt how even a young, inexperienced doctor like me can make a difference in the community. Even though I stayed there for 7 days, I was instrumental in training the nursing staff and village health workers in many minor procedures like dressing of wounds, small abscess drainage, giving first aid to trauma patients and such others. And it was heartening to see them put to use the skills with all alacrity, which improved the health care deliverance of the PHC a couple of knots higher.

Among all my postings as an internee, I have enjoyed my P&SM most and found it the most practical and challenging field of medicine relevant to present day needs. Also a career in P&SM blends with my personality. I have been a leader of student community throughout my student days. I am an active participant of extra curricular activities and am always ready to shoulder any responsibility. As I grew up I found my interest in community and social welfare increasing further. As a doctor I want to make a real difference in the life of people and reach out to as many people as possible, especially the underprivileged and down trodden. How else than being a community medicine specialist?

With all these ideas in my mind, I came to C.H.C. for further guidance and found my belief of P&SM being my field of work being further reinforced by the short talk I had with revered DR.Ravi Narayan. He convinced me beyond doubt that C.H.C. is the place to start my work in P&SM. This notion was later endorsed by many people who worked in your esteemed organization previously.

As Galen told, "Since both in time and importance, health precedes disease, we ought to consider how health may be preserved, and then how one may best cure the disease". I would like to give my small contribution towards health and its promotion. I believe my educational background, my personality and my will to work for community health and its promotion makes me an ideal candidate for your fellowship programme. I aver that if selected, I would prove worthy of myself.

Kindly accept my candidature .Thanking you,

Yours sincerely,

Vinay.V.

ANNEXURE NO.2. LEARNING OBJECTIVES OF Dr.VINAY.V., AS A COMMUNITY HEALTH FELLOW IN C.H.C.

The initial learning objectives of Dr.Vinay.V., as a community health fellow in C.H.C., sponsored by Sir Ratan Tata Trust of Mumbai, as evolved in consultation with mentor and friend Dr.Thelma Narayan are as follows:

ACADEMIC DEVELOPMENT:

1. To identify my area of interest in Public Health stream of medicine.
2. To understand and broaden my current knowledge of health and its various determinants and dimensions.
3. To have first hand experience of 'community' and its dynamics.
4. To have first hand experience of current health system in place.
5. To develop my skills in academic writing, discussions and presentations.
6. To get the broader and clearer picture of various organizations, public and private, involved in health action & related social activities aimed towards 'Human Development'.
7. To foster my skills, especially those important for community based work like planning, organization, communication, health education, training of health activists, community needs assessment, evaluation, etc.
8. To understand from practical experience, how a voluntary organization aimed towards Human Development carriers its activities i.e. to observe C.H.C. at work.

PERSONAL DEVELOPMENT:

1. To understand 'Myself' better and hence to choose my way of life.
2. To identify my strengths & to build on them and to learn about my weaknesses & to work towards their correction.
3. To improve my communication skills, foster my skills of networking with people and further my capacity to build inter-personal relationships.

AIM:

To develop myself into a 'Community Activist', working towards a healthy and better community, in a meaningful and effective manner.

These are broad based and basic objectives which can be expanded or modified further in the process of fellowship in terms of focus, priority and significance; in the true spirits of 'interactive' nature of fellowship.

SELF APPRAISAL OF THE PROCESS OF REALIZATION OF MY LEARNING OBJECTIVES

This is an attempt by me to make an honest & open minded self appraisal of my Fellowship period, its experiences & the learnings in the light of my Learning Objectives, set forth at the beginning of my Fellowship period.

ACADEMIC DEVELOPMENT:

1. **To identify my area of interest in Public Health stream of medicine**.

Even though my fellowship process was designed consciously to have wide ranging experiences in the field of Community Health, there was always a constant search & reflection during the entire process to find my focus area for my future work. As a result, each step in the process was a construction based on my learnings & reflections of the previous process/ess. Though some of the steps in the process were not due to intentional planning, like the relief work in Tamil Nadu in the after math of the Tsunami disaster, they were undertaken with the right spirit & understanding of the often unexpected emergency demands of the practice of Community Health. Thus, some of the 'breaks' that appear to mar the smooth continuance of my fellowship period were a sweet serendipity.

My interest in Child Health led me to Society for Education, Action and Research in Community Health (SEARCH). However, my experiences in SEARCH expanded my understanding of the practice of Community Health & shifted my focus in Community Health on the 'philosophy & operationalization of Community Health Workers (CHW) scheme' in communities. The concept & its understanding was furthered by perusing the available literature, discussions with experienced people in the topic, & also during my stint in Chattisgarh, as the research assistant for External Evaluation of Mitanin Program; one of the many attempts to scale up CHW program from a small, NGO run program to huge, Public owned program catering to the entire state. The culmination of my learning process in the CHW scheme in

Fellowship period came in Holy Cross Comprehensive Rural Health Project (HCCRHP) in Hannur, where I was involved in the selection & training of CHW & hence, was able to assess my preparedness & experience the joys & sorrows of my preferred work.

Another area that has enthralled & at the same time befuddled me is the issue of Health as a Human Right & the associated themes, particularly the issues of equity in health & increasing commercialization of medical education & health care in India & their impact on the Health of Indian communities. At every stage of my fellowship process, the issues of Health & Health Care in reference to my learnings from my field visits & discussions were also analyzed, apart from the usual connotations, with reference to Health as a Human Right & I tried to understand the different community health processes in this light. It was also a theme which gave me a deeper understanding of the work of various people & organizations, with whom I had an interaction with & which seemed miles apart in their focus areas, which are basing themselves on this motif & hence deriving the necessary strength for their work. It was also interesting, confusing & infuriating to witness the broken promise of 'Health For All by 2000 A.D.' by all the concerned stake holders, particularly the State & widening inequity in Health among various communities within India. One definite outcome of my fellowship is that it has given me one broad framework for all my activities in Community Health i.e. the framework of Health as a Human Right; & whether I choose to work directly or indirectly on this theme, it will always be the guiding principle for all my works towards achieving equity in health.

In conclusion, the fellowship period has helped to find the focus & has laid down the foundation for my future activities in Community Health namely:

- Organization of primary community based health care & realization of 'Health for All', particularly in the underserved & marginalized communities.
- To evolve a model of Community Health Worker scheme that would help to realize the fond dream of placing the real power & onus of Health Action back to the communities & enlightened activism.

- To work towards the realization of Health as a Human Right in India & elsewhere in the world, & placing Equity as the core issue of all the Health Actions.

2. **To understand and broaden my current knowledge of health and its various determinants and dimensions.**

Without any malicious intent & with all the due respect it deserves, the MBBS course in Bangalore Medical College (BMC), as anywhere else in Karnataka, was replete with study of diseases & failed to give a wider picture on the determinants & dimensions of health. It was only during my chance meetings with the proponents of Community Health that I was stimulated to think & investigate the various 'other' dimensions & determinants of Health, which exposed my little understanding of the 'real' issues of Health.

Hence, the fellowship process was also aimed to give me a broader & more comprehensive picture of Health & its dimensions & determinants. The fact that the team at CHC & the fellows with whom I shared my fellowship period were from a multidisciplinary background, including social sciences, went a long way in realizing this objective. In addition, during all my field placements, I had an opportunity to interact with the cross section of the organizers & beneficiaries of various health actions including the members of the community, field workers, field supervisors, & also the leaders of the projects, which greatly enhanced my understanding of Health & it's broader meaning, very different from the narrow approach of bio-medical sciences approach of health. Furthermore, during all my discussions, presentations & analysis with my mentors & fellow students, this aspect was given an important position which reinforced the learnings.

As a result of the above processes, I can see clear differences in my own approach to various health problems & challenges on the field as compared to my early approaches. This was particularly evident when I went to HCCRHP in Hannur, where this particular knowledge came in handy while trying to analyze the reasons & understand the unreasonable poor health status of the marginalized communities

like women, people from lower caste & the poor people as compared to other groups of the people from the same communities. To highlight some of the very important learnings on this issue, from among the various learnings, are:

- That the issue of economic & subsequent social marginalization, be it gender related or caste related or in relation to vocational status, is a reality in India & it plays probably the most important role in determining the health status of a large majority of community members & hence, the community. Hence, it requires special understanding & approaches while planning for a health program for a particular area & it is pertinent to make conscious special provisions so as to reach out for these neglected & marginalized sections of society.
- No doubt hospitals and medical & paramedical professional people are important for a community to maintain health; their role in promoting, preserving & restoring health in communities is over estimated. It is not just the 'germs' or the genetic factors or the immunological factors or the idiopathic factors (about which the 'Medical' world seems to be obsessed with) that are threatening the health of communities, but there are equally important social, economic, political & cultural factors that are undermining the ability of the people to enjoy a good & healthy life. Hence, it is binding to have a more participatory, multi disciplinary & comprehensive Health Actions, if we are serious about achieving Health for All.
- That the Health Systems, both public & private, play a very important role in promoting, preserving & restoring health in communities. However, one single model for a nation as diverse as India is a questionable model and there is a need for community ownership of Health Systems foe it be effective, accountable and appropriate.

3. To have first hand experience of 'community' and its dynamics.

It was also pertinent for me to have an experience in the community and its dynamics from close quarters. Some of the social issues like that of childhood bonded labor, casteism, gender inequalities, extreme poverty and such others were not understood corresponding to the gravity they call for. Hence, apart from knowing the issues through reading and discussions it was critical for me to experience the same for a deeper appreciation of the social issues.

I was fortunate to have had wide ranging experiences during the Fellowship period. Starting from Shodhgram in Gadchirolli the journey of my fellowship took me along the length and breadth of the Chattisgarh and finally grounded me in Hannur. Apart from these, there were also innumerable number of opportunities to also meet and learn from different communities in Bangalore and elsewhere.

One definite input of my Fellowship was to develop more sensitivity towards the cultural, traditional and social diversities of different communities and appreciation of the fact that one 'carpet policy' will not work in India. Also, my interaction with the tribal communities especially in Gadchirolli and Chattisgarh opened my mind to the new world of tribals and their tribulations in the present day scenario. The Gandhian philosophy in Shodhgram was inspiring and has motivated me to know more about the same. More importantly, the brush-off I had with the extreme poverty in Hannur region and my personal involvement in the emancipation of a 10 year old child from the bonded labor has been the most disturbing experience and has furthered my fire to understand the existing world order and the factors that perpetuate poverty. In addition, the extreme division of the society along the caste lines and the condition of the dalits in the region of Hannur was shocking and brought to the fore the realities of social determinants of Health.

4. To have first hand experience of current health system in place in India.

Since my long-term goal at the time of entering the fellowship was concerned with Health Systems and I had limited experience in the same, this was added as one of the learning objective.

I had a variegated experience of Health Systems across many regions of India in both public and private, both for and not-for profit, health systems. From the cost effective, multi-specialty hospital in the rural area of Swami Vivekananda Youth Movement (SVYM), to tribal friendly hospital and CHW system in SEARCH, to the huge public health initiative in Chattisgarh, to a 'model- primary health centre' in Ganyari by Jana Swasthya Sahayog (JSS) I was a witness to large number of initiatives and health systems in India. These experiences have just primed me to further understand this complex and critical issue in my future.

5. **To develop my skills in academic writing, discussions and presentations.**

I was providential for having provided with the numerous opportunities during my fellowship period to hone my academic skills. Reporting of every activity in itself was a learning experience, for this was a new experience for me and I am thankful for all my mentors who perused every piece of report I produced and giving me the feedback on the same. At the same time, the fellowship orientation program was a golden opportunity in the realization of above objective. The program, with priming form the mentors followed by presentations and discussions on chosen topics by the fellows from multidisciplinary background was an enriching period. Also, the nutrition project in Hosur, 2nd State People's Health Assembly in Karnataka and tsunami sharing program in BMC are few of the specific instances that helped me to achieve the above objective. However, I would say that the feedback from mentors and fellows was the most critical factor in the realization of the above objective.

6. **To get the broader and clearer picture of various organizations, public and private, involved in health action & related social activities aimed towards 'Human Development'.**

This objective was added as an after-thought since the sphere of human development had a special place in my heart, for I felt pain when I saw poor people. There was no special understanding about poverty except the sad feeling I

experienced when I met a poor child or a woman. It was this feeling that prompted me to have the above objective in my fellowship period.

Every organization I visited and every discussion I had with various people on Health and Development have gone a long way in altering the way I looked at the world and it's development. They have basically given me a new framework to evaluate the necessity and effectiveness of every action I undertake in communities.

I feel at this point of time that every organization I visited was involved in the health action and most of them linked this with 'Human Development'. I am using quotes to put in human development since development is usually spoken in economic language where trade and commerce become the indicators of development which I do not agree with. However, with the experiences I had during the last one year especially the discussions with various people during the course of fellowship; I believe in human development as any process which will lead to happiness and contentment of whole communities in a sustainable manner. Taking this definition into account, health and development become closely related issues where one can neglect either at the peril of neglecting the both. It is this realization that I value the most in my fellowship period.

7. **To foster my skills, especially those important for community based health work like planning, organization, communication, health education, training of health activists, community needs assessment, evaluation, etc.**

Since I had a vague idea of the kind of long-term work I wanted to undertake when I joined the fellowship, these objectives were drawn to equip me with the necessary skills and knowledge for the same.

The multifarious activities during the fellowship period have provided me with numerous chances to develop the above mentioned skills. Each activity during the fellowship has helped me to enhance a particular skill. For instances, the nutrition project in Hosur gave me a chance to plan and formulate a small study, the Mitanin Experience was a great learning experience which equipped me with the basics of

evaluation methods, the HCCRHP at Hannur gave me the opportunity to involve myself in the training of Health Activists.

8. **To understand from practical experience, how a voluntary organization aimed towards Human Development carriers its activities i.e. to observe C.H.C. at work.**

I intended to work in a voluntary sector and to understand it is the first step towards it and hence, this objective. I am grateful for the team of CHC for providing me with invaluable experience of how CHC functions by allowing me to attend the team meetings even though I was not, strictly speaking, a team member and understand the dynamics of it.

PERSONAL DEVELOPMENT:

1. **To understand 'Myself' better and hence to choose my way of life.**

One unique character of the fellowship period is it that it did not just build my academic interest in the subject of community health but it actually helped me to understand life and live it accordingly. Even though I was an honest and straight forward person even before fellowship, this period has been particularly important in terms of giving me courage to actually live by the principles I valued but found it difficult to practice. It would also always be remembered fondly for the sheer number of principled people I met and the interesting lessons learnt from them. The joy that I derived being with such people is inexplicable and they remain to be my inspiration.

At the same time, I would also say that this period has been tumultuous for it has questioned some very basic principles I believed in and has left me shattered at times by disproving some basic conceptions I had about this world. It is the times like these that have taught me the value of mentors, friends and books. It is also these experiences that led me to investigate into the 'other world', which is well hidden from the superficial eyes. It is during these investigations that I discovered myself, with whatever little knowledge I gathered in these periods, to be a socialist,

then a Gandhian and then that I stand for the humanity as a whole. It is this quality of the fellowship that I found the most challenging; the constant questions that shatter my beliefs leading to confusion which would further lead to investigation into the new ideas ending in additional and new knowledge. At the same time, the greatest lesson I have learnt for the life is that learning is a lifelong process and the only way for constant personal and professional growth is to be an attentive student of life at all times.

Thus, the fellowship was a great period in terms of helping me to understand myself better and for giving me a broad set of principles, equity, justice and freedom, which will continue to guide all my future works.

2. **To identify my strengths & to build on them and to learn about my weaknesses & to work towards their correction.**

The fellowship has also been important in terms of furthering my strengths and working towards amending my weakness with the help of my mentors, fellows and all CHC staff. These experiences have been reflected in every report of my experiences in the fellowship period presented in the section 2. Hence, I believe that a lengthy appraisal on the same in this part is unwarranted.

3. **To improve my communication skills, foster my skills of networking with people and further my capacity to build inter-personal relationships.**

The fellowship period in CHC has been an absolute occasion for building my communication and networking skills evidenced by the diverse people I now know all over India. At this juncture I personally feel more confident in accosting people and initiating conversation, which I used to shy away previously. Apart from this, I believe it would be more appropriate for the people around me to evaluate this particular skill of mine rather than me talking about the same.

SWOT ANALYSIS OF CHC FELLOWSHIP IN COMMUNITY HEALTH

STRENGTHS:

- **Dr.Thelma Narayan and Dr.Ravi Narayan as mentors**: I cannot stress more than enough of the good fortune of fellows to have such wonderful human beings and such experienced community health practitioners as being our mentors. Inspite of all their work pressures and time constraints, they always find time to interact and guide us through all our tribulations and triumphs of our experiences. It is this personal attention that we get from them that has greatly helped us to place our experiences in the right perspectives and learn invaluable lessons from them. The passion of Dr.Ravi and the scientific rigor of Dr.Thelma have personally inspired me to emulate them.

- **Multi-disciplinary background of CHC fellows**: A blend of fellows from diverse background has gone a long way in mutual learning process, which I believe will stand in good stead when we begin our work in communities. The perspective of each fellow on an issue based on their background and training has helped to internalize the complexities involved in community health work and the importance of analyzing situations from various perspectives and to formulate appropriately solutions.

- **Flexibility of the program**: The most important aspect of the program is the internal flexibility of the program, in terms of the selection, mentoring and all other processes of the program. For, if not for that 'open position', I would not have had the opportunity to join the fellowship and would have lost an opportunity to pursue my interest in community health. It is very important for the program to maintain this particular flexibility since, many potential fellows, like me, who would have graduated in times not in league with the fellowship program would loose out on an opportunity and I believe it will

also defeat the purpose of the fellowship scheme to a great extent. In addition, the flexibility the program presents to the fellows to pursue their diverse interest in the field of health is the most critical factor for shaping the future of fellows. It is this flexibility that has helped me for I had a zest to work with communities but was not sure on the particular area in community health to work on. The flexibility in the fellowship provided me with wide ranging experiences which actually helped me to find my focus area for my future work. It is also the flexibility of the program that was responsible for my extension of the fellowship period from 6 months to 1 year. Hence, the flexibility of the whole program should not be tinkered in any major way.

- **The 'new paradigm' approach**: Another unique feature of the fellowship scheme is the introduction of fellows to the 'new paradigm' where we are introduced to the system of holistic approach towards the health. The paradigm taking into consideration the social, political, cultural and economic factors apart from the biomedical factors that affect health of communities, have grounded us on a firm platform for further analysis of community health problems in all their complexities. This has resulted in shaping us to get to the root of all problems rather than scratching the surface and dealing with just the symptoms.

- **The 'open-structure' of the fellowship scheme**: In the world where education and training has become highly structured and constricting, the CHCFS with its 'open-structure' provides unique opportunities to young people like me to actually explore and find our focus areas for further training and work. My deepest concern is that when CHC is planning to transform into a 'Community Health School', this aspect may be compromised for the sake of formal degrees. Hence, I request all stakeholders in CHCFS to continue this program, even if it has to run parallel to the formal degree program, in the present 'open-structure'. Minor alterations, if absolutely necessary, can be carried out to fix certain topics as core requirements and leaving the rest of

the time for the fellows to explore the field in a way they would wish to; but the essential 'open-structured' nature of the program should be continued.

- **CHC contacts and field mentors:** I am not able to comprehend the depth and breadth of the contacts CHC has in the arena of public health and I believe this places CHC in a unique position to offer fellows with the appropriate field placement for any type of experience the fellows would request for. This ability of CHC has blessed me with opportunities to have been mentored by the likes of Dr.Abhay Bang and other eminent community health practitioners in India. I am also providential to have come in contact with a large number of distinguished people with diverse philosophies in community health which has helped me to learn hard but all important lessons in community health in the shortest possible time. Thus the system of field mentoring put into place by CHC has immensely helped me to derive maximum benefit from them.

- **Introduction to 'movements' approach:** The initiation to 'movements' and 'activism' was a totally novel process for me. It is a unique process, atleast for me, for having a chance to get exposed to 'movements' approach from such close quarters and to get actually involved in them. This has opened a totally new approach in community health for me and I firmly believe that if not for CHCFS, I would never have had an opportunity to study and learn about movements in such an effective manner. I am so impressed by this motif that it is going to be one of my focus areas of my future work.

- **Improving analytical capabilities:** The fellowship period has an inbuilt beautiful process pushing us towards investigating 'true causes' and equipping us with the necessary framework to analyze situations, articles and reports perspicaciously. It has given me the ability to 'read in between the lines' exemplified by the way I view and understand the National Pulse Polio Immunization Program at present compared to my previous viewpoint on the same.

However, 'the strength' of the fellowship, apart from equipping us with the knowledge and skills for community health practice, lies in its processes designed to provides us with the inspiration and principles to make a difference in people's lives, for a better and just society.

WEAKNESS:

- **Lack of common quarters for fellows:** I felt the lack of common residential quarters for the fellows when they come together for orientation program and sharing sessions. I believe that,, had it been the case, it would have provided us with more time for further discussions and closer interactions.

- **Lack of computer facilities:** Even though CHC as an organization has many computers, as a fellow I sometimes felt the lack of adequate computer facilities. This was especially true during the orientation and sharing sessions when all fellows would come together and would have difficulty having an access to a computer to write their reports or prepare a presentation.

- **Lack of a session on 'research methodologies' during orientation period:** Even though I understand that CHFS is not a formal course and the orientation program offers the sessions on widest range of issues and topics, I felt a lacuna in terms of the absence of introduction to 'research methods' in community health. Even though we get exposed to the methods during the course of fellowship, it would serve well to have a session on the same during the orientation period.

OPPORTUNITIES:

- CHCFS has an immense potential to make a huge contribution to the community health field in India and elsewhere. If and when the fellows reach a critical number and start acting in a concerted manner, there is every

possibility for the translation of the 'new (alternative) paradigm' as the guiding and dominant paradigm of community health in India and elsewhere.

- There is also an opportunity to come up with a yearly or a half yearly publication of unique and powerful experiences of fellows in the field and the same can be made available in schools of medicine, social sciences and allied organisations to share their experiences and also to generate interest and promote the idea of 'new paradigm' to larger audience.

- CHFS has the potential of altering the public health system for better if it gets an opportunity to actually induct public sector functionaries also as fellows.

- CHFS has the potential to tap into the potential pool of young graduates in the field of health in India, provided the system is adapted in other states of India along with the networking with CHC.

- It also has a potential to be modified to fit into a formal degree program as and when CHC will develop into an Alternative Learning Centre.

THREATS:

- Exclusive pressure on Dr.Ravi and Dr.Thelma as the chief-mentors cannot continue for long. There has to be at least two more senior people to share the responsibility and reduce the inhuman pressures on them.

- The evolution of CHC into a school of community health may result in the sacrifice of the 'open-structured' CHFS for more formal degree programs; which would rob off opportunities for young fellows like me with an open mind to explore all the possibilities of community health before deciding on a focal issue.

TO 'SEARCH' IN SEARCH OF KNOWLEDGE, INSPIRATION….

BACK GROUND:

As a part of my fellowship program in Community Medicine in CHC in collaboration with Sir Ratan Tata Trust in Mumbai, & in accordance with my learning objectives, I had a long discussion with my mentor Dr.Thelma Narayan in November identifying the place for my educational visit, to further my knowledge of Community Medicine & experience a 'real' community health project at work. Since I had 'Child Health' as my priority area, she suggested 'SEARCH'(Society for Education, Action & Research in Community Health) located in Gadchirolli district of Maharashtra as a possibility. She talked with great love & respect about 'SEARCH' & Dr.Abhay Bang & Dr.Rani Bang, the motive forces behind SEARCH. She introduced me to their pioneering work in the field of Community Health, especially their ground-breaking research aimed at improving the health status of rural people especially the much neglected woman & child community, within community setup, using community participation & community resources as the tools for community empowerment! She also asked me to read the Anubhav[4] series on 'SEARCH' to find out more of the same. The book gave me a bird's eye view of the works being carried out in 'SEARCH' & their research programs excited me to no bounds. I immediately decided 'SEARCH' is one place I ought to visit & study. With Dr.Thelma Narayan's help I was able to arrange the same & Dr.Abhay Bang kindly agreed to take me in for a month, between 23rd November 2004 & 24th December 2004. As agreed, I spent a month in 'SEARCH' between November & December of 2004. I try to look back at my experience in SEARCH through this report.

THE PROCESS OF LEARNING IN 'SEARCH':

My program of learning for the first week of my stay in SEARCH was ready even before I reached Shodhgram! I was really taken aback by their warm welcome & diligent planning. Also, I had a chance to meet Dr.Abhay Bang on the first day itself.

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[4] Anubhav is a series of books published by VHAI to disseminate information about various pioneering NGOs in health field & their work in brief.

The first week of my visit consisted of having a bird's eye view of all the programs in progress in SEARCH. The methodologies adapted were:

- Presentation of various health programs by the team members undertaking the program
- Discussion of the health programs with the team members
- Literature review of the programs
- Field visits to different villages under the health program of SEARCH to practically witness the various health interventions under taken by trained village health workers
- Discussion of the field work with village health workers

Thus at the end of one week, I had a fair amount of knowledge about the various community health programs undertaken by SEARCH.

I reported my learnings from the enriching experience to Dr.Abhay Bang[5] & also presented to him my learning objectives in SEARCH. He, with a suggestion that the first three of my objectives as realistic, impressed me of the fact that the process of learning research methods in community takes lots of time & energy along with concentrated reading! Also, he felt that the future works I had suggested were not realistic due to the constraint of time. Instead he suggested me to undertake case studies of three different community health programs in progress in SEARCH. He explained to me of the relevance of such a study with following points:

- I would vicariously experience the process of planning, implementation, evaluation & fine tuning of health programs, which is the crux of community health work.
- Also, the process would help me identify the dynamics of the working of an NGO involved in community health program.
- In addition the topics chosen were such that, each topic would take me through one of the most important determinant of community health. In toto I was to study the whole range of determinants of community health!

[5] Annexure No.1. Learning objectives of Dr.Vinay in SEARCH

- Study of Tribal malaria control program (TMCP), alcohol deaddiction program & study of hidden child mortality in Maharashtra were the programs selected for my study.
- I was given freedom & flexibility regarding the methods I would like to use to do case studies. The various methods I used were identical with the methods I followed in the first week, already mentioned, but with more depth.

I first undertook the study TMCP[6]. At the end of study & reporting, the process of which took me two weeks, Dr.Abhay Bang gave me an option to either follow my learning program as planned earlier or to continue my study in malaria further & try & suggest amendments for the short comings I pointed out in my case study. I was more than happy to continue on malaria program. But in the next one week I was in SEARCH, due to lack of data, both from SEARCH & Government malaria office, I was unable to complete the process I had started.

LESSONS LEARNT:

My stay in SEARCH was one of the most productive periods of my life in the sense of both professional & personal learnings. All my learnings are mentioned in the reports I am attaching to this as annexures. The lessons learnt cover almost the entire gamut of learning objectives we (Myself & Dr.Thelma) had set forth for myself at the beginning of my fellowship in CHC!

CONCLUSION:

My study visit to SEARCH was one of the most profound experiences of my life. I came back with new found knowledge in community health & also with personal enrichment. More than anything else, I was enthused to pursue my future life in community medicine & my earlier decision to do the same was further reinforced.

Retrospectively my study visit to SEARCHI would rate as one of the **most memorable & productive periods of my life**, not just for the lessons it taught me concerning community health but also for **its profound effect on my consciousness.** It was in

[6] Annexure No.2. Case Study Of 'Tribal Malaria Control Program' Undertaken By 'Search' In 36 Tribal Villages Of Gadchiroli District Of Maharastra

'SEARCH' I visualized my thoughts & dreams in concrete form. It dispelled all my apprehensions in a single blow & helped me to **find the 'mission of my life'!** Thus I consider my visit to 'SEARCH' as a **'pilgrimage'** rather than a study visit!

ANNEXURE No.1. MY REPORT AFTER FIRST WEEK IN 'SEARCH'

Learning objectives of Dr.Vinay.V. in SEARCH:

1. To have a first hand experience of the dynamics & working of a 'community health organization'.
2. To visualize & learn practically the various components of a 'community health program', at the level of community & involving communities themselves, aimed at improvement & promotion of health status of children in a community.
3. To understand the formation, functioning & growth of SEARCH as a model NGO involved in community health research.
4. To learn the skills for research in community health, with special emphasis on child health.

My experiences in SEARCH so-far:

1. HBNC (home based neonatal care):

- A novel concept formulated in addressing the much neglected, but a very vital component of child health i.e. HOME BASED NEONATAL CARE. It also proved that it is practically possible to place the 'health' of communities in their own hands & it is the surest & cheapest way of achieving 'Health for All'.
- HBNC appears to me all the more important & unique because of the following reasons:

    1. It was a long time since there was a felt need within the scientific community for an affordable, accessible, acceptable & reliable program to address the health problems of neonates to consolidate & move ahead in improving the health status of children world wide. To think of SEARCH based in some remote village with a staff of less than 100 people finds the solution is unfathomable in the realms of common imagination.

2. The 'operation' of HBNC is independent of socio-economic status of the community, both in the process & expected outputs, making it a replicable model across wide areas of India & the world. Also it means that the 'confounding' factor of low SES coming in the way of implementation of many initiatives is not to be so in HBNC.

3. The various 'components' of HBNC are so modeled that even if HBNC is not adopted as a 'whole', even a few components when replicated will be effective in the improvement of child health status. This type of flexibility in the operation of the program makes it all the more unique & important.

4. HBNC symbolizes the true spirit of 'Community Empowerment'.

2. Multitude of subjects, on which research was & is being done by SEARCH.

3. Field experiences:

1. Visit to Kannar Tola, a tribal village where I had a chance to meet with a Sanghi named Kunda. I also had a chance to see Youth Education Program in progress.

2. Visit to Rajghatta & see the female VHW Mrs.Maya Aegnutalwar at work in HBNC.

3. To see Mrs.Kajubai Undirwada, female VHW of Ambeshivani, injecting Vit-K to a 6- hour old neonate with the skill of a trained nurse!

4. A small visit to Mr.Purshottam Bavane, a male VHW & to Mrs.Birjulabai Tute, a TBA.

5. An overview of SEARCH's fight against the foremost social evil, Alcoholism. I felt it to be different from other initiatives of the same kind in the following ways:

1. The movement was able to have a legislation passed from the government declaring Gadchirolli to be an Alcohol free district, both in the sense of marketing & drinking of alcohol! The approach of Dr.Abhay Bang of providing a breakup of the public sector revenue &

expenditure due to sale of alcohol to persuade Government is commendable.

2. The 'sobriety rate' achieved by the deaddiction cell of SEARCH (about 58%) is substantially high compared to other such initiatives worldwide.

6. The fruitful relationship SEARCH has developed with tribal people & the means of 'involving tribal community' in their own health program through 'Arogya Sansad' is very interesting & thought worthy.
7. My first experience of 'community life'.

Lessons learnt so-far:

1. 'Dreams', however preposterous they may sound initially, are the 'Motive Forces' behind any human achievement.
2. I have learnt deal about 'Community Health' & its implications & many a doubts in my mind regarding the working of 'Community Health' are cleared now. To name a few:
   - The initial few years of any community health project though are frustrating & too often scarcely rewarding in terms of measurable outputs achieved, are very crucial for the development of good rapport & partnership with the community. This is the foundation, on the strength of which the future of the project depends upon.
   - 'Clarity of vision & goal' is very important while working in a community or else, we will be so overwhelmed by multitude of problems beseeching the community that in the process of addressing them; we may find ourselves lost in the community without any fruitful progress.
   - 'Prioritizing' of the problems is very important.
   - 'Patience' is the key to success in this field of work. With due respect to Dr.Abhay Bang, if I had the vision of HBNC, probably I would have rushed up doing it within a year or two (& probably compromised

with the quality of work & jeopardizing its success!). But SEARCH, with its HBNC project has given me the clarity of vision regarding the conceptualization, formulation, implementation, evaluation & fine-tuning of a community based program.

- SEARCH also solved a nagging doubt in my mind regarding the work of 'health promoting organization'. My doubt was, whether a successful & sustainable improvement in the health of people can be achieved without an 'ultra-modern, super specialty hospital' & substantial change in 'socio-economic status' of the community. SEARCH has effectively demonstrated & proved beyond doubt that the answer to the above question is a bold 'YES'.
- SEARCH has reinforced my faith in rational, systematic & scientific approach to solve any problem. It has added patience, teamwork& technical expertise to the list.
- SEARCHS's experiments have more than proved to me about the effectiveness & importance of appropriate technology in addressing community health problems.
- 'Prime people' involved in community health projects should live within the community.
- A lot of pre-project preparation & an extreme clarity of ideas is a requisite for the success of a project.

Probable areas in which I can work:

(This is what I thought of. It needs to be discussed with revered Dr.Abhay Bang & final decision will be taken in consultation with him, according to his suggestion)

1. Study of the importance & causes of low birth weight in babies & possible interventions to decrease the incidence of the same.

3. Evaluation of the effect of health education component of HBNC on the desirable
course & out-come of pregnancy.

4. Effect of indoor air pollution on the health status of children.

5. Study of cultural & traditional practices of the community affecting the pregnancy & pregnancy outcome.
6. Comparison of children managed for birth asphyxia by VHW with normal/birth asphyxiated hospital managed children.
7. Preparation of health education materials.

ANNEXURE No.2. CASE STUDY OF ‘TRIBAL MALARIA CONTROL PROGRAM’ UNDERTAKEN BY ‘SEARCH’ IN 36 TRIBAL VILLAGES OF GADCHIROLI DISTRICT OF MAHARASTRA

CONTENTS

Abbreviations used in this document

Background

Part one: The conceptualization and implementation of 'Tribal Malaria Control Program'

1. Getting started
2. Seeking community participation in the formulation of health program
3. The process of planning the program
4. The 'program' proper
5. The process
6. The work in the community
7. The 'me-too' syndrome
8. The 'KAP' study & fine tuning of the program
9. Moving forward
10. Midterm evaluation
11. The first big jolt to 'TMCP'
12. Time to pause, reflect, & continue
13. Conclusions & some posers

Part two: 'Tribal Malaria Control Program' as a model 'community health program':

1. A strong & enlightened leadership
2. A strong partnership with the community even before the conceptualization of 'TMCP'
3. 'Community involvement' at each step of the program
4. Importance of understanding & respecting the community
5. Clear vision of 'oneself' & the 'process'
6. Adequate & appropriate support of 'THV' by 'SEARCH'
7. Community capacity building
8. The 'unique structure' of the program
9. Facing adversities boldly, admitting mistakes & learning from mistakes
10. 'Short comings' in 'TMCP'

ABBREVIATIONS USED IN THIS DOCUMENT

API	Annual Parasitic Index
BSE	Blood Smear Examination
IRS	Indoor Residual Spraying
ITN	Insecticide Treated mosquito Net
KAP	Knowledge, Attitude & Practice
MDS	Maa Danteshwari Sevak
NGO	Non Governmental Organization
OPD	Out Patient Department
SEARCH	Society for Education, Action, and Research in Community Health
Tab.	Tablet
THV	Tribal Health Volunteer
TMCP	Tribal Malaria Control Program
TVHP	Tribal Village Health Program
VHAI	Voluntary Health Association of India
WHO	World Health Organization

CASE STUDY OF TRIBAL MALARIA CONTROL PROGRAM UNDERTAKEN BY 'SEARCH' IN 36 TRIBAL VILLAGES OF GADCHIROLI DISTRICT OF MAHARASTRA

BACKGROUND:

Malaria is an infectious disease caused by parasites of genus Plasmodium & transmitted to human beings by certain species of infected female anopheles mosquito. Although the disease is known to mankind & studied with great aplomb since times immemorial, to both cure & control the disease, it is still the designated 'The No.1 Priority Tropical Disease' of WHO[7]. The statistics, both from the world & from India, speak volumes for the justification of the above dubious distinction of malaria. In the world, about 100 countries are malarious with 2.4 billion people at risk, about 300-500 million cases are reported every year, & 1.5-3 million people are killed annually[8]. In India, the official statistics say that there were 2 million cases of malaria with 972 deaths in 2000[2]. However, with chronic under reporting being a major constraint in India, the deaths due to malaria is estimated to be 73795[3] annually. In addition, given the fact that malaria occurs predominantly in agrarian & tribal regions with lot of morbidity & economic strain on already stressed people, it has been considered as one of the major public health problems in India & worldwide, with many resources earmarked to reduce & control it.

Gadchiroli is one of the underdeveloped, tribal districts of Maharastra with a population of approximately 9.7lakhs[4]. Being a tribal district with lots of forested land & the main occupation of the people being agriculture, both of which are identified risk factors for high incidence of malaria, it is considered to be an endemic region for malaria with API>5. Add to this the poor outreach of the health facilities, general apathy

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[7] WHO home website
[8] Park textbook of Preventive & Social medicine, 17th edition

3 Towards an appropriate malaria control strategy, VHAI
[4] Statistic information based on 2001 India census

of the successive governments to address the problem of tribals, the inadequacy of successive national malaria control programs, both in design & implementation, & the repressed voice of tribals & one can imagine the plight of people left to tend for themselves. No wonder the health indicators of the district are poor & one among the worst in Maharastra. The incidence of malaria was high with a high case fatality rate, & very few people assessed the scarce health facilities when sick. In addition, there were many regular & focal outbreaks of malaria epidemics, resulting in added mortality & morbidity of the people of Gadchiroli. In toto, malaria was one of the important causes for the poor health status of the people of Gadchiroli.

It was in 1986 that a NGO by name SEARCH (Society for Education, Action and Research in Community Health) was setup by a dedicated & inspired doctor couple. They came to Gadchiroli with two small kids, an ambulance, three assistants, lots of knowledge & high ideals to start their work in 'community research & action' with an objective of 'Arogya Swaraj'. Though their first undertaking was a 'failure', the sheer strength of their motivation & dedication had won many a people in the region & they started their work independently in the community of Gadchiroli. At the same time they started reaching out to the tribal people in the district through the weekly OPD for tribals in Chaathgaav, a small village 19 km from the district headquarters & a center for the tribal villages of the region & organizing health camps within the tribal villages on demand from tribals & when they were badly affected by epidemics of diseases. Their working, knowledge & partnership with tribals of the region were further strengthened in 1993 when SEARCH moved to its own campus 'Shod gram', a residential quarters for the staff of SEARCH along with a 'Tribal Friendly Hospital'[5], just 2kms from Chaathgaav. A fruitful & faithful partnership between SEARCH & tribals was thus in place by the end of 1993.

[5] Building Community Partnership & bringing in Community Involvement

PART ONE: THE CONCEPTUALIZATION AND IMPLEMENTATION OF 'TRIBAL MALARIA CONTROL PROGRAM

GETTING STARTED:

It was in 1998 that the team in SEARCH decided to work more closely with the tribals & to take up 'Community empowerment' in tribal areas to address their health care needs & problems. An all-important lesson that, there will be no community involvement in a health program if the felt need of the community is not addressed, learnt by SEARCH in 1988-89 through their 'Sickle Cell Anemia Study In Tribals of Gadchiroli'[6] was not forgotten. Keeping this lesson in mind, the team of SEARCH decided to involve tribals in their own health program from the beginning. To realize the same, a 'Tribal Jatra'[7] was organized for 2 days within the campus of SEARCH in April 1998 & more than 1000 tribals, along with their leaders (zamindar, manzi, bhoomia, patel, traditional healers), from conveniently & randomly selected 50 tribal villages[8] attended the Jatra with great enthusiasm. The Jatra was used as a platform to sensitize the tribals on issues related to health & further the bond between SEARCH & tribals. It was during this Jatra that a 'Health Assembly'[9] of 50 villages, with representatives from all villages, was formed to provide a platform for the community to address their problems & discuss the possible solutions. The Jatra was successful & ended with a decision to have the same annually.

The team of SEARCH was ready to take the big plunge during the 2nd Health Assembly in April 1999. It asked the community to rank their health problems according to their own priority i.e. 'Felt Need' of the tribals. After a laborious process of 'Voting'[10], three problems were identified as the priority health problems namely:

- Malaria
- Diarrhea
- Backache

[6] The importance of 'Felt Needs'
[7] The actual process of 'Community Involvement'
[8] The importance of knowing one's limitations
[9] The health assembly
[10] Identifying the Felt Needs

This was a shock to SEARCH, which was thinking of anemia, child health, & such other 'conventional health need' as possible outcomes. Nevertheless, SEARCH decided that it would take up these as the 'felt health needs of the community' & try to address them with 'active participation' from the community.

In the staff meeting of SEARCH, that followed the Health Assembly 1999, the following decisions were taken to address the problems identified:

- A 'Participatory Approach' to find the solution, will be followed,
- A community based solution & not a hospital based solution to be formulated to address the problems &
- A committee for the 'Tribal Village Health Program' (TVHP) was formed with following members
  - Dr.Abhay Bang & Dr.Rani Bang- Chief Advisors & Technical Advisors
  - Mr.Tushaar Ghorkade-Program Coordinator
  - Mr.Mahadev Satpute & Mr.Haridas Sakhare -Supervisors

SEEKING 'COMMUNITY PARTIPATION' IN THE FORMULATION OF THE HEALTH PROGRAM:

To seek the 'Participation' of the community in the formulation of the solution & prepare a comprehensive program to address their health needs, the SEARCH team of TVHP went promptly to each tribal village with the report of second Health Assembly & asked their 'Solution' to address their own problems[7]. The tribals initially thought of camp based medical service as the solution. However, when they were made to realize the futility of the same in the long run, in terms of sustainability & regularity, they had to rethink on their solution. Later the tribals came out with the age-old, nevertheless the best among all possible solutions. They suggested that, they will pick two volunteers from each village & asked SEARCH to train & supervise them. SEARCH was glad at such a solution, as it had the same but unexpressed solution in its mind. So a 'Plan' of

Tribal Health Program with the formation of an army of voluntary health workers was formalized.

SEARCH, with lessons learnt from the experiences of other NGOs with similar programs in India & elsewhere, wanted 'genuine' community participation & didn't want to make the tribals 'dependents' on SEARCH[11]. To materialize the same, it put forth the following pre-conditions for the tribals:

- That any village willing to join the program must select two volunteers from the village residents themselves & volunteers will not be remunerated by SEARCH in any ways.
- That all villages wanting to join should collect 1kg of rice from each household of that village, out of which SEARCH will keep 50% & rest 50%, will be given to the volunteers in recognition of their services.
- A consent letter from the village to SEARCH signed by the members, stating their acceptance of the above.

In exchange, SEARCH agreed to provide the following:

- Training to the THV
- Supervision of the work of THV in community
- Technical assistance
- Laboratory facilities for the Tribal Health Program
- Medicines to cover the 'identified needs'
- Hospital services to those in need at a nominal cost

Even though the tribals themselves had sought 1 week time to meet the conditions of SEARCH, it was only after an agonizing wait of 2 months that 14 villages (out of 50 villages!) came forward to join the program with all the prerequisites met! SEARCH was happy to work with them even though they were less in number than envisaged earlier, as the work would continue with clear 'conscience' that the 'real community participation' has been achieved.

[11] How to test the 'real' willingness of the community?

THE PROCESS OF PLANNING THE PROGRAM:

The process of giving 'the structure' to the envisaged Tribal Malaria Control program, along with two other health problems, began with earnest efforts within SEARCH, starting with a review meeting to discuss the dialogue that happened with tribals & formulate the plan of action.

First, to increase the acceptance of Tribal Health Volunteers (THV) & make the program successful, they were christened as 'Maa Danteshwari Sewak' (MDS)[12], meaning messenger of God Danteshwari, the reigning God of tribals who commanded great respect & belief of tribal people.

The second step was to find the actual situation & reasons behind the high prevalence of malaria in the communities. With retrospective analysis into the experiences of SEARCH in these villages & an informal discussion with MDSs, the following ideas emerged:

- The villages were malaria endemic regions, with seasonal type of transmission of malaria & with the risk for periodic epidemics.
- Even though the important strain of Plasmodium in the region was the dreaded falciparum, there was considerable number of infection due to Plasmodium vivax also, especially in the months of January & February.
- The various reasons for high incidence of malaria in the region were identified as:
    - The predominant occupation of the people was agriculture.
    - People ventured into the forest frequently with little personal protection from vectors.
    - A very conducive climate for high transmission of malaria
    - Poor sanitation in villages with problems of 'open bathroom' & water logging providing the perfect setting for breeding of mosquitoes.
    - The ignorance of tribal people about diseases in general & malaria in specific, reflected in their attitude & behavior towards diseases, such as

[12] Importance of understanding & respecting local customs & traditions

not using bed nets, opposing IRS, seeking health care from 'traditional healers', etc.

- The poor outreach of Government health services.

Then, the committee of TVHP of SEARCH decided that all THV would be given residential, full time training for a week within the campus of SEARCH, to serve as a link between the tribal community & SEARCH & also to work as village health workers to cater to the basic health needs of the tribal community in general & malaria, diarrhea & backache in particular. The two supervisors would supervise the work of THV in the field & help them in their difficulties & doubts. One weekly meeting of the supervisors & technical team of SEARCH would be held every Saturday to review the ongoing program, address any difficulties, & maintain the supply chain. In addition, it was decided that refresher training would be held for THV every 6 months. The stock taking was to be at the end of the year & with consultation of the tribal community at the time of 3rd Health Assembly.

THE 'PROGRAM' PROPER:

The final touches for Tribal Malaria Control Program were given after a discussion within SEARCH considering all the above-mentioned points. It was thought that the program must be undertaken in a phased manner[13], as the 'capacity building'[14] within the tribals would be a slow process. The final draft for the initial proposed program was as follows:

AIM: To reduce the incidence of malaria within the intervention villages, by using participatory community approach, to a level, where malaria ceases to be a priority public health problem.

OBJECTIVES:

[13] Importance of Phasing a program
[14] The process of Capacity Building

- To provide prompt & timely curative services to the affected people in the intervention villages

INTERVENTIONS:

- Training of THV to deal with 'presumed' malaria cases & supervision of their work by SEARCH
- Spreading health education within the community with the help of THV, to suspect malaria & seek timely medical care
- Referral health services through the hospital
- Setting up of village clinics during epidemics
- Ambulance facilities to shift serious & complicated cases, to the hospital

MIDTERM EVALUATION GOAL:

- The feedback from the community at the end of one year of the program, about what is their perception about the mortality & morbidity within their community due to malaria as compared to previous years, was the proposed tool for the midterm evaluation of the program.

DUTIES OF THV (UNDER TMCP):

- To serve as a link between Tribal community & SEARCH
- Diagnosis & treatment of self-presenting & actively detected fever cases
    - Make the diagnosis, take & forward to SEARCH, through supervisors, the thick blood smear of the patient & give treatment (excepting pregnant woman whom they were advised to refer to a hospital directly)
    - Check the response to treatment
    - Refer to a hospital (any hospital including SEARCH), if response to treatment is not satisfactory or the patient is very sick, with a referral slip
    - Make inventory of stock of drugs, & reorder as appropriate

        - Collect the reports of BSE & give radical treatment to patients with positive BSE
        - Record & report activities to supervisor
    - To spread basic health education of malaria within their communities

DUTIES OF SUPERVISORS (UNDER TMCP):

- On-field supervision of the work of THV i.e. To acknowledge, react & guide the THV
- A link between THV & SEARCH for exchange of slides & reports
- Replenish stock at community level, make inventory of own stock & reorder as appropriate
- Periodic on-field retraining of THV
- Consolidation of the work at community level & reporting the same to SEARCH every week
- Observation of current trends of malaria within the tribal community & reporting the same to SEARCH

COMMITMENT OF 'SEARCH' (UNDER TMCP):

- Training of the THV
- Supervise the work of THV in community through the supervisors & weekly meetings
- Technical assistance in the form of
    - Development of the practical rules for diagnosis, treatment, referral, & promote their use by one & all involved in the program
    - Laboratory support to TMCP
    - Refresher training of the THV incorporating the following:
        - Revision of their knowledge & skills & fine tuning them
        - Reporting to them their mistakes, & discussing the possible solutions
        - Addressing their problems
        - Up gradation of their knowledge & skills
        - Restoring & improving their motivation

  - Evaluation of the work of THVs & grading the same with the help of supervisors
- Regular supply of materials required for the optimum working of THV in the community
  - Supply of medicines
  - Supply of slides, lancets, cotton, spirit & such other materials necessary to collect blood smear
  - Supply of reference materials for dealing with the community like mass health education booklets, information sheet on drug dosages, criteria for referral, etc.
  - Supply of stationery to maintain the records
- Ambulance services to shift serious cases to the hospital
- Hospital services to those in need, at a nominal cost
- Surveillance of the whole program & take appropriate actions when deemed necessary

In the true spirits of any community health programs, TMCP was decided to be a flexible & continuously modifiable program in terms of focus, priority, content, actions, & any such deemed necessary, by the community & SEARCH.

THE PROCESS:

WORKS WITHIN 'SEARCH':

TVHP committee in SEARCH met & discussed on the finer aspects of the program. The list of venue, duration, methods, content, & trainers to be used in the training program was finalized. The 'practical rules' for various activities of THV under TMCP were also drawn, as follows:

Rules for presumptive diagnosis of malaria:

- Fever with chills &/or rigors
- Alternate day fever

Therapeutic guidelines:

- Any case of fever (excepting cases specified under referral guidelines), self presenting or actively detected, should be started with presumptive treatment of malaria with Tab.Chloroquine, after the blood smear is taken, outlined as follows:

Age of the patient	1ST DAY (Dose of chloroquine in mg)	2ND DAY (Dose of chloroquine in mg)	3RD DAY (Dose of chloroquine in mg)
>12 Years	1200	600	600
6-12 Years	600	600	300
3-6 Years	150	75	75
1-3 Years	75	75	37.5
0-1 Years	37.5	37.5	18.75

- If the BSE of the slide turns out to be positive to malaria parasite, the patient should be given radical treatment with Tab.Primaquine 30mg/day for 5 days.

Guidelines for referral:

THVs were trained to refer cases with following characteristics to a nearby hospital at the earliest:

- All cases started with the presumptive treatment of malaria & fever not subsiding within 3 days of starting the treatment
- All febrile illness in children with one or more of the following symptoms:
    - Altered consciousness, lethargy or coma
    - Convulsions
    - Not able to drink
    - Persistent vomiting
    - Severe pallor/anemia

- Breathing difficulties
- Yellow eyes
- Speech ataxia

➢ All febrile illness in adults with any of the above characteristics &/or dark &/or limited production of urine

➢ All pregnant women with signs & symptoms consistent with malaria

THV were supplied with referral slips & were informed to use the ambulance facility provided by SEARCH.

Operational guidelines:

➢ Each supervisor was allocated 7 villages each & were supposed to visit at least one village each day & hence visit their whole area once every week.

➢ All slides collected in a week by all THV are to be collected by the supervisors & deposit of the same in SEARCH on Saturday, the weekly meting day. They also had to collect all reports of the previous week on Saturday & distribute it to all THV by Monday, so that the maximum lag period for a THV to get BSE report was not more than a week.

➢ The supply of drugs & other materials & the record of the same was the responsibility of supervisors

➢ Weekly meetings to be held every Saturday in SEARCH, between supervisors & other members of TVHP to discuss, evaluate & find appropriates solutions to on-field problems if any

With all these preparations, SEARCH was now ready to train the THV & carry its TMCP forward.

TRAINING OF THV:

The first step of the program was to train the THV to carry out their envisaged functions effectively. SEARCH realized the potential & importance of 'an army of motivated, trained, organized, & supervised THV' to realize the goal of true community empowerment, it had set forth to achieve. Hence the training proposed by SEARCH

included along with the impartation of knowledge & skill, the development of 'right attitude'[15].

The training was planned to be a full time affair, within the campus of SEARCH for 7 days initially. The trainers were the members of TVHP committee, who had good experience in the same. The training objective was to prepare & orient THV, to carry out their envisaged functions (mentioned earlier) effectively. SEARCH consciously avoided the 'traditional didactic method' of teaching & adopted a much more interactive & mutually beneficial 'popular (problem-posing)' method of training[16]. The various methods used included role-plays, slide shows, simulation games, demonstration, group discussions, and case studies. Also the skill of preparation of a thick blood smear of a patient suspected as a malaria case, was imparted with much delicacy & patience. The THVs were also informed of the test at the end of the training period & warned that, any THV failing the test will not be given the title of MDS, until he/she retakes the test & passes it. It was also seen that the THVs were not overburdened with the amount of learning, by restricting the 'classes' to a maximum of one hour at a stretch with interspersed sports & games to freshen them up. The training was very participatory & demonstrative in nature & THV were made to 'see' what they learn.

At the end of the training period, an evaluation of the THV was carried out through a questionnaire designed to test their newfound knowledge & skill. To the astonishment of SEARCH, all THV passed the test with flying colours! The army was now ready to undertake the mission of Tribal Village Health Program.

THE WORK IN THE COMMUNITY:

With all the preparations outlined earlier, the TMCP was ready to be implemented in the 14 villages. The army of young, enthusiastic, trained & prepared THV were let loose in the field to realize the things they learnt in SEARCH, under the Supervisors. Even

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[15] The 'unique' training
[16] Didactic VS Popular method of teaching

though there were many initial glitches in the implementation process, THVs carried on their duties with vigor & were able to overcome most of the glitches through their newly acquired knowledge, skills & above all, the 'leadership qualities' [17]imbibed in them by SEARCH. They were constantly helped by the supervisors in the field & also encouraged by SEARCH to formulate their own 'solutions' to overcome the on-field problems. Spurred by the enthusiasm & dedication of THV & constant support by SEARCH, the TMCP along with other components of TVHP became a great success. The health status of the people of 14 villages saw a dramatic improvement & mortality & morbidity due to malaria fell sharply (as perceived by the community) within 6 months of the start of the program. The communities thrived on a new found 'empowerment'[18].

THE 'ME-TOO' SYNDROME:

The TVHP had such a visible success that, just after 6 months of its inception, another 22 tribal villages which had not joined the program initially in spite of the invitation by SEARCH, now realized their mistake & came forward to join the TVHP with all the prerequisites met! This happened as a spontaneous process following the on-field implementation of TVHP, without any goading from SEARCH!

This came as a welcome surprise to SEARCH & it decided to accept the request of the latecomers. At the same time, SEARCH thought that if this was let to continue there would be the problem of other villages willing to join the program at sporadic intervals posing an 'operational difficulty', & hence decided to restrict its activities to these 36 villages only.

Having decided thus, SEARCH took to training the THV & implementation of its TVHP in 22 latecomers. Thus by the end of 6 months of initiating the TVHP, 36 villages had joined the movement & TVHP became active in all these 36 villages.

[17] The field difficulties & the solutions
[18] The 'Human Flourishing'

THE 'KAP' STUDY & FINE TUNING OF THE PROGRAM:

Once the fieldwork by THV started moving smoothly & the problem of treatment of acute malaria has been addressed, SEARCH started to think of incorporating the much important & long time solution, 'preventive practices' into TMCP & make it a comprehensive program. As a part of initiating the same, it started a KAP (Knowledge, Attitude & Practice) study of the people of 36 villages towards malaria, to select & implement the appropriate preventive practices. The study was done using THVs & its outcome was as follows:

- People's knowledge of malaria was unacceptably low
- People resisted IRS[19] from governmental workers because of the following reasons:
    - Didn't know the use of spraying
    - Thought that it was an attack on their privacy
    - Complained of bad after effects of spraying like bad after smell, white spots on the wall, etc
    - Thought that it would destroy the quality of stored food grains
    - As it was against their tradition to let anyone meddle with their 'place of worship'
- People didn't know about bed nets & used to sleep in open places
- People used to spend most of the times in forest & paddy fields, both of which were swarming with mosquitoes, with little or no personal protection from mosquito bite
- The general sanitation of villages was poor & offered a fertile ground for breeding of mosquitoes

Once the study identified the problem areas, it was the time to formulate solutions. The TVHP committee sat with THV to take stock & identify solutions. The committee elaborated on the findings & presented to THVs the possible solutions that were in use

[19] Importance of assessment of KAP of a community & address them before undertaking any interventions

worldwide. THVs were encouraged to go through the suggestions & to pick & suggest their own solutions appropriate to their community. The solutions emerged were simple, albeit very effective ones.

Solutions 'proper':

- To spread health education among the community regarding the mode of transmission of malaria & to emphasize on them the importance of IRS, personal protection against mosquito bites by using bed nets & to maintain a clean village to control malaria.
- Encouraging & motivating the communities to take a collective action in the form of novel 'Shramadhan' to improve the sanitation of village.

Interventions & their methods:

- Health education both at community group level & individual level, to emphasize the mode of transmission of malaria, the importance of IRS, use of bed nets & to maintain a clean village to control malaria. The various methods of health education used were as follows:
    - At the community level:
        - Slide shows depicting mosquitoes, their life cycle, breeding grounds, etc
        - Role plays to emphasize the disease, importance of seeking care, personal & community protection against malaria
        - Demonstrations of breeding ground for mosquitoes in their own village, the beneficial effect of IRS, etc.
        - Posters spreading more health education on malaria
    - At the individual level
        - House to house visit by THV spreading awareness about malaria & various methods of controlling the disease
- The novel concept of 'Shramadhan'[20] was initiated in five villages as a pilot program to test the strength of 'united community action' to its own

[20] The strength of united community action & the importance of its use

development. It was used as a tool to improve the sanitation of the village by 'voluntary contribution' of work by each member of the community, to reduce the mosquito breeding sites by filling in the water holes & pools in the village with mud & stones & also to provide a good system of sanitation by proper channeling of sewage & construction of soak pits.

Outputs:

- Demand on the ITN started pouring in
- Spraying was accepted within the community & there was even 'demand' from the community for IRS
- 'Shramadhan' became hugely successful & the concept caught up soon with the well-organized tribal community & many communities took the initiative themselves & started duplicating the novel process, without waiting for the SEARCH to suggest them[21]

More problems!:

- SEARCH never wanted dependence & always a participatory approach from the community. Now, there was the problem of how to meet the demand of ITN, with the above two principles intact?
- Even though IRS was getting accepted from the community, there were many inherent problems related to it like,
  - The sprayers came in when the community was out in the fields to work
  - Many houses were missed due to various other reasons

More solutions! :

- SEARCH with community's participation was able to make arrangements for the sale of ITN at a reasonable price of Rs.30 & more than 1500 families brought it! In addition, THVs were trained to treat the nets at the village itself, thus fostering real empowerment of the community!

[21] This is community empowerment!

- SEARCH wrote to the concerned department of the Government relating to the problem faced by the community during IRS & made arrangements to see that the village would be informed some days before the proposed spraying activity. Now that the community knew in advance, the date of spraying, they started taking 'polo' (the weekly off-day of tribals) on that day, so that all houses in the community would have IRS under the strict supervision of THV[22]!

Now that community had bed nets, SEARCH wanted to know the actual use of the same by the community. It was surprised that very few homes with ITNs were actually using it! On enquiring, it found that though the community had brought ITNs, they did not know how to use it! The onus again fell on SEARCH to teach them to use ITNs[23].

MOVING FORWARD:

With so many activities going on in the field, it was the time to 3rd Health Assembly once again. The activities undertaken by the SEARCH were endorsed in the assembly & further demands, both by SEARCH & Tribal community, were put forward, & discussed in the assembly. Some of the important problems addressed in the assembly are as follows:

- SEARCH felt that it was time to have more 'supervisors' & it had chosen five THVs with excellent grading to be elevated to the post of 'Sanghi'[24], which was accepted & highly endorsed by the tribal community. Since Sanghi was to be a regular worker & envisaged by the SEARCH, SEARCH offered to pay remuneration to the cadre. The various activities of Sanghi included:
    - Helping THVs in their difficulties
    - To overcome language barrier between tribals & SEARCH
    - To build rapport & collect information on health issues from tribals in a systematic manner
    - To spread health education among tribals in a more regular way, compared to THV

[22] The importance of community participation!
[23] The simple thing of understanding the community & the process of decentralization
[24] The new human order

- To act as links between THV & field supervisors of SEARCH
- To help field supervisors of SEARCH to organize refresher & other such trainings deemed necessary for tribals.

➢ A great surprise was in offering to SEARCH! The 'traditional healers', whom the 'civilized world' despises & deprecates but the tribal community respects, & who always looked at modern practice of medicine with the sense of a cynic, came forward voluntarily[25] to learn the 'modern approach' to tackle malaria! SEARCH was too glad to let such an opportunity go unheard. It immediately agreed on the proposal & arranged the training to the group & gave the group all the rights & responsibilities enjoyed by THV. Thus, a newfound partnership was established in the community.

➢ Many other important decisions other than those concerning malaria were taken & the partnership was on its path of further growth.

Following the assembly, the program was carried on with renewed vigor.

MIDTERM EALUATION:

Now that TVHP had firm roots entrenched in the community, SEARCH thought that the time was ripe to give the program a more scientific & epidemiological touch to maximize the effectiveness & efficiency of the program. To do the same it needed to answer two questions namely:

➢ What is the true magnitude of the problem of malaria in the community?

➢ What is the impact of the TMCP on the prevalence & incidence of malaria in the intervention villages?

To answer the same, SEARCH decided to conduct a cross-sectional study for estimating the point prevalence of malaria fever in the villages in which TMCP was in progress compared to adjacent villages without the benefit of TMCP. The study was designed within SEARCH & using Sanghis, the survey was conducted in two malaria endemic seasons namely August-2002 & Febrauary-2003.

[25] Respecting the community & winning the adversaries

The findings of the study were very encouraging. Few important facts that emerged from the study are as follows:

- The point parasite incidence rate of Plasmodium was 0.2 in intervention villages compared to 0.6 in control villages
- Number of children suffering with malaria in intervention villages were 05 compared to 13 from control villages
- 56.2% of people in intervention villages had ITN compared to just 17.8 in control villages

The study was a reassurance to SEARCH that all was going well within the TMCP, & SEARCH continued forward with the program without further changes, until that fateful year of 2003!

THE FIRST BIG JOLT TO 'TMCP':

2003 was a year the TMCP committee of SEARCH is not going to forget in a hurry! The year did not start auspiciously as tribals were mired in draught due to failure of monsoons in late 2002. However, as the year progressed & monsoons arrived, the region experienced more than its normal share of rainfall. With it came the big epidemic[26] of malaria in the late months 2003, which nobody had anticipated. Scores of tribal people were taken ill & even few deaths occurred due to the epidemic. It was not new to find the Government apparatus caught off guard. However, it was a new experience for SEARCH to visualize itself in such a situation.

Shocked as it was, SEARCH responded to the situation with all the urgency & vigor the situation demanded. It threw open its gates to all the patients suspected of malaria & the 20-bedded hospital was filled with more than 350 patients, admitted on the same day. SEARCH mobilized all its resources & attended to all the patients with utmost care. At the same time, the press spurred by the apathy & negligence showed by the

[26] The importance of surveillance

Government apparatus in responding to the situation; highlighted the work of SEARCH & took the Government to task. This coerced the Government to wake up & take appropriate action. The main objective of epidemic control of both SEARCH & Government were:

- Provide relief to the affected population
- Contain transmission, if possible in affected areas
- Improve emergency preparedness in order to prevent future epidemics

SEARCH carried out many interventions to control the epidemic namely:

- To provide early diagnosis & prompt treatment to suspected cases of malaria
- It also arranged treatment camps to badly affected villages
- It saw that the supply of drugs was prompt & uninterrupted to THV
- It forced the Government machinery to take up IRS on a war footing
- It also supplied biotech & other chemicals to control mosquito population

Thus, the epidemic of malaria was controlled with great difficulty & minimum casualty. It was the right time for SEARCH to do the introspection & take corrective measures.

<u>TIME TO 'PAUSE', REFLECT & CONTINUE:</u>

The team in SEARCH was both embarrassed & feeling guilty about the calamity of malaria epidemic of 2003. However, it faced the situation boldly & was prepared to learn from the mistake[27]. It called an emergency meeting of all the members involved in TMCP & started the retrospective analysis into what went wrong in TMCP. Some of the questions posed were:

- What was the cause for the epidemic?
- What deficiencies prevented the prediction of epidemic?
- What problems, if any, affected the early detection, confirmation of the epidemic & timely response?

[27] Facing adversity boldly, admitting mistakes & learning from mistakes

- What rule should be followed in future to avoid such mistakes?

Answers were not forthcoming easily. However, the answers emerged in the end to all these questions were:

- There was no IRS within the village communities even once during 2003
- There was no supply of deltamethrin from the government which hampered the dipping of ITN in the villages
- Drought in 2003 followed by heavy rainfall for longer duration in 2004 had resulted in enormous increase in mosquito population
- Complacency among the community about malaria control
- Delay in treatment of early cases
- By some sheer coincidence, it was vacation time in SEARCH when the epidemic showed its ugly face

With these reasons, emerged the valuable lessons for SEARCH & it further fine-tuned the TMCP through the lessons learnt:

- It decided to have an early warning system in place
- It decided to use the situation as a reinforcement of the value of preventive measures in the community
- It also learnt that proactive measures need to be followed if the Government doesn't fulfill its duties
- Complacency is a great scrooge for any program was learnt in a hard way & SEARCH decided to be on eternal vigilance hence forth

With these decisions, SEARCH carried on its TMCP forward & used the next i.e. 4th Health Assembly to further the program & used the same to reinforce the community of the importance of Shrmadhan, ITN & IRS use & introduced larvicidal Guppy fishes in the villages for the control of further breeding of mosquitoes. One more round of health education of the community on malaria was carried on with much gusto. In addition, SEARCH started to analyze the data collected by the THVs every month.

CONCLUSION & SOME POSERS:

TMCP comes as a well-conceived community health program to address the felt need of the community i.e. to control malaria. The process has incorporated all the pre-requisites of a 'good' health program & stands as an example for a 'model community health program'. Despite the setback in the form of an epidemic in 2003, TMCP has been able to largely address the problems posed by malaria in the tribal community. There is a definite improvement in the knowledge, attitude, & practice of tribals regarding malaria & its control in the community. There also seems to be a great decrease in malaria mortality & morbidity in the community, even though the same cannot be specified in quantitative terms, as there is absence of the baseline data.

In addition, in the process TMCP along with the other components of TVHP have been able to give an unexpected gain to SEARCH's vision of 'community empowerment'. They have slowly but surely evolved from being the vehicles of improving health to that of overall community development. It is this aspect of the program that makes them the 'true representatives' of a model community health program.

Now, with an epidemic behind them, there is a disturbing trend of THVs demanding remuneration for their service from SEARCH, the claim of which is being supported by the community. This surely poses the most vital question of what is really meant by 'Community Empowerment'? Is any such process, really possible? If 'yes', what is the 'right path' to do it? TMCP is now in its critical stage to find the answers to these questions & move forward.

PART TWO: 'TMCP' AS A MODEL 'COMMUNITY HEALTH PROGRAM':

Why did the TMCP develop the way it is? To answer this, an attempt has been made to step back & identify a list of issues which addresses both the factors that have contributed to the success of TMCP in addressing the No.1 health problem of the tribals & the factors that have limited the TMCP in attaining its full potential.

SEARCH has consciously tried to make TMCP a 'true' community health program from times even before its inception. The various factors that classify TMCP as a 'Model' community health program are:

A STRONG & ENLIGHTENED LEADERSHIP:

Dr.Abhay Bang & Dr.Rani Bang started SEARCH in 1976. They had understood that, the usual way of medical care, mainly curative & western medical model, was not improving the health of the individuals or communities & instead was creating a system of dependency on 'the modern medical model', which was inadequate & ill-equipped to address the real cause of ill-health in the communities. One of the missions of SEARCH in addition to 'action oriented community research in health' was to enable & empower people & communities to take health into their own hands.

With such high ideals in mind & equipped with knowledge & motivation to serve people, the gateway of Dr.Bangs into the community was as physicians. They understood this very well & started their work in community as such. However, they always had their 'goal' in mind & used every opportunity that came their way to build inroads into the community & build a strong relationship with them. In addition, they took the opportunity to understand the community well. During the same period they were building the 'core team' of SEARCH-of dedicated, motivated & knowledgeable members- on the strength of which the future of their 'project' depended upon. The next process was to move into their own campus nearer to the

community they envisaged to serve. Then they started the process of long cherished TVHP.

The above processes amply demonstrate the deep understanding the leaders had in their mind about their work. It also goes to show the systematic & rational way adapted by the leaders to address the problems. In addition, the way in which the doctors learnt the lesson through their 'Sickle Cell Anemia Study In Tribals of Gadchiroli' demonstrates their learning aptitude & humbleness to accept failures. Their unyielding stand in addressing the 'Alcohol' problem in Gadchiroli & their successful movement to ban alcohol sale & consumption in the district, against the 'vested' interest of very influential people, speaks volumes about their determination, organizational capacity, & tenacity to stand in adversity behind the values they believe in & cherish.

With such able leadership at the helm & ably backed by a well prepared team it is no surprise that SEARCH has become one of the premiere 'Community Health Organization' in the country.

A STRONG PARTNERSHIP WITH THE COMMUNITY EVEN BEFORE THE CONCEPTUALIZATION OF 'TMCP':

It is constantly seen that a program is first envisaged in private minds, imposed on the community & then the process of building 'partnership' is undertaken, which has spelt doom for many good initiatives. However, the case with TMCP was a different story. SEARCH consciously had stalled the installation of Tribal Health Programs for a long period (more than a decade!), the time, which it used judiciously, & carefully to establish a meaningful & mutually beneficial, strong 'Partnership' with the tribals in the area.

The process of building partnership, which by no means is an easy work, was initiated as early as in 1986, when SEARCH started its work in Gadchiroli. It

rightfully approached tribal community through its leaders, as it did not have any direct contacts with the tribals. It showed its genuine willingness to help tribals in their development through some small & some not so small, but each one a significant, initiative. To name a few of them:

- Organizing OPD services at a place easily accessible & at a price acceptable to the tribals & also to organize village camps at the time of epidemics, which is no small work, had earned the respect & trust of tribals
- Establishing a 'Tribal friendly Hospital': How many of us, the doctors, can imagine a hospital which looks like a 'hut', has a temple for the 'God' of attending patients, a receptionist not so like a 'model' & speaking a tribal dialect, wards that look like the local people's home & not only accommodating the patient but also the relatives, & ever obliging 'staff' who respect the patients for the 'human beings' they are? Also how many hospitals are built in consultation with, apart from the architect, the people for whom it is constructed to? Well here in SEARCH, the people at the helm had understood the real meaning of 'community participation' & built a hospital acceptable to the people who it was meant to serve. The involvement of the community & respect for its sentiments right from the design of the hospital to the consecration of the Temple showed the deep sense of respect & commitment, SEARCH had towards tribal development. This one act went a long way in fostering the already established bond between SEARCH & Tribal community.

It was only because of such a 'strong bond' that was in place, SEARCH was able to undertake all its future programs on Health Promotion of tribal community with full participation & co-operation from the community.

<u>'COMMUNITY INVOLVEMENT' AT EACH STEP OF THE PROGRAM:</u>

Even though the importance of 'Community Involvement' is accepted as a prerequisite in the success of any such program, most of the time, it is paid only lip service by the program managers. Many a time the concept of community

involvement is given a shortcut by most of them as both the concept & the process is not exactly known to them or they think it is a 'time wasting tactic'. As a result, most often than not, the programs end on a disastrous note, as is evident in most of the National Health Programs of our country. Sometimes it is also seen that community involvement is sought at only certain stages of the program, thinking that the community by itself is either ignorant or incapable of knowing its own problems!

However, SEARCH rightfully involved the community right from the conceptualization of the program through the implementation process & even in the evaluation of the program! The unique way by which SEARCH was able to involve the much shy & introvert tribal community through ingenious ideas of Tribal Jatra & forming their own Health Assembly is another example of pains taken by SEARCH to involve the tribal community. This process also did not mean just involving the community in decision-making process, but also utilizing citizens to generate their own ideas & trusting that the community knows what it needs & has the ability to achieve it! This one process of 'complete community involvement' looks to me the 'crux' for the success of TMCP.

(Also, it should be noted that SEARCH did not merely seek community 'participation' but 'involved' the community in the process of its own empowerment. This needs to be given some consideration as most of the times 'participation' is passive & hence, I think the words used in most textbooks need to be relooked.)

IMPORTANCE OF UNDERSTANDING & RESPECTING THE COMMUNITY:

Another important feature of TMCP is the deep understanding & respect shown by SEARCH towards tribal community. They are evident in each step SEARCH took towards realization of TMCP. Be it constructing a temple in the hospital or organizing a Jatra to assemble people in one place or naming THVs as 'Maa

Danteshwari Sevak' to increase their acceptance or taking advantage of the custom of Community Meetings to shape community opinions or training the traditional healers to be a part of program or pacing of the program or the methods adapted in training the THV, SEARCH demonstrates its deep understanding & respect of the community. By doing so, it enhanced its own position in the community & was also able to steer the program in the right direction.

CLEAR VISION OF 'ONESELF' & THE 'PROCESS':

SEARCH also demonstrates the importance of knowing one's strengths & limitations & also the clarity of prioritizing the problems it can solve & the process one has to adapt. This is evident by the fact that even though there are 100 such tribal villages in the vicinity & some of them are keen to become the part of TVHP, SEARCH is still skeptical of the possibility. For, it thinks it is unrealistic for SEARCH with the limited staff to do justice to all of them. Also the fact that TMCP didn't start with all its components in one go, but evolved over a period of time, in consonant with the 'capacity building' of THV shows the clarity of vision of the process by the team in SEARCH.

ADEQUATE & APPROPRIATE SUPPORT OF 'THV' BY 'SEARCH':

TECHINAL:

Adequate & appropriate training, retraining & constant supervision of THV in the field is probably the most vital factor for the success of TMCP. The methods & content of the training, which aimed at producing not only knowledgeable & skilled workers but also workers with the right attitude, should be emulated in all such programs. In addition, the importance of constant field supervision cannot be stressed further & the foresight of SEARCH in developing Supervisors among THVs themselves, may serve as a part of further 'community empowerment', also in making the program sustainable & widely replicable in adjacent tribal areas!

INFRASTRUCURAL:

The constant supply of drugs & materials required for blood smear collection, from SEARCH & regular feedback in the form of reports on BSE is a part of the success story. It not only kept THV ready to face patients in community at any time of the day but also helped to increase their motivation in work & trust in SEARCH. In addition, the referral support provided by SEARCH through its hospital & ambulance service went a long way in strengthening the ground work of THV & make TMCP a success.

COMMUNITY CAPACITY BUILDING:

Empowerment of the community is essential if malaria control is to be effective. SEARCH brings us back to the basics of the community organizing, to a process where communities are challenged, respected, & transformed. From the very beginning until now, there has been a continual exchange of learning & understanding occurring between TMCP members & community members, with a focus on addressing the root cause of the disease. The staff of TMCP had to adapt to the real needs of the community, to listen, to provide technical assistance when needed, & help people to create their own change from the ground up! From a stage where most of the community members didn't know what malaria is & never cared to seek health care inspite of severe illness, to a stage where community members demand for IRS, queue up to do Shramadhan, use their ITN appropriately, & rush to seek advise from a THV at the slightest hint of fever is no 'ordinary change'. This is the essence of TMCP!

THE 'UNIQUE' STRUCTURE' OF THE PROGRAM:

TMCP is a unique program incorporating all the needs for its success, as mentioned below:

- It was built to serve the felt needs of a community with full involvement of the community
- The program had a flexible approach right from the inception in the sense that even though there were 'fixed' objectives to be achieved & interventions to be followed, there was scope for the change of priorities, focus & process in the program which is very essential in a community health program
- The program was designed appropriately keeping in mind of the local needs, KAP & local capacity i.e. there was the true 'decentralization' process
- The program was taken up in a 'phased' manner in tune with the capacity building process
- There was always the constant vigil on any new intervention planned regarding its practical implementation & its usefulness in the community. For instance, when ITNs were promoted in the community, SEARCH did not stop at just distribution of the same in community, as is the process in Government programs. It went on to gauge the benefit of the same & then realized even though ITNs were available in the houses the community members did not know how to use it! It then embarked on the process of raising the awareness of the community in using the same.
- Even though SEARCH's experience with the Public sector was bitter, it involved in a meaningful partnership with the same when the need arose in TMCP.

It is this structure of the program, which was one of the key factors for the success of TMCP.

FACING ADVERSITIES BOLDLY, ADMITTING MISTAKES & LEARNING FROM MISTAKES:

When there was an outbreak of epidemic of malaria in 2003, SEARCH did not indulge in the blaming game & escape from its own responsibility in the shortcoming, even though it had valid reasons (as it was the responsibility of the Government to carry IRS, the absence of which was the main cause for the epidemic)

to do so! Instead, it focused on how best it can deal with the unexpected situation & tide over the crisis. Following the crisis management, it undertook a retrospective analysis into its program & tried to correct its mistake of not having an early warning system in place by resolving to develop one in near future! This character of facing adversities boldly, admitting mistakes, & learning from mistakes i.e. to have accountability of oneself to the program is a very rare commodity, but essential for any successful venture!

<u>'SHORT COMINGS' IN 'TMCP':</u>

For all its spectacular success of TMCP as a model of community health program, the epidemic of malaria in 2003 stands as a testimonial for some of the short comings of the program. The few inadequacies that can be listed are as follows:

- The absence of an early warning system to predict an epidemic outbreak is the glaring deficiency of the program. It is true that it is not possible to have an 'early warning & monitoring system' in its truest form in SEARCH, because of the costs involved & lack of modern technical resources. Nevertheless, it is possible to have a surveillance system in its simple form, which can analyze the routine data collected & can serve as the early warning system. This appears to be the 'component', which needs urgent attention if the 2003 embarrassment is to be avoided in future.
- Even though SEARCH has taken pains to know the 'true' condition on the ground, I feel there is a lack of relevant epidemiological data in its complete form. The epidemiological data is of prime importance in any malaria control program as it dictates the selection of appropriate intervention measures in that community.
- Since it is an accepted fact that high prevalence of malaria is responsible for many adverse effects on pregnancy & its outcome, there is a need to evolve a strategy within TMCP to address this very critical public health problem.

Apart from above inadequacies, I feel that there are a few important facts to be kept in mind while new strategies are incorporated into TMCP in future:

- Since the incumbent parasite in the region is the dreaded Plasmodium falciparum, which is known to develop drug resistance to chloroquine, it is imperative to have routine information on sensitivity of parasites in the region to various anti malarial drugs. This may also pave the path for increased partnership with the public health system.
- Also, because the current strain of falciparun is sensitive to cheap & easily available chloroquine, it becomes important that any future undertakings under TMCP needs to keep it in mind & try to preserve the status quo. Some strategies, which foster the development of drug resistance without offering much benefit to community in exchange, as 'mass drug administration' & such others should be taken up after considering risk-benefit analysis.
- Even though health education is already taken up in a 'big' way, the interim report by Mr.Bejoy P. Nambiar of Tata Institute of Social Sciences, Mumbai indicate that there are still a substantial number of people in the community with little or no knowledge of malaria as a disease per-se. This needs further reflection & calls for a fine-tuning in the strategy adapted for health education in the community.
- The use of radical treatment with Tab.Primaquine in all cases of positive BSE, during all seasons & in the form of fixed 5 days treatment irrespective of the type of strain of plasmodium, & the use of same in infants needs to be relooked.

Inspite of these 'short comings', TMCP stands as a 'model' of 'Community Health Program', for showing to the world that 'capacity building' & 'empowerment' can become reality in the community & given a space to speak& be heard, most people could be their own agents of change.

ANNEXURE No.3. REPORT OF MY WORK IN SEARCH DURING LAST ONE WEEK (14-12-2004 TO 20-12-2004)

(AS SUBMITTED TO DR.ABHAY BANG)

After having submitted my case study of 'Tribal Malaria Control Program' undertaken by 'SEARCH' in 36 tribal villages of Gadchiroli district of Maharastra, I undertook the following tasks as suggested by Dr.Abhay Bang:

1. To find & suggest, if possible, an early warning system to malaria epidemic in the region:

I took an extensive review of available literature both on internet & books on early warning system to malaria epidemics. Even though there were many systems in Africa trying to do the same, the initiatives had met with limited success due to many constraints. Nevertheless, I found the WHO's modification of Cullen's method to detect (not predict!) an epidemic in its most earliest phase is a very practicable thing to do in SEARCH & worth a try. In addition, a three-tier method to have a varying scale of alertness depending on various factors affecting malaria epidemics as followed in Eritrea seems to me a simple & effective method. (I & Meghana would be giving a report on both of these by 24th of this month)

I tried to go through the available data in SEARCH of last five years to find & correlate the data to get a possible picture of local condition of malaria. However, as the data was very incomplete & some of it still not found, I am not successful as of now in the same task. I think it would be a good idea to enter the weekly data SEARCH gets from the field into a computer if SEARCH wants to derive any meaningful use of the same!

2. To suggest an indigenous & cheap method of personal protective measure to prevent mosquito bites:

Although I tried reviewing the above said topic, my search always ended in NEEM, a tree not found in local area. However, as neem tree is suitable to grow in the local conditions, I believe planting innumerable plants of neem in the villages with

community partnership would be useful in the long run. In addition, I intend to continue my search of an indigenous & cheap method of personal protective measure to prevent mosquito bites suited for the local condition here & if I come up with an answer I will be communicating it to You at the earliest.

3. Meeting the district NMCP officer:

I tried meeting the district NMCP officer. But, he was not available all throughout the previous week. The officials in the NMCP were very casual & uncooperative! Nevertheless, I am still trying to meet the district NMCP officer & seek clarifications regarding the routine use of Primaquine, current guidelines of NMCP, resistance pattern of the local malaria parasites & also to try & get data on monthly rainfall of previous years in the region, if any such things exist in the office!

I was also following the deaddiction camp for alcoholics going on in the campus, which I am finding to be very different from such initiatives outside, both in the process & result.

ANNEXURE NO.4. LETTER OF GRATITUDE

To, 20-12-2004,

Dr.Abhay Bang, Shod gram.

Director-SEARCH,

Shod gram,

Gadchiroli(D).

From,

Dr.Vinay.V.,

Fellow of community medicine,

Community Health Cell,

Bangalore.

Respected Sir,

I take this opportunity to gratefully thank You & all the team members of SEARCH for having provided a young medical graduate like me, exploring the option of Community Medicine, with a true learning experience & motivation.

When I started my exploration into the world of Community Medicine in CHC(Community Health Cell) with a special interest in Child Health, my mentor Dr.Thelma Narayan suggested that SEARCH would be the ideal place to start my journey. My ever-inspirational figure Dr.Ravi Narayan endorsed her fully. I found great respect & love when they talked about SEARCH. I now come to understand the reason behind that love & respect in their voice. SEARCH, under the able guidance of You & Dr.Rani Bang, is a living example of real 'community medicine' at work. I, as a medical student, was never exposed to such monumental work & it will be an understatement to say that I am overwhelmed by the multitude of activities going on in SEARCH.

I think it would be futile to try to list all that I have learnt during my short stay in SEARCH, for the list may run into pages & pages. I think it would be suffice to sum up my experiences in three little sentences i.e. **I have seen a real community health**

project at work, have been introduced into the world of dynamics of community medicine & more than all, I have learnt to understand & appreciate the idea of 'true' community empowerment.

I take this opportunity to thank all the team members of SEARCH for the wonderful people they are & for the wonderful work they are doing. They have been great companions & teachers, at the same time. I am going to miss them for a long time to come!

More importantly, I take this opportunity to convey my heart felt gratitude to You, Sir. You had been a great teacher & motivator. I am grateful for the valuable time You gave me & the invaluable lessons You taught me. Your words have become a source of motivation for me. The experiences You have shared with me will always be a guide to me in future. You will remain as one of the 'teacher' I value most in my life. Thank You, Sir.

At the outset, I also hope that SEARCH continues to inspire & teach students like me in future. With the dearth of 'model doctor-teachers' outside, lack of community health orientation of the present medical education & the lure of 'private, specialized practice', community medicine, though much essential & appropriate, is loosing attraction in medical undergraduates. It is only when organizations like SEARCH & its work comes to be widely known in the student community, the revival of community medicine is possible. Hence I request SEARCH never to turn down the sincere requests of any student like me willing to learn invaluable lessons in community medicine. Also, I request Dr.Abhay Bang to continue to guide & motivate young people like us & dedicate some time in his busy schedule for this worthwhile cause!

I also take this opportunity to convey greetings & best wishes from all the team members at CHC. I hope this association lasts long

Thanks once again,

Yours faithfully,

Vinay.V.

TSUNAMI RELIEF WORK- A BRIEF REPORT OF THE FIRST TEAM FROM CHC, BANGALORE

BACKGROUND:

Tsunami, an unknown word till recently has imprinted itself in the psyche of all Indians. When the most powerful earthquake in more than 40 years struck deep under the Indian Ocean off Sumatra in the early morning hours of 26th December, the earth wobbled in its axis & the past of thousands of people across more than ten Asian nations was washed off. The quake measuring 9 on the Richter scale triggered tsunami as high as 10 m traveling with a speed of 800kmph, obliterating coastal villages & seaside resorts. Fishermen, tourists, homes, boats, fishing nets & anything & everything within 0.5-1 km range from the coastal line were swept away by walls of water that rose from the ocean.

When the waves retreated the smell of death hung in the air. More than 1.5 lakh people, mostly fishermen & their families, were dead. Many more people were left with their past wiped off & future bleak & uncertain.

In India the tsunami struck the eastern coast particularly the coastal regions of Tamilnadu & Pondicharry & the Andaman & Nicobar islands leaving more than 12000 people dead & many more thousands homeless.

The suddenness & ferocity with which the tsunami struck was hitherto unknown to Indians. But as the news of the disaster slowly spread across the world & after the grueling & heart-rending scenes reached to every household, the world woke up. Aid in the form of human volunteers & material help started poring in into the affected areas at a rate probably never seen before!

Never to be found sleeping in such situations, CHC, a non-government resource organization working for the promotion of community health, based in Bangalore, was flooded with calls from people & various organizations, requesting for help & offering help, at the same time! For Dr.Thelma Narayan & Dr.Ravi Narayan, the people at the helm of CHC, disaster relief work has become a tradition. True to its tradition, CHC in collaboration with another NGO Action Aid-Chennai organized a

group of 10 volunteers, mostly doctors, to provide relief to the affected people of Tamilnadu. This is the report of this first team of relief workers from CHC.

PLANNING THE RESPONSE:

As soon as the team [9]consisting of 7 doctors, a social worker & a theology teacher was formulated, Dr.Ravi & Dr.Thelma called the team to CHC for a briefing session on 27th Dec 2004. The meeting provided the opportunity for all the team members to get to know each other. Dr.Ravi & Dr.Thelma from their rich experiences of disaster relief work in the past sensitized the enthusiastic but totally clueless group regarding the nature & process of the disaster relief work. Some important points stressed were:

1. The importance of the team to work in a coordinated & complimentary fashion.
2. The priority of the relief work was to give medical care to the people in need. But it was also stressed that, the team's work was not just to treat physically ill but to provide 'help' to the affected population in whatever way deemed necessary by the team.
3. The importance of psychosocial aspect of health was stressed & restoration of 'human dignity & self respect' among the affected population was deemed as a vital component of our work.
4. The need for a roving team to constantly move around in a village to assess the general condition of life of the people & also to have a critical look at the public health aspects was stressed.
5. The importance of data collection regarding the loss of life & property & also to keep record of patients being treated was stressed.
6. Also the team was sensitized about the need to take care of themselves & to have a team meeting every evening after the work to share the experiences & to formulate the plan of action for the next day. We were made to understand that the team meeting would serve to improve the morale of the team as a

[9] Annexure No.1. The list of team members & their details.

whole & also in addressing the problems faced in the field & to arrive at appropriate solutions to solve them.

7. The importance of working in close collaboration with local groups, resource mapping of the region we were working in & to be in constant touch with local government authorities was also stressed. CHC also gave many local contact numbers to facilitate the same.
8. Lastly, it was pointed out that the work the team does should be 'complimentary' to the relief work already going on in the area & the team was warned against unnecessary duplication of work. Also, the team was made to understand that the work initiated by the team is not a touch & go process but the other people coming into our place, as replacements will continue the work. Hence, it was decided that the team along with providing relief to acute problems should also build a base in the community for the next teams coming in to carry on the long-term rehabilitative works.

Also, the CHC team provided all the volunteers with the list of essential things[10] to be carried. Many small manuals regarding disaster response in its earliest phases were also provided to the team to assist them in their preparations. It also asked one of the team members to be in constant touch with CHC, updating the CHC of the works going on in the field & also asked each volunteer to be in constant touch with their families. A small amount of money was also provided to meet the expenses of the team. With the best of wishes from all the team members at CHC, the relief team was ready to move.

ON THE 'MOVE':

In the early morning hours of 30th Dec-2004, the team left to Chennai in a vehicle provided by Action Aid-Bangalore & equipped with medicines & water supply. There was a sense of apprehension in all the team members regarding the nature of their work. Nevertheless, each member was enthusiastic about the prospect of disaster relief work & was really rearing to go to the field. Also the long journey provided the team members with an opportunity to get acquainted with each other

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[10] Annexure.No.2. Check list of essential items.

& to share with the others one of their special skills. Dr.Keerthi Sunder, an instructor of first-aid gave a demonstration of the same. Dr.Sri Krishna & Dr.Krishna Murthy sensitized the team members of the critical factors of public health in disaster management. Mrs.Susan Bennema, who had worked in a similar situation previously, shared her experience regarding the data collection in such situations. Dr.Shilpa helped us to acquire a working knowledge of Tamil.

IN ACTION-AID, CHENNAI:

Mr.Rajendran from CHC who was in the affected area since the disaster struck was waiting for us in the Action Aid office. Immediately a meeting was held in the office & Mr.Ajay of Action Aid Chennai who was co-coordinating the relief work gave us a brief description of the ground situation & the nature of the work expected from our team. He also said that the situation demanded that we work in the Nagapattinam district; one of the worst affected areas & gave us the map of villages to be covered by our team. Some of the important points noted were:

1. He gave us a list of 63 villages along the coast from northern tip towards south of the Nagapattinam, which had been inadequately covered till then. He also provided us with a map of the same. It was also decided that the base camp would be in either Mayiladuthurai or Sirkazhi, two towns situated to the north of Nagapattinam, whichever the team deemed to be convenient.
2. Even though the mortality had been high, the morbidity especially in terms of physical injuries was observed to be low. Also as of then, there was no epidemic reported.
3. The affected population had been shifted to temporary camps housed mainly in schools, dharmashaalas, choultries, etc. The camps were near to urban centers & also at least 4 km away from the coastline. He had observed overcrowding in most camps & said that the sanitation, hygiene & other public health aspects were greatly neglected. Even though the government was giving its best efforts to meet the health care demands of the displaced population, there was a need for more doctors in the region.

4. He also pointed us of the fact that the fishermen community was a close-knit group & each village had a leader who commanded great respect from the villagers. Also, he informed us about a local organization by name 'Sneha', based in Nagapattinam, which had one volunteer in each of the affected camp. He gave us local contact numbers & asked us to work in tandem with them.
5. We were informed that NGOs all across the state were working in tandem & had formed a forum to keep watch on the relief works being carried out in the area. Also a data collection form was handed to us & informed about the importance of baseline data in long term.
6. He specially requested us to look into the following aspects:
    - Check on availability of the medical personnel in camps
    - The issue of overcrowding in the camp
    - To be ready to face public health problems in the form of diarrhea, respiratory problems & warned us of the possible outbreak of malaria.
    - Sanitation & hygiene in camps
    - Status of villages proper

With these words he wished us all to do a good job. Also, the office in Chennai provided us with the financial support & medicine supply.

<u>IN THE 'FIELD':</u>

The team arrived in Sirkazhi, a small town 20 km north of Nagapattinam on 31st Dec-2004. Weary of the long travel in hot & dry climate & with the inevitable disappointment of not being in the field already, team members were feeling low. But once we entered Sirkazhi, things started to happen on a fast pace. Dr.Gautham Mehta, one of the team members contacted the local Jain Community who generously offered their hospitality. They offered lodging, transport facilities & food for the entire team for the next one-week. At the same time few members of our group were able to find the local government CMO & engage him in the discussion. He promised to provide us with paramedical staff the next day & also to take our team to the needy areas.

We had our first team meeting in the evening. It was decided that the team would divide itself into two teams, one as a medical relief team & another roving team. The medical relief team consisting of doctors Krisna Murthy, Gautham, Shilpa, Keerthi, Raghavendra, Vinay & Pradeep would move with the CMO & provide medical care to the needy people. The rest of the team would work as a roving team moving from village to village collecting data & doing needs assessment. It was decided that depending upon the assessment done by the roving team the strategy to be adapted in the coming days would be decided. Also the team engaged in sorting out the medical supplies to be carried the next day. If the morale of the team was low prior to the meeting, all were on a high with a sense of expectation after the meeting. All retired to a well-deserved rest to start afresh for the work in hand the next day.

OUR FIRST-DAY AT WORK:

The medical-relief team:

On the first day of the year 2005, the team in tandem with government officials visited four camps housing displaced population of Palyar, Kottaimedu, Madvaimeedu& Thirumalaivasal villages. They also visited the devastated villages of Palyar & Thirumalaivasal. The observations made by the team are as follows:

- The team was sweetly surprised that the affected people had remarkable resilience! Even though the sea had taken away everything, their will to live & rebuild their life remained intact.
- The camps were overcrowded
- Mostly women & children stay in the camps during mornings & men only during nights
- The food was being supplied either through packages or the community kitchen established by the government in the camps
- Water was mostly supplied in packets. In some places government had made arrangements to supply chlorinated water through tankers
- The sanitation in the camps was poor & people mostly followed open-air defecation. Children used to defecate close to living places & played in the

soiled area. Also, some places housing the camps had lavorataries, which were locked! The waste was littered very close to the camps.

- Most camps had medical relief teams of government doctors & some even had a resident doctor. The medical supplies seemed adequate.
- The relief materials were arriving regularly but the clothes mostly went unused
- People had little or no knowledge of health & diseases
- That the village leaders of the well-organized villages had actually a census data regarding the loss of life & property in their villages!

The actual works carried out are as follows;

- A health camp was organized in most of these camps & the people attending were treated for different ailments. Most important health problems treated were respiratory tract infections, few cases of diarrhea, scabies, anemia & fever. Many cases of fractures were also observed.
- Health education regarding cleanliness, hygiene, sanitation & use of ORS during diarrhea was organized in two camps.
- The locks of the toilets were broken & toilets cleaned with the help of local community people to make them fit for use.
- Children were involved in the cleanliness drive & were given a practical training regarding the personal hygiene.
- Chlorination of the water tank in Palyar village was undertaken with involvement of local municipal authorities.
- Community leaders were sensitized regarding the placing of kitchen far away from the toilets, as it was observed that in Kottaimeedu camp, kitchen was located within 10m of the toilet!

The roving team:

The roving team visited six villages on 1-1-2005 & their observations were as follows:

- There is no need for medical help per-se in most of the villages as the government had taken I t up in a big way.

- Shelter, boats & nets were the biggest problems to be addressed, both on short term & long term basis.
- Food & water was in surplus at that period of time.
- Sanitary measures in the camp were poor & the only form of sanitation followed was in the form of spraying bleaching powder.
- The organization within the community differed from village to village. Some villagers had themselves organized well whereas some villages were in utter chaos. In the organized villages the relief work was going on well with each family getting the relief materials on a regular basis.
- Debris clearance was also thought to be a priority.
- Need for stoves, kerosene, and dry food grains for the next phase of relief was felt important.
- Need to guard against the rumors require some consideration.
- Discussion with the people yielded some insights into the felt needs of the community such as:
    1. Need for a 'wall' along the coast to protect against future fury of the sea
    2. Need an early warning system to be in place to guard their life & property.
    3. Bringing back boats into the inland for repair.
    4. Most of the villagers wanted new houses constructed at least 2 km from the seashore.
- The government had appointed IAS officers as in charge-officers of 6-10 villages & each officer visited the villages at least twice each day to co-ordinate the relief work.
- Also, the District Commissioner held meeting with all NGOs working in the district regularly in the evenings.

A team meeting was organized in the evening to discuss all of the above & following decisions were taken:

- Government of Tamilnadu needs to be appreciated for the good work that is being done in the affected area. At the same time it was thought that with

passing of time, there might be attrition in the response. Hence it was decided to keep a constant vigil over the government work & to involve the affected community in the same.

- Since there was no dearth of medical relief, it was thought that to continue visiting camps would be waste of time & resources. Instead it was decided to identify two villages in need & undertaking of comprehensive relief works in them. By this it was thought that our resources could be used in a meaningful way.
- Also, the work done by roving team came in for a special praise & it was decided to continue having it in place at least for the next three days, with three members working for that.
- Kottaimeedu & Madvaimeedu villages were initially identified for our long term relief work due to the following reasons:
    1. Manageable population size
    2. Proximity to Sirkazhi
    3. 'Perceived need' in the community for such a team to be present there
    4. Presence of local links in the villages in the form of 'Sneha' members
    5. Proximity of the two villages to each other
- The work of our team in these villages was decided to be that of the 'facilitator' role & the same was defined initially as follows:
    1. Community building it terms of organizing them into a powerful well informed group & enhancing their capacity to deal with their problems in an effective way.
    2. It was also decided that a constant presence of our team in a village would help to increase our acceptance in the community & also it would help us in terms of long-term psychosocial rehabilitation.
    3. Dissemination of the information regarding the governmental plans for their rehabilitation.
    4. Giving them health education & building their capacity in terms of taking their health into their own hands.

5. To keep a vigil over the sanitation, hygiene, food & water supply in the community & to take corrective action if any unacceptable practices were found & involving the community in the same.
6. Also it was decided that any help the community wanted from us, if it was feasible, would be provided.
7. Also, it was decided that the doctors in the team would be involved mainly in the provision of medical care & also to keep a watch on issues of public health importance. The non-medical members were to secure the social contacts in the community & facilitate the process of community building.

- If the roving team felt that there is a need for the medical relief team in any of the village they visited, it would be arranged the next day.

Before the beginning of the meeting, most of the doctors in the team felt sweetly disappointed that there is not much of work for them to do in terms of 'biomedical practice' of medicine. But once the meeting was over there was a sense of purpose to their presence in the region & lifted their spirits.

Thus at end of a single day's work the team was able to formulate the plan of action for future. This gave a sense of responsibility & usefulness in the members & also a concrete path to be followed by different members of the team to have maximum gain for themselves & also the community. Thus with the priorities decided, work distributed & goals set, the relief work in the affected area began & continued in right earnest during our future stay in the region. Also, during the visit of the roving team on 2nd Jan-2005 one more village named Keelamorkarai was found to be badly organized & the whole team felt the need for our presence there & hence it was included as the last addition for our long term relief work. The work carried out by our team in the next 6 days is summarized below.

DIALOGUE WITH THE COMMUNITY & THE PROCESS OF COMMUNITY BUILDING:

Mr.Rajendran, Mrs.Susan & Dr.Shilpa with the advantage of knowing Tamil took the lead in community building process. They formed a good relationship with the local Sneha volunteer & also established a firm working relationship with the village leaders. Also village meetings were organized in all the three villages. Leaders, men, women, youth & even local government officials attended the meetings. Meetings provided a platform for the people to come together & express their opinion. They also helped the people to collectively decide the future of their village. But the most important purpose served by the meeting was to bring the whole community together in a place & express their grief in a collective manner. This we think provided a healing touch beyond any imagination.

Most of these meetings that followed the initial meeting helped the people to formulate a collective opinion on their future. Most opinions expressed in the village meetings were similar & are as follows:

1. People wanted to rebuild their village at least 2km inside the coast line & in a place with easy assess to roads, hospitals, schools & market place
2. Shelter, both temporary & permanent, was one of the priorities of the community.
3. Top most priority was given to the issue of livelihood. As most of them had lost boats & fishing nets & they didn't have any resources to buy the same, people expressed their doubts on the means of their immediate livelihood. Also, they expressed their helplessness regarding their limited skills in areas other than fishing & wanted a vocational training in fishing related activities to sustain themselves till they can go fishing in the sea. The problem of livelihood was further aggravated by the fact that it takes at least 6-8 months for them to get boats delivered after the order for the same is placed!
4. Women, who were involved in a village meeting for the first time in one of the villages, requested for the provision of loans to setup business in fishing related field.

5. Women also stressed on the need for basic materials to setup their home like food grains, kerosene, stove, blankets, utensils & such others.
6. People wanted special schemes from the government to compensate & safeguard life of orphans, widows & old people who have lost their family.
7. Community also felt strongly about having an early disaster warning system in place. They also felt that a centralized system without proper communication channel with the fishing community will be of no help.

Thus the community was involved in a fruitful manner by our team led by Mr.Rajendran. We also used the opportunity to establish a firm relationship between the community & ourselves. Also where we found the communities to be disorganized, we tried to impress upon them the importance of organization for their own good. We also made them realize the importance of having their own data records for future reference & while government starts distributing compensation money. Also, in Madvaaimeedu, we were able to form separate women & youth groups & arrange weekly meetings with them. The youth group was urged to take up the job of debris clearing in the village. Women group was introduced to the idea of micro credit system.

Thus by the time we left the region, we were sure that a firm foundation for community building was in place & it was to the coming teams to build on it.

HEALTH RELATED WORKS:

We organized a regular OPD in the villages identified for our long term work. Even though most of the health problems were of regular ailments we understood the importance of having regular medical care to win the confidence of the community. Also, Dr.Ravi had stressed on the need to 'listen' to the people as this one act of giving time to people to speak their heart out would help to heal their psychological wounds! As we made our appearance every day in the village people started coming out with many real medical problems. We were confronted with fractures, reproductive tract infections, anemia & many other health problems. However, we didn't find psychological problems, at least not overt problems, as was expected. Also, we kept a strong vigilance for cases of diarrhea, malaria & such other diseases

that can develop into epidemics in the community. In Keelamorkarai, when we found that cattle were sick & dying of diarrhea very close to the camp, we brought the same to the attention of local authorities. They immediately arranged for the investigation of the same with a veterinary doctor & also arranged for the proper disposal of the bodies. Any medicine in short supply was procured with the help of local authorities & if it was not possible & the team deemed it as an essential need, the same were procured from our own resources.

More important than the OPD, the health work was carried out on field. Each day one of us would go on a field inspection of the camp & used to note down the issues threatening the health of the community. This would then be taken up with the local authorities, communities themselves & the concerned people. Through this we not only kept the government authorities on their toes to maintain a healthy camp, we were also able to improve on some of the prevailing conditions in the camp. Some examples for our works in this area are as follows:

- Changing the source of water supply in Keelamorkarai camp. Even though water was being supplied in tankers from surrounding villages, the water initially supplied was saline. Once we took this to the notice of IAS officer in charge of the village, he promptly asked the local officials to change the source of water to a place where water was potable.
- We brought to the notice of the local authorities of the poor sanitation & bad hygiene of the camp housing more than 100 children in Keelamarkarai. We suggested them to take up the work of cleaning the surroundings, placement of dustbins for the litter to be collected, provision of a community soap to wash the hands of children before the food & provision to be made for construction of trench latrines. We were surprised the next day to find all our requests carried out!
- When the community leaders were made to realize the health risk posed to the community due to the proximity of the community kitchen to the toilets in Kottaimeedu camp, they promptly shifted toilets to far off place.
- Even though the timing of health education was thought to be inappropriate & also its effectiveness in the community was doubted, it was thought that

atleast some basic health education regarding personal hygiene, sanitation & ORS use during diarrhea was deemed necessary. Dr.Sri Krishna & Dr.Krishna Murthy prepared material for the same in English which was translated into tamil by Mr.Rajendran. Later the local people prepared the charts. With the help of these charts an effort was made to give basic health education in the community, especially to the women community & children.

- Health education regarding the precautions to be taken while preparing & distributing food & also the necessity to maintain personal hygiene was imparted to the cooks of community kitchens.

Thus we practiced a sweet mix of clinical & preventive medicine.

During all these works we worked in close collaboration with the government agencies. Whenever needed we offered our services to the local authorities & also demanded their cooperation when we deemed it to be necessary. At the same time a resource book regarding the details of all our contacts, demographic data & such others for the benefit of the teams following us was maintained. The roving team also collected data from 17 affected villages. Team meetings were held with alarming regularity! The daily proceedings were also reported to Dr.Thelma & Dr.Ravi daily & to Mr.Ajay on a regular basis. Also a set of recommendations was formulated to orient the team following us to the region.

It seemed such a short period when it was time for our team to leave the region. Most of us felt, in spite of the pathos around, a sense of satisfaction for having contributed our own small efforts in rebuilding the devastated community. We left the place with a heavy heart.

-A REPORT COMPILED BY DR.VINAY, FELLOW OF 'CHC'.

ANNEXURE NO.1. THE LIST OF TEAM MEMBERS & THEIR DETAILS.

Volunteer's Name	Address and Contact No.	Qualification / Experience	Languages Known	Duration
Mr.s Susan Bennema	SAIACS Po Box 7747, Kothanur Post, BANGALORE – 560 077 Ph.: 9844072628 9341324750 CORbennema@hotmail.com	Medical Psychiatric Social Worker Worked in Latur ; Worked in Action Aid	Tamil, Malyalam and Telugu	4 weeks
Mr. Cornelin Bennema	SAIACS Po Box 7747, Kothanur Post, BANGALORE – 560 077 Ph.: 9844072628 9341324750 CORbennema@hotmail.com	Teaches theology (of Dutch origin, with a PIO card and Indian driving license).	English, Dutch	4 weeks
Dr. Keerthi Sunder G.S.	No. 16, J.C.Nagar, 9th Main, Mahalakshmipuram, BANGALORE – 560 086 Ph.: 080-56909701 Email: keerthigs@indiatimes.com	MBBS Teaches First Aid and Home Nursing at St. John's Ambulance Association	Kannada, English, Understands Tamil.	10 – 14 days

Dr. Gautham Kumar	#2nd, 'B' Street, Ist Cross, Magadi Road, BANGALORE – 560 023 Ph.: 9886434581 / 23352266 ® Email: gouthiya@yahoo.com	MBBS,	Kannada, English and Tamil.	7 – 10 days
Dr. Vinay Viswanatha	S/o Viswanatha C., 'Sriniketan', 23rd Cross, S.I.T. Extension, TUMKUR – 572103 Ph.: 0816 – 2276539 Email: vviny@yahoo.com Ph.: 984423113	MBBS, Community Health Intern at CHC	Kannada, English, Hindi. Can manage Tamil.	2 weeks
Dr. Krishnamurthy	108, 7th Main, 3rd Cross, KCS Extension, RPC Layout, Vijaya Nagar II Stage, BANGALORE –5 60 040 Ph.: 9341236508 Email: dr_krishnamurthy@hotmail.com	MBBS, PG – MD (Community Medicine) 3rd year. Rapid nutrition assessment in Rajasthan (Jan. 2003); Uttaranchal Medical camp (Oct. 2004).	English, Kannada, Hindi, Fairly comfortable in Tamil	2 weeks
Dr. Shilpa Govardhan	60, Shreyus Apartment, Door No. 12, 18th Cross, Malleshwaram, BANGALORE – 560 055 9886107501	Medical Graduate from BMC	Tamil Kannada English Hindi	1 week

	Ph.: 080 – 23442264® shilpagovardhan@yahoo.co.in			
Dr. Srikrishna	944810 7639			

Dr. Pradeep Kumar S.	#28, 3rd Cross, Anjanappa Layout Attiguppe, Vijayanagar, Bangalore – 560 040 Ph.: 984577-976 Email: graynco@yahoo.com	MBBS	Kannada, English and little Tamil	1 Week
Dr.Raghavendra Charan M P	1249, Ist F Main, 2nd Phase, Girinagar, BANGALORE – 560 085 Ph.: 080 – 26721304 Mobie: 9341045679 Email: raghavendracharan@yahoo.com	MBBS	Kannada, English and little Tamil	1 Week

ANNEXURE.NO.2. CHECK LIST OF ESSENTIAL ITEMS.

1. Torch
2. Personal Medicines (Crocin, Amox 500, Septran, Norfloxacin, Anriemetic, Rantac, CPM, Bandaid, Cotton, Electral etc.)
3. Mosquito repellant
4. Chlorine/Halogen tablets
5. ID cards/Medical Council Registration.
6. Driving License/Residence Permit
7. Stethoscope
8. B. P. Apparatus
9. Toiletries – Soap, Comb, Paste, Toothbrush, Shampoo etc.
10. Tissue Papers, Towel
11. Mat, Bed Sheet, Blanket, Pillow etc.
12. Washing soap
13. Water bottles (preferably one with nozzle)
14. Clothes, cap, umbrella
15. Shoes (Preferably)
16. Candles, Lighter/Match Box
17. Books – Park Text Book of Preventive and Social Medicine, First Aid, Disaster Management, WHO Handbook – Emergency Medical Kit

REPORT OF 'A MEET WITH TSUNAMI DISASTER RELIEF DOCTORS FROM BMC' ORGANISED IN BMC

PREFACE:

Disaster struck the world in the form of tsunami on 26th December. When the most powerful earthquake in more than 40 years struck deep under the Indian Ocean off Sumatra in the early morning hours of 26th December, the earth wobbled in its axis & the past of thousands of people across twelve Asian nations was washed off. The quake measuring 9 on the Richter scale (9.3 is the recent estimation!) triggered tsunami as high as 15 m traveling with a speed of 800kmph, obliterating coastal villages & seaside resorts. Fishermen, tourists, homes, boats, fishing nets & anything & everything within 0.5-1 km range from the coastal line were swept away by walls of water that rose from the ocean.

In India the tsunami struck the eastern coast particularly the coastal regions of Tamilnadu & Pondicharry & the Andaman & Nicobar islands leaving more than 12000 people dead & many more thousands homeless.

The suddenness & ferocity with which the tsunami struck was hitherto unknown to Indians. But as the news of the disaster slowly spread across the world & after the grueling & heart-rending scenes reached to every household, the world woke up. Aid in the form of human volunteers including medical, paramedical & non-medical personnel & material help started poring in into the affected areas in a scale probably never seen before!

Bangalore Medical College (BMC), a prestigious medical college situated in Bangalore, is known for its academic excellence & committed staff. When Government of Karnataka requested for a team of health workers to be sent to tsunami affected regions in Tamilnadu, BMC promptly responded to the emergency & sent a team consisting of 4 doctors & 16 nurses. At the same time, a group of young doctors consisting of a Community Medicine postgraduate student, 3 present internees & 7 recently graduated doctors from 1998-99 batch of BMC were sent in as disaster relief teams in two batches from Community Health Cell (CHC), a resource

group in community health in Bangalore. These teams cumulatively worked in the affected regions during the first three weeks after disaster.

Medical Education Unit of BMC thought that it is important to provide a platform for all the team members from BMC, who had been to tsunami relief work, to share their experience. In addition, it was thought that it should be used as a platform to bring out a resolution to be sent to Government of Karnataka as a supplement to their efforts in forming a comprehensive disaster management committee in BMC for preventing & managing post disaster emergency situations. With the support from the BMC Students Association & CHC, the MEU of BMC organized the meeting titled 'A Meet With Tsunami Disaster Relief Doctors From BMC' on 31st January 2005 between 2.30 & 5 pm, at MEU Conference hall in Victoria Hospital.

PARTICIPANTS:

Apart from the team members who had been to Tsunami relief work[11] Dr.T.Rajeshvari, Principal of BMC Presided over the function. Dr.Ravi Narayan, Coordinator, Global secretariat of People's Health Movement was the Chief Guest of the function. In addition, Dr.K.S.Siddaraj, Superintendent of Victoria Hospital, Dr.N.Chandrashekar, Superintendent of Bowring & Lady Curzon Hospital, Dr.Shashidhar Buggi, Superintendent of SDS T.B. & Rajiv Gandhi Institute of Chest Diseases attended the meet as special invitees. Apart from the above dignitaries, many staff members, postgraduate & undergraduate students of BMC were present in the meet. Dr.T.K.Nagabhushana, coordinator of MEU of BMC facilitated the meet.

OBJECTIVES OF THE MEET:

1. Learning more about Tsunami & post-tsunami management in Doctor's perspective
2. Sharing thoughts & experiences about tsunami relief work
3. To bring out a resolution to be sent to Government of Karnataka as a supplement to their efforts in forming a comprehensive committee for preventing & managing post disaster emergency situations.

[11] Annexure No.1. List of all team members from BMC who went to Tsunami relief works

METHODOLOGY:

Presentation, discussion & brain storming session[12] were the methods used to share the experiences of Tsunami relief work & formulation of the resolution to be sent to Government of Karnataka.

THE 'MEET' PROPER:

Dr.T.K.Nagabhushana welcomed the audience & enlightened them about Tsunami & its various facets. Dr.Veeranna Gowda[13], Professor of Medicine, BMC & also the leader of the official team from BMC shared his team's experiences in the field. Dr.Vinay.V. & Dr.Paras, members of the first & second CHC teams respectively, presented their team's work & experiences with the help of power point presentations. These presentations were followed by question & answer session where the audience posed their doubts to the team representatives for clarifications. Dr.Ravi Narayan then gave the over view of the work of various disaster relief teams from CHC, both present & in the past, & highlighted some challenge & opportunities. Dr.K.S.Siddaraj & Dr.Shashidhar Buggi addressed the gathering & gave their valuable opinions regarding their impression of the work done by the teams in the field & also, the work to be undertaken in BMC. Dr.T.Rajeshvari, then inspired the gathering by sharing her observations of the evening & also, by proposing to undertake many positive works in BMC to contribute for the rehabilitation phase of Tsunami disaster. The meet ended with a positive note with the under taking of a resolution to prevail upon the Government of Karnataka to develop a disaster management team in BMC! In addition, it was resolved to place on record the services rendered by all those who went to help the affected communities.

[12] Annexure No.2. Notes from addresses from various dignitaries
[13] Annexure No.3. Experience of the official team from BMC

ISSUES THAT EMERGED FROM THE MEET:

The various issues that emerged due to consultation & reflections of all the participants with invaluable inputs from our Principal & Superintendents are as follows:

1. Dedication of 100 bed ward in the new building (under construction) of SDS T.B. & Rajiv Gandhi Institute of Chest Diseases for emergency care in disaster & disaster-like situations (Dr.Shashidhar Buggi).
2. Introduction in the curriculum of both UG & PG medical & paramedical courses , the topic on 'disaster preparedness & management"(Dr.Veeranna Gowda)
3. In the lines of St.Johns medical college's bold step of considering the service of medical internees in such situations as a part of Community Medicine training during 1971 Bangladesh refugee camp relief management, our Principal promised to look at the same in a positive manner. She even considered of discussing the same with the university authorities.
4. Also, an idea of bringing a booklet of memoirs of various people from BMC, who have volunteered in the disaster relief work, with a collection of experiences & issues faced in the field by them was mooted (Dr.T.K.Nagabhushana).
5. In addition, it was agreed that BMC, being a premiere institute of medical education & health services, will take positive step in setting up a comprehensive disaster management cell under its banner & a decision was taken to inform the same to higher authorities to prevail upon the Government of Karnataka for suitable action.

CONCLUSION:

The meet was a success in fulfilling the objectives set before. In addition, it brought out many spontaneous good will decisions to the forefront. A consolidated unanimous resolution for establishment of a cell with 'be prepared' motto was placed on record.

APPENDIX 1. DETAILS OF VILUNTEERS

1. DETAILS OF VOLUNTEER FOR FIRST TEAM THROUGH COMMUNITY HEALTH CELL (29.12.2004)

Volunteer's Name	Address and Contact No.	Qualification / Experience	Languages Known	Duration of stay
Dr. Keerthi Sundar G.S.	No. 16, J.C.Nagar, 9th Main, Mahalakshmipuram, BANGALORE – 560 086 Ph.: 080-56909701 Email:keerthigs@indiatimes.com	Medical Graduate, teaches First Aid and Home Nursing at St. John's Ambulance Association	Kannada, English, understands Tamil.	10 – 14 days
Dr. Gautham Kumar	#2nd, 'B' Street, Ist Cross, Magadi Road, BANGALORE – 560 023 Ph.: 9886434581 / 23352266 ® Email: gouthiya@yahoo.com	MBBS,	Kannada, English and Tamil.	7 – 10 days
Dr. Vinay Viswanath	S/o Viswanatha C., 'Sriniketan', 23rd Cross, S.I.T. Extension, TUMKUR – 572103 Ph.: 0816 – 2276539 Email: vviny@yahoo.com Ph.: 9844231137 Hengeru 6th Cross,	MBBS, Community Health Intern at CHC	Kannada, English, Hindi. Can manage Tamil.	2 weeks

	Nrupathunga Nagar, Nagarabhavi, BANGALORE Ph.: 080 23212202			

Dr. Krishnamurthy	108, 7th Main, 3rd Cross, KCS Extension, RPC Layout, Vijaya Nagar II Stage, BANGALORE –5 60 040 Ph.: 9341236508 Email: dr_krishnamurthy@hotmail.com	MBBS, PG – MD (Community Medicine) 3rd year. Rapid nutrition assessment in Rajasthan (Jan. 2003); Uttaranchal Medical camp (Oct. 2004).	English, Kannada, Hindi, fairly comfortable in Tamil	2 weeks
Dr. Shilpa Govardhan	60, Shreyus Apartment, Door No. 12, 18th Cross, Malleshwaram, BANGALORE – 560 055 9886107501 Ph.: 080 – 23442264® shilpagovardhan@yahoo.co.in	MBBS	English, Kannada, Hindi, Tamil	1 week

Dr. Pradeep Kumar S.	#28, 3rd Cross, Anjanappa Layout Attiguppe, Vijayanagar, Bangalore – 560 040 Ph.: 984577-976 Email: graynco@yahoo.com	MBBS	Kannada, English and little Tamil	1 week
Dr.Raghavendra Charan MP	1249, Ist F Main, 2nd Phase, Girinagar, BANGALORE – 560 085 Ph.: 080 – 26721304 Mobie: 9341045679 Email: raghavendracharan@yahoo.com	MBBS	Kannada, English and little Tamil	1 week

DETAILS OF VOLUNTEER FOR SECOND TEAM THROUGH COMMUNITY HEALTH CELL (6.1.2005)

Volunteer's Name	Address and Contact No.	Qualification / Experience	Languages Known	Duration of stay
Dr. Prasanth Baliga	C/o Dr.Ramesh Baliga, Rukmini Sadan, Deshpande Nagar, Baliga Cross, Hubli – 580029 Ph.: 0836 – 2252562 9844023205	MBBS	Kannada, Little bit of Tamil, and Hindi	1 week

Dr.Sondev Bansal	#1863, 12th Main, 5th Cross, Raghavendra Block, Srinagar, BANGALORE	MBBS	Kannada, Hindi and English	5 days
Dr.Paras Malhotra	#162 (5/2), 2nd Cross, 2nd Main, Chamarajpet, BANGALORE	MBBS	Kannada, Hindi and English	5 days
Dr. Arabind Behura	29, Kanakapura Main Road, Basavanagudi BANGALORE – 560 004	MBBS	Bengali, Hindi, English, Kannada and Oriya	1 week

ANNEXURE NO.2. NOTES FROM ADDRESSES OF DIGNITARIES

Welcome speech & introduction to the topic by Dr.T.S.Nagabhushana:

Dr.T.S.Nagabhushana, warmly welcomed all the participants to the meet. He expressed his happiness about the fact that so many doctors from BMC had responded to the call of distress. Later, he spoke briefly about Tsunami & enlightened the audience about various facets of the same. He also spoke about the all important issue of identification & respectful burial of dead bodies in such situations. He drew the attention of the audience to the WHO guide lines of the same. He quoted the example of Prof. Dr.Hande, a revered professor of medicine in BMC in 1980s. When Victoria Hospital was over stretched in 1972 with injured & dead people due to air bus accident, he arranged for the respectful preservation of dead bodies & arranged for the identification of most of the bodies. The unidentified bodies were later given respectful funeral with last rites being performed by priests belonging to all religions! He spoke of the importance of giving the respect & dignity to any human, whether dead or alive, as entitled.

Also, he made a very valid point saying that more deaths are taking place due to man made calamities like war & sanctions! He observed that as doctors with a duty of ensuring 'healthy life' to people around us, we have the responsibility to oppose & take measure within our limit such mindless activities of humans! He called for the participants to contribute their little efforts to ensure peace on earth.

He came out strongly against the insanity of the governments in engaging the precious resources on waging war & destruction. He called for allotment of more resources towards ensuring health to all the people. Saying that death due to dog bites & road traffic accidents claimed more life every year in India than tsunami, he said it was time to spend more energies, time & good sense to take care of these issues.

Sharing experiences of tsunami relief work by Dr.Veeranna Gowda:

Dr.Veeranna Gowda shared his experiences as the team leader of official team from BMC. It was touching to hear that he volunteered to go to the affected area in spite of a crisis in his personal life (he was bereaved due to loss of his mother just recently).

He explained that as a leader he had to face many difficulties. First of all, procurement of medicines was a big problem in a short notice. Also, in field, his team was scared with rumours of more tsunamis making rounds. As a leader he ably lead his team & able to convince that they will continue to work in the affected areas at a safe distance fro the coast. In addition, he felt that it was difficult in such situations to manage a big team (his team had 18 members) as it was difficult for such a big team to move from place to place.

He spoke of the works of his team in the area & shared his observation that there were not many overt medical problems in the sense of physical injuries. At the same time he praised the efforts, both from the government & civil societies, for their relief work.

Reflections by Dr.Ravi Narayan:

Dr.Ravi Narayan then presented his reflections on the experiences shared by different teams. He appreciated the spirit shown by various people associated with BMC. He also shared his experience of work in disaster like situations. He fondly remembered his work in East Bengal refugee camps for 3 months. He stressed that it is one of the situations that one learns more about community medicine with all its implications & importance. He made a valid point that such opportunities can be used to train medical students in community medicine. He also endorsed the views of Dr.T.S.Nagabhushana that even dead people have a right to be buried with dignity & that we as doctors need to be sensitive to such situations. He appreciated the efforts of all team members who had lent a helping hand in post tsunami disaster relief & further stressed the need to evolve a policy to develop a disaster management team in BMC.

Address by Dr.K.S.Siddaraj:

Dr.K.S.Siddaraj shared his experience as the Superintendent of the Victoria Hospital how he was requested by the Government of Karnataka to send a medical relief team with a short notice. He also co related the experience of how difficult it was to

arrange a team on such a short notice with the fact that if a disaster was to strike Bangalore, how inadequately prepared we were to face such a situation! He then explained about the efforts BMC is putting in to build a well equipped trauma care & emergency centre in Victoria hospital complete with 8 ambulances!

Address by Dr.Shashidhar Buggi:

Dr.Shashidhar Buggi was very appreciative of the initiative from BMC to provide relief in tsunami affected areas. He surprised all of us by revealing to all the participants that the building in which we were having the meet was originally intended to house the disaster management cell of BMC! He also chose the occasion to share the fact that SDS T.B. & Rajiv Gandhi Institute of Chest Diseases was dedicating a ward of 100 new beds in the new hospital under construction was being exclusively dedicated to emergency care in disaster & disaster like situations! He also endorsed the idea of formation of a disaster management cell in BMC. At the same time he pointed out at the long process if we wait for the Government to act & hence suggested that in addition to sending a proposal to Government BMC has to start processes in its own capacity to build such a team within its own resources.

Presidential address by Dr.T.Rajeshvari:

Our beloved principal openly expressed her appreciation to all the BMCites who had been to tsunami affected areas. She also pointed out the importance of holding such meetings as the present one which will not only help to share the experiences but also serve as the impetus for new activities in the college. She was impressed of the model followed by St.Johns medical college during East Bengal relief camp (as explained by Dr.Ravi Narayan) & offered to take up the issue with the University authorities. She also was happy that an initiative has been made to develop links with voluntary organisations & appreciated the idea of having BMC volunteers having gone through CHC included in the meet in BMC. She also expressed her interest in developing a disaster management cell in BMC. Overall she expressed satisfaction on her side that BMC was contributing positively for the growth of our nation & expressed the confidence that it will continue in future also.

EXPERIENCES AS A TECHNICAL TEAM MEMBER OF CHC IN THE 'CHILDHOOD NUTRITION PROJECT' ON REQUEST BY TVS-MOTOR INDUSTRY

A BREIF REPORT ON VISIT TO TWO VILLAGES ON INVITATION BY RURAL HEALTH DEVELOPMENT CELL OF TVS FACTORY IN HOSUR

BACKGROUND:

As a part of ongoing Rural Health Development Program & to plan for future collaboration & to define the same in terms of focus, concept & activities, the CHC team was invited by RHDC to visit Andiwadi village to have a direct dialogue with expecting & new mothers of the village. Since we felt it would be more useful to visit one of the ICDS project, we decided to do the same also.

PURPOSE OF THE VISIT:

1. To have a direct dialogue with expecting & nursing mothers of Andiwadi & Kothagondapalli villages.
2. To visit an ICDS project to have a brief situational picture on nutritional & health status of the attending children.
3. To define & expand the exact nature of collaboration between CHC & RHDC of TVS factory for future works.
4. To collect demographic data & other data, deemed necessary for future activities.

THE VISIT PROPER:

We, Mr.Chander & Dr.Vinay, the representing team members from CHC had a preparatory discussion[14] with Dr.Thelma Narayan before embarking on the visit.. We first met Dr.Rajan Babu, the Chief-Medical-Officer & person-in-charge of RHD of TVS factory, who promised to send a formal request for collaboration with CHC. Later, we visited the ICDS project in Kothagondapalli[15] & had a brief encounter with

[14] Annexure No.1
[15] Details of visit in annexure no.2

the staff & children. Lastly, we visited Andiwadi village along with three officers of RHDC, where we had a very satisfying dialogue[16] with expecting & nursing mothers of the above mentioned villages.

OUTCOME:

1. Dr.Rajan Babu agreed to send a formal request for collaboration.
2. Data pertinent for future action in RHD for Andiwadi & Kothagondapalli villages collected.
3. Partly successful in establishing a meaningful working relationship with anganwadi workers & mothers.
4. A very stimulating & informative discussion with the expecting & nursing mothers of both villages.

CONCLUSION:

Though we were partly successful in carrying out the objectives of the visit in general, we felt there is a need for defining exactly the nature, scope & terms of collaboration at the earliest; to have a meaningful & fruitful partnership.

[16] Details of visit in annexure no.3

ANNEXURE NO.1.PREPARATORY DISCUSSION WITH Dr.THELMA NARAYAN

A very insightful discussion with Dr.Thelma Narayan, for which Dr.Vinay arrived late, during which she gave us a overview of what should be our focus during the visit & oriented us towards the exact job at hand. She even discussed about the various data to be collected & stressed on the need for formal agreement & importance of establishing a good rapport with concerned people. She also cautioned us about carefully selecting the method of pedagogy, appropriate to the group. The discussion gave us that final ounce of orientation.

ANNEXURE NO.2.VISIT TO KOTHAGONDAPALLI ICDS PROJECT

Kothagondapalli, a village, is a 10 min drive from TVS Factory, where RHDC of TVS has been working in various capacities since 1994.

OBSERVATIONS:

1. The anganawadi is housed within the campus of Government school with a separate room & kitchen to itself.
2. The building as a whole was constructed by the Government. The 'uplifting' in terms of painting, maintenance, toilet provision, gardening, enclosure construction & maintenance of playfield is undertaken by RHDC.
3. The campus as a whole was well lighted & ventilated with pleasant & salubrious surroundings.
4. The anganawadi was spacious, cleanly maintained with a separate, clean kitchen with a gobar gas fuelled stove for cooking.
5. There was enough space for children to play within the room, albeit without enough toys.
6. There is assess to drinking water & clean toilet.
7. There was a low attendance of enrolled children. Out of 35 only 24 were present, the reason given was the farness of the anganawadi from their houses.Children present at the time of visit were reasonably healthy & most of them were well nourished. However there were a few malnourished children (There is a need for a detailed study of the same which was postponed due to lack of time).
8. The food being served was hot, but not very inviting. All children were made to wash their hands & say their prayer before being served food, with each child getting a separate plate for eating.
9. The children seemed more than ready to cooperate with a stranger & happily submitted themselves for 'examination' by Dr.Vinay.
10. The staff members were cooperative & friendly with us. They seemed very well informed about their duties & seemed to be doing the same reasonably well. They also seemed to be genuinely interested in their work. They also

reported enough support from Government in terms of supply of food & medicines.

Various functions performed by the staff as told by them are as follows:

- Nutritional supplementation to all children in the age group of 0-6 years & all expecting & lactating mothers. They also followed differential quantity as prescribed by the authorities.
- ANC for expecting mothers including tetanus immunization every 2nd Monday of the month with help of visiting ANM.
- PNC for nursing mothers.
- Immunization of all children, as prescribed by authorities, on every 2nd Wednesday of the month with help of visiting ANM.
- Distribution of IFA tablets to expecting mothers & all girls between 11-19 years, administration of Vitamin-A to all children at 6 months of age & then 2ml every 6 months till 5 years of age,distribution of paracetamol, albendazole & clotrimazole to people in need.
- Referral services for sick people.
- Health education to all women between 15-45 years.
- Non-formal education to all children between 2-6 years of age.
- Periodic meetings with women, adolescent girls & with village legislative council.
- Maintenance of records including growth monitoring, general health of children & performing sensex duty.

11. However, the glaring defect was the inability of the staff to maintain growth-charts of children, a duty so important, due to acute shortage in the supply of growth charts by the government!

12. The staff was enthusiastic in further improvements of the anganawadi in general & ready to give help in whatever way they can.

IMPRESSION:

The anganawadi though well maintained, had further scope for improvement & needs a detailed study before any improvements are suggested.

ANNEXURE NO.3.THE DIALOUGE PROCESS AT ANDIWADI WITH EXPECTING & NURSING MOTHERS OF BOTH VILLAGES

Andiwadi, a village situated about 8 kms from TVS factory was the rendezvous for our dialogue with expecting & nursing mothers of above mentioned two villages. The meeting was arranged by RHDC & was attended by anganawadi workers of two villages & 9 expecting & nursing mothers. The meeting took place in the beautiful & secure anganawadi of Andiwadi village.

The dialogue was held in a very informal manner, with the participants and resource persons mingling freely. Mr.Chander initiated the dialogue in a captivating manner by asking the participants of the fate of a planting planted in wilderness & not cared! It helped to break the ice & also gave the woman an ideal platform to start the dialogue. Then on, the dialogue continued with good participation & some of the observations as made by Dr.Vinay are as follows:

1. The participating group was a good mixture of woman from different economic levels, though it cannot be said so of their social class.
2. Only 2-3 participants were very active & others answered only when questioned. There was not much initiation of dialogue from the side of participants.
3. The coordinator was articulate, expressive & tactful, stimulating the women to think & participate.
4. The knowledge of most of the participants regarding child health & rearing was commendable.

Some samples of the dialogue are given below (not an exhaustive list but only a small part representing the effectiveness of dialogue):

- Mr.SJC: Why should you feed children?

  Women: “To fill stomach; to help in growth;to maintain health of the children”.
- Mr.SJC: When should breast feeding started? Weaning-When & how?

Women: BF just after the birth; no prelacteal feeds to be given; Weening to start in 3-6 months

With ragi porridge & other soft foods; confusion among the group regarding marketed baby foods

& on informing, by us, that they are not necessary, one even questioned us by asking how come then that the doctor prescribes it?; most said they have never bottle fed their babies!

- Mr.SJC: Immunization-When, How many?

  Women: Most of them knew of OPV, BCG, DPT, but not many knew of Measles vaccine. Also they were ignorant of number of doses of each & the disease against which different vaccines were used. But most mothers agreed on the importance of vaccination in the promotion of their child's health.

- Mr.SJC: What are their 'unmet needs'?

  Women:1. Only rice not enough, variety of food deemed necessary.

  2. Need more playthings.

  3. Need to have more plates to serve food for children.

  4. Make 'balawadi' attractive to children, so that they 'love' to come there.

- Mr.SJC: Why do they think some children are not attending anganawadi?

  Women: " Some people think sending their children to anganwadi with all 'other' children will make their children dirty"; some fear that there will be sharing of plates; distance problem; children don't like to be kept 'prisoners' in a closed place, they like to play as 'free birds'

- Mr.SJC: Any other significant problem they wanted to discuss?

  Women: Most of them strongly felt something is needed to be done to children of coolies, as the children will become 'children of street', literally living on their own in the streets, after anganawadi closes till their parents return home from their work.

- Mr.SJC: Why do people send their children to anganawadi?

  Women: Food; preschool- so that their children become smart; to see that 'headache' is transferred to someone else for atleast sometime!

- Mr.SJCL: How can they help to address the identified problem?
  Women: (After some minutes of silence) "You give the suggestions…..then we will see how we can help….."

IMPRESSION:

There is an urgent need to address some of the misconceptions of the mothers about anganawadis, the most important being the dangerous misconception of Govt. supplied 'supplementary nutrition' as a 'replacement' to home nutrition, which makes the basic objective of ICDS scheme of 'improving child nutrition', a distant dream. Also there is need to further the health knowledge of mothers regarding doses of immunization & other aspects of child care. It seems necessary to consider how best can we make anganawadis 'attractive' to children & increase the attendance. What seems to be a real problem, but conveniently overlooked is 'the street children' problem. It is an emergency problem which needs to be addressed on a war footing. Also it is pertinent for us to now evolve a strategy for effective 'community participation' if we are to make Rural Health Development a reality.

PROJECT PROPOSAL FOR ASSESSMENT OF NUTRITIONAL STATUS OF CHILDREN (0-6YEARS) IN 6 VILLAGES IN HOSUR TALUKA

AIM:

Assessment of nutritional status of children between 0-6 years of age in 6 villages of Hosur taluka of Krishnagiri district of Tamilnadu state & to plan & enable measures to mitigate malnutrition in children & to promote the development of children & ensure them a healthy childhood.

OBJECTIVES:

- To assess the nutritional status of children aged 0-6 years in 6 villages of Hosur taluka where health division of Community Development department of TVS Motors (TVSM) is working.
- To identify the various factors; social, economical, political, educational & cultural; that affect the nutritional status of the children in that area.
- To plan & enable the local community & Community Development department of TVSM to take collective action to adapt & maintain rational & appropriate nutritional practices of the children to restore their nutritional status to normalcy & maintain the same.

THE PROCESS:

The whole project will be taken in two phases:

1. Assessment phase including collection & analysis of child nutrition data &
2. Post assessment action phase includes evolving a plan to enable the local community & health division of Community Development department of TVSE to take collective action to adapt & maintain rational & appropriate nutritional practices of the children.

ASSESSMENT PHASE:

It includes the following processes:

- An action based & participatory community approach will be the guiding principle for the whole process. Meeting the local people & building working relationship with them will be the first step of the project. Local people includes the staff at health division of Community Development department of TVS Motors, the community leaders of all 6 villages, representatives from parents, women, men, children & elderly groups of the community, the anganwadi workers & ANMs of the area. The meeting would serve as a place to:
    - Know the willingness of the community to participate in the project
    - Inform & discuss, with all parties involved, the objectives & methodology of the project
    - To understand & build rapport with the community
    - To involve every stake holder in decision making process
    - To finalize the logistics of the assessment phase of the project
    - To collect past records, whatever is available, regarding the health status of the children in the community
    - To build a causal model of malnutrition
- Methodology used for the assessment of nutritional status of the children would be a 'cross sectional study' of all the children through house to house visits & recording their weight using Salter scale & height (for children >2 years)/length (for children <2 years) using fibre glass scale/infantometer. The data will be collected with the involvement of the local people. The data collected will be collated with the past records of the children to assess the nutritional status. The NCHS values for weight & height of children, as recommended by WHO, will be used as the reference values to draw inferences.
- In addition, based on the causal model of malnutrition, a questionnaire designed to study the various factors; social, economical, political & cultural; that affect the nutritional status of the children in that area will be

administered to a representative sample of the different groups in the community.

- The process will be designed & implemented with full participation of the local people. The community will be asked on how best can we involve them in the process (& also will be asked to provide 2 volunteers in each village for the entire process to move forward. Then, the volunteers will be involved in a discussion where the whole process of the project will be discussed with them & their needs identified. In addition, their inputs will be incorporated in the design of the questionnaire. A training program to build capacity of the volunteers to undertake the project themselves will be planned.)

COMPONENTS OF THE ASSESSMENT PHASE:

1. **Meeting with the local people:** Meetings will be held with local communities & staff members of RHDC of TVSE with the objectives mentioned earlier. Also, these meetings will be made participatory & will be used to serve the following requirements:
    - Build a team within these villages to assist us in the project. In addition, capacity building of the same to be undertaken during the process of project execution to enable them to continue the work in future
    - Construct a simple & functional hypothetical causal model of malnutrition

2. **Collection of vital statistics:** It is important to have a general picture of the community in which a health program is being planned. Apart from helping us in providing on the demographic profile of the region & an approximate number in the target group (children of 0-6 years), it also helps in giving a broader picture of the overall health status of the children in the region. RHDC can obtain the same from the local governmental authorities. The data deemed pertinent for the project are number of children in 0-6 year age group,

sex ratio in the same age group, IMR, 1-4 mortality rate, vaccination coverage, life expectancy of the area, spacing of the child birth, details of families with 0-6 year old children & any other deemed necessary during actual process.

3. **Collection of previous records of the children**: Such as growth charts, birth certificates, under 5 health records, records from pre primary child care centres & any other records pertaining to the health of the children under study.

4. **Clinical examination**: Clinical examination of all the children to search for specific signs of malnutrition to be carried out. The specific signs of malnutrition that will be looked in each child will be as follows:
    - Hairs: Sparse, thin, easy pluck ability, hypo pigmentation, without sheen, flag sign
    - Eyes: Dry eyes, Bitot's spots, keratomalacia, xeropthalmia, pallor
    - Tongue & mouth: Sore, red & glazed tongue; cheilosis; pallor
    - Skin: Erythema, Hyper pigmentation, raw hypo pigmentation; easy bruisability; dry, inelastic & mosaic skin; phrynoderma
    - General appearance: Wasted muscles & bony prominences; no fat under the skin; protuberant abdomen; generally apathetic or highly irritable child; child which has stopped feeding; oedema;

5. **Anthropometric measurements**: The height & weight of each child is to be measured & then weight for age (under weight), weight for height/ weight for length (acute malnutrition) & height for age/ length for age will be calculated for a sample of children. The age of the child in question will be assessed according to the data in birth record or if no such data is available using the local calendar or an approximate age is calculated using the clinical examination. All measurements are to be obtained under standard conditions using standard equipment & standard techniques. The NCHS values of height & weight for age in children will be used as reference values to draw

conclusions. The same will be recorded on a growth chart & the importance of maintaining the same in future will be stressed. If previous records of weight & height are available, the same will be collated with the current measurements to know the trend of nutritional status & to identify the 'at risk age', if any, in the community.

6. **Community survey:** Once a simple & functional causal model of malnutrition is built & major determinants for the cause of malnutrition identified, analysis of the data will be taken up & priority areas for intervention will be identified.

A period of one month is envisaged to be the time period to carry out all the above activities. Once, the above process is over, the project moves into the post-assessment action phase.

QUESTIONNAIRE FOR 'KAP' STUDY OF CHILD FEEDING PRACTICE

Name of the interviewer: ______________________________ Date: ______________

Village name: ________________

Section A. GENERAL INFORMATION

(*Note: interview mothers who have chid/ren below 6 years of age*

If the mother has died and the child is raised by a guardian interview the guardian)

1. Name of the respondent* ________________________________ age ______

*Respondent means the mother or the guardian of children below 6 years of age

2. Address ____

____

____

3. Name of the husband ____________________________________age ______

4. Name of the Head of the household ______________________ age _______

   Sex ________

Family details

Type of family: **a.** Joint family **b.** nuclear family **c.** single parent

Sl. No	Name	Age	Sex	Relationship to HOF	Educational Status*	Occupation	Income
1.							
2.							
3.							
4.							

5.							
6.							
7.							
8.							
9.							
10.							

*Record as **A.** Just knows to read & write **B.** Up to 4th Std **C**. Up to 7th Std
D. Up to 10th Std **E.** Up to PUC **F.** Higher than PUC

6. Type of housing

a. Thatched

b. Semi pucca

c. Pucca

7. Details of children under five years

(*Note: fill according to birth order. DOB and weight as the mother remembers, look for any documentary evidence available)*

Sl. No	Name	DOB	Age	Sex	Birth weight	Whether attending school / AW regularly *	if irregular, reasons
1.							
2							
3.							

* R: regularly IR: Irregularly

Section B

(Elicit information about baby less than 6 months of age in the family)

1.Did/do you breast feed the baby?

a. Yes

b. No

If yes go to question no 2

If no go to question no 10

2. How soon after the birth was the baby put to breast?

a. soon after birth (< six hours)

b. First day

c. Second day

d. If > two days .specify _______day/week

3. What did the baby get as first feed?

a. Mothers milk

b. Animals milk

c. Sugar water

d. Any other _____________ (specify)

4. Was the colostrum fed to baby?

a. Yes

b. No

If yes go to question no 6

If no go to question no 5

5. Why was the baby not fed with colostrum?

a. Bad for baby's health

b. Too thick for baby to digest

c. Colostrums is impure

d. Any other ________________________

6. Baby was exclusively breast fed till _________ months / years

7. Did you stop breast feeding the baby any time during the above period?

a. Yes

b. No

8. If yes why?

Child:

a. Had fever

b. Measles

c. Diarrhoea

d. Cough and cold

e. Any other ________________

Mother:

a. Had fever

b. Became pregnant

c. Cold and cough

d. Breast problems

e. Any other ____________________

9. What was the baby fed with during such episodes?

a. Boiled and cooled water

b. Plain water

c. Sugar water

d. ORS

e. Animal milk

f. Any other _____________________

(Stop the interview if the baby is still on exclusive breast feeding.)

10. If not breast fed, why?

a. Death of mother

b. Not able to produce breast milk

c. Specify reasons

11. If not breast fed what did you feed the baby with?

a. Animal milk

b. Milk powder

c. Any other _______________

11. If not breast, how was the alternative food/milk fed to the baby?

a. Bottle

b. Cup and spoon

c. Pallada

d. Any to other

12. If the baby was fed with animal milk/milk powder, was water added for dilution?

a. Yes

b. No

13. If yes, up to what age did you continue to do that?

Year ________ month _________

SECTION.C.WEANING

(Elicit information about the baby started with weaning & less than 2 years of age)

1. At what age did the child started receiving food other than breast milk on a regular basis?

AGE (in months)	Age when started (Tick at the appropriate age)	What food is given first?
0-3		
4-6		
7-9		
10-12		
12+		

2. Did you continue to breast feed the baby even after the baby start receiving other feed regularly?

a. Yes

b. No

If yes go to question No.3.

If No go to question No.4.

3. Till what age did you continue to breast feed the baby? _____Years____Months

4. List out all the foods your baby received. (Record in the order of first served→ last served)

Name of the food	Age of starting (In months if , 1 year, In years & months if >1 year)	Method of feeding*

*Method of feeding: Record as

A if bottle fed **B** if fed with pallada **C** if fed with cup & spoon **D** if fed with hands **E** if any other method is used & specify the method used

5. Describe what exactly the baby was fed in the last 24 hours (record in the chronological order & in as much detail as possible)

Time of serving	Food	Quantity of feed*	Method of serving**

*Amount of food to be recorded as follows:

Liquids: in ml/feed (Find out the local measure & usual utensils used to feed the children & approximate it to the nearest ml)

Solids: in no of cups/feed (Quantify the utensils used locally to feed the children)

** Method of feeding: Record as

A if bottle fed **B** if fed with pallada **C** if fed with cup & spoon **D** if fed with hands **E** if any other method is used & specify the method used

6. Who fed the baby in last 24 hours? (Record all the people involved. If possible, identify the mail person who cares & feeds the children most of the time)

a. Mother

b. Siblings

c. Elderly people in the house

d. Any other___________

CASE STUDIES OF MITANIN PROGRAM

CASE STUDY 1:

Mrs. XXX was selected to be a Mitanin in YYY block and later promoted to be the BRP of the same block. During the course of her work she became pregnant. But she refused to take leave and continued to work. It was during her field visit to one of the hamlets, 4 km away from YYY the labor pains set-in and she delivered a baby boy in the hamlet while on duty!

ZZZ (the new born baby boy) is 8 months old at present and accompanies his mother to all training sessions and all her field visits. He is fondly called **'Sangathan ka beta'** by others.

CASE STUDY 2:

The women's committee formed by Mrs.XXX, a Mitanin of YYY hamlet, is so strong and motivated that they successfully acted against the irregular and erring primary school teacher of their hamlet to mend his old ways and to be regular to the school.

He now sends in regular reports regarding school activities to the women's committee and attends school regularly and follows scheduled time for the school. He even writes to them (for permission on the days he is not able to run the school.

He sent in an attendance report of school children while the meeting was going on, on the day of our visit.

CASE STUDY 3:

The school teacher of the Primary School (govt.) at YYY was reportedly a drunkard. He was very irregular and reportedly ran the school according to his whims and fancies. Most often he came to school at 11 am or 12 noon and stayed till 2 pm only. It is said that he did not give mid-day meals to the children regularly and sold the rations in the open market.

The women in YYY village put up with this helplessly as they didn't have any information regarding their children's right to education and their entitlement for midday meals. This went on till the Mitanin program was introduced.

Once, XXX was trained to be the Mitanin and she was educated about their rights and entitlements, she carried the same message to the women's committee of her village. The women committee decided to take collective action against the erring teacher and forwarded a 'complaint' to the district magistrate (SDM).

The SDM came to their village and conducted an 'enquiry' about the knowledge of the women and met a few men and sarpanch of the village. These men were supposedly 'bribed' by the school teacher with liquor and hence the inquiry produced no results.

XXX and other women were livid when they learnt about this and again forwarded a complaint to the SDM They also asked him the reasons why they were not informed about the enquiry? The SDM was taken aback and he went on another enquiry to the village with prior information to the women's village health committee.

On the day of enquiry XXX and other women of the village spoke fearlessly to the SDM and apprised him of the irregularities in the school and mid-day meals program. Also they accused sarpanch and other men of abetting with the school teacher in front of sarpanch himself. They were able to convince the SDM about their complaint. The SDM promptly took action and warned the school teacher of stringent disciplinary action if he didn't mend his ways.

School teacher was taken aback by these developments. Nevertheless, he reformed to a great extent and started opening the school regularly during scheduled hours and also providing mid-day meals regularly.

CASE STUDY NO. 4

The women of YYY Gram Panchayat never attended Gram Sabhas. Gram Sabhas were never meant for women! It was for the 'men' of the village and it was their prerogative to decide what is good and what is bad for the village.

Then came the Mitanin program and XXX from the YYY hamlet was trained. She organized a village women's health committee. Slowly the women started realizing the 'real' issues and also tried to come out of their 'cocoons'.

XXX and few women mustered enough courage to go to a Gram Sabha meeting. The men were surprised at their presence in Gram Sabha. Sarpanch asked them caustically "why have you come here"? Ramabai soije evenly: Why are you sitting here

The 'men' of the village realized that there was a change and accepted it graciously. Also, XXX started bringing good inputs into Gram Sabha. Now she is more than welcome into the Gram Sabha and pre-meeting information is sent to her to make sure she attends all meetings!

CASE STUDY NO. 5

The fair price shop catering to the needs of people in XXX hamlet was entirely unfair. People never used to get the rice earmarked for 'below poverty line' card holders (Rs. 3/- per kg). Also rice priced Rs. 6/- per kg for poor but about poverty line card holders was being sold as Rs. 9/- per kg and also only a fraction of quantity was available for the poor people. The remaining of the stock was being sold by 'seth' (the manager of the fair price dept) to the open market.

The women came to know about PDS and its rules and regulations through XXX (the Mitanin) they discussed of the unfairness of fair price depo and took the issue to district administrators.

The 'seth' was enraged when he learnt about the complaint. He threatened the women (XXX and two of her associates) of dire conservancies. As a result of which, the women got scared and did not return to their homes. Instead, they roamed around in the forests with a 'club' for personal protection dreading of 'arrest' by the police (as Seth had collusion with state policy

department). Men from her village didn't come to her support. But women community firmly stood behind her and gave her and her associates the much needed support.

The enquiry held by the district administrators was again a dreadful affair for the women. They were intimated and the whole setup looked very threatening. In spite of perceived dangers, the women firmly stood their ground during the enquiry and wee able to convince the district administration about the 'fraud' at fair price depo. As a consequence, the management of the fair price depo was transferred from the corrupt seth to the sarpanch of the village and Rs. 3/- kg/rice was introduced.

Presently, people get their entitled rice and other rations at the price and quantity fixed by the government regularly. Also many eligible people who hadn't got BPL cards previously have been distributed cards.

<u>CASE STUDY NO.6:</u>

AAA, one of the remotest villages in the area had four widely spread out hamlets with more than 80 houses. It took us almost 120 minutes to travel 18 kms & reach the village in our jeep from the nearest 'good' road.

The village hadn't seen an ANM since many years without any Public Health facilities including immunization facilities reaching them. The anganwadi is managed by the helper. There is a primary & middle school managed by a head master & a teacher. People have to walk or the patients have to be carried, for 4-5 km to reach the nearest quack, & for 10-12 km to get a local transport to go to the nearest PHC which is 18 km from the village. On top of it there is no doctor in the PHC for the past 6 months as the incumbent doctor was deputed on training without a replacement doctor. The whole PHC is being managed by a single Compounder who provides Health care to more than 10000 people belonging to 30 surrounding villages!

In this village, two Mitanins were selected & were given two books without any training! In addition, one of the selected Mitanin was a 65 year old lady who couldn't walk for more than half a kilometre & hence not able to go to any outside place for the training. The other Mitanin is a middle aged illiterate lady who is not interested to be a Mitanin. The Panchayat member doesn't know anything about the program!

CASE STUDY NO.7:

Mrs.XXX was awarded as the 'Best Mitanin' & working in AAA block. She is an enthusiastic Mitanin who has taken her work of Mitanin seriously. She took an initiative to motivate the men in her village to undergo Vasectomy operation & was responsible for many a men undergoing the above said procedure. But this brought her in direct conflict with the ANM. The incentive (Rs.50) was the contentious issue & since the Mitanin was responsible for motivation she took the incentive. This angered the ANM & she refused to follow up the 'cases' in the village & also to remove the sutures. The Mitanin had to take the man in question to a local doctor for the suture removal using her own money! This issue illustrates the possible conflicts of interests between the Mitanin & ANM under the present settings & the issue demands proper attention!

CASE STUDY NO.8:

The concept of Mitanin being a 'voluntary health worker' is not ingrained in the minds of general Public. She is greatly misunderstood to be a Government functionary & this caused a lot of problems for the Mitanins.

One example was the refusal to enlist a widowed Mitanin in 'Food for Work' program by the Panchayat, on the basis of her being a government functionary. This particular Mitanin was a poor widow with very little land & depended on daily wages for her survival! This also stands as a testimonial for the inadequate involvement of the Panchayat & community in the program. Also, this stands in stark contrast to the concept of Panchayat support to remunerate Mitanins !

CASE STUDY NO.9:

XXX is a village in AAA block of YYY district in Chhattisgarh. The village has a primary school & an anganwadi. However the ANM of the area refuses to visit the village in spite of easy access to the village. Instead, she has asked all people of the village wanting to avail her services to travel to the neighboring village ZZZ, which is 1-2 km from XXX, to which she

visits once in a week. As a result of this a large majority of children of XXX are under immunized or not immunized at all. Also, the ANC of pregnant women has also suffered.
Mitanin program was started in this block since November 2002 & 5 women of the village were selected & trained to be Mitanins. After they have learned the importance of immunization of the children & ANC of pregnant woman in their training they requested the ANM to visit their village, for which the ANM refused. Determined not to deny their community for the access of the all important immunization & ANC, they now take special care in mobilizing all the children & pregnant women of XXX & take them to ZZZ on the day of the ANM visit! They are hopeful that a day may come when their village will also be 'accepted' by the Public Health System & the community will realize the Right to Health!

CASE STUDY NO.10:

Mrs.XXX is an 8th std pass woman aged 22 years & resides in YYY village of ZZZ block of Chhattisgarh. Her husband is a post-graduate with MA & LLB degrees & practicing farming in the village. They have 2 children & totally 6 members live in the family house.
She was selected to be a Mitanin of her village by the Gram Sabha in late 2002 following Kalajatha in their Panchayat (AAA). She has attended 6 trainings spread over last two & half years in AAA (1 km from her village) & BBB (1 km from her village). The trainings were held at irregular intervals & employed mostly 'book reading' & lectures by the trainers. She has received totally 7 books during these trainings. She says she enjoyed the training but feels she would have learned better if trainings included skits, role plays or audio visual aids & if they were held regularly.
She comes across as a confident, affable woman who is proud of being 'herself'. She says the most satisfying aspect of being a Mitanin was to get to know about her own 'womanhood'. On enquiry she also comes across as one of the good Mitanins with appreciable level of knowledge of health & diseases. She with the other Mitanins of the village has also taken up initiatives to ensure immunization of children & ANC of all pregnant women of the village.
She also appears to be a strong, empowered lady. During our visit to her house for her interview, there was a drunkard interfering with our discussion. In addition, many neighbors had crowded around us & were creating commotion. She deftly handled them & asked the drunkard to leave the place & asked her neighbors to allow us to discuss without interruption.

Her husband was very supportive of her & encouraged her to work as Mitanin. Both of them felt that she would continue to work as a Mitanin even if no remuneration was given but at the same time felt that it would be more encouraging to get some remuneration for their efforts.

CASE STUDY NO.11:

XXX is a village that falls exactly midway between AAA & BBB. It has a PHC which caters to the scattered population of more than 13 villages of 7 panhayats in the surrounding areas. There was no doctor at 4 pm when we passed through the way on 07-04-05. The next day we visited the PHC at 10 Am & found that 4 staff members were present & the compounder was involved in the 'distribution' of drugs to the patient. The whole building was in a dilapidated condition with a big polythene sheet covering the roof from inside. The 'examination' table looked like it would break down any moment. There was cold storage box from UNICEF which was left unutilized. On enquiry we learnt that on an average about 5-10 patients visited the PHC everyday. In addition the people visiting the PHC & living in the neighboring houses informed that the PHC doctor came to PHC irregularly & hence the people of the surrounding village didn't depend upon the PHC for their health care needs!

The doctor came at about 11.45 AM & she spent 15 minutes with us discussing the Mitanin program. Even though the program was being implemented in the block by the Public Health System itself, she knew little about the status of the program in the area & said that the Mitanins are in the villages & hence the field staff knows them better than the PHC based staff!

CASE STUDY NO.12:

Dr.XXX is a recently graduated doctor from YYY medical college in ZZZ. She has joined the Public Health Department of Chhattisgarh state as a Medical officer on a contract basis of two years. She has been involved in the Mitanin program since July-2003 as a trainer & after her transfer to AAA in August-2004, as a DRP in AAA block. She is presently involved in the implementation of the program in AAA block along with the BMO.

At the time she came to AAA, the program was almost ‘dead’ with no training for more than 6 months. In addition, many trainers had stopped working due to lack of remuneration. There was also a high rate of attrition of Mitanins.

But both the doctors took it upon themselves to invigorate the program. Dr.XXX personally met more than 250 Mitanins & said that she personally could count 70-80 Mitanins who had ceased to function as Mitanins. They recruited trainers to replace the discontinued trainers. To mobilize the people & build public interest in the program they planned to have one more round of kalajatha. Since malaria was the most prevalent public health problem in the area, they used kalajatha on malaria to rally people around the program. Also many new Mitanins were selected & given training.

The doctor feels that the program is a very good initiative to reach out health services to the community & also as a tool of Women empowerment. She feels the program can effectively help to improve ANC, Immunization & particularly during epidemics as early warning system & to reduce deaths. At the same time she felt that the program should be given full & uninterrupted support for at least 5 years before it bears any fruits. She also feels that the trainers are not able to meet the needs of the Mitanins & trainers themselves need capacity building. The most important constraint that could damage the program, according to her, was the irregular financial flow. Until the financial floe is stream lined the program may nod achieve the desired success. She felt strongly about the long delays in the payment of Trainers & almost had quit the program herself on this issue! She stated that the Women’s Health Committees had been formed but were largely nonfunctional as there was no capacity building of the same.

CASE STUDY NO.13:

In the block of XXX, rainy seasons were known to cause epidemics of Diarrhea in children with avoidable deaths of few children even!

After the training & deployment of Mitanins in the block & the early initiation of management of diarrhea by the Mitanins, the situation has shown a great improvement. The Mitanins are also vigilant of the situation & inform the Public health functionaries of the area, of the field situation during rains & alert the system on possible situation of epidemic spread

early. This has resulted in the early initiation of preventive & promotive measures to control & mitigate the effects of epidemics.

This according to the BMO of XXX CHC & YYY has resulted in the ‘zero’ deaths of children during the rainy season of 2004 due to diarrhea!

CASE STUDY NO.14:

Dr.XXX is a block medical officer of YYY CHC. We (Amulya & Vinay) visited the CHC on 05-04-2005 as part of our formal evaluation process of Mitanin Program. We went to the CHC at 9.30 AM. The attender of the CHC welcomed us & asked us to wait for the BMO in his office. When there was no sign of BMO even at 10.15 AM, we enquired of his whereabouts & were given some unconvincing excuses & we were told that the BMO was on his way to the hospital. We waited for another 15 minutes before we came to know that the BMO’s house was in the same street about 200 meters away from the CHC.

Tired of waiting, we decided to meet the BMO in his house itself & went in search of his house. We were surprised to see a ‘crowd’ of patients in his house waiting for the private consultation. The doctor was not taken aback when we introduced ourselves & the purpose of our visit. He asked us to wait near the CHC & informed that he will be coming to the CHC by11.00 AM. We observed that he collected Rs.100 for every consultation! We took a photograph of the same & went back to CHC to wait for him.

In CHC we came to know that the story was a regular one & it was 11.45 AM before the BMO finally arrived in the CHC.

What was striking of the whole visit was the blatant way in which the BMO practiced his private consultation in the regular hours of CHC & the unapologetic way of the BMO in receiving us!!

CASE STUDY NO.15:

XXX is a big village of more than five thousand population in the block of YYY. We visited the village on 05-04-2005 as a part of evaluation process of Mitanin program. The village had just 2 Mitanins covering the whole village!

To our sweet surprise we found that the village Gram Sabha was having one of its regular meetings in the school building. We gave a visit to the meeting & met the members of Gram Sabha. The Sarpanch, the Sachiv & 18 members of the Gram Sabha were present in the meeting.

The main agenda of the meeting was to send a request to the Government to open a sub-centre in their village as they met the requirement & there was a great need of the same in their village. The Mitanin of the village, who was envisaged to play a key role as a link between Public health system & the community was not attending the important meeting & the Gram Sabha didn't even deemed it necessary to invite her! Also, a request for more tube wells in their village to improve the drinking water access in the village was on their agenda.

Even though a few of the members knew of the Mitanin in their village they pleaded their ignorance on the concept, work & operation of the program. They even didn't know about the selection process or of the expected work of the Mitanins in their village. Then the responsibility fell on us to explain to the Gram Sabha of the concept & operation of the whole program!

REPORT OF THE WORKSHOP FOR PRIMARY SCHOOL TEACHERS ON 'WATER & HEALTH'

BACKGROUND:

Bharat Gyan Vigyan Samithi (BGVS) is a nation wide science movement working towards promotion of scientific thinking & attitude in the people with special emphasis on school children. It is in the fore front of many programs designed to address the issue of popularizing scientific thinking & attitude & has taken a proactive approach for reforms in education system in India. The Karnataka chapter of BGVS, with many luminary people in its wings, has played a major role in the reforms of school education in Karnataka to make learning a joyful activity for the children & also shifting the attitude of teaching from content oriented to attitude oriented. The 'Chinnara mela', the annual 'Children's science forum' organized by BGVS, Karnataka are two examples of such activities. Through such activities BGVS has also been successful in having scores of teachers as its volunteers in many of its activities & is also bringing out a monthly magazine in kannada by name 'Teachers' to cater to the needs of teachers in Karnataka.

When UNICEF & Karnataka Rural Water Supply & Sanitation Authority (KRWSSA) announced pilot projects of 'School Hygiene Project' in various schools of Karnataka BGVS, Karnataka with its rich experience in such activities agreed to test the idea in three districts of Karnataka. The project involves training of 50 children of a Government primary school on the topic of safe water, sanitation & hygiene with the aim of promoting Healthy Way of Life in villages.

As a part of the project, training of Primary school teachers on the same topic was deemed necessary to have long term sustainability & effect of the program. Magadi & Ramanagaram talukas of Bangalore Rural District were two such places where the pilot project by BGVS was going on. It was decided to initiate the training program for teachers from these two places & BGVS requested CHC for its support. CHC known in the field for its prowess as a resource group in Community health agreed to extend help even though the request had a very short leading time of less than 16 hours! As a part of my overall fellowship learning objectives & with personal interest

in Child Health, I agreed to be one of the presenters in the Training program. This, I must say that, I agreed half scared as I didn't have much time for preparation but with the encouraging words from the team at CHC, I was ready to learn & improvise. As a part of it I was involved in training work shop with around 200 primary school teachers as participants in 4 groups of 50 teachers in 4 sessions spread over two days. This is a report of my experiences of the program.

THE WORKSHOP:

Topic : Water & Health

Participants : 4 workshops with 2 parallel work shops at 2 centres involving 200 primary school teachers, 100 each from Magadi & Ramanagaram, with 50 participants in each workshop

Sessions : 4 sessions per day for 2 days for the participants of each workshop

Venues : Block Resource centres in Magadi & Ramanagaram of Bangalore rural district

Dates : 24th & 27th of June 2005

Methodology:

The workshops started with invocation followed by introduction of the participants & the resource persons. I would then give a brief introduction to the topic 'Water- The source of life'. Later the 50 participants were divided into 5 groups & each group given a topic. The topics were:

1. Health & Water: What is the meaning of Health?
   What do you understand by the term 'Pure Water'?
2. Our Village & Water: The sub topics given were sources of drinking water in their villages, methods of collection, storage, purification & usage of drinking water, distance of the sources of water from most homes in the villages, people involved in the collection of water & mode of excreta disposal in their villages.
3. Water & its effects on health

4. Causes for the deterioration of quality & quantity of water in their villages
5. Preventive & remedial measures to be adapted to ensure safe drinking water in their villages

The groups then would have 20-30 minutes to discuss among themselves & elaborate on the given topic. They would represent the group's consensus on a drawing paper with the help of a marker. At the end of the period each group would then present their views on the given topic with the chart in the back ground. A discussion would then ensue with full participation from all the participants on their views over the topic & inputs from the resource person completing the whole picture. This way all 5 teams would present their topic & at the end of 90 minutes period, the topic of Water & Health would have been covered. There would be tea break followed by presentation on allied topics by other resource persons. Thus at the end of 2 days, the participants would be given a comprehensive information on Water, Health & Hygiene.

OBSERVATIONS:

The group of teachers in the work shop seemed genuinely interested & showed great deal of enthusiasm in their participation in the work shop. Their knowledge levels were a sweetly surprising revelation for me. 'The state of physical & mental wellbeing permitting a person to lead a happy life'-the definition given to Health showed that their understanding of health, though not complete, had broader view than the doctors themselves!

They also gave a bird's eye view of the condition of villages regarding the use of drinking water & brought to the forum the real picture of villages. Though it can be said that there has been a substantial improvement of the drinking water situation in the villages compared to the times of our independence, the situation seems to be far from ideal & lots deserved to be achieved. The problem of rampant flurosis in certain areas of Ramnagaram as explained by the teachers needs to be given due attention on an emergency basis. There is a need for the investigation of the Public

health problem of flurosis on a priority basis & formulation of the solutions for the same.

‘SWOT’ ANALYSIS:

Strengths:

- The strength of the whole program lies in the selection of the topic itself. The topic is a relevant one by the fact that the Water is the source of all life on this earth & safe drinking water & sanitation are attributed a major chunk in the improvement of Health status & life expectancy in the world. However in our nation, majority of the people live in rural areas & only 62% of the villages have access to safe drinking water .Also the sources of water are fast depleting both in quality & quantity putting a strain on the life of already marginalized rural people. In addition, the fruits of growing body of knowledge on selection & supply of safe drinking water & sanitation have barely reached our rural masses that are left far behind in the advancing world. Hence the topic is a highly relevant one in the present context.
- The selection of primary school children & teachers as participants is also a laudable one for the fact that the teachers in Rural India are still highly respected by the community & their words reach wide & far in the community. Also, the good practices that are fostered in childhood make a lasting effect on the life of both individuals & the communities. Also in our rural settings, messages carried by our children to their homes are given much importance. This program provides an opportunity to also fill in the lacuna of scarce health education as a part of regular discourse in our school.
- The school teachers attending the workshop were enthusiastic & showed their willingness in the mutual learning process. They participated with great enthusiasm & the charts produced by the groups of teacher stood as a testimonial for their participation. In addition, the knowledge of the teachers regarding the issue of water & health was commendable. The discussion that

followed the presentations was a lively one with many learnings form both the side.

- The teachers also exhibited great level of local knowledge & asked clarifications for wide ranging issues of health & water. A group of teachers from the region of Ramanagaram also put forth the problem of rampant flurosis in the region affecting the health of children & enquired of the solutions for the same.
- The program was taken up in collaboration of many Governmental agencies including the Education Department & KRWSSA. This is a significant step forward towards achieving inter sectoral coordination towards realizing Health for all. The arrangements done by the local BRCs for the program were also commendable & the rooms of BRC equipped to conduct such training programs was a sight to behold.
- The BGVS on its part had also produced training manual in local language in a short notice & also many songs & plays on the issue were printed & distributed. Also, many games had been planned to suit the education objectives. It is this type of improvisations in the methods of teaching to suit the needs of children that stood out as unique ones. Also, the topic of Water, Health & Hygiene was not strictly confined to the bio-medical convention of water borne diseases & their control but the issues covered also included the broader picture of water shortage, water pollution &, more importantly, local problems regarding the same.

<u>Weakness:</u>

- The planning of the whole program was done within a short period & hence it suffered in many qualitative aspects. With the resource people being contacted in the evening of a day before the program, the preparation from their part was not adequate. Also this resulted in the non-preparation of audio-visual aids which would have further enhanced the effectiveness of the program.

- The non-involvement of the local resource persons & public health system is an important concept that requires considerations. In the context of long term sustainability & capacity building of the local people for local action, it makes more sense to involve local people in the program. In addition, involvement of the public health system which has a mandate to promote school health, the absence of their involvement needs to be rectified in the future.
- Time constraint was also one of the factors that affected the effectiveness of the whole program. Many teachers had to leave by 5 pm to catch the bus for their village which resulted in incomplete sessions on both the days I attended.
- Field visits & on the field demonstration & understanding of the concepts of health & water would be desirable in future programs.
- Communication gap resulted in many avoidable delays & hence effective communication is required for maximum effectiveness of the programs. In addition, communication of the objectives & goal of such programs need to be communicated to the participants & resource persons in clear terms well ahead of the proposed dates to make the program more effective.

Opportunities:

- This comes as a golden opportunity to address the lacunae of near absence of Health education in our schools. This opportunity has to be used to demonstrate the importance & success of such initiatives to push forward the agenda of introduction of health education as a regular course in school discourse.
- This also presents an opportunity to build effective inter sectoral relations between various governmental departments which is one of the stated objectives of Karnataka State Integrated Health Policy.
- This program can also be used as a platform to build health consciousness in teachers & students & hence increase people's participation in the promotion of their own health.

- As already experienced, with increased awareness of health & related aspects of water, this can be developed into an effective forum to address the village community's information needs on issues of health & water, with more capacity building in times to come.
- It has been a proven fact that education of children & messages conveyed by teachers play an important role in the slow process of community transformation & social change which has to be given due consideration & acted upon.

Threats:

- Long term sustainability of the program & frequent reinforcement of the ideas are the essential pre-requisites for such type of programs aiming at changing harmful social practices & promoting healthy life styles. In such a scenario, if the program is continued with help from 'outside' resource persons without development of the local resource people, it puts a question mark over the long time sustainability undermining effectiveness of the program.
- The decision making process of the program is also another area which requires due diligence on the part of the program designers. If the decision making process continues to be plagued by short time notices & hence resulting in ad-hoc decision making, it may result in the compromise of the quality & effectiveness of the whole program.

STUDY VISIT TO 'HCCRHP' – A REFLECTION

BACKGROUND:

'ASHA' program, a brain child of Holy Cross Comprehensive Rural Health Project (HCCRHP) of Hanur, envisages residential training & empowering of young girls to be 'Health & Social activists' in their villages. These girls come from the marginalized families from impoverished villages of Hanur taluka of Chamarajanagar district of Karnataka state. The girls are variably educated – some up to 7th standard & only a handful of them up to pre-university college level. It is understood that the program not only trains the girls for their 'transformation' into becoming responsible & enlightened women & possibly 'village health workers', but also to help them to learn various non-formal skills to aid them to break out of poverty chain & lead a happy & healthy life. With these broad objectives in mind, ASHA program was started in Prakash Palya in June 2005 with 35 girls as the first 'partners' of the program.

I, Dr.Vinay Viswanatha, a graduate in Medicine from Bangalore Medical College, am presently undergoing Ratan Tata Fellowship Program in Community Health through Community Health Cell, a resource centre in Community Health in Bangalore. The fellowship program has given me, a confused recent medical graduate, an opportunity to explore the field of Community Health as a profession & life option. In the last 10 months, since initiation of the program, I have had innumerable opportunities to witness pioneering works in Community Health from close quarters & learn invaluable lessons from them. It has also given me an opportunity to closely interact with the leading Community Health Workers across the nation, who have left a deep impact on me, apart from leading me in the path of 'New Community Health'.

During these experiences, the idea of Village Health Workers has captured my imagination. The Health Worker program at SEARCH & Mitanin Program in Chhattisgarh have overawed me & stimulated me to explore the concept of Community Health Workers for a deeper understanding & operationalisation of the same. It is with this background I came to HCCRHP, to further my understanding of

the Community Health Worker Program & test my readiness in the participation of the same. In consultation with my dear mentor Dr.Thelma Narayan & Dr.Sr.Aquinas, the project co-coordinator of HCCRHP, it was decided that I would be spending 3 weeks in Hannur. It was also decided that training of ASHA would be the focus during my learning process in Hanur. Hence this field placement provided me with an opportunity for actually training the proposed Health Workers & practically experience the joys & sorrows of the same.

THE PROCESS & THE EXPERIENCES:

Once I reached Hanur, I was given a short orientation about the various Community Health programs undertaken by the HCCRHP. It was a sweet revelation & a humble experience for me to witness the wide range of issues of Public Health importance that were & are being addressed by the small but dedicated staff at HCCRHP. Apart from the 'conventional' health topics like that of Tuberculosis, training of traditional 'Dais' (Birth Attendants), the project also gave equal importance to wide ranging issues of 'The New Public Health' domain like that of addressing the issue of poverty, child labor, educational deprivation of the children, & training of Village Health Workers. In addition, I was also introduced to the newly started program of ASHA & Health Promoting Schools program. I was taken around the various villages in the taluka to gain a first hand experience of the village life in the area. I also visited the Satvidya School in Prakash Palya where the ASHA trainees were residing.

Following the orientation, I was given the opportunity to be a 'Trainer' of ASHA girls. This was a new experience for me. Here was an opportunity to actually implement the knowledge of 'theory', which I had gained over the period of fellowship, visiting similar projects & learning from various books.

Accordingly I spent around 10 days with the ASHA girls trying to teach & learn with them. Even though I was not predetermined with the topics I would be dealing with, I atleast was sure about the methodology to be adapted for the training process. I followed the 'participatory' method of training, my own crude version of the Paulo-Friere method of training for transformation.

The topics dealt by our group in the short period were varied & interesting. Apart from the pre-determined topics on Health & hygiene, Environmental sanitation, Water & health & Diarrhea, there were many off shoots from these topics which are the burning social issues of the region. The issues of early marriage, problems of menstruating girls, the low & often neglected social status of the women, child labor, educational deprivation of the children especially girl children, casteism, the aspirations, fears & the challenges of the ASHA girls, the meaning & scope of health & many such relevant social problems were discussed & elaborated for further understanding of the issues.

As already mentioned earlier, a participatory method of training was attempted. I made a conscious effort not to look & act like a 'teacher almighty', but as a fellow learner (to what extent I was successful, is a matter for some introspection & evaluation!). We sat in a circle & often started the sessions with songs on health & social issues, many times pertaining to the proposed topic of the discussion. Following the songs, we would get on with a discussion of the topic. Many times we used to break into smaller groups of 8-9 people & discuss the issue at hand. The groups would then write down all the points arising out of the discussion in a paper & one of the members would present their group's view on the topic. Later, we used to collate the points to have a clearer picture of the issue & would then embark upon a lengthy discussion to exchange our knowledge on the topics. The 'pure' health topics would then be dealt from me with short discourses, whereas the social issues were a real challenge & many would end on an open note after much discussions & confusions. Further more, when the topics required demonstrations (like preparing Oral Rehydration Solution at home, looking for signs of dehydration in children, examining pulse) we used to do the procedures practically. We even had two role plays, conceptualized & enacted by two groups of ASHA girls, on problems of menstruating girls in the villages (what is also important is the fact that the role plays were conceptualized, practiced & enacted within a period of 2 hours!). We also formed a team of four girls to be the 'Satvidya hygiene & sanitation monitoring committee' who drew the action plan to promote & monitor hygiene & sanitation, both personal & environmental, in the Satvidya campus. With the insistence of

'notes' from the girls, I prepared one on Diarrhea & Management of childhood diarrhea. The 'notes' on Water, Sanitation & Hygiene is pending which will be given shortly.

In addition, I was also involved in many discussions with the various staff members of the HCCRHP. The discussions were an eye opener to me regarding many burning social issues which have a deep impact on the health of the people. Many issues which are 'thought' to be primitive & hence non-existent in the mindset of urban people, including me, were discussed with alarming regularity throwing me into the reality of the rural India. The discussions with Dr.Sr.Auinas on her work in the area, her impressions of the joys & sorrows of Community Health Work proved to be a great learning experience. It was reassuring to learn that she faced the same dilemmas, as I am now facing as a novice, when she started her journey in Community Health work & the methods that have helped her to resolve many of them.

Furthermore, I had opportunities to visit the villages in connection with ongoing Community Health Work of the HCCRHP. These visits brought me in face with the reality of bonded labor of children which shook my senses & shattered the very foundation of my understanding of Humanity in general & reality of India in particular. Also, my visits to some of the villages presented the general conditions of the villages in the region & the hardships of the people. There is not even a single woman of more than 25 years of age, who is minimally educated, in three out of the four villages we visited. Another village had one woman educated up to 3rd standard. A minority of the present generation of girl children are educated up to 5th standard. The rest of the girls are like their mothers, without any education & working in homes & fields waiting to be married off at the tender age of 12-14 years! The penury of the people is sickening. The back breaking work they do to earn two half-meals a day compelled me to recall the 'India Shining' slogan of our 'revered' ex-Government! If this is the condition of the people in the cultivation season, I couldn't imagine their plight in the off-season. Forget land redistribution, a distant mirage, even the minimum daily wages looks like a forgotten promise. People are

forced to work for Rs.7000-10000 for a year as bonded laborers & send their children to bonded labor for a pittance of Rs.3000 a year!

I believe a stray dog in Bangalore would have a better life than most people here! If this is the reality in the so-called better state of Karnataka, what would be the plight of crores of people in the lands of worse-off states of India? What has happened to the lofty promises made during our Independence? Which is the India that is referred to by our Honourable Governments when they speak of 'a developing, strong India'? Is this part of India forgotten or is this not India at all? Or is it a conscious strategy to see that the weakest of Indians are weeded out in this way so that only the 'stronger' Indians survive to make a strong & healthy India?

MY LEARNINGS:

My study visit to HCCRHP as already mentioned was primarily with the following learning objectives:

1. To further my understanding of the concept & operationalisation of Community Health Workers
2. To get involved in the training process of Community Health Workers & to realize my readiness & to put into practice my preparations for the same

During the three weeks of my stay in Hannur, I think, I realized all the above learning objectives & learnt much more. Retrospectively, I think, my sojourn in Hannur not only served to realize the above learning objectives, it has also helped to evolve my understanding of the Humanity in general & the way the society functions in specific.