REPORT ON THE

COMMUNITY HEALTH
FELLOWSHIP

AT
COMMUNITY HEALTH CELL

FROM **Jan 6 2005** TO **July 6 2005**

By
Elsa Thomas

Mentor
Dr.Thelma Narayan
Community health cell, Bangalore

GRATITUDE

I acknowledge my deep gratitude to Dr.Thelma Narayan for her ever encouraging presence and contribution in my life in the past few months. I have been lucky to have her as my mentor during my fellowship programme at CHC. Thanks Dr.Thelma for your ongoing dialogue and shared experiences and reflections which made my fellowship a rich and lasting experience.

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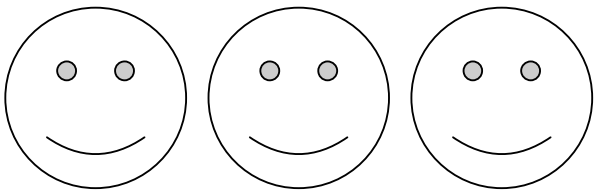


Introduction

Journey in to medical profession

During my first year of life as a young religious when I started working in the peripheries of Bangalore I came across with people who are lacking in good health and health care as well. On number of occasions I had to accompany the sick people to the city hospital. This was a first hand experience for me to experience the vulnerabilities, difficulties, insecurities and insults the economically poor people are made to face when they have to approach a tertiary or multispeciality hospital seeking treatment. For me it was an emotionally and spiritually moving experience and a challenging time. During my school and college days knowing the desire of my parents to make me a 'doctor' I had deviated from it consciously by graduating in mathematics, because I did not want to sacrifice my night sleep by being a doctor. But the experience of the difficulties of the people led me to give away my comforts and likes. Providing them with health care system which will uphold their dignity as human being was a challenge to me. It is this experience and challenge that led me to embrace medical profession.

Life in the medical school for the long five and half years made me a doctor who can diagnose the disease and treat it. Being part of the catholic run medical college I had some orientation to social-pastoral aspect of health care. But emphasis was on the competitive aspect of medical profession- how fast one can get in to a post graduation course, which are the most attractive and money yielding fields and areas of the medical profession etc…

After my graduation I started working in the remote areas of Andhra Pradesh in a 50 bedded general hospital. The hospital was trying to cater to the needs of the patients from the surrounding villages including both tribals and non-tribal. My initial enthusiasm about being a saviour to all those affected by any kind of illness bore good results in terms of being available to them when ever they need me or even conducting medical camps at far away places on hills etc… many a times patients would be brought in a dying stage. And I would feel helpless to attend to such patients. Children who are unconscious for 2-3 days, treated by many local so called 'doctors', having spent all their money and even sold their assets to obtain money for the treatment, women who are dying of anaemia and its complications, elderly who are affected by complications due to hypertension, diabetic, tobacco and alcohol abuse and so on and so forth. Many children were dying of preventable diseases. Many women were dying during and after childbirth. All these depressing scenes began to disturb my peace. I was searching for alternative ways of handling these situations. Gradually I began

to feel the need for developing a different dimension of health care. So I started thinking in terms of 'prevention of illness and promotion of health'. Tried to organize women's groups and awareness programmes for them. Conducted training programmes for women health promoters for far away villages. Tried to equip them with necessary knowledge about preventing diseases and what to do in case some one falls ill.
Even though my approach to health care was taking a different turn, the pressure was building up in terms of getting my self specialized in obstetrics and gynaecology because hospital as an institution needs personnel to for its long term sustenance. Not fully realizing its implications, I set out for my post graduation studies. After the specialization in obstetrics and gynaecology I returned to the place with renewed enthusiasm and energy and determination to make a change in the lives of the people whom I serve.

Background scene to my fellowship programme

When I resumed my duties back in the hospital after my post graduation, I found my self tied down to the walls of the hospital due to the emergencies and in-patients. My presence was needed at any time. This restricted my reaching out to the villages. I could only cater to those who come to the hospital. Trying to find ways and means to overcome these obstacles were reaching me no where. Yet the intense desire to promote health and to prevent illness still remained a priority issue in me. Being in such a remote place one finds it hard to find birds of the same feather. So I had hardly anybody to share my thoughts and insights with an equal wavelength and intensity. Due to lack of personnel and infrastructure for a planned outreach I was facing difficulties in various ways. My small attempts were not bearing much fruits. I felt that I was called up on to address the felt human needs of the people, to make a paradigm shift, to make the health ministry relevant and useful for the people. Helping the patients to recover even when they come in very bad state by pooling all your resources-emotional, moral, economic and physical including transfusing them with blood from your body gives a lot of professional satisfaction. Yet I was longing for the fulfilment of doing what is most relevant for the people. When the frustrations in relation to the profession began to mount up I had to check with myself if I am on the right track or if there are other people who think in the same line. So I began my search. Decided to take a break from the formal set up of the hospital work. During my search I happened to meet Dr. Sr. Aquinas who introduced me to CHC and the fellowship training. So I made a flying visit to Dr. Thelma and that informal meeting was my interview to the fellowship as well.

LEARNING OBJECTIVES

(Jan 2005)

1. To find ways and means of responding to the concerns I have towards the people whom I am called to serve.

2. To articulate and to give a sketch to the restlessness I feel with regard to my responsibility as a health provider in my place of work.

3. To equip myself to conduct training programmes for health staff to work in the hospital as well as in the community.

4. To understand better the meaning of community health.

5. To help my search for more meaningful service as a healthcare provider.

6. To give a thrust to preventive medicine than curative medicine and to integrate both.

7. To find answers and solutions to my frustrating experiences and problems in the health ministry in spite of my well meaning sincere service and dedication.

8. To redefine and to reorient the health ministry in my place of work.

9. To have an exposure to various organizations/places where the integrated and holistic approach to health is provided.

10. To learn from better experienced persons in this field.

My tsunami experiences

Circumstances that led me to tsunami service

It was during my search period the Dec 26th 2004 the black Sunday's incident took place. For seven nations in Asia the giant killer waves tsunami caused untold devastation and misery to millions of people. Here in India , the most affected areas were along the sea costs of Tamilnadu, Kerala, Anthra Pradesh and Andaman Nicobar islands. Indian costs had left nearly 9000 dead and several thousands missing. Tamilnadu had suffered significant damage compared to other states. According to Tamilnadu government the total population affected were 9, 84,564 and the number of houses damaged were 1, 26,182. Number of affected villages in Tamilnadu was 376. To add to this there the heavy loss of fishing boats and fishing nets and the live stocks and crops as well. During this natural calamity I was rather free from my responsibilities and responding to the need of the time was the most beautiful and relevant thing I could do. So I was looking for opportunities to venture in to tsunami relief work. At this juncture when I came in contact with CHC I realized that was the best platform from where I could extend my service. So as part of my fellowship I went to Nagapttinam area with CHC team to help in relief and rehabilitation of the tsunami affected people.

Facts, experiences and learning

It was during the early second week after the devastation and destruction caused by the killer tsunami that I reached to the north of Nagapattinam. The survivors of tsunami were still grief, despair and shock over the trail of death and destruction that tsunami had left behind. Relief operations and efforts involving countless agencies besides government, the flow of aid from far and near were poring into the midst of the affected people. These were real expressions of sympathy and solidarity from the global community towards the survivors.

<u>Placement for tsunami relief work</u>

With CHC team operating from Sirkazhi, I was working in three different villages namely Maduvamedu, Keelemoovarkare and Kottayamedu.
While I was with CHAI team we operated from Vailankanni reaching out to almost 15 surrounding villages.

Health care for the tsunami afffected

As a health care provider, my role and responsibility towards these grief stricken lot was to help them recover physically, emotionally and mentally from the shock and aftermath of the painful tragic experiences they have undergone. Many were wounded, injured and bruised physically. The due medial care was given to them. Those who are severely injured were admitted to the hospital and treated. Even though a health team send by the government was present in each affected village from morning till evening, people felt comfortable and safe with us as they had better confidence in us. People were living at their friend's /relative's house or at the relief camps. Our team would go round and visit them in their families /groups or as individuals. Women who sustained injuries were uncomfortable to come to the health centre placed at public spots to obtain the necessary treatment. Because they were not given the needed privacy for examination and dressing of their wounds and personal care. For whoever needed medical care, it was provided at their doorsteps and attended to the needs of the women who are injured. As health personnel we not only provided them with the necessary treatment for their injuries and ailments, but also we made sure that we helped them to take the necessary precautions and preventive measures against any outbreak of epidemics especially in relief camps. And the attempt was successful except for a few isolated incidents of measles and chickenpox which had nothing to with tsunami but related to seasonal variations.

Shift of focus with sensitivity

We as a medical team and directly involved health personnel, in the course of time realized that medical relief was not the need of the time but the need for restoring mental and emotional health. Therefore we had to make a clear choice and prioritize the urgent needs of the time and shift our focus accordingly. As there were numerous visitors and tourists pouring into the affected villages, it needed some time for us to build rapport with the people and become familiar with them. At the first visit one is considered a passer-by or a curious visitor or a tourist. Once you were seen coming back to the same village and same people repeatedly, they felt comfortable, confident and cared for. Then they would pour out their heart-rending stories, traumatic experiences and painful memories of the Dec 26th and their life thereafter. When we approach them with warmth and genuine interest, they were eager to talk about what happened to them.

Being with the people and sharing their grief and pain was very meaningful and comforting gesture to them. And this experience gave me a sense of satisfaction of reaching out not materially but in self-giving.

In their shoes

Fishermen known for their skills in knowing and negotiating the sea, now feared the sea for its unpredictable violence and destructive nature as that of Dec 26th 2004. They suspected that the sea may be holding many more surprises for them for the days ahead. The daily news about the after-quakes, tremors at Andaman, Nicobar and elsewhere in India too gave substance to their fears. They also were concerned about leaving behind their dear ones on the shore if they have to go to sea for their livelihood. They were also wondering what to expect when they return if ever they go to sea! Who can promise them any security or guarantee them their safety?

Fisher-folks are people who have been leading a healthy, rich, active and adventurous life have been rendered jobless, left idle, weeing away their time in gambling and drinking. Because fishing is the only trade they know and are well versed in. The boat owners among them had a very luxurious life, owning everything possible-TV, computers, mobile phones, extravagant daily foods, and lakhs of money hoarded at home. Now they were left with nothing to call their own! In this sense, tsunami was a great leveller among the fisher folks between the boat owners and the coolie-fishermen. Having spared no section of the fishing community tsunami reduced the status based division among them. Just imagine after having owned for oneself everything, lost to the last penny and possession and even a change of clothing, having to run & queue up for the food at three times a day to pacify the hungry stomach! Fisher-folks whether poor or rich, are people with self respect and dignity. Now they have to force themselves to stretch their hand to receive the packet of food items or clothes for themselves and for their family members. Imagine the deep pain one may experience in this situation! I considered it a great challenge for me to be with them sharing their pain, understanding them and assisting them. I admired them for their endurance and courage, the way they have faced this unexplainable aftermath of the disaster. In spite of the grief and shock, they exhibited great courage to face life once again even when it has offered them worst of its kind.

As health care providers we considered that addressing physical, psychological and socio-economic concerns of the affected people were important. Therefore we began focussing on the psycho-social care of the individuals, families and community. Counselling was done as individuals or as families depending on the need. Children, women and men were gathered in groups to help them to share their grief. "my daughter is not dead, you just can't take her away from me…" Amrutha grieves over her 2 year old daughter Rosy whose body was found by the rescue workers. Coming

together of the family members was encouraged and motivated them to care for each other. Rituals like prayer for the dead, or remembering them in some way found to be meaningful and helpful for the survivors to mourn their dead and to share their grief. These were opportunities for the survivors to ventilate their feelings and emotions. During the individual or group interactions, we would identify those who needed special attention to handle their depression, suicidal tendencies and attended to them by giving the necessary help and counselling. Some were found to be having related to sleep, developing guilt complex that they survived while their dear ones died or they were not able to help those who died etc. "I could not save my daughter from the waves, I am a killer." Said Malar, a fisher woman. In these situations, what was most needed and appealing was a listening ear, a healing presence or a healing touch and just that. Also motivating them to get back to their normal, daily activities was a booster to their recovery.

Unequal impact and unique needs

Children were the worst victims of tsunami. Many of them orphaned, thousands of them lost someone dear to them- parent/brother/sister/relative/ friend! Children faced death and destruction at their tender age! Their homes and schools destroyed! This tsunami generation will carry with them the long lasting psychological aftermath of tsunami. For the children who have lost their parent/parents, the tragedy of human loss, the horrifying experience of being engulfed by the water, frantic trial of escape and numerous deaths and dead bodies before their eyes, lay heavy upon their minds. Effects of these experiences are compounded by the lack of emotional support and the uncertainty of their future.

Children afraid to leave their parents, parents frightened to send their children to school, children frightened by the very sight of the sea or even at the sound of the waves at night are just examples of the insecurity they felt. They kept repeating 'Do not go to sea shore, tsunami will come again'. The brunt of tsunami's aftermath on this young generation needed to be handled effectively.

A one and half year old remained under the overturned boat, in the tight grip of his dead grandmother for 3days until the relief team heard a feeble cry of a child and rescued him. What will be the long-term consequences of this tragic survival for this child?

Another 8 months old toddler was found alive among the bushes about 12 hours after tsunami.

By virtue of their less developed coping mechanisms and abilities and inability to articulate their needs, the care given to them may not be adequate. And so they may grow up as a high-risk generation. As emergency measures to combat these problems, attempts were made for on-site interventions of connecting them to their available relatives, protecting them and reassuring them. For older ones who are able to converse, immediate cross intervention methods adopted were meeting them in groups or as individuals, helping them to talk about their experience of tsunami and bring out their intense feelings of panic and grief by way of drawing and acting.

While children were at school, parents would peep in now and then to make sure the safety of their wards. Once while our team was conducting group activities for the 4th Std students of Nagapattinam school, they heard a cry from outside. All 150 children ran out of the hall and reached on the terrace though there was not even a staircase for the building. Some iron rods were jetting out on the wall outside the building –and the children climbed up carrying their bags using these rods as staircase. It just shows the intensity of the deep rooted fear in them. This is the vulnerability exposed of the tsunami survivors.

The elderly

Young and the middle aged were able to make a re-start. But the elderly, who were unable to start afresh, needed special attention. No one could be untouched by the pain these elderly victims were undergoing. Already vulnerable due to age, illness, dependency was multiplied by the loss of dear ones or caretakers. Their past has been washed away and their future looks bleak.

Anjamma 65years old lady having lost her husband years ago was cared by her sister's family. Gift of tsunami for her was the loss of all the members of her sister' family and all their property. Anjamma sustained physical injuries and was admitted to the hospital for next 2 weeks after the tsunami. On her return she just had the possession of her clothes on her body and abed sheet supplied by the hospital. No home, no food, no dear ones, no caretakers, not even a change of personal clothes! She managed to pick up a sari buried under the mud and debris on he sea shore, washed and used for herself. She had no access to the relief materials supplied by the NGOs neither the govt supply of rice, dhal and Rs.4000/- even. How many more Anjammas will be there unidentified by none in the costal villages devastated by tsunami? Do these Anjammas and others deserve so much of suffering? What am I to tell them? Do for them? How to respond to them?

Nature has been unfair to the disadvantaged in exposing them to more and more insecurities. Karthikeyan 78 years old man mourning for her dear wife taken away by the waves of tsunami – nothing could console him even after about 40 days.

Farmers and dalits

In the costal villages were groups of farmers who were indirectly affected by tsunami. Their crops were destructed due to the sea water and they were rendered jobless. Their need was not noticed and recognized by anyone until they made their presence felt to the government. Dalit communities who were involved in salt pans, shrimp farms were also hit badly as their livelihood was affected and they were the victims of social exclusion. During the relief phase hardly anyone or anything reached them. It took awhile to reach out to them by the NGO sector as well as by the government. During the rehabilitation phase the scenario was a bit different as many NGOs and even government included the farmers and dalit communities in their rehabilitation packages.

Interaction and net working with govt. and other NGOs

It was my first experience of networking with government and other NGOs. And I would say it indeed a learning experience for me. Approaching the banks to help the women folks to get some loan was a tedious task. Time and time again we had to go and meet the bank manager to brief and debrief him about the situations in the costal villages. At first the bank manager had absolutely no faith in the fisher people and so he initiated nothing to help them. It is only after we physically took him to a coastal village and gave him a first hand experience of effect of tsunami that he was ready to lend a helping hand for these people. Interacting with the SHGs directly at he village gave the bank authorities a little more confidence in them.

My experience of pleading to the district collector to gear up the various regulatory bodies and government machineries in favour of the tsunami victims was something that I may not forget. When I brought to the attention of Nagapattinam district collector the quality of drinking water provided, he answered saying " if you have the will and ability to provide them better drinking water for Nagapattinam , you may do so". There were instances of bribery taken and incentives accepted to release the ex-gratia or even the family allowance of Rs. 4000/- . This incidents were handled with more care and concern for the victims by the collector even if he had to pull up the concerned officer or even punish them.

Initially when CHC began its relief we need to base ourselves with a local NGO. And it was SNEHA and SEVA, two NGOs working in the coastal villages that welcomed our presence and gave space for us to network with them during the relief and rehabilitation phases. It was again a learning experience. There were many aspects which we felt comfortable with as well as not so comfortable or with room for improvement. In certain areas, SNEHA and SEVA's weaknesses became CHC's weaknesses too. Some interested had vested interests in coming to help the tsunami victims. There were people who wanted to join or change the NGO groups for a reward of almost 100% increase in their salary. Some other new NGOs propped up during the Tsunami era would not recruit any local people on their staff. NGOs were pouring in with loads of relief materials and other offers irrespective of whether it was needed for the tsunami victims. At times NGOs failed to analyse the situation from the fisher folk's point of view. It was very obvious when 'India's heritage group' clubbed with RSS tried to be passionate with their idea of propagating 'cow protection and organic farming'. This enthusiasm was not shared with fisher people. Hare Krishna group provided the tsunami victims with excellent and expensive food for five days. But when the people pleaded for help for buying boats and nets the Hare Krishna group said that their ideology did not encourage the killing of fish. Yet the civic sense; the compassion from the individuals, institutions and the corporates getting themselves deeply involved in relief and rehab operations taking it as their own work were really touching. This was human action trying to defeat the ferocity of the nature.

Beyond tsunami

Did the aids poured in to the coastal villages encourage or propagate the already prevailing inequalities? Were they motivation for acknowledged and accepted idleness?
Did the relief and rehab effort promote the people's participation for enlarging and widening the opportunities for sustainable livelihoods? Are they based on a pro-nature, pro-poor and pro-women orientation?
Displacement, crowded & unhygienic living conditions, lack of privacy at the temporary shelters are major areas of concerns regarding the tsunami victims.

LIFE SKILL EDUCATION TRAINING

(training of trainers) for HRFDL-NESA
9-11TH March 2005 at ISI, Bangalore

This Programme was organised for the dalit activists of NESA and HRFDL as a joint venture networking with community health cell. CHC as usual took up the responsibility of conducting the training programme by providing the resource person. So Mr.Chander, staff of CHC was the resource person for the training and I accompanied him. Participants were about 15 young people who are dalits. Some of them with a background of finishing their 12th and a working knowledge of English. But the enthusiasm and energy in them to learn more in order to be the leaders was encouraging.

1st day

We started the session at 9.30am with a game to introduce and familiarize with each other. Then the participants were asked to share their expectations about the training programme. After the sharing of the expectations a pre-evaluation of their knowledge about health was done thru a questionnaire.
The first day's sessions were the following:

1. Understanding health
2. Understanding health and community health
3. Introduction to life skills linking to health
4. Learning creative thinking skills
5. Learning critical thinking skills

2nd day

The second day started with report presentation of the first day by one of the participant. It was followed by sharing of their learning, insights and information and suggestions for the day's programme.
The second day's sessions included:

1. Self awareness
2. Interpersonal relationship and effective communication
3. Managing emotion
4. Understanding human sexuality

3rd day

The third day's sessions were

1. Problem solving
2. Decision making

3. Empathy
4. Substance abuse

At the end of the third day the program concluded by summing up and evaluating the whole three days. The participants gave a feed back that they enjoyed and benefited from the sessions. Because it was participatory and incorporated with games and activities the whole group got involved themselves.

Dr. Shirdi prasad's presence and expertise made the sessions more live and rich. He conducted exercises to get the participants to understand different emotions and how to handle them.

Evaluation of the training program

- Too short a time to handle the topics
- Participants needed more information on each topic than it was given to them because they were beginners to the training.
- Request for follow up and further training.
- All the participants were at different levels and so benefited differently
- Participants wanted many more topics to be covered in detail.

Learning

I played a dual role in the training program. One as participant and other as a help to the resource person. Both roles helped me to learn many things. As a participant I learned to how to adjust to the learning of a beginner in the health field and to come down to their level of understanding. Being a participant to a very great extent like them put the other participant at ease for them to clarify their doubts. As a resource person in assisting to conduct the training program I learned how to plan for training and the needs of a beginner in health field. I learned how to conduct training. I learned how to link community health with life skills.

INITIATION TO RE-THINKING AND RE-ORIENTING HEALTH CARE MINISTRY

At St.Martin de Pores hospital, Cherukunnu, Canannore, Kerala
15 & 16th march 2005

Origin & History of the Hospital

St. Martin de Pores hospital at Cherukunnu, Canannore at present is a 250 bedded missionary hospital. It was a very humble beginning. From 1946 to 1961 the sisters were running a dispensary to cater to the needs of the people. At that time the need of the locality for a health care institution was very much felt by these early missionaries. As the years passed by the need of the hospital where patients can be treated as in-patients was inevitable, and they responded to it by expanding it to a hospital 1961. The hospital was catering to the needs of the most underprivileged mainly dalits. Hospital also attended to the leprosy patients. Leprosy patients were treated and rehabilitated. Hospital also had out-reach programs at remote villages.

Growth & Development

Though a humble beginning and very much apt to the needs of the time , now it has grown to a well furnished institution with multispeciality , with a strength of around 50 doctors and adequate staff nurses. The institution also runs a college of nursing. Though the institution's primary motto is to impart care, concern and wholesome healing, it also has to compete with other health care institution for its long term sustenance. So it has to update and improve its standards and procure standard and modern amenities and equipments and also get qualified and efficient professional. Responding to these needs the hospital has grown beyond our imagination and control.

Present concerns

- Now for the people involved as decision makers it is a question of carrying it own Vs re-orienting.
- The sisters involved in the hospital are careful and diligent to the 'promotion of spiritual and pastoral aspect of health care'.
- The hospital was started to answer a special purpose of responding to the need of that time.
- Are we responding the needs of the present time?
- How to take it forward?
- Do we need to re-orient or re-structure to answer to the need of the present time?
- And what is the acute, felt needs of the time?

- Do we adopt a holistic approach to health?
- And if we have to do it, how can we do it?
- How do we promote, realise and safeguard progressively the ideals in spiritual, moral, medical, nursing, social and all phases of health endeavour?

A deeper look in to all the above mentioned areas of concern was initiated during the meeting. But we also realize and acknowledge it is a difficult task. To accept these concerns as challenges and open the new horizon to respond with vision to the needs of the present times is the great work placed before us.

WITH METHA PATKAR
AT THE UNIVERSITY OF BANGALORE
on 'DEVELOPMENT IN THE THIRD WORLD COUNTRIES'
March 22nd, 2005

Program overview

Metha Patkar was invited to address the students of mass media communication at Bangalore University on the 22nd of March 2005. It was my curiosity to hear her speaking and to get an insight in to the thought process of this present day deity of social transformation and people's movement, Metha Patkr that lead me to Bangalore University. I wanted to know what motivated her to dedicate much of her time and energy for the cause of people! And what made her so very appealing to the common people? I was over whelmed to see the packed room, students, teachers, journalists, media personnel searching to find some space to foot themselves if not for a seat. In spite of her late arrival people waited patiently. When she arrived there was no much pomp and fuss about it.
She spoke for an hour and a half with the audience spell bound. She dealt with various aspects of development definition of development, development in first world, development in third world and re-defining development. At the end of her deliberations she invited the audience for queries, doubts and challenges.

Reminiscences and reflections

- Definition of development for the first word countries Vs third world countries
- If development is re-defined- Development devoid of disparity
  - Development devoid of displacement
  - Development that grant the right to natural resources

- Ground realities of real India seen in the peripheries of mega cities, slums, river valleys.
- Domestic workers – struggling for minimum wages
- Construction workers - struggling for a little space to call their own house
- Dalit farmers pleading for subsidy but nil where as Coca-Cola thrives…
- Exploitation of migrant tribal/non-tribal girls
- Trafficking go women and girls for commercial sexual exploitation

- No primary education reached India's every child…
- Competition in achieving nuclear power
- No competition in reducing poverty
- India being categorized as developing country, as part of third world sector……
- The third world consciousness….
- If one can respond to these situations with meaning…
- Respond to contribute meaningfully

- Half of the population in India facing inhuman situations
- What are communication / media doing?
- What is it communicating if it does not bring forth the aspirations, deadly experiences of the majority of the humanity who are facing in humane situations?
- Inflation of information and knowledge
- Knowledge allowing the modern society to do amniocentesis and kill female foetuses.
- Doctors being instrumental in propagating and popularizing prenatal sex determination tests – completely missing ethics in the modern medical profession
- If I have the right to know, I also have the right to act after knowing. Am I doing it?

WITH STREET CHILDREN AT J.P. NAGAR, BANGALORE

On 29th march, 2005

It was a day dedicated to the children on the streets of J.P. nagar, Bangalore. With Mr.Chandar I set out for the venue where we had agreed to meet street kids. Most of these street kids are engaged in some work or the other. When we reached the spot all of them were engaged in their routine daily labour as coolies, assistant to welders, cleaners, motorists, plumbers and any thing that they can get a hand in. The first question they asked us was what we are going to do with them if they spend time with us? Two of hem took the initiative to gather the working children on the J.P.Nagar Street. Both girls and boys in almost equal number gathered together. They were active, energetic and noisy. It was a mighty task to get them to sit down if not quietens them. Only something that moves on a screen could capture their attention for more than ten minutes. After spending time with them to build rapport, we taught them basic about health.

We dealt mainly with

- ✓ Ill effects of substance abuse and tobacco use
- ✓ How to keep away from these wises?
- ✓ How to take care of themselves from occupational hazards
- ✓ Motivation for pursuing studies
- ✓ How to help those with drug or tobacco use

Slide show about ill effects of tobacco and drug use interested them much and kept them listening and learning. Some of the children showed initiative to clarify their doubts. Some others were concerned that their mothers, fathers were using tobacco or gutkha. They even brought them to us so that they can get first hand information about ill effects of tobacco. This is children being the agents of change!

Children shared with us their difficulties they face at home, at work place and their inability to continue their school. They also mentioned about the effect of peer pressure to get in to the bad habits of tobacco, drugs and other addictions. After the teaching session the children were given snacks and tea. They went back to their work after their learning process.

The second part of the session evolved thru the efforts of the children. The elders some of them called and brought forcefully by the children and others own their own, made the second group. They were interested in getting more information about all that we taught the children. Some of the

women admitted that they were using tobacco or gutkha. They expressed their desire to leave this habit but did not know how to and where to get help for the same. On their own they were not able to do it. They also had many areas of concern to clarify and clearout, especially regarding gynaecological problems. The women found it easy, convenient to get the necessary help me being a lady gynaecologist.

Lessons and Insights

- Right of the children to live as children – for whom is it a reality? Not for these street kids who are trying to eke out their own and for their dear ones a living.
- These children, though deprived of education and the process of learning, they are capable of serious thinking, analysis and acting.
- They feel solidarity with their friends who are equally deprived.
- They are able to sense those with genuine concern for them.
- Root causes for these children working on the street are poverty, migration, displacement and unemployment of elders.
- Working children are exploited and abused.
- There is no protection for working children.
- The number of children on the street is increasing.
- Children suffer because of over work.
- They are deprived of their childhood.
- The problems faced by these children are many. They are related to education, health, family, addictions, exploitation, and lack of protection, love, care and support.

IWHM (International women's health movement)
The Southern India Zonal Consultation
On 2-3 April 2005 at Aikya Training Centre, Ravogudlu Village, Bangalore South, Karnataka

Participants

There were 47 participants from four states - 6 from Andhra Pradesh, 23 from Karnataka, 9 from Kerala, and 9 from Tamil Nadu in the IWHM Southern Zonal Consultation. Other participants included Sabala from IWHM Organizing Committee who coordinated the southern zonal consultation and gave participants a background to IWHM and described the IWHM process. Lakshmi Menon was also present to document this consultation.

Process

The southern zonal consultation was hosted by Aikya, at Ravogudlu village, Bangalore South, Karnataka. Ms Philomena Vincent coordinated the logistics. The venue was the Aikya Training Centre which is located 30 kilometers south of Bangalore and this distance was responsible for delay in beginning the consultation as several participants from other states arrived in Bangalore on the morning of the meeting and had to be transported on extremely bad roads to the venue of the consultation. The problem was further compounded by electricity failure, as a result of which several participants were unable to make electronic presentations on the first day.

However the venue provided some positives: participants were able to experience rural life, albeit with more conveniences than a local villager can even dream of. The training centre for rediscovering the healing value of herbs and plants also provided a natural setting for the consultation.

The participants from the four states did not have any state-level meetings. There were very few songs were sung during the consultation and one form of cultural expression was presented. The consultation process involved presentations and discussions and participants also broke into groups for in depth discussion on state-specific women's health concerns.

Presentations

1. Overview of women's health concerns in southern states by Dr. Sundari Ravindran, Achutha Menon Centre for Health Studies, Sri Chitra Tirunal University, Thiruvanathapuram, Kerala.

This presentation gave an overview of women's health status in the southern region. Itexamined some achievements such as literacy, immunisation, family planning/ lower TFR(total fertility rate), increase in institutional deliveries, and a high level of mobilisation of women's awareness. However these achievements mask a lot and many new problems have emerged.

Inequalities go unnoticed when we talk of averages. While, overall a state has made much progress severe inequalities exist within each state at district, urban and

rural levels, and among scheduled castes and tribes. For instance, poverty, malnutrition, diseases of poverty, poor infrastructure and health services are concentrated in some geographical regions and among some classes.

Development model is widening the inequalities. Economic liberalization has forced focus on growth not based on production but on service sector; employment is not generated resulting in migration; promotion of tourism is resulting in sex trafficking and HIV; growing violence against women and increased mental health problems. Rural areas do not factor in development planning. There is much focus on information technology, which is skill oriented. Mass media has resulted in growing aspirations and consumerism. Education and health sectors are increasingly being privatized and women bear the brunt of financial burden. There is a need to break the myth of self help groups (SHGs) which is supposed to help women. However in reality women become more indebted as they are not provided means of livelihood.

Health sector reform: Development model has private sector as its engine of growth and development. Further WTO pressures have adverse effects especially on health sector, e.g. the recent Patent Amendment which means higher costs of drugs. Government is taking minimal role in providing healthcare and health funding, charging user fee in public healthcare system. The government is also encouraging private sector without ability to regulate it. The private sector logic seems to be "set up shop where there is demand" and promoting health insurance and healthcare industry, thus creating healthcare markets. Other countries' experiences have been an increase in healthcare costs. A few studies show indebtedness in Kerala just for a normal delivery, fuelling irrational therapy.

Medical technology: indiscriminate use of medical technology is rampant, such as sex-selective abortions, c-section deliveries, hysterectomies, mushrooming fertility clinics and HRT (hormonal replacement treatments; while life-saving and much needed technologies remain scarce, e.g. cancer screening, spot tests for RTIs/HIV, female condoms.

Sexual and reproductive health and rights: Population control is still the centre of focus despite the shift in RCH policy. Early marriage is the trend in southern region and adolescent fertility rate in 15-19 years in urban areas is higher than the national average. Early sterilization at the age of 23 years is a cause for much concern. Many tsunami-affected sterilized women survivors who lost their children are devastated. There is increase in the abortion rate, but no pregnancy prevention. Early sterilization also exposes women to HIV risk, especially in the instance of multiple partners. Male responsibility in contraception and safe sex among adolescents and young population is practically absent, leaving girls and young women vulnerable to HIV and pregnancy. Increased hysterectomies and early menopause have aggravated women's mental health problems, and indiscriminate hormonal replacement therapies make women vulnerable to cancers.

Many more health issues need to be documented and proper studies need to be conducted, and some issues can be brought to light only through field experiences.

2. State Discussions: The participants then broke into state groups to discuss 1) health problems of women and 2) strategies that have been evolved by NGOs.

Andhra Pradesh: 1)Women's health problems - Illiteracy, superstitions, lack of sanitation and drinking water, low wages, heavy work load, drought and migration

have adverse impact on women's health. Other problems include lack of women's decision-making ability even though there are many SHGs, violence against women; sexual abuse and sex trafficking, high school dropout rate, early marriage, and abortions are some problems faced by adolescent girls. Women's health problems include malnutrition, poor hygiene practices (sandbags, cow dung packs used as sanitary napkins), white discharge, cervicites, breast and cervical cancer, uterus prolapse, unnecessary hysterectomies, increasing HIV cases, inability to access VCCT and drugs. Ignorance and misconceptions, difficulties in access to public health care and non-availability of doctors and drugs at PHC levels have compounded their problems. Two child norm and family planning, causing frequent abortions are perceived as abuse on women's bodies. Other problems that need to be better addressed are of disability, mental problems and increasing number of children with mental retardation.
2) NGO Strategies- Herbal medicines are being used by trained women for treatment of white discharge and RTIs, community health workers and dais are being trained and their services are being utilized, adolescent girls are being taught hygiene and trained in making sanitary napkins, an NGO is working on sex trafficking and providing health services to commercial sex workers. Academy for Nursing Studies, an NGO is using new strategies like Samuhika Sreemanthan, Balintha Darsan, Mahila Veduha, etc., for training on reproductive health issues. There is also a campaign against child marriages and early hysterectomies, which are bearing positive results.

Karnataka: 1) Women's health problems concerning adolescent girls include lack of knowledge in reproductive health issues, premarital sexual relations, unwed pregnancies many times leading to unsafe abortions and suicides. Gender inequalities result in less freedom/mobility and decision-making ability, low education and early, forced marriages. Women face discrimination with low salaries, poor social support and financial dependence, violence which have a direct impact on their health. They suffer from widely prevalent anemia, RTIS, unsafe deliveries and do not have routine postpartum care and poor nutrition.. Women also have poor access to public healthcare and get poor quality of public healthcare services in PHCs, health posts and government hospitals especially for poor women. Most women have very little knowledge on their health rights and entitlements. 2) NGO Strategies include developing interventions for adolescents in school programme in the areas of nutrition and hygiene and reproductive health. Health sessions for women in the areas of gender issues, early marriage, reproductive health, breast and cervical cancers, STIs/RTIs, pregnancy care and post delivery care through methods like puppet shows, video shows, charts, street plays, demonstrations, etc. Providing medical assistance to women and children belonging to below poverty line, training of trainers (voluntary health facilitators which has not been successful; anganwadi follow-up and teachers training. Self-help groups and financial independence, campaign against alcoholism and successful in banning arrack in the village.

Kerala: 1) Women's health problems - include over-medicalisation of women's bodies with increased OTC drugs, pregnancy tests, ultra sound and scanning procedures; HRT, unregulated privatization of healthcare, early sterilization and unnecessary hysterectomies, backaches, mental health problems, suicides, disability problems, sex trafficking and sexual abuse, HIV and child sexual abuse. Teenage pregnancies, abortion and suicide are also increasing.

2) NGO Strategies include promotion of alternative healthcare system, and networking and sharing information among women's groups. Recommendations include regulation of private sector, gender sensitisation of healthcare providers; sex education to be prioritized. NGOs are calling for strengthening public health system, implementing gender sensitive programmes and media to be gender sensitive in reporting.

Tamil Nadu: 1) Women's health problems Adolescent girls: lack of sex education; sexual exploitation by school personnel and others outside the school; teenage pregnancy, premarital pregnancy and unsafe abortions; premarital pregnancy often end in suicides; and anemia. Women suffer from RTIs/STIs; increasing cases of HIV/AIDs, migrant workers are more prone to HIV; there is a stigma attached to using female condoms and government doctors neglect treating sexually transmitted diseases. Depression during reproductive age is very common. Tsunami has further aggravated the health of women in particular. They bore the brunt of loss of family and property. Salt and sand embedded in the vagina has caused much problem; lactating mothers and pregnant women suffered additional trauma, and the government's rehabilitation/relief measures did not take into account women's health and livelihoods. Shelter camps did not provide privacy for women, and health camps did not cater to women's special health needs such as providing underwear and sanitary napkins.

2) NGO Strategies suggested are women's organizations should join together as a network to work on health issues; information regarding women's health issues should reach all grassroots organizations; like-minded doctors and nurses should be involved; health should be seen from a rights perspective; NGOs should take the role of questioning the government on health issues.

Several papers were presented on various topics. They include:

1. Why women's health status, Access to health care, initiatives in health empowerment in Karnataka by Dr. Sr. Elsa Thomas, Community Health Cell, Bangalore.

2. Patent law amendment by Reshma Sarkar, Lawyers Collective HIV/AIDS Unit, Bangalore.

3. Gender-based violence in Kerala by Aleyamma Vijayan, Sakhi, Thiruvanathapuram, Kerala.

4. Child sexual abuse: an exploratory study of the Kerala Scenario by Seema Bhaskaran, Sakhi, Thiruvanathapuram, Kerala.

5. Gender, poverty and health: a study of the agricultural women workers of Kerala by Dr. C.U. Thresia, Achutha Menon Centre for Health Studies, Sri Chitra Tirunal University, Thiruvanathapuram, Kerala.

6. Delay in seeking care and health outcomes for young abortion seekers by C.V. Sowmini, ICMR Thiruvanathapuram, Kerala.

7. Reducing the burden of breast cancer in Kerala: feasible options by Dr Pyari, T.T., Kerala.

8. Health issues of dalit adolescent girls by S.M. Shanti Ramesh, Solidarity for Women, Tindivanam, Villipurum district, Tamil Nadu.

9. Dalit women's Issues on RTI, STI, and HIV/AIDS by K.K. Amrithavalli, Tamil Nadu Depressed Women Welfare Society, Tiruchirapalli.

10. Impact of child marriages on health of women by Dr Mamatha Raghuveer, Taruni, Warangal, Tamil Nadu.

11. Making adolescents safer: promoting reproductive health, social change and economic power in Karnataka state by M.B. Sumithra, Samuha, Bangalore

12. Women and mental health by Niveditha, Richmond Fellowship Society (India), Bangalore

13. Impact of tsunami in women's health by Dr Buelah Azaraiah, Initiatives for Women in Development (IWID), Chennai, Tamil Nadu.

14. Panchayati Raj Institutions (PRIs) and elected women representatives' (EWRs) role in utilisation of reproductive child health services by Asha Benakappa, Centre for Budget Policy Studies, Bangalore.

Some space was provided for the following participants to share their experience:

Revitalising local health traditions and empowering women by Dr Anne Victoria, Pudokkotai, Tamil Nadu

Promoting herbal therapies in rural areas by Rangamma, Sri Sanghshema Trust, Penukhonda taluka, Andhra Pradesh.

Gender, power and susceptibility to HIV/STIs in India by G. Kruthekha, Samraksha-Samuha, Bangalore.

Women and disability by Lilli Samuel, Sandeep Seva Nilayam, Karnaktaka.

Experiences of Rural Women's Social Education Centre by Vallary Patrick and Sabitha, J., RUWSEC, Chengalpathu, Chennai, Tamil Nadu.

Experiences of Mahila Jagruti Sanghatana in rural health issues by Sunandamma and Rathnamma, Mahila Jagruti Sanghatana,Raichur district, Karnataka .

A form of cultural expression was also presented. Shakuntala Narsinha, journalist, Bangalore presented "Co-opting cultural strands for addressing women's health - some novel experiences from rural India"

At the end of all presentations, participants prioritized women's health concerns and identified marginalized groups of women which needed special attention. The participants also identified strategies for action in order to take their work forward.

Women's health concerns

1. Poverty - livelihood/nutrition/migration/trafficking/HIV-AIDS.
2. Violence and effects on women and on mental health.
3. Reproductive and sexual health.
   - Control over reproductive and sexual choices
   - Irrational use of abortions as contraceptive
   - Sterilization/hysterectomies
   - Child marriage
   - RTIs/STIs
4. Role of SHGs and impact on women.
5. Concerns of Adolescents.
   - Teenage pregnancies/Abortions
6. Over-medicalisation and misuse of medical technologies.
7. Privatization of medicine and knowledge.
8. Disaster and its impact on women.
9. Occupational Health.
10. Traditional Medicine/ knowledge.

Categories of marginalized groups highlighted in the southern zonal consultation

Adolescent girls.
Dalit women/ fishing community.
Disabled women.
HIV positive women.
Aged women.

Strategies

Strengthening Panchayats/ Local Committees / Pressure groups.
Training, organising and recognition of dais and healers.
Regulation of Private sectors.
Networking at state level.
Dissemination of information.
Disaster preparedness and management.
Empowering ourselves to demand for health as our right.
Reviving of traditional knowledge and practices - herbal medicine.
Sexuality education.
Life skills Education.
Kitchen Herbal Garden.
Research Intervention programme.
Campaign against Patent Bill.
Change in Policies.
Ensuring state accountability of health services.
Transferring of services to panchayat.

Way Forward

The participants decided to have state-level meetings to further discuss their issues of concerns and plan of action. The following groups have taken responsibility to conduct state-level meetings and network: Philomena Vincent of Aikya - Karnataka, Aleyamma of Sakhi - Kerala, Buelah of IWID - Tamil Nadu and Shanthi of Academy of Nursing Studies for Andhra Pradesh.

Conclusion

The IWHM southern zonal consultation brought out many important issues of women's health concerns in the region. Health issues of dalit women and adolescents' and young women's health were brought up in more than one presentation. The problem of RTIs, STDs and HIV/AIDS also came up repeatedly. The other recurring concerns were access to quality public healthcare services and violence against women. Initiatives having long-term impact were in promoting herbal medicines especially in rural areas, which went beyond addressing health problems and contributed towards providing livelihood and building self-confidence. Some interesting and innovative strategies used, include the use of popular folk songs and lullabies to spread health messages especially in areas with low level of literacy, intervention at the level of elected women representatives and panchayati Raj institutions for utilization of RCH services. Some of the initiatives can well be duplicated in other areas, such as, the rural and urban economic strategies of the Adolescent Resource Centre and its efforts at providing a creative, safe space for adolescents and young women in Karnataka.

An important outcome of this consultation is the opportunity health activists got to meet each other and share their work and concerns. It has helped to understand health concerns of each state and plan strategies to address these concerns as state and regional networks.

The consultation can be best described by participants' views. Vallary Patro of RUWSEC, Chengalpattu, TamilNadu said "My participation in the IWHM process was an opportunity to learn the different angles from which NGOs worked in the area of health. It has been a great effort by the organizers to bring together participants to discuss issues of concern to bring about changes from their own initiative and capacity and as a part of networking system like the IWHM".

Time was too short to discuss in detail all the issues concerning women's health pointed out Seema Bhaskaran of Sakhi, Thiruvanathapuram, Kerala. She hoped that the issue of child sexual abuse will be taken up in international forum (IWHM) and that international pressure will give support and address this problem.

Three rural women, Ratnamma, Holiamma and Sunandamma and Jagruti Mahila Sangatna of Raichur district in Karnataka said they learnt a lot in this southern zonal consultation, especially the relation between violence and women's health, gender discrimination and also the Patent Act amendment and its impact. Women in rural areas are not allowed to leave their homes and when they manage to come for meetings like this they are afraid to speak for fear of not being accepted. However, this meeting allowed space for participants to discuss in small groups where they felt free to speak and were also encouraged to speak in their own language. They feel very good about this opportunity and will share the discussions in their villages.

Presentation done by Sr.Dr.Elsa Thomas, CHC, Bangalore at the Zonal IWHM, Bangalre on the 1st April 2005

WOMEN'S HEALTH STATUS, ACCESS TO HEALTH CARE, INITIATIVES IN HEALTH EMPOWERMENT IN KARNATAKA

WOMEN'S HEALTH

"Health is a personal and social state of balance and well being in which a woman feels strong, active ,creative , wise and worthwhile ; where her own body's power of healing is intact; where all her diverse capacities and rhythms are valued; where she may make choices, express herself and move about freely."

Women & health program, India 1996

I stand here before you on behalf of all women of Karnataka state to present the present status of women in Karnataka and also to talk about extend of access to health care available and also to give a brief information about the initiatives taken place in the area of health empowerment of women.

With this background let me place before you these 3 Questions.
What is women's health status?
How does it differ from that of men?
What are the reasons for the differences?

Now I would like to highlight Why the need to look at women's health as a separate agenda? Humanity is inclusive of men, women, children, aged, adolescents, youth, differently able and so on and so forth… Out of these various categories why women's group is considered separately?
First of all to consider the worth of the woman as a person, to give dignity as an individual, to give equal status for women in the society.
Why is this so very important? Because when ever we speak of women most often what is projected is the usefulness of women's existence. Usefulness in the sense cooking, cleaning, childbearing, nurturing etc.. But there is something more than that as a woman. Reclaiming our identity a person. That is what I am trying to bring out.

5000 brides are murdered or commit suicide per year in relation to dowry.
70% of the illiterate are women.
70% of the people in abject poverty are women.
50- 70 % of women experience domestic violence.
50% of women in India lack basic sanitation ands safe drinking water.

So should not we consider women's health as a separate agenda?
Now if we take a look at the most exploited utilitarian aspect of women,
It goes like this……
Women forming the half of the humanity do two thirds of its works but own only one – hundredth of its property and earn only one –tenth of its income.

Once again the health of women is to be given prime importance because it is going to affect the health of her family and especially that of her children. This will bring about a whole generation with poor health.

Also we need to look at women's health as a separate agenda because the current economic trends are pushing the women to work in informal sectors where there is lack of social security including even that of maternity and sickness benefits. The rising cost of medical care, drugs, diagnostics and health care over the past decade have resulted in increased home care further increasing the work load on the women.

What are the factors directly affecting the women's poor health status? The most important factors are over work, poor nutrition and violence through out her life. These 3 factors form a triad or vicious cycle and affect her health.

Other factors are Social exclusion, isolation, lower social status, and lower access to health care and lower utilization of health care …

Violence is an issue of power relation between man and women. Therefore women are victims of violence in the society, community and family too. The family which is seen as a source of nurturance and care is often the site of violence. Female feticide, infanticide, wife battering, dowry harassment and many other forms of violence exist within the so called "private sphere" of a women's life. 50 % of the women in India experience domestic violence. A recent study shows that female feticide is rampant in India. In a clinic 8000 abortion conducted in one year 7999 were female fetuses. Through out her life women faces violence. The different forms of violence faced at various stages of her life are illustrated here. This gender based violence affects the health of women seriously. To the extend of some of them committing suicide, some are murdered, some others affected in less dramatic but still equally serious ways.
So the poor health of women is not just biological. The reasons for it are the social causes.

Karnataka

Coming to have a look at Karnataka, its present reality in terms of health status – health situation of women is not at all secure. Low FLR, high MMR, Low sex ratio reflects their precarious state. While the women are heavily exploited, women are also left out of "democratic politics". Some key indicators reflecting women's health and development are – gender ratio, MMR and FLR. 2001 census shows sex ratio to be 964 in Karnataka which was 960 in 1991. At the national level it is 933 in 2001 which was 927 in 1991. Karnataka being above the national average is no consoling factor. Among the districts of the states only 3 districts i.e. Udupi (1127), Dakshina kannada (1023), and Hassan (1005) registered sex ratio in favour of women. Lowest sex ration has been recorded in Bangalore (906) in 2001.

Life expectancy at birth (LEB) for female in Karnataka is 66.3yrs where as the national average is 63.4yrs . for male it is 65yrs in Karnataka where as national average for male is 62.4yrs.

Female literacy rate (FLR)

At the state level it has gone up from 56.04% in 1991 to 67.04% in 2001.

At the national level it has gone up from 44.34% in 1991 to 57.45% in 2001.

Male literacy rate has gone up from 67.26% in 1991 to 76.29% in 2001 in the state.

Bangalore at 83.91% has the highest number of literates and Raichur at 49.54% has the lowest LR. FLR is highest in BLR (78 .98%)

Male LR is highest in Dakshina kannada(89.74%).

MMR

Is the statistics of the number of women who die of causes related to pregnancy and child birth.

In Karnataka it is 450. Karnataka shows 7th highest MMR among all the states in India. National average is 453.

Though the GoK claimed to have improved the health infrastructure over the past few years and also the health and democratic scenario compares favorably with the national averages, however the gaps remain – large urban –rural differences & differences between districts.

Under nutrition and anemia in women continue to remain unacceptably high. Women's health, mental health, disability care are still relatively neglected. Gender inequalities leading to poor health of women is indicated by high MMR, anemia in women and violence against women.

Gender related health Index (GHI) measures Gender inequalities in selected health parameters like LEB & IMR.

GHI has been computed for all the districts of Karnataka. Dakshina kannada take the lead in terms of gender equity in terms of health as it scores 0.807 which is comparable to that of Kerala. Bellary with GHI of 0.484 is at the bottom. Districts like bellary , bijapur, bidar, gulbarga are below the state average. It indicates that in these districts, females are discriminated against in the sphere of social well being.

Based on the above said factors, showing poor health in general and other developmental indicators, districts like Raichur, Koppal, Gulbarga are characterized as category C.

GOK aspiring to work towards a better quality of health and life initiated several steps to combat the shortcomings of the existing health system. Karnataka govt initiated a few things which not many other states have done so far. The first step was to set up a Task force for health and family welfare (KTFH) which consisted of a 14 member team which included govt. and non-govt. expertise on public health issues. CHC BLR of which am part of now has contributed its expertise to great extends for the same.
Two main tasks entrusted to this task force were

1) Review the existing health system to determine if it met its Objectives.
2) Revitalization and reinstitutionalization of the public health character of the health services.

Task force submitted their report after studying &verifying the health system in 2001.
GOK initiated actions based on the recommendations.
A project proposal "Towards equity and quality in health and health care services" as done ion march 2002.
In that project proposal GOK has expressed certain policies, objectives and strategies pertaining to Women's health empowerment.

The Policy concerns are

To consider women as a whole person
with all her diverse needs
To focus on the entire life cycle of women
To use all possible strategies for empowering women
To use community development approach
To enhance women's access to health care
To include male participation.

General objectives of the policy

- improve women's health status over next 5 yrs
- improve women's access to quality health care
- make health services gender sensitive & women friendly

Specific objectives of the policy

To improve the nutrition status of <6 girls
To reduce infant and <5 mortality with gender sensitivity

- Reduce mortality rate in young women
- Reduce anemia among girls & women
- Increase women's access to quality health care

Strategies

To enumerate them, they are too many. So I have picked up a few important ones to highlight. These are gender sensitization, women's health empowerment training, nutrition intervention etc..

Gender Sensitization

- Training for all health personnel –state programme officers
- District health staff
- Taluk level
- PHC staff
- Gendered analysis of the formulation & implementation of all health programmes.
- Develop gender sensitive, women friendly approach in implementation of health programmes.
- Gender desk/unit with special programme officer set up.

Women's Health Empowerment &Training

- With specific objectives
  Increase self esteem, self confidence & self reliance
- Increase knowledge – health status
  health problems
  Govt service programmes
- Develop skills in - community organization
  Training
  Communication skills
  Capacity building
  Form local net works
- Generate demand on health services through
  Advocacy skills
  Increased social control of govt
  Health Schemes.
- Expand TOT approach to all the districts of Karnataka
- Develop core group trainers on women's health in 6 months.
- Publish the District & community level leaders training manuals in1 year.

Nutrition Interventions

Special focus on - girl children

Women
Adolescents

- Nutrition education &health promotion.
- Improve effectiveness of nutrition services for <6 children particularly <2s, through ICDS, ensuring access to girls, urban poor, tribal &under privileged groups, adolescents pregnant &lactating mothers.
- Interventions to reduce Iron deficiency anaemia.
- Special package of nutrition interventions (complementary food) for >2 children in 7 category dts & for tribal children.
- Reduction in Vit. A deficiency.
- Increase technical expertise on nutrition in the state, dts & sub district levels.
- Monitoring, Evaluation and studies.

Women Health Personal

LMO
ANM
Trained nurses

Access to Essential & Emergency Ob.Care

Training for nurse obstetricians
In-service anesthesia course

Training, Continuing Education

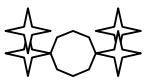
Training of dais

Counseling & Mental Health Services For Women

Trained professional
Training programme for PHC staff

Can we offer women a world, Where we are heard? Where we matter?

The challenge is we need an alternative perspective, a woman's perspective and a democratic perspective.



PEOPLE'S HEALTH DAY (WORLD HEALTH DAY)

At Asirvad, 30,St.Mark's Road Cross, Bangalore
On 7th April 2005

Proceedings and Learning

People's health day was organized by **JANAAROGYA ANDOLANA (JAAK)**. The theme for the day was ***'WOMEN'S RIGHT TO HEALTH CARE'***
Participants were about a hundred. Participants being people from all walks of life added color and vitality to the gathering.

Women out numbered the men. Do I attribute it to the theme being 'women's right to health care'? If so does it mean that men have no part in it or they have no contribution to offer? It raises many doubts and questions. It is true that women have gained ground in the struggle for equality with men over the past few years, but serious challenges remain. A profound look in to the unfavorable attitude of the society towards women reveals that gender inequality is deeply rooted in policies, legislation and societal institutions in our country. The challenges facing us therefore are alarming. They can be resolved only by changing our mind-set that depends on attitudes and perceptions.

The day's program started with the welcome address by Dr. Prakash Rao, Chairman of JAAK. He welcomed the gathering to and briefed the group about the day's event.
Dr.Thelma Narayan, Joint Convenor, Janaswasthya Abhiyan, addressed the group and introduced the theme of the event to the gathering. She stressed on the importance of the empowerment of women.
Dr.Ruth Manorama, Director Women's Voice, Bangalore, released the JAA-K news letter.
Dr. Sr. Elsa Thomas talked about "***Women's health status in Karnataka and the initiatives taken for empowerment of health in Karnataka***". She also

illustrated "***Women and their Rights"*** according to the Indian Constitution, explaining the support provided by the State to the cause of women

Mrs.Cynthia Stephen presented her paper on ***"Factors Affecting Women's Health".*** She described how women are perceived in various institutions like family, community, and work place and how it affects their day –to –day life!

Mrs.Usha Shastry of CIVIDEP talked about the ***"Factors Promoting Women's Health".***

Summing up of the program was done by Fr.Francis Guntipilly, Ashirvad, Bangalore, with special thrust on '***Way Forward –Action Plan For Karnataka'***.

Reflections

Women empowerment and gender issued are talked about widely, but the actual situations in the lives of women are not addressed aptly.

Understanding of gender relations in the context of power equations, culture of silence which is clearly evident and experienced in prevalent caste, class and gender (social ladder) hierarchy existing in our system is needed.

Understand how the internalization of culture leads to the psyche of domination in one sex and the psyche of submission, subordination and subjugation in another sex.

Acknowledge 'Patriarchy' as potential factor responsible for a particular mind set formation and as an ideology working towards increasing inequalities.

Assume responsibility and role of creating a society where roles, responsibilities, qualities and behavior patterns are not determined and imposed by gender, caste, class or race.

Post Tsunami reflection and dialogue-developing a PHM approach to a long term post disaster involvement

8-9th April 2005, Chennai

Humanitarian workers, those who go from one disaster to another, know that it is not enough to blithely set out to help people. And if the disaster is spread over nations divided by wide seas, old wars, steady prejudice and privilege then there is very little space for Pollyannas. Around 150 days after the tsunami, humanitarian aid workers are pausing to review and regroup. In a meeting organized by the People's Health Movement on 8 and 9 April 2005 over 60 non-governmental organizations and funding agencies from around the world came together in Chennai to share experiences, chart the road ahead and debate the role of aid workers. The aid workers were primarily representatives from India, Sri Lanka and Thailand, three of the nations most affected by the tsunami. Also present were aid workers from dozens of countries like Nicaragua and Bangladesh who have learnt about disasters from painful encounters. A document that records some of these discussions and decisions is about to be released by the People's Health Movement under the name of the Chennai Declaration.

The tsunami is over a hundred days old and unfortunately no longer a saleable commodity in mainstream media. The stories are still fresh on the lips of relief workers though. This is not the chest-thumping stuff of my-disaster-is-bigger-than-yours." "It hurts that my mother is gone," says a young girl simply in one of Satya Sivaraman's short films. Many stories are that of pain and grief, things that hurt, things that are simple. But many other stories aid workers shared at the consultation were like puzzles set by mysterious creatures to test the heroes of legends. In helping communities rebuild should NGO's perpetuate the same inequalities or use these opportunities to change exploitative situations? Where does intervention end and where does intrusion begin? When should aid end?

It may have been alright for Alexander to take his sword and cut through the Gordian knot but machismo is really not an option for aid workers. And diplomacy is sorely tested as aid workers try to rebuild in areas where the communities are at war with each other or the state is at war is with its own people.

Walls that tsunamis cannot break

Since December 2004 stories of great generosity, courage and love have warmed a world chilled from the apocalyptic wave. Aid workers from every nation affirmed that local communities, families and friends have often played a sterling role in rescue and relief work. Ethnic and religious lines were crossed often to do so especially in the first couple of weeks after the tsunami. But there are some walls that tsunamis cannot break. Vimal Nathan, Director, NESA Bangalore recounted the story of a fisherman's bitterness. "I lost everything. I lost family members. I lost my boats and nets. I can learn to deal with this world. How can I deal with a world that buries my people with Dalits?"

In Aceh, Indonesia, the military have made it clear that aid workers are there on sufferance and no tsunami is to interfere with the army's daylight killings. Aid workers can either register a strong protest on the risk of being sent away from crucial work or close their eyes to human right violations.

Nothing to lose?

Inequalities that existed before the disaster are magnified after the disaster. Women, the aged, children and people with disabilities continue to be marginalized. An already hostile world becomes more complicated to navigate. The delegates talked of the widespread

differences in aid allocation and distribution. The poorest of the tsunami affected areas, pointed out Saulina Arnold of the Tsunami Relief and Rehabilitation Committee, have received the least compensation. In that peculiar discipline called bureaucratic common sense, there is no need to compensate those who did not lose anything. So the man who lost three boats eventually gets money to buy new boats but what of the men who until that Sunday morning were the ones who actually took the boats out to sea? Dr. Balaji Sampath the TamilNadu Science Forum said with a still-startled air, "There is no department to deal with the loss of livelihood of agricultural labor. In a country where 40 per cent of the population is agricultural labour." At the same time in many tsunami-affected places NGO salaries have shot up by as much as 1000 per cent in the three months after the tsunami. And NGOs that came in post-tsunami rarely hire from the local populations.

"The tremendous generosity and solidarity expressed by people the world over and the massive flow of assistance to the affected countries should have led to a process towards achieving a higher standard of living for affected people," said Sarath Fernando of MONLAR, Sri Lanka. The participants of the conference warmly agreed that the relief measures must not merely aim to restore the communities to their pre-tsunami condition. Sarvodaya, a key organization in Sri Lanka has already laid plans to use the tsunami relief operations for Deshodaya or a national reawakening.

But one point of deeply troubling inequity was brought up by aid workers over and over again at the consultation. According to funding policy the millions of dollars being pumped in must go exclusively to the tsunami victims. Never mind that aid has been withdrawn from Africa and Latin America where it is needed just as much. So as goodie trucks pass through areas of Sri Lanka people affected by decades of war cannot stake claims. Aid workers talk of the excruciating task of distributing materials among the tsunami victims while their just as desperately poor neighbors look on. "When thinking of how much money is allocated to tsunami relief, we need to remember that 30,000 children around the world die of preventable diseases everyday," pointed out Dr. Unnikrishnan PV, Action Aid International.

The tightrope of the mind

Aid workers declared that this was the first time that there had been such popular emphasis on psycho-social care. For the survivors of the tsunami, the landscape had been rendered unfamiliar and untrustworthy overnight. Psycho-social care would certainly be beneficial but what would be the nature of this care? How would this fit into the culture of the survivor communities? Insights and debates were varied. Many agreed that psycho-social care should be planned for groups and communities and perhaps not individuals as in traditional Western psychotherapy. Though the work of institutions such as NIMHANS, Bangalore after the tsunami was applauded, skepticism abounded about the competence of some who were riding "the psycho-social bandwagon." Is psycho-social care less beneficial if the source is non-medical or non-secular? Is support automatically rendered suspect because it comes from a monk or a priest? Introspection awaits the aid worker.

Beaches of discontent

In India, Sri Lanka and other nations debates have been raging around the creation of buffer zones and coastal regulation zones. In the 20-20 vision of hindsight it seems obvious that people should not have been ever allowed to set up home and business on the beach. While conservators were referring to complex and long-term measures to protect the coastal environment, governments cheerfully latched on to the idea of evicting people from beachfront real estate for their own safety. People who have lived on the coasts for generations and hardly see the seaside as a great place to get a tan are now being told by governments across South Asia to move anywhere between a 100 meters to 500 meters away from the sea. Even if one attributes solid gold intentions to the establishment the fact remains that these countries do not have the land to relocate the displaced.

The question of housing remains complicated. Aid workers recount with irony that they were told there is a time and place for consulting people and right now isn't the time. So people are

stuck in asbestos topped ovens in tropical weather. In some places it has been the fear of fire or the sea that led to the popular thatched roof houses being replaced. But if people are not using them it becomes clear that here is another instance of good intentions being just not enough.

The ethical and practical concerns of dealing with what Thomas Siebert of Medico International called a 'constellation of suffering' remains rocky. However, documents such as the Chennai Declaration could spark more introspection, discussion and useful insights.

The Chennai Declaration - 9 April 2005

Preamble:

We, the participants of the post-tsunami PHM Dialogue held in Chennai from 8-9 April 2005 pledge to strive for a people-centered approach in the rehabilitation of affected communities that sees them not as passive beneficiaries of aid but as active participants in their own empowerment. We firmly believe that all rehabilitation work and processes should ensure equity and dignity of both the affected people and the communities they live with or amidst. We firmly believe that aid is a right and not charity. We celebrate the tremendous generosity and solidarity expressed by people the world over towards the constellation of suffering that only became visible on 26 December 2004.

Issues of concern

Human rights and politics of aid:

The current substandard quality of relief and rehabilitation must and can be raised by increasing the level of participation of the communities affected by the disaster.

Understand the various problems of the post-tsunami situation in a holistic and historical manner and not just as arising from the disaster of 26 December, 2004

Respond to the post-tsunami situation in a way that helps build long-term traditions of respect for human rights among both affected communities as well as those interacting with them in any manner.

Emphasize the human rights of affected communities, balancing concepts of traditional rights with those arising from the various international declarations and treaties on human rights.

A reliable database of all affected communities should be created to ensure fairness in rehabilitation.

Defend the rights of people affected by tsunami from forced evictions, discrimination in provision of relief, cheating and exploitation by commercial interests

Rehabilitation and development measures should be environmentally sound, sustainable and appropriate to local culture and tradition.

NGOs and other stakeholders should work together to plan and implement rehabilitation and development initiatives

Promote community ownership of assets created

Ensure that all new constructions are disaster-safe and provide for the future expansion and set up community infrastructure to protect people from various disasters

Make sure that livelihood options are locally relevant and acceptable and do not lead to indebtedness or dependence of any kind.

Donations should be culturally sensitive and should not be damage the local economy through dumping or be a means of introducing GM foods. Aid should not be used for market promotion of products such as inappropriate pharmaceuticals. Clothes, particularly second hand clothes are not appropriate donations.

Expose the politics of international aid that results in the strengthening of exploitative hierarchies that existed in the pre-tsunami period.

Oppose the extensive use of armies for relief and rehabilitation operations in post-disaster situations

Ensure transparency and accountability in rehabilitation operations in order to better protect the rights of affected people especially in areas of civil and armed conflict or without democratic representation.

Community, public health and psychosocial concerns

Strengthen comprehensive primary health care systems with local community involvement

There should be no discrimination of any marginalized social groups including women, children, minorities, people with disabilities and senior citizens.

Humanitarian workers should be given basic training in psychosocial care.

There should be periodic assessment of public health status with community participation covering aspects of psychosocial health and disability.

Prevent overmedicalization. Promote traditional and holistic problems of treatment.

Attention should be focused on alcoholism-related problems and the situation leading to alcoholism among disaster-affected communities.

Emphasize the responsibility of the state to ensure safe drinking water

Provide adequate sanitation taking into account local needs and acceptance.

Health facilities brought to disaster affected communities should be sustainable.

Ensure food security and take care of special food and nutrition needs of children.

Address ecological concerns while providing relief, make provision for waste management and recycling facilities.

When providing public health facilities, ensure the health of animals to protect livestock and to prevent outbreak of epidemics.

Prevent infectious diseases and ensure vector control.

Defend the rights of affected people to healthcare, water supply, nutrition, education, employment and other basic necessities.

Psychosocial health can be promoted by ensuring that communities have a high degree of participation as well as access to information during all relief and rehabilitation operations

Gender and social exclusion

Use the rehabilitation process as an opportunity to capacitate and provide skills especially to vulnerable and marginal sections of the society.

Humanitarian and state agencies should adopt a non-exclusive approach to distribution of aid and strive to remove existing discriminatory practices among the affected population.

Women should be part of relief and rehabilitation planning and implementation. This can be made possible by equal representation of women in the relief and rehabilitation committees.

Encourage the formation of women's organizations such as self-help groups, make them accessible to all women in the organization and encourage these organizations to be more proactive to become sustainable.

Promote joint ownership of newly-created assets among all members of affected families so that gender disparities are not further widened.

Rehabilitation, disaster response and development

Rehabilitation and development measures should ultimately lead to more social, economic and gender equity and reduce the vulnerabilities of local people to future disasters.

Relief, rehabilitation and development measures should make use of locally available resources and employ local people.

Make provisions for the care and security for care givers

General Principles

The situation prior to the disaster should not be taken as the standard of rehabilitation efforts and all effort should be made to achieve as high a standard of living as possible for affected communities.

The local community, local self-governance institutions, and elected representatives should have a key role in relief and rehabilitation planning and implementation.

The land rights of affected communities must be fiercely protected and they must have a high degree of participation in resettlement.

Relief measures as well as livelihoods promoted as part of rehabilitation measures should be ecologically sustainable.

Create decentralized disaster warning systems and should ensure community access and control.

Ensure right to information of affected communities about all rehabilitation and development measures undertaken by the state and non-government agencies, both local and international.

Non-government agencies who have assumed responsibility in the post-disaster scenario for functions performed by the government must ensure the clear restoration of these functions.

Recognize that post-disaster situations are often used as a pretext by governments and vested interests to promote neo-liberal, anti-poor policies and programmes including privatization of common assets and denial of customary rights of local communities.

Recognize that the 'disaster-affected' are not just those who are the most directly and visibly struck and that the umbrella of disaster relief and rehabilitation should be broadened.

The planning of relief and rehabilitation must include clear time-frames.Mechanisms needs to be put into place to monitor relief measures particularly to ensure favourable programmes of development for marginalized communities such as indigeneous peoples, Dalits, ethnic and sexual minorities.

EVALUATION AND PLANNING AT CHC
26-28th April 2005

CHC a unit of SOCHARA for its past 21 years has continued its effort to improve health and access to health care of the poor and marginalized, through policy works, mainstreaming, training, providing information services, networking and active participation in the people's health movement. Promotion of community health based on the social paradigm is its guiding principle. During the past 21 years CHC has grown from grass root initiatives and campaigns to global policy making and advocacy. At this point CHC has initiated a participatory review, evaluation and reflection. As per the 20th year review's recommendation, the evolution of Community Health Learning Centre in to an institute for community health, public health and health policy takes priority for this workshop.

Participants for the workshop included six SOCHARA members, nine CHC staffs, three present and one past community health fellows.

Proceedings & Happenings

Dr.Thelma Narayn welcomed the participants to the workshop and introduced the aim, purpose and the importance of the workshop.

Dr.Ravi Narayan initiated the remembering of the forerunners in community health. CHC had the opportunity of the presence and blessings of many pioneers in community health. The wealth of wisdom and guidance they have granted to CHC was something to be cherished. To mention a few of them they are Dr. Varghese Benjamin, Dr. C.M. Francis, Fr. Claude D'souza, Dr. George Joseph, Prof. Debabar Banerjee, Dr.N.H. Anitha and Ms. Padmasini Asuri.

At the beginning of the day's programme, all the participants introduced themselves and shared their expectations about the workshop.

Dr.Thelma presented on National Rural Health Mission (NRHM), including Accredited Social Health Activists (ASHA). Following there was a discussion on national rural health mission and accredited social health activists, facilitated by Dr. Ravi D'souza.

Later in the day Dr.Sunil Kaul presented on ANT (Action for North-East Trust)- about his involvement in Assam which was very inspiring and thought provoking. It was followed by a presentation from Dr. Sr. Aquinas about her work at Hannur, the comprehensive Rural Helath Program(CHRP).
Then the presentations followed were Jaagrutha Mahila Krishi-Coolie karmikara Sanghatana by Eddie Premdas and Health Policy of the Catholic Church by Dr. Ravi D'souza.

In the evening Dr. Thelma Shared about CHC/SOCHARA work in the past seven years.

The second of the work shop started by sharing from the participants 1) the pleasant experience of the day one, 2) any concern that had emerged, 3) one ideology about community learning centre.
Dr. Ravi Narayan facilitated the charter for initiative as discussion on Vision, Mission, and Strategy of the learning centre. The participants were divided in to groups and discussion on goals, target group, the why, how and who about the learning centre was done. Then the groups presented to the assembly their findings and we researched together on the same ideas.
Later in the evening group discussions were done on the technical resources mainly curriculum, training process, field practice and faculty selection.

The third day's programme started with the reporting by each group the result of their discussion about the technical resources. Then Dr.Ravi Narayan facilitated the group to move from idea to reality. He encouraged the participants to take a step forward and identify the area in which each one would like to contribute in some way or other and to commit them to it. The different areas of contribution suggested were faculty, advisor, field trainer,

visiting faculty and module generator. Amazingly everyone opted most willingly for different areas of contribution. The third day's program continued with discussions on Governance, sustainability and institution building, locating CHC/SOCHARA's initiatives in the broader context. At the end of the day the charter the tentative draft for CHC that emerged from the workshop learning centre was presented to the assembly.

CHARTER for CHC LEARNING CENTRE

1. Given that the present reality of people's health is dominated by a market driven, bio-medical and techno-centric health care model, we aim to build a people- centred perspective of health that stresses on issues of equity, justice and human dignity….

2. The centre will be an institution that provides a space for learning community health perspectives and approaches to address India's health challenges, keeping the various diversities in view. It will also be a space for people to explore and discover alternatives to existing dominant paradigms which affect health.

3. The centre aims to create a critical mass of people, who will be exposed to people-centred initiatives for people's health. It seeks to influence people and structures that affect people's health directly or indirectly to adder's health challenges in an equitable and non-exploitative manner.

4. The centre will bring together the collective wisdom of communities and grass root workers in the mainstream public health discourse while drawing from multidisciplinary knowledge. It will use training process of experiential learning and of interactive, non-didactic and learner centred training methods. Courses and modules to address different sections of the society will be specially designed in order to demystify public health and bring it in to the domain of common people. Through dissemination of information and campaign methods and by networking with like minded people and institutions

the centre will reach out to lay people to make public health a mass movement.

5. The centre will undertake research and advocacy on public health issues to affect changes in State policy and people's practices. The underlying principle of learning will be to expose the learner to the determinants of health and to identify systemic deficiencies while recognizing and harnessing people's ability to develop alternatives to address them.

CRI CONSULTATION , Don Bosco, Okhla, NEWDELHI
1-4 May, 2005

'Equitable Collaboration Of Men And Women In The Church-Towards Agender Policy'

SALIENT POINTS FROM THE TALKS AND INTERVENTIONS

Inaugural Session.

The inaugural session began by invoking the blessings of the most Holy Trinity (Regional CRI Secretary, under the leadership of Sr. Gloria). Bro. Mani, the Secretary National CRI extended a hearty welcome to all.

Archbishop Vincent M. Concessao, Archbishop of Delhi

Referred to the new Pope telling Cardinal Topno, "India is important - India has contributions to make to the universal Church". He emphasized the following.

We had difficulties in the past and even now there are struggles and hardships when we trying to bring about a transformation. Given our rich heritage of religious plurality and culture there could be differences in the perception of theology from the view of the West and East.

We have to discern God's plan in the context of different cultures, traditions, beliefs etc. A positive approach would call for openness, humility and courage to change of mindset. Inspiration must come from the living word of God.

Pope John Paul II in his letter to women highlighted the contributions that women have made to bring changes in the society.

The change you bring would not only be a help to the Church in India but also to the universal Church and the whole world. He appreciated the National CRI for taking upon itself this great task of formulating a policy for the Church.

Bro. Varghese Theckanath SG, CRI National President said

This Consultation has a historic significance to the Religious and the Church in India as it has to give a gender policy and the CRI has initiated and nurtured to this event. Religious Group in India forming 10% of the Religious in the global Church is vibrant with vitality and commitment. The Consultation is important to all men and women Religious. It is not only important to us all but also necessary. It is important to CRI itself to revitalize itself and to be emergent and dynamic.

The Consultation is to give voice, to end the culture of silence. Even in the history of English language, the terms to refer to women were absent for 400 years and they appeared only in the 12th century. The Consultation brings a new hope for India as it is told that awakens the women power would be a super power. The content of the Consultation would cover theological, political and psychological spheres.

It is told that stereotyping is a condition for discrimination and the past gives numerous examples of discrimination against women. Even St. Paul while proclaiming an egalitarian society beyond gender counterbalances the vision by placing women secondary to men. There are Church Fathers who had said that women should not teach or aspire for anything. It is said that St. John Chrysostom is reported to have said that there were many dangerous animals and the most dangerous one is woman. Even in the latest trend in the Church also places woman secondary to man stating that it is for man to have ideas and the women's role is to act. Theology should include a reflection from the grass-roots.

There cannot be true partnership when the power to govern is restricted to men. The sample study by the FORUM (Forum of Religious for Justice and Peace) on the gender discrimination in 1994 brought out that the women play only 3.2%, .5% and .1% play significant roles at the diocesan, national and international levels respectively. It is rare that any power is given to women in highest Church bodies. At the psychological levels, women are led to passivity.

Sr. Vincent, President, Women's Section and National Vice President, CRI highlighted the following.

In order to make the society more humanized, women have to make special contribution in new thinking and in the process of decision making. Women need not wait to be empowered by men as they have only to release the power within. If the first two millennia belonged to men, the third one must go to women. It is necessary to focus on the positive aspects of women's roles in the society. Women could form solidarity groups as women by nature would respond to and care for spontaneously by transforming the negative aspects of power into the positive aspects of understanding and caring. There has been a growing trend to show that women are far superior to men in performances like studies.

Fr. Antony CMI, President, Priests' Section and National Vice President, CRI said,

God had not made any discrimination as man and woman were created in God's own image and likeness. It is not only in the patriarchal societies that man plays dominant roles but also in the matriarchal societies as being institutionalized in the so-called matriarchal Nair society by the institutionalized dominant role played by an elderly man called "Karnavan". Women do play leading roles in the apostolate of education, social work, healing mission and even in the pastoral work, there is a big scope for women. Even the mere lack of Priests demand such a role as the ratio between the Priests and Catholics in Africa for example is just 1:30,000. While we not have a say now in the sacramental ministry, we should identify the areas in the common priesthood in which women could play prominent roles.

Bro. Mani, the National Secretary, CRI spelt out the dynamics of the Consultation.

This Consultation is unique as the Participants are a group of experts their own fields with 50% being Major Superiors. Such a status demands them to give rather than to receive. It may also be noted that only one third of the time is allotted to inputs. Everything in the Consultation should ignite the mind. We are here to formulate a gender policy in the Church. This could be networked in the context of similar studies and we should help the emergence of an accepted general gender policy. He called for one point evaluation, "What is your personal contribution" during the workshop".

THE GENDER QUESTION – A filed analysis by Sr. Kochurani

Is gender a question at all?

For any consultation, the starting point ought to be the lived experience of people in relation to the question at hand. Hence a field analysis of the gender question was considered essential as preparatory work for this consultation. As the consultation would focus on collaboration between women and men in the Church, it was decided to discuss the question of collaboration with groups of priests and religious, the professional men and women in the Church.

The analysis was restricted to six workshops to be held in places representing the different regions of CRI from the south, central and north of India. She mostly focused on the insights gathered from these workshops as it could throw light in our search towards indicators for gender policy in the Church.

General Observations:

- A striking feature generally observed in these workshops has been the fact that irrespective of the socio- geographical considerations, participants of the North as well as South expressed the very same concern with regard to the gender question. Gender was deeply acknowledged as a serious concern especially by the women in all groups. Men in general were aware of the problematic and open to discuss it except for a few who strongly felt there was no problem as God has made man and woman so differently and so they need to function different ways as done in the Church at present.

- In two of the workshops the very use of the term collaboration was debated. Many questions were raised in this regard. At what level is collaboration exercised? Who initiates and who are the collaborates? Is it a subordinate role played to assist a major group holding the reigns or is it a joint venture to achieve a common goal or mission? Some of the participants felt that this expression was inapt and needs to be re-defined as it implies joining in an undertaking initiated by another on the terms and conditions of the initiator. Can collaborations possible between unequals? In the Church where are the men and where are the women? And how can we talk in terms of a healthy collaboration from such unequal levels where we stand?

- In one workshop, the male participants were interested in discussing on "collaboration between priests and religious in the Church" keeping the gender question out. Limiting the issue to well defined ecclesiastical roles within the sociological and theological comfort zones were apparently safe. It appeared as though addressing the gender issue was threatening, as it would challenge world views, mindsets, long established roles and behaviours.

- The question before her was whether gender was a serious concern only for women? Certainly it is the wounded that feel the pain. In some places there was refusal even to recognize that there are gender discrimination in the diocese.

Gender Issues

The participants discussed the gender question separately in groups of men and women. The open search into the question revealed several obstacles to collaboration between women and men in the Church. The major issues include:

1. Blocks to communication

    - Women expressed concern over men feeling threatened when women become assertive
    - Even though sisters are co-opted into parish council, they have no voice in the planning of pastoral activities. Sisters only expected to implement them.
    - Five out of six workshops brought out the issue of the pulpit being used against the sisters either for subtle communications or even frontal attacks. Derogatory remarks and corrections are made against sisters from the pulpit or at the gathering of laity in the parish.
    - Sisters also acknowledged that there is a tendency among women to be not assertive enough or to be less communicative at meetings due to the belief that priests are trained in theology and have better knowledge.

2. Domesticated roles

    - Sisters are taken for granted

3. Inadequate Formation

    - The seminary formation of men and theological studies tend to reinforce their early family socialization of considering themselves superior to women
    - Seminarians are not gender sensitised
    - Psychological immaturity of men for a celibate commitment is not fully addressed
    - In very many cases they do not know how to enter into a relationship with women respecting their sexual integrity.
    - Both men and women were unanimous in stating the inadequate formation programme for women religious
    - A ritualistic and pious spirituality not that of Jesus' spirituality.

- Women need to be formed and training very many other fields.

4. False understanding of the charism

5. Other related issues

Emerging concerns

- Urgency for gender sensitization
- Women reclaim your worth
- Men allow women space
- 40 women who hold doctorates in Kerala. Where are they?
- Men being the part of the problem, they are also solution to the problem.
- Moving towards a sharing of power, authority, leadership, knowledge, decision making, service and finance.
- Why don't the Bishops trust the Sisters?
- The empowerment of the women religious awakens the sleeping giant.
- Rise up to a new consciousness of being women in the Church and the society.
- National and regional networkings rediscover their identity as women; learn to say no to situations that are oppressive and unjust.
- Facilitating structural change
- Inducting women into the policy making and leadership structures of the Church.

The Position of women according to Church Teaching by G. Gispert –Sauch, S.J

Church of course includes all of us, but it evident that we want to know clearly what the official teachers of the community, the bishops with and under the Pope, say on the place of women in the Church and in society. He mostly concentrated his presentation on the broader context of what Christian faith says about women as women. For this is basic to understand the teaching of the magisterium on the ecclesial and social roles of women, which takes for granted the faith intuitions based on the biblical revelations.

Interventions and reaction from the assembly

- Deeply disturbed, pained,
- What is the purpose of the paper at this juncture?
- The suffering love of women that which sustains the faith of the Church to be admired
- Some others were shocked with the presentation and they asked what we are going to do with such contribution.
- A clear thinking has to emerge. We have to focus on the rights of women.
- The teachings of the Church? Which Church? Is it the teachings of Jesus Christ or the official Church?
- I am not surprised at the presentation because that is the teachings of the Church.
- Because of Vat II had said that the Church is the people of God. That element was not highlighted in the presentation.

PLEANRY AFTER GROUP DISCUSSION ON MAJOR CONCERNS

Concerns

- Insensitivity of the Church to take up the issues concerning women and inadequate representation to women in Church bodies
- Perpetuation of gender discrimination and inculcation of patriarchal values in the family, educational institutions, in priestly and religious formation, and in the Church.
- Ritualism and practices of spirituality that reinforces clericalism
- Social concerns are not the concerns of the Church
- Re-interpretation of the Religious life and the vows today's world…
- To act justly, to work humbly and to love tenderly.
- Insensitivity in the Church
- Hierarchical Church and political Church
- Inadequate leadership does not give confidence and perpetuate a culture of silence
- Power and governance: sacramental and governing power is vested in one person
- Democratic approach in the whole process of the Church
- Re-interpretation of the Bible and theology
- Prayers written by men
- Biblical and theological misinterpretation of the role of women in the Church, resulting in ritualism and other-worldly spirituality.
- Violence, harassment and abuse of women and double standard of morality and where is question of justice in the Church.
- Perpetuation of gender discrimination starting with the lowest unit.
- Promotion of patriarhcal values.
- Inadequate representation of women in CBCI, CCBI
- Inadequate training of Sisters in theology and philosophy
- Develop the theology of dissent.
- Rigid and one-side Canon law
- The methodology of Jesus was confronting the powers from within and without. We too have a duty to challenge and confront such powers.
- Human rights violations, we are supposed to be the prophetic voice today
- Major Superiors listen to the Bishops and the Priests and take decisions without giving a hearing to their Sisters and Brothers
- Economic empowerment of the Sisters: Just remuneration to the Sisters, working in collaborative ministries… Just wages not paid..
- Who decides? Where is this partnership in the mission?
- Increasing clericalisation and centralization of power in the Church
- Formation that lacks content with social issues
- Misinterpretation of the vows that promotes subjugation of women instead of making them liberated and empowered
- Culture of silence

Theological insights – a New Paradigm shift by Sr. Evelyn Monteiro

Responses

- Formation was emphasized. It has to be focused in the policy that we are drafting.

-Motherly model is not a comprehensive concept. It must be brotherly and sisterly model…
- Models are changing terms
- We need to change the concept and mind set.
- Why are women bracketed along with Tribals, Dalits etc?
- We need to re-discover the real identity of women.
- Oppression against women, marginalization, violence, cultural oppression.
- The social reality must be challenged along with the formation….
- All of us including women are patriarch cal because we are brought up in such climate..

The empowered women, a global concern by Prof. Anjali Gandhi (Text not given)

Gender and sex

- Social and biological
- Biological difference between man and woman
- Boys excel of their thinking process - Girls in verbal skill
- His brain is built for action - her's for talking (he does- she communicates)
- Boys have four times more vasopressin the neurotransmitter that creates a persistent drive to find a mate.
- Testosterone makes men more aggressive, impatient

Misconceptions clarified

- Women are not weak or second sex
- Nursing baby = running five miles (500 burns calories a day)
- Men 10% taller 20% heavier and 30% stronger
- Gender based socialization
- Men outnumber women in homicide violence, war victims, self inflicted injuries, Stress related diseases

Causes of discrimination: cultural, process of parenting

- Sometimes for the use of physical power of men over women, subjugation of elderly women to abuse for economic reasons
- Glorification of virtues such as patience, morality and sacrifice..
- Glorification of the role of wife, mother and neglect pf women as a person
- Interpretation of religious dogmas to subdue women.

Biological

- Relevance of the concept of purity and pollution related female sexuality.
- Women seen as reproductive units rather than as persons…

Political

- However, representation of women in politics, bureaucracy, law etc

- Lack of political will to frame and implement law safeguarding the rights of women.
- Reluctance of the state to intervene in families in favour of women

Economic

- Minimum participation of women in income generating activities
- De valuation of women's work and contribution
- Discrimination of women in terms of employment and wages
- Restricted entry of women in education and technical training opportunities
- Limited access of women in property, land and other assets
- Implied division of occupation on the basis of sex

Some significant statistics

Parliament seats	-	8.2%
Cabinet post	-	7%
Local govt.	-	27%
HDI	-	138
GDI	-	118
GEM ranking	-	86%
Adm. and Mgr position	-	2%
Prof. and technical workers	-	21%
Illiterate	-	62%

International Conventions ratified by India

- International Labour Organization (ILO) Night work (women)
- Equal remuneration convention
- International Convention on All Forms of racial Discrimination against women (CEDAW)
- International Convention on Economic, Social and Cultural Rights
- International Convention on the Rights of the Child
- International Covenant Civil and political Rights
- SAARC Convention on Preventing and Combating the Trafficking in Women and Children for Prostitution
- International Convention against Trans-national organized Crime

Interventions

- Gender policy – whether it is society, Church or multi- nationals –where do we stand in the question of gender how do we treat our women
- Education is to be geared towards gender mainstreaming
- What is your experience with religious men and women or how you come across religious
- Religion do respect women and whatever is laid down by various religions are not been practiced the oppression is laid down by the men. It is men who interpret the scriptures –
- Probably things will change if women start interpreting them.
- Women had been very powerful in India. If you allow some one to suppress you but you resist it ultimately the society will accept you.

- Three thousand years of subjugation – so it will take time to undo
- Post-modernism talks about feminism which is attuned to a particular culture
- Men have to listen and women have to observe
- The women's movements have done well in India
- When you are making the policies in the Church are there women involved?
- UN Conventions are your basic documents –
- You should catch hold of those standards where you are safe
- Economic power and gender – how do you see- unequal remuneration and how it affects the women
- Feminization of poverty – 98 % of Indian women are in unorganized sector
- Empowerment comes at the organizational level
- Advocating human rights and legal literacy are very important
- Globalization has done much to women who are working in the organized sector but not in the unorganized.
- Increasing instance of incest, rape, sexual harassment etc
- The reproductive system of the women is not taken into consideration
- We have to educate the men- have more men in our workshops on gender Sensitization
- What is the stand of the government -Is there a gender policy of the government?
- Yes – 2001 Gender policy – due to pressure of the international world but no policy can brining about a change unless there is a change in the mindset .
- What are we doing for the empowerment of women?
- Representation of women
- Situate ourselves – where do we want to journey from here?
- Convert into a collective dream. Actual experience of the people, the ideological framework ecclesial frame work within which we operate today

TOWARDS A GENDER POLICY IN THE CHURCH- SUMMARY

Introduction

The Catholic Church is an institution that has stood the test of two millennia. This was made possible because of the openness it has shown down the centuries towards the historical developments manifested in the signs of the times. Faith is lived out by reading the signs of the times in the light of the word of God. As context changes, our response also should change.

We profess in the Creed the catholicity of the church. Today the world has reached the awareness that the ways women perceive things, interpret them, and arrive at conclusions is different from the way men do. Hence it is a sad fact that in the Catholic Church, women's perspectives, interpretations and positions are completely absent. To this extent, the Church cannot be catholic and all-inclusive. Hence this situation makes the Church devoid of its professed nature.

Jesus' ministry preaching and activity was centered around his dream of the Reign of God that has to come on earth. The Reign of God is a situation wherein people acknowledge God to be their source and the fellow beings to be their brothers and sisters and live a life befitting a fraternity. The present situation leaves the Reign of God a faraway dream.

Human history is proving the fact that peoples and communities are coming closer towards one another, and differences are slowly giving way to participation, convergence and communion. As Christians we believe that this happens as a result of the work of the Holy Spirit among the peoples of the world. As long as the Church remains patriarchal in nature and masculine in perception, this work of the Holy Spirit will be obstructed and defeated.

Jesus was a champion of human rights in his times. He stood on behalf of the oppressed and marginalized, especially the women. Jesus Christ instituted the Church in order to continue his mission. Thus the Church should have been the champion of promoting human rights within the world. But it would be certainly disturbing if at an age wherein human rights have been clearly spelt out, and human rights awareness so much grown, the church fails to recognize the rights of half of its members – the women.

It is certainly very encouraging that the Catholic Church has come up with a letter addressed to its Bishops "On the Collaboration of men and women in the Church and the world." Though the title speaks of collaboration of "men and women", the content entirely is dealing the importance of women's issues, the importance of feminine values in the life of society and the Church. It also gives clear guidelines to address women's issues and to work for women's emancipation. It calls for a changed and transformed relationship of men with women. It instructs the bishops to enhance women's participation in the mission and life of the church. It is in concrete response to the directives in this letter that the church in India makes an examination of conscience and tries to arrive at a policy regarding women. Hence the National Consultation on "Collaboration of Men and Women in the Church" participated by the national executive committee of the CRI, together with some religious activists who really work at gender sensitization in the country, at Don Bosco Specialized Training Centre, Okhla, Delhi, 1-4 May 2005 suggests the following outlines towards a gender policy in the Church.

Concern 1: **Perpetuation of gender discrimination and inculcation of patriarchal values in the family, educational institutions, in priestly and religious formation, and in the church.**

Guidelines towards Policy making:

1. *Family*.
    a. Family education programs and marriage preparation courses which will include pro-life education, health education, parenting skills, participatory parenting, and deal with issues of female foeticide, stereotyping of gender roles, inclusive language, dowry.
2. *Educational institutions*.
    a. Promotion of gender sensitivity in schools, by encouraging co-education, creativity, analytical-critical thinking, and habits of research, health education, value education, and education of parents towards gender sensitivity and overcoming of patriarchal values.
3. *Formation*.
    a. Common formation programs for men and women.

b. Empowerment of women religious for leadership in Church and society by means of adequate training in areas such as philosophy and theology.
c. Formation of formators, especially in the area of sexuality and affective maturity.
d. Promotion of gender sensitivity at all levels of seminary formation.

4. *Church*.
    a. Gender sensitivity in teaching and preaching of priests, and in pastoral letters of Bishops.
    b. Revision of catechetical texts.
    c. Preparation of women specialists in canon law.
    d. Establishment of a theological centre run by women.
    e. Induction of more women on the seminary staff.

Strategies:

1. Take Gender Sensitization as theme of the forthcoming National, Regional and local CRI meetings and assemblies.
2. Regional CRI to prepare individuals and constitute teams of sensitized people (including laypeople) for animation towards feminist orientation.
3. Family:
    a. The local and regional CRI to study and support strategies regarding animation of the family.
    b. Network with women's groups and NGO's.
4. Educational institutions
    a. Regional CRI will organize gender sensitization programs for heads of educational institutions.
    b. Suggest "Gender Sensitization through Education" as a theme for the forthcoming AINACS meeting.
    c. Use of media techniques for gender sensitization.
    d. Encourage and advocate co-educational schools.
    e. Prepare and disseminate value education text books for classes I-XII on gender sensitivity and feminism.
5. Formation
    a. Regional CRI to organize short live-in programs for men and women formees (e.g. on interpersonal skills, communication skills, gender sensitivity).
    b. In seminaries as well as in religious formation houses, the curriculum should include psychology of men and women, feminism, gender sensitivity, etc.
    c. Major superiors to ensure that libraries and reading rooms of local houses have serious and relevant materials.
    d. Formators should be trained to affective and sexual maturity. Send them to co-educational centers.
6. Church
    a. Conscientization of Women's Commissions, AMOR, CCWI, etc.
    b. Encourage scholars to critique existing catechetical texts. Include women in preparation or revision of catechetical aids.
    c. Encourage departments of feminist theology in theologates, headed by women where possible.

d. Prepare women religious scholars, and be willing to supply their services to theology centers.

***Concern 2*: Biblical and theological misinterpretation of the role of women in the church, influencing beliefs and practices.**

Guidelines towards policy making:

1. Deconstruction of the patriarchal image of God.
2. Replacement of exclusive masculine symbols and vocabulary regarding divine-human realities.
3. Feminist reading of the Bible, feminist theology, and the use of inclusive language at all levels and in all sectors of faith formation.
4. Dismantling of the patriarchal portrayal of Mary as a submissive, passive woman and return to the biblical image of Mary as a liberated woman.
5. Removal of liturgical texts derogatory to women and highlighting feasts of great woman saints.
6. Promotion of a feminine mode of praying and a spirituality arising from life.

Strategies:

1. Deconstruction…
    a. Inculcate in children the father-mother image of God.
    b. Emphasize the humanity of Jesus rather than his masculinity.
    c. Promote researches in feminist theology.
    d. Train more personnel, men as well as women, in feminist theology.
2. Construction of new symbols and imagery
    a. Start using inclusive language, also in the liturgy.
    b. Create mission oriented hymns rather than pious ones
    c. Present God as female and male in pictures, paintings and images.
3. Feminist reading…
    a. Encourage reading of biographies of modern feminists and social activists in our formation houses and communities.
    b. Circulate literature on feminist theology in communities and study houses.
    c. Take relevant scriptural passages for weddings and other occasions.
4. Mariology…
    a. Mary to be shown as an empowered woman in pictures and images.
    b. Reconstruct Mariology.
5. Highlight feasts of great woman saints.
6. Prayer and spirituality
    a. Reflect on the way we use prayer books and liturgy of the hours. Prayer should reflect our realities and be based on life experience.
    b. Encourage eco-friendly prayer.
    c. Become aware of sacredness of the body and encourage use of the body in prayer.

***Concern 3*: Gender insensitivity among Clergy and Religious expressed through inadequate representation of women in ecclesiastical bodies, and formulation of discriminatory and arbitrary policies in various dioceses and religious congregations.**

Guidelines towards policy making:

1. Recognition of the intellectual capacities of women and provision of opportunities for developing and expressing them.
2. Adequate representation of women in church commissions and church institutions.
3. Formation of the laity, especially women and women catechists, and allotment of finances for this purpose.
4. Concerned parties must have a definite say in the process of making decisions and policies that affect them.
5. All ministries and services, not only those directly under the diocese, must be recognized as part of the mission of the same church.
6. Appointment of persons with gender awareness to the Women's Commission, to ensure its effective functioning.
7. Commissions to investigate disputes within religious congregations should include women.

Strategies:

1. Increase representation of women in church commissions, and in governing bodies of church institutions such as St. John's and Caritas.
2. Committee of 5 comprising of regional CRI and diocesan clergy, be set up in each diocese to address issues affecting life and mission of the diocese.
3. All policies regarding new works in the diocese to be made by the bishop in the spirit of *Mutuae Relationes*.
4. Any selection of members, including lay representatives to women's commissions, should be made from names suggested by bodies such as the executive of the women's section of CRI and CCWI.
5. Within the next 5 years, by 2010, every diocese must train at least 50 laity, esp. women, in various fields to actively participate in the life of the church and generate resources within the diocese for the above.
6. Every parish to have women's groups for active involvement in life of the church.
7. Monitoring committee (consisting of laity, religious and clergy) for all the above strategies in every diocese.

***Concern 4*: Violence, harassment and abuse of women and double standards in the Church.**

Guidelines towards policy making:

1. Establishment of legal cells at parish and diocesan levels for handling issues related to harassment and abuse of women by church personnel.
2. Establishment of arbitration bodies at parish and diocesan levels to monitor cases of serious violations of women's rights.
3. Remodel Diocesan Women's Commissions to address issues of violence and scandals.
4. Clear policies for just wages and fair service conditions for those who work within institutions run by religious, dioceses or bishops' conferences.
5. Ensuring just remuneration and fair service conditions for religious by means of clear contracts with bishops.

6. Foster greater inter-congregational solidarity for sharing concerns and establishing bonds.
7. Church authorities should not impose financial contributions from religious without dialogue.

Strategies:

1. CRI will organize awareness building programs for handling issues relating to women, and for monitoring serious abuse. Congregations with resources and personnel will come forward to organize such programs.
2. Clear cut policies to be formulated by CRI and CBCI regarding sexual abuse.
3. Establish legal cells at diocesan level or in large parishes.
4. Networking between CRI and women's cells, at parish, diocesan, regional levels.
5. More sisters to study law and journalism
6. Policies to be made, where inexistent, for redressal of grievances of our employees, addressing issues of age of employment; wages; leave; sexual abuse; job security especially in unorganized sector; girls brought from other states. Implementation of these policies should be monitored. Network with organizations working for domestic workers.
7. Make it a policy that sisters should not work in maintenance positions in bishop's houses, seminaries, etc. National CRI to take a firm stand on this question.
8. Reinforce the policy that sisters should not work abroad in maintenance positions. Young sisters should not be sent abroad for initial formation.
9. Exposure of sisters to the realities and abuses suffered by women. [better formulation]
10. Refusal to sign unclear or unjust contracts.
11. CRI to send reminders, seek feedback, and conduct evaluation of implementation of the above policies.
12. Religious congregations / CRI could adopt / adapt CBCI service conditions to local units.
13. Networking with organizations and people's movements outside the church to fight women's causes.
14. Congregations should help members to attain psychosexual maturity and assertive mentality.
15. Encourage women religious to enter the legal profession.
16. Strengthen and revitalize local CRI units. Strengthen relationships and solidarity among members, through informal and formal visits.

***Concern 5*: Increasing clericalization and centralization of power in the church.**

Guidelines towards policy making:

1. Emphasizing the participatory style of functioning, shared authority and collegiality.
2. Inclusion of women in bodies for policy making, administration and arbitration at all levels in the Church.
3. Concrete measures promoting participation, transparency and accountability in administration.

4. Measures to be worked out in the case of bishops or priests who use the sacraments as a means to control or harass women religious.

Strategies:

1. Participatory style…
    a. 50% women representatives in church commissions and committees. Representatives from existing groups and organizations, area wise.
    b. Training all church personnel, men and women, to participatory leadership styles.
    c. Separate pastoral roles from administrative roles.
    d. To avoid exploitation, there should be just remuneration for those in administrative and pastoral roles.
    e. More collaboration and solidarity among parishes and institutions, e.g. twinning.
2. participation in policy making
    a. Fair representation from diocesan priests, religious, youth, laypersons in policy making.
    b. Every diocese to have an arbitration body composed of impartial and competent persons, men as well as women.
3. Participation, transparency, accountability
    a. Set up a body with authority for facilitating and monitoring transparency, participation and accountability at all levels.
    b. Generation of income and collection of revenues, budgets and accounts to be presented and passed at all levels.
4. Measures to be worked out…
    a. Arbitration body to ensure that sacraments are not used to control women, religious as well as lay.
5. A small group of competent CRI members should take a proactive and assertive role at national and local level.

Master strategies:

1. Have gender sensitivity as theme of National CRI Assembly.
2. Small initiatives at personal and local levels.
3. Identify areas of immediate concern.

RDT (Rural development trust) Anathapur

My observations about RDT

Origin of Community Health Sector

- Health Sector emerged as an independent sector in August 1998
- Co-operation & Co-ordination with other sectors is continuing wherever required & feasible
- Starting with just 3 members headed by Director with health background, the sector has been growing up both in terms of coverage of villages and also in terms of qualified & well-trained professional staff

Community health sector grow to the extend of involving 1512 villages and having a health staff of 126.

Accepted a policy "Towards Gender Equity" to allow more Space for Women Staff to Grow & Show Potential in Community Health Sector.

RDT Provides an access to preventive & curative health care to the poor & deprived sections at grass-root level with special focus on women, children and disabled persons. Professional Health Care provided at the affordable cost to women, children and disabled persons.

Women- Gender Discrimination – Vicious cycle of poverty & under development. This is manifested in many ways;

- Men's apathy towards women health
- Severity of sickness / disease
- Severity of sickness / disease
- Fear & inhibition to share health problems
- Victims of STD/ HIV /AIDs
- Reproductive health problems
- Excess workload - both inside & outside
- Migration of men
- Fear of losing daily wages
- No Assets
- Lack of education & skills
- Nutritional deficiencies / Anemia

- Early marriages

Specific objectives and activities of RDT are

1. Awareness & Capacity Building

Improving awareness among rural people especially women on various health & gender related health issues.

2. Capacity Building of Community Health Workers (CHWs)

Improving & upgrading the skills of "Health Volunteers" popularly called CHWs (Community Health Workers) through Field & Hospital Based Training, Refresher Courses & Monthly Plan & Review Meetings.

CHWs are approachable, accountable, accessible and answerable.

Role of CHWs popularly called as 'handy Doctors' are;

- Conducting Aseptic Deliveries
- Treating Minor Ailments
- Ensuring Immunization of eligible children & mothers
- Motivating Women for Family Planning
- Involving in Nutrition Program
- Extending required support to RDT & Govt.,

Health Check-ups by Health Organizers

Provides improved health care at grass-root level to both antenatal& postnatal mothers & others in community through:

- Health Education
- Conducting Health Clinics including conducting of Clinical investigations including blood & urine tests & recording of BP levels
- Giving Medical Treatment
- Referring cases to higher institutions or specialist doctors & extending follow up services
- Extending Nutritional Support

Health care programme for the children -Improves health of children belonging to poor communities through regular School Health Check-ups & Follow up services.

Identification and treatment of chronic and major disease like cardiac problems, epilepsy is done with good results.

Nutrition programmes Improves nutritional status of antenatal, postnatal mothers & children in the age group of 0 to 4 years through supply of boiled eggs on every alternate day in community schools .

Vaccination against Hepatitis B-prevents the incidence of Hepatitis-B among all eligible children belonging to target families including disabled children pursuing special education in RDT Special Schools & Girls in RDT run Bridge Course Residential Schools.

Other Initiatives of Community Health Sector
Are:

1. co-ordinating mobile dental clinics
2. co-ordinating DoT programmes
3. organizing eye camps
4. Pulse Polio Program – Collaboration with Government

Major accomplishments of RDT are

- Expanded Community Health Program to all project villages
- Recruitment of female staff (75%)
- Conducting antenatal clinics & school health clinics thrice a year
- Continuous support to the district administration for the successful execution of Universal Pulse Polio Program
- 100% coverage of eligible children under Hepatitis-B Vaccination & immunizing all staff members
- Covering all eligible children (0-4 yrs), antenatal mothers & postnatal mothers under Nutrition Program in all project villages
- Covering BC villages & inclusion of orphans & aged people also under the Nutrition Program
- Extending services to the victims of Natural Calamities (Earthquake & Tsunami)
- Timely identification of chronic cases (564) due to regular health clinics
- Motivating parents for the heart surgery to their children suffering RHD & CHD (67 cases by the end of 2004)
- Successfully co-ordinating DOT Program & Blindness control program in collaboration with the Government

RDT & me

I was very much interested in going to RDT and spend some quality time there.
What attracted me to RDT?

- The well organized and functioning community health sector
- People's active involvement
- Well trained community health workers
- A comprehensive program
- Genuine interest shown by the staff at all levels of functioning.
- Dedication and commitment shown by the staff
- RDT is a system which integrate both institutionalized health care and community health
- Comprehensive programmes for the underprivileged sector with conscious exclusion of privileged sector even in the hospital
- Primary health care is given importance
- Socio-economic development is taken care of
- Networking with government and other organization
- Effort to maximize the emotional care given to HIV affected patients and their relatives
- Efforts to bring about social changes in the communities regarding attitude towards HIV patients
- Efforts to bring about acceptance of HIV patients by their own families and society
- All round care of HIV patients including their rehabilitation

Outcome of my visit

With enthusiasm and eagerness I set out for RDT. I had planned to spend almost 2months over there. I planned to involve both in the institutionalized health care especially in the dept of OBG as well as community health dept. because I wanted have an experience of how these two dept net work and collaborate. Though my interest was spending as much time as possible with community health programme, the RDT administration was interested in absorbing me into the hospital OBG dept as a staff. I guess this was because they were running short of staff to cope up with increasing workload in the hospital.

Unfortunately the climatic conditions of Anathapur did not suit me and I found it very difficult to adjust to it.

It was extremely hot beyond my imagination and explanation. In the peak of summer my sudden arrival from Bangalore weather to the burning heat of Anathapur was not acceptable to my body. It reacted to its maximum ability with heat stroke and all associated symptoms and complications.

So, though unwillingly, I had to return to Bangalore without accomplishing my purpose.

ANTI TOBACCO PROGRAMME-TRAINING FOR BMW
JUNE 3rd, 2005

About 60 Bangalore municipality workers gathered together for a short training programme as part of the **World No Tobacco Day** program which had the theme **"Health professional against Tobacco"**.

A brief story about the origin of "World No-Tobacco day-31st May"

The Forty –second World Health Assembly, convened in May 1989, noted that tobacco use was responsible for annual premature death of two million people around the world. The assembly expressed concern about an increase in tobacco consumption in the developing countries while acknowledging its decrease in the developed countries because of public awareness, appropriate legislation and regulations. In order to generate awareness amongst masses, against the serous health risks associated with tobacco consumption, the assembly proclaimed 31st May each year to be observed as 'World No-Tobacco Day'.

The theme **"TOBACCO & PUBLIC HEALTH"** was dealt with Mr.Chander from CHC. Dr. Vijayalakshmi from Jayadeva Institute of Cardilogy, Bangalore, illustrated the "***CARDIOVASCULAR DISEASES RELATED TO SMOKING & THE ECONOMIC IMPACT OF SMOKING***". Dr.Rajeev from Dept. of Radiation Oncology, M.S.Ramaiah Hospital, Bangalore, highlighted the **" SOCIAL IMPLICATIONS OF SMAOKING".** The salient points of information imparted to the participants were

Tobacco use as a major public health problem

- Kills 5 million / yr / world
- 8-9 lakhs people /yr in India
- 7 out of every 10 deaths in developing countries

Tobacco has serious

Health, Environmental and Economic Implications.

ENVIRONMENTAL IMPLICATIONS

- 1kg tobacco curing-8kgof wood
- 1 tone tobacco curing-118 trees
- It consumes an estimated 200,000 hectors of wood land /yr
- 76.2% of tobacco for cigarette is cured by cutting indigenous fruit trees & neem trees
- Who estimate-7billion tones paper for packing cigarettes
- Who estimate-7billion tones paper for packing cigarettes
- 20-40 yrs to grow trees
- 1 hector of tobacco needs 2.18 hector of forest trees
- Tobacco crops causes twice the land erosion

ECONOMIC IMPLICATIONS

- Smoking 20 cigarettes / day spends Rs. 10,950/- per yr
- For 30 yrs spends rs.3,28,5000/-
- Money spend on health problems as consequences of smoking?

HEALTH IMPLICATIONS

Tobacco is

Not human friendly

Not environment friendly

Damage is unimaginable & unrepairable

Impact on family in particular & society in general is unfathomable

- 25% of heart attacks due to tobacco
- 20000 gangrene
- 60% lung diseases (bronchitis, emphysema)
- 50% of cancer in males
- 25% of cancer in females
- Brain tumour is more common in smokers
- Each cigarette reduces life by 5 minutes
- If 12 cigarettes /day – 1hr
- Every yr life is shortened by 16 days
- Cigarette contain 4000 chemicals
- 40 are carcinogenic
- 3 are deadly

1. Nicotine

Addictive
Diffuses in blood
Quick fix to smoker
1 cigar= 1mg of nicotine
(1mg iv- stat death)

2. Co (carbon monoxide)
Diffuses in to blood
Binds to Hb – replaces oxygen
Leads to IHD

3. Tar
Solid irritant
Coats lungs
Blocks airways – emphysema, bronchitis, lung cancer

SMOKERS & HEART PROBLEMS

- Nicotine & co are the main culprits
- Death rate in heart diseases is increased by 6-8 times in smoker than in non smoker
- Most die before retirement

Tobacco is the only legally allowed substance that kills majority of people

Tobacco consumed in various forms

- Smoking - cigarette, beedi, chutta, hukka
- Non-smoking – pan, gutkha

BAD EFFECTS OF TOBACCO USE

- Cancers – oral, lung, oesophagus, stomach, bladder, cervix
- Sterility
- Cardiovascular diseases
- Gangrene (TAO)
- Bad breath
- GIT problems
- Infections

Why females smoke?

- False belief that nicotine reduces the appetite-maintains physique
- To be part of high class society
- Imitate role models
- To reduce mental tension
- As addiction

- Brand promotion with glamorous, sexy, sporty models which encourages
- Social selling
- Personal problems, family problems
- Lack of knowledge & attitude
- Brand promotion with glamorous, sexy, sporty models which encourages
- Social selling
- Personal problems, family problems
- Lack of knowledge & attitude

Why children smoke?

- Smoking parents &elders
- Influence from films ,media, friends
- Cultural habits
- Role models

Management options

- General(non-pharmacological)
- Nicotine replacement
- Non-nicotine medications

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SEICA ASSEMBLY At TRIVANDRUM, KERALA
June 20th to july 13th, 2005

Paper presented by Sr. Elsa Thomas

POVERTY ISSUES IN INDIA

POVERTY IN GLOBAL CONTEXT

Poverty amid plenty is the world's greatest challenge. At the outset we seek to expand the understanding of poverty and it's causes and set out actions to create a world free of poverty in all it's dimensions. It both builds on our past thinking and strategies and substantially broadens and deepens what we judge to be necessary to meet the challenge of reducing poverty.

It argues that major reductions in human deprivation are indeed possible. And that the forces of global integration and technological advance can and must be harnessed to serve the interests of people. Whether this occurs will depend on how markets, institutions, and societies function –and on the choices for public actions globally, nationally and locally.

We accept the established view of poverty as encompassing not only low income and consumption but also low achievement in education, health, nutrition and other areas of human developments. Therefore definition of poverty expands to include powerlessness & voiceless ness, and vulnerability & fear.

These different dimensions of poverty and human deprivation interact with each other. So do interventions to improve the well being of the poor people. Increasing education leads to better health outcome. Improving health increases income earning potential. Providing safety nets allows poor people to engage in the higher- risk, higher-return activities. And eliminating discrimination against women, ethnic minorities and other disadvantaged groups both directly improve their well being and enhance their ability to increase the income.

Poverty remains a global problem of huge proportion.

Of the world's 6 billion people, 2.8 billion live on less than $2 on a day. 1.2 billion are less than $1 a day.

Six infants of every 100 do not see their first birthday and 8 do not survive to their fifth. Of these who do reach school age, 14 girls and 9 boys out of 100 do not go to primary school.

INDIAN SCENARIO

Present population of India is 1075 million

- 34% under the age of 15years
- 58 % are between 15 and 59
- 7% over the age of 60

India is the second country in the world after chins to cross the one billion mark. The population of the country rose by 21.34% between 1991-2001.

Population explosion

Every 2 seconds an Indian is born29 per every minute, within an hour 1,768, by the day's end 42,434 and every month 1,273,033. **Annually 15,531,000- another Netherlands (15.8million)is added to the subcontinent.** Every year we almost add the population of an entire continent like Australia (19million). In 1980-1999, Australia has added 4.3 million only. In contrast India has added 310.2million to its population. Since independence, within a span of 50 years, India's population has nearly tripled. In 1952 India was the first country to formulate a population policy. One of the population policy members points out:
'A lovely document which can be formed and hung on walls'.

By the year 2016

- 28 % under 15years of age. (from519 to 800million)
- 64% in the age group of 15-59(from 62 to 112million)
- 9 % will be 60 and above

India's population will be

- 1.179 billion in 2011
- 1.264 billion in 2016
  (more than the population of Europe excluding Russia)
- 1.363 billion in 2025
- 1.628 billion in 2050
  (Ref: national population policy, Population reference bureau)

In the next three decade India will overtake china as the most populous country in the world.

Current problems due to population:

- resource requirements,
- lack of education and employment,
- demands on environment and imbalance caused,
- pressure on urban areas and infrastructure,

- increase in demands for and reclamation of lands,
- ecological imbalance.

India's new population policy has the long term goal to achieve a stable population by 2045. For this some of the national socio-demographic goals to be achieved by 2010 are:

1. make school education up to age of 14 free and compulsory,
2. reduce IMR to below 30 per 1000 live births,
3. reduce MMR <100/ 100,000live births,
4. achieve universal immunisation of children against all accine preventable diseases,
5. promote delayed marriage for girls, not earlier than 18 and preferably after the age of 20.
6. integrate Indian system of medicine in the reproductive and child health services.

Population	1078 million
Urban population	28%-about 285 million
Major ethnic and linguistic groups	Indo-Aryan (72%), Mongoloid (3%) and Dravidians (25%)
Languages	Hindi, English (official languages for central government) and 15 other major languages, plus many smaller languages
Religion	A secular state with the majority population following Hinduism (83%). Other major religions are Islam (14%), Christianity (2.4%) and Sikhism (2%).
Population annual growth rate	1.8%
Life expectancy(at birth)	64 years
Infant mortality (under one)	67 per 1000 live births
Under five mortality	93 per 1000 live births
Maternal mortality rate	540 per 100,000 live births
GNP per capita	$480

Adult literacy rate	68%/45% Male/Female
Percentage population with access to safe drinking water	Total 84% Urban 95% Rural 79%

When we look at India as a nation, to begin with, we are faced with a humanitarian crisis. In India millions of people continue to live in conditions of intolerable poverty and deprivation. Diseases such as tuberculosis, malaria, diarrhoea that can be prevented or cured with simple medical care are allowed to ruin their lives. The latest National Family Health Survey (1998-1999) indicates that half of Indian children are undernourished and more than half of adult women suffer from anaemia. At the time of survey, one third of young children had fever; twenty percent had diarrhoea, and another twenty percent symptoms of acute respiratory infection. The condition gets much worse when we consider the more deprived regions such as BIMARU states. In Bihar close to half of the population live below poverty line ,65 % women are unable to read and write, 90% children are deprived of adequate vaccination, and one fourth are severely undernourished. If we descend further down the well of poverty and visit some of the more deprived villages and slums, we find the living conditions that can be described as a humanitarian emergency.
It is a crying shame that about 135 million people in India have no access to basic health facilities. 256 million people lack safe drinking water. 70% of the population lack proper sanitation facilities.150 million households have no electricity.

Beyond such tragic situation, there is the failure to create conditions that would enable people as a whole, not merely the deprived sections, to develop their talents and help social life to flourish. It is depressing to look around us and consider what people do for a living. Many perform tasks that effectively reduce human beings to machines, such as digging trenches, pulling rickshaws or carrying crushing weights over long distances. Countless women are trapped in dark and smoke-filled kitchens. Children if they go to school at all, see their creative potential and intellectual curiosity stifled by rote learning and classroom idleness, with intermittent dose of physical punishment. Few people are substantially engaged in creative and fulfilling activities. All this is happening in our country with enormous human and material resources as well as a demonstrated potential for excellence.

WOMEN

In India women constitute 48% of the population. They suffer many disadvantages as compared to man terms of literacy rates, labour participation and earning. Low FLR (female literacy rate), high MMR

(maternal mortality rate) and low sex ratio reflect their precarious state.

- Gender ratio=933 (2001 census)

The census lists "sex- selective female abortions", "female infanticide" and "neglect" - typically through giving girls less food and medical care than boys - as "important reasons commonly put forward" for the gender anomaly. Dowry is a big problem related to declining sex-ratio. The sly advertisements placed by health clinics or even advertisements in market places reveal this fact. In the 1980s, it was typically: "Pay 500 rupees now to avoid 50,000 later". With the spread of ultrasound in the past decade, the message is the same, the cost higher: "Spend 1,000 rupees today, Avoid 1 Lakh (Rs100,000) tomorrow".

Even in southern states such as Tamil Nadu, which have made big strides in population control, smaller families plus medical techniques are leading to more female infanticide and foeticide. Dowry payments are formally illegal. So too is sex-determination under the Pre-natal Diagnostic Techniques (Regulation and Prevention of Misuse Act), 1994.

- Life expectancy at birth for female is 63.4years (male =62.4years)
- Gender Demographic imbalances stem as much from socio-cultural practices as from economic factors. The BIMARU states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh, despite some improvements, still show figures indicating backwardness in terms of various health indicators. Despite these adverse findings, demographic imbalances such as negative sex ratios are not highest in these states. On the contrary, it is the prosperous states of Hariyana and Punjab that are among the worst with adult sex ratios of 869 and 886 respectively compared to the national figure of 933 females per 1000 males in 2001. While economic factors such as poverty and deprivation seem to ratio is 933 in 2001 which was 927 in 1991.

- Female literacy rate in India has gone up from 44.34% in 1991 to 57.45%in 2001. (MLR=76.29%)

57%of women are illiterate as compared to 33% of males. Almost 70 per cent of India's non-literate citizens are women. Not just in literacy - at all levels, whether it is primary school, secondary school or college, women are fewer in number than men. This is an index of discrimination against women

- MMR in India is the second highest in the world, 453 per 100,000 live births.
- 70% of the people in abject poverty are women.
- 80% of women are anaemic.
- 50% of he women in India lack and basic sanitation.
- Each year 125,000 women die from pregnancy related causes.(one in every 200 pregnancies ends with woman dying)
- Only 53.8% receive tetanus toxoid injections during pregnancy
- Only 46.8% get their blood pressure measured.
- 58% reduce their food intake during pregnancy.
- 67% of deliveries still take place at home.
- only 43% of home deliveries are supervised by health assistants

What is the reason for all these? The current economic trends push women to work in the unorganised sectors which leave them with hardly any social security. Also the rising cost of health care and drugs force them to seek for home care.

In India, Health programmes for women continue to focus almost exclusively on our reproductive or child-bearing function reducing the woman merely to her womb. This attitude hinders considering the worth of woman as a person, to give dignity as an individual and to bring equal status to women as that of man. Sometimes they mention the girl child or the adolescent girl but often these are more in the form of token gestures! This is an old problem - the way a patriarchal society values women only for her child bearing role! It is also a new problem - the state trying to control the population and targeting women's bodies as the easiest way to achieve it.

- 5000 brides are murdered or commit suicide per year in relation to dowry.
- 50-70% of women experience domestic violence.

- 62.3% of Indian households have access to safe water. 81% urban and 55% rural households.

According to World Health Organization (WHO) and public health norms, in order to meet basic health and hygiene needs, a minimum of 50 liters of water per capita is required a day. The government allocates 40 liters, including for those who own livestock, and the actual delivery is less than 10 liters. Often even this is not available, sending women scrambling for water.

Women in rural areas trudge barefoot in the hot sun for hours over wastelands, across thorny fields, or rough terrain in search of water, often muddy and brackish water, but still welcome for the parched throats back home. On an average a rural woman walks 14,000 km a year just to fetch water. Their urban sisters are only slightly better off, they do not walk such distances but stand in long-winding queues for hours on end to collect water from the roadside taps or the water lorries.

????????While economic factors such as poverty and deprivation seem to affect educational attainments and health status of women in most states, demographic imbalances or work participation levels are better explained through attitudinal biases in society, observes Dr Rustagi.

Women and power for decision making-

Gender-based power relations mean that women experience poverty differently and more forcefully than men do. Women are more vulnerable to chronic poverty because of gender inequalities in the distribution of income, access to productive inputs, such as credit, command over property or control over earned income, as well as gender biases in labour markets.

Affluent upper-caste males usually make all the decisions for the society and the male as the head of the family regarding family issues. Even if they want to be fair, as long as the process of decision-making is not participatory, they land up assuming that their perception of needs and their sense of values is the same as that of the entire society.

Women and work

- In 1991women and girls comprised 22.5% of the official workforce.
- Now only 4% women are in the organized sector. 78% of the rural women are engaged in agriculture.
- Now women constitute 90% of the total marginal workers of the country (bidi-rolling, agarbathi making, bangle making, weaving, brassware, leather, crafts and other small scale industries.) yet only 3% of them are recorded as laborers.
- Women get an average 30% lower wages than men.
- A study by SEWA of 14 trade found that 85% of the women earned only 50% of the official poverty level income.

Women & globalisation /liberalisation

- Privatization and reduction of public services reduces the employment opportunities for women.
- Globalization has increased the number of low paid, part-time and exploitative jobs.
- Mechanization and automation which have become prevalent in the market based economy has adversely affected the village based traditional economy.
- In spite of economic growth joblessness has increased and this is pushing the women in to the unorganized sector.
- Export processing zones-EPZ means more dangers, hot and unsanitary conditions. Unnecessary body searches are routine. there are no maternity benefits. Minimum wages are never enforced. Labor laws are given ago by.

- Migration of males has been a major factor leading to increasing proportion of female maintained households, leading to extreme poverty. So women have to bear the triple burden of caring, farming and income generation.
- Women as home-makers have to balance out the extra costs due to increase of costs in public utilities and education and health care as a result of cuts in public subsidies.
- Rise of consumerism actually comes hand in hand with globalization and the need of MNCs to sell their products to accumulate more surpluses for themselves.
- Occupational sex segregation is a stark reality in the open economy which tend to result in worse working conditions, lower pay and inferior carrier opportunities.
- Migration of women for economic reasons often give rise to exploitation and trafficking of women at the local, regional and global level.

CHILD ISSUES IN INDIA

There are more than 375million children in India, the largest number for any country in the world. India is still caught between legal and policy commitments to children on the one hand, and the fallout of the process of globalization on the other. Women and children account for 73%of BPL. More than 75milion children suffer malnutrition in spite of buffer food stocks.

Who is a child and what does law say? The convention on the rights of the child which India has ratified, defines children are those below 18years of age. Constitution in Art 24 considers below 14years as age not fit for hazardous employment. Social scientists include females in the age 15-19years in girl child demographic data compulsory education is up to 14 yrs. (Cf Art 45) Art 39(f) requires children to be given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity.

Indian government over the years adapted many policies and made commitments for various schemes for the welfare of children. The government of India has declared it's commitment to every child in the Ninth Five year Plan (1997-2002). But despite these laws, policies and commitments, what is the actual situation of India's children vis-avis health, education, early childhood care and protection? Score card on children

For every 1000 children born in a year, 48 die within 28 days of birth. in rural areas 52 children out of 1000 die at birth. 6/100 die before reaching the age of one year. 8 children die before reaching the age of five. Approximately 70% of infant deaths occur in the first week of life.

Acute lower respiratory infection (ALRI) continues to claim 15-20 % of infant deaths, especially during the first 3-4 months of life. 380,000deaths occur each year due to vitamin A, Iron and iodine deficiencies. And 210,000 children are born cretins or turn blind at pre-school age.

Every year 7-8 lakhs children die from preventable diseases like diarrhea. 75 million children below the age of 5 years are malnourished. 45% of children below 1year are severely and chronically malnourished. Only 44% of children have completed the immunization schedule. A massive 14 have not received a single vaccine.

Child related issues in contemporary India is seen in the context of the existing class, caste and gender inequities and the effect of current policies upon these prevailing inequities.

Aware of this, the votaries of the new economic paradigm are trying to make some effort at lowest possible costs to contain the inevitable negative changes in infant and child mortality rates!

Though some decline in child mortality is gained by some of these measures this is far from adequate, and ill sustained. To the children suffering from ill health there is no relief. In many countries infant mortality has actually gone up after structural adjustment!

Child labour

Government survey says that there are 20 million working children in India. But the reality is that there are over 100million working children in India. 2001 census states there are 1.25 crores of working children in 5-14 age group. Out of these 1.07 crores are of 10-14 yrs of age. The existing law prohibits the employment of children before 14 yrs of age in factories ,mines and hazardous employment and regulate the working conditions of children in other non-hazardous areas of employment.
Child labour invariably damages their growth and development and violates their basic rights. Thus child labor of any description is hazardous and this should include the labour put in by children in their own poor households at the cost of their own health and education. Their main health problem is survival. Especially true for children in dangerous occupation like firework making, rag picking etc. The other important problem is the constant drudgery and strain of their work. The children who survive are often scarred for life by hampered growth, occupational disease and having remained unschooled while their peers move ahead. These are handicaps that rob them of their full potential and leave them with handicaps that can almost never be made up.

Bonded child labour is more in some industries like beedis, brick-kilns, carpet making and in certain areas.
Universal free and compulsory elementary education, employment for all adults and the complete eradication of child labour are the only adequate remedy for the health of these children. Implementation of a comprehensive child rights code that addresses the problem of child labour as a human rights issue is an urgent necessity.

Street chidren

Most of the children on the street belong to the age of 7-18 years.(boys out number the girls. They come to towns & cities from various parts of the country, with a wide range of religious, cultural and linguistic backgrounds. But being smart, we quickly learn to communicate in the principal languages spoken in their new place of living.

Problems they Face...

Deprived of adult protection, guidance, love and support, they are abused by all and sundry. They get beaten u by the local police. Both boys and girls amongst them are easy prey for sexual assault and child prostitution.

Living without shelter, sleeping under bridges, on pavements, railway stations and in cement pipes - affects them psychologically. They develop a sense of inferiority and insecurity. They also learn not to trust adults. Their life is governed by a 'here & now' attitude. They do dream about their future - but they also know that they will remain dreams!

Because they look dirty, they are not allowed to use public parks. They never get to play like other 'normal' kids.

Unable to expend their surplus energy through play, their life becomes centered around films and gambling. Many of them become easy prey to drugs and die a slow death, unnoticed and unlamented.

Question of schools and health facilities for them! Even those who know to read, slowly lapse into illiteracy.

They have to earn their living and the jobs that they get are of the worst sort like rag-picking- dirty, unhygienic and hazardous.

Their irregular, unhygienic and inadequate intake of food makes them malnourished and susceptible to a variety of illnesses - infectious diseases, gastrointestinal problems, STDs, scabies, fever and jaundice.

EDUCATION

In India getting educated is the right of every child and giving it free of cost is the government's responsibility. India has some of the world's best scientific talent and educational institutions. Yet 40 million children are not even in primary school. And less than half of those that enter the primary school complete eight years of education.

Let us take a deeper look in to the current education scenario. Despite the numerous education plans and schemes, government aids and what not, Statistics shows that the literacy level has manages to crawl up to 64.8 %(rural figures are even less) from 18.3% in 1951.

Total population (6-14yrs)	=193 million
Enrolments in primary School	= 82%
Drop out rate at primary School	=39%
Drop out rate of girls at primary School	=39%
Drop out rate at upper primary school	=54.6%
Drop out rate of girls at upper primary	=56.9%

Today there are numerous private schools and colleges across the country. There is an alarming divide between the type of education offered in the government system and in the private or those mushrooming schools catering to the 'elite' groups of the society. But frankly how many of them are affordable, standardised and reputable? Education in these private schools has the impact of western influence and to a large extend it has been affected for the worse.

The very distinct impacts of globalisation on education in India are:

1) commodification of education

Education has become more of a commodity which can be bought if one has money. The more money you have the better commodity you get. This way the rich elites can afford better education and further prosper, making it much more difficult for the marginalized to climb-up the discriminatory social ladder.

2) Capitalistic approach

Education is a business now, both among the students and management of the educational system. From the administrion's point of view it is the quantity of students that matters more than the quality of education from the student's point of view it is that of an investment (with fees of professional colleges running in to lakhs of rupees). The higher the student pays it may be beneficial to him /her to be able to get back the investment.

3)Result oriented

Schools and colleges are emphasising more and more on the results. Exams are given more importance than what is relevant with regard to the subject. The overemphasis on the result is based on the myth that only good marks can earn a job in the future rather than the knowledge of the subject.

4) Glamourization of education

A few courses are being over glamourized by the institutes and the media for its demand in western countries. So a high number of student population is deviated in to these courses with hope of a high paying job. This is being misutilized by the institutions who take advantage of the situation and increase the fees. It is also very disadvantageous for the economy of the country due to brain drain.

HEALTH SYSTEM

Present trends in health care are

SC/PHC/CHC	= 1, 6315
Dispensaries & hospitals	= 38031
Beds (pvt & public)	=9, 14543
Nursing personnel	= 832000
Doctors	= 603840

This shows that our country has a vast health care delivery system created by govt, voluntary and private sectors. How ever it has created a paradoxical situation.

1) a very few hospital located in the areas of high mortality and poor facilities in the rural areas.
2) hospitals, dispensaries are without appropriate humanpower, diagnostic, therapeutic services and drugs.
3) Unused diagnostic facilities and drugs in some places and shortage of the same in some other places.
4) Secondary and tertiary institutions have good facilities. But they face difficulties due to changing health care needs, rapid advancement of technology and rapid turn over of staff.

India has the lowest health budget per capita but spends 60% of it on family planning.

The privatisation of health sector has increased the burden of the poor. Studies suggest that illness is the second highest cause for rural indebtedness/suicides.

Government spending on public health fell from 1.26 of GDP in 1990 to 1.12 in 1995-1996 and at present 9%. Only 50% of villages have any government health facility. Highly subsidized colleges churn out large number of doctors, yet health centres in rural areas remain unstaffed.

Tuberculosis is a serious health problem in India even today. Approximately 18lakhs new cases are detected every year and out of these 8 lakhs are highly infectious. About 4.17 lakh persons die of TB every year. 3million people are affected by malaria every year.

HIV infection in India is very rampant. India account for 10% of global HIV infections. About 5million people are affected by HIV. Prevalence rate is 0.8%. Majority of the people affected are in the age group of 15-49years.Out of the 5million affected 50% are women. A.P, Maharashtra, Manipur, Nagaland, Tamilnadu are high prevalent states. Gujarat, Goa, pondichery are moderately prevalent. National Aids Control Programme (NACO) is under implementation through out the country. Much effort is done to provide anti-retro viral drugs to the affected and to treat other opportunistic infections in them. High-risk situations and lack of awareness demand concrete actions. Poverty, depletion of rural employment opportunities, cast and gender based exploitation, violence against women including trafficking of young girls and boys into sexual and domestic servitude heightens the vulnerabilities. Now realizing the magnitude of the problem preventive methods against the spread of the disease is undertaken.

The new patent (amendment) bill passed on 23march 2005 change the face of how Indians are able to obtain the life saving medicines and the price we pay for them! The new patent law affects the health of ALL PEOPLE by making the medicines unavailable and unaffordable. It does so by preventing Indian drug companies from making generic drugs, or seeking permission from the government to make low-cost medicines. When the company does not get permission, then the patient pays more for the drug. If the company in rare instances gets permission, then they have to pay to continue production, and thus the patient pays more for the drug. The new upward price regime proposed by the new patent will affect almost 90%of drugs. Life saving drugs will cost about 20-30% more.

There is a great and pressing need for a radical shift in the health care system from concentration on disease to health, from curative medical care to preventive health care, from individual to community centred health care and to enable people to demand health as their right. We need to strengthen and promote health care based on the situations and the need of the people.

URBAN POOR

The introduction of globalization, privatization and liberalization has forced more and more people to migrate to the urban areas. Due to heavy urbanization there are found to be increasing number of slums. About 30% of the country's urban population are slum dwellers. Almost 4.8 million slum dwellers are homeless. They are migrants, mostly poor dalits. They may be unskilled and illiterate. The situation of slum dwellers is pathetic due to lack shelter, unsafe environment, lack of employment, education, of proper sanitation facilities, and other basic amenities. We represent world's largest democracy and have a truly remarkable constitution, yet millions of people are still living in sub human conditions on pavements, in squatter settlements and unauthorized slums, under constant threat of eviction.

In Tamilnadu urban population is about 43.79% of 6.2 crores .Out of that 28.38lakhs are slum dwellers and pavement dwellers. In Karnataka 20% of the urban population are slum dwellers. The same is true for Andhra Pradesh too.

LABOUR & UNEMPLYOMENT

The number of unemployed increased from 26million in 1994 to 27 million in 2000 according to the report of NSSO (national sample survey organization). Only a small percentage (8-9%) of the total workforce of the country is employed in the organized sector.

Employment & Unemployment

	1993-1994	**1999-2000**
Population	894.01million	1000.397millions
Labour force	335.97	363.33
Work force	315.84	336.75
Unemployment rate	5.99	7.32
Nuber of unemployed	20.13	26.58

FOOD SECURITY & STARVATION

The richest one–sixth of the population mainly urban have been improving and diversifying their diet and the nutritional decline for the three-fifths mainly rural has been increasing as well. The urban elite as they enjoy a diversified diet, they also try to reduce their adipose tissue in slimming clinics where as the seven-tenth of the rural population is below the norm of 2400 calories per day (the norm adopted in all poverty studies), about one-tenth has the intake around the norm and only one–fifth has intake above the norm. Huge quantities of grain (more than 50 million tones) are lying in public go downs across the country even as hunger debilitates millions of lives. The rising rural unemployment, falling per head grain intake, rise in nutritional deficit make India once a developing economy in to a Republic of Hunger.

- Cereal consumption per capita has fallen from 17kgs /month to 13 kgs per month.
- Calorie intake has also declined. Forty percent of males and 41% pf females suffer chronic energy deficiency.
- A shocking 50% of children under five are malnourished.
- 70% of children are anaemic because of nutritional deficiencies.

ANALYSIS OF THE PRESENT SCENARIO

The above presented situation, particularly the humanitarian aspect is associated with the violations of basic social and economic rights, mentioned in the Indian constitution. The constitutional Directives urges the States to "secure a social order for the welfare of the people". They also define a whole range of more specific entitlements such as 'right to adequate means of livelihood', 'free and compulsory education for all children' and the 'right to work'. These are basic social rights to which the State to be held accountable.

In reality, however the democratic process in India has achieved very little so far in terms of providing basic economic and social rights to its people. This is the main failure of Indian democracy. Basic social issues such as health, nutrition, education, employment are of little concern to the political leadership.

About 50 yrs ago Dr.Ambedkar said 'In politics we will have equality and in social and economic life we will have inequality'. Thanks to globalization today we have in India the economic disparity at its maximum. 2001 census shows that 40% of India's population is living BPL. 47% of India' population are undernourished. Also we have 70,000 millionaires in India that is for every 15000, one millionaire (11th june 2005, Times of India). True to his prediction, we have a situation in India where social and economic inequality also prevents the poor from their active and continuous participation in democratic institutions. Most people in India are disempowered and marginalized. The only area of participation and hence equality, is the vote they cast at every election. The underprivileged are effectively excluded from democratic participation, whether it is in the form of contesting elections or seeking redress in the court or lobbying government authorities or making their voice heard through media. Therefore India has a 'non-participatory democracy'.

EFFECTS OF GLOBALIZATION

Globalisation process includes positive as well as negative tendencies. Globalisation has social dimension and an acquisitive dimension. Social dimension consist of utilizing the growing possibilities of global co-operation to promote development, democracy, peace, justice and related aspects of collective human progress. These opportunities have been poorly used so far.

The acquisitive dimension consists of harnessing the globalisation process at the service of power and privilege. This has been the dominant tendency so far. Thus globalisation has been put at the service of business interests and powerful governments. It includes double standards of al kinds mainly to the advantage of powerful corporations and governments. For instance, capital mobility is high

on the agenda, but not labour mobility; intellectual property rights are a major concern but not pollution control.
It is assumed that only by participating in global markets does the third world get access to jobs and livelihoods. However globalisation dose not create jobs, it destroys livelihood and hijacks the resources of the poor. Globalisation is not a process of inclusion. It is a planned project of exclusion. It draws the resources and economies of the poor in to the global market and global corporate ownership by displacing poor people from their livelihoods, life-support systems and life-styles. Globalisation is completing the process of colonisation which led to the conquest and ownership of land and territory. Now biodiversity and water, the very basis of life's processes, which have been so far held in common by local communities for equal rights to biological sustenance and economic livelihoods are being colonised. Agriculture which is still the livelihood of three quarters of humanity is threatened thru 'trade liberalisation'. Globalisation of food and agriculture system in effect means the corporate take over of the food chain, the erosion of food rights, destruction of cultural diversity of food and the biological diversity of crops, and the displacement of millions from the land based , rural livelihoods.

The epidemics of farmer's suicides in India are the most drastic impact of trade liberalisation in agriculture. India is the home of cotton. But under the conditions of globalisation, cotton cultivation is pushing the farmers to suicide and cotton has become a symbol of new slavery and new bondage. Globalisation led to increased exports. Increased cotton exports led to increased cotton cultivation including semi-arid areas such as warangal in A.P. where farmers earlier grew food crops for sustenance. Warangal predominantly a food crop area under the corporate push switched over from their paddy, pulses, millets, oilseeds and vegetable crops which had sustained them to the sowing of cotton. Seed companies used video vans to show advertising films to sell hybrid cotton seeds by promising that they would make them millionaires. Hybrid seed was sold as 'white gold'. However instead of becoming millionaires, the poor peasants were driven in to debt bondage from which they could be freed only by suicides. Farmers could no longer grow the open pollinated indigenous varieties of seed instead of hybrid for various reasons. So they were forced to purchase the hybrid seeds every year at high cost for peasants and for environment as well. Hybrids are very vulnerable to pests' attacks. So use of pesticides also increased. Pesticide use increased to 200% over a decade from 1980s to 1990s n the AP. Across India over 2000 farmers have committed suicide due to debts by the 2000. In warangal district (A.P.) alone it was 500. Farmers in Andhra and Karnataka state have uprooted the genetically engineered seeds in protest and have filed a case in Supreme Court to stop the introduction of genetically engineered crops in Indian agriculture.

The export oriented agriculture peasants are displaced from all farming like shrimp, flowers, vegetables, and meat. These displaced peasants are hungry since they have lost their food security and livelihoods.

Another example to state regarding the effect of global markets taking over is the hijack of Indian wheat by Cargil. Wheat is the 'kanak' of northern India.
A few years ago (1996) cargil the largest of giant grain trading corporations in the world bought 2 million tones of wheat from India at $60 per tonne and sold it in the international market at $240 per tonne making a net profit of $360 million. A few months later India had to import 2million tonnes of wheat at international rates due to domestic scarcity and rising food prices. For the international market it just appeared as 4million tonnes of wheat global trade.

CASTE SYSTEM & SUBALTERAN PEOPLE

CASTE SYSTEM

Dalits are fixed at the lowest rung in the caste hierarchy based on ritual purity and occupations. They have been striped of their dignity and denied basic human rights. They have been relegated to do the so called 'polluting' tasks like cremating dead bodies, cleaning toilets and sewages, and working with leather etc.
They are considered 'untouchables'. To avoid pollution by mixing with them, dalits are segregated and denied access to many common or community facilities such as schools, temples, water tanks, toilets etc. to this day thousands of villages have separate area for dalit houses, separate well for dalits, tea shops with separate glasses for dalits. Such discrimination occurs despite laws against such practices. These socially disadvantaged groups continue to lag behind the rest of the society. Scheduled caste people constitute a sizable proportion of the country's population.

SC population = 175.7 million (17.5% of the population)
ST population = 88.8 million (8.6%)
Minorities =188.9 million (8.6%)

A FEW EXAMPLES TO SITE

MANUAL SCAVENGRS
There are about 6.76lakhs of people who are counted as scavengers in the country. Up to 2001-2002 18,000 scavengers were trained and rehabilitated.

Rajesh a 25 year old dropout has been carrying a tin of night soil in his hand every morning for the past 10 yrs. He carries the scooped up night soil on his head and deposits in a place far away from the village. He earns a sum of rupees of Rs.50/ month for his effort.

(National Human Rights Commission Report)

Narayanamma 56, works as a Safai Karmachari in Awanthpur Municipality, Andrapradesh. She has been scavenging for the past 19yrs.She goes to the community dry toilet. She has to clean 400 seats of dry toilets every day of 15-16 bamboo baskets of human excreta. Her health is ruined. She suffers from diarrhoea and vomiting frequently.

(National Human Rights Commission Report)

ATROCITIES AGAINST DALITS

Discrimination of dalit women in school.

The principal and teacher of a school prevented students from taking a mid-day meal cooked by a dalit woman.

SIX YOUTHS RAPED A DALIT GIRL IN BANGALORE.
Decan Herald 17th may 2003

Insulting the modesty of woman , Madurai

Muthumari ,38, a dalit woman was humiliated when she was returning from the field .She was harassed by Raja, son of Sellathevar. She managed to escape from him at 7pm. When her husband Pitachi came, she narrated the incident to him and he consoled her. At 8pm Raja came with his wife Vijaya and 15 other people with them. They entered the house and splashed human excreta mixed with water and Vijaya compelled Muthumari to drink the human excreata. When muthumari fainted they left her. Muthumari and her relatives went to the police station to lodge their complaints.

But no action was taken against the criminals. Then they lodged a complaint to the collector and SP through the support of People's Watch , Madurai. Raja was booked under SC/ST Prevention of atrocity Act and criminal charges of attempting to outrage the modesty of women.

The new India Express, 30th sept 2004

MID NIGHT MASSACRE

The landlords who wanted to seize 51 acres of land that was allocated to dalits, entered the houses, shot indiscriminately, raided 14 houses, killed 61 people, injured an additional 20 people, murdered 7 local fishermen, and brutally raped and murdered 5 girls. The girls were shot in the chest and vagina.

These are realities staring at us. Are we aware /unaware?
Do these realities stir our blood? Why a particular group of people marginalised? Brutalised? Butchered?

ENVIRONMENT

About 1600 scientists met under the aegis of United Nations in 1992 and issued a serious warning to humanity. They began saying, Human beings and the natural world are on a collision course. Human activities inflict harsh and often irreversible damage on the environment and on critical resources. If not checked, many of our current practices put at serious risk the future that we wish for human society and the plant and the animal kingdoms and may so alter the living world that it will be unable to sustain life in the manner that we know. Fundamental changes are urgent if we are to avoid the collision our present course will bring.
Indian Environmental groups and the government agencies are slowly awakening to the magnitude of the crisis. As a country with an economy based on agriculture, Indians are much more vulnerable to the changes on the environmental front.

Climate change and crisis on water:

A Japanese scientist, Dr. Osaki told that Asia was heading for a serious water crisis borne out of the changes in the climate. He said that Indians would face an 80% increase of water stress in next twenty years. He projected a map of South India progressively drying up in a period of twenty years. People are facing equal difficulties in procuring drinking water both in southern metro like Chennai and northern city like Agra. An attempt to privatize the water distribution in the capital city of Delhi by the MNCs has left the delhites without even drinking water.

Polluted Air:

Fresh air is a rare commodity in the cities. A study shows that over 5000 people become victims of air pollution.
Soil in trouble:
The earth needs 1200 years to prepare the six inches of fertile soil which, when left unprotected, gets washed away in a single rain. Soil erosion is rampant in the hilly areas.

We have been pumping in pollutants on to the soil, especially the lethal pesticides. Blind use of pesticides and fertilizers has ruined the health of the soil.

Disappearing forests:

Four fifth of world's forests have already been cleared, fragmented or degraded. On an average, 16 million hectares of forests are felled every year. This directly results in depletion of species, species-habitats and bio-diversity. This indirectly results in depletion of topsoil and ground water availability through decrease of ground water recharge. A person needs oxygen produced by 16 big trees. In India 36 people share a single tree. Any country needs 33% of its land to be under forest cover. India has less than 11% of forestland.

Depletion of the rich bio-diversity of the land:

India is the one of the 12 mega-diversity regions on the globe. Depletion of the plant and animal species is perhaps the biggest environmental problem of a country like India. This is because the depletion of the bio-diversity effects irreversible changes on the earth.

Because of the interconnectedness of life, extinction of a single species affects the life of about two dozen other species. Scientists say that every hour one species disappears forever from the earth.

Unsustainable explosion of population:

The earth is finite. Its ability to absorb wastes and destructive affluent is finite. Its ability to provide food and energy is finite. Therefore its ability to provide for the growing numbers of people is limited.

Pressures resulting from unrestrained population growth put demands on the natural world that can overwhelm any efforts to achieve a sustainable future.

The scientists of Taru mitra, an ecological movement for students say "We the under- signed senior members of the world's scientific community, hereby warn all humanity of what lies ahead. A great change in our stewardship of the earth and the life on it is required, if vast human misery s to be avoided and our global home on this planet is not to be irretrievably mutilated."

The poor are the most vulnerable:

Take any environmental disaster, the first and the worst victims are the poor. A degraded, deforested waterless, polluted land ill force the poor Indian woman to walk longer and work harder.

Resource/need	**1993**	**2000**	**2025**
Human Population(crores)	88	99	151
Food requirement (million tons)			
Water requirement Cubic Km)	552	750	335
Fuel wood (million tons)	313	400	600
Land Uses (million hector)	140	140	140

The rich survive al the environment related disasters. The poor are the most vulnerable. One of the evil effects of globalization is the loss of the bargaining power of the poor countries which results in greater

environmental degradation which further causes greater poverty. Regeneration of the Earth especially the rich bio-diversity is directly proportional to the bargaining power of the poor. There is an urgent need to interpret our commitment to the poor in relation to the ecological crisis.

We need a new spirituality:

As we reflect on what is happening in the light of the Gospel, we are convinced that this assault on creation is sinful and contrary to the teaching of our faith. The Bible tells us that God created this world, that He loves this world and is pleased with it and that He created man and woman and charged them to be stewards of His creation. God who created our world loves life and wishes to share this life with every creature. Catholic Bishop of Philippines says in their pastoral letter, "God, who created this beautiful land, will hold us responsible for plundering it and leaving it."

Need for an integrated creation spirituality:

The salvaging effort to heal the earth mainly has been to resort to scientific solutions. Pope John Paul II begs to disagree and consider the ecological crisis as an out come of a deep inner moral and spiritual degradation. Our children are progressively getting alienated from the earth. The earth has become a commodity to be exploited than a mother to be treated with respect.

We need to develop an eco friendly spirituality. The spiritual heads of all religions gathered at the UN stated," we believe that the universe is sacred. We believe in the sanctity and integrity of all life and life forms. We affirm the principles of peace and non violence in governing human behavior towards one another and all life."

Time for action:

To quote the Philippino Bishops, "This earth is our home: we must care for it, watch over it protect it and love it. We must be particularly careful to protect what remains of our forests, rivers and corals, and to heal wherever we can the damage which has already been done. "

The responsibility to look after God's creation rests n all people ho are devoted to God. Just as the longest journey begins with the smallest steps, the campaign for God's earth begins with our own personal decision to lead an environment friendly life in small and tiny steps.

Why are they treated as unwanted things? Are they not human beings? Don't they have feelings and desires?

FOR MY COUNTRY

''Where the mind is without fear and the head is held high;
where knowledge is free;

where the world has not been broken up in to fragments by narrow domestic walls;
where words come out from the depth of truth;…..
In to that heaven of freedom, my father, let my country awake.''

TAGORE

LEARNINGS

1. Strategic planning
2. SWOT analysis

STRATEGIC PLANNING

Strategic planning is basically looking outside, within and inside to see where are we? And deciding where do we want to go? So it involves strategizing how can we get there?

Strategic planning

- **Defines** clearly
  1) **what** the organization wants,
  2) **what** it is all about,
  3) **who** it wishes to serve,
  4) **what** it intends to get out of its own efforts and
  5) **how** specifically it should move over time.

- **Ensures**
  1) That the **strategic activities** and **tasks** are consistent with the **people** doing those tasks,
  2) The **structures** adopted by management and the **systems** employed by the organisation.

- **Is concerned** with

  T**he identification of specific key results areas** which proceed from the **vision** and **objectives** of the organisation

- **Tends to be long range**

Strategic plan has two wings.

- **Conceptual Wing is:** Visionary
  Conceptualisations
  Directional
- **Operational Wing** is likely to be: shorter term
  Tactical
  Focused
  Implementable and
  Measurable.

A Good Strategic plan

- Serve as a framework for decisions or for securing support/approval.
- Provide a basis for more detailed planning.
- Explain the concerns to others in order to inform, motivate & involve.
- Assist in monitoring and evaluation purposes.
- provides an accurate explanation why the organisation exists and what it hopes to achieve in the future.
- the general thrust of the organisation that is anchored on the vision.
- Stimulate change and become building block for next plan.

VISION

A vision is an ideal state or condition which an organization wants to attain. It creates focus, and defines the direction, purpose, hope and dreams of what an organization can accomplish.

MISSION

- Provides an accurate explanation why the organisation exists and what it hopes to achieve in the future.
- The general thrust of the organisation that is anchored on the vision.

TERMINAL PERFORMANCE OBJECTIVES

- Well-defined purpose consistent with the mission
- Measurable end results often stated in general terms.
- Must be translated into Key Result Areas (KRA) and Performance Indicators (PIs)

KEY RESULT AREAS

Are expected outcomes, which, if attained, indicate the attainment of objectives.

PERFORMANCE INDICATORS

- Help an organization define and measure progress toward organisational goals.
- Is a **reliable/stable index** of a phenomenon
- Which may not in itself be directly measure.

- It must be **quantified**.

SWOT ANALYSIS

SWOT analysis is a tool for strategy formulation.
SWOT matrix

- Is a basic, straightforward model that provides direction and serves as a basis for formulating strategies.
- Has four elements
  - STRENGTHS
  - WEAKNESSES
  - OPPORTUNITIES
  - THREATS

SWOT analysis assess the internal organization strengths and weaknesses.
SWOT analysis matrix scans the external environment opportunities and threats.

- S-O Strategy – how can the strengths be employed to take advantage of the opportunities?
- S-T Strategy - how can the strengths be used to counteract the threats?
- W-O Strategy - How can weakeness be overcomed by using the opportunities?
- W-T Strategy - How can the weakness be overcomed to counteract the threats?

Use SWOTs
To help identify possible strategies by

- **Building** on strengths,
- **Resolving** weaknesses,
- **Exploiting** opportunities and
- **Avoiding** threats.

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ANIMATION PROGRAM FOR
CRI Regional Unit,Bangalore, July 2005
At St.Joseph's Auditorium , Grant Road, Bangalore
By Sr.Elsa Thomas

THEME : GENDER CONCERNS IN THE CHURCH

Introduction

Is gender a question at all? And for whom? As far as the Indian women are concerned, the gender question has been raised as a serious issue over the last two to three decades. In a women's special issue of Outlook magazine, Mrinal Pande points to language as the first indicator of gender becoming a real issue over the years. The mainstreaming of words such as gender politics, reproductive rights, sexual harassment and female foeticide in the media is not indicative of an expanding vocabulary but captures a transformation of popular perception.

Gender

Gender refers to the socio-cultural definition of man and woman, the way societies distinguish men and women and assign them social roles. It refers to masculine and feminine qualities, behaviour patterns, roles, responsibilities, rights and expectations. Gender is a social construct which refers to NORMS, VALUES, CUSTOMS and PRACTICES by which biological differences are transformed and exaggerated in to a much wider social system. Gender identities of women and men are psychologically and socially which means historically and culturally determined. Gender is variable; it changes from time to time, culture to culture, even family to family.

Gendering/gender indoctrination

All the social and cultural 'packaging' that is done for girls and boys from birth onwards is 'gendering'. As soon as a child is born families and society begin the process of gendering. Girls are given pink dresses and boys blue. Girls are provided with dolls where as boys are encouraged to play with cars, aircraft models. Boys are encouraged to be out going and girls are expected to be home-bound in a middle class family. Society even determines a different dress code for men and women. The mode of dress can and does influence the mobility, sense of freedom and dignity of people. Every society prescribes different norms for girls and boys, women and men, which determines every aspect of their lives and their future. In most societies women are expected to have and perfect qualities such as gentleness, caring, nurturing. Men are expected to be strong, self confident and competitive. Women are expected to be obedient and submissive. Men are expected to be rational. I can narrate examples from my own life experiences. *Recently I was travelling in an auto rickshaw. When the auto driver turned to a side lane I asked him why he is going thru that road and not the route told by me. Suddenly he turned around and told me(sumane bai muchhi kuthukolli,enu kelilike illa etc..)* another example – *recently I was in Kerala and I was to take a 5hour journey by bus with 2 other sisters. So I stood in the queue and got the coupon. I was the second person in the queue and even then we were allotted the back seats. So I asked the person concerned why he allotted us the back seats in spite of being the second person in the queue? He answered me saying that those are the ladies seats and so I give to you. Then I requested him to change our seats and give us front seats. He found me too strange to demand for a front seat and replied to me saying 'here no ladies demand for front seats, are you wanting to sit with men? Please go away with what is allotted for you'.* Yet another incident- *I work in the remote areas of Andhra Pradesh. Initially when we used to ride a bicycle or a two wheeler people used to stop what they are doing and stare at us. Once one of the villagers went to my superior with a complaint against me saying 'it is good for her to slow down a bit, she drives too fast like the boys'.*

Men are considered to be the heads of households, bread-winners, owners and managers of property, and active in politics, religion, business. Women on the other hand are expected and trained to bear and look after children, to nurse the infirm and old, to do all the house hold works and so on. When Sonia Gandhi entered in to politics how many people commented saying 'can't she sit at home and relax?'.

Not just qualities and characteristics, but even the spaces are gendered. Football stadium, street corners, tea-shops, pan-shops, cinema hall, pubs all can become male spaces. Women normally go into them accompanied by men or a group of women. If they cannot help going in to them alone they are expected to leave as fast as possible, if they do not wish to get into trouble. Under no circumstances should they consider lingering around like men. If they do so their husband will find it difficult because their wife is no

more the 'good' and further labelled as 'bad'. Similarly kitchen or public well is almost entirely a female space. I am at a loss to find a social space for entertainment that is exclusively for women. So this ongoing process of gendering is carried on within families and society.

Patriarchy – cause of gender inequality

It is important to mention patriarchy when dealing with present day relations between women and men. Gender relations are skewed because of the existence of patriarchy. The word 'patriarchy' literally means 'rule of the father'. In common parlance patriarchy means male domination. Now it is used generally to refer to male domination, to the power relationships by which men dominate women, and to characterise a system whereby women are kept subordinate in a number of ways.

The subordination that women experience daily, regardless of the class women might belong to, takes various forms i.e., discrimination, disregard, insult, control, exploitation, oppression, violence- within the family, at work place, and in society. The details and extent may be different but the theme is the same. Patriarchy is both a social structure and an ideology or a belief system according to which men are superior. Religion has played an important role in creating and perpetuating patriarchal ideology. Examples are spread of notions of superiority through stories like, Eve was created from Adam's rib; or man is created in the image of God, etc. Today media and even educational institutions spread patriarchal ideology by showing men to be stronger in decision-making positions, and women as voracious consumers and dependent. Ideology plays an important role in perpetuating social systems and controlling people's minds. For example, by reducing women merely to their bodies and objectifying them, media encourages violence against women. Ideology provides the justification for such social behaviour.

Analysis of the main institutions in society such as family, religion, law, politics, education, economics and media, demonstrate quite clearly that they are all patriarchal in nature, and are the pillars of patriarchal structure. This well knit and deep rooted system makes patriarchy seem invincible; it also makes it seem natural.

Gender sensitivity / Gender sensitization

What does it mean? Different people mean different things by referring to these words. The simple meaning of gender sensitivity is acknowledging that women are subordinated in most societies and that this subordination is harmful not only for women but also for men and the entire society. It means being aware of why men and women behave differently, and understanding their needs and concerns. Gender sensitivity implies making plans which do not ignore and further marginalize women, but will take care

of women's special needs and make efforts to involve and empower women. In short it means, transforming gender relations.

If we go still deeper, gender sensitivity means not only understanding but also challenging patriarchy and other inter-connected hierarchies like those of caste, class and race. We believe gender sensitization is necessary at all levels in all organizations. We believe gender sensitization begins with each one of us, our families, communities and organizations. It requires not only the intellectual understanding of concepts like gender and patriarchy but using this understanding to transform our own ways of thinking and behaving. Because understanding alone does not change social realities, what changes society is people's behaviour and actions? In other words gender sensitivity requires internalizing our understanding and applying these insights in to our behaviour. Gender sensitivity does not only mean 'main (man) streaming' women, it means examining the mainstream from a feminist perspective. If it is patriarchal, unjust and unsustainable then women need to challenge and change it, instead of joining it. Gender sensitivity also means acknowledging that all issues –economic, cultural, social or political – are women's issues because women represent half the population.

Gender sensitivity and gender justice definitely require equal participation of men and women in power distribution and in decision-making processes. A careful scrutiny is also required to check the language used, the jokes told, the songs sung, the comments passed and so on to bring in a culture and style that is gender friendly and inclusive.

Recognizing and understanding the extent of gender inequality and its consequences, the secular world is addressing the issues related to it in a very healthy manner. Women from all walks of life are learning to define the truth of who they are, thus challenging humanity to enter into new consciousness of being and becoming human.

Women have started questioning the ways their lives have been defined in terms of home, relationships and work. With the entry of women into the paid work force in both the formal and informal sectors in large numbers, the gender demarcation of private and public space is increasingly challenged. Household work is no longer the specialized task of women alone. So also the conventional parenting patterns are being questioned that both the father and mother shoulder responsibilities in the caring and nurturing of children. Issues such as domestic violence, sexual abuse and dowry harassment customarily considered private concerns are being brought in to open. The personal has become political, challenging the state to come to the defence of the violated and exploited through protective

laws. The gender question is being raised persistently in the socio-political and economic spheres, demanding revolutionary changes.
Can religion alienate itself from this unfolding evolutionary process of human becoming? Almost all the religions have assigned women to clear-cut spaces depending on their gender hermeneutics. Any attempts to cross the borders are met with stiff resistance as evident in the recent episode that shook the Islamic community when a woman dared to lead prayers.

Where does the church stand before the emerging gender concerns? Is gender a question at all for the church?

Patriarchal mode of thinking defined the norms of the Catholic Church. Even though half its members are women, the feminine contributions are systematically excluded. The exclusion and oppression of women in the church became legitimized from the church's very inception itself. Thanks to the conformist religious consciousness presided over by the patriarchal mindset.

Reading the pulse of the time, aware of the felt need to respond to it with a prophetic vision, National CRI called for a consultation in may 2005. The theme for the same was '*Collaboration between men and women in the Church-Towards a gender policy'*. Thru this consultation, a process of thinking and voicing of the present day concerns are initiated. Now it is for each of us to take forward this process and bring it into completion.

National CRI with the help of Streevani, a Pune based organization, committed to the empowerment of women and promotion of gender-justice, conducted some spade work before the commencement of consultation. It was a field study discussing the question of collaboration between women and men in the church, with groups of priests and religious. The insights gathered from this field study may throw some light in our search towards the gender concerns and gender policy in the church.

A striking observation brought out by this field study was that gender was deeply acknowledged as a concern by the women at large. Men were aware of it at varying degrees, some of them open to discuss it. But some priests strongly felt there was no such problem and were of the opinion that God has made man and woman differently and so they need to function in different ways as done in the church at present.
Many questions were raised with regard to collaboration. But the main question is - In the Church where are the men and where are the women? What kind of collaboration can there be between unequals? How can we

talk in terms of a healthy collaboration from such unequal levels where we stand?

Some church members are interested in discussing on 'collaboration between priests and religious in the church' keeping the gender question out. Addressing the sensitive gender issue may be threatening, as it would challenge the mindsets, age old views, long established roles and behaviour patterns. It may also challenge one to get out of the comfort zones to make space for others!

Even while the anguish and woes of the oppressed are ringing loud in the ears, some Bishops in our country could hold their heads high and say-'in reality, there is no problem… if at all there is a problem it is with the laity who have high expectations of priests and religious'.

Gender related issues as obstacles to effective collaboration & participation in the church.

1. Masculanized spirituality

The Bible like Bhagavad-Gita and the Koran, is a product of a patriarchal culture and history. It has been a powerful force in subjugating women's status. It is exclusive in its very language itself. The expressions like the temptress eve, the veiled head and the silenced women became the norms of justification for women's exclusion from full participation in the church. *Gen.1.26:Then God said, 'let us make man in our image, after our likeness……'* . The early church fathers were very vocal in their pronouncements to exclude women from all ecclesial leadership. The androcentric mind of the church fathers became the mind of the church. The prayers of the church reflect a masculinized spirituality. Just take a look at the psalms we recite. *Ps.8-what is man that you care for him, you have made little less than a God, with glory and honour you crowned him….*
Ps.48- though he flattered himself while he lived, men will praise me for my success….
Ps.79- may your hand be upon the man you have chosen, the man you have given your strength….
Ps.113- he will bless the sons of Israel, he will bless the sons of Aron…
Ps.126- Truly sons are a gift from the lord, a blessing…..so on and so forth.
It is written by men for men. How many of us feel uncomfortable to recite it? We do not even realize it. Because the patriarchal mindset makes it appears natural for us to feel comfortable to recite a masculanized and exclusive prayer. Those of us who feel uncomfortable with it may be labelled as 'abnormal'. Until a few years ago women were excluded from studying theology. Just as women have to present themselves in the secular

world as Mrs.----- that is as an extension of a man, so women have to relate to God rather exclusively thru men. By men we are baptized and confirmed, from them we receive Eucharist, to them we have to go with every secret sin, who preside over the marriage or religious vows, and will anoint us at the moment of death. Abundance of male spiritual directors and retreat preachers help to hand over to women the spirituality that is constructed from man's perspective. This restricts woman's ability to utilize her own experience as a revelation of God's qualities and activities.

2. Communication blocks and lack of dialogue.

- Difficulties with regard to dialogue and communication with priests are major obstacles to collaboration for women religious.
- Even when sisters are members of parish councils, they have no voice in the planning of pastoral activities. Policies are taken and decisions are made, but without consultation with sisters. However sisters are expected to implement them.
- Church men feel threatened when women become assertive.
- Pulpit is being used for indirect communication and attacks. Remarks and corrections are made against sisters from the pulpit or at any gathering in the parish.
- Tendency of sisters not to be assertive enough or to be less communicative at meetings are due to beliefs that priests are trained better and have better knowledge. Even when women religious out-number men, they will be verbally paralysed, a characteristic culture of silence imbibed by a great majority of women religious in India.

3. Domesticated roles

- Women religious play a subservient and subordinate role in the church. The presence and person of sisters and the work done by the sisters are taken for granted. To put it in a mild form, at times the work allotted to sisters are those works which the male counter parts are not ready to do! Examples are sacristy work, Sunday school, family visits etc. *example-One of the parish I recently visited is looked after by a men religious order. Parish church is in their campus. In the same campus, there are between 30-40 brothers under formation. Yet to do the work of the sacristy sisters are engaged.* How do we explain this fact? Is it because sisters have nothing else to do or do not want to do anything else? For me it is an enigma.
- The involvement of sisters in the church is conditioned by stereotyped roles. In many of the seminaries run by the dioceses or even some formation houses of religious men, sisters continue to serve in the kitchen and sacristy thus perpetuating a system of subordination. In some other institution run by men religious, sisters

are given the responsibility of boarding houses, to do their cooking and to meet needs of home care and call it networking and collaboration. The ecclesial policy in general seems to be '*we need you so far and no more'*.

- Whether it is full time pastoral work or home care done by sisters, remuneration paid to them is either minimal or even nil at times. The exploitation of women religious as cheap labour force is more pronounced in institutions run by the church.
- It is better for sisters to acknowledge that having internalized gender role stereotypes they do not confront unjust situations that lead to exploitation. This also proves the trend among the sisters to accept subservience as style of life.

3. Inadequate formation

- There is a great lacuna in the formation programmes for both men and women in the church. The present seminary formation of men tends to reinforce their early family socialization of considering themselves superior to women. Sufficient efforts are not made towards a gender sensitization of seminarians and priests.
- Formation of women religious and their style of community life generally focuses more on the maintenance of a ritualistic spirituality and existing congregational apostolate and much less on the holistic intellectual development. Does it prepare you to take each step with confidence and security or does it mould you into a '*silenced, subservient, hardworking, humble and pious* group of women? May I cite one example- *one young girl joined the convent and she spent her first year in the initial formation and went home for holidays. In the convent she was taught to walk without making any sound. So she continued to tip-toe at home. Her mother found it strange to see her otherwise chirpy, noisy daughter tip-toeing without any sound. Her mother turned to her daughter and said, 'this is your home, here you are not a slave. I want to see you taking each step with confidence and security of a daughter'*.
- Deficient training in theology and pastoral skills put women at a disadvantage in relation to men in the ecclesial situation. Sisters need better formation. Sisters need to become assertive. Also sisters need serious intellectual and spiritual formation that will help them develop leadership qualities. The spiritual maturity needs to be expressed in effective apostolic commitment, thus the religious life becomes a school of freedom and creativity in quest for God and for social justice.
- Inadequate formation given to religious both men and women in the areas of sexuality and celibacy often reduces one's ability to relate to the opposite gender. Experiences of sexual abuses in relationships and men going scot-free and women getting punished is a reality.

Caste, language and other communitarian ties play a role in the way religious and priests clique and collaborate.

Emerging concerns

a. Urgency for gender sensitization

Gender sensitization implies consciousness raising in women and men that both are challenged to grow integrating the masculine and feminine qualities that will make them better human beings. Women need to reclaim their worth as human persons and men need to allow women the space needed for this growth. Exposure of women and men to feminist thinking from a sociological and theological perspective at the early stages of formation and as part of an on-going formation could contribute greatly towards gender sensitization. Women and Men need to move from complementarity to mutuality, which implies a give and take of resources and joining hands at different dimensions of mission.

b. Deciphering power

If power is understood as domination, then certainly this is not a Gospel value and there is no question of sharing power. But when power is defined as empowerment, every person needs to have power in terms of having access to resources that will help tap one's potential and realize one's goals. Power exercised as empowerment enhances the power of others. Abuse of clerical power is a critical issue. The major abuse of power is *'sacramental blackmailing',* clergy using sacraments as weapons and withholding them from sisters in times of conflicts. In the church it is time that women who are considered 'second class citizens' begin to share power in terms of authority, knowledge, decision-making, leadership and even finances. There cannot be a healthy collaboration between men and women without sharing of these powers.

c. Empowerment of women religious

Women religious are a major task force in the mission of the church in India. Even though they are a high potential group, they are also one of the most powerless and voiceless group in the church. Secular world has termed it a *'sleeping giant'*. Though they do not lack institutional, economic, and numerical power, empowerment is at bay. The religious validations of their powerlessness make them more vulnerable to exploitation as their subjection is masked by an aura of sanctity. Women religious need to rise up to a new consciousness of being women in the church and in the society.

Dear sisters let us not walk in the church as well as in society, with shame and timidity as though we are slaves, but as daughters with confidence and security because this is our home. Rediscovering our identity as women, women of strength and confidence, women religious should learn to say NO to situations that compromise our integrity and lead to our exploitation. Then we become equal partners with men in the mission of the church and a credible sign of gender justice.

d. Facilitating structural changes

At the structural level, the hierarchical set-up of the church based on ordination automatically excludes women from leadership and decision-making. The existing structures are conducive for exploitation but not for collaboration. For example: the priest becomes the sole authority in the parish. Women religious are at the mercy of the benevolence of the priest for greater participation in matters which involve their intellectual contribution and opinions. Exclusion of women from policy-making structures of the church is an issue of concern while discussing gender policies. We need to develop alternative structures of functioning that have moved beyond the patriarchal forces of domination. There is need for affirmative action that in all the ecclesiastical structures, that women's participation is ensured.

Conclusion

Undoing the century old conditioning of both men and women is not an easy task. The change will not happen overnight. It involves diligent planning and working towards a conscious, concrete, commitment to change by both men and women. Let the initiative taken by CRI at the national and regional levels be the leaven. Let us wake up to this challenge, responding with prophetic vision. Let us together take bold steps to make the church a credible sign of gender-justice and a sacrament of liberation to this world of today.

Questions for Discussions

1. Discuss structures, culture and style prevalent in the church that 1) enhance and 2) inhibit the effective collaboration between men and women in the church.

2. Suggest ways and means to bring in equal participation and collaboration among men and women in the church.

3. Discuss what is lacking in the formation programmes for men & women religious and propose concrete ways to make it liberative and empowering**.**

INWARD – OUTWARD JOURNEY THROUGH MY FELLOWSHIP EXPERIENCES

Strengths

- **Fellowship helped me to move from bio-medical understanding of diseases to a social awareness of the issues involved.**
- **I got clarity about my own thoughts, values and inclinations, confirmation that it is alright and am on the right track.**
- **Am undergoing the process of paradigm shifting in my understanding of health and its various components and sense of**

direction about my involvement in it.

- Motivation and interest to work towards community health is strengthened to a great extent.
- Now am looking deeper in to the issues related to health and feel the acute need for bringing changes into health care system.
- Would wish to establish a health care system which will care for the health of the people and not only treat the disease when it has occurred or aberration takes place to the normal healthy situation.
- I would look at community health as enabling / empowering the individual/people/community to maintain good health.
- Better understanding of rural poverty and urban poverty and the urban-rural differences.
- Better understanding of caste, gender in relation to health and development.

- I got more focused on the empowerment of women and was able to gather information and learn more about women's empowerment at

various levels and among different groups.

- Learned about the working of an organization on a daily basis with equality, integrity, respect, faith in people's ability and flexibility as values and principles.
- Learned to use all the opportunities possible to train myself to be a community health trainer.
- Skills acquired – networking ability

participatory approach

reporting & documentation

bit of public speaking

Limitations

- I missed some of the field experiences which I was looking forward to, mainly first hand experience of some community health projects.
- Wanted to learn more of analytical skills and organizational skills.
- I still feel incompetent as a health trainer. Therefore I need to continue my own training as a trainer.

Way forward & new challenges

 # Would like to initiate in my place of work a comprehensive health care model which will promote wholistic health of the individual, the family and the community aimed at a healthy society.

 # Would like to network with government and other partner agencies to maintain health rather than attending to them after the health is destroyed.

 # Would like to help people recognize health as a basic right.

 # Wish to accept the challenge of identifying with the poor and to engage with struggles, to help them avail the primary health care facilities.

 # Plan to take up promotion of health as important ideology to be developed and imparted to the society starting from school level.

 # Plan to promote health education in schools – to educate children to promote health by character building to be able to say NO to the habits and influences which will succumb them to be a prey to HIV and other STDs.

 # Wish to be a health professional who will help to attain the dignity of a human person and make a difference in the lives of people.

 # Wish to promote empowerment of women.

 # Wish to be an agent of change and transformation I the lives of women and other marginalized groups.

 # Wish to challenge what is not addressing the aspirations of the people.