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REPORT ON

COMMUNITY HEALTH

FELLOWSHIP SCHEME

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COMMUNITY HEALTH CELL
BANGLORE

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PREFACE

First of all I would like to thank CHC for their inspiration and support that gave enormous strength and courage to do this study. They had been guiding all through these period of six months, which further provoked me to improve the other skills and enriched my experiences manifolds. I would also like to show my hedt felt gratitude especially to Fr.Claude D'Souza for his endless support and inspirations. Six months not a very longtime in the CHC fellowship, and the team, to whom I am most indebted for the initial , and continuing , support and encouragement, particularly for the team and the mentor. But the person with whom I have shared most of time "discussing the Topic "community health " has been Dr.Ravi the much loved and respected. With such generous help from all these it was impossible not to absorb enthusiasm for the past and hope for the future The director has had the energy to take the fellowship into many exciting areas and I have greatly enjoyed being part of this new wave of activity. Finally, I want to say to all CHC team how much I have appreciated and enjoyed our close contact over six months .My life has been immeasurably enriched by these encounters. At a personal level I would very much like to continue and stay in touch with CHC so that it may enlighten and make us grow in all dimensions.

Prologue /Acknowledgement.

We are still trying to build a society rooted in fundamental values such as justice and fairness..
The measure of success has to be the state people below poverty line. For the conditions of the people living below poverty line, always been a rock of reality upon which our morals state of our society has foundered. Many if not most prefer to ignore the presence of inequality and casteism . But when it comes to poor people and programs that help poor children get the opportunities t move out of poverty, we're told that the government can't afford it. We have got to be about the business of helping people to understand the issue today is not inadequate resources but inadequate will and inadequate priorities. And I believe the time is ripe for such an effort to be successful. We all start out with high ideals like improving national health and Nutrition, but everyday realities often overshadow those concerns

I deserve no credit for my interest in racial justice. I was particularly sensitive to the doctrine of racism other wise castesim in India, that poisons every society in touches. The conviction that "Health For All meant" that all people should have equal opportunities to live fully and not to be subjected to the injuries and scars that stem from social injustice was a part of the air.

INTRODUCTION

Born in a family where parents both involved in social work , had a great opportunity to learn and understand the lives of poor, neglected people and their living conditions. Inspired by the thoughts of Dr. B.R Ambedkar and by the motivation by the people working together in the circle, for the empowerment and development of the Dalits , it was deeply carved inside which made me to choose no other roads than to render any form of services where needed. Had an opportunity to study Medicine in Russia Moscow. Experiencing a new culture in a completely different society had helped me to learn many differences by comparison. Had also several bitter experiences of being assaulted by the racists. Apart from medicine many things had to be learnt from this alien land.

Few years after the graduation , was preparing to choose the field and set the first step of service. Initially some basic ideas and knowledge of serving a rural community was acquired. Felt that it would not be sufficient. Fr. Claude D'souza , the person whom I am very grateful, was he person who had guided me to do this internship and enrich my experiences manifolds.

The CHC team was kind and supportive all through the days of my studies and correction of thoughts. And their inspirations and efforts activated me to learn more and pursue new skills. I am very grateful to the team and heart fully thank them for their support and kindness.

The preparations for the field visit and study was made soon after the first three weeks orientation at CHC. The first slogan adopted by any medical professional would be "FIRST DO NO HARM" and greatly believing that this should be also be applied in any approaches in entering community was kept in mind. The field selection and the learning objectives were divided as per suggestions and advices taken from the mentor , Dr. Ravi Narayanan and the in formations of the organizations to be visited was given before in hand.

The period of the fellowship was six months and it was planned in my case as three phases. The first phase was an dalit organization called ' Navasarjan' , Gujarat, and the middle was Palavercaud , Chennai and the last phase at Jan Swasthya Shaogh, Chattisgargh. In all the three phases The one common plan of the all the visits was identifying the people who were in great need of the services and how it was obtained.

Health of a community can be assessed through measurement of existing health status of people. Such measurements are called health indicators. These indicators however shows very poor picture of disease prevalence or ill health ratio in a wide area covering many communities. In a way , this field visits was like an expedition, also to discover how cultural values, customs, attitudes availability of education , lifestyles, standards of living, habits, health service availability , beliefs, religion has an impact on the health of an individual as well as in community whole.

Acknowledgement.

The fellowship training in community health got started on the 15th of September with a general introduction of the participants and the staffs working in CHC. The very first that stuck me was the participants coming from various disciplines and their perspectives towards health. I was indeed impressed with the objectives of the organization and reasons for which it was formed.

From the very beginning we were informed about the social determinants of health and also the health status in India. While understanding the current Health status and also the community we were also able to understand and learn the different exisisting systems in India and their functions. We were shown several documentaries on the health systems and the documentary about the medical termination of pregnancy made a sense how the health system itself been commercialized.,

Understanding the difference.

I was made clear with the difference between the equality and the equity. And in the society I knew there were a number of so called the marginalized. It was also easy for me understand their need for entitlement and their fights for their rights. The understanding of the global human rights was also clarified that "all human beings are born free equal in dignity and rights. And this is beyond the boundaries and states".I also learned sme of the civil ,economic, cultural and solidarity rights and also the convergence of the human rights with public rights.

Days and the topics discussed.

16-10-05. We discussed the factors influencing health. Also the risk factors causative factors and the social determinants. The discussion was open and therefore we shared our point of view and actively participated in bringing out the problems that we faced directly.

17-10-05 to 21-10-05. Visit to VGKK in B.R.hills.

22-10-05. We debriefed our visits to VGKK. We made an analysis on the project that worked and my personal point of views comparing to the similar organization working in the rural area in T.N. On the same day we were asked to read 'health as a human right'.

23-10-05.Mr.Eddie gave brief lecture on 'Understanding the communtiy'. He gave some examples of the ignorance of the downtrodden people and their lifestyles and how important is that a person before entering a community should know it. In addition he gave us information how the communities in India are scattered due to the socio economic religious and political systems

24-09-05. We watched a documentary on 'medical termination of pregnancy' and the government acts in relevant to it. Later we had a discussions and the participants in the medical profession added their own personal experiences.

26-09-05. We discussed about the community health and the public health. "I understood that community health is a process of enabling people to exercise collectivity and their responsibility of their own health and demand health as their right". We also got some information of the health systems and the structures that exists today.

27-09-05. Dr.Thelma was briefing about the peoples charter for health. Followed by Mr.Chander about the Peoples health movement , the aims and its objectives.

28-09-05. The seminar was on exploring communalism, Casteism and social research. Mr.Eddie very well explained about the issues and expressed the need for he 'enititlement'.In the after noon Dr. Thelma took a session on 'Gender and women's health empowerment.'. She shared with us how the women's day came into celebration

30-09-05. We made a visit to Mrs. Padmasini Asuri, a well known nutritionist who had been working in govt. programmes for several years .She gave some tips to cook a healthy food with easily available resources and cheap of cost. She also insisted that we should help people to understand the value of the food one consumes. It need not be the quantity ,but the quality. Also some hints for supplementary child feedings (traditional).

01-10-05. Visit to Dodaballapur (GASS).This is a village some 60 kms from Bangalore. The organization worked specially for the mentally disabled and for the 'differently abled ' people also working with some women in group formations. They also work to eradicate alcoholism in their areas. I was very impressed with their organizational structure .Volunteers and the staffs were chosen from their own community even from the affected and the work is made simple and more effective.

03-10-05 to 07-10-05. We had a whole week of modules in the mornings and the presentation by our fellows in the noon. Myself and Sandhya made a presentation on the CINI's project in West Bengal Calcutta .I also came to know more things that was not in the literature through Mr.Shekar who had been working there recently.

10-11-05 and 11-11-05. We had our senior fellows making the presentation. I was very much impressed about their works and studies . Had more discussions with them and came to know all the progressive plans and their critics on certain issues. This made a sense for me to build up tactics in reaching a new and unknown community .

13-10-05. It was a cultural day. Some of the staff members came with their kids and it added beauty to this auspicious day. Some of our fellows were dictating jokes some games and some group songs and dance. Lunch was served and had a long chat together.

MY POINTS OF INTRESTS:-

The Division:-

Very much aquainted with he the division in the whole society I was able to understand the Patriachy that tames the minds of the people of being segregated and live lives according to their own norms. Was

able to put forth my own point of view on the fundamentalisim. communalisim , casteism and also came to know about these issues fom different fellows from their own areas. Mr.Eddie made a long lecture right from the origin and made a point that development cannot be possible without breaking all these divisions,. I totally agree to that point and made a long discussion with him.

Health and nutrition :-

Since food is the basis of all living things ,the food that we take should contain all necessary nutrients that is required for a healthy
living. Mrs. Padmasini Asuri a specialist in nutrition and diet gave us some useful tips of preparing a food with the easily available and of cheap cost with rich nutritional components. We cooked with her and discussed the need for the awareness of nutrition.

In search of mental illness:-

We had a visit to the 'Grammine abouodhays seve samasthe'(GASS) in Dodaballapur. The organisation was set up for the mentally ill and the differentially abled and also for the visually impaired.I was quite impressed with the job and went interviewing some villagers of that area. There was a great welcome for the job that they were doing and it did serve a lot of people in that area. This was quite inspiring and the whole set up was well planned. I also met with a person suffering from dementia and his family. As his wife said that atleast the people from GASS was ready to share my problem than my neighbour. I felt that human concerns are the first thing which the people need in disparity than any material. Other than pure medical assistance these people would provide also some income generation programmes for the family to run. This is an example of them being more progressive in the their thoughts and in their work that they are doing.

Towards Globalisation:-

Dr.Thelma's explanation of globalization from Gamma to Gates was a thought provoking one and still there was doubts of how could that has an effect on the poor in the rural India..? The discussions were open and one could debate on a certain issue brought by him. Finally, after going through the positive and the negative aspects of the issue it showed to me that it brings a lot of disaster than good to the community. Only the OECD's get benefited through that and not the others.

Visit to B.R hills:-

We had to make along journey by bus with Mr. Chandan accompanying us. And this was an area covered by the tribals predominately by the people so called the soligas.The environment itself was too tranquil and free from any noises. We visited VGKK and the school pupils. The school was a residential one and could accommodate more than 400 pupils. The classes was going on according its schedule and school children were well organized .Early morning they were doing some yoga and breathing exercises to keep them selves healthy from the cold climate. After we visited the P.H.C and had a short conversation with the doctor.I was very much impressed with his attitude towards community.. He was also assisted by two house surgeons, interns from mysore. We did also make a visit to Yelandur, a rural hospital with 30 beds and treatments for mentally ill patients and epilepsy was given. This is very typicall because the patients often have to come to nimhans in Bangalore with such

illness to be treated. Here there was also a mobile dental clinic visiting every Sunday. Since the population is so scattered it is not always easy for them as they said to make medical camps often.

We all together stayed and studied for 4 days.We had our food with the kids in their mess, usually they used to serve 'Raggi Modhu' a high protein ragi diet,which was a new food for me.

Visit to APSA:-

This is an organization which has multi dimensional development program form children to the elderly people. I came to know that they were making some great steps to prevent the child labor and crisis line to rescue any child being subjected to any kind of violence. Especially when Mr.Kshitish Rus the director of APSA was mentioning about the lands of the poor being taken by the Rich industrialist and the poor being left homeless. Last week there was 32 calls and immediate action was taken as told by the APSA team coordinator.

MY LEARNING OBJECTIVES

After a good start of preparation and learning community health from CHC , in spite of all emerging ideas and the desire to acknowledge every issues in a broader sense ,considering the practical difficulty in pursuing all the knowledge in every issue, I made up a list where I could focus , learn ,observe and work out together with NGO working for it. I hope that, also discussing with my mentor would clarify and enrich my vision throughout this course. Here are the lists of my learning objectives

- Exploring various models of health care and health supportive programmes by the government as well as the non govt.,provided for the people in both urban and the rural areas.
- Studying and identifying the best health practices in communities.
- Developing training module for the health volunteers involved in the rural health care and health supported programmes.
- Strategic interventions of the N.G.O's in the health sector and their contributions and effective services.
- Impact of the self help groups on women's empowerment.
- To understand the vulnerable migrants and the street kids and the programmes focusing on their development. Also to know about the drop in center .
- To discover and learn dalit organizations ,meet their leaders, discuss their current situations etc.,

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Gujarat

Capital : Gandhinagar

Population : 50 596 992

Population desity : 258/sqkms

Sex ratio : 921/1000 males

Birth rate : 25.4

Death rate : 7.9

IMR : 63

Literacy rate : 69.97 %

Male literacy : 80.50 %

Female literacy : 58.60%

No: of hospitals and dispensaries: 9783

No: of police /1000 : 1.4

Percentage child vaccinated :53%

No : colleges (eng and med) :48

No: of schools ;-

Primary : 14,789

middle :20,044

secondary : 6,177

06-11-005 : This was the day I reached Ahemedabad after a tiresome two days train journey. I reached the place called DSK (Dalit Shakthi Kendra) a suburb atleast 12kms awayfrom the city. It was a big campus and I was given a place to say.

About DSK :-

DSK or Dalit Shakthi Kendra is a ploy technical college run by the NGO trust called NAVSARJAN .This college is recognized by the government of Gujarat and conduct courses in various disciplines. The courses at DSK are:

-Mechanical engineering
-Auto rewinding
-electrical engineering
-welding and painting
- carpentry

-Police training

-Tailoring

- Textile or fabric designing

-Computer training

-Driving

-Photography and Documentation.

This campus has a office of Navsarjan which is the headquaters of all the offices in 20 districts .There are also huge halls for a monthly meetings with field staffs.The buildings and the auditoriums are spacious enough for conducting these courses and there is a huge playground and gym especially for the students in the police training course. Police training is the course which anyone would have rarely heard in an poly technical college , but it is a kind of preparation for those who are applying for the police services , to make them physically and mentally eligible. They have surprisingly good number of students joining this course , increasing in number annually. Carpentry is one of the other course with more students and in Gujarat as I was told it was a good business and it is the place of excellent wood designs . The driving course is a six months and a shorter one and the it ends it getting a license at the end of the course.

There are 12 teachers or instructors who are mostly residential. Most of them are been trained here earlier and are well aware of the rules and regulations of the campus. The teachers join along the students in the evening prayer or reflective session which is a daily routine . This session did impress me a lot and took part in it whenever I stayed in DSK. It is a sort of self-acceptance building tolerance in a person and amongst a group.

Some of the rules and regulations in the campus.

- Use of any kind of tobacco inside the campus is strictly prohibited.
- Consumption of alcohol is prohibited.
- It is a residential college and going outside is only with permission.
- Plates and glasses used by students should be washed after every meal.
- Morning exercise is must for all including girls

These were all the things I was told by the two instructors who came to receive me in the midnight of my arrival. They also praised Mr. Martin whom they

were working for Dalits and nothing towards health. Studying the lives and health conditions of Dalits is one of my learning objectives and here I am in the right place !
Mr.Martin did not have much time to share so I was given few books to read .I was interested in "Migration in search of Labour" and "Manual scavenging in Gujarat". In the evening I was given a brief introduction o the other staffs in the DSK and explained them the purpose of my visit. Ms.Manjula , program director was coordinating with me and she told her expectations and we sorted out plan for the week.

I was suggested to make field report in Karakodi , Kutch .The disatance was quite far and the there was a jeep going to the place .Mr.Eddislav , a Swiss photographer was going and I had to accompany him.

RANN OF KUTCH:

I was given a brief introduction about the community that they are working for .They are basically salt pan workers who are migrating from the villages to the desert for more than four months .We reached the field Karaodi around 3:00 pm and took a postmaster the local field staff's friend to show us the route to locate . Because most of the families in the desert live in houses far from each other and it is not possible to see the houses from far due to the mirage . Finally we reached at a house. A man by name Ratillal bhai is the haed of his small family. He had been working in the salt pan since his childhood and now with his family. There was an interaction and I wanted to listen him more. He says:

"I have been working in the salt pan for a period of thirty years .This land is not my property. I have two boys aged 11yrs brought here to work with me. Small kids are left at home as they could not withstand these extreme climate. We get water once in 3 days and with that we manage cooking bathing etc..., My wife too is employed . We get vegetables once a week and the truck driver brings them as there are no other modes of transport .We get an advance of 6000/- Rs and with that we have to manage house food ,oil and engine fuel. I had a debt of Rs 2000 which is spent on time of delivery. I have to go 7kms far to hospital if any fever ."

When I asking about his and his family's health conditions he seemed to be not much bothered as he said only strong and well experienced persons could work and survive here. He also complained that he had minor hear aches and foot ulcers. The kids had tooth decay and mild signs of vit A deficiency. While asking weather he had got any help from the government he says that he had been given boots and hats by the Mahila mandals group.

Later the field staff enquired about the process of salt making and the labour involved. I could sense that these hand made salts would be purchased by the mediators and it will be sold to bigger companies to refine and packed with their own emblems and introduced in the markets for a higher price. But the salt makers are still migratory workers who are indebted and poorly fed on the dry vegetables and little water.! What we discussed in the group about occupational health hazards and the medical care is far beyond a question to these deserted community. There is no doubt that their(especially the young's) nutritional level falls from norm to substantiate level leading to malnutrition level. I hope that there will some action from the Navsarjan as they seemed to study and conduct various programs for their development.

Me being there for a day or two could only give them some health guidance and stressed the importance of nutrition ,Also explaining the consequences of long exposure to sun the natural phenomenon of increasing blood pressure , dehydration also renal calculus formation due to higher production of ergo calciferol. The community was

quite interested in knowing about the risk factors leading to their ill health and was even not heard much before.

Visit and study of technical courses in DSK :

I took the day in visiting and absorbing the various departments of teachings in the DSK campus. People around the village say that this institution is particularly training only the Dalit community people . But what I have heard from Mr.Martin , the students from other community also invited.., provided that they would accept to share and live together with the Dalit community students without differentiating. But it is very rare that such people come forward to join this institution. This is ,to say ,may be a vision of Navsarjan that equality in minds will be estabilished after long period of sensitization for which they are working tirelessly .

- Carpentary:

There are 11 students in the faculty. Majority of them tenth class drop outs and some them intermediate .They are otherwise been motivated to do labour works to support he family or stay in the villages to do farming. While interacting with them they said they were interested in this work and its affordable to do the course. There were few who could not pay the amount (due to fiancial problems) which is not at all expensive comparing to other courses, so they are working in the campus to pay back .Over all they are still not feeling bad about studying with others who could afford.

The auditorium where the training is held is big enough .There is a storage unit and a production unit. They made chairs ,tables and other decorative furniture . Mr.Raja bhai ,the instructor helps students in designing and measurements. He also does markets and gets orders for production. Most of his previous students are taken for jobs and has passion for teaching the skill.

- Electrical technician course :

Has strength of 10 students and all males. The instructor ,.Mr.Rajesh was himself trained here few years before .The students are trained to handle the modern electrical devices . Most of the students had a little experience before joining the course and they now will be given a certificate to apply for any private or government jobs.

- Tailoring :

There are around 40 students and is the highly populated department. The majority are girls . There are short term and long term courses .There is a possibility of doing a dual course well . Most of the girls who are undergoing this course are either school drop outs or belong to very poor families whose family income is below the average.The instructor Mr.Vasu bhai together with the textile designer Ms.Nita ben take care of the production .They make garments ,bed covers ,pillow covers , etc.., and it is kept in the office show room for sale. They also take orders from schools .

- Driving :

About 10 students are in the driving course. They are given theoretical and mechanical classes in addition to the driving. The driving classes starts at 9:00am in the

morning and each gets 5kms drive. Theinstructor Mr.Vittal bai is a strict kind of person and takes more effort to make the students qualify in the final test drive. The students are also satisfied and confident with the routine classes.

These were all information that I had gathered in the day and also tried to organize some health workshops with their help. Majority of them were interested in knowing the nature and cause of major diseases and the necessary precautions and prevention. We had to fix a day ,that too on a holiday so that we could have a whole day in discussions without spoiling the routine classes.

In the evening I discussed with Ms.Manjula about the planned field visits and she suggested me to watch the documentary on manual scavenging. Also watched the documentary on the lives of Dalits called "I am Dalit and who are you?"

Manual Scavenging in Paliyad

10-11-05 : Reached Paliyad by bus with a field worker Mr.Suresh who was working for the scavengers community. It took 5hrs by bus from Ahmedabad. Paliyad is a small village and the glimse gave me a picture of what I have seen in the documentary of manual scavenging in Ranpur.This village is closer to the Ranpur .

At first met a person , a fellow worker and then got into the streets walking to the scavengers community living areas .We first visited Mr.Somabhai Parmar' house. It was a tiled house and spacious inside. Mr.Somabhai is the head of the family and had been working as a 'safai kamdar' or a scavenger for all his yearsand now is kind of retired.His wife Ms.Lecla ben is still working as a safai worker and just returned after her morning routine with a basket broom and a tin plate .Before I wanted to introduce myself I was served a glass of tea .

(*The tea matter* *Tasting a tea made in their house means that you are not a high caste person or you do not believe in the caste system or do not practice unsociability. This was a simple test to confirm my caste which I did not know later explained by Mr.ramesh with a smile.)

So I made my introduction and explained the purpose of the visit. (however they seemed to remain confused about my visit and stay). Anyhow they expected some health check up as the name community health when translated in hindhi meant differently.

We visited some of the other houses who were involved in scavenging and fixed time for a meeting. Mr.Suresh had list of the families in the village who were Bangi's (scavengers) and valmikis (drummers). He is working for protecting the rights of these people , by fighting with the local municipality against compelled manual scavenging by the higher officials and the higher caste people. It was amazing to see that he had evidence to what all he was arguing for and the municipal officer was quite not agreeing to his demands.

Evening we walked down the streets to visit some more families. We also visited the community health center and met the doctors. They complained more about the irregularity of the patients visits and negligence about their health due to poor financial conditions.

The next day was planned visit Mr. Kallubai who is a drummer by profession and his wife Mrs.Hansa ben ,a scavenger. They were happy about the Navsarjan's field worker supporting them in protecting their rights to refuse the manual scavenging. The family members do have good contacts with other members of the community and take part in discussions and make decisions .

It was a day that he did not find any work as he goes for work on call when there is any wedding or other family functions in the town. Busy repairing with the drum waiting for the Navarathri when he will be engaged and earn some money .While asking about his family health he says his wife complains pain in the joints and he himself rarely feels pain the foot.

Also he says ,that he drinks before going to job of drumming as it gives more enthusiasm and less pain standing and drumming for hours. And her wife who has just returned from her morning routine wanted her for a BP check. I agreed and before I asked her when did she did the recent check up she did not get checked up but got medicines from hospitals through her husband when had fever.

It is significant ,that she or women like her are knew that visiting hospital for a general medical check up for minor health problems is a luxury . She was over women of 40's and pale .Signs of anemia is well seen .Complaints of pain in hip and knee joints. She even feels dizzy sometimes and gets tired often. But still doesn't believes in getting treatment from the CHC which is few meters away. I measure her blood pressure and advised her to follow the hospital to get iron and folic acid and take a course.

Indebtedness ···! Its all stones. Some quick-fix solutions...

That evening after the visit I was informed by the Mr.Suresh that on of the community member had a serious health problem and would want to visit him. His house was some what far on the other end of the town and we decided to go late evening as he will not be available . Later we got the message that he has returned home and wanted to see us. It was 11:00 pm night and since he had to go to the hospital in Nadiyath which is far , we visited him at midnight.

Mr.Ramabhai Pramar was the person whom we wanted to visit. He is 42 yrs and the head of the family and was a safai worker . His sad story begun after he was informed by the hospital that he had a kidney stone. Previously was having a intermittent low back pain when did not take it much seriously but got medicines from the hospital. Now he is at bed rest at home ,voluntarily retired and wife taking care of the family .We met her wife and children .They had said that they have taken loan every where for his treatment and now they still could not make up the sum for his operation.

The family thought that he his going to die soon if not operated. But I could see Mr.Ramabhai was not at the stage where immediate intervention would be life saving . I went through all his medical reports and scan results. He was diagnosed renal calculi and red cells in the urine found. But the stones are about 0.8 cm s in diameter and sited not in the site of obstruction. I tried to explain him and the family that once again consult the doctor and enquire if he could conservatively be cured in a long term (if the calculi be fragmented). The operation ,totally estimated to the sum of 20000/Rs which will make them more in debt and ruin the family .The only assert the have is their house .His two sons are young and they are not earning and Mr.Ramabai sometimes feel that he will die and spare this house than to see his family suffer.

The whole night went in discussions to help him out of the situation .Finally he gained some courage and agreed to consult with the doctor once again .The family was satisfied with our guidance and support .I was sure that correct information or the counseling was not accessed by them, either because the disease sounded highly scientific hence not understandable or could be made to look as life threatening so they did not turn for an alternative medical care rather than arranging money for the operation.

So to this context we played ,I assume, that we played a vital role for changing the negative mindset of family and the community towards the hapless victim Mr. Ramabhai .The results and the outcomes of our interventions were unknown until the last weeks of my stay in Gujarat . I heard that he was taken for the conservative therapy avoiding the operation and could wait for observation. Meanwhile the filed worker held talks with the municipal in regards to get his gratuity and other funds.

Some references from thebook Davidson's Principles and practice in Medicine.

" small stones, less than 0.5cm in diameters, are usually passed naturally, larger stones may require active intervention.Immediate action is required if anuria,infection or hydronephrosis develops. Attempts to dissolve calcli have failed, but in a few centres a lithotripter is available, using this apparatus calculi can be fragmented in vivo, by shock waves ,generated under water , focused on the stone, and applied to the body surface.The fragments are then passed in urine".

"Stones in the renal pelvis can be removed by open operation,removed endoscopically via percutaneous nephrostomy , or fragmented using the lithotripter ."

Few indications for interventions in renal calculi :-

- The patient is anuric.
- The ureter or pelvic-ureteric junction is obstructed, totally or partially,by a stone unlikely to pass spontaneously or which has not been removed for years.
- Infection is present.

- The patient has intolerable or recurrent pain.

A visit to model school in Raika village :-

23-11-05 : The visit was earlier planned with Mr. Martin and Naveen Thomas from CHC. We left around 9:30 am and it took 2 hrs to each there. Two of the social worker students who have come for field exposure also accompanied us. The school was a quite far from the village and had a quiet atmosphere. The children were well aware of our coming and they warmly welcomed us.

Martin says that he visits them seldom but children liked his visits. He also some books and toys for the children that he had got with from abroad. After a brief introduction of others and me to the teachers and the children we sat in discussions with the teachers to know more about the school .

Some information about the school and the future plans ..

The Idea of this model school was a more worked trying to ensure that the children grows up with not the formal education alone as the other schools but give the children an different outlook of the present days world and exercise freedom. As Mr. Martin said there is nothing in this school that the children are prohibited to touch.

The children are of various age groups and they are all mostly from the village background .It was interesting to observe that they well mannered and polite in communicating with us. This is a residential school and the teachers also stays in the campus.

There are 3 female and 2 male teachers and they had been specially trained by the organization (Navsarjan) after their basic teachers training.

Strength :

No : of children in total : 19	
No: of girls	:3
No: of boys	:16

Structure:

The school building is three separate blocks and each block has a big hall and two separate class rooms.

The buildings are carefully designed specially to make easy for the kids to open or close a window or the door. Child friendly furniture and writing boards of the

reachable height are adding credit to this model school which I only seen in big cities where very few elite could afford.

The Eco- San Toilets :

Scarcity in water resources is one of the common problem in the area ,and the water has to transported from the near town. For such and several other reasons the Eco san toilets are been introduced . This construction is engineered by an expert from Sweden and assures that it is not too expensive and eco- friendly.

Surprisingly the usage and methods were well acknowledged by the school children and even they illustrated the way to use it do's and the don'ts . Perhaps the love and care for nature has been inculcated right form the childhood which is lacking in many of the private and public schools .

Interventions and actions....

- Discussions and planning with teachers for making a health profile for the children.
- First aid information and the immediate measures that has to taken by the teachers in case of emergency.
- Making health and nutritional charts by the children with drawings with its caloric values.
- Explaining and answering the questions , understanding ill health and diseases from their point .
- Individual consultation of the children with the teachers and measurements of height , weight and BMI are recorded in their respective profiles.
- For the First aid kit , plasters and antiseptic solutions ..etc purchased and the outdated medicines were disposed.

The Summing up the 3 day stay at the school ....

This was a rich experience and provided large space for studying the daily routine of the children and the need for attention in health. After summing up the profiles the importance to increase in quality and calorific value was addressed and recommendations made to the director.

Basically , most of the children from poor Dalit families in the most remote places , whose parents are indebted ,poor laborers and cannot offer education or healthy food for their children . There is no question of girl child being sent for schooling. As the figure shows ,(total only 3 girls from19) one could easily understand the need of girl child at home for domestic work and school is still a far dream .

" It has become national value-the principle that everybody who needs medical care can get it and nobody asks you if you're rich or poor, where you work. Knowing that everybody gets the same care helps to hold society together –it makes everybody equally valued." *

A vision of health insurance system as it finds this as a unifying force in the country. Looking in depth , the idea of the health insurance , which is successfully established in many rich countries ., is promising to address the issues equality in medical care .But question is how implemented in a rural considering the village as a social unit, an integral part of the larger society making the health care services available to them .

Jawar Health insurance scheme could be one of the pioneers in experimenting the process. Studies done by Ms .Nita Rao , senior fellow of CHC in her report had unveiled many facts about the scheme . Although the scheme underwent numerous changes it still continues to provide health services in rural .

Health Insurance – A general understanding.

Insurance provides the means by which risks, or uncertain events are shared between people. Premiums are paid to an insurance institution which compensates any insured victim of the event for any financial loss resulting from the fact that what is unpredictable for an individual is highly predictable for a large number of individuals.

Insurance inevitably has a redistributive consequences, their nature and magnitude depending on the financing of the schemes and the way in which premiums are assessed. Because the occurrence of the event being uncertain , some participants will draw out more than they pay in , thus resulting in redistribution from the healthy to sick.

An individuals demand for private health insurance will be determined by the factors such as the price of the insurance ,that is the premiums to be paid: the individuals assessment of the probability of loss(especially financial) resulting from the illness: the likely magnitude of that loss: his income and most specially, the degree to which he is risk averse(felstien1979).

(*Sources from the book "The economics of health in developing countries" edited by Kenneth Lee)

Session on "MY BODY" and "Communicable diseases".

Date : 27-11-05

Venue : Training hall CTC, Dalit Shakthi Kendra, village Nani devti.

Participants: poly technical students and the instructors and other staffs(60)

Time : 11: 00 am .

Plans of the session :-

- Introduction
- Illustrative explanation of body organs with the model chart.
- Functions of organs
- Related diseases
- Questions
- Discussions on "Health problems faced today"

The session got extended up to 2:00pm since there were a lot of discussions at the end .

What is Primary health care ....?

Most ill health could be prevented by cheap methods.

- Adequate water supply.
- Adequate nutrition.
- Safe sanitation.
- Immunization against major diseases.
- Treatment for cuts and common ailments.
- Health education.
- Community participation in primary health services.
- Training of local health workers.

28-11-05: Visit to Trust owned school Navsarjan vidhalaya at village Kataria:

It is one of the trust owned schools . The same model as in Raika but here the strength in population of the school was higher than in Raika .

The charts were made and the health profile done with assistance of the school teachers.

Revision with a wider vision:-

It was interesting to observe that in this school with a larger group there was more cooperation and active participation by the school children . It was maybe an insight " when equality in minds practiced right from childhood there is an excellent understanding amongst the group and great tolerance emerge".

There was not a single child who was feeling the complex and abstained from participating in learning activities.

Payments of Rs 500/- per month on education and food and accommodation per child is cheap but still a luxury for the Dalit parents to afford. Stressing the value of education the teachers also motivate the parents in shaping the child's future.

Health as an entry point :

Health education and community health can play a vital role in increasing peoples consciousness' and not only about their health need but also about the evils in society which is the main cause of their sickness and health"

Community health should also be a way to motivate and mobilize the people to resist the domination of he traditionally powerful. It offers an effective way to bring people together to discuss their day to day problems and take responsibility for them If they take responsibility for better health this also leads them to do the same in other related spheres of concern ------

These are few insights of community health by Henry Volken , Ajoy Kumar and Sara Kaithathara in the book " Learning from the Rural Poor" a shared experience of the mobile Orientation and training Team ,Published in the year 1981.

07-12-05 Visit to Jasdan.

Objective : To study the health and health needs of the mahila groups in the district.

Duration : 3 days

Field coordinators : Mr.Dhaya Bhai
Ms. Rekha
Ms.Shanthu

Villages covered : Jeevapar
Jasapar
Harijj

The First Meeting :-

The village mahila groups (there were two groups) assembled in a training hall at the Mr.Dhaya 's residence.

There were 30 women gathered and they were all of various caste . There was a village health worker Mrs.Rekha who works in the sub centre.

Initially introductions made and soon started discussions on the Health topics and accessibility of health care . Summing up they ...

- They part in Immunization campaigns viz..polio T.B
- Had received health information once a month by the FHW
- No Ambulatory services
- Chlorine tablets and ORS packets available from FHW in need.
- Midday meal program goes well in Balwadi
- No proper sanitation and toilet facility.

(* None in the whole group had a toilet facility at heir houses except the leader)

The discussions continued and had a quick individual check up for pressure and weight measured.

List of few cases studied and their complaints.:-

-

Mrs :Banni. Age: 40 yrs

Complaints: Decreased appetitie,
-low back pain and pain at joints in lower extremeties.

B.P : 100/80
Mr.Nathi Ben Age :40 yrs.

Complaints : Leg pain
Knows that she is diabetic since 3 years
Had not gone for blood test for a year
Takes Glysip tablets.

Ms.Jaya ben : Age : 45 yrs B.P : 135/90 Pulse : 88'min

Complaints: Dizzines ,Headache
Hysterectomy done the last year .
3 times blood transused...?

Mrs:Nanu ben Age 50 yrs BP: 135/90

Complaints : Dizziness..,
Pain in the Knee joint and legs.
Antacids and pain killers taken random

Mrs: Raji ben Age : 60

Complaints : Abdominal pain indigestion.
No solid foods taken .
Few months severe abdominal pain occurred and hospitalized.
Not taking any drugs at present.

Mrs: Heeru ben Age : 50 BP: 125/85

Complaints : Body pain. Pain in joints.
Survived an road accident 2 years back.
Takes dextrose iv once in two weeks.

Mrs Jaya Ben Age : 30 Bp: 120/80

Complaints : low back pain.
Lower abdominal pain.
Itching sensation.

An short interview with the SHG group leader :

Mrs .Shanthu ben , leader of the local women group shared few of their action oriented experience since the group was formed. Samakya was the name given to the group was formed 5 years since by an NGO in Rajkot. A sum of Rupees 500 given the group monthly by the NGO to supports its functioning and to held meetings.

The group apart from its routine meetings takes part actively in "Mahila athikar campaigns" and deal with the rights of women .They do pay an special attention to divorce cases, violence against women's cases and este bsed violence cases. One of the senior most women group member Mrs Shanthi Ben of the age 80 is still a member and does contribute a lot in organizing meetings and group discussions. Her valuable insights are greatly appreciated by the group members but she having got injured by a fall, had no scope of getting her arm fixed . She had broken her fore arm fractured and bandaged with a cloth with which she manages movements . She has been to CHC for medical aid , but could not afford for the charges and was sent back.

Need for a strategy :

The right for health care is primarily a claim to entitlement, a positive right, not a protective fence. Any amendment guaranteeing the right to health should have a focus on primary health care which is preventive and curative. It should also have a special focus on he health of a women – more specifically on their reproductive health , on prenatal care.

Meeting with the Sarpanch (the village headman) :

Village : Jasapar

Name of the village head man : Mr Babu bhai Dildabai Patel.

Period elected : 2002 to 2007 (previous 5 years was also elected)

Few information about the village and health given by Mr Babu bai are :

- The total population of the village is 2500.male 1300 and female 1200.
- There are two schools one primary (up to 7th grade) and a private (10th grade)
- PHC for the village is in Sanath which is 4km far.
- CHC is about 17km far.
- 95% of the villagers are Hindus and 20 people are muslims.
- 90% of the villagers are farmers and others weavers ,carpenters and welders.
- Granted sum of Rupees 25lakhs for te water reservoir construction.
- Health conditions are not bad in comparison with the other neighboring villages.
- Optimistic in the functions and other actions of the Women groups . "There is a unity amongst the women after such formation"
- Training for the women in watershed construction is conducted in Rajkot.
- 250 toilets have been constructed and 90 more to be constructed under "Saka Kari Yojana".
- Has not problem with the transport.
- Doctors are involved in discussions " Gramma sabha" board members and the TB control programs explained.

Some Observations :

Not interrupting the flow of information from the village headman one could easily sense how wealthy and healthy atmosphere prevails in such a rural remote. Some specific observations made are ..

- About 99% of the women group members did not have toilet facilities in the homes.
- The irregular transport (bulla carts) and the timing are unpredictable.
- No job guaranteed for women in the watershed projects
- Poor sanitation.

1

Improving standards....

It is hard to assimilate the facts which pushes us in to more complexity of understanding "community health" which is all based on the plans of the (Government top to down)alone and its plans involving in rural development. The need based planning , and quality health care will be promoted supplementing the existing rural development programs either by peoples demand or the village headman who plays dominant role in decision making for the development of the community –the village.

The schemes of training the women seem to have be designed keeping in view the needs of the rural poor in general. They do not address to the peculiar role and needs of the rural women , particularly the double workload. Support facilities like job training and technical skill trainings are either inadequate or lacking in the proposed training endeeavours.

* The Constitution of India has specific provisions that relate to the right to health .They are the Directive Principles of state policy –Articles 42 and 47 – and therefore they are non-justifiable . Article 42 and Article 47 are the guidelines that the stte must use to achieve certain standards of the living for its citizens. Although the Directive Principles of the state policy are compelling argument for the right to health, there are needs to be clearly defined right to health so that the individuals can have this rights enforced and violations can be redressed.

The Indian judiciary has interpreted the right to health in many ways, eg, through the public interest litigation as well litigation arising out of claims that individuals have made on state, with respect to health services.

The issues of adequacy of medical health services was addressed in quite number of cases decided by the supreme court. It has been for example , that the failure on the part of a government hospital or health centre to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21.

It has also been held that the lack of financial resources cannot be a reason for the state to shy away from its constitutional obligation. This would then imply that the right to life includes the right to primary health care. With regard to maintaining a clean environment, which is critical to a persons health, there are many questions that the state has deliberated on. It was held by the court that a public body constituted for the principal statutory duty of ensuring sanitation and the health is not entitled to immunity on breach of this duty.

The question that must be discussed more thoroughly is whether an amendment to the constitution, which will state the fundament right to health is desirable. Enumerated rights have an edge over the wider interpretations of existing rights as states can be held accountable for violations. However the extensive case law that is available does not ensure that health care facilities and public health standards ensuring health are guaranteed to every citizen.

(* From the study and report by the fourth-year students of the National Law institute , Bhopal in the article in the Manushi issue 152.)

A Village visit :

Village : Jasvanthpura District : Patan

Field Cordinators: Ramila ben
Narendhar bai
Chetna ben

Purpose of visit : -To study the objectives of the SHG's
- conduct discussions to promote sanitation .

Place : At Mrs.Pallabhai Parmar's residence.

The information of the village as dictated by the mahila groups are :-

- The Mahila group was formed since 5 years
- Members deposit Rs.50 per month.
- A sum of Rs.1500 withdrawn from Bank. (microcredit-programme)
- Loan used for purchase of cattles (income generation)
- Meetings within the group held once a month.
- Female literacy in the community is too low and need to be encouraged.

In the health aspects when interviewed...

- PHC is located17 kilometers far from the village.
- Health care providers include
  Anganwadi worker(1)
  ANM residing in the village(1)
  Trained dhai(2)
- No disabled persons in the village
- Abortion and family planning are done mostly in PHC(Harij)
- Vaccination for Polio done at regular intervals.
- Drugs for malaria prevention provided by the care givers
- Awareness of HIV/AIDS/STI either not reached or not understood by the members in the community is limited.

Discussions with the members of SHG :

Being aware of present conditions including health, the role of SHG's participation in development of the community was discussed. Other issues such as illiteracy, importance of girl child education, caste inequalities were also brought into discussions in ad hoc. The field coordinators (trained and oriented by Navasarja) work basically on primary education, handled the discussions progressively.

Monitoring Changes : (from observations)

Daughter of one of the member of SHG had done a tailoring course at DSK and now finds some source of income to support her self. The field coordinators initially encouraged her to learn a skill, even though she did not have basic schooling. The motivation and the encouragement by SHG members ,improved her confidence to survive in a male dominated society. A large number of others seem to realize the necessity of women education. "A process of learning through examples and not by explaining processes which is effective in the context of rural community".

Village visit

Village :keshani Taluk: chanasmataji District : Patan

Field coordinators. Mohan bai
Pushpa ben
Nimisha ben

Purpose of visit : To study SHG's role in community participation and development.

The Group was gathered in few minutes and a place for discussions arranged by the field coordinators . After a short introduction and explaining the purpose of visit the group showed interest in sharing their views of community health as they shared..

- The group was formed since one year. (Propose of group formation was not well understood by any of the members and the women participation in the panchayat was something new as per tradition .There were few opposition from the men which as described still exists today)
- Finally the objective of the group formation was made clear after endless efforts of the coordinators. Unity, security, exposure , decision making, income generating , etc where accepted by the women group.
- Savings in the post office by women is encouraged by SHG.
- Health related information either given by NGO through the field staffs or the village health worker in the village.
- Female literacy is encouraged by the SHG (very few25% are sensitized in girl child education and the others (75%)even though sensitized could not help due to familial constraints.)
- Government health services are good and medicines are available. The hospital includes a female doctor too.
- Women are mostly hospitalized during the time of delivery.
- Monthy meetings in the group are held twice.

* " The word Development always implies a favourable change , a step from simple to complex , from inferior to superior, from worse to better. The word indicates that one is doing well because one is advancing in the sense of necessary, ineluctable universal law and toward a desirable goal".

* " But for the two thirds of the people on earth, this positive meaning of the world development- profoundly rooted after two centuries of its social construction – is a reminder of *what they are not* . It is a reminder of undesirable, undignified condition. To escape from it , they need to be enslaved to others experiences and dreams".

(* sources from the book "The Development Dictionary" –A Guide to Knowledge as Power edited by Wolgang Sachs.)

Few Insights :

+ The attempt to sensitize rural women in various issues being the priority in basic women group formation is appreciated .For poor and workingclass women , defining work only that is paid labour is artificial ,since jobs paid for wages are usually an extension of work performed at home. The role of women is very much limited and mostly the developmental activities from her are not self generated , a needed or thought necessary unless external forces such as NGO's trigger them up. The NGO's, not to

blame them, well define that the impact of women empowerment will find the key to solve the major problems in the society.

+ In the context of community health , the women playing a major role in promoting health inside the family by raising the children , choosing the food, quantity quality, frequency , deciding in times of pregnancy , who also take very less care on themselves as they spend most of the time in 'looking after'- has definitely enormous potential, to understand, support , teach and promote community health in their own geographical location. However gender sensitization still might be a controversy for a state where traditions are strongly practiced. This slow process should be some way or the other catalyzed to achieve, what needed to be achieved from the community point of view. This will be at the cost of knowledge and coordinating their existing skills with the links involved with health.

A short field study and observations at Palvercud

Palvrecaud is located in Tamil Nadu and about 40 kms from the chennai city. It is basically a costal area and a part of the town is an island. Majority of them are fisher men in the locality. There are several NGO's already working with this community and few landed after Tsunami disaster. Even it is closely connected to a big city , the living conditions had remained the same for many years. The commuity comprised of fisher mens , merchants and smale scale industries owners , and few population of migrants.

Having given a brief understanding about the area and the community by the Amir , who had been working in the field for six months , planned and made arrangements for my visits with the the coordinators of the linked organizations.

List of learning objectives tried to study at Palvercaud.

- To conduct sessions on "My Body and Health" for the youth club which was already organized in Palvercaud.
- To visit the Balwadi and study the health condition and nutrientional status of the children.
- To Visit government hospital (PHC) in Palvercaud and collect cases.
- Visits to hamlets and direct identification of patients neglected health care.
- Meet the families of the migrants and study the life situations and factors influencing ill health.
- To visit and study the Tsunami affected areas and monitor the present living conditions.

02-01-2006 : Reached Palvercaud at 10:00 am . Took part in meeting with the MSS(madras social service society) . The meeting was arranged for the youths in the evening as many of the youths were students from the college, and it was on working day.

Asha took a session on "determinants of Health" .The students response was huge and they needed much more explanation in relevance t the topic. From the beginning the

happen to show intrest to the topic and wished that they would like not only to participate in discussions but also contribute.

The session was followed by a short game play by the students to pass a message that health shall be promoted by means of "unity and understanding". Afer a short break for tea I took a session on "My Body and Health". Giving them a simple understanding of positions of internal body organs, their name and functions. Named few systems and how they are inter-related to a single made body .It was interactive sessions and few students were relating organs with diseases. *One of the observation made was none in the group could name more than five organs in Tamil neither English.

(*Relating this with clinical experience , it was always hard for an doctor to explain the nature of the disease to patients who are totally ignorant of their body organs and practically most of such cases are not explained of the illnesses, often leading to misconceptions. Few even name the disease differently with a little understanding which pushes them to try for other home remedy.)

Preparations for Action :

Amir had planned earlier with the youth group members , an action plan by the volunteers. They have agreed together to clean up the hospital premises of the government PHC . So discussions were held in the group to choose time and date.

03-01-06 : A visit o a Balwadi.

The Balwadi is run by an organization Jeeva Jothi (NGO) and has been functioning since a year. Ms. Malavi , the field coordinator helped me to get an overall view of the community and the need of the balwadi in the hamlet. The other balwadi and the primary school is located not more than 300 meters far. The kids were having the midday meal on he time of visit and the teacher gave us few information of the children and their health.

Few of them are...

- There are 39 children out of which 23 boys and 26 girls.
- They are served one meal a day in the midday. (And the meal served was boiled rice with vegetables).
- The parents most often do not give other food supplements during the whole day.
- Scabies and skin infections are the most common health problems of the children.
- Most of the kids are transferred from the government balwadi in the light house kuppam to here after the tsunami disaster.
- No information about the kids being vaccinated for Polio.

Observations and facts findings.

As the teacher says, there were very few kids coming to the balwadi initially when started. Soon after tsunami the government buildings (the balwadi)were partly damaged and renovation has not been done even after year. (The NGO run balwadi was a timely replacements for the kids where they would be fed and taken care

of. Most of the children's family engaged in fishing .Since the husband and his wife are engaged to fish and sell , they greatly depend on the balwadi to feed and nursed.)

And now the teacher from the government employed complaints that there are not enough children in the balwadi to run it. All the health programs are been temporarily stopped. The teacher also complaints the shelter is the main factor for its failure in its functioning. Although the NGO run balwadi might function well it is still under doubt for its stability.

A small partition (the neglected ones)

AIDAN MEET

MFC – MEET

"Quality and cost of health care in the context of the goal of universal access"
January 27-28,2006
Snehadeepam Retreat centre, Vellore

Session I: 10-11:30 AM

Role of the Health care system from a public Health Perspective : An introductory overview.

The welcome address was given by the Anand Zacharia and followed by introductions of the participants. Surprisingly, a large number of participants were from the non medical field , but who are intensively working in the community envisaged for a increase in quality of life. The group of participants consisted a mixed combinations of doctors, surgeons, pharmo-chemists,social scientists, social workers, grass root level workers, leaders of organizations, their coordinators, professors, students and government staffs from the welfare department and health departments.

The introduction of MFC and its determinants, was given by Sarojini N.B and Mr. Ananth Phadke shared about the theme. Mr. Binayak Sen made a speech on the context : Reflections from the field. At the beginning of the session quite few participants who were earlier active members of MFC wanted a clear understanding of the expectations from MFC and their role in contribution this workshop and further activities. Mrs. Ritu Priya (coordinator)structured the sessions carefully tailoring interests of majority of the participants.

Quality of health services : Trends and demands.

To this context , Mr.Prachin Kumar R.Ghodajkar made a brief out line of common understanding of quality health services and how it is presumed and why quality is necessary. Quoting from the WHO List of reasons

- Increased demand for improvement of care, appropriate care effective services.
- Need for stardisation and variance contrl.
- Necessity of cost saving
- Bench marking, accreditation, certification and regulations, report card providers and performance
- To define and meet patients needs and expectations.

- To enhance marketing and competition.
- To meet the desire for recognition and to strive for excellence.
- Ethical consideration.

The other dimensions of quality of health care were discussed . In terms of health care systems the three components of it was brought into notice.These include..

1. Input- includes physical infrastructure, man power , drugs , chemicals equipments and instruments
2. Process-includes different preventive promotive , curative , and rehabilitative services, procedure, protocols, of different diagnostic and therapeutic patient care procedures, relationship of communication between the patient and the care giver.
3. Outcome –includes different mortality rates, patient of community satisfaction, and cost of care.

Each of these components of health care is measurable and has certain quality dimensions. To include, Baru and kurian (2002) had given different dimensions of Quality. These are tangible and intangible dimensions.

Tangible dimensions-include location of health services and their availability, accessibility, affordability to popuation being served

Intandible dimensions include-
-Functional quality –manner of services delivery i.e issues like time taken , ques, organization of services, administrative procedures involved.
-Technical quality –effectiveness and comprehensiveness of care.
-Interactive quality- includes aspects like reliability, responsiveness , assurance, empathy provided by the care giver.
-Corporate quality- it refers to socio economic and cultural acess(issues like caste , class, gender , which impinge upon utilization services) to health institutions.

Assessment of Quality :

Different criteria can be used to assess the quality of health care services, which include criteria related to structures, institutional processes, clinical processes and outcome. Concept of accessibility and community satisfaction are also crucial for quality assessment.

Exploring the second phase of my field study…

To get an idea and to understand the most effective health services that could be reached in the rural , I considered that the JSS (Jan Swasthya Sayog) will help me in my study of understanding the rural health care. My meeting with Dr. Anurag Bhargav of JSS after his presentation on T.B ,made me decide to know more about his work and experiences. Fortunately, I was invited to visit them and assist in few of their works. I was asked to list out my learning objectives and it was decided that we would go through the plan.

My learning objectives were : -

1 -To know the various sections of the health centre and their services.

2 -To get acquaintance and learn the most effective outreach clinics and involved other health awareness programs at the village level.

3 -To understand and a low cost medical care providing and the importance rural lab, its implications in the cost reduction.

4 -To study the malnourished children (0-5yrs) and make a focus study on the socio economic background of the families .

5 -To study the appropriate technologies that are used in the village programs and the training of village health workers by the medical personals.

6 -To learn impact women groups (organized by JSS) and their role in facilitating the health care provision.

7-Organisational structure of JSS and is future plans..

My expectations from organization and how I could do this study:-

First of all I would thank Dr. Anurag and Mr.Chatterji for accepting me to support in their work for a period of month . As per their guidance and the excellent cooperation the field staffs , Mr.Proful and Chain Singh made my study quick and feasible .I should also thank the other field coordinators who was willing to share their experiences even after their tiresome field works , which even more inspired me to know much about thier motivation and dedication in their work.

I was not sure at the first weather I could ever able to cover all my objectives of study , so I got permission from the concerned ,to plan my field visits with the local coordinators when free and not as per their routine. Along with that I was asked to make few more enquiries for the data entry of JSS. So I did not miss much in the short duration of work and study.

Few Words about JSS :

Jan Swasthya Shayog is a registered organization of health professionals (many of whom had their training at All India Institute of Medical Sciences) commited to developing Low cost , effective, people oriented , community based health program in the tribal areas of Bilaspur district in Chhatisgargh.

The group has evolved out of a common understanding and a vision of the need to provide high quality curative services at low cost to those who require them the most (the rural poor) , and yet at the same time , the need to develop community based initiatives with the involvement of the village communities which can address their the health problems in a real and lasting sense.

There is a shared perception that academic skills should be applied to doing relevant field based research into critical public health problems., and also used to develop low cost , effective appropriate technology for health.

The Group now consists of a research chemist ,

- 1 Research chemist

- 2 Pediatricians
- 2 Physicians
- 1 Pedriatric surgeon
- 1 Gynecologist
- 1 ENT specialist
- 1 Ayurvedic physician
- 1 Microbiologist

Working Environment (JSS)

Jan Swasthya Sahyog has developed as an organization on a broadly non heirarchial models of working where most peopletake up multiple functions.The area in which it work has great need for work in health care while it allows the oppetunity to understand socio-economic as well as the technical/operational determinants of ill health. Thus working here is likely to provide a great sense of personal and professional satisfaction.

Clinical Program :

The JSS health cetre is situated at village Ganiyari,20 km from Bilaspur city , and is approachable by a good quality road, with a traveling time of 30 minutes. The JSS clinical program consists of out patient and inpatient services (15 bed inpatient ward) and 3 out reach clinics in 3 different village clusters . the program now enjoys high credibility in the area, with patients waiting overnight to get seen the next day. The out patient service operates 3 general clinics per week with an average of 5 doctors attending the OPD , and special TB clinic once a week. The mobile out reach service operate once a week each at 3 different locations which are fixed and located 25-30 km from JSS health centre in 3 village clusters. The inpatient service at JSS consist of 15 bed general ward along with some observation beds in the OPDs. The inpatient admissions comprise a large number of post operative patients and adults and children with general medical problems.

The surgical service at JSS operates thrice a week. The chief surgeon is a pediatric surgeon with keen interest in general surgery, while there are two other surgeons, one gynecologist and the other an ENT surgeon.

The clinical program is supported by a registration department which maintains medical records, a pharmacy which stocks only essential drugs and dispenses at subsidized rates, a laboratory which performs 40 different kinds of tests and has microbiology facilities (including for AFB cultures), radiology services (X-ray and ultrasound), and a well stocked library.

The village health Program

The village health program now in its 6 th year , operates in 40 tribal and forest related villages with 70 village workers who represent their village communities forming the core of the program. Many of these women who were chosen by their villages were illiterate to start with , and the training of the women with poor literacy but good social skills has been an enormous challenge. These village health workers now treat a variety of common ailments , and dispense 20 different kinds of medications, provide appropriate

advice for refferal , and participate in village level initiatives evolved in collabration with JSS.

The village health program is involved

- In the continuing training of village health workers,
- In activities aimed at decreasing the prevalence of childhood undernutrition.
- In antenatal care of village women.
- In innovative inititatives aimed at control of falciparummalaria and tuberclosis. The malaria control effort for example organizes the transport of blood slides prepared by the village health worker on a daily basis to the JSS health centre at Ganiyari through buses which ply through the road ahead villages and then the transport of smear examination reports (in lab within 2 hours) back to the village on the same day.
- In application of low cost technological tools in the diagnosis, control and treatment at the community level.
- In promoting primary level animal care at village level through the village level animal health worker.
- In maintaining a dadabase which includes demographic characteristics, economic changes in the family and occurrence of major illnesses.
- In creating a medium through the village health worker cooperatives, productes which are health promating, and which can go towards making the cooperatives self sustainable.Promoting food security in a poor irrigated area through application of techniques like the system of rice intensification which offer high yield without additional inputs,promoting of finger millet cultivation.

(04-02-06) A busy day at Ganniyari Jss hospital. I was with Dr.Anurag in clinics.We went for a quick rounds in the inpatient wards.I was also given the patients history for my detailed understanding the need and the seriousness of which they got to be hospitalized.It was too hard for me to understand that how could these serious cases be treated in this small hospital with four doctors and few nurses . As there was atleast four of the cancer patients at the statge of metastasis and the family members attending them hoping for cure. In clinics while Dr.Anurag was narrating his past working experiences in Jss and most of the cases reffered to goverenment hospitals comes back in a more severe stage.

To get introduction with the data collections and filing of the patients history from the archive, with the suggestion of Dr.Anurag ,wanted to collect data s for analysis .We decided to work on DM,NIDDM,IDDM. Picking up the diabetic cards from 2003-2005 of patients from 30-35yrs, I started to enter that in to the epi-data .Even though it is hectic job I thought I would do at least few hours daily so it will be easy to sort out and analyze at the end giving a evidence of quality of the treatment and also tracking for other unknown complications associated with the disease.

- despite the busy consultations and clinical works why do the doctors insist that every records, of each visits of the patients is registered on time and updated and even the lab results are been updated as soon investigations done.

-what is the reason in making people(patients) to carry the records by themselves and getting to get registered every time they visit.

-Why the doctors have to do all these epi-data work if they already get too less time of their own.

- What is that they try to work over..?

All my querries were tried to be answered by Doctors during the busy clinical hours itself but I thought by sitting with them in the clinics and during individual patient consultation would obviously clear my doubt.

Finding solutions..

-Sometimes, few patients loose their records and the course of the therapy taken would not be know and would be considered a new patient again.

-Patient would detained for the lab results to arrive amidst of the busy crowd,and would record the results patiently .It would help for refernce in his/her next visit.

-Epidata are one of the best ways to make a quick analyses and for further comparisons and research. I learned using this epidata by Dr.Anurag whom I should thank especially for taking a great care and regularly correcting my misconceptions.

I did learn the importance of maintaining records no matter even a patient attends hospital once.

Need For the workshop .....

The work related experiences and also the dilemmas of the doctors working in the rural set up has faced several events that cause confusion and obfuscation. Listing few

- The Out breaks of diseases are always Mysterious.
- The diarrheas are always "gastroenteritis" and almost never cholera
- The deaths due to starvation are always due to disease and not hunger ,
- The suicides re explained as a result of depression (at best)

The insights , - that 'cure' to diseases are mostly not possible only by providing , team of doctors, or a bag of grain or a cheque of compensation.

Aims of the workshop :

- Develop a common platform for a discussion on the development process and poverty as it leads to poor health , to reassert the centrality of food in human health in public health discourse
- Generate a clear picture of the state of development ,nutrition and health in Chhatisgargh and else where in the country.
- Develop an informed critique of the developmental process based on evidence ,clearly showing the links between rural development ,food nutrition and health.

- Undrstanding the poverty line concept and the lacunae in the context of the health problems of poor people especially of those living in the rural areas .
- Develop a common platform for activism for campaigns like consolidation of the National Employment Gaurantee Act, And Right to health and Right to food, through publications , litigations or other forms of intervention on the basis of understanding thus developed.

Preparations for the proposed workshop " HUNGER AND HEALTH"

The workshop was planned on the 10th feb 2006. It is an inter disciplinary dialogue held at Jan swasthya sayog health centre, at village Ganiyari.

Given a task of collecting and analyzing data's , from the hospital registry for the Dr.Anurag 's presentation .

The data's include the list of All diabetic Patients 30 and below , and serum ketone positive lab results .

Coordinating with other coordinators for the arrangements and deliberately working out the questions for discussions.

HUNGER AND HEALTH : AN INTER DISCIPLINARY DIALOGUE
FEBRUARY 10 – 11 , 2006

VENUE

JAN SWASTHYA SAYOG HEALTH CENTRE

VILLAGE GANIYARI – 495, KOTA ROAD, DITRICT BILASPUR , CHATTISGARGH

PROGRAMME

10 FEBRUARY 2006

Welcome address

10:00 am Introduction to the basic ideas .Health situation as we see it and its linkages to nutrition and food availability, Yougesh Jain, Jan swasthya sahyog. (30 minutes)

Session I

10:30 Am A study of the linkages between Health anfd nutrition as seen in Tuberclosis Anurag Bhargav , Jan swasthya sahyog. (30 minutes)

11:00 AM Trends in the health ststus of the people over the last 50 years ; the changing importance of nutrition / Food in primary Health Care , revisiting Mc Kewowns hypothesis in the Indian context Imrana Quadeer , Jawharlal Nerhu University (45 minutes)

11:45 AM Effect of Hunger / undernutrition on the patterns of medical and surgical illness, their outcome in medical andd surgrical problems and on health care seeking behavior . Anurag Bhargav and Raman Kataria , Jan Swasthya Sahyog (30 minutes)

12:15 AM Effect of Hunger / under nutrition on pattern of illnesses –in children. S. Sridhar , Care – Basics (30 minutes)

12:45 Discussions (45 minutes)

Session II

2:00 PM Nutritional status , its trends ,and trends of its determinants in the last 50 years in India: class disaggregated data . Revisiting the caloric norm – should we consider it ? Povert6y line or nutrition line : Imlications of stunning and low weights for health and disease .
Veena Shatrughna , NIN , Hyderabad (45 minutes)

02:45 PM Discussion (30 minutes)

03:30 PM Food situation in India : Trends in food availability , distribution and consumption. Implications of the present crisis.
Utsa Patnaik, Jawarharlal University (45 minutes)

04: 15 PM " Right to food in Chhatisgargh"
Ilina sen ,Rupanatar , Chattisgargh (20 minutes)

04:40 PM The 'Right to food' Petition and the Implications of Entitlements in the Chattisgargh and Madhya Pradesh.
Biraj Patnaik (20 minutes)

05:10 PM Understanding the Development Paradigm pursued : the example of Bhakra Nangal and the states of Haryana and Punjab

05:30 PM Discussions (30 minutes)

Sharing session

08:00 PM The right to health campaign and the Right to food Campaign in Koria District Sulakshana and Sameer (30 minutes)

08:30 PM The experience of Bt cotton cultivation in Western Madhya Pradesh
Ashish Gupta and Amulya Nidhi (30minutes)

11 February 2006

Session IV

09:30 AM Development in Agriculture in India in the past 50 years :
Critique of the Green Revolution and the Present crisis
Dr Sultan Ismail ,Chennai (40 minutes)

10 : 10 AM Subversion of the Indian Agriculture Policy and Politics.
Jacob Nellithanam , JSS (20 minutes)

10:30 AM Discussions (30 minutes)

Session V

11:15 AM Fifty years of Rural Development and the Plae of food for the people: what went wrong ?
K B Saxena , New Delhi (30 minutes)

11: 45AM Trends in Development taking Chattisgargh and Baghelkand as case in point with special reference to food production
Dunu Roy , New Delhi (30 minutes)

12:15 AM Discussions (30 minutes)

Session VI

01:30 PM Food Availability and Government Schemes : Utilization , Scope

	and Limitations. Vikas Sheell , Collector , Bilaspur District.	(30 minutes)
02:00 PM	Towards an Alternative paradigm : Invited responses	
02:00PM	Health sector reforms in Chattisgargh and the Centrality of Food in the process T Sundararamen , SHRC , Raipur.	(20 minutes)
03:00PM	Common understanding of Linkages. Binay Sen	(20 minutes)
03:20 PM	Planning for future : Panel Discussion	
04:30 PM	Joint Statement.	

HUNGER AND HEALTH

The welcome address was given by Dr. Yogesh Jain of JSS. He gave an introduction of the basic ideas of the workshop. Talking about the health situation and its linkage to nutrition and food availability. He also linked with the nutritional level illness with poverty, income and spirit. Under nutrition also leads to high chances of illness and severity of illness and decline in the mental health of the people .The problems of undernourishment and pregnancy giving way to the lower birth weight of the neonatal is increasing.

Some of data's presented on the first day of the campaign...

- ✓ The median wt of the women - 43 kg and men – 50 kg.
- ✓ 33% are adivasi and 27% Dalits.
- ✓ 40% are indebted and 20% landless
- ✓ 44% belong to BPL
- ✓ 30% women have BMI < 17
- ✓ 74 % of the newborn are of weight 2.5kg and below.
- ✓ In 664 pts (women) screened 67% are hypertensive.
- ✓ 35% of death without any consultation from any health care providers.

While trying to meet the health of 1110 villages 150 villages with the mobile clinics they found out median weight for women-43 kg and men- 50kgs. His point was.., that any drug therapy on individuals with these abnormal weights would be worsening health and working conditions of such patients than complete cure . A study conducted by Jss and their survey on their area of work gave these median weights.

Sex	Height (cm)	Weight (kg)	BMI

Women	150	41	18.4
Men	160	50	19.1

21:02:2006 . As planned earlier the day was spent

-revolutionary approach of appropriate technology used as a major tool by JSS in community health
- Aquainting withvariety of equipments used and their limitations.
- Training methods for the users.

Mr .Chain sing , an electrician and Mr. Madhukar field manager helped in exploring almost all of the equipments with few demonstrations and their practical implementations.

Appropriate Technology : " An important tool in rural health care"

Technology is necessary in health care at all levels , in prevention , diagnosis , in treatment and rehabilitation. Health technology advanced with years but has very less impact on the indices of public health especially the underprivileged.

A step taken (JSS) :

JSS has been working over last five years on developing health related technologies for health care needs of the people with limited resources identified at the field level. They strive to ensure that these technologies be as accurate , if nopt more , as prevailing ones and yet be simple , acceptable , and yet cheap and which can be used in the low- resource settings in the rural and community levels. They als0o hope that they can be used by sall levels of health workers especially the most periperhal health workers and would make diagnosis more rational and decrease misuse of drugs . The scope of such appropriate technologies includes aids , skills and tecghiques and technologies that could be applied towards the above aims.

Health related technology kits already developed.

Diagnostic Kits

1. **Urinary tract infection :** The current available techniques used for th diagnosis of UTI involve either microbial culture,(which is not available at ,most of the places) Microscopy done by a well trained technician and a good microscope. UTI in pregnancy there is a need for accurate diagnosis .
   The kit is based on detecting nitrite and the activity of the enzyme ,
   which is produced in the pus cell in the urine. Besides this kit gives the report in less than 10 minutes .this kit has been also tested .the sensity and the specificity of this test in certain situation is over 95 %.

Measurement of anemia status

Severe anemia is easily diagnosed clinically in adults but lesser grades of anemia are diagnosed by health professionals reliably.The estimation of the anemia status is done by measuring the packed cell volume of the centrifuged blood.'Semi skilled' health worker can perform it as it does not involve a venous puncture to collect blood samples. It requires only a finger prick sample. Thus it is more suitable for use in the field situation. This kit utilizes a portable capillary centrifuge and has been used extensively and found to be working reliably. This works on AC mains or a battery. Some biochemical tests as glucose estimation is also carried out.

Measurement of the anemia status using copper sulphate solutions

At community level to diagnose anemia status another method is used is by measuring the density of blood using different concentrations of copper sulphate solutions .The density of blood is primarily determined by Hemoglobin and if the different concentrations of CuSO4 taken a d allow the drops of blood to fall on it , the ability of blood drops to sink or float will depend on its density .3 Different concentrations are standardized ,and that correlates with 11,9,6 grams percent.

Thus it allows a rapid very visible and cheap way to classify hemoglobin and as an advantage that it can be easily performed by village level health workers.

Diagnosis of Sickle cell anemia:

Sickle cell anemia is a common disease not only in several tribal groups and several caste groups, where it caused a life long morbidity and often death. An accurate diagnosis is a must to make a correct therapeutic plan . Much as the screening tests is often available in several health care set ups , the confirmatory tests is not available easily and if available is rather expensive .The kit used is based on the conventional electrophoresis, but available at a fraction of cost of the one available in the market. This has been evaluated.

Sputum concentration for increasing he sensitivity of microscopic Diagnosis of TB.

An unique technique developed and pioneered by Dr. Vasanthakumari has been adapted which has an advantage of providing concentration of TB bacteria without the need for centrifugation. It is a single step technique requiring little hands on time is very easy to learn and perform. The increase in detection rate of TB bacteria in sputum than others is 33%. The greater advantage is that it allows in classification of a large number of patients as sputum positive and avoids the expense / logistic difficulties of chest X- rays. The technique also facilitates the follow- up sputum positive patients during treatment when culture facilities are not available.

A kit useful at community level for disease prevention :

Microbial testing of water and disinfection system.

The H2S paper strip test was developed by the DRDO in Gwalior as a simple test for th e detection of fecal contamination of water. It was used during the out break of water borne illnesses to identify safe sources of drinking water. The technique involved incubation of the water sample in the H2S paper strip bottle in the laboratory for 48 hours. JSS ha s adapted this test to use at the village level. This paper strip test to detect fecal contamination of drinking water can be used by the community themselves. Instead of the laboratory based incubation it was found that if the

water saple is incubated by contact with the body , comparable results are obtained. If there is a fecal contamination the water turns black.

Once the water is detected to be fecally contaminated , the water can be treated using a ultraviolet light based treatment apparatus . Unlike the commercial UV based technology it can be used for the water that is not running can be used where there is no electricity and can be shared by many households.

This disinfecting system uses a 254 nm light from a 9 W tube light . In 10 minutes 50 liters of clear water can be disinfected . It can run using either AC mains 12V battery or a cycle dynamo. The progress and completion of the disinfection process is also displayed.

Diagnostic Kits under field evalution

1. Glucose

Blood glucose is an important test in as much as it allows to diagnos ands monitor diabetes milletus , and increasingly important public health problem . Its estimation is also important in monitoring the sick patients, say with malaria.

In the kit for glucose estimation , a dedicated calorimeter is used to read the developed colour by glucose present in the plasma and otolouidine reaction. The plasma that is separated while checking for anemia using the capillary centrifuge can be used for this.This test run on AC mains or battery. Better version of this kit is being evaluated presently. This chemical test does not require refrigeration for its agents.

2. Vaginal tract infections :

A Vaginal infections are an important cause of morbidity in women Its diagnosis is either not available (due to the lack of Suitable lab set up , lack of women health workers , or even due to reluctance of several women to allow even women health workers to per month an internal examination to collect a fluid specimen from the vagina) , or is not even attempted!. Several recommendations from important national and supra national thus recommended empirical therapy for anyone woman presents with vaginal discharge.

In order to rationalize the diagnsis of this sset of infections , this kit has developed which uses a self adminisdteredd absorbent testing pad which the woman can use to collect a vaginal fluid sample on her own. An alogrithim of effectively use these three tests for the diagnosis of the vaginal infections is also included in the kit.
The results allow one to distinguish excessive normal discharge from vaginal infections.

3. Reproductive health test kit.

This kit incorporates the above mentioned tests to diagnose UTI that does not need a microscope and to diagnose (presence por absence) of vaginitis or cervicitis amoung the women with the vaginal discharge.Besides , It include urine pregnancy tests strip that can enable a village health worker to diagnose early pregnancy so that subsequent decisions be taken. It also includes reagents that enable the detection of proteinuria as a secondarymarker of pregnancy induced hypertension – another common problem that causes significant mortality andd morbidity both in mother and baby. This assembly of these 4 diagnostic tests inaddition to the anemia diagnosis tests has the potential of strenghthening reproductive health programme by adding a laboratory component to public health.

Equipments useful in Diagnosis and evaluation in health care :

1 . Stadioameter

Height is arguablythe bestway to measure the nutritional status of the entire community , but is sparingly uswed for the want of a simple technology that is portable.Use of the height is also necessary to identify high risk pregnancy who should be adviced institutional deliveries.it can be used to asses the body mass index which is a robust marker of Nutrional status.Using a flexible tape stuck to a wall is liable to be inaccurate. Our portable and expensive device can measure in the field or even in the clinics.

2. Breath counter :

Mesurement of respiratory rates is eswsentia;l for the early diagnosis of lower respiratory tract infections in children that accounts for a large number of deaths .The accurate measurements of respiratiory rates and remembering the different rate cut offs for different age groups is not easy. Semiliterate and neo literate health workers find it diffucult to measure rates in young children , where rates are high , to maintain coordination between counting the breaths and the watch to rememmber various age specific cut offs for abnormal rewspiratory rates.In fact it is difficult for even the literates and higher level health workers including nurses and doctors. The Breath counter is a micro controlled based counter runs on 9V battery , and records the rate of breathing by just pressing on a button and gives the out put form of green red signal for abnormal high rate or otherwise.

3. Teaching stethoscope :

This training allows thhe trainer to teach and evaluate the use of a stethoscope in clinical care. A stethoscpe is required in the measurement of blood pressure , ffetal heart sounds in a pregnant woman and hearing the breath sounds to diagnos chest problems and in several other situations. Essentially it has one chest piece and two ear pieces, one for the trainer and trainee

3. Easy to read blood pressure appartatus :

Measurement of blod pressure is a useful skill in picking up hypertension , n important public health prob;lem .In pregnancy its mearement has the very important funtion of picking up pregnancy induced hypertension / preeclamsia, which if untreated can lead to morbidity and mortality for both thebaby and the mother .This skill is traditionally performed by senior health professionals like the nurse and the doctor ' the more peripheral health workers , say the village level usually do not measure this important parameter because of the lack of availability of a simplke , easy to understand apparatus.

The easy the read blood pressure apparatus has the abnormal blood pressure ranges for both the systolic and the diastolic values colouredred.This enables health workers with the limited literacy skills to be able to measure blood pressure.

Training Material.

1. Growth booklets for growth monitoring :

We belive that the growth monitoring is an important tool in nutrition improvement stratergies.But understanding the concept of the graph is not easy for the

health workers with the limited literacy skills. This growth booklet is an attempt to over come this problem. The grwth monitoring is wth the healp of a booklet , and not a card or a graph , is based on the two assumptions namelythat each child should follow his / her own trajectory of growth , which depends on the birth weight. If the child grws normally , th echild should not slip below the designated trajectory. Aalso , given additional inputs an undernoiurished child should catch up the trajectory of a normal child , but atleast retain his/her previously designated trajectory.Thus there is in fact a series of booklets to cater a range of birth weights that depict different trajectories for different weight and sex categories.

The second assumtion is that each point on the growth trajectory is designated a separate page where the visual depiction and the interpretation of the growth is done on a actual picture of the weighing scale aided by a long established norm of red danger and green means normal scheme on the dial of the scale. The viewer can simply plot the weight on the picture and immediately read the nutrition status depending on where the plotting pencil stands – red or green.

Seeing their child's weight pictorially by a long established norm of red means danger green means normal is likely toi impress them about the need for action. In this way , growth monitoring is likely to increase the acceptability of health education , acceptability of food supplementation and impress the need to treat infections / illness in their child early. At a community level this is ,ore likely to lead to demand for implementation of food programmes or for a change in agricultural practices.

In an environment of poverty , he growth booklet is record for the family : it may be the only record of the child. The family mebers and the community are likely to see the relation between food and the growth better, which unfortunately is not well appreciated by several people. The medical community , has medicalized hunger ass "malnutrition and is inclined to suggest non food ways of managing it. Wit the help of the growth booklet the parents can see the benefit on the consequences of illness on the nutritional status , and conversely see the benefit on the on the weight of the child due to additional food during recovery from illnesses.

Items useful at the community level for disease prevention and treatment.

1.Mosquito repellant oil based on neem , DMPA and and citronella.

In tribal areas where falcoiparum malaria is a major public healtryh problem , mosquito nets alone are not enough for prevention of mosquito bites as peoples get bitten in the evening hours , often at night while guarding the harvest , and in the early hours of the morning when people go out for work in the forest. Therefore there is a need for a mosquito repellant which should be effective and yet cheap. Effective mosquito repellant creams and oils with a good odour at a fractin of commercial cost using 5% neem oil , 10% Dimethyl phthalate and 5% citronella oil made in mahua oil have been developed here . They have been evaluated and found to be effective and acceptable with one time application orotacxts against mosquito bites for atleast 4 hours.

2. ORS packet

JSS has trained the village health workersto make their own ORS in a packet form. Plastic spoons of such a volume that they contain the required amount os slts and table sugar have been prepared. The packs are sealed thenby VHW's. The ORS packs contains the following.

- sodium chloride : 3.5 g
- trisodium citrate : 2.9g

- Potassium chloride: 1.5g
- Sucrose :40 g

3. Safe delivery kits for the mother and, baby and the bith attendants.

At the time of birth of he child , there is a clearly a requirement of an aasortment of items that should be clean , appropriate and readily available. Thus it has been been a common practice in public health care t make available delivery kits to pregnant woman . However , most of the delivery kits those seen do not have all things that are required at the time of delivery , both for the baby and the mother for atleast one post partum day, and which is covinent use. The delivery kits that have been developed here have looked at these issues and have evolved over time on the basis of feedbacks from the users. The kits are ethylene oxide sterilized .They also contain a pictorial booklet suggesting its use and a list of advice for the mother and child.

4.First aid kit for village.

This kit has 29 items and als includes things like bamboo splints for fractures of the lower limb, a cloth to make a triangular sling for clavicular fracture, A peripheral blood smear making slide kit box an easy to read thermometer and few disposable syringes for safe injections.

4. Soap :

Soaps are made by the village health workers using locally available chaeap oils (Mahua) , from mustard or kusum oil gor use as a public health measure. These soaps that are rather economical , yet retain all the attractive properties like foam good smell and softness and lack of dryness after soap use.

Nutritinal formulatory :

Under nutrition is mainly caused by poor food availability(shown in their study) and a knowledge about feeding practices and the choice of foods has a role. Once the child (or adult0 slips into the severe under nutrition , besides availability of appropriate foods there a role for certain micronutrients that should be available in cheap and convenient formulation.

Formulations formulated to tackle Nutritional status are ....

Type of intervention	Target	Objective	Formulations	
Oil	Calorie undernut	Increse calorie density	200 ml bottles	
Amylase rich flour	Under 5 children	Ready to eat semisolid food in ares where milk is not available	200gms packets	
Amla pachak	Iron deficiency anemia, pregnant	Vitamin C provision	35 kgs packs, to finish in 1 week , enough to provide the desired Vit C to ensure	

	woman		iron absorption /day	
Choona namak	Calcium deficiency	Povision of calcium	500mg elemental calcium satchets	
Mineral; mix	Severe calorie undernutrition	Potassium , zinc and magnesium supplements	As 'bataashas' containing the appropriate amounts.	

1 Amylase Rich flour :

Semisolid and liquid preparations of food which are calorie dense is an important requirement of complementary feeding in children in the post weaning period i.e. from 6 months to 2 years of age .This is a critical time for children who were been well nourished slip into under nutrition. Amylase rich flour prepared by germinating cereals such as wheat , Ragi and jowar is useful in softening ceral based foods , making it sweeter , more digestible and adding nutritional value.

2. Edible oil supplementation:

Adding oil to the food is a simple way to increase the calorie density and the calories delivered without increasing the volume of food. Such advice can be made more effctive by making available such exclusive bottles that contain adequate oil for a week's need of a child.

4. Amla paachak :

A ready source of Vitamin C , that is food based and is dry and thus can be dispensed is necessary , given the fact the bulk of food that is consumed is cereal – pulse based. Amla is perhaps the richest source of dietary Vitamin C , and significant amounts remain even after it is dried.

5. Choona namak :

A dietary source of calcium is necessary and the drug based calcium is either expensive , or most formulations contain very little calcium. The preparation(satchet) of calcium salts and contains actually 1.25 grams of calcium carbonate which provides 500mg of elemental calcium is supposed to added in food like salt. 2 satchets of this should provide 1 gram of elemntal calcium enough of therapeutic measure for pregnant and lactating women , for osetomalacia and oestoporosis and for rickets.

6. Mineral mix :

Due to chronic food deficiency , besides calorie deficiency, it is also observed deficiency of several minerals – whicjh if not supplied specifically will retard the recovery from the state of under nutrition. Among the prominent ones are pottasim , zinc, and magnesium. Several studies have shown the failure to supplement have resulted in higher deaths and , morbidity in the setting of severe under nutrition. A candy form – bataashas made of the mineral mix made and to be taken daily.They provide potassium supplements too.

Mission of the health care professionals.

The knowledge about all the above techniques was well defined by the author in his report and the efforts of JSS in its implication has taken medical into a new dimension of alternative care " health care by self education and awareness"

Thus this is a step taken ahead by the medical professionals of JSS to fulfill a mission of not only a mission to restore the sick to health but also to work out the choice of more applicable strategy for continuing the health care which is more relevant and appropriate promoting low cost quality healthcare.

16-02-06 : A visit to a ration shop at village Nevra

Amongst the government functionaries, food security and availability plays a vital role in the health of a community especially in villages where cost is also a important factor in chronic hunger and malnutrition. So the first step to get a basic idea of availability of food sources and the rise in prices this visit was planned with the help of the field coordinator Mr. Chain singh who is from the community itself. The purpose of the visit was also to study weather the provisions supplied also affords to cover the basic minimum calories needed for a average person and his family.

We managed to find sometime to have a conversation with the retailer after his duties and got the lists of the provisions in store and that in demand. We also interrogated with few consumers to study the purchasing power of the mob. The items available per person or a ration card-holder were....

1) Sugar 1 unit (1 unit =500grams) , and 2 units for a family with more than two members 14 years.
2) Kerosene 3 liters/card/ @ Rs 9:23 paise
3) Rice or wheat 35 kilograms per month
   Rice @ Rs 6:12paise per Kilo
   Wheat @ Rs. 4:65 paise per kilo.
4) Iodized salt 2 kilos per card @ Rs .25

These are the main previsions that are available in the store and one can purchase them on the working days from 10:30 Am t 5:30 Pm. Also they could purchase and no time limits , during the whole month .

The ration shop also functions with the Cooperative bank located in the same building itself. The government also supplies fertilizers here for farmers with subsidies.

Learnings from the prices :

Comparing from the prices of the provisions available in the ration shop with that of the private in the village there is a huge difference. At a point affordability to these food items might not be the question.., but for whom and to what extent is the priority. They majority of the population are agricultural workers and others being laborers whose economic status is under fluctuations still finding hard to adjust with these prices.

Some needs of JSS :

Having selected a strategy for identifying needs, the next has to set goals or objectives. How to address the needs that are identified? Ensuring that every health worker in JSS at least attend one course during a year: or they may be a long-term, phased goals such as improving the health of the people in the district through improved performance by health care personal. Most programmes include that combination of both short and long term goals, arranged in order of priority. The initial goals of continuing the training program might be..

- ❖ To inventory current medical resources in the district
- ❖ To assess the current level of performance of health workers
- ❖ To provide more effective supervision of health workers
- ❖ To motivate health worker towards self learning
- ❖ To provide educational resources (eg.books,journals) for health workers
- ❖ To help health workers become more effective in providing antenatal care (or maternal/child health services or any other targeted programme)
- ❖ To decrease the level ofcertain diseases in the community by more effective prevention and treatment.

In search of default...(village visits)

25-02-06 Morning was another busy day at Ganiyari hospital. The day was planned to accompany Mr. Madhukar , the field manager on his default studies. Morning at OPD , review registers of the TB default cases . Around 11:30 am with the kits and list patients to visit was finalized. The objective of such visits are ...

- × To monitor the health conditions of patients after a course of anti TB drugs therapy (HRZE)
- × To study causes of the intermittent treatment regime and the patients other socio economic conditions.
- × To detect any relapse and collect sputum for examination .
- × To also investigate the family members and give information the disease and prevention.

The first visited village was "Son puri" bout 30 kms from the Ganiyari Hospital. The patient was located and the questionnaire filled by the field worker .The patients weight , height and present complaints are recorded. The questionnaire includes the details of …

- Was the patient taking treatment elsewhere
- Any disability or decrease in working capacity at the end of course
- Nearest connecting town (distance?)
- Patients informed where he could get TB drugs .?
- Is the patient migrating
- Any familial death of the patients in the recent past.
- Asserts owned /sold during the period .
- Patients opinion of continuing treatment etc.

At the end of the intervention (enquiry) the patient is given a default notice card which has to produced for his next hospital visit . Mantoux test is done instantly for the family members (children under 10years).

26-02-06: In OPD , studying TB cases . TB control is an essential component of PHC. As we see a numerous cases visiting the clinic primarily infected by TB. Dr. Anurag's explanation on drug resistance caused by the weak TB control programs added more curiosity for further investigations. As in literature which states "primary resistance results from transmission of infection from pool of patients with acquired resistance over a number of years". Even if TB controll measures are easy and accessible in all sub-centres, PHCs, CHCs and District hospitals the MDR (of the patients) are hardly ruled out. The Mass chemo-prophylaxis of the TB positive patients further lead to liver toxicity and HIV and malnutrition are the two major risk factors in TB patients.

Some few other cases seen…

i. Diagnosed Periodic paralysis of 39 year old woman . Carried to the clinic by her husband. Complaints of reduced movements in both lower limbs for a short course of time (few hours) As her husband says that the episodes of occurrence was rare and now becoming too frequent. She has this since her second delivery. The case was suggested that it may be associated with hyper-thyroidism and so was given a primary care and referred to a Neuro surgeon in the city with a supporting letter. It was really a hard decision to make by her husband but the fear of getting into indebtedness was really a deterring factor. However the doctor understanding the economical situation carefully guides the husband of the possibility of the cure.

INVESTIGATION RATE LIST
JSS LABORATORY , GANIYARI

TEST	PRICE OF TEST
HAEMATOLOGY :	
Haemoglobin	Rs . 5
Packed cell volume	Rs . 5

Total leukocyte count	Rs . 5
Differential count	
Absolute Eosinophil count	Rs. 10
Reticulocyte count	Rs.5
Sickling test Hb Elactrophoresis	Rs.20
ESR	Rs.5
PS for RBC morphology	Rs.5
PS for malaria parasites	Rs.5
Prothrombin Time	Rs.100
Bleeding Time	Rs.5
Clotting time	Rs.5

URINE:

Urine routine	Rs.5
Urine specific gravity	Rs. 5
Urine nitrate	Rs.5
Urine ketone	Rs.5
Urine bile pigment	Rs.5
Urine microscopic examinaion	Rs. 5
Urine routine and M/E	Rs.10
Urine pregnancy test	Rs.10

STOOL EXAMINATION :

Microscopy without concentration	Rs.5
Microscopy with formal ether concentration	Rs.10
Kinyouns Stain for coccoidian oocysts	Rs.10
Stol occult blood	Rs.5
Reducing substances and pH	Rs.5
Fat (semi quantitative)	Rs.5

VAGINAL FLUID EXAMINATION :

Microscopy of saline maount , KOH mount, and gram smear. Rs.15

CSF

TLC and DLC	Rs.10
Gram and Z-N stain	Rs.10
Protien and Glucose	Rs.20
All CSF test as panel	Rs.35

SPUTUM

Sputum for AFB	Rs.5
Sputum concentration for AFB	Rs.5

Sputum gram stain	Rs.5
SKIN	
KOH mounts for Fungus	Rs.5
Slit skin smear for AFB	Rs.5
SEMEN ANALYSIS	Rs. 25
SEROLOGY	
Blood Groupings and typing	Rs.10
HCV antibodies	Rs.90
HbsAg	Rs.25
RPR (VDRL)	Rs.15
WIDAL	Rs.15
Also with TITRE	Rs.50
Rheumatoid Factor with Titre	Rs.15
HIV antibodies	Rs.50
BIOCHEMISTRY	
Blood Glucose	Rs.15
Blood Urea	Rs.20
Serum Creatinine	Rs.15
Serum Bilirubin Total and Direct	Rs.20
Serum Alt	Rs.15
Serum AST	Rs.15
Serum Alkaline Phosphate	Rs.20
Serum uric Acid	Rs.15
Serum Protien and Albumin	Rs. 25
Serum Cholesterol Total	Rs.40
Serum Choleterol HDL	Rs.25
MICROBIOLOGY	
Culture and Sensitivity testing for Aerobic bacteria	Rs.80
Blood culture, Aerobic	Rs.125
Gram and Z-N stain for any sample	Rs. 15

Prudent use of lab technologies :

However the lab tests are just a confirmatory process in diagnosis of diseases it should be used very cautiously in rural community health practices to lessen the financial burden of the patient and their families. Comparatively the cost of lab tests in JSS is much less than any other private diagnostic center in the state. The patients should be given the exact information about the need for a laboratory proof to break the

diagnosis. Because most tests only affect the probability of a disease being present or absent.

A workshop on Child Sexual Abuse.

Specific Objectives of the organization- THULIR

- to determine the prevalence of child sexual abuse among the school going girls and boys in Chennai, TamilNadu
- To understand the nature of child sexual abuse with relation to
- Type if abuse
- Frequency of abuse
- Age of onset of abuse
- Relational proximity of the abuser
- Process of abuse
- To understand the disclosure pattern of children and accessibility to support systems.
- To contribute to the existing information and knowledge base on child sexual abuse in India
- To contribute towards improving Child protection policies and practice.
- To strengthen the initiative to have a comprehensive law on child sexual abusee in the country.
- To contribute towards spreading awareness and information about sexal abuse among children, families and the stake holders in the larger community.

Defnition of Child sexual Abuse :

" Any behavior by an older or more powerful person on a child for his / her sexual gratification. This includes both touch as well as non touch forms , including , but not limited to :

-Exhibitionism

- Voyeurism
- Making the child touch offender's private parts
- Touching the child's private parts
- Forcing or trickling the child to watch pornography
- Sexual intercourse (vaginal/anal/oral)"

Presentations of the Thulir organization :

The presentation involved ,was much focused on the results obtained from the from the research study included in the schools within the Chennai corporation zone limits. Also focusing the need for addressing the issue and importance of prevention through the notion of personal safety education .

This presentation included.

* A study conducted by the organization in 24 schools covering 2211 students and a pilot study conducted in 7 schools with 519 students.
* The Methodologies and the ethical standards used in the study.

- Defining CSA and challenges in dealing the issue.
- The results of the study and graphical representation of the reported sexual abused victims.
- Prevalence of different forms of abuse
- Some severe forms of abuse (individual case study reports)
- Categorization of the abuser
- CSA with reference to Socio-economic class
- CSA with respect to family type
- Age of onset of Abuse
- Disclosure and seeking help
- Conclusion.

Time was a factor.To present all the reports and findings of the study the given time for presenting was not sufficient . Some few minutes were given for the participants to question and share with the reference to the context. It was at the concluding phase, the concept of personal safety education gained recognition as the most prudent and cost effective strategy for addressing CSA.

Personal safety education :

The concept of personal safety Education works to allow every child the right to feel safe all the time , using a methodology that promotes the safety of self against abuse. The program is an extension of the safety rules we teach our children, that is don't play with fire , look both sides before and while crossing the road etc... Besides empowering children to take part in their own protection , it strengthens the ability f those morally , socially and professionally responsible for the protection of children , that is the state parents educators and the larger community.

What is Personal Safety?

- Personal safety is curriculum designed to protect children from abuse , specifically sexual abuse.
- Personal safety empowers children to take part in their own protection by giving them age-appropriate information, skills and self esteem.
- Personal safety teaches children that their body belongs only to them and nobody has the right to touch them and in the way they don't like or understand.
- Personal safety teaches the children to understand their emotions to help keep them safe , using fear and anger in positive ways.
- Personal safety teaches assertiveness skills , helping children to stand up for their own rights without violating the rights of the others
- Personal safety builds a support system of each child including the family school, community, and friends.
- Personal safety builds empathy for one another.
- Personal safety teaches the children that only the offender is to blame for any inappropriate sexual touch.

Some statistics about CSA in India.

- In a survey with 3509 school girls in new delhi by Sakshi in 1997 63% had

Report on Visit to Snehadaan as part of workshop on

'Right to Health care in the era of Globalization'

Date : 7:03:06

Members Present

Snehadaan staff:
Fr. Baby – Director
Mr. Sunil – Outreach programme Officer
Ms. Diana - Counsellor
Sr. Sylvia – Staff Nurse
Ms. Kamala & Ms Manjula – Care

Workshop delegates:

Dr. Narendra Gupta
Dr. Vasundhara
Dr. Anant Bhan
Dr. Jyothi Gupta
Dr. Neeta Rao
Mr. Naveen Thomas
Mr. Eddie Premdas
Dr. Abraham Mathews
Dr Vinay
Ms. Madhumitha
Ms. Manju Shah
Dr. Arun Gupta
Ms. Sathya
Ms. Sathyashree
Ms. Asha

Followed by the session on impacts of globalization by Dr. Ravi Narayanan , the team of fellows made a visit to Snehadaan, a care and support center for people living with HIV/AIDS situated on Sarjapur Road 20 km from Bangalore city. A former fellow of CHC, Mr. Sunil George had taken the responsibility to organize and coordinate the session on HIV/AIDS.

The team of fellows reached the center premises by 3:30 pm post lunch and were welcomed by Fr. Baby, the director of the institution and his team.

This was followed by a brief introduction about the organization by Ms.Diana, who works as a counselor. She gave an overview of the history, mission and vision of the organization which was started in the year 1977. The history dates back to 420 years. The fellows had an opportunity to explore the infrastructural facilities available to the residents and the quality of healthcare provided.

The organization has facilities to care for 52 patients and their major areas of intervention were counseling services, treatment for opportunistic infections and palliative care. There are separate wards for men and women and an intensive care unit. There are a good number of dedicated healthcare providers including doctors, nurses and care givers. The patients seek help through referral and stay in the center for a couple of weeks to feel better and go back. ARV drugs or CD4 test are not being done by the center but patients procure it from government hospitals.

There is provision for a surgical room where dressings are done. Occasionally even deliveries are conducted in the small O.T present with minimal precautionary methods. The center is also recognized as a DOTS provider. Family members are allowed to visit the residents and during serious illness they are made to stay within the campus. The patients are given nutritious food and are encouraged to engage in physical activities in the physiotherapy unit and gymnasium.There is also facilities like ambulance during emergencies and also a mortuary.

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