**JAN SWASTHYA SAHYOG**
**GANIYARI, BILASPUR**
**CHHATISGARH.**

- Learning objectives
- Health workers training
- Scabies survey
  - Introduction of the study
  - Village information
  - Why study done
  - Information about scabies
  - Findings

**Placement :-** JAN SWASTHYA SAHYOG (JSS),
Ganiyari, Bilaspur, Chhattisgarh.

**Learning objectives:-**

Following are my learning objectives for the second field placemetn in JSS.

- **To know about the organization (JAN SWASTHYA SAHYOG).**
- To do a community based survey on the prevalence of the scabies.
- Involvement in the Selection process of community health workers.
- Training of community health workers.

In the way to fulfill the learning objectives, and due to short placement of a month, I was not able to work on some of the following objectives;

- Planning and monitoring of different health programmes.
- To understand the involvement of JSS in the NRHM process.

But I came to know more about

- The appropriate technology for health.

Programme of the Jan Swasthya Sahyog.

My schedule during working days were as follows ;

A) On 28 of November 2006 I attended a meeting at JSS with the HIV/AIDS patient. The Chattisgarh Aids control Society wanted to start a programme with HIV positive people, with this initiative a group is formed of HIV+ people called Chattisgarh Network for Positive People.

b) From 05/12/06 to 08/12/06 - I did a pilot survey in the field are of JSS, to know the condition of scabies disease.

c) From 09/12/06 to 14/12/06 - I did asurvey on the scabies in two villages called Damanpur and Bandipara of Kota block.

d) From 15/12/06 to 16/12/06 - I attended health workers training in Shivtarai Village. This training programe was attended by the 13 new village health workers, who were selected by the JSS. In this training programme specially training given on the two issues or problem seen as a prevalence in the villages. First training on malaria and second on scabies. In the third Day the programme of slide

preparation or taking of blood smears was the most interesting work done by the health workers.

**New health worker training**

**Shivtrai village**. (15 to 17 December 2006).

To spread the work in the new villages after a long process JSS started a training programme for the new selected health worker in a programme village Shivtarai.
13 female health workers, out of total 17 village health workers from different villages attended this programme for two days. The process of the selection of the health workers was on the voluntary basis. Selection process done with the consent of gram sabha and family members of the selected person. Village team of JSS asked the name of either one or two health workers and then they got these few voluntary activists. Most of them are either illiterate of had left their education up to second standard.

Most of the health workers had came there with their children, they were on their respected cast in the village. This was probably the first time in their life where they are out of their village alone, and committed to the health. This training programme had an informal way to interact with each other. In this training the challenge before the trainer to was to motivate them for the discussion, to eradicate the hesitation, they were feeling and to provide and free environment to create their understanding regarding health and sanitation and make them understand about the health conditions and the realities.

Primary objectives of the training were to train them for the recognition of the common disease have prevalence around them; like Malaria, fever, pneumonia, and main objective was to train them to preparer thick blood smears at village level. These thick smears are helpful to at least diagnosis of malaria. These blood smears slides comes to the village center Ganiyari by public transport system, an innovative mechanism developed by the JSS for the early diagnosis of malaria.

**My learning's** :- to attend and look after a health workers programme was involved in my learning objectives, and this is one of my interested area in health. But it is not easy that I had been feeling earlier. Through this training programe I have following learnings :

- During the training I felt that now a days these health workers are the only hope to provide good and quality services to the un reached or out reached area where to get the public health services still is a like a dream.
- Selection of the health worker is a quite lengthy time consuming and hectic process. It is not easy to find out or make agree voluntary and women health worker. Due to gender sensitivity, and traditional culture, customs and beliefs, it is quite for the women to break them and come from the village for the social benefits.
- Due to culture or local beliefs and family structure girls drop out rate is higher in the tribal area, so it is too difficult to find out at least primary level educated women for the programme.
- Due to shy nature of women they often feel hesitation and don't talk frequently, this is the main problem during training to provide them free environment and motivate them to speak frequently. To solve this problem the trainer or facilitator has to have and know about them complete information, facilitation of the facilitator is a skill to make effective to the training.
- Command over the issue and information about the local belief culture, customs and traditions is also an important factor for the success of the training

**Appropriate technology**

Technology is and essential component of health care at all levels, which works for the detection, diagnosis, treatment, prevention, availability, accessibility, and maximum utilization in the positive sense. There for the availability of appropriate health related technologies in the field of health care is an essential tool in providing health care in the rural or out reach areas. Technologies have developed rapidly in field of health care, in the last several years, and peoples are getting benefited continuously as a life saving form. Now the several severe diseases when doctors were not able to even diagnosis, now being treated successfully. Some times it is looks like a boon given by the god, to save life. But these life saving technologies are only available to a particular section, not for every one, due to high cost in the urban areas, which is not possible to use by the poor.

However the availability of the health related technologies at the primary health care level in the rural are extremely limited. In the case of many diseases and conditions of public health system

To meet the requirements or health needs in the rural areas of JSS is working and serving with the appropriate technology, and this process is still continue: Following are the man concern developed as appropriate technology;

- Measurement of anemia using copersulfate
- Diagnosis of sickle cell anemia
- Breath counter
- Measurement of hight
- Reproductive health kit
- Easy to read thermometer.
- Ors
- Tablet breaker
- Safe delivery kit
- First aid kit
- Water disinfection system.

## Scabies prevalence study

### Objective of the survey

Following are the main objectives of my study on scabies.

1. To see the prevalence of scabies in the rural areas.
2. To see the economical conditions in the rural area.
3. To see the indebtedness in the rural areas, due to scabies and other illness.
4. To look at the socio-economical conditions in the rural area.
5. To know the awareness level the scabies in the rural areas.
6. To know perception regarding scabies.
7. To see the health conditions in the rural areas.
8. To see the family status of the families in the village.

**Back ground of the Villages**

Universe of the study

In the social research, society is the laboratory, for the social researchers. In my study I did my survey in the two villages of Bilaspur districts Kota and Lormi block one village each.

Following is the information for these two villages:-

1 **Davanpur** this is the village comes under the KOTA block, of Bilaspur district. 56 km away from Bilaspur, and 26 km from the KOTA block, no bus facility available or public transport available to reach this village. Peoples use two sides to reach this village one from kota and second from Shivtarai, but peoples have to cross small rivers from both sides to reach the village, and often in the rainy season these small rivers got over flooded, which cause to cut all the connections from the others. Most of the population is depend on the agriculture work and something they suppose to get from the forest. Most of the people work for the livelihood in others fields also it means they can be called agricultural labors. Agriculture production in their own field is not sufficient to fulfill their food requirements for the whole year. They want or get rice as their wage. Crops dependents on the rain and they don't have means to do irrigation for their lands. Most of the land is has taken over by them illegally, they called it "Beja kabja".

2 **Jakad bandha** is more then 80 km away from the main district bilaspur and 40 km away from LORMI block of Bilaspur district. This is the highly forested area and Achahanakmar is the main village govt. of CHATTISGARH has been declared a sanctuary to this pure tribal area. This village is consisting here in three parts, URAO PARA, BAIGA PARA, and last one is jakadbandha. Three tribes are living here, in ORAO PARA most of the population is URAO tribals, and rest of the village is consists of GONDs and URAOs. This tribal village has 96 pure kachcha but clean house hold. Most of the peoples are land less labor, but for the livelihood they have captured some land in their words it is called "Beja Kabja" and doing farming activities which depends on the rain, like others tribals areas here also the lack of basic services can be seen. Basic primary public health services are disappeared. Peoples have to migrate for the search of the livelihood, to the far most area, like Bilaspur, Delhi, Bombay, Hydrabad, Bhopal, Kolkata, etc.

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in the absence of main persons of the family only women has to look after for their families. Education services and even Aanganwadies are not working and even being trained properly. One private mission school is here with more then 50 student from different near and far villages. Rice is the only crop being received by the village peoples, and up to some extent they use some forest seasonable crop which contributes something for their economical condition. Use of local home made liquor is very common in these areas and also the part of culture.

Three lakes are around the village. But in the summer seasons only one lake has the water to full fill the requirement of daily use of the village. To fulfill the requirement of the drinking water of the village there are only four hand pumps are serving to the whole village. Wells are also in the village but it is rarely used by the villagers.

**Why the study**

In the recent years this had been felt that peoples of the rural area suffering very much form the problem of scabies, and during the village intervention it found that the prevalence is higher and peoples are complaining regarding the problem of scabies. If the peoples have the personal hygiene and sanitation, and if they are taking the regular bath, then the mite that is the cause of scabies will disappear. But the condition in the rural areas is just different. Peoples are spending un necessary money the treatment on the scabies. Jhola chap Doctors are treating this problem through the saline bottle and injection and charging 20 to 50 Rs. For the treatment, that could be cure in just Rs 5 to 6. this un necessary treatment becomes the cause of rural indebtedness. Most of the time peoples goes to the local healers or tend to Jhad-phook due to cultural beliefs and blind faith. That also pushes them to the indebtedness. Most of the affected from the scabies are children and women, which becomes ignore or separated in the community and even in the family and doesn't come to show them self if they are suffering from the problem. Children are ignored due to lack of attention of the parents or lack of money, they does their local treatment. Their one visit from the village to health centre becomes cause of lose of their one days wage, and it becomes more severe when irrational treatment done by the doctors.

**In this Proforma following were the information to be collected.**
Respondent, caste, class, gender, family, Family members, economical condition, land food, prevalence of scabies, house hold information, and in the last their perception about the problem.

**Something about scabies**

Scabies is caused by the mite Sarcoptes scabiei, variety hominis, as shown by the Italian biologists Diacinto Cestoni in the 18th century. It produces intense, itchy skin rashes when the impregnated female tunnels into the stratum corneum of the skin and deposits eggs in the burrow. The larvae, which hatch in 3-10 days, move about on the skin, molt into a "nymphal" stage, and then mature into adult mites. The adult mites live 3-4 weeks in the host's skin.

The motion of the mite in and on the skin produces an intense itch which may resemble an allergic reaction in appearance. The presence of the eggs produces a massive allergic response which, in turn, produces more itching.

Scabies is transmitted readily, often throughout an entire household, by skin-to-skin contact with an infected person (e.g. bed partners, schoolmates, daycare), and thus is sometimes, although inaccurately, classed as a sexually transmitted disease. Spread by clothing, bedding, or towels is a less significant risk, though possible.

**Onset**

It takes approximately 4-6 weeks to develop symptoms after initial infestation. Therefore, a person may have been contagious for at least a month before being diagnosed. This means that person might have passed scabies to anyone at that time with whom they had close contact. Someone who sleeps in the same room with a person with scabies has a high possibility of having scabies as well, although they may not show symptoms.

The symptoms are caused by an allergic reaction that the body develops over time to the mites and their by-products under the skin, thus the 4-6 week "incubation" period. There are usually relatively few mites on a normal, healthy person--about 11 females in burrows. Scabies are microscopic although sometimes they are visible as a pinpoint of white. The females burrow into the skin and lay eggs there. Males roam on top of the skin, however, they can and do occasionally burrow. Both males and females surface at times, especially at night. They can be washed or scratched off (however scratching should be done with a washcloth to avoid cutting the skin as this can lead to infection), which, although not a cure, helps to keep the total population low. Also, humans create antibodies to the scabies mites which do kill some of them.

***Signs, symptoms, and diagnosis***

A scabies burrow can be seen under magnification. The scaly patch is due to scratching of the original papule. The mite travels from there, where it can be seen as a dark spot at the end of the burrow.

A delayed hypersensitivity (allergic) response resulting in a papular eruption (red, elevated area on skin) often occurs 30-40 days after infestation. While there may be hundreds of papules, fewer than 10 burrows are typically found. The burrow appears as a fine, wavy and slightly scaly line a few millimeters to one centimeter long. A tiny mite (0.3 to 0.4 mm) may sometimes be seen at the end of the burrow. Most burrows occur in the webs of fingers, flexing surfaces of the wrists, around elbows and armpits, the areolae of the breasts in females and on genitals of males, along the belt line, and on the lower buttocks. The face usually does not become involved in adults.

The rash may become secondarily infected; scratching the rash may break the skin and make secondary infection more likely. In persons with severely reduced immunity, such as those with HIV infection, or people being treated with immunosuppressive drugs like steroids, a widespread rash with thick scaling may result. This variety of scabies is called **Norwegian scabies**.

Scabies is frequently misdiagnosed as intense pruritus (itching of healthy skin) before popular eruptions form. Upon initial pruritus the burrows appear as small, barely noticeable bumps on the hands and may be slightly shiny and dark in color rather than red. Initially the itching may not exactly correlate to the location of these bumps. As the infestation progresses, these bumps become more red in color.

Generally diagnosis is made by finding burrows, which often may be difficult because they are scarce, because they are obscured by scratch marks, or by secondary dermatitis (unrelated skin irritation). If burrows are not found in the primary areas known to be affected, the entire skin surface of the body should be examined.

The suspicious area can be rubbed with ink from a fountain pen or alternately a topical tetracycline solution which will glow under a special light. The surface is then wiped off with an alcohol pad; if the person is infected with scabies, the characteristic zigzag or S pattern of the burrow across the skin will appear.

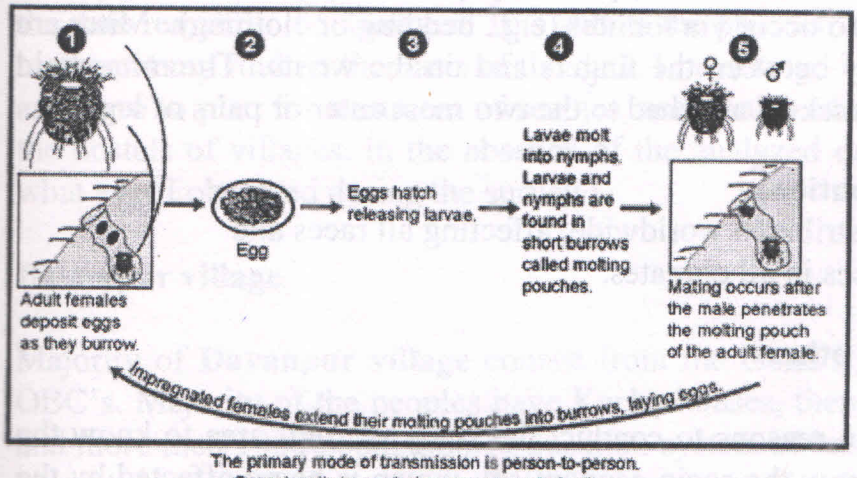
When a suspected burrow is found, diagnosis may be confirmed by microscopy of surface scrapings, which are placed on a slide in glycerol,

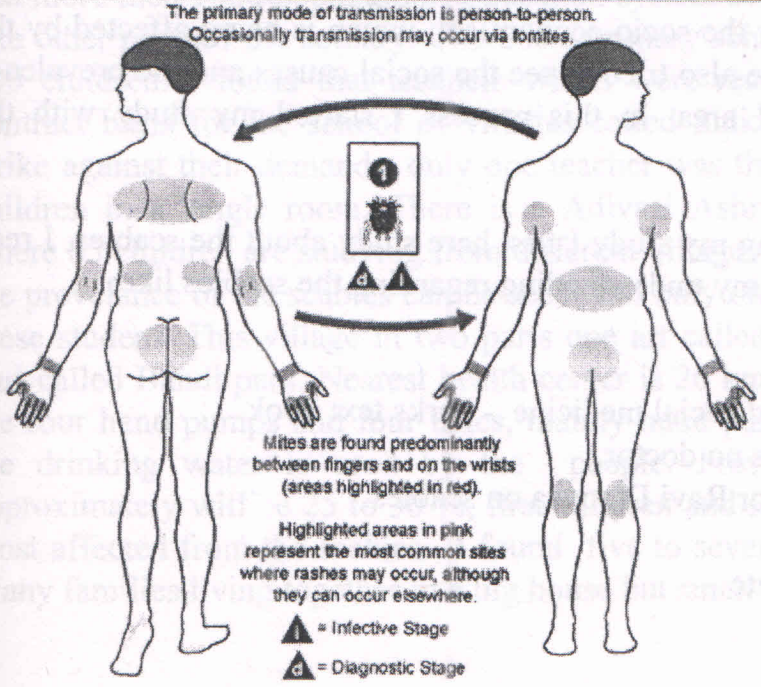
mineral oil or immersion in oil and covered with a coverslip. Avoiding potassium hydroxide is necessary because it may dissolve fecal pellets. Positive diagnosis is made when the mite, ova, or fecal pellets are found.

**Causal Agent:**

*Sarcoptes scabei*, human itch or mange mites, are in the arthropod class Arachnida, subclass Acari, family Sarcoptidae. The mites burrow into the skin but never below the stratum corneum. The burrows appear as raised serpentine lines up to several centimeters long. Other races of scabies may cause infestations in other mammals such as domestic cats, dogs, pigs, and horses. It should be noted that races of mites found on other animals may establish infestations in humans. They may cause temporary itching due to dermatitis but they do not multiply on the human host.

**Life Cycle:**




*Sarcoptes scabei* undergoes four stages in its life cycle; egg, larva, nymph and adult. Females deposit eggs at 2 to 3 day intervals as they burrow through the skin ❶. Eggs are oval and 0.1 to 0.15 mm in length ❷and incubation time is 3 to 8 days. After the eggs hatch, the larvae migrate to the skin surface and burrow into the intact stratum corneum to construct almost invisible, short burrows called molting pouches. The larval stage,

which emerges from the eggs, has only 3 pairs of legs ❸, and this form lasts 2 to 3 days. After larvae molt, the resulting nymphs have 4 pairs of legs ❹. This form molts into slightly larger nymphs before molting into adults. Larvae and nymphs may often be found in molting pouches or in hair follicles and look similar to adults, only smaller. Adults are round, sac-like eyeless mites. Females are 0.3 to 0.4 mm long and 0.25 to 0.35 mm wide, and males are slightly more than half that size. Mating occurs after the nomadic male penetrates the molting pouch of the adult female ❺. Impregnated females extend their molting pouches into the characteristic serpentine burrows, laying eggs in the process. The impregnated females burrow into the skin and spend the remaining 2 months of their lives in tunnels under the surface of the skin. Males are rarely seen. They make a temporary gallery in the skin before mating.
Transmission occurs by the transfer of ovigerous females during personal contact. Mode of transmission is primarily person to person contact, but transmission may also occur via fomites (e.g., bedding or clothing). Mites are found predominantly between the fingers and on the wrists. The mites hold onto the skin using suckers attached to the two most anterior pairs of legs.

**Geographic Distribution:**
Scabies mites are distributed worldwide, affecting all races and socioeconomic classes in all climates.

**study of books and others**

These were the main reasons to conduct the study of rural area to know the perception and to know the socio-economical, which is being affected by the disease. In this study we also tried to see the social causes and the prevalence of scabies in the rural area. In this process I started my study with the following steps

In the process of starting my study I first here study about the scabies, I read various books to create my understanding regarding the scabies like;

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- Preventive and social medicine - Parks text book.
- Where there is no doctor.
- Notes of doctor Ravi D'souza on scabies.
- wikipedia
- NDTV.com. etc

Doctors of the JSS helped me to diagnose the scabies patients, in the OPD I sit with them and asked my doubt regarding the scabies. In the field the health workers and village health team of Jan Swasthya Sahyog helped me to identify the scabies. I also discussed about the treatment of scabies.

Then I discussed the about the questionnaire with Dr. Yogesh jain, but before finalize the Performa I did a informal pilot survey. I did some informal visits and talk with the affected and non affected peoples, to find out the perception of the peoples about the scabies. Then after having some grass root level information I discussed with my mentors finalized my questionnaire for the survey for the study.

**Findings of study**

Survey has been completed in both Davanpur and Jakadbandha Villages. But the date remain to be analyzed. It is still in the process, so that I am not able to present my find on the basis of the data. I have to go back to JSS Ganiyari and have to plan for treatment of scabies, and health education on scabies in the hostels of villages. In the absence of the analyzed data, I am presenting what ever I observed during the survey ;

**Davanpur village**

Majority of **Davanpur village** consist from the Gond's and rest belongs to OBC's. Majority of the peoples have Kacha houses, there are 136 household and more then 1000 population. Education system of has the same condition like other parts of the country. There is a primary school and with more then 100 children. I found that teachers which were recruited by the govt. on contract basis for the school of villages called Shiksha karmi were on the strike against their demands, only one teacher was there to interact with the children in a single room. There is a Adivasi Ashram up to 5$^{th}$ standard, where 85 children are studying from different villages around them, here also the prevelance of the scabies can be seen, and only one teacher is appoint for these student. This village in two parts one art called Davanpur and second part called Bandi para. Nearest health center is 26 km away from here. Here are four hand pumps and four lakes, mainly hand pumps are being used for the drinking water is used by the people. Prevalence of the scabies approximately will be 25 to 30 %, first children and second women were the most affected from the scabies . I found five to seven members in a family. Many families living together in a big house but small rooms.

**Jakadbandha Village**

This village is 80 km away from the main district bilaspur and 40 km away from LORMI block of Bilaspur district. This is the highly forested area and Achahanakmar is the main village govt. of CHATTISGARH has been declared a century to this pure tribal area. This village is consisting here in three parts, URAO PARA, BAIGA PARA, and last one is jakadbandha. Prevalence of scabies in this village is not common. Very few cases I found which were effected by the scabies. All 96 kach houses were in sequence their was the proper ventilation in the houses due to small houses people often expose their personal things like bed and bad sheets in the sun it could be the main reason of the absence of scabies. Peoples often Migrate for the search of livelihood on different places. Peoples. Villages get only one crop during the rainy season. Most of the people are land less labors and depends on the forest work, which is often has a very low wage.

In both of these villages health conditions are not differ from the others parts of the area. There no health facilities are available. Peoples are dying from the curable diseases, like malaria. To cope up with the health problems of the this tribal and semi tribal area one organisations called Jan Swasthya sahyog is working since last more then 10 years, a team of like minded Doctors trained from the one of the pioneer institution of India, had a same desire to serve the most vulnerable section of the society. After long journey of two in the different parts of the country finally their journey stopped on the little place Ganiyari a small village 18 km away form the Bilaspur, the main fast growing commercial area of Chattisgarh state. Just 100 km away from this so called fast growing developing area public health needs are not meeting to the peoples.

# OTHER ACTIVITIES

- **JSA Meetings ( NCC, STATE )**
- **MFC / AIDAN**
- **Indian Social Forum (ISF)**

## Jan Swasthya Abhiyan Meet

### Preparatory Workshop for National Health Assembly II

### 4-6th January, 2007

The Jan Swasthya Abhiyan coalition consists of over 22 networks and 1000 organisations as well as a large number of individuals that endorse the Indian People's Health Charter a consensus document that arose out of the Jan Swasthya Sabha held in December 2000 when concerned networks, organisations and individuals met to discuss the Health for All Challenge.

JSA Is the result the of a conference organized by WHO and UNICEF at Alma Ata in 1978,where all the developing countries including India were the signatory of the conference. In this conference all the developing countries signed that they will provide health for all up to 2000 AD. After the 22 years later, it realized by the health professionals and developmental activists that promise made by the govt. in 1978 Is not going to be fulfilled. So that al the activists at international and national level came together on Savar Bangladesh in December 2000, in Peoples Health Assembly, where concerned networks, organizations and individuals met to discuss the Health for All Challenge, and formed a ***Peoples Health Movement*** at international level and ***Jan Swasthya Abhiyan*** which is the part the of Peoples Health Movement International.

This was the national preparatory meeting for the second national peoples health assembly, which is going to be organized in Bhopal on 23 to 25 march 2007 in Bhopal. Dr. Amit Sen Gupta gave the introduction of the national peoples health assembly and following were the main objectives of organizing this preparatory meeting.

- State wise reporting for the rural health watch.
- Opening of the dialog books in the assembly.
- Group discussion of national books.
- State level programme talk
- Discussion on the people's health workshop.

Many organizations from the different states presented their programmes taking place in their state for the preparation of JSA assembly. They mainly reported about following

- Participants of state workshop ; many organizations attended the workshop and what are the activities in process.
- Rural health watch survey of the state : - the state JSA where they have done their survey presented about it that how the issues they are picking up like some organizations were interested to take up the issue of malnutrition, availability of drugs, in the state peoples health workshop.
- Local health assembly :- some states were doing activities at local level and like public hearings at local level with the help of BMO's or CMO's. sensitizations of local and panchayat leaders in different villages.
- District health assembly and state health assembly.
- Issues, which will be taken through the state workshop :- main feature of the state assembly will be the public hearings and data of peoples rural health watch will be presented by the state JSA.

On six of January 2007 JSA announced and launches officially Peoples Health Assembly (JAN SWASTYA SABHA) in the presence of many health and developmental organisation's, NGO's followed by the press conference in which different. Mr. Amit sen gupta, Dr. Ajay khare, (JSA joint convenor) Dr. Mire Shiva organize this meet.

**JSA state workshop (Chattisgarh)**
From 1/12/06 to 02/12/06

This was the first state level workshop which I attended the meeting of the **Jan Swasthya Abhiyan** (JSA) in Dallirajhara Durg distt. Programme started with the consolidation to the founder of Shaheed Hospital, and then various topics were discussed in the meeting regarding health 20 to 30 were present in this workshop and issues that were facing by the orgnisations were discussed such as human right issue,displacement migration, occupational health, function of PHCs role of local politics in the management of PHCs and availability of doctors, medicines blood, Govt. norms and regulation to manage the blod bank, Janni Suraksha yogna, lack of information of govt. schemes to the public health personnel diagnosis of T.B. etc the main issues

discussed by among the organizations. Each organization expressed the health scenario and the problems they are facing in regarding field where these organizations are working. Dr. Anurag Bhargav discussed on the drug policy of the Govt. and told about how the health of the poor patient are being exploited, essentials drugs are not available in the market on the name of branded drugs how the big medicines companies are robbing on the pocket of the poor people, life saving medicines are continue are coming out form the criteria of price controlling. Human right issues were discussed in this meeting. In this concern the Salva-Judum problem and exploitation, displacement of adivasies from the forest is on the name of development and interesting is that all these things being done by the govt. is another question that what the role should be played by the govt. and what the role is govt. playing, which totally against the democracy and humanity. Condition of women and girls is being worsen sexual exploitation and gunda gardi of police persons has no limits on the people and specially of the women who are help less to live in the camps. Through the JSA people could create the pressure on the govt. to make more responsible toward their duties and responsibilities. These conditions is showing that the coalition of health movements and social movements for the sake of peoples and the nation is the priority and demand of Humanity.

MFC/AIDAN
27 to 29 dec. 2006

this was the first meeting of its kind in which 40 to 50 professional in the community health background came together for two and three days from different parts of the country, sit together and discussed on the public health education. Before this mfc meet one more meeting called AIDAN (All India Drug Action Network) took place.

I am not able to give here my reflection regarding the meeting, because CHC were organizing this meeting and we were busy in the arrangements of the participants.

On the second day mfc meeting happened. I have to present my reflection also for this meeting, but again I am really sorry that I didn't participate fully in this meeting also, due to management of the whole progamme. But what ever I attended is not sufficient for my reflection on those rich discussions

## India Social forum

Duration: - 09 **to13th November 2006**

**Few words** – The first WSF was held from 25 January to 30 January 2001 in Porto Alegre, Brazil, organized by many groups involved in the alternative globalization movement. The WSF was sponsored, in part, by the Porto Alegre government, led by Brazilian Worker's Party (PT). The town was experimenting with an innovative model for the local government which combined the traditional representative institutions with the participation of open assemblies of the people. 12,000 people attended from around the world. At the time, Brasil was also in a moment of transformation that later would lead to the electoral victory of the PT candidate Luiz Inácio Lula da Silva.
World Social Forum came in: ATTAC saw the conference as an opportunity to bring together the best minds working on alternatives to neo-liberal economic policies-not just new systems of taxation but everything from sustainable farming to participatory democracy to cooperative production to independent media. From this process of information swapping ATTAC believed its "common agenda" would emerge.

A community health fellow I have spent three months and going through the fourth month in this India social Forum. This is my first experience in this kind of convention where a lot of groups come on a common platform, and put their experiences on various issues, which they are facing in their respective field areas. Many issues discusses such as - development, displacement & migration of Dalits and indigenous peoples, Discrimination, Child issues, Women issues, health Issues, Land, Education, Food Security, Etc. All of these problems have their root in so called Development.

Further I am presenting my reflection on the issues, which I attended during my stay in convention.
**09-11-06**: - this was the first day of the convention. In the morning we completed the process of the registration then visited to the convention ground. There were many organizations from all over India putting their stalls and showing their issues, demand charters, books, and signatures campaign.
In the evening the plenary has started and continue till the midnight. Different social activists express their view on the aims and objectives of the India Social Forum. Such as our aim is that the present world could be change where the equity will be every where and no discrimination will be seen on the name of cast class and gender. The aim of our gathering is that such a

huge amount of the people suffering by the same problem and their root are in present system. This system should be pro-people.

**10-11-06** :- in the morning of the 10 of November we had to attend the pre decided session but we were getting difficulty to find out the places, and due to first day session started some time letter. In the first session I listened to MEDHA PATKER on the issue of displacement and development. Like jungle is the property of Acivaises, govt. is responsible for rehabilitation and it should be the priority of the govt. to look after the displaced majority of the community who are their own people. Dames the sign of development of capitalistic society, cement and iron lobby is taking over the govt. machinery. I went to the 3 screening session where they were showing the movies on the different issues like Iraq war and protest against COCA COLA, and PEPSI in the middle East and African countries, Women empowerment, and working man in the home.
The third session which I attended was on land and livelihood organizing by **Ekta Parishad.**

Different Peoples from the different parts of India were putting their views on problems they are facing due to developmental policies. They were against the unbalanced development policies of the govt. which is the cause of migration and poverty of Dalits, Tribels and other backward classes of the community in different places of India.and put following data of these vulnerable classes of the community.
Among the population of India, 16 crores are Dalits, and 08 crores are Adivasi. Over the last 50 years various policies and programmes were made for their development but still the conditions are not satisfactory, 45% Adivasi, and 36 % Dalits, communities are facing extreme poverty. On the name of the development more then 50 million peoples has been displaced out which 40% are Dalits. Rehabilitation process is still unseen. Govt. of the states is not paying serious attention; most of the agriculture land has been captured legally or illegally through the govt. or others land lords. Agriculture labor is Dalits community but they don't have their own land, in all of these processes the conditions of women and children is most vulnerable they are facing more socio-economical, and cultural problems.
The land reforms and proper decentralized Panchayat system could only the mean to solve the problems. *Only through the community participation in the governance and community control and monitoring over the public health services can improve the status of Human life and we can achieve the development goals.*

After Noon session (12 : 03 )

In the afternoon session I attended the Jan Swasthya Abhiyan session on "**child health**".

Only good health leads to the development and empowerment. But the govt. doesn't have effective policies to improve the health conditions of all the classes of the community at all levels. in the context of the child health only internationally funded programmes like Pulse Polio, and HIV/AIDS are being focused polio vaccine is include in primary vaccination given right from the birth of the child, But because of UNICEF is funding for this programme, it has became a separate national programme. Primary data of NFHS – 3 shows that routine vaccination is falling, Govt. bodies concerned are not conformed about how many dose are required for the child. After the vaccination polio has seen in some cases. Human Rights organisation considering that it is an issue for of Human rights violation. A lot of lacunas are in the pulse polio campaign like polio is a disease concerned with the water, infection happens due to lack of sanitation and open sewage system, but in this campaign water issues are not being address. There is not any provision in the campaign to solve Nutrition and other health aspect properly. Besides all of these programmes regarding Child Health, Malnutrition, Infant Mortality Rates, Safe Drinking Water and Sanitation, issues are interlinked and concerned with the Child Health, and by the time becoming more severe only through strengthening of public health system, maximum people of the community who are marginalized, most vulnerable and prone to the diseases could be served. Other important thing is to understand the nature of programme, creating awareness in the community and realization of importance of the programme are the factors effecting to the programme.

After Noon (4-7) (11-11-06)

**Urban Health in the context of Globalization.**

Due to Globalization and Development health is affecting very much in both urban and rural areas. Same the conditions of the slum peoples are getting verse, they not very good. Now the urban renewal mission is contributing more and creating problems more severe, slums are being displaced and govt. and corporations are escaping to take the responsibility of rehabilitation and is not providing basic public health services, like water supply, power supply, sanitation, and health care services etc. These problems are together effecting on health and the living conditions of the peoples of slum community.

On the name of urban renewal mission Rs. 5000 crore are allocated for the master plan of 60 cities of India. It is estimated that there are 40 lakh labors are in Delhi and due to high migration rate in next 20 it will reach up to 40 lakh, but according master plan Delhi govt. will not establish or will not invest in any which could be helpful to provide the employment to the labor class.

On the name of development in lucknow a slum has been displaced by the order of high court. Due to high cost of medicines lay mans are not able to afford health treatment, free of cost treatment is not available in govt. hospitals, medicines are not available their. 354 medicines falls in price control in 1977, but in 1995 only 74 remains under it. Now the public private partnership is a biggest source of earning money, live example is Appolo hospital. Delhi Govt. has 23 crores yearly income, by the investment of 47 crores. But the treatment of the common man is still a dream to avail the facilities or treatment, due to expensive treatment.

Diseases are becoming more then earlier days, now due to these peoples are dying, water level is getting down and due to development earth is getting recharge, rain water is not being stopped, with the concept of water harvesting peoples are still not familiar and facing the problem of water scarcity. Drinking water is not available; public health services are poor, privatized water supply contributing in the problem to be more serious. Ground water is getting contaminated continuously due to industrialization and Slums people are helpless to use this water. Not any international agencies are taking these problems seriously and coming together to raise the voice against the govt. policies, corporate, and industrialists.

**Saving India's Public Health**

Public health system is the only system by which we can reach or serve to the maximum number of peoples with appropriate and affordable cost. Now the public health policies of India's is not in the hand of our policy makers or has been hijacked though the structural adjustment programmes (SAP) of US agencies like World Bank and IMF. Now the community is the only hope to save the public health system. The democratic and decentralized system of the country provides the opportunity to the peoples to strengthen to the system whether it could be health, Education and others. Community involvement in the health programme, through prioritizing needs, decision-making, planning, implementation and monitoring could play the major role to save the public health system of the country.

In this process National Rural Health Mission (NRHM) could be mile stone. The concept of the ASHA, community health workers, and public private partnership, is trying to ensure the community participation in the public health system.

But the lacunas are still being seen, state govt. is not looking interested to implement the process of the NRHM selection of the ASHA health workers is not properly taking place. Surpanch and other panchayt members is demanding money up 3000 to 5000 for the selection of ASHA workers. Where the ASHA workers have been selected, still not getting proper trainings, and assuming like the assistant of Anganwadies or ANM's. Unless the community will take part honestly, we can't expect success of any public health programme. A lot of problems are in the community, and resources are limited. Therefore maximum utilization of resources is possible only through the community participation for the development.

**Conference on Right to Education (Morning) (11-11-06)**
**Modern right to education bill 2006**

Education is one of the most important fundamental right of the people, and subject of the state to provide free and compulsory education to 6-14 years children.

but with the development it is looking like a dream to have free and compulsory education. in the present era privatization is breaking the back bone of the education system. Modern right to education bill 2006 is working as a strong Jake for the irresponsibility's of the govt. and has washed all the dreams of good and quality education. 11$^{th}$ five year plan says "that we have a lot of opportunities in the Information Technology sector, because we working 24* 7 for the Americans professionals, so that education should be technology based that will help to the capitalist to invest in the education sector and it will becomes more privatized on the name of providing good and quality education.

Due to facilitation of the private market govt. is keeping down their hands to ensure the privatization.. At one hand this Act has provisions to take and action against parents who are not sending their children to school, on the other hand govt. is not doing any provisions and don't have any policy or programme to reduce poverty for the families where their children are the only source of income. Bill is saying children of the families who don't have residential proof will not be able to get admission in the schools, then what about thousands of labor families who are migrating every to search of food

and livelihood. Govt. will not open any school where private schools are existing. This is the policy to promote the privatization of the education.

**Girl child labor** :- in the so called developing nations, the conditions of the girl child labor is getting worse, especially in the backward areas where they are working as a bounded labor. there are a lot issues regarding girl child labor like- advance credit, lack of food accessibility, customs and traditions, and dowry, are the biggest cause of the girl child labor, early marriage, heavy house hold work, early pregnancy, long working working hours, agriculture activities, are keeping them away from the education. some data says that women in the villages takes 4 to 5 hour sleep, during night, and it is more harmful during the pregnancy.

**Dalit Education.:-**

Education is one of the best tools of the development. Education teaches men about the life and help men to accumulate in the society so that education is for every one and it is a fundamental human right.

But right from the beginning a particular section of the society is keeping away from education, and they had not any right to have education in ancient period, only good education was available only for the rich and economically sound section of the society. A particular section of the society who had power were dominated over all the resources and utilizing it. After the independence a lot of efforts were carried out for upliftment and the development for poor, backward and vulnerable sections of the society like Dalits minorities, and tribals. Under the section 14 govt. is responsible to provide free and compulsory education upto 14 years children. But now it is a dream to get quality education in govt. schools, in rural and out reach areas. govt. is coming out from the responsibilities to provide education, and handing over it to the private sectors, which is being used as a money making machine. Education field is developing like a business sector, business men are investing on it, good and quality education is available only in big schools who r charging high fee to its students. In this scenario good and quality education is a big dream to the peoples who are living in the out reach and rural areas. They can't even think for this type of education, beside all of these problems the cast system is making worse difficult for Dalits and Adivasi students. where the these problems like Dalits and untouchables are exist, teachers don't behave properly with dalit students, almost all the bed work like sanitation, sweeping, fetching water, falls into account of dalit students. In the rural areas of Rajasthan and Gujrat, teachers don't like to teach dalit students.

I think the main problem is existing in power relations. In the rural areas if power will be in the hand of the locally dominant or a particular group they will think for development for their own class or section to eradicate the problems democratic approach could be one of the solution, but where we want to development of particular marginalized and vulnerable group power structure should be according to need of the community for their empowerment their own involvement in decision making and planning are must and they have to be understand or realized that this is their own programe.

For the development of the vulnerable and marginalized sections it is must to develop the structure according to their need. Resources must be hand over to them and govt. should monitor and assist only in the planning and monitoring. In case of the education of the dalit section, the dalit majority will be responsible for the education of the dalit section, or at least monitoring should be done through the dalists peoples.

**National Alliance for Right to Education and Equity.**

**By Professor – YASHPAL**

Education is one of the most beautiful concepts of the world. Man should always think positive because positive thinking infinite possibilities for instance globalization is creating disparities around the globe between rich and poor man and Human societies. But with the positive thinking one can beautiful and best possible use of this globalization. like we can connect our villages through the internet. It will helpful to disseminate information regarding health, education, employment, agriculture, etc. govt. should work toward it if we want to development.
there is infinite possibilities, because Universe is infinite. Hope comes from the possibilities, so that the death of hope is a unscientific thinking. Hope keeps you alive and motivate for the invention.

**National Coordination Committee (NCC) meeting of Jan Swasthya Abhiyan (JSS).**

**Place :- Indian Social Forum**

on 13 of November 2006, evening NCC meeting of Jan Swasthya Abhiyan conducted during the ISF convention. Attendant of the meeting were the

social health activists from various organizations working in the field of health in the different parts of the country.
Dr. T. Sundar Raman, Dr. Abhay shukla, Dr. Dhananjay, Dr. Joe Varghees, Mrs. Indira, Dr. Vandana Prasad, Dr. Ajay Khare, mr. Sant, Mr. Naveen Thomas, Mr. Rakesh Chandore, Mr. Juned Kamal Etc.

Main Issues discussed in the meeting;

Peoples Rural Health watch survey : most of the organizations are still working at their own level and it almost has competed. This survey has been completed in Madhya Pradesh and Rajasthan. under the rural health watch states who didn't complete the will complete it a soon as possible, or up to the End of December 2006. So that it will be helpful to prepare the report for NHA – 2.

Circulation of Action Alert : this magazine was started to up date and strive the health information and health activities among the partners and other organizations directly or indirectly concerned with Jan Swasthya Abhiyan. Earlier it was continue, but interrupted in between due to problem to access of the internet or mail services. but now it will be continue from the JSA secretariat.
National security registration Act.
Public Private Partnership task group. Alternative action plan has to frame for this task group. Community monitoring is also one of the tool to look after PPP implementation. Many programme national wide are running without knowing its effects on health of the community, like Pulse Polio campaign, National malaria programme, T.B. programme, etc.

**Preparation of National Health Assembly (NHA) – 2.**

Place - Ravindra Bhavan, Bhopal, Madhya Pradesh.

Dates - 23rd to 25th March 2007.

Funding - finance is a back bone of every programme. there is approximate estimate for NHA – 2 is about 25 lakh. this is quite a big amount, so that different organizations by representing their states will contribute for NHA – 2. others suggestions that are comings, that many organizations could do funding for this programme, but the problem is that all the organization who are capable for the funding, are being criticized for their

role in the health field. so that the funding of the programme is a big challenge before JSA.
some suggestions that will be implement during and before NHA-2 are follows,
registration fee will be charged on the participants, some funding organization will be contact like TATA Trust, CRY, and ICICI bank, for funding under the supervision of a task group formed at secretariat level.

**Translation of NHA-2 books** :- for new books written for the NHA 2 will be translated in to Hindi and local languages. book no. one Globalization and health came into account of BGVS M.P. for the Hindi translation.

**State Health Assemblies :-** organization in their each respective states will conduct public hearings up to the January 2007. organizations will plan according to that, and will send programme to the JSA sec.
National Secretariat :- A national secretariat will be formed for the National Health Assembly – 2.
Following members will look after the work of National Secretariat.

Dr. Ekbal, Mr. Naveen Thomas, Dr. Ajay Khare, Dr. Vandana, and Mrs. Deepa, Dr. Dhananjay, Dr. Joe Verghees, and Mr. Tejram.

Another important section of Indian Social Forum that was organized by the JSA simulteneously was organized by the people

**Conclusion:-**

In the end of this report I would like to say that India Social Forum is a social congregation and provide a plat form where various groups working in the country on the different issues came together to see a dream of another world where equity, respect, equality, equal distribution of resources, equal opportunity, or in a one word equal world without discrimination will be a reality.
It is good to come together and to make realize or aware to others regarding the actual problems of the society or community, but if we will critically examine to this problem, then we will realize that this was congregation of cattle's, where lots of cattle's in small crowd were roaming and enjoying only. In the program halls there own peoples were listening to them, most of the people don't know what is going in the next programme hall. Some popular social activists had covered all the crowd. Various programme which I wanted to go could not start due to lack of peoples. in the last which I felt

that lack of togetherness in all the groups. we are living in the society, directly or indirectly we are fighting from the globalize forces, our enemy is same then why we are fighting separately. We should have to be together; our linkages will provide us support and will be helpful to be strengthening our movement. There was not any agenda came into existence on behalf of India social forum, that what will be the future strategy of the movement and how we have to fight in the future.

Presence of media without any coverage even in local news paper is another question in India social forum that why it did not happen. Why the media was not giving coverage, media is a strong source of democracy then why media is not being allowed to expose the social problems. This had done by media with consciousness or without consciousness?

I have to know the answer of all above questions. In a movement each and every step must be discussed for the success. Especially to the organizations who are working on the health field.

# LEARNING'S AND CONCLUTIONS

## Learning's and Conclusion

During this fellowship programme I interacted with various people's organizations, and various programmes which contributed in my experience a lot, other wise I may not be able to get all these things in a very short time. This all took place through my fellowship programme. For this I am very much indebted to Dr. Thelma Narayam, Dr.Ravi Narayan and all CHC team.

Followings are my learning during my six month's period.

Each of these have its very vast range of the topics:

- **Understanding regarding community**: - community it self is very complex thing. In this Fellowship programme I went through various experiences, which helped me to learn about the community. Community is not only the group of peoples which live together, interact with each other share their experiences and have some kind of relations. They live in different places, some peoples migrate like *Banjara* community and some prefer to be together. For the control over the society they have some rules and regulations. If these rules and regulations come in to hand of people who are not community oriented then this is the starting point of the problems from where the clashes and issues get started. Therefore as a community health activist our role is to always try to build community. Use of life skills will be helpful for problem solving and conflict resolution. We live and believe in democratic system, because it gives the freedom to put own view and critical thinking for the betterment and development of the community.

- **Community health** is a process to involve the community to take up the responsibility to providing the services for their own health. This is a pure community owned action which helps people to mobilize the community towards common action. This is the involvement of all the community members together in decision making, planning, monitoring, implementation and evaluation, without any discrimination of caste, class and gender. This is community effort to make the community take responsibility for it self.

- **Public Health** :- it is an organized community effort which not only demand for the services form the system, but also responsible for the health of community. What ever the requirements of a large

community required to live the satisfactory and standard, life with dignity comes under the public health. Therefore fulfillment of these requirement not only public health services are responsibility but also community itself to provide and to demand for over all development of the community. This is the primary responsibility of the govt. to ensure all these services to the community.

- **Community Based Rehabilitation (CBR)**:- during my first placement in the community based rehabilitation forum (CBRF) I got an opportunity to learn about the community Based Rehabilitation. It is the process to sensitize community for the persons with disabilities their requirements, needs, to stop discrimination, to spread solidarity and the integration of persons with disabilities in the community and the family itself. As a health point of view we can say that for the development of the society and community health it much more necessary the involvement of every person of community in each and every process of community initiation. It the process of maximum utilization of available resources. Which help to plan every thing in a holistic manner for the development of the community.

The Persons with Disability (equal opportunity and protection of rights and full participation) Act 1995 is a milestone in the field of disability. This is the first Act, talks about the rights and entitlements of persons with disabilities and provides the opportunity to them to participate in the community with their full potential and abilities. Persons With Disability Act 1995, was one of my area of interest in the Community Based Rehabilitation Forum, which helped me to learn about the rights based approach of persons with disabilities. Through the study on the disability I came to know the reality of PWDs all over India. For the development of persons with disabilities CBR Forum is a platform to provide financial and technical assistance to the organizations who are working for the development, upliftment, and integration of PWDs in rural areas, such as Centre for Overall Development (C.O.D.) a NGO in Thamrassery panchayat Kozikod Distt. Kerala. Providing financial assistance to PWDs to perform this activity organization is running a fan manufacturing unit. In this unit 12 workers out of 30 are PWDs. This organization is going to integrate the rights of PWDs in their other projects.

Understanding about the rural community and village health workers training have taught me various lessons, that how members of the community could be dedicated toward their work. In consequence I want to share one of my experiences;

During my field placement in the JSS, one day on field visit 80 km away from the main centre Ganiyari and 100 km away from Bilaspur, a woman was suffering from severe anemia. She was living in a small hut of 10 ft*10ft. Her blood test showed only three gm hemoglobin was in blood. Earlier two children have died and this time too her child has died during the birth. When health worker went her home and requested her to come with us for the treatment, she did not agree, as she cant go out with out any known person and permission of her husband. Then the team member of JSS requested other women to come with her. Then she agreed and came to Ganiyari main hospital. In Ganiyari another trouble was that we were not getting anyone to donate her blood. The same blood group was also not available in the hospital. Then two persons including me donated blood to save her life.

That she was not agreeing to come from the village has many reasons like her family was very poor, a women cant go out with out the permission of her husband, distance of health centre from the village, public transport is not available up to 25 km from the village. And after 25 km only few transports are available. Beside this cultural and traditional factors also effect on the health of people. Lack of food is also one of the major reasons for malnourishment of the woman. People have to migrate for their livelihood. All these factors are the determinants of health that worsen the life of the community.

If our village health team did not reach the woman, she could have died.

**Other learning's were about the importance of the following:**

- Understanding about Social and Health Movement.
- Rural health conditions in the villages.
- Execution of the village health programmes.
- Health training of the health workers.
- Local customs and traditions.
- Community health system.
- Public health services.
- Appropriate technologies.
- Food habits of the in the rural areas.
- House hold information of the villages.
- Economical conditions of the villages, especially about the tribal areas.
- Education level in the rural areas.
- Concept of phulwari.
- Malnutrition and public health.

# ANNEXURE

JUNED KAMAL
Community Health Fellow,
Community Health Cell, (CHC) Bangalore.

Agency - **Jan Swasthya Sahyog** (JSS)
Duration - November, 2006 to February, 2007.

Week 1& 2 - Orientation of the Jan Swasthya Sahyog, and its activities

Observation of different aspect of JSS work.

- Patient care — Out Patient, In Patient
- Laboratory
- Appropriate Technology
- Out Reach Work — Village Clinic, Health Work
- Community Health Section

Week 3 & 6th - Project on epidemiology and control of Scabies
Objectives
Methodology
Primary Steps
Health Education
Treatment / Management
Follow up
Documentation

Week 7th - Presentation of findings of the project.

## EPIDEMIOLOGY & CONTROL OF SCABIES

Objectives:-

1 To study the epidemiology of scabies in a community, related specially to the following –

- Age
- Sex
- Occupation
- Income Level
- Awareness / level of Hygiene and sanitation.
- Educational level
- Family Size
- Community Group

2 To plan, design, and conduct a health education campaign on scabies, cause, spread, treatment, and prevention.

3 To control scabies in the community.

Methodology

1 Identify one or two villages with a high prevalence of scabies. ( Total population approximately 1000 – 1500 )
2 Design a proforma for a house to house survey of the disease.
3 Read available literature on the Scabies and be well acquainted with facts of the disease.
4 Conduct a survey for the disease to determine the above epidemiological features incidence and prevalence.
5 Plan design and conduct a health education campaign on the scabies:-
   - Preparation of health education material in the local language.
   - Health education sessions at individual, family, and community level, on cause treatment and prevention of the disease.
   - Awareness level before and after health education.
6 Control of scabies in the community – mass treatment campaign followed by a rapid assessment of control methods.
7 Prepare a report on the survey and the control measures.
8 Presentation of the report.

Preliminary Steps :

1 Procure medicines to treat scabies – GBH lotion, gentian violet solution, cotrimoxazole tablets.
2 Read available literature on Scabies.
   - Notes on Hindi and English,
   - Text book of preventive and social medicine (PSM) Park.
   - Where there is a No-Doctor.
3 Design a proforma for use in survey.
4 Design health education material on scabies.

# CBR Forum's view of CBR

## Basic Principles of a CBR Programme

1. Enabling services at the home settings of Persons with Disabilities (see Annexure A for details).
2. Capacity building of local human resources, especially PWDs to provide services.
3. Delivery of optimum quality of services which will build on the traditional good practices of rehabilitation.
4. Ensure that the community who benefits from such services gradually takes over the responsibility of managing rehabilitation programmes.
5. Ensure participation and involvement of Persons with Disabilities in Planning, Monitoring and Managing the programmes.
6. CBR programmes must be flexible so that they can operate at the local level and within the context of local conditions.
7. Local resources should be tapped to the maximum.
8. Ensure that the rights of PWDs are not denied.

## Essential Components of a CBR Programme

1. The programme should **cover all types of Persons with Disabilities of age groups** who need rehabilitation services (see Annexure 2 for details).

2. The programme should have a **multi-sectoral approach** having health, education, economic programmes and social integration interventions.

3. The programme should have access to or generate a **good and effective referral system**.

4. The programmes should aim at **full integration of the Person with Disabilities** into his / her community.

5. The programme needs to have **committed and well trained community members as service providers**.

6. The programme should have **gender and disability focus and balance**. (Special attention to care for needs of women and girls.)

7. The programme should **strike a balance between provision of service delivery and empowering the person with disability, family and community** through regular transfer of skills.

8. The programme should **ensure that the rights of the Persons with Disabilities are not denied** through advocacy at local, state and national level.

# Rehabilitating a PWD in a holistic manner

**Two dimensions: society and the individual:**

When planning out the rehabilitation of a PWD in the above context it is important to look at the situation in a holistic manner.

In drawing up an Individual Rehabilitation Plan, it is important to ensure that:
(a) the social dimension is looked into to enable the PWD to function effectively in society and
(b) all the areas of growth of the individual PWD (and all his / her needs) are attended to.

It is with the above in mind that adequate interventions have to be planned both at the societal and individual level. For instance, while the community is made aware of the need for prevention through inoculation, the staff of the local PHC have to be available to ensure that the inoculations can be administered. Again, while the individual PWDs need for mobility through provision of aids and appliances (crutches, calipers, walkers, wheel chairs) has to be cared for, the need for society to ensure that there is accessibility through provision of good roads, ramps, railings etc. has to be looked into.

**Holistic rehabilitation through all six areas of growth :**

When planning interventions we also have to bear in mind that we have to give attention to the needs in the following six areas of growth:
(1) Physical
(2) Psycho-sexual
(3) Intellectual
(4) Socio-cultural
(5) Economic
(6) Spiritual

It is to be noted that holistic rehabilitation will be a reality only when needs in all these areas of growth are cared for.

**Listing of needs under all six areas of growth :**

Against each of these areas of growth, the societal needs that have to be cared for have been highlighted and individual needs have been listed. It is to be noted that this listing of societal needs / individual needs is not an exhaustive one but a pointer of the methodology to be followed. The individual's need will be realized fully only if the societal dimension is fulfilled. They are two sides of the same coin.

For instance under the area of *Physical Growth*, the *societal needs* to be cared for are:
(I) Appropriate Health services and Accessibility in family and society.

while the *individual needs* listed are:
(1.1) Prevention of disabilities and secondary complications and
(1.2) Physical assessment, intervention and mobility.

**Listing of CBR interventions under all six areas of growth :**

Specific interventions have then been suggested to realize each need at both the individual and societal levels. For instance the interventions listed under the societal dimension:
*(I) Health services and Accessibility in family and society* are:

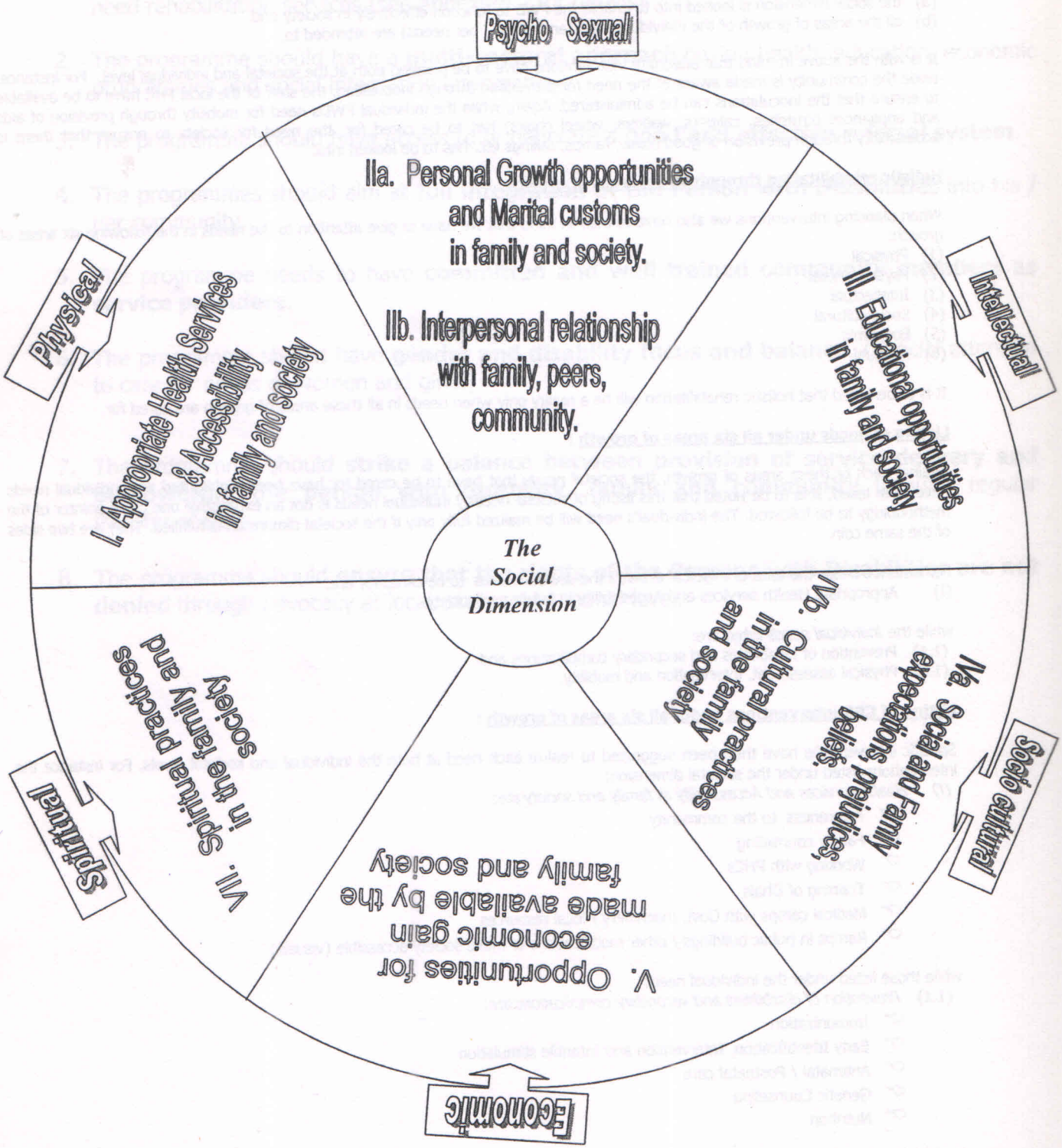
- Awareness to the community
- Family counseling
- Working with PHCs
- Training of Dhais
- Medical camps with Govt. machinery / local resources
- Ramps in public buildings / other modifications to make society accessible (visuals)

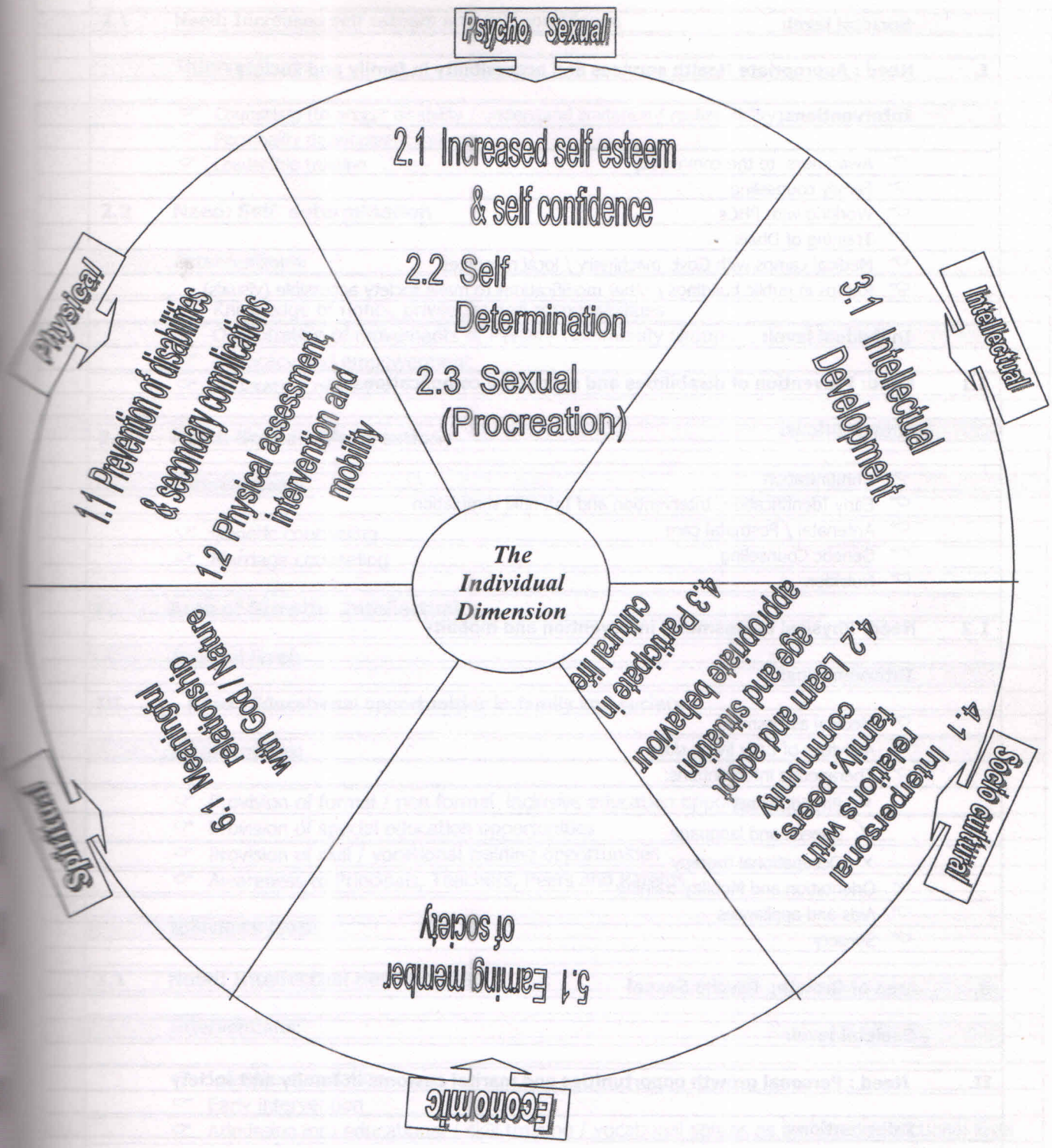
while those listed under the individual need:
(1.1) *Prevention of disabilities and secondary complications* are:

- Immunization
- Early Identification, Intervention and Infantile stimulation
- Antenatal / Postnatal care
- Genetic Counseling
- Nutrition

It will have to be borne in mind that the above interventions will have to be CBR in nature. This would imply an implicit planning as to how the PWDs, their family members and the community could be involved in each of the above interventions.

# *The Social Model of Rehabilitation*




Psycho Sexual
2.1 Increased self esteem & self confidence
2.2 Self Determination
2.3 Sexual (Procreation)
Intellectual
3.1 Intellectual Development
Socio cultural
4.1 Interpersonal relations with family, peers, community
4.2 Learn and adopt age and situation appropriate behaviour
4.3 Participate in cultural life
Economic
5.1 Earning member of society
Spiritual
6.1 Meaningful relationship with God / Nature
Physical
1.1 Prevention of disabilities & secondary complications
1.2 Physical assessment, intervention and mobility
The Individual Dimension

| Areas of growth, needs and interventions |
|---|
| **A. Area of Growth: Physical** |
| **Societal level:** |
| **I. Need : Appropriate Health services and accessibility in family and society** |
| **Interventions:** |
| ☞ Awareness to the community |
| ☞ Family counseling |
| ☞ Working with PHCs |
| ☞ Training of Dhais |
| ☞ Medical camps with Govt. machinery / local resources |
| ☞ Ramps in public buildings / other modifications to make society accessible (visuals) |
| **Individual level:** |
| **1.1 Need: Prevention of disabilities and secondary complications** |
| **Interventions:** |
| ☞ Immunization |
| ☞ Early Identification, Intervention and Infantile stimulation |
| ☞ Antenatal / Postnatal care |
| ☞ Genetic Counseling |
| ☞ Nutrition |
| **1.2 Need: Physical assessment, intervention and mobility** |
| **Interventions:** |
| ☞ Medical assessment |
| ☞ Activities of daily living skills |
| ☞ Therapeutic interventions: |
| ✓ Physiotherapy |
| ✓ Speech and language |
| ✓ Occupational therapy |
| ☞ Orientation and Mobility training |
| ☞ Aids and appliances |
| ☞ Surgery |
| **B. Area of Growth: Psycho Sexual** |
| **Societal level:** |
| **II. Need : Personal growth opportunities and marital customs in family and society** |
| **Interventions:** |
| ☞ Creating local resources (counseling cells / training sessions) to care for the growth of individuals |
| ☞ Pro active action by Government agencies |
| ☞ Family counseling |
| ☞ Training school teachers / leaders / local doctors to impart sex education |

| | |
|---|---|
| | **Individual level:** |
| **2.1** | **Need: Increased self esteem and self confidence** |
| | **Interventions:** |
| | ☞ Counseling (to accept disability / understand limitation / realize ability) |
| | ☞ Personality development training |
| | ☞ Leadership training |
| **2.2** | **Need: Self determination** |
| | **Interventions:** |
| | ☞ Knowledge of rights, privileges and responsibilities |
| | ☞ Organization of movements of PWDs / Community Groups |
| | ☞ Advocacy and empowerment |
| | ☞ Federation of PWDs |
| **2.3** | **Need: Sexual (Procreation)** |
| | **Interventions:** |
| | ☞ Genetic counseling |
| | ☞ Marriage counseling |
| **C.** | **Area of Growth: Intellectual** |
| | **Societal level:** |
| **III.** | **Need : Educational opportunities in family and society** |
| | **Interventions:** |
| | ☞ Provision of formal / non formal inclusive education opportunities |
| | ☞ Provision of special education opportunities |
| | ☞ Provision of skill / vocational training opportunities |
| | ☞ Awareness to Principals, Teachers, Peers and Parents |
| | **Individual level:** |
| **3.1** | **Need: Intellectual development** |
| | **Interventions:** |
| | ☞ Infantile stimulation |
| | ☞ Early intervention |
| | ☞ Admission into educational / skill training / vocational setups as per need / functional level |

**D. Area of Growth: Socio cultural**

**Societal level:**

**IVa. Need : Social and family expectations, prejudices, beliefs**

**Interventions:**

- Awareness to community / family on superstitious beliefs / myths.
- Awareness to community on disabilities, modes of communication with PWDs etc.
- Attitudinal change of the family / community

**IVb. Need : Cultural practices in the family and society**

**Interventions:**

- Provision of opportunities for PWDs to take an active part in cultural events
- Sensitize local cultural troupes to train and include PWDs in cultural performances

**Individual level:**

**4.1 Need: Interpersonal relationship with family, peers, community.**

**Interventions:**

- Develop communication skills
- Promote play activity
- Creation of recreation clubs

**4.2 Need: Learn and adopt age and situation appropriate behaviour**

**Interventions:**

- Counseling and guidance
- Behaviour modification

**4.3 Need: Participate in the cultural life of the community**

**Interventions:**

- PWDs attend and take an active part in cultural functions

**E. Area of Growth: Economic**

**Societal level:**

**V. Need : Opportunities for economic gain made available by family and community**

**Interventions:**

- Opportunities for vocational training / skill training
- Income Generation Programmes
- Availability of local resources / Government schemes
- Disability friendly policies of financial institutions / Government

| | |
|---|---|
| | **Individual level:** |
| **5.1** | **Need: Earning member of society** |
| | **Interventions:** |
| | ☞ Pre vocational training |
| | ☞ Vocational / skill training |
| | ☞ Habit of savings |
| | ☞ Mobilize local resources / Government schemes |
| | ☞ Networking with financial institutions |
| | ☞ Income Generation Programmes |
| | ☞ Placement / Self Employment |
| **F.** | **Area of Growth: Spiritual** |
| | **Societal level:** |
| **VI.** | **Need : Spiritual practices in the family and society** |
| | **Interventions:** |
| | ☞ Opportunities for religious education |
| | ☞ Accessibility to places of worship |
| | ☞ Create opportunity to participate in religious rites / practices |
| | ☞ Counseling, if needed (not to blame God for disability / not a punishment of previous life) |
| | **Individual level:** |
| **7.1** | **Need: Meaningful relationship with God / Nature** |
| | **Interventions:** |
| | ☞ Take steps to obtain religious education |
| | ☞ Join family / community in places of worship |
| | ☞ Participate in religious rites / practices |
| | ☞ Conseling, if needed. |

# Drawing up a Rehabilitation Plan

Partner's have been invited to use the above input on holistic rehabilitation to draw up plans for the rehabilitation of PWDs.

**(A) Status before intervention:**

| Status: Needs before intervention | Interventions made | Process followed | Linkages established |
|---|---|---|---|
| 1.1<br>1.2 | 1.1<br>1.2 | 1.1<br>1.2 | 1.1<br>1.2 |
| | | | |

The partner organization needs to begin by determining the status of the individual PWD and the milieu in which he / she lives before intervention. In order to do this effectively the partner has to determine:

(a) the interventions made by the PWD to realize his / her needs,
(b) the interventions made by the family and the community to enable the PWD to realize his / her needs,
(c) the process in which these interventions were made and
(d) the type of linkages that were established in the process.

In order to do the above the partner will have to dialogue with the PWD, his / her family and community members.

**(B) Plan for intervention:**

| Plan: Needs at time of intervention | Planned interventions | Foreseen process | Desirable Linkages |
|---|---|---|---|
| 1.1<br>1.2 | 1.1<br>1.2 | 1.1<br>1.2 | 1.1<br>1.2 |
| | | | |

After obtaining a clear picture of the status of the family, the society and the individual PWD before intervention, the partner organization has to take steps to draw up an effective intervention plan. This plan necessarily has to build up on what has already been done earlier. Here too the PWD, his / her family and community members have necessarily to be involved if we speak of a true CBR intervention.

Here the partner needs to determine:

(a) the needs of the PWD at the time of intervention,
(b) the needs to be cared for by the community to enable the PWD to realize his / her needs
(c) the type of intervention required to answer these needs,
(d) the process to be used for each specific intervention so as to ensure that the intervention is CBR in nature and
(e) the linkages that need to be established to ensure greater efficacy and sustainability.

**(C) Actual intervention, Impact and Future plan:**

| Foreseen Needs at time of intervention | Actual Interventions made | Process followed | Linkages established | Impact | Future course of action |
|---|---|---|---|---|---|
| 1.1<br>1.2 | 1.1<br>1.2 | 1.1<br>1.2 | 1.1<br>1.2 | 1.1<br>1.2 | 1.1<br>1.2 |
| **Other Needs perceived at time of monitoring** | **Planned interventions** | **Foreseen process** | **Desirable Linkages** | | |
| 1.3<br>1.4 | 1.3<br>1.4 | 1.3<br>1.4 | 1.3<br>1.4 | | |
| | | | | | |

Having drawn up the rehabilitation plan the partner organization will have to ensure that the plan is monitored at least every six months. The PWD, his / her family and the community will have to be involved in the monitoring process.

The monitoring groups will have to determine:

(a) which of the needs of the PWD the partner organization has attempted to answer,
(b) the type of intervention made to answer these needs,
(c) if the process used for each specific intervention was CBR in nature,
(d) what linkages were established to ensure greater efficacy and sustainability,
(e) the impact of each and every intervention in the life of the PWD (Eg.: if aids and appliances were give, how has this brought about a change in his / her way of life?) and
(f) the future course of action to be taken, if any.

Understandably, the PWD may have become aware of other needs along the way. Hence, here the monitoring team has to determine:
Here the partner needs to determine:

(a) the new needs of the PWD at the time of monitoring,
(b) the new needs to be cared for by the community to enable the PWD to realize his / her needs
(c) the type of intervention required to answer these needs,
(d) the process to be used for each specific intervention so as to ensure that the intervention is CBR in nature and
(e) the linkages that need to be established to ensure greater efficacy and sustainability.

**(D) Learning:**

Having gone through the above process the partner organization, PWDs, their family members and the community will have to document the lessons they have learnt. This process of documentation will help the PWDs, families and community become aware of their own potentials and capacity to take forward the programme. It will also be a learning tool for others to emulate.

## Annexure A

## Basic Principles of a CBR Programme

### 1. Enabling services at the home settings of Persons with Disabilities

IBR has its limitations in terms of coverage, high costs and location mostly in urban areas to meet the need of Persons with Disabilities who mostly live in rural areas. Enabling services at the home settings of Persons with Disabilities would have the following **advantages**:

a. **Services can reach a maximum number of Persons with Disabilities** of all ages, all types of disabilities (physical, sensory and mental) and both sexes. The Persons with Disabilities are taken care of **in their own community and familiar surroundings** without being segregated in an institution where their interactions are mainly limited with others having the same disability.

b. **Interventions are provided by family members and the community with external professional guidance.** Family integration and integration with a non-disabled peer group and community will enhance a smooth social integration without many of the emotional or behavioural problems.

c. **It provides a wide range of opportunities for the Persons with Disabilities for full participation and equalization of opportunity.**

d. The Persons with Disabilities are also exposed to the day-to-day risks. This **equips them with confidence and teaches them skills to overcome problems** and achieve their rehabilitation with maximum self help.

e. **The integration process** right from the early stages helps to **achieve the rehabilitation of Persons with Disabilities.**

f. **It gives an opportunity to the community to develop awareness** about (a) the developmental needs of Persons with Disabilities, (b) the skills they need to acquire, and (c) knowledge about integration itself.

### 2. Capacity building of local human resources, especially PWDs to provide services.

One of the principles of CBR is to **demystify the technical skills of professionals and train community members** so that the needs of persons with disability can be met in their own communities to a great extent. Moreover, the **chances that the programmes will sustain are greater**, since the trained community members are more often than not likely to live there without migrating.

The need to train community members to provide interventions to Persons with Disabilities from the community arose due to the following **reasons**:

a. *The **dearth of qualified rehabilitation professionals** in our country.*

b. *The few who are trained are mostly urban based or go overseas for better career prospects and **more often than not would not like to live and work in rural areas.***

c. *Most Persons with Disabilities **cannot afford** to meet the cost of professional interventions due to their economic conditions.*

**3. Delivery of optimum quality of services which will build on the traditional good practices of rehabilitation.**

One of the principles of CBR is to **make the interventions cost-effective without compromising on quality**. Care should be taken to **build on the traditional good practices of rehabilitation keeping in mind the customs and beliefs of the target community**. Bear in mind that only those customs and beliefs that are good for rehabilitation have to be picked up and applied to make rehabilitation effective and acceptable:

a. In the area of pre, post and ante-natal care the traditional birth attendants could be trained which would help in prevention of disabilities.

b. The traditional diet of the target community can be studied and built upon to make the diet more nutritious in order to prevent disabilities caused due to malnutrition.

c. Some herbal medicines and other forms of treatment that are practiced in the community can be studied and if proved to be effective in improving the physical condition or in the prevention of disabilities can be promoted.

d. Aids and appliances can be used making use of locally available material, which would perhaps be more suitable for the conditions in the community.

e. Tri-wheelers, trolleys and other play material that are made for children who are not disabled can also be used effectively for children with disabilities. This not only helps in early stimulation and play therapy but also helps in social integration with peers.

**4. Ensure that the community who benefits from such services gradually takes over the responsibility of managing rehabilitation programmes.**

4.1 In order to achieve this, **the local community should, from the beginning be involved in planning and service delivery to Persons with Disabilities**. The community should **recognize the needs** of the Persons with Disabilities and **appreciate their potential** for becoming contributing members if the required opportunities are extended to them.

4.2 **Mainstreaming of all activities** should occur so that the responsibility for Persons with Disabilities becomes a part of the community's responsibility for its members regardless of disability.

4.3 Stress should be laid on **equal opportunities** for Persons with Disabilities and non-disabled persons, **depending on their aptitude, merit and training**.

4.4 When the community learns to take care of its Persons with Disabilities, it **enhances its own potential for being a better community**.

**5. Ensure participation and involvement of Persons with Disabilities in Planning, Monitoring and Managing the programmes.**

5.1. It should be made clear to **Persons with Disabilities** that they are being regarded both as **recipients** of service as well as **contributors** to community welfare.

5.2. In order to give significance to the involvement of Persons with Disabilities, they must have **distinct decision making roles.**

5.3. Persons with Disabilities must be **encouraged to do maximum** for themselves as well as other Persons with Disabilities and their families. In fact, where disability is concerned they should play a **leadership role**.

**6. CBR programmes must be flexible so that they can operate at the local level and within the context of local conditions.**

6.1. There **should not be only one model of CBR** because different social and economic contexts and different needs of individual communities will require different solutions.

6.2. **Flexible local programmes** will ensure community involvement and result in a variety of programme models, which are **appropriate for different places**.

**7. Local resources should be tapped to the maximum.**

7.1 There should be **integration, coordination and convergence of all locally available resources.**

7.2 **Specialized services** or agencies extending services should play only a **supplementary role** in the service delivery mechanism and **only when such services are not available locally.**

**8. Ensure that the rights of PWDs are not denied.**

8.1 Various groups of PWDs should join together as a network so as to ensure that they have a common voice to demand for the rights due to them through advocacy at the local, state and national level.

## Annexure B

### Essential Components of a CBR Programme

1. **The programme should cover all types of Persons with Disabilities of age groups who need rehabilitation services.**

☞ **Providing assistance for people with all types of disabilities** (physical, sensory, and mental), for people of all ages, including older people and for people affected by Leprosy should be the focus of the CBR programmes.

2. **The programme should have a multi-sectoral approach having health, education, economic programmes and social integration interventions.**

☞ **Creation of a positive attitude towards people with disabilities:** this component of a CBR programme is essential to ensure equalization of opportunities for people with disabilities within their own community. Positive attitudes among community members can be created by involving them in the process of programme design and implementation, and by transferring knowledge about disability issues to community members.

☞ **Provision of functional rehabilitation services:** often people with disabilities require assistance to overcome or minimize the effects of their functional limitations (disabilities). In communities where professional services are not accessible or available, CBR workers should be trained to provide primary rehabilitation therapy in the areas of rehabilitation such as Medical services, Eye care services, Hearing services, Physiotherapy, Occupational therapy, Orientation and mobility training, Speech therapy, Psychological counseling, Orthotics and prosthetics, Other devices.

☞ **Provision of education and training opportunities:** people with disabilities must have equal access to educational opportunities and to training that will enable them to make the best use of the opportunities that occur in their lives. In communities where professional services are not accessible or available, CBR workers should be trained to provide basic levels of service in the following areas:

(a) Early childhood intervention and referral, especially to medical rehabilitation services.
(b) Education in regular schools.
(c) Non-formal education where regular schooling is not available.
(d) Special education in regular or special schools.
(e) Sign language training.
(f) Braille training.
(g) Training in daily living skills.

☞ **Creation of micro and macro income-generation opportunities**: people with disabilities need access to micro and macro income-generation activities, including obtaining financial credit through existing systems, wherever possible. In slums and rural areas, income-generation activities should focus on locally appropriate vocational skills. Training in these skills is best conducted by community members who, with minimal assistance can easily transfer their skills and knowledge to people with disabilities.

☞ **Provision of care facilities:** often, people with severe and profound disabilities are in need of assistance. When they have no families or their families are incapable of caring for them, in order for them to survive, long-term care facilities must be provided in the community where they can get the assistance that they need. Moreover, day-care facilities may be needed to provide respite for families who either work or need time off for other activities.

☞ **Prevention of the causes of disabilities:** many types of disability can be prevented by relatively simple measures. Proper nutrition is one of the more significant ways of preventing disabilities. Another important area of disability prevention is the detection of disability in young children and intervention early in their development, to minimize the effect of impairment. There are many other areas of disability prevention that are also important. These include activities to decrease the number of accidents in the home, on the road and at work, as well as other initiatives to encourage people to pursue healthy lifestyles over the course of their lives. The emphasis on prevention of disability will not only reduce the incidence of disability, but will also reduce the intensity of the handicapping effect of disability. This will ensure that available resources can be better utilized for providing services to the existing population with disabilities.

☞ **Management, monitoring and evaluation:** the effectiveness and efficiency of all CBR programme components, both in the community and in the area of service delivery outside the community depend on effective management practices. The impact of programme activities must be measured on a regular basis. People must be trained in effective management practices. Data must be collected, reviewed and evaluated to ensure that programme objectives are met. In this way, the success or failure of a CBR programme can be honestly measured.

**3. The programme should have access to or generate a good and effective referral system.**

☞ The community will have to identify and establish linkages with the existing systems like:

- ✓ Health System
- ✓ Education System
- ✓ Local Government
- ✓ Financial Institutions
- ✓ Training Centres
- ✓ Business Houses and Industries
- ✓ Service Clubs and Organizations
- ✓ Local Markets
- ✓ Skilled Workers etc.

This would enable them to access their services to improve the quality of life of persons with disability.

**4. The programmes should aim at full integration of the Person with Disabilities into his / her community.**

☞ The CBR programme should aim at identifying the potentials and needs of Person with Disabilities and providin0g appropriate interventions to optimize these, so that the Person with Disabilities can **live a life of dignity and respect to the fullest of his / her abilities**, integrated into all spheres of life within the limitations of his / her disability.

**5. The programme needs to have committed and well trained community members as service providers.**

☞ Working with parents and families in CBR is a must. To a large extent, parents / families can make our efforts successful. It is not realistic to say that we will train the entire community. All community members are not likely to be willing. Therefore it is essential to **identify those members of the community who are committed and willing to give time for the programme on a regular basis and train them systematically over a year or two**, so that they can at least carry out the role of a CBR worker. If an external organisation is implementing CBR programmes in a particular target area, it is always advisable to employ as staff people from the same target area. **This would not only make the programme more effective and acceptable but would also in the long-term help in sustaining the programmes.**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COMMUNITY
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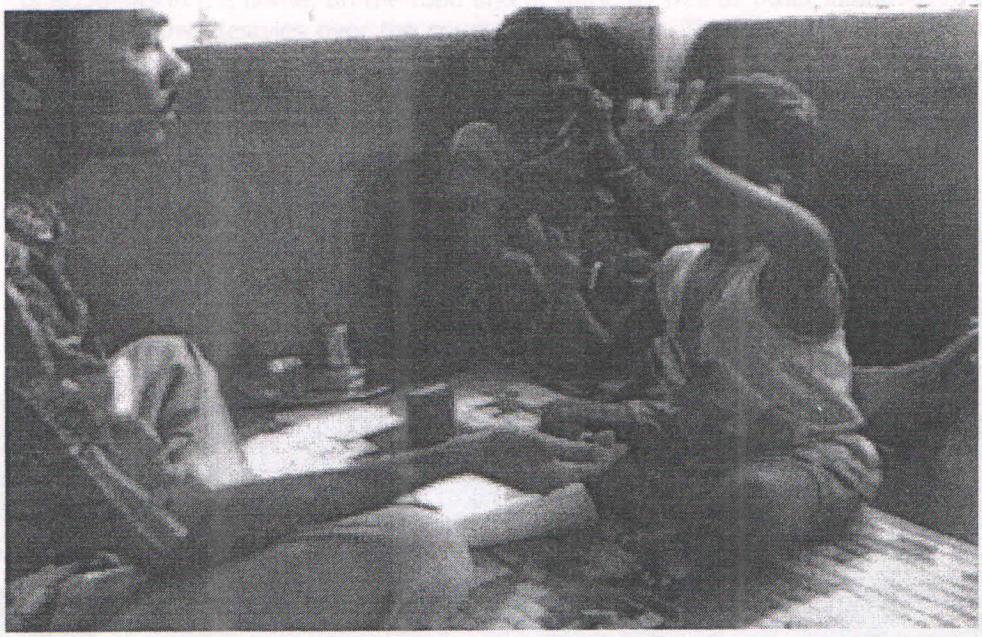
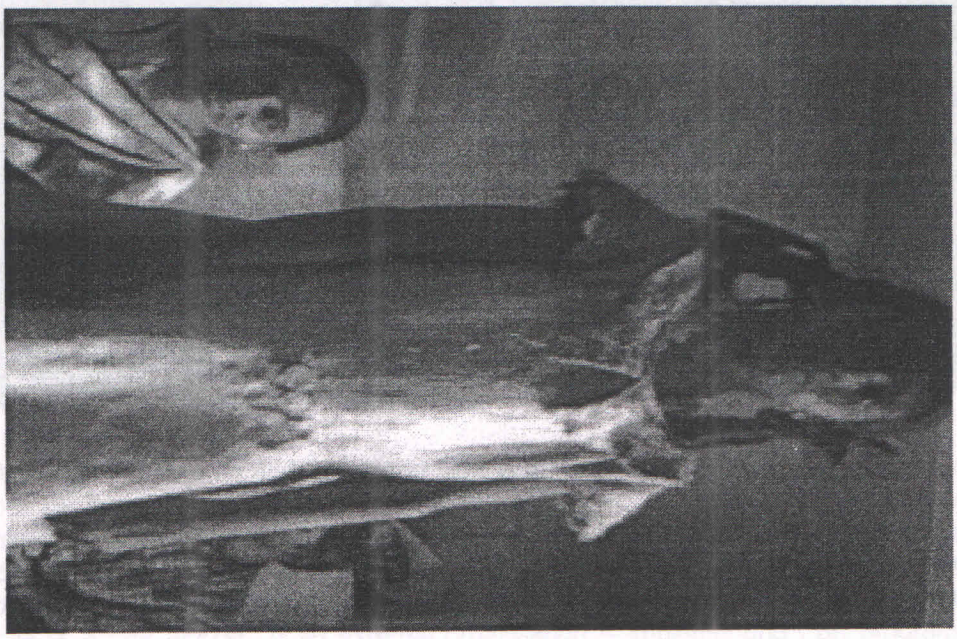
CBR intervention with a Hearing Impairment Child Annexure ……..

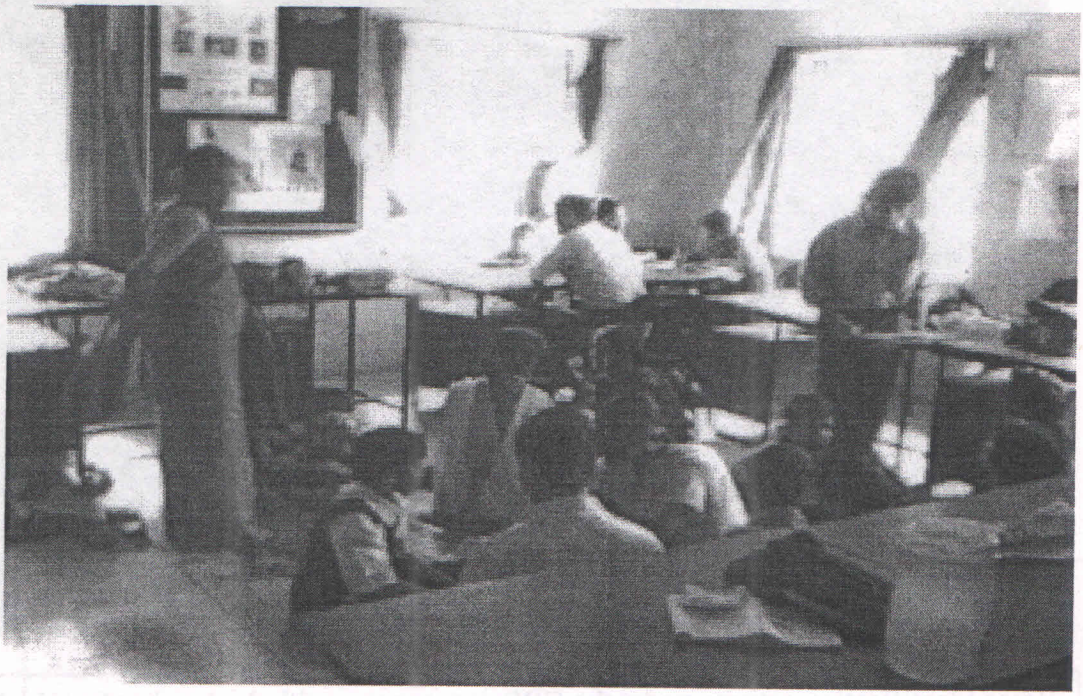
1



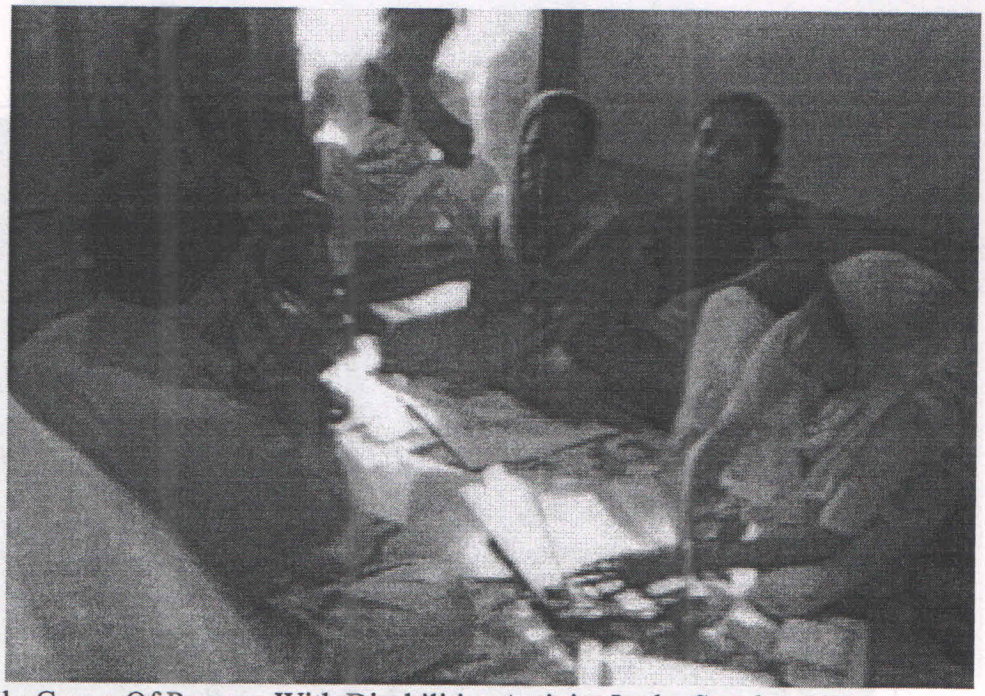
CBR intervention with a Hearing Impairment Child. Annexure ……..



CBR intervention with a Cebral Palsy Girl Annexure……..

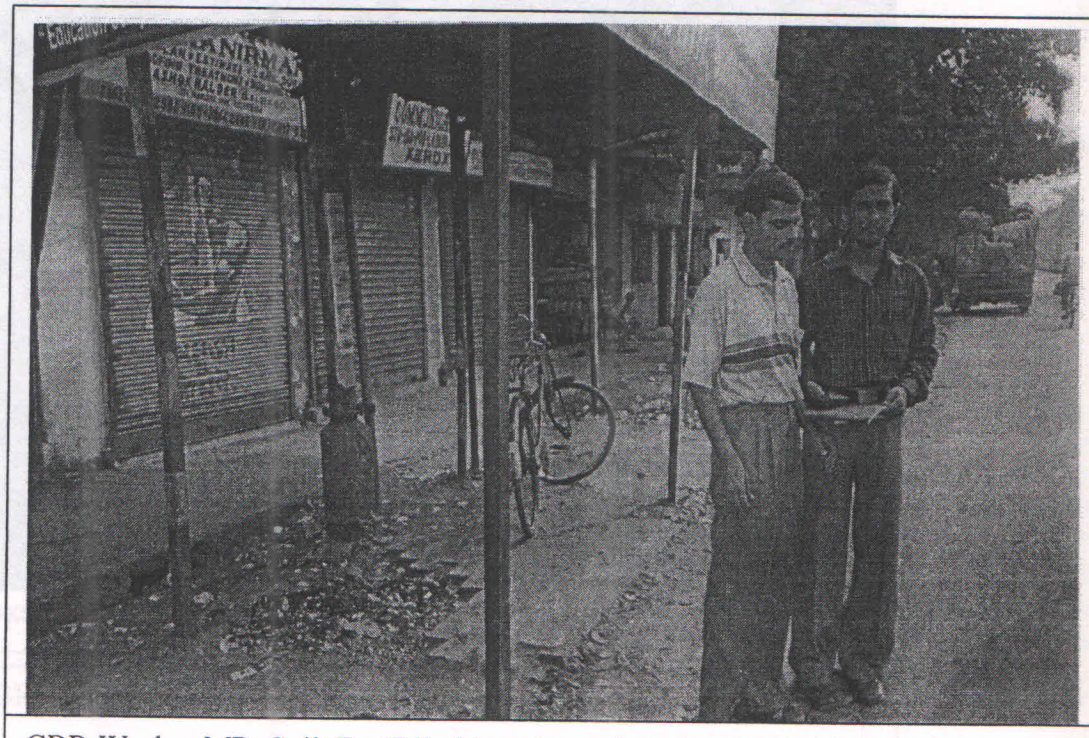


Open Day Activity In the Sanchar Annexure no.....



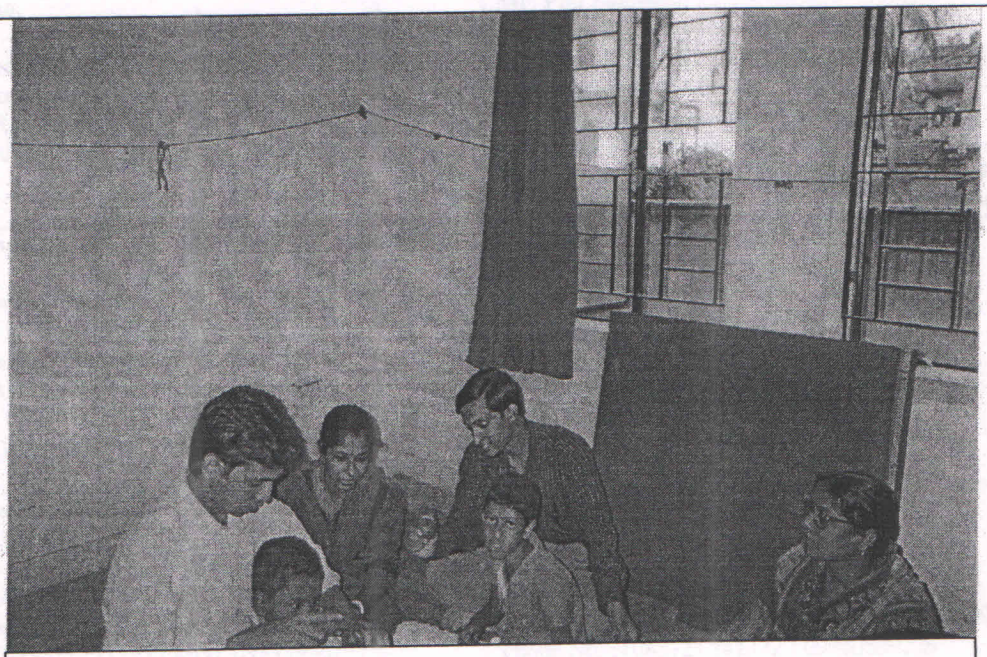
Self Help Group Of Persons With Disabilities Activity In the Sanchar Annexure no.....

Voice identification activity under the CBR programme, with the hearing Impaired Child Anoop Das with his mother
Annexure Photo - 4.5.3.4



CBR Worker MR. Sujit Da (Blind impairment) during the field visit

UP - CBR intervention with C.P. Child **Sunny Mondal** s/o Chandan Mondal regarding Daily Living Activities
Annexure …Photo…4.5.3.1



Annexure 4.5.3.5
**Harit Rupam Shah**, Autistic child with the mail CBR worker and his parents.

# LIST OF ACTIVE PARTNERS OF CBR FORUM

| *Andhra Pradesh:* | |
|---|---|
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अस्पताल
एवं
सामुदायिक स्वास्थ्य सुविधाएं
गनियारी- जिला- बिलासपुर
ओ.पी.डी. खुलने का समय
तीन दिन खुलेगा।
सोमवार
बुधवार
शुक्रवार

## Advocacy in CBR of Persons with Disabilities

This paper has three sections. The first section is on 'advocacy', second on CBR of persons with disabilities and the third is on portions of the Persons with Disabilities Act and ways to advocate for the rights of persons with disabilities.

### Section 1 – What is advocacy?

Advocacy is finding of public, legal space in which to systematically organize an action, spread awareness on public policy, lobby with and influence leaders and opinion makers. The actions could be an attempt to

a) Shape public policy to advance social justice and human rights
b) Focus on inadequacy or discrimination in public policy or legislations
c) Enforce implementation of rights given by a policy or legislation

The public policies taken up for advocacy are often a specific issue, as for example, women's issue, rights of children, education and rights of persons with disabilities.

### Advocacy involves

- Resisting discrimination against a disadvantage group
- Supporting and empowering the disadvantaged groups to ensure that larger leel policies percolate to reality at the local and individual level
- Accessing information and networking with other groups and individuals forming coalitions to maximize the influence
- Adopting a non-violent approach, within the public and legal framework, to achieve the objective

### Advocacy is not

- A mere combination of various tactics and strategies; and
- It is not a substitute for mobilization of the disadvantaged people and their involvement or participation

### Key elements in Advocacy

- There should be a social cause, pertaining to a class of persons, a disadvantaged or marginalized group
- It requires the affected people to come together and work in cooperation. This effort should be continuous and systematic
- It is directed towards the establishment, for example, the government, the government, the police, an authority practicing discrimination
- It is aimed to bring about changes – change in public policy, change in people's attitudes, institutional structures, in laws, rules etc.

**Benefits of Advocacy**

- It builds confidence in the people engaged in action, in their ability to bring about changes that matters to them
- It educates people on issues that affect their lives
- It takes the issues to a wider audience and helps change public policies, rules etc.
- It demands and enforces action on important issues

**Advocacy involves gathering information and key actions**

- Collect data from the field to base the arguments on facts and figures
- Get statistical information, such as the census, to know the population figures, literacy rates, male/ female ration, education, family income and so on to project a proper picture
- Scientific information, if available, from field and research reports, can be very useful to argue the case
- Personal stories can be used effectively to demonstrate what happens in practice. It can be effective as it touches people's emotions/ feelings
- The relevant laws, rules, policies and
- Reports from government and other authentic sources

**Key strategies and action**

- Spreading awareness in public and among leaders
- Media action – give information to public media
- Submit petitions, letters and memorandums to officials
- Lobbying with legislators and others, to raise the issue at a suitable forum
- Network and coalition with a wide variety of groups, organizations with whom a common working understanding can be reached
- Demonstrations, protests, dharnas, etc.
- Filing Public Interest Litigation (PIL)

Advocacy is a pro-active, planned and co-ordinated action. With practices, one should be able to anticipate events/ problems before they actually occur.

Contact and get as much support as possible from all sections for your cause. Wider, grass root support can strengthen the argument. Put forward the case in a rational manner. Do your homework. Develop credibility. Know your rights and laws.

Advocacy requires THINKING, but most of all ACTION.

**Section – 2 – CBR – Definition by WHO, UNESCO and ILO is:**

"Community based rehabilitation is a strategy within community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities".

CBR is implemented through the combined efforts of disabled people, their families and communities, and the appropriate health, education, vocational and social services.

Through creating awareness, organizing and training in the community, CBR programmes seek to empower the disabled and enhance their potential. It offers them the same opportunities to attend school, receive vocational training and develop income-generating activities, across the available social and health services, to participate and be an equal citizen in the community.

**Section – 3 – CBR, Advocacy and the legislation for rights and protection on persons with disabilities.**

**The Persons with Disabilities (Equal Opportunities, Protection of rights and Full Participation) Act** focuses on three aspects:

1. Rights of disabled persons, such as the right to education, rehabilitation measures, concessions and benefits, training in vocational skills, employment, social acceptance and equal opportunities.
2. Responsibilities of the government and the family towards the disabled persons, such as providing opportunities to disabled persons to reach his/ her full potential, through making use of opportunities provided.
3. Non-discrimination of persons with disabilities

In terms of rights of persons with disabilities, the PD Act specifies that

- Scholarships and travel concessions: The government shall provide schemes for benefits like maintenance allowance, scholarships, travel concessions etc.
- Special schools and rehabilitation services: The availability of special schools, rehabilitation and intervention services will be made available in all districts
- Support to students: Books, learning aids etc., must be supplied in order to make integrated education meaningful to the disabled child.
- Right to education: The Act lays down that "The appropriate government and local authorities shall ensure that every child with a disability has access to free education in an appropriate environment till he (or she) attains the age of eighteen years."
- The Act further provides that the government must provide schemes for part-time classes for those who could not pursue education on a whole time basis, and education through open schools etc.
- Disabled persons' right to access: The appropriate government shall prepare schemes for accessible transport facilities and removal of architectural barriers in schools, colleges and in other public places.
- Disabled people have the rights to lead an independent life: Disabled children have the right to vocational training to be able to learn a skill
- Workshop for producing and repair and maintenance of aids and appliances have to be set up, especially in rural areas.

- Survey and collecting information: The Act provides that the government and local authorities shall take measures like undertaking surveys on the causes of disability, screening children for identifying 'at-risk' cases, sponsoring and promoting awareness programmes, promoting health care through training staff at primary health care units etc.
- The Act provides for the prevention of disabilities, making the government responsible to ensure that such schemes are implemented.
- Disabled children have a right to be an active part of their community: In furtherance of this, the Act provides that the government shall endeavour to promote the integration of students with disabilities in regular schools. It also states that necessary concessions must be made in school curriculums for disabled children.

**Responsibilities of the governments towards disabled person**

- The Act specifies that the government should make plans, programmes and schemes for the welfare and betterment of life of PWDs. State level committees have been constituted to plan such programmes and schemes. Five members from NGO sector are represented in these committees
- One could ask if these committees meet regularly and ask the government to make public the decisions of these meetings, as part of right to information. One can also question when such decisions are not implemented.
- Commissioners have been appointed in all the states, whose responsibility is to ensure that plans are implemented. Their job is to ensure that violation of the rights of persons with disabilities and discriminations against them are prevented.
- NGOs can meet with the Commissioner and offer support to him/ her to ensure the above.

**Non-discrimination in the PD Act:**

- Provisions are made in the Act that no child or a person with disability is discriminated only because of his or her disability. The affected person or the NGO working in that area can bring such incidence to the notice of the State Commissioner, who should look into the complaints and take remedial action.
- The affected person, family or NGO working in that area should bring such matters to the notice of the Commissioner/ concerned authority to take action and to rectify the situation.

**The National Trust for Welfare of persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999** provides for the setting up of a Trust:

- To strengthen facilities for the care and protection of persons with the four specified disabilities
- To evolve procedure for the appointment of guardians and trustees for persons with disabilities requiring such protection.

(Please read the full Act for more details)

**Action on these accordingly, should be taken at three levels –**

- Individual and family
- Community/ society
- Governmental/ Political level

- **At Individual level**, and through NGOs, we can create awareness on the provisions and rights under the Act. We cannot remain passive and expect the government to take responsibility and act in favour of disabled people
- **At family level**. The responsibility of the parents to ensure that their child with disability is given proper care and trained in activities of daily living, so that he/ she can grow up to live an independent life
- Each one of us can put in some effort at home, school, in public and at work place in small but significant ways to help in this. For example, a school teacher can ensure that children with disability are enabled to attend class, and included in regular activities of the school and games etc.
- In rural areas where disabled persons have no special facility, where resources are limited, admitting disabled children into school itself is a big thing. By being with other children, he/she will feel encouraged and accepted. Children who are not so severely disabled should be integrated in to regular schools.
- In our work place, office, factory or institution, we can ensure that disabled people are given jobs. We can persuade our friends to do so as well.
- **At community/ society level,** creating awareness on disability is important. Giving positive image of persons with disabilities through writing slogans on walls, street plays, songs and other visual aids are also helpful.
- The PWD Act has been summarized in an easily understandable language and been translated into regional languages. NGOs can publish this widely.
- **At the government/ political level,** influencing and advocating with the planners to include project and schemes for disabled persons is an important step. At present this is not being done by many organizations. Unless there is pressure on the government, it will not act. Individuals and organizations in all the states can come together to gain enough political strength.

**Need to communicate and network**

Raising awareness is only the first step to bring about a change. However, just raising awareness will not bring about a change. The system should also be made to provide opportunities for disabled people to benefit from them. For this, we need to work at different levels. Networking among NGOs is a positive way to do this.

In Bangalore, four years ago, several NGOs working with disabled people, parents of children with disabilities, their advocates and other concerned citizens formed a coalition called 'Disability Network'. It works to raise awareness among NGOs and general public on disability issues, acts as a forum for discussion and

takes up issues with the concerned authorities regarding the provisions of the Act. Matters concerning issue of ID Cards, travel concession, school examination system, access in public places, benefits and facilities and other issues have been taken up successfully with the government through this Network.

In Andhra, Tamil Nadu and other states too similar networks have been formed. It is important that disabled people and NGOs come together to build a strong movement. There is an urgent need for advocacy and lobbying with the concerned authorities for the protection of rights, providing equal opportunities and enable full participation as provided in the two Acts. This can happen only when all concerned join together and act.

# SCABIES

Scabies is a common, highly infectious disease of the skin, caused by the scabies mite. It is mainly seen in children, but can also affect adults.

**Cause :**

A small insect called the scabies mite, which can just be seen by the naked eye. Scabies is not spread by dirty water.

**Symptoms and signs :**

1. Small swellings all over the body, but more common
   - between the fingers,
   - on the wrists,
   - around the waist,
   - in the groin,
   - on the buttocks (especially in children),
   - below the breasts.

2. Itching which is worse at night.

3. Sores with pus – due to scratching and through infected clothing.

**How is it spread ?**

It is spread through close body contact and through infected clothing.

**Treatment :**

(a) Important points to remember :

- Treat all members of the family or household at the same time.
- Ointment or lotion to be applied correctly over the whole body below the chin.

(b) Medicines for scabies :

1. **Gamma benzene hexachloride (GBH)** – 1% cream, ointment or lotion. Most effective, needs one application only. Do not use in children below one year of age and in pregnant and breast-feeding women.
2. **Benzyl benzoate** – 25% lotion – effective, but needs two applications. To be used diluted 1:3 in children below one year, and 1:1 in older children.
3. **Neem and haldi paste** – Grind neem leaves with turmeric and apply to the whole body after a bath. Repeat the applications for another two days, without bathing. A bath may be taken on the fourth day.

(c) Application of cream or lotion:

1. GBH 1% cream or lotion – After a bath in the evening, applies to the whole body below the chin, applying more on the affected areas, eg. between the fingers. Let it remain overnight for 12 to 24 hours, and then a bath may be taken.

2. Benzyl benzoate 25% lotion –

| | | |
|---|---|---|
| 1st day evening | - | Bath. |
| | - | Apply lotion to whole body below chin. |
| 2nd day | - | No bath. |
| | - | Apply lotion again as above. |
| 3rd day | - | Bathe and wear fresh clothes. |

(d) In case of infected scabies (with sores and pus), the infection should be treated first before treating the scabies.

- Give co – trimoxazole to the patient for at least five days.
- Gentian violet 0.5% solution may be applied once daily on sores.
- After sores heal, use one of the above lotions or creams.

Itching may continue for 2-3 weeks after treatment. Explain this to the patient, and give chlorpheniramine maleate tablets twice a day.

(e) Other measures:

Keep all clothes (including bedding) out in the sun for 4 to 6 hours to kill the scabies mites living in them.

**Prevention of scabies :**

| | | |
|---|---|---|
| Good personal hygiene | - | bathing daily. |
| | - | Changing clothes daily. |
| | - | Washing clothes regularly. |

April 2005.

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# Annexure

F.N. ...

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| आय | स्त्रोत |
|---|---|
| | |

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F.N. .....

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| कमांक | सदस्य कमांक | G B H का उपयोग | Frequency of use | Contect persons | Perception about GHB |
|---|---|---|---|---|---|
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हस्ताक्षर .....

दिनांक .....

# XXXIII MFC ANNUAL MEET

## Public Health Education in India: Lacunae, Challenges & the Way Ahead

**Programme**

*DAY 1 (28th Dec.)*

**Session 1**

9.30-1.30

10.30-11.00 Tea Break

**History of Public Health Education (PHE)**

(prefacing the discussion with paper highlights)

a. Public Health Education in India: A Historical Review
b. Development of PHE in Other Countries: A Comparison
c. Public Health and the NGO Sector
d. A Counter-Culture View of PH in India

Chair: Anant Phadke

Summarising the issues: Ritu Priya

1.30-2.30 LUNCH

**Session 2**

2.30-5.30

3.30-4.00 Tea Break

**Public Health Education – Institutional Experiences**

a. SIHFW
b. Primary and Paramedic Worker Training
c. Community Health Cell
d. CEHAT
e. PSM departments
f. CHAD, Vellore
g. Achyuta Menon Centre,
h. CSMCH, JNU

Chair: Veena Shatrugana

Summarising the issues: Renu Khanna

*DAY 2 (29th Dec.)*

**Session 3**

9.00-1.30

10.30-11.00 Tea Break

**Towards an MFC Perspective on PHE: Democratisation & Public Health**

a. Cross-cutting Issues of Structure, Content & Learning Methods

b. Multiple Frameworks

- PHE Needs as Seen From the Grass-roots
- Public Health Foundation India
- Reforming Medical Education & Health Service Systems
- Public Health Movement

Chair: Chinu Srinivasan

Summarizing the issues: Alpana Sagar

**12.30-1.30 Group Discussion (4 groups)**

a. Integrating the PH perspective in various disciplines
b. Content of PHE
c. Teaching/Learning Methods
d. Regulation & Monitoring of PHE

1.30-2.30 LUNCH

2.30-3.00 Group discussion contd.

**Session 4**

**The Way Ahead**

**– Strategies, Commitments**

3.00-4.00

Group Reporting in Plenary
Summary of issues: Rakhal Gaitonde

4.00-5.30

a. Gathering the Threads, and Outline of What We Feel Should be Done
b. Towards Actualising the Plan, Specifying Commitments

Facilitators: Thelma Narayan & Ritu Priya

**Please Note:**

Sharing sessions of personal reflections, dilemmas and work experience will be held post-dinner.
Annual General Body Meeting of the MFC on the 30th December, 8.30-1.00.

ANUP DAS

| Status | Targets (Oct to Dec' 06) |
|---|---|
| 1. He needs help to make a straight line by using dote ~~ferng~~. He can make 3" straight line. | 1. He would ~~make~~ able to make a straight ~~ling~~ upto 7". |
| 2. Cow, dog, motor cycle Auto picture to picture matching he can. | 2. picture to objects matching like (By cycle, |
| 3. 1, 2, 3 Numbers identifi-cation and objects cant-ing he required help for sometimes. | 3. Counting he will learn upto 10. |
| 4. He can identify his name comparioring with two name (father and him self) | 4. He will learn to write his name. |
| 5. He doesn't interest to use Hearing aids above 5 minutes. He can't give proper ~~performance~~ responce that will help is to identify that he can receive sound by this Hearing aids. | 5. ~~identification and discrimination~~ He wallld able to identify the source and quality of 3 type of sounds. ( |

03.10.06

Individual Rehabilitation Plan of Anup Das.

Ref. No -

Sunny Mondal

| Status | Targets (Oct to Dec' 06) |
|---|---|
| 1. ~~[illegible]~~ He can't speak his name clearly, And identify the name plate. | 1. He would able to identify his name plate card from the two name like father's name and himself. |
| 2. Present concentration span is upto 30 seconds. | 2. Concentration span will be develop upto 40 seconds with some activities → (i) colour within a picture (ii) told the name and its function in common objects (iii) picture to objects matching |
| 3. (a) Required complete Physical and Verbal prompt. | 3. A.D.L<br>a) He will give coconut oil on the head by using two hand. |
| b) He can take water in a mug, but put it in-forent of the body/forehead | b) He will learn to give water on the head with a mug for 5 times. |
| c) He can eat rice. He can try to mix up rice with vegitable ~~back~~ with verbal prompt. But required long time + Sometime physical support. | c) Feeding => He would learnt to mix up rice with some vegitable at the time of feeding / lunch. |
| d) Required Verbal and Sometimes for physical Support. | d) Dressing => He will learn to wear a half-pant in siting position (within 10 minutes). |

IRP Of Sunny Mondal.

Ref. No. ->.

Ashique Gazi

| Status | Target (July to Sept' 2006 |
|---|---|
| 1. He is required full physical support to maintain crawling position, and also to come in this position. He can just maintain 4/5 seconds, otherwise he try to straighting his body. | 1. Physical ⇒ He will move with bottom Suffling and also & hand support (in both side). |
| 2/a. He is required full support it was not possible to do by his & mother, alone. Therefore we have made a special bathing chain. on 22-06-06. | 2. A.D.L ⇒<br>ⓐ Bathing → He would be sit with full support he will learn (i) put 2 mugs water on his head (ii) to give full concentration & ~~this~~ and his eye-hand coordination. |
| 2/b. He needs a complete help to wear a half pant in laying position (a pillow under his head). He can put off the pant in laying position. He is not interested to use his hand | ⓑ Dressing → He will learn to ~~put~~ wear a pant for this knee joint in laying position (A pillow will be given under his head). |
| 2/c. If mother gives rice in his left hand, Sometimes he give release this muscle . time to bring rice in to his mouth. | ⓒ Feeding → When he would be hungry and mother'll give rice in to his left hand he would brought his left hand & rice towards his mouth. $\frac{3}{10}$ times. |

## Hope

When the Darkness of the light will recede
When the morning glow will flow
When the dream will come true
When the heart will beat with joy
That day shell

When no one will weep helpless
When no one will sleep hungry
When all will have roof above
When al will have content heart
When people will not die
On foot path of the cities
When the alms will not be kept
On the palm of the workers
When every laboring hand
Will enjoy right full share
That will come

When operation will not be tolerated
When the home will not be burnt down
When the blood will not be flow on the street.
When the eyes
Will not be filled with pan
That day shell come

When in the name of religion
People will not be taught hatred
When this earth will be
Sprinkled with colorful petals of love
When the rays of peace will
Light the world

That day shell come
That day shell come

Javed Akhtar