Community Health Learning Programme 2009

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A Report on the Community Health Learning Experience

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REPORT

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What led me to the fellowship:

My academic background is a BA in Development Studies which I completed in 2006. My first two years of field experience in Bangalore after college gave me the confidence that I can work with communities. Being part of a grassroots organisation (Association for Voluntary Action and Services) that fights for land and shelter rights, I saw how establishing land tenure can be a vital process of urban poverty alleviation. I learnt about the complex challenges the urban poor face and began to understand how healthcare could be one of the leading causes of debt among the urban poor. Despite this invaluable exposure, I began to feel stifled when work didn't involve looking at the systemic processes that effect populations at large. I was also unable to draw from my academic framework of development; there was no cohesion between what I studied and what I was doing.

My responsibilities soon shifted to the younger generation of the urban poor- children, adolescents and youth, and I enjoyed learning from them. While I was involved with leadership building programmes, I found there was a need for adolescent education that boldly addresses the realities of coming of age, sexual experimentation, activity and abuse, as well as the emotional vulnerabilities of young adulthood. Although this didn't happen then, in 2008 I moved on to an internship in Ethiopia which exposed me to these very themes. There I engaged with an internationally funded programme that helped build and articulate adolescent sexual-reproductive health (SRH) *rights*. This spurred my interest in SRH rights as a whole, and I was eager to explore this field further. I valued the exposure to the politics of international development, which made me appreciate the strong, vibrant civil society we have in India, and our efforts to negotiate, resist and articulate our own development.

Interestingly, this was the first time I saw the centrality of public health discourse in development work and I realised that if I was planning on becoming a "development professional" (as I imagined then) I ought to learn something about public health. So this was the beginning of my interest in SRH and my understanding of how social development and public health problems and solutions are interlinked.

When I heard about the CHLP I thought it would be an opportunity to learn about the relationship between public health and community (even while the word *community* was riddled with ambiguity). Being from a completely non-health or science related background, *if* I were selected I knew this was going to give me a foundation on how health relates to development, and that was crucial for me.

Orientation

The five week orientation period for the Community Health Learning Program 2009 was technical, pragmatic, and theoretical but above all dangerously thought-provoking. These new points of view were refreshing, disturbing, and guilt-inducing, recurrently jolting me into a state of mental and physical paralysis. Why? Because at times the scale of poverty, the complexity and depth of suffering and the dearth of visible change can be that disillusioning. In some ways I was left feeling 'what can one individual really do when the rules of the game are inherently inequitable'? Nonetheless, it built a strong frame of reference, a value system if you will, that I will hold steadfast in my future. Below I highlight the broad concepts that impacted me the most.

Health must be looked at in the context of class, gender and *caste*:

When looking at health for the marginalized and if the marginalized in India, three fundamental factors play a vital role- class, gender and caste. These three socially constructed conditions have everything to do with an individual, a group or a community's capacity to be healthy.

Often times the health of an individual suffers because of a societal structure or norm. For example a woman's nutrition is affected by her status in that society and therefore is an issue of gender inequality. Being overworked, eating last, and eating only the leftovers could be the underlying reasons why she's malnourished.

When looking at occupational health, one needs explore why some communities are more at risk than others to hazards or poor health. Why are certain communities by and large in certain professions? Who occupies the highest paying, most power yielding jobs in terms of class, gender and caste? Why and how? When being a health worker, the anatomy of a social illness can't be overlooked in order to understand the physical health of individuals and communities.

2. Awareness, Availability, Access, Affordability and Capability

The foundation that CHC establishes in understanding health involves first looking at it as "a state of complete physical, mental, and social well-being and not merely the absence of disease..."[1].

'Health as wellbeing' is a far more comprehensive framework that encourages us to look deeper into the social determinants of poor health. From what I understand health isn't achieved (broadly and immediately) because of problems of awareness (about a disease/infection/illness). If the knowledge/demand exists, it could be the sheer lack of necessary medical support or availability. If the appropriate services exist, people in need may not be able to access them for various reasons including distance. Further pricing and affordability is a huge factor in preventing access. And finally, *capability* is imperative. Capability involves cross-cutting, social factors that are not conventionally addressed. A prime example given was an unmarried or widowed woman who does not get treated for a reproductive tract infection. She knows- that there is an infection that needs medical treatment (awareness), where the services are readily provided and how to reach it (availability & access), that the treatment is free or is able pay for it (affordability) yet she still does not get

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[1] WHO definition

treated because of the social misconception that RTIs are only contracted through sexual activity. Therefore stigma and discrimination can sometimes be the primary reason people do not avail of certain medical services and suffer from poor health.

The importance of the public sector:
Looking at the private sector as, in principle, compensating for the lack of a fully functioning public sector is an insular and comfortable view for those who can afford to entirely depend on it. Merely looking at the increasing accessibility of the private sector masks the inequitable processes that make it so. However, it could very well be a chicken-egg debate. Is it because the public sector is dysfunctional that the private sector can thrive; or is the uncontrolled rise of the private sector that further enables public inefficiency? Although I felt the CHC view being somewhat binary in its view of the private sector, it was nevertheless essential to look at facts such as public spending on health, the pharmaceutical industry's profit margins, and let them speak for themselves.

An important initiation was to begin to understand why the Indian public health system doesn't meet demands - Starting with the budget allocation for health, to state responsibility of planning, to every level of implementation. The vast shortage of staff and major gaps in infrastructure emphasizes the need for intersectoral efforts if the health system is to ever get healthy. E.g. A doctor posted to a remote PHC will only be motivated to remain there if his or her basic needs such as water and sanitation, quality education for his/her children are met.

The growing solidarity of the People's Health Movement and its specific country chapters plays a key role in bringing health back to public agenda. On a national level the introduction of the National Rural Health Mission promises essentially, to put people in the centre. Never before has a government programme involved community in its planning, monitoring and evaluation. For the government to mandate this, at least in theory, is promising. Further, hearing about lessons from some pilot states for community monitoring proved that inroads are being made to strengthen the health system from within.

Ultimately, no NGO or numerous networks of NGOs or other private actors can make themselves accessible to over 500,000 villages. The government is the primary and the largest service provider. Efforts to support and improve public systems are the only sustainable option to improve the health of this country.

Globalization is really making the poor poorer:
The role of international institutions in regulating national governments cannot be emphasized enough. And it wouldn't be reductionist to say that their function is more exploitive than beneficial.

- Structural Adjustment Programs (historically) and their failures
- The stipulations of the World Trade Organization and its direct effect on farmers and other small stakeholders
- The establishment of New Institutions in governance that privatise basic amenities on the basis of efficiency but deny universal access
- International targeted/vertical funding interventions that don't improve the overall health of communities
- The monopoly of allopathy and the lobbying power of the pharmaceutical industry

These products of globalization have exacerbated not abated the problems of the poor.

Balance between theory and practice:
The CHLP helps you strengthen the application of theoretical knowledge, as well as to challenge the validity of certain kinds of knowledge through substantive exposure to ground realities. Further, engaging with communities must lead to new frameworks of understanding poverty and marginalization. Translating that experiential knowledge to bigger picture change, for me is also an important thrust of this programme. Knowing (to some degree) before doing/acting; and conversely doing to learn more should be a balanced cyclical process, which I see CHC enabling.

Group Learning

Another tremendous strength of the CHLP is the group learning sessions, when we reconvened after our various placements to share our experiences, debate and learn from each other. Our placements were diverse, learning objectives wide-ranging too, yet the information gathered through these sessions was always relevant and useful.

It was also an opportunity to express concerns, fears and support each other through a subtle or considerable paradigm shift, and negotiate new understandings.

Finally it was an enjoyable way to learn about the incredible work going on all over the country. To learn of various other inspirational people and organisations than you had a chance to see yourself, to hear of all the different approaches of bringing about 'health for all'. That certainly enabled a multifaceted understanding of community health.

CHLP 2009

Presentation of work with respect to Learning Objectives

Learning Objective	What	Where did I learn	How	What did I learn
1. Understand the strengths and weaknesses of family planning policies	What is the policymaker's mindset and the common man's understanding of family planning?	CHC THI RUWSEC MRS Palya	Reading RCH II, Population Policies Reconsidered, Beyond Numbers and other papers and news articles Exposure to- Female sterilization camp, Raichur Consultations for Copper T and tubectomy at THI MTP at RUWSEC Speaking with Dr. Balasubramaniam, Demographer & other staff at RUWSEC Rakhal & Subha Shri Participants of my independent study	Despite the articulation of a non-coercive, non-incentive based national population policy various violations of human and reproductive rights continue in the name of family planning and fertility control The south of India does not have a 'population problem' and according to the NFHS3, all states have reached national targets From the top down, economic development has an impact on reduction in fertility. More directly investment in improving healthcare and education does too. Some states like Tamil Nadu have had a strong push towards a two-child norm, with political backing Conversely, from the bottom up, economic reasons or the rising cost of living seems to promote the two-child norm among couples seen or spoken to More equitable gender relations and the 'quest for modernity' are conducive conditions for women to exercise how many children they want to have and when they want to have them. Due to poor quality family planning services in the government sector and expensive services in the private sector, in some cases family planning is unaffordable Reproductive health needs to receive greater priority in family planning programmes, family planning cannot take precedence over RH
2. Explore the social determinants of sexual reproductive health (SRH)	What are the causes of poor SRH? Awareness, access, affordability, ability? i. Adolescent SRH i. Male as Partner education (MAP)	THI RUWSEC MRS Palya	Reading Growing up in Rural Karnataka (Belaku study) Adolescent Sexual and Reproductive Health And Rights In India (CREA study) RUWSEC papers Exposure to patients with gynecological or sexual health problems and pregnant	Adolescents, especially girls have little or no access to accurate information on sex, reproduction and sexual health Unequal gender norms promote men or boys to access more information and be more aggressive with sexual experimentation Adolescent education and skills training has a definite impact on vulnerable youth- in shaping healthy attitudes and improving confidence and self worth. Some evidence shows how this impacts their decision-making in regards to their sexual-reproductive lives Pregnant women don't always have the family support for timely ANC Internal examinations are rarely practiced during ANCs in most government and private facilities, according to THI Postnatal care is absent without the presence of maternal health focused

			women at THI Abortion seeking couple at RUWSEC RUWSEC staff of adolescent and male educator programmes Participants of my independent study	voluntary efforts At RUWSEC, forced sex within marriage was leading to unwanted pregnancies and/or repeated, often unsafe abortions Women don't seek care for gynecological problems until severe, in comparison, women seek plural health systems to stay healthy during pregnancy. Despite this poor diagnoses and untimely referrals have a severe and often fatal impact on maternal and neonatal health. Women are still largely vulnerable to sexually transmitted disease, condom prevalence extremely low among married couples At RUWSEC MAP education helped better communication between partners and reduced violence. Forms of support for men eg. Help for alcohol de-addiction, in turn helped better women's lives, but inconclusive to say their SRH Accountability of the health system A great need for affordable, good quality obstetric care exists. While services are available both in the public and private sector, the poor often have to pay exorbitant amounts to handle obstetric complications caused by poor screening during ANC at smaller govt. facilities Corruption is endemic in govt. facilities, and significantly conditions the quality of care given Callousness at the hands of healthcare providers during ANC and delivery can have various kinds effects, not least maternal morbidity Overall, sexual health took a back seat to reproductive health. This is possibly because in the absence of HIV/AIDS, sexual health isn't perceived to cause serious health problems. While pregnancy and childbirth are natural experiences, too often they become life threatening experiences.
3. Explore how do INGOs and donor agencies recognize and promote community based knowledge, practices and participation	Are unequal power relations detrimental to the autonomy of CBOs?	THI RUWSEC	Learning about the relationship between- THI and Skillshare International And RUWSEC and their funders including Ford Foundation and Mc Aurther Foundation	THI and Skillshare seemed to have a healthy mutual exchange of knowledge, with Skillshare helping improve the organizational structure and functioning and THI creating best practices that Skillshare adopts. However this may have more to do with the equal power relationship between Dr. Regi and Lalitha and the Skillshare representative From discussions with Dr. Balasubramaniam, RUWSEC has had to change their approach, including a large research and documentation component to their organization due to a change in funding patterns. This however has equipped RUWSEC to train budding grassroots organizations and document their best practices and approaches in great detail. RUWSEC has been decisive in turning down funding for research areas if they don't deem it suitable or relevant. Both local NGOs, especially THI seemed highly autonomous and authoritative, and did not seem undermined by their international partners or funders.

Timeline of Activity

Time	Activity	Significant reading
June/July	▪ Visits- Sangama and APSA	▪ RCH II ▪ CREA study on Adolescent sexual-reproductive health rights
August	▪ Placement- Tribal Health Initiative ▪ 'Daughters of Fire'	
September	▪ Short placement- Vimochana ▪ IPHU ▪ Right to Food Campaign ▪ Urban Health meeting at CHC ▪ Meetings -RUWSEC-Commonhealth ABIDe, CIVIC	▪ Population Policies Reconsidered ▪ Beyond Numbers
October	▪ Karnataka Flood Relief fundraising ▪ NIMHANS – psychosocial training for disaster relief volunteers ▪ Visit- Belaku Trust ▪ Placement- Rural Women's Social Education Centre (RUWSEC) ▪ Self development workshop	▪ growing up in rural karnataka – Concerns and Health Issues of School Students ▪ 'Yes to abortion, No to sexual rights' and 'Women and the Politics of Population and Development' ▪ RUWSEC publications
Nov- Jan	▪ Independent research study in women's fertility experience (MRS Palya)	▪ Gendered health systems biased against maternal survival: preliminary findings from Koppal, Karnataka, India ▪ Birth on the Threshold ▪ Reproductive Health Matters 'Maternal mortality and morbidity: is pregnancy getting safer for women?' (selected papers)

Important Visits

Potnal

The field visit to Potnal, Raichur during the orientation period was a short but concentrated thrust into some of the complex realities people face, especially in regard to caste and gender. Double and triple marginalization were some of the issues exposed, meaning the multiple burdens of class, caste and gender. It was encouraging to learn how dalit women's groups such as Jagruthi Mahila Sangata have demanded and to some extent established their rights. The power of social organisation and solidarity was also palpable.

This was also my first engagement with PHCs, the PDS system and the panchayat. Despite the increasing presence of private actors these visits not only exposed the problems but also the centrality of public systems and people's dependence on it.

Association for the Promotion of Social Action (APSA)

I chose to visit APSA to learn more about their sexual health programme for street children as it relates to my objective to understand the social determinants of sexual-reproductive health. Here is the information gathered about APSA's intervention-

Meindert Schaap, a psychologist from the Netherlands along with BOSCO, conducted a study of 25 of street boys in Bangalore which revealed a high level of unsafe sexual activity among them. This led him to develop a programme that targets this vulnerable section to increase awareness about unsafe sexual practices and their outcomes. At the time I visited pilot workshops with street children had been conducted by APSA and a few NGO partners, and results and lessons were being consolidated to improve the programme. By the end of the CHLP, APSA had begun training various NGOs working with street children; teenage boys and girls specifically, to understand their level of sexual activity and possible interventions to prevent high risk behaviour.

I also had a chance to see the various other programmes running on the APSA campus which are as follows-

i. Multiple education programmes to cater to the specific needs of urban poor; children from migrant families; and children in distress; bridging classes for dropouts
ii. Working with SHGs from various parts of Bangalore to strengthen their knowledge of entitlements and advocate with local governments
iii. A large vocational centre for training in computers, electronics, carpentry and printmaking for adolescents and young adults
iv. A shelter for runaway or vulnerable children and teenagers
v. A child helpline that networks with the police and other NGOs for a appropriate action and rehabilitation for various issues including abuse, labour and trafficking

Sangama

Sangama is an organisation working to establish the rights of sexual minorities. It deals with the issues of transgenders, gays, lesbians and bisexuals. They offer counselling services, run testing centres and are involved with various advocacy issues. Some of the issues highlighted were- the ostracisation of sexual minorities from their families and communities; the lack of acknowledgement by governments as being citizens entitled to full rights; the harassment and abuse of transgenders by the police force; and the specific health risks they face.

Until my exposure to Sangama I had not been aware of the various types of sexual minorities and the nuances of their sexual orientation. Castration being a requisite to becoming a *hijra; double-deckers* (who are men who have sex with men but also cross dress to play the female counterpart in homosexual relations) are some of these types.

I heard about some of the customary practices of the *hijra* community (such as begging) and the unfortunate inevitability of turning to sex work as the only viable income.

To start to understand the extent of the discrimination against sexual minorities and the violence, both physical and sexual, they face in their fight to assert their sexuality was very

saddening. However on a positive note, I feel that sexual minorities (through alliances and organisations) have created a stronger platform to talk about sexuality explicitly over heterosexuals who often get limited to speaking about sexuality in the context of marriage and reproduction. Reproduction being enmeshed in heterosexual sexuality, acts as a way of diluting the issues that relate to sexuality, and further sexual health alone. Overall the visit to Sangama provided an opportunity to hear about the systemic and societal oppression of sexual minorities, especially among the poor; and the small but promising victories achieved to establish their rights.

Other activities:

'India Courts of Women: Dowry and Related Forms of Violence Against Women'
This event organised principally by Vimochana was an incredible opportunity to understand dowry as a symptom of women's status in India. Before then, I did not understand the extent to which violent forms of dowry are being practiced. And it was shocking to learn that since the inception of the Dowry Prohibition Act of 1961, not one person has served time for a dowry death.

The speeches and testimonies made me see the link between the rise of consumerism and increasing violence against women through the practice of dowry. Hearing how violence against women doesn't bar class, caste or religion was also revealing. However I feel the repercussions are more acute when poverty itself is a form of violence against women, and that the feminization of poverty through the practice of dowry only makes women more vulnerable to violence.

In all, the meeting offered a rare opportunity to meet prominent feminists and national level discourses, as well ordinary women whose lives have not been significantly changed by strong women's movements. It propelled me to question how public discourse can impact private lives, a theme that I hope to explore long term.

Commonhealth & RUWSEC Meeting, Chennai
A chance decision attend a meeting on institutional delivery in Chennai paved the way for a crucial field placement which laid the foundation for my final project. Here is the synopsis.

The meeting that involved representatives working in maternal or women's health in Tamil Nadu. It was to highlight the impact of the increasing institutionalization of deliveries under the NRHM. However the increase of public institutional deliveries without enough emphasis on *safe* delivery has lead to various maternal and neo-natal complications. Institutional delivery may be an indicator of broader development but not necessarily safe delivery.
The meeting was called to highlight the issues around the recent increase in public institutional delivery and to redefine it in the framework of safe delivery.

Some trends based on specific studies:

- Institutional delivery has increased form 1.9% in 1999 to 16% today
- Since the introduction of the NRHM, there has also been a decrease in private hospital delivery and an increase in PHCs
- Lack of skilled personnel is leading to unsafe deliveries in the name of institutional deliveries
- In private hospitals, cesarean sections were 4.2 times higher than in government hospitals

- People feel the quality of care is better in PHCs over district hospitals
- Very few medical practitioners conduct active management of third stage of delivery (AMTSD) or partogram, conversely TBAs are much more open to learn safe delivery practices
- The functionality of the subcenter is undermined with the shift towards PHCs
- Referral systems are not practical and do not put the safety of the mother first
- Maternal and neonatal deaths, especially when related to the mismanagement of delivery both at public and private institutions goes unreported
- Apathy and corruption in public health institution is rife
- Safe delivery for HIV positive women is still not widely available, nor is information on PMCT, family planning, safe abortion services or neo-natal care for children born to positive women
- Birth companion scheme introduced in 2004 has helped ensure better treatment of mothers during delivery

What is still needed:

- Awareness about maternal health has to be initiated pre-conception
- Detection and treatment of communicable diseases during pregnancy
- Follow up of child development services needs to be initiated
- Addressing wider issues like sanitation to bring down MMR (such as in Sri Lanka)
- Distinction between maternal and child mortality and morbidity, with enough focus on morbidity
- Body of data on the relationship between institutionalization and maternal health needs to be effectively documented or it will remain anecdotal and unable to dent policy

'The Right to Food' Campaign

During the course of the CHLP, at times I was encouraged to engage in activities that may not directly relate to my learning objectives but would widen my purview. The 'Right to Food Campaign' was one of them. This was the first time I've been involved in any campaign. It has been a personal choice not to, as I've never seen myself as activist material (in the prototypical sense). And the experience, completely out of my comfort zone, did not come without its lessons. I found myself trying to decipher the National Food Security Bill draft, surprisingly so were other activists well into the campaign. There were factions within the campaign (the Karnataka chapter alone)- some opposed the bill outright while others felt it only needed expansion. Seeing the multiplicity of views made me realise how difficult it is to gain complete solidarity on an issue. Triumph

The entire experience- mobilising students, promoting awareness on the issue, preparing material for the protest, participating and fasting on the protest day, had its little victories. However, to draw from the cyclical process of learning from the orientation period, in the future I wish to learn much more about an issue and its background before I get involved in supporting or opposing it.

IPHU

The ten day short course on 'Health and Equity' run by the People's Health Movement's (PHM) International Public Health University (IPHU) in Bangalore was a rare experience for many reasons. Firstly it was an opportunity to meet and network with 'health for all' activists- veterans and novices alike, from around the country and the globe. As a novice I was able to understand the history of PHM, the events leading up to its inception, and how it has grown in

number and spread to many new countries. This conveyed a sense of national and global solidarity, which was new and exciting to me.

Below I outline the major lessons I took away from the IPHU:

- ***The role of PHM, how it works***

Before the IPHU I did not fully understand what the PHM is- an organisation, a network, a movement? I'm now comfortable with the concept of it being a combination of all these, and as David Legge put it, 'an organisation of network of networks'.

The alliances that the PHM enables are on all levels, from local to global. Each level has the ability to link with the next level and so on, ultimately leading several countries both in the developing and developed world, to fight global deterrents to equity in health.

- ***Globalisation is central to the PHM discourse***

A major thrust of the PHM's efforts is to fight the negative processes and outcomes of globalisation. The current neo-liberal economic order is heavily critiqued for promoting the unequal distribution of wealth, which enables inequity in health. Plainly put the expansion of the market economy into the health sector, as described in the IPHU, has led to 'private insurance for the rich, social insurance for the middle class and a safety net for the poor'.

Concepts introduced by Amit Sen Gupta, such as speculative capital and how it impacts the health sector were new to me, and which I found stimulating.

The IPHU also threw light on the positives of globalisation. The networks the PHM helps form shows how globalisation can take place from below through solidarity at a local level, and intervention at an international level.

- ***Similarities and differences between other developing countries***

The strength of the course I also found, was hearing voices from other countries. My interest has been to understand the common challenges in many parts of the world, not India alone. This was an opportunity to hear how community health approaches have been used in other countries. The experience of how the PHM in the Philippines has been continually fighting the privatisation of healthcare and prevented the shutting down of particular government healthcare centres presents some of our common battles.

However it was also clear that each country has specific needs and the PHM plays varying degrees of importance in development efforts in health according to its capacity and level of establishment in that country.

- ***The human in environmental health***

The presentations on environmental and occupational health were considerably different from discourses on environment I have heard before. Previously I felt environment was too strongly linked with ecology and lacked any human element to it. "Environment began to symbolise something out there" (as one speaker put it) and I wasn't moved by an environment disconnected from human beings. Environmental health, as the presenters of the day conveyed

was the very living space of human beings. These environmental spaces were redefined for me and I also understood its close link with occupational health.

- ***Theory and practice working cyclically***

The entire course drew on both theory and practice. (Recent) history of political and economic change, policy analysis, and ground realities were all interconnected. It seems like policy analysis can explain particular outcomes; and the communication of ground realities can in turn influence policy.

The course material too drew equally from theory and concepts, and showed how these theories have been interpreted and applied by communities. Sant's sharing of SATI's experience is an example of this. His presentation showed how community monitoring was applied through direct monitoring of health services, and in this case, forced a health system to function more accountably. Properly documented, these experiences have the potential to dent policy.

Additionally, through the IPHU I understood the foundations of rights based approaches (RBA), as well as its uses. Previously in regards to RBA, I had seen theory and practice as mutually exclusive. Renu Khanna was very effective in explaining the ideology, as well as the applicability of the rights based approach. The Universal Declaration of Human Rights may be an ideal, but using the framework to identify and understand specific violations of human rights was very constructive.

- ***Future PHM activists- 3 areas of PHM, my future role***

It was useful to understand the three forms the PHM broadly takes (or the paths it offers). First is an activist role with direct engagement with communities, campaigns and movements. The second is the role of a researcher, to gather new evidence to substantiate the principles of the PHM. The third is the IPHU itself. The way I understand it, the aim of IPHU is to foster young people to take one or more of these paths. Clearly, the purpose of the IPHU is to build a human resource base that strengthens the PHM which in turn furthers its purpose of enabling 'health for all'.

With Amit Sen Gupta introducing the Global Health Watch and possibilities of contributing to it, this was the first time I considered research as a profession, as it shed light on how research too can be a form of activism.

- ***Self reflection: "You can't be part of the solution until you realise you're part of the problem"***

This was a concept I really grappled with during the IPHU, mostly because I agreed with it to some degree. That "capital was accumulated by destroying people's health"[2] is not a cross only governments ought to bear, but 'privileged' citizens of the world too. Unfortunately, that induces a feeling more complex than guilt. To accept that I feed into and benefit from a system that is inequitable leaves me conflicted. This may not be a constructive feeling, but it is something I continue to understand, accommodate, make changes for and try to be at peace with.

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[2] David Legge, day 2

Placements

Tribal Health Initiative (THI)

My one month placement at Tribal Health Initiative was a unique, incredible experience. It was the first for many experiences for me- exposure to development work in remote rural areas; interaction with adivasi communities; living with communities; being beside a woman in labour; seeing a caesarean section and tubectomy in the operating theatre; seeing full physical gynaecological examinations, as well as antenatal and postnatal check ups.

Fifteen years since its inception by doctors Regi and Lalitha, today THI focuses largely on both curative and preventive health work. Below I describe explicate some of the lessons I learnt in regard to the challenges of doing health work with communities in this remote rural area.

Access

Remoteness is the biggest deterrent to health in the villages of Sittilingi valley, Kalryan hills and beyond- making *access* a major determinant of health for most.

New linkages by road has meant many changes for the communities- cellphone services, bus services to some remote villages, more two wheelers, DTH satellite TV on the one hand; and HIV- more exposure to communicable diseases, harmful cultural practices of other communities (dowry) and rapid socio-cultural changes on the other. Road access has accelerated an influx of new ideas, practices and services. But very rarely do communities get a chance to negotiate the adoption of new practices; rather it is accepted as inevitable and unstoppable.

Personnel

Since the inception of the hospital as an actively running institution, problems arose with having enough trained health personnel. It has been both a practical and forced decision to train local people to be paramedical and administrative staff. All the nurses, pharmacists, the lab technician, drivers, office staff are from relatively nearby villages. Needless to say, no other qualified doctors apart from Regi and Lalitha have chosen to stay for long periods of time in a remote village such as Sittilingi.

Stakeholders

The introduction of the National Rural Health Mission (NRHM) has had positive and negative outcomes in these areas. The Primary Health Centres (PHC) have more equipment but are not necessarily better equipped with trained staff. The 6,000 rupee cash incentive for institutional delivery has decreased the number of home births considerably. However, due to the shortage of manpower, particularly adequately trained paramedical and medical staff, any complicated deliveries are grossly mismanaged. To meet government targets, they often accelerate labour and send women home still reeling from the anesthesia (as told by an informant doctor at the Harur Government Hospital)

According to Dr. Regi, other stakeholders such as the so called "quacks" aren't necessarily doing damage to the health of communities in the area. As he explained, even unqualified doctors have their uses in that they access some of the most remote areas and can deliver immediate relief to suffering patients. THI has cultivated a good rapport with some of them, and patients are even referred back and forth to each other. This has help build the credibility

of some smaller doctors and created a non-threatening, non-competitive environment for them to interact, practice and co-exist.

In the Kalryan hills area, Worldvision seems to have a huge presence. However, none of the NGOs engage in curative healthcare. I was interested to know the capacity and areas of their work in those villages. Still, I would be surprised if it was anything more than a donor beneficiary relationship exists. Community ownership in their projects seems even more unlikely.

Balance between curative and preventive healthcare

What cannot be denied is the need for curative work. For instance, simple treatments like prescribing iron supplements to pregnant mothers have had an impact on decreasing neonatal mortality. Post-natal and ante-natal services and safe institutional delivery have significantly improved maternal health for hundreds of women every year. As much as capacity building of communities to demand quality government services is crucial, there is a strong need from communities for THI run services to continue.

Sustainable growth and expansion

THI decided to expand to 21 new villages in the Kalvaryan Hills. During the course of the Participatory Rural Appraisal (PRA) alone of these new villages, three maternal deaths occurred, indicating the poor condition of maternal health THI suspected. Since a Health Auxiliary program has been successful in improving maternal health in the exisiting 21 villages they work in, the same intervention is proposed for the new villages. Supplemented by a new OPD in Vellumalai (one of the central villages in the hills), one woman will be elected by each village to be trained in identification and medication of small illnesses (and timely referral) and issues of maternal and child health including monthly antenatal check ups, promoting institutional or safe home delivery, and essential neonatal care. The prerequisite for the candidate is not a formal education but the aptitude to learn and the intention to serve her community.

Overall, my placement in THI was extremely inspiring, showing me both, my capabilities and weaknesses. The challenges of the 'community health' model (not to imply that there is only one) are immense. But however difficult in establishing, it also seems like the only logical way for change. Programmes change, funding comes and goes, NGO agendas are time-bound. The only real *sustainable* answer seems to be for people to take their health into their own hands.

Thulir

Thulir, an education resource centre although administratively linked to THI, functions independently. Run by architects Krishna and Anu, Thulir provides an alternative learning environment for school going children so they better understand subjects and improve their language skills. In addition, Thulir offers a comprehensive vocational training programme for adolescent boys and girls who have dropped out of school. Their approach is not pedantic but hands-on learning, offering a wide range of activities- bee keeping, electrical work, construction work, jewellery making to name a few. Notably, all their practices have an underlying ethic of being environmentally sustainable.

Thulir has been successful in addressing the shift away from agricultural work in these communities and how that impacts young people. The couple realized that rural adolescents,

being active outdoors, learn much better with their hands. The confidence built through these programmes has not only led to successful professional work for some, but has also encouraged others to re-write their examinations and continue/complete their education.

Although small in the numbers it reaches, Thulir has created a unique educational model that recognizes the social, cultural and economic realities of the rural poor (specific to these communities) in their teaching methods. In doing so, it is effective in constructively impacting the futures of rural adolescents in a rapidly changing environment.

Vimochana (short placement)

Since attending 'India Courts of Women', I was keen to spend time with Vimochana (a women's rights organisation that primarily deals with domestic abuse) and better understand how organizations can impact matters in the private sphere of women's lives. I spent one week with Vimochana learning about their interventions and also made a visit to one of the communities they actively work with. I also helped with documenting the proceedings of 'India Courts of Women: Dowry and Related Forms of Violence Against Women'.

During my time with there I saw how they conduct crisis interventions with victims of domestic abuse, and methods of negotiations with their families. I learnt how incredibly strong women are even when they have been brutally controlled.

One of the lessons I learnt from Vimochana is that enabling change in one woman's life is as important as influencing national and international dialogue on women's rights. Their strength is that they work at micro and macro levels simultaneously- never out of touch with ground reality, yet also trying to change the larger system of patriarchy.

RUWSEC

Rural Women's Social Education Centre was founded in 1981 by 12 dalit women and Dr. Sundari Ravindran. RUWSEC grew out of a larger national adult education programme to focus on the needs of dalit women in Kacheepuram District, Tamil Nadu.

The strength of RUWSEC I found, as an external observer, is that it has adapted to the evolving needs of communities as well as new funding patterns, and works with different demographic groups. In the process, more than nine organisations have grown out of RUWSEC, founded by former RUWSEC staff. Some of these organisations continue a close association with RUWSEC as partner organisations.

Further (and partly due to a shift in funding) RUWSEC began publishing their activities in the form of impact assessment, training manuals and research papers. High quality publications therefore are among RUWSEC's many resources.

Since its inception RUWSEC has engaged in many initiatives in 98 villages of Thiruporur and Thiruvalkundram taluks. Today they engage in the following programmes:

- Life skills education programme for young people
- Prevention of violence against women
- Improving quality of care in public health institutions

- Protection and promotion of human rights of 'dalits' and strengthening participatory grassroot democracy

My exposure and learning was by visiting activities of the first two initiatives. The activities however came under three of RUWSEC's partner organisations- 'Social Women's Education Empowerment Trust' (SWEET), 'Social Women's Awareness Trust' (SWAT) and 'Women's Empowerment Action Trust' (WEAT).

Adolescent workshop in schools (run by SWEET)

I was blown away by the context of this training programme, it was both daring and thought provoking. This was the third of a sequence of sessions with 8th std students, both boys and girls. I expected the content to shy away from sensitive subjects, more so because it was held on the school premises. Instead it challenged gender norms (division of labour and professions) and harmful traditional beliefs about women, and explicitly described the functioning of the reproductive organs. This session of the programme was separate for boys and girls, and for the girls menstruation and menstrual hygiene were discussed in detail.

Challenges: Although hygienic practices were discussed, the school like many others had no running water, making this new knowledge inapplicable. The myths and misconceptions about menstruation again could be dispelled in the minds of the young girls but performing hygienic practices (like drying the menstrual cloth in the sun etc.) may never be possible due to family constraints. It was unclear weather RUWSEC worked in those villages with the other family members to instil the same knowledge.

Adolescent skills training in colleges (run by SWAT)

This 2 day workshop in a private girls college (spread over two Saturdays) touched on some of the major life skills- communication, interpersonal relationships, management of emotions and stress management, and decision making.

I found this session packed relatively less punch than the one run in schools, mostly because it wasn't its intension to address SRH issues specifically. Although it discussed challenges that pertain to adolescents and girls I felt it still played safe in its content, or rather was not introducing anything radically new to think about. Perhaps the limiting factor was the size of the group, which was too large to enable open communication with all. As a result the older, more outspoken girls were more interactive, sideling the others.

Nevertheless, it was encouraging to hear the views some girls had on premarital sex, arranged marriage and self image, which although conventional; were conveyed assertively.

Training of health workers

This was a session to evaluate the knowledge of health workers trained intermittently (due to multiple women on maternal leave) over the course of the year.

Although this training encourages the women to be more active participants in their communities and therefore local political processes (the panchayat), there wasn't a clear indication if this was happening. One woman, part of the Village Health and Sanitation Committee (VHSC) in her community, was not aware of what her role entailed and the purpose of the committee.

The question ranged from prevention of mother to child transmission of HIV (PMCT) to the biological determination of sex, to also challenging norms of 'the dutiful wife'. The content of the training was deep and wide-ranging; however difficulty in attending the trainings prevented all the women from internalizing some of the information shared.
Nonetheless, it was promising to see a forum where women could freely talk about matters of sexual-reproductive health and gather more useful information.

Training of prevention of violence against women committee
This session by WEAT was very stimulating. The women in these committees were extremely strong, vocal, and intelligent and took their role very seriously. As part of the prevention of violence against women committees, they a source of support for abused women and are trained to take appropriate action for the wellbeing of women in their communities. The interventions range from counselling and offering immediate support for the women (sometimes even shelter); counselling for the couple; taking the issue to the wider family and/or the panchayat; helping the woman file a police complaint, getting medical help. Finally this programme also engages a lawyer to follow up with legal action in extreme cases.

WEAT also does training programmes for anganwadi teachers on gender based violence. They believe this is an important group to have targeted training as they interact very closely with the women in communities, young girls and pregnant women.

Young couples' counselling
This is an intervention currently run by SWEET, however I was not able to observe this programme. The objective is to facilitate better communication between newly married couples to reduce incidence of abuse and increase the wellbeing of both partners. Men are encouraged to take a more participatory role as 'partners' in supporting their wives and issues of SRH are discussed. The programme has been successful and has been approved by and currently runs periodically in a government hospital.

Anecdotal information shared with me:
Role of mothers in law in maternal nutrition- the founder of SWEET, Bhavani, told me that pregnant women who are meant to receive vitamin supplements along with their IFA tablets at the anganwadis were not taking it because their mothers-in-law wanted them instead. This is perpetuated by the misconception that vitamins will make the foetus grow too large for the woman and hinder delivery.

A senior RUWSEC staff member, Selvi, shared that in her village the upper caste *modhliar* community now mix freely with the dalit community because of the loss of traditional livelihood practices (previously handloom) and the adoption of industrial employment outside the village. The younger generation from both communities have assimilated due to the adoption of the same profession. As a result, she believes there is no discrimination between these castes today.

TN demographic transition- Dr. Balasubramaniam, demographer and current Director of RUWSEC shared some views on the fertility decline in Tamil Nadu. Unlike Kerala, in TN fertility declined drastically, without a decline in maternal or infant mortality. He believes along with a shift away from the agricultural sector there has been a shift in people's perspective to children as an economic burden. Today it is widely a two-child norm (abeit with son preference) and people believe they cannot afford to support large families. He sees the promotion of the two-child norm in the political ethos of dominant parties to have also greatly contributed to this

shift. A much more in depth study has been done on the demographic transition of TN, which he was a part of.

Reproductive health clinic

Although primarily functioning as a reproductive health clinic, mainly for dalit women, the clinic also offers general clinical services for men too. Also (unlike THI's preferential treatment for adivasis) there is no disincentive for non-dalit people to avail of the services.

What was unique to the clinic was the counselling facility. Patients coming in for reproductive health services are encouraged to visit the counsellor first, as doctors face time constraints in talking to patients in detail. Information revealed during counselling is sometimes detrimental to understanding the patient's condition.

Although through the NRHM, PHCs in the near by areas have improved greatly in their functioning, RUWSEC's reproductive health clinic is a model of sorts and a standard for the PHCs to live up to. The clinic was planned by RUWSEC members, based on their needs. As a result, one of its features is numerous working toilets!

I witnessed an MTP, though I couldn't bear watching until the end. The couple were young with one child under the age of one. This was an unplanned and unwanted pregnancy. It seemed from the outside like joint decision making for the MTP took place, and for the most part, that the husband was supporting the wife. She was young and very afraid of the abortion. She was so unhappy about her unplanned pregnancy that her husband and she decided to get a tubectomy done at the time of the MTP. This was denied by the health practitioner as she was too young and so was her only child and they were suggested spacing methods. Many family planning options were offered and the woman was not pressured to use any particular one. Dr. Subha Shri said that, although uncommon, it was not completely out of the ordinary for a couple to complete family planning with one child.

Community Health and working with communities

Community as a source of knowledge

I learnt that to work with communities one must begin with humility and the sensitivity to acknowledge that you may come with formal education but not the wisdom and experience the community has. Distinguishing between harmful traditional practices and practices that can be harnessed and developed for the betterment of the community is valuable. There has to be a mutual exchange of knowledge and skills and drawing and building on their existing knowledge rather than replacing it with completely new forms is crucial. My decree is to not go in with all the answers, and accept that learning more about the community will incite more questions.

Social illnesses

Community health is about critically examining the social determinants that prevent a community's ability to be healthy. This means not only addressing the medical conditions people face but understanding their root causes, which are often within the societal structures. Therefore without an anthropological approach to looking at health issues, meaning an effort to understand the caste, class and gender dynamics that could underlie a health problem, the cure will only be superficial.

The right to health is embedded in the right to education, livelihood, gender equality etc. Understanding the interconnectedness of these rights is essential to achieving the right to health.

Process enabling

During the orientation period Dr. Ravi Narayan said the CHLP intends to make *process* managers of us, not programme managers, and that stayed with me through the programme. I'm now clear that the key to sustainable solutions for problems of the marginalised is to enable processes that increase their own capabilities. And that capability primarily lies in the assertion of a wide range of rights.

Since rights are not given and must be claimed, *social organisation* becomes a key process for enabling the assertion and attainment of rights. I never fully understood the power and importance of social organisation before the CHLP. I relegated it to the practice of a certain brand of activists. Today I see that social organisation in smaller and larger ways is the essential to changing harmful, exploitive and unjust practices. Programmes have a beginning and end, a change in a process begins to change a system. Naturally systemic change takes much longer but is the only path to sustainability.

Sustained commitment → Trust

From my placements I have learned that a requisite to enable processes of social organisation and the various kinds of capacity building is long term sustained commitment.

To alleviate the donor-beneficiary relationship and foster a mutual exchange of knowledge and skills is no easy task. It takes years and years of effort. Both the organisations I was placed with were between 10-20 years old and the initial years of building trust among the people was said to be the hardest.

Publications

"Women and the politics of population and development in India"
By T.K Sundari Ravindran

Population reduction programmes are still sterilization focussed, incentive driven, provider controlled and with limited choices. Side effects and patient complaints are ignored and secondary infections caused by IUDs in women already suffering from gynaecological problems are common. There is no follow up and no assurance of quality and abortion and delivery is often used as an entry point for sterilization.

Fertility control needs to be addressed in the context of high maternal mortality and morbidity. A new framework needs to be formed and top priority needs to be given to reduce maternal mortality and morbidity and improve reproductive health.

'"Yes" to abortion, but "No" to sexual rights'
The Paradoxical Reality of Married Women in Rural Tamil Nadu, India'
By T.K Sundari Ravindran

This paper impacted me greatly. The essence of the study is that access to abortion was not an indication of fulfilment of SRH rights. What was revealed is that non abortion users faced less coercive, non-consensual sex, physical and sexual violence. Abortion was an indication of unwanted pregnancies as a result of coercive sex. This poses a powerful critique to popular

understanding that women who access safe abortion services are those who have the ability to exercise their reproductive right to limit childbearing. It showed that there is a complex gender power imbalance that underlies family planning decision making.

Adolescent Sexual and Reproductive Health And Rights In India
Working Paper by Creating Resources for Empowerment in Action (CREA)

This paper outlines, from the outset, the complexity in the very terminology of adolescents, with 'children', 'minors' and 'adolescents' used interchangeably.

Additionally the National Youth Policy, the Reproductive and Child Health (RCH) programme and the Integrated Child Development Services (ICDS) define the age group that constitutes adolescence differently. The lack of a common definition of adolescence makes policy level interventions more challenging.

Even though 'young India' (comprising of mainly adolescents) makes up 1/5th of the country's population, health programs for this broad age group are largely ignored by the government, as they are seen as "healthy and therefore in less need of services". The reality is that there are health risks specific to this age group. The lack of information about even basic biological processes (such as menarche) only increases these risks.

The national average age for first child birth is 19 and many states are lower. The paper states that early marriage and childbirth are a primary cause for poor reproductive health.

- Girls under 18 are 2-5 times more likely to die during pregnancy or childbirth
- Adolescent pregnant mothers run a higher obstetric risk for premature delivery, giving birth to a low birth weight baby, prolonged and obstructed labour, and severe intrapartum and postpartum haemorrhage

Although the RCH programme introduces 'family life education' (instead of the earlier population education) for adolescents, the paper argues that the focus is limited to reproduction, conception, menstrual, and genital hygiene. "Sexual and reproductive self-determination [is] looked at only in the context of violations, disease or family planning". And this limited information is disseminated with a either scientific or moral stand. Adolescent sexuality is not addressed- teenage pregnancies and the needs of unmarried girls are completely sidelined. There are various other issues specific to this broad age group such as sexual abuse, child prostitution and sexual violence which are not addressed at all.

This paper argues that the Indian health system only views adolescents in terms of disease control and prevention. They propose that one of the first steps towards ensuring adequate reproductive and sexual health care for adolescents is to provide them with information about their bodies, puberty, relationships, sex and sexuality.

"...the effects of denial, as evident today in countries around the world, are more devastating than the difficulties of change."

Growing up in rural Karnataka
Belaku Trust publication

This study was a comprehensive exploration into the lives of school going adolescents in Kanakpura, Karnataka. Knowledge of sexual-reproductive health was only one aspect of the

study. Their findings showed that girls and boys have different kinds and levels of access to information regarding sex, reproduction and sexuality. This resulted in more misconceptions and less information among girls, and a skewed, even perverse understanding of sex and sexuality among boys. It was also more socially acceptable for boys to make sexual advances but a detriment to a girl's reputation to reciprocate even affection. All this led to considerable eve teasing and an unhealthy equation among boys and girls which limits them to only interact on basis of the acceptance or rejection of a physical relationship.

The study also explored the specific kinds of stress young girls and boys face within the home, and their pressure to fit defined and binary gender norms (the submissive wife and good caretaker of children for the girls; and a strong provider for the family for the boys). The study offered an insightful and comprehensive base for those intending to work with adolescents.

Gendered health systems biased against maternal survival: preliminary findings from Koppal, Karnataka, India
Asha George, Aditi Iyer and Gita Sen
This is an incredible paper and resource for those concerned with maternal health in India. The paper offers an exploration of maternal mortality and morbidity, connecting it to an underlying bias and delegitimation of women at the hands of healthcare providers and within the home. It offers a careful examination of health seeking behaviour that shows a failure in acknowledgement of problems pregnant women face and accountability of providers, compelling one to consider these failures *as* gender bias.

Continuity of care and irrational referrals are challenges within the health system that are based on '"technical and managerial capacity constraints". Yet the paper argues that within these challenges lies an intrinsic apathy to save women's lives. It is this bias that the paper explores.

My personal journey & my future

It's hard to put into words what the CHLP has done for me. I believe it has impacted me on a very fundamental level, an actual amendment to my world view. Whether or not I like it, the learning now feels primordial, and I can only build on it. Perhaps all of life's learning is incremental but the point is, it has been internalised in a way that the core cannot be altered.

When I enter a community now I wish to understand why things are the way they are, why people behave the way they do. So my skills in social analysis have improved. I am also more aware of the systemic problems that impede health. Keeping in mind systems, both tangible and intangible, has helped greatly has helped me see the multiple layers of marginalisation.

Overall, on a personal level, I feel much stronger, more independent and more secure in myself. I'm more open to people, new experiences and I'm not afraid of a challenge. There's a confidence in me that I too can contribute to realising the dream of 'health for all'.

There has been a shift in terms of interest area for work too. When I came into the CHLP I was filled with questions and concerns about the impact of "over-population" on vulnerability. Although my concerns were about the burdens it represented for women and children, my views were still parochial and needed changing. As a result of the CHLP my interest has shifted from population as an issue to matters that pertain to women's health. I see family planning as

only a part of what women need for their health and wellbeing. Safe motherhood is a much more encompassing issue in women's lives and despite existing efforts, needs considerable attention. I have also got very interested in the study of gender dynamics and its impact on women's health, particularly maternal health.

As a result of this understanding, for the future I see myself with an organisation that focuses on reproductive and maternal health through a rights based framework. I want to be in a position that I'm touch with communities and ground realities yet producing work that can also bring about change at a policy level. I'm wary of vertical approaches to any health intervention, and those that do not offer a critical gender analysis in working in women's health. The CHLP has certainly impacted my decision making for my future, and given me clarity and focus to see what I have the sustained commitment to work for.

ANNEXURE I

Newsletter Contribution:

Population Control Conundrum

Since independence in India, fertility reduction has played an obstinate role in government health agendas and budgets. The late 1970s, following the state of emergency, witnessed an extremely coercive population policy that resulted in manifold human rights violations, with poor health and dire social outcomes.

In 1994 at the United Nations' International Conference on Population and Development in Cairo, India was one of 179 countries that promised to promote the reproductive health of women; censuring coercive population policies. In 2000 India furthered its commitment to the ICPD through the inception of the new National Population Policy, which categorically faults punitive measures to reduce fertility rates; offering a target free approach without incentives and disincentives, with the voluntary and informed choice of citizens; and a focus on maternal and child health.

Omitting these commitments, punitive measures to reduce fertility rates have surfaced once again through the inception of the 'two-child norm' in many states. Studies in Madhya Pradesh, Rajasthan, Andhra Pradesh and Bihar have shown various violations of the NPP and the ICPD. Expulsion of the third child from social welfare schemes (PDS) and even government schools has been reported. In Andhra Pradesh "motivators" of sterilization are bribed with gold chains, in Bihar they're rewarded with arms licenses. Worse still is the rampant disqualification of people (informed or uninformed of the implementation of the two-child norm) from political posts in Panchayati Raj Instituions (PRIs). The deeper repercussions of this punitive measure are outlined below.

Women bear the brunt

A study in 12 districts of Mandhya Pradesh has shown that since the implementation of the two-child norm, in order to retain Panchayat posts, women were forced into unsafe abortions; husbands abandoned wives to denounce responsibility of the third child; female feticide and infanticide was on the rise; and the giving up of children (usually female) for adoption was common. In a country where son preference is still critical to family planning, the enforcement

of the two-child norm will only skew the existing, alarmingly disproportionate sex-ratio further, and cause more harm to women in the process.

Ironically, while the abuse of women's basic human rights continues in the name of the two-child norm, great strides are being taken toward a 50% reservation for women in PRIs.

Marginalizing the marginalized

With ample evidence linking poverty and fertility, it is explicable that dalits, adivasis and other marginalized communities often experience higher fertility rates- due to poorer access to healthcare, living conditions and information. While there is reservation for SC/STs in Panchayats, the study in MP showed they made up a disproportionately large number of the dismissals (50%). It is both unfortunate and illogical that the promotion of inclusion and representation of SC/STs, the basis for reservation, can be so grossly undermined and derailed by another State policy.

Youth loose out

36% of India's population is at the prime reproductive age (therefore young) and it is likely that they make up the largest portion of couples conceiving a third child beyond the stipulated date. Denying their political representation at PRIs based on fertility is irrational. The study in MP showed positions vacated by younger representatives were replaced by elders. On the one hand, while efforts are underway to strengthen the National Youth Congress; at the grassroots level, progress to include 'young India' in decision-making is being unravelled by the two-child norm.

Development vs. Population control

Kerala and China are both cited as cases of considerable decline in fertility rates; however Kerala did not resort to coercive measures. Today Kerala's total fertility rate has dropped below the national replacement level at 1.9. Investments in health and education brought down maternal and infant mortality, and increased women's access to healthcare and information.

Punitive measures of the two-child norm, such as the disqualification of women, SC/STs and youth from PRI posts, and expulsion from social welfare schemes will only exacerbate the conditions that cause high fertility in the first place. Narrow, targeted approaches to reducing fertility rates without addressing the root causes of high fertility, or complementary action to strengthen reproductive health services have not only failed to reach desired targets but have clearly allowed for human rights violations along the way. High fertility rates are a direct reflection of poor healthcare infrastructure, education, and decision-making power of women; neither can it be addressed in isolation from food, livelihood, employment and all basic forms of social security. Planners of state population policies must pay attention to the *causes* of high fertility, and address it in ways that are sustainable, democratic and humane.

ANNEXURE II

FIELD PROJECT WORK PROPOSAL

*Without POA timeline & budget

Title : QUALITATIVE STUDY ON THE FERTILITY EXPERIENCE OF WOMEN IN MRS PALYA SLUM

Background :

Fertility rates in south India have significantly declined in the last decade, with all south Indian states either at or below the national TFR target of 2.1 children per family[3]. The decline in fertility has been attributed to various factors, most prominently- a concurrent decline in infant mortality; access to greater economic opportunities for men and women; and the strengthening of the public health and education system.

Our already inadequate health budget however allocates more funding to family planning than more crucial reproductive health services. Access to comprehensive reproductive health services would not only prevent unplanned or unintended pregnancies but would also respond to complications in pregnancy and childbirth by providing emergency obstetric care; safe abortion services and post- abortion care; promote awareness of and treatment for sexually transmitted diseases and reproductive tract infections. Lastly, and equally critical is to address unequal gender relations and sexual and gender-based violence within marriage that affects the reproductive health and well-being of women.

Although family planning programmes largely focus on raising awareness and access to family planning services for women (particularly through integration into the Reproductive and Child Health programme); it is men not women who often decide the adoption or rejection of contraceptive methods. Young women in particular remain powerless in exercising their sexual-reproductive rights to only engage in non-coercive safe sexual practices and prevent unwanted pregnancies.

Aim and objective:

The objective of the study is to understand the factors that influence the fertility experience of women in an urban poor community. The study will assess possible determinants such as awareness of family planning methods; perceptions of those methods; access to services and quality of services; forced or coercive sex within marriage; and socio-cultural pressures on increased fertility and/or son preference.

Study area:

The study will take place in MRS Palya, an urban poor community located in Bangalore. Association for Voluntary Action and Services (AVAS) is an NGO working with the community for over a decade. Their focus has been land and shelter rights for the community, and they have established housing for over 100 families. Dwaraknath Reddy Ramanarpanam Trust (DRRT) has partnered with AVAS in supporting education and income generation efforts as well as financial support for medical treatment.

The majority of the community are originally from Andhra Pradesh but migrated to Bangalore close to two decades ago. Significant livelihoods include domestic work, daily wage labour and corporation contract cleaning and women largely engage in the workforce.

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[3] NFHS 3 data

Methodology:

1. Meeting with the Managing Trustee of AVAS and DRRT to introduce the study and approve of the chosen area
2. Framing the research question
3. Developing research tools
4. Meeting with AVAS staff to explain the study, background and proposed action plan, gather feedback and suggestions
5. Discussion with AVAS community workers to explain study and begin exploring the areas of the study with them, gather opinions, beliefs and trends observed by them. Get suggestions on ways to move forward. Explain the criteria for selecting women for the study
6. Discussion with a group of women who fit the criteria communicating the broad areas of the study and objective, gather feedback
7. Selection of women for in-depth interviews
8. Translation of interview guide
9. Developing the informed consent form and translation
10. Conducting pilot in-depth unstructured interviews with 2 women
11. Refining the interview guide as necessary
12. Conducting interviews with 10 women
13. Transcription of interviews
14. Analysis of data
15. Consolidation into report
16. Writing a research paper to explain the findings
17. Dissemination of findings with participants and AVAS staff
18. Planning appropriate action based on the findings with the AVAS team

Plan of action:

November week 1 & 2

- Finalize research subject area
- Generate research questions
- Meet AVAS & DRRT Managing Trustee, Anita Reddy, to introduce study and approve study area

November week 3 & 4

- Frame research question
- Develop research tools- interview guide
- Define selection criteria of women below the age of 35- recently married with no children, recently married with one child, married with more than one child, married and completed family planning
- Discuss study with AVAS staff and gather feedback
- Discuss study with AVAS community workers and gather feedback
- Make any modifications to study/plan of action based on suggestions by AVAS
- Learn appropriate language use (in Telugu) for subject

December week 1 & 2

- Meet with a group of women who fit the criteria to broadly introduce the study and subject area, gather feedback and suggestions begin consolidating data
- Select women who are willing to participate in in-depth unstructured interviews

- Develop informed consent form and explain to participants
- Conduct pilot interviews with 2 women
- Refine interview guide accordingly

December week 3 & 4

- Conduct in-depth unstructured interviews with 10 women (multiple meetings may be necessary to complete each interview

As a result of these findings, action will be taken to translate the felt need of the women into appropriate interventions e.g. counselling for married couples, life skills workshop for adolescents or raising awareness on reproductive health or GBV. This will be done with AVAS, the NGO working with this community and suitable resource groups.

Plan of Action

- Develop questions for in depth unstructured interviews with women
- Learn appropriate language in Telugu for discussions
- Develop innovative research tools to reduce discomfort when talking about sensitive/private matters (with consultation with Dr. Sundari Ravindran and Dr. Mala)
- Developing the informed voluntary consent form
- Translation of questionnaire and informed consent into local language
- Meeting with AVAS staff to explain the objective of the study
- Re-establishing rapport with local AVAS supporting staff, getting her advice on conducting the study
- Meeting with married women below the age of 35 who are currently or have completed childbearing
- Identifying and selecting 10 women for in-depth interviews
- Pilot interviews with 2 women
- Multiple meetings with each woman to establish rapport and comfort due to the sensitive nature of the study
- In-depth unstructured interviews
- Analysis of data and findings and consolidation into report
- Writing a research paper to explain the findings
- Dissemination of findings with participants and AVAS
- Planning appropriate action based on the findings with the AVAS team-trainings/workshops on reproductive health, various forms of contraception (uses and side effects); mapping of RH services, adolescent life skills training with a focus on SRH; counselling for married couples

Fertility Experience Study
First meeting at MRS Palya on 30/11/09

- Meeting held with AVAS staff Rahath, 2 community workers, Muniamma and Thaiamma, and 1 community health worker, Anjali
- Background and objective of the research study explained
- Prompted their thoughts and opinions at every stage, suggestions on how to take it forward shared
- The four women shared their own experiences of pregnancy, delivery and tubectomy

New trends observed by them-

- Size of families significantly less- two child families largely desired. Largely attributed to the rise in cost of living, women working, needing to earn more to maintain the same standard of living
- 1 child families are also emerging with couples that are better off economically with a very strong desire to give their child the best education
- Son preference has reduced, conversely in couples with only sons want a daughter
- Larger than two child families can be seen when the couple either wants either a son *or* a daughter
- The influence of the older generation- mother in law, over family planning is less. They say women are able to decide over the wishes of the mother in law

Contraceptive adoption

- Oral pill not used
- Copper T has been worked for some women but has led to infections in many others (improper insertion) therefore not used much
- Abortion is still used as a spacing method
- MTP services very poor in government hospitals so women tend to seek abortions more in private hospitals
- Back street abortions are not sought anymore
- Needing the husband's signature to perform a MTP is strongly contested by the community workers, they believe it should be removed
- Hormone patch only heard of recently (through a Marie Stopes workshop) and is not used by any women in the area
- Condoms available at the aganwadi, low usage but available
- Various side effects such as weight gain (even with the copper T) put off women from adopting certain contraceptives
- It was agreed that men still associate the condom with HIV prevention and not pregnancy prevention. If their wives are "good", no need to use condoms with her

Maternal health

- Pregnant women receiving iron and calcium supplements regularly at the aganwadis
- Caesarean sections still performed widely and unnecessarily, women insinuated that it could also be to push tubectomys
- Two types of tubectomys available- few unsuccessful cases with laparoscopic method, the community workers believed the other method was best
- Women go to government hospitals for antenatal check ups but finally deliver at private hospital because the quality of care and treatment of patients is so poor
- Women are abused, not given assistance until birthing begins
- Bribing to show the mother the newly born baby is common with different rates for boy and girl babies
- Some women deliver at government hospitals because the birth certificates in private hospitals is sometimes not valid in schools
- Women are not given the rest they need after a tubectomy and delivery
- After delivery, the mother's nutrition and health suffers greatly due to the superstitions regarding the mother's food intake worsening the new born child health. It common that the mother is given grossly inadequate food and water during the first 10 days after delivery

Other observations

- Violence within marriage common but sexual violence leading to unwanted pregnancy did not seem categorically accepted by the community workers
- Indicated dowry harassment and violence
- Women seem to have negotiating power within marriage; 'forced sex' per se did not strike a cord. Instead they expressed that men have unrealistic expectations of their sex lives based on media representations
- They were keen that I focus on the younger generation- young couples for this study
- Suggested that the first meeting with women be called on the grounds of reproductive health information, or women won't be willing to participate
- Suggested I be very casual in my approach and one on one interaction with them for them to be more at ease speaking about these issues

Fertility Experience Study
Meeting with women in MRS Palya on 07/12/09

My introduction:

- My background with AVAS
- What I'm currently doing in health, my interest area being women's health
- Why women's health is important- time from menarche to childbirth involves many changes to the body. Health is vulnerable. These changes in a woman's life comes with responsibilities and challenges/issues
- Now the norm is smaller families, but who takes these decisions? Husband, mother in law. Does what women think count?
- It is a woman's right to choose when to conceive, how many children to have and when to have them. It is something husbands and wives should discuss and take a joint decision in, but often this is not the case/not possible
- When you go to healthcare providers (govt & pvt) how are you treated? Do they answer questions you have about your pregnancy related health? Do they provide you with useful information?
- This time through marriage, pregnancy and childbearing come with many challenges/issues. If we are able to understand these issues properly from talking to you all, it is possible to help bring about that useful change (TN example of labour room attendant)

Questions and answers during the discussions:

Have vaginal examinations ever been done during antenatal check ups?
Differences between public and private healthcare providers, which did they use
After delivery, have healthcare providers ever pressured you towards sterilization?
What were your experiences during delivery?
How are decisions taken regarding the family?
Post delivery customs and women's nutrition

Women said that vaginal examinations are never done, only physical examinations (to the stomach). However vaccinations are given properly.
In one case high BP was believed to be known but not alerted to the patient and it caused complications later in the pregnancy
Many of them claimed unnecessary caesarean sections were done and they've heard of more. There was a clear belief that women are duped into c-sections to make money.

Some women were very vocal about their disillusionment with the public sector, how corrupt it is and how much they had to spend at every stage to get things done.
One woman went into her experience in great detail.
There were multiple stories about the struggles with the health system during delivery, bad referral systems. Largely women said they were happier with the private sector- one pays but at least the quality is better (settings clean). But overall, all complain that nothing gets done without money, both at the private and public.
Nobody claimed to be pressured about getting sterilizations, however most of the women only had one child so far.
Women said that both men and women want smaller families, and husbands and wives both want only two children, therefore it is a joint decision
Women said they were given very little food and water after delivery but didn't elaborate
Women also said (in an unrelated issue) that they find out very late about their first pregnancy. I was unclear why because they did say they would go for a check up if they missed a period.

Questions directed to specific women-
(To a woman who had completed childbearing) Did you use anything to prevent pregnancy, what have you done now?

(To a currently pregnant woman) How long have you been married? What kind of examination was done for you? (Vaginal?)

The woman said she did not use any method to prevent pregnancy (with a tone that felt like there was no need either) She had a sterilization after her second child.

The woman who was pregnant was married for 4 years. A vaginal examination was not done for this woman, only a physical.

Questions asked to me-
What about the pill, what side effects does it have?
Can you conceive if you've been on it?
What other methods are there?
Aren't they bad for women? Don't they cause problems?

I said the pill suits some woman, doesn't for others. Weight gain, mood swings are possible side effects. Six months after you stop taking it, fertility comes back to normal.

I mentioned IUDs, that they could also have other side effects like heavy bleeding. That sometimes healthcare providers don't explain the benefits and side effects to the user. By then the women had to leave but more than a few agreed to longer one on one discussions.

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